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MAKING THE COMPETITION FOR HEALTH CARE DOLLARS A FAIR FIGHT: THE ROLE OF ANTITRUST LAW IN IMPROVING EFFICIENCY IN THE U.S. HEALTH CARE MARKET

Stephanie A. Alessi[*]

ABSTRACT

In an effort to slow the ever-increasing costs of health care in the United States, the U.S. health policy community has highlighted price transparency as one strategy to give consumers more control over their health care choices. But to empower consumers requires more than just making price information available. In certain markets throughout the country, dominant firms have built up significant market power, which gives them the leverage to effectively neuter any increase in consumer power that would be gained from price transparency. Thus, before a price transparency initiative can be successful, something must be done to break down the market power that stands in the way of consumer choice.

This article argues that antitrust law may provide the enforcement tool, or at least the theoretical approach, to facilitate a real effort toward price transparency. It describes several theories under which an antitrust lawsuit could be alleged, ranging from challenges against most-favored-nation clauses imposed by insurers to unlawful tying arrangements leveraged by dominant hospital networks, and it analyzes the legal and policy implications of these claims. In concluding, this article highlights the best options to address the problems of hidden prices and market inefficiencies in the health care system, arguing that even if antitrust law is not the solution, its rationale and policy justifications should nonetheless support policy efforts to work toward making the price of health care fair, visible, and efficient.

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INTRODUCTION

The U.S. health policy community, in its continual search for tools to slow the ever-increasing costs of health care in the United States, has recently cast its spotlight on the need for transparency in health care pricing.[1] This concern arises out of a growing realization that different hospitals' prices for the same service can vary by thousands of dollars, even for the same patient.[2] Not only do these variations confuse the already-complicated health care payment system, but the existence of such a wide disparity in prices also violates basic U.S. notions of fairness and justice. Price transparency seems to make financial sense for a nation that is always looking for new ways to lower health care costs. The economic argument is simple: If health care consumers—patients—know how much their health services cost, they can choose lower-cost providers and, collectively, demand lower prices across the board. Prominent health economists and policymakers have argued that making prices transparent is an important element of health care reform because it will "allow consumers to plan ahead and choose lower-cost providers."[3] But, in spite of price transparency's apparent promise to make health care prices fair, in practice it may not be as simple a solution as it seems.

In many places across the country, patients cannot respond to price fluctuations according to a straightforward economic model. Other players in the complex health care market—most notably, large insurers and provider networks—often hold substantial amounts of market power and thus can stand in the way of efforts to effectuate meaningful change for patients.[4] The underlying issue is intricately tied up with a lack of transparency, but in many cases hidden prices are only a symptom of the problem rather than a cause. In certain markets where a small number of parties have built up market power, those dominant parties can exercise significant pricing freedom. Because of the convoluted structure of the U.S. health care and health insurance markets, these parties rarely must

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1 *See, e.g.*, Morgan A. Muir, Stephanie A. Alessi, & Jaime S. King, *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WM. & MARY POL'Y REV. 319 (2013).

2 *See, e.g.*, Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699 (2010); Peter Waldman, *Sutter Health's Market Power Is Questioned*, BLOOMBERG BUSINESSWEEK (Aug. 26, 2010), http://www.businessweek.com/magazine/content/10_36/b4193015983853.htm.

3 Ezekiel Emanuel et al., *A Systemic Approach to Containing Healthcare Spending*, 367 NEW ENG. J. MED. 949, 951 (2012), *available at* http://www.nejm.org/doi/full/10.1056/NEJMsb1205901.

4 The complexity of the health care market also contributes to high transaction costs, which make it even more difficult to overcome externalities. *See* Bronwyn Howell, New Zealand Inst. for the Study of Competition & Regulation Inc. & Victoria Mgmt. Sch., *Unveiling 'Invisible Hands': Two-Sided Platforms in Health Care Markets* 4–5 (Mar. 2006).

answer directly to patients for their high prices, and so the lack of counterbalancing market forces enables them to continue to leverage their price-setting power without regard for patient preferences—and often without even making the prices known to patients. As these dominant parties continue to raise prices and earn more money, their power grows, creating a cycle of increasing profits that serves to exacerbate an already-lopsided wealth distribution.[5]

As a result, price transparency may be insufficient—and even counterproductive—to making health care prices fair and affordable. In markets where patients lack market power, making price information public could have the unintended consequence of enabling dominant insurers and/or providers to collude with one another and set prices even higher.[6] Some economists have suggested solving this problem by limiting the information that is made public,[7] but to do so would also limit the information that patients are able to use as the basis of their health care decisions.[8] To respond appropriately to the prices of their health care options in the marketplace, patients need full information about both the price and quality of the care they are to receive.[9] How, then, can the public learn the true value of the health care they pay for while avoiding the risk of facilitating collusion in certain markets?

It has been suggested that the "aggressive enforcement of antitrust laws" can help prevent the problem of collusion.[10] This article applies this suggestion even earlier, before the opportunity to collude arises in the first place, and argues that antitrust law has a role to play in breaking down market power as a necessary precursor to health care price transparency and a tool to increase efficiency in health care markets. Market power is closely linked to hidden prices and other inefficiencies.[11] Thus, by first breaking down dominant parties' market power and then mandating price

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5 *See* Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 851 (2011); *see also* Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 973 (2012) ("Some health care systems, commonly referred to as 'must-have' providers—meaning providers that health plans must include in their networks to attract employers and consumers—have used their clout to raise prices.").

6 David Cutler & Leemore Dafny, *Designing Transparency Systems for Medical Care Practices*, 364 NEW ENG. J. MED. 894, 894 (2011).

7 *See supra.*

8 Muir et al., *supra* note 1, at 325.

9 *See id.* at 323–24.

10 Emanuel et al., *supra* note 3, at 951.

11 Market power is defined as the ability to control prices in the relevant market. *Glossary of Statistical Terms: Market Power*, OECD.ORG, http://stats.oecd.org/glossary/detail.asp?ID=3256 (last updated Mar. 16, 2002); *see also infra* Part I.C.2.

transparency, it may be possible to give patients the leverage to demand prices that are fair, visible, and efficient.[12] This article argues that antitrust law may provide the enforcement tool, or at least the theoretical approach, to facilitate a real effort toward fair and transparent prices.

Part I of this article provides background on federal and state antitrust law. It briefly describes some of the most important U.S. antitrust laws and considers the implications of market definition in the health care industry. Then, Part II examines a current trend in antitrust challenges in the health care industry: most-favored-nation clauses. Ultimately, however, it argues that while such challenges may provide some benefit to consumers, they likely will not be sufficient to bring about fair and transparent prices for patients. Next, Part III explores the various types of tying arrangements—most notably, ties created by large hospital networks—that may give rise to antitrust scrutiny. It analyzes the legal theories that would support such claims and the implications of these various claims from both a legal and a policy standpoint. In concluding, this article highlights the best options to address the problems of hidden prices and market inefficiencies in the health care system, arguing that even if antitrust law is not the solution, its rationale and policy justifications should nonetheless support policy efforts to solve this problem.

I. ANTITRUST LAW AND HEALTH CARE MARKET DEFINITION: A BRIEF OVERVIEW

The antitrust laws were crafted to discourage behaviors that could cause harm to consumers in a competitive market. Importantly, antitrust law focuses on *consumer* welfare, in contrast to activities that may harm a *competitor*.[13] In the health care industry, this means that antitrust law aims to enable patients to respond to price and quality information about health care services in a way that reflects their values. Thus, an antitrust suit in this context would challenge the unreasonable business practices of the dominant parties that keep patients from being able to exercise their preferences and thereby facilitate high prices. This part provides an overview of the federal and state (using California as an illustrative example) antitrust laws under which such a challenge could be brought.

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12 *See* Muir et al., *supra* note 1, at 365.

13 *See, e.g.*, State Oil Co. v. Khan, 522 U.S. 3, 4 (1997). As antitrust scholar Robert Bork explains, the public policy goal of antitrust law is to protect competition, not competitors. *See* ROBERT BORK, THE ANTITRUST PARADOX 51 (1978) ("The only legitimate goal of American antitrust law is the maximization of consumer welfare . . . .").

A. Federal Law

The Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") enforce federal antitrust law on behalf of the United States.[14] Private individuals—usually competitors or consumers—who can show that they have been injured by anticompetitive behavior, can also sue privately for treble damages.[15] To prove the injury necessary to have standing to bring a private antitrust suit, a competitor must show both a tendency of the alleged violation to reduce competition in a certain market and an injury resulting from that decrease in competition—that is, not from another of the defendant's actions that does not violate antitrust law.[16] Even if not yet injured, a plaintiff may seek injunctive relief against the threat of competitive injury.[17]

The Sherman Act is the primary vehicle for U.S. antitrust enforcement,[18] and it provides two theories of antitrust liability: (1) unlawful agreements in restraint of trade and (2) single-firm monopolization or attempted monopolization. By challenging the lawfulness of these business practices, it may be possible to lessen the ability of powerful actors to conceal prices from other parties—including consumers—and to enable both price competition and closer regulatory scrutiny to help reduce their negotiating leverage.[19]

1. Sherman Act § 1—Unlawful Agreements

Section One of the Sherman Act prohibits multiple parties from engaging in a contract, combination, or conspiracy that constitutes an unreasonable restraint of trade.[20] To prove a Section One violation, a plaintiff must establish (1) the existence of a multi-party agreement[21] and

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14 The two agencies share jurisdiction over health care industries, allocating cases under a process known as "clearance."

15 Clayton Act, 15 U.S.C. § 15. The Clayton Act allows a plaintiff to enforce the "antitrust laws," which include the Sherman Act and the Clayton Act, as well as portions of other federal laws. *Id.* § 12.

16 Tennessean Truckstop, Inc. v. NTS, Inc., 875 F.2d 86, 88 (6th Cir. 1989).

17 Clayton Act, 15 U.S.C. § 26.

18 The Federal Trade Commission Act and the Clayton Act also govern U.S. antitrust law. They are not discussed in detail in this article but substantively are largely similar to the Sherman Act. Other laws governing merger analysis are outside the scope of this article.

19 *See* Berenson et al., *supra* note 5, at 979.

20 Sherman Antitrust Act of 1890, 15 U.S.C. § 1.

21 To successfully allege a violation of Section One, it is crucial that there be two parties, because a single party cannot make an agreement with itself. *See* United States v. Colgate & Co., 250 U.S. 300, 307 (1919) ("In the absence of any purpose to create or maintain a monopoly, the [Sherman Act] does not restrict the long recognized right of trader or manufacturer engaged in an entirely private business, freely to exercise his own independent discretion as to parties with whom he will deal. And, of course, he may announce in advance the circumstances under which he will refuse to sell.").

(2) that the agreement is an unreasonable restraint of trade.[22] Types of agreements that are illegal under Section One include those that amount to price fixing, market allocation, output restrictions, or stabilizing prices using non-price controls, as well as other agreements that are found to unreasonably restrain trade.

Although some agreements, such as price fixing among competitors, constitute per se antitrust violations, modern courts generally apply the "rule of reason" to test whether the anticompetitive harm of a particular restraint might be outweighed by pro-competitive benefits.[23] In applying the rule of reason to an alleged violation, "the factfinder weighs all of the circumstances" to determine if the agreement is an unreasonable restraint of trade, looking first to the plaintiff's allegations of anticompetitive harm and then to the defendant's arguments about the pro-competitive benefits that arise from the restraint.[24] Relevant factors in this fact-intensive analysis may include information about the business, the history and nature of the restraint, and the business's market power.[25]

2. Sherman Act § 2—Monopolization and Attempted Monopolization

Section Two of the Sherman Act forbids a party with monopoly power from willfully acquiring or maintaining that power.[26] Simply gaining monopoly power by "skill, foresight and industry," however, does not constitute a violation of antitrust law.[27] Thus, a monopolist does not necessarily violate Section Two if it built up its power by lawful means, but such a firm has a heightened obligation to avoid willfully maintaining its monopoly status.

Section Two also forbids attempted monopolization. Attempted monopolization claims require that the plaintiff prove "(1) that the defendant has engaged in predatory or anticompetitive conduct with (2) a specific intent to monopolize and (3) a dangerous probability of achieving monopoly power," which is measured by the defendant's ability to

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22 For an agreement to be an unreasonable restraint of trade, either the two parties must be competitors or the agreement must directly affect others in the market. In the context of health care, this means that certain agreements between insurers and providers do not constitute unreasonable restraints of trade, because they do not directly impact competition. *See, e.g.*, Royal Drug Co. v. Group Life & Health Ins. Co., 737 F.2d 1433 (5th Cir. 1984).

23 Leegin Creative Leather Prods. v. PSKS, Inc., 551 U.S. 877, 885 (2007).

24 Continental T.V., Inc. v. GTE Sylvania Inc., 433 U.S. 36, 49 (1977).

25 *Leegin*, 551 U.S. at 885 (citing State Oil Co. v. Khan, 522 U.S. 3, 10 (1997); Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984)).

26 Sherman Antitrust Act of 1890, 15 U.S.C. § 2.

27 United States v. Aluminum Co. of Am., 148 F.2d 416, 430 (2d Cir. 1945).

foreclose competition in the relevant market.[28] This analysis requires consideration of the defendant firm's economic power, including a calculation of market share, in the relevant product and geographic markets.[29]

B. State Law: California

In addition to the Sherman Act and other federal laws, state governments can also raise antitrust challenges under state antitrust laws. Because this article focuses on the policy rationales underlying antitrust law—not the intricacies of each individual state's law—it does not attempt to analyze the details of all fifty states' antitrust laws. Rather, it uses California law as an example of how state law can supplement federal law in an antitrust suit. By way of illustration, two California statutes are noteworthy: the Cartwright Act and the Unfair Competition Law.

1. California Cartwright Act

California's primary antitrust law is the Cartwright Act.[30] The Cartwright Act is similar to Section One of the Sherman Act in that it prohibits certain restraints of trade. Unlike the Sherman Act, the Cartwright Act specifies several types of agreements that are unlawful—for example, price fixing, market allocation, and exclusive dealing.[31] Still, it is well established in California case law that the Cartwright Act is modeled after the Sherman Act and therefore, for analytical purposes, federal interpretation of the Sherman Act also applies to the Cartwright Act.[32] Consequently, while this article does not explicitly differentiate between federal and state law in its analysis, the same or similar arguments can be used in either jurisdiction.

2. California Unfair Competition Law

Although the California Unfair Competition Law ("UCL") is not an antitrust law per se, it can be used as a catch-all for anticompetitive behavior that does not necessarily constitute a violation of a specific law but that still causes harm to consumers.[33] The statute defines "unfair competition" as "any unlawful, unfair or fraudulent business act or

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28 Spectrum Sports v. McQuillan, 506 U.S. 447, 456 (1993).

29 *Id.* at 459.

30 *See* CAL. BUS. & PROF. CODE §§ 16720–28.

31 *See id.* §§ 16720, 16727.

32 Marin Cnty. Bd. of Realtors, Inc. v. Palsson, 16 Cal. 3d 920, 925 (1976).

33 *See* CAL. CIV. CODE §§ 17200–10.

practice" and provides a cause of action for injunctive relief, civil penalties, and/or restitutionary damages for engaging in unfair competition.[34] Because the UCL is not limited to "unlawful" practice but also encompasses "unfair" and "fraudulent" acts, it applies to a broader scope of actions beyond just violations of specific antitrust laws.[35] The California Supreme Court has defined unfair competition as "conduct that threatens an incipient violation of an antitrust law, or violates the policy or spirit of one of those laws because its effects are comparable or the same as a violation of the law, or otherwise significantly threatens or harms competition."[36] Therefore, analyzing an allegation of competitive harm under the UCL is largely parallel to the analysis of specific antitrust violations, but it also covers conduct that may not rise to the level of an explicit violation. The UCL thus offers a useful vehicle for challenging acts that harm competition in California, notwithstanding any determinations about liability under the antitrust-specific laws.

C. Market Analysis in the California Health Care Industry

When applying any of these antitrust laws, a critical step in the inquiry is to measure the defendant firm's market power in the relevant market. This requires initial analysis to define the relevant product and geographic markets, followed by an evaluation of the defendant firm's market power therein in order to determine if it is sufficient to control prices. Because of the unique features of the health care market, this can be a difficult task and has in fact proved to be a significant hurdle in some lawsuits.[37] This section considers each of these issues in turn.

1. Defining the Market

To establish whether a party has power in a specific market for purposes of antitrust analysis, it is first necessary to define the relevant product and geographic markets in which the party operates. To do so requires asking: What is the smallest set of products and geographic area in which the party would be able to raise and sustain prices? This section addresses how this question is answered in the health care market.

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34 *See id.* §§ 17200, 17203, 17206, 17206.1.

35 Cel-Tech Commc'ns, Inc. v. L.A. Cellular Tel. Co., 973 P.2d 527, 560–61 (1999); *see also id.* at 563 (stating that acts that have explicitly been deemed lawful are not actionable under the UCL, but those that have neither been deemed lawful nor unlawful may be).

36 *Id.* at 565.

37 *See, e.g.*, Order Granting Motion to Dismiss, Sidibe v. Sutter Health, No. C 12-04854 LB (N.D. Cal. Nov. 7, 2013) (finding that plaintiffs failed to adequately define the relevant markets and dismissing complaint with leave to amend).

a. Product Market

The relevant product market is the group of products that constitute reasonable substitutes for each other. This determination depends on consumers' cross-elasticity of demand: If the price of the product increases, the products with which consumers would replace it are part of the relevant product market.[38] Antitrust plaintiffs generally try to define very specific product markets in order to increase the likelihood that the defendant will be found to be dominant in that small market.

In the hospital industry, however, courts have tended to view the product market broadly, as a single "cluster market" that encompasses all inpatient services, rather than viewing each individual service as a separate product.[39] Some legal scholars have challenged this reliance on cluster markets, arguing that defining hospital services so broadly "obscures high levels of concentration" that would otherwise open dominant parties to antitrust enforcement.[40] But despite these concerns, it is typical for antitrust litigants in the health care industry to allege a product market that includes a broad swath of "inpatient services" without distinguishing between individual services. For example, in the recently filed case *Sidibe v. Sutter Health*, a class action antitrust suit against a large hospital network, the plaintiffs alleged a relevant product market consisting of "Inpatient Hospital Services."[41] The plaintiffs noted: "Although Individual Hospital Services are not substitutes for each other (e.g., obstetrics and cardiac services are not substitutes for each other), the various individual Inpatient Hospital Services can be aggregated for analytic convenience and has so been aggregated by courts, antitrust enforcers, and industry sources . . . ."[42] Thus, notwithstanding the arguments in favor of more specific product market definition, it is a well-established practice in the health care industry to use the cluster market approach to defining the relevant product market as all "inpatient hospital services."

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38 United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 380–81 (1956).

39 Havighurst & Richman, *supra* note 5, at 869 (citing *In re* Hosp. Corp. of Am., 106 F.T.C. 455 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986)). Havighurst and Richman go on to cite Ian Ayres, *Rationalizing Antitrust Cluster Markets*, 95 YALE L.J. 109 (1985), for the proposition that "the cluster-market approach may be justified where goods or services are in some way complementary in production, consumption, or distribution." Havighurst & Richman, *supra* note 5, at 869 n.63. This is especially relevant for analyzing tying claims. *See infra* Part III.A.

40 Havighurst & Richman, *supra* note 5, at 869.

41 Third Amended Complaint and Demand for Jury Trial, Sidibe v. Sutter Health, No. 3:12-cv-4854-LB, at 12 (N.D. Cal. Dec. 9, 2013).

42 *Id.* The plaintiffs specifically excluded from the product market military or veterans' hospitals, same-day outpatient services, and "psychiatric, substance abuse, and rehabilitation services." *Id.*

b. Geographic Market

The geographic market is defined by where the seller operates and where consumers look to purchase the product.[43] In the case of a hospital, the boundaries of the geographic market depend not only on the hospital's service area, but also on the existence of barriers to entry for competitors and on consumers' ability to switch to other hospitals.[44] How the party itself defines the geographic market may also be relevant. The California Health and Safety Code, for instance, requires that all health plans identify their prospective enrollees' general geographic areas and report the providers available therein.[45] Other measures define geographic areas by using geo-political boundaries, such as by combining zip codes. For example, using the "Geozip" method, the San Francisco area would include all zip codes beginning with 941.[46]

In merger cases, market definition is generally established with the "hypothetical monopolist" test. The hypothetical monopolist test asks what the smallest possible set of products and geographic area is in which a profit-maximizing firm with no competition could sustain a "small but significant and non-transitory" price increase.[47] Essentially, this test asks whether the merger creates a danger that the firm could get away with anticompetitive behavior—that is, whether the merger would give it enough power to be able to raise prices at its whim, without losing

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43 Tampa Elec. Co. v. Nashville Coal Co., 365 U.S. 320, 327 (1961) ("[T]he area of effective competition in the known line of commerce must be charted by careful selection of the market area in which the seller operates, and to which the purchaser can practicably turn for supplies. In short, the threatened foreclosure of competition must be in relation to the market affected.").

44 Drs. Steuer & Latham, P.A. v. Nat'l Med. Enters., 672 F. Supp. 1489, 1511 (D. S.C. 1987) ("Because we are concerned only with an area in which competition could be harmed, the relevant geographic market must be broad enough that buyers would be unable to switch to alternative sellers in sufficient numbers to defeat an exercise of market power by firms in the area." (quoting Matter of Hosp. Corp. of Am., 106 F.T.C. 361, 466 (1995), *aff'd*, Hosp. Corp. of Am. v. F.T.C., 807 F.2d 1381, *cert. denied*, 481 U.S. 1038 (1987)). Recent antitrust history, however, has tended to overestimate the size of geographic markets in hospital merger analyses. Thomas L. Greaney, *Statement Before the Committee on the Judiciary United States House of Representatives Subcommittee on Intellectual Property, Competition, and the Internet on "Health Care Consolidation and Competition After PPACA"* 4 (May 18, 2012), *available at* http://judiciary.house.gov/_files/hearings/Hearings%202012/Greaney%2005182012.pdf; *see also* FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, ch. 4, at 6 (July 2004) [hereinafter IMPROVING HEALTH CARE] (recognizing consistent criticism that the Elzinga-Hogarty test should not be the only basis for defining the geographic market).

45 CAL. HEALTH & SAFETY CODE § 1367.26(a)(1).

46 *See, e.g.*, Ingenix, *Benchmark Products Presentation* (Apr. 2005), *available at* http://www.dmhc.ca.gov/aboutthedmhc/org/boards/fssb/notes/050419ipp.pdf. Ingenix (now known as OptumInsight) performs efficiency analyses for health care actors and government agencies; it has evaluated California's health care market and separated the state into twenty-eight different geographic areas based on its "Geozip" coding system. *See id.* at 10; *see also* OptumInsight, *Government: Improve Health Outcomes, Reduce Costs and Increase Efficiency*, http://www.optuminsight.com/government.html (last visited Apr. 14, 2014).

47 IMPROVING HEALTH CARE, *supra* note 44, ch. 6, at 4

customers. In hospital mergers specifically, courts use the "Elzinga-Hogarty" test to define the hospital's geographic market. The Elzinga-Hogarty test considers evidence of how many patients leave or enter a specific area for hospital services:[48]

> [I]f the patient flow data show large numbers of patients coming into or going out of the area for inpatient hospital care, then the geographic market is hypothesized to be broader than originally thought . . . . A geographic market definition is usually described as 'strong' if less than 10 percent of discharged patients from the merging hospitals' area come into or out of the area.[49]

Critics of this methodology, however, point out that patient migration does not necessarily mean that a patient "would respond to a small price increase by using hospitals outside of the merging hospitals' core geographic area," because it ignores the many other reasons a patient might travel for health care services.[50] That is to say, this kind of data does not show how patients would react to an increase in price and therefore does not prove anything about the substitutability of hospitals.[51] In fact, empirical studies have shown that most patients do not "view distant hospitals as close substitutes for most services," but rather that those individuals that do travel have "distinct reasons" for doing so and thus do not "inhibit merging local hospitals from increasing prices substantially."[52] Therefore, in spite of the existence of a number of measures for defining a hospital's relevant geographic market, it is questionable whether these methods provide a fully accurate picture of those markets. Instead, these tests represent a crude attempt to apply market analysis to an industry that does not behave like a typical economic market. As a result, even if an antitrust lawsuit is supported by economic evidence about anticompetitive behavior in the health care marketplace, it may be difficult to establish liability due to the industry's lack of accurate market measures.

In a complaint recently filed in the Northern District of California, defining the geographic market has been an early center of contention. In *Sidibe v. Sutter Health*, after the court dismissed an earlier complaint for a

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48 *Id.* ch. 4, at 7–8.

49 *Id.* ch. 4, at 8.

50 *Id.* (citing reasons such as "perceived and actual variations in quality, insurance coverage, out-of-pocket cost, sophistication of services, and family connections").

51 *Id.*

52 *Id.* ch. 4, at 9 (quoting CORY CAPPS ET AL., THE SILENT MAJORITY FALLACY OF THE ELZINGA-HOGARTY CRITERIA: A CRITIQUE AND NEW APPROACH TO ANALYZING HOSPITAL MERGERS 1 (Nat'l Bureau of Econ. Research, Working Paper No. w8216, 2001)).

failure to identify specific local geographic markets,[53] the plaintiffs amended their complaint to allege fourteen specific hospital service areas in Northern California as defined by the Dartmouth Atlas of Health Care.[54] The Dartmouth Atlas, a "well-established industry authority," defines health service areas as "a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area."[55] This definition, the plaintiffs argued, also comports with the requirements of the California Knox-Keene Act regarding the geographic reach of hospitals covered by health plans.[56] They further alleged six somewhat-broader "Metropolitan Statistical Areas," as defined by the Office of Management and Budget's analysis of census data, as relevant geographic markets for the sale of health plans.[57] If the court accepts these data-backed methods of geographic market definition, it could establish these tools as standard measurements of health care market size and facilitate future antitrust challenges. Moreover, in the immediate case, this could finally open the door for a substantive argument about the legality of the defendant's alleged unlawful business practices.

2. Measuring Market Power

Once a plaintiff has crossed the not-insignificant hurdle of defining the relevant market, the question arises whether the defendant has market power. That is, does the defendant have the ability to control prices in the relevant market as it has been defined? A party's market share provides a useful starting point to measure market power. However, market share rarely offers a complete picture of a firm's actual ability to control prices. Circumstantial factors such as barriers to entry and the ability of competitors to increase output in the short run also prove crucial to measuring market power.

In the California health care market, for instance, looking only at percentage market share often significantly underestimates a party's actual market power. This is due to a number of factors, including regulatory barriers to entry such as those controlled by the Department of Managed Health Care, as well as the inclusion of Kaiser Permanente's hospitals in market share analysis despite the fact that these facilities are only

53 Order Granting Motion to Dismiss, Sidibe v. Sutter Health, No. C 12-04854 LB, at 17–18 (N.D. Cal. Nov. 7, 2013).

54 Third Amended Complaint and Demand for Jury Trial, Sidibe v. Sutter Health, No. 3:12-cv-4854-LB, at 7 (N.D. Cal. Dec. 9, 2013).

55 *Id.*

56 *Id.* at 13–14.

57 *Id.* at 20–24.

accessible to Kaiser plan members.[58] Moreover, certain hospitals enjoy significant consumer demand due to their reputation or their ability to provide specialized services. This heightened demand, while not necessarily reflected in a straightforward market share analysis, often provides enough leverage so that it is implausible for insurers to threaten exclusion during health plan contract negotiations.[59] Therefore, an analysis of market power must consider not only market share, but also the whole ecosystem in which a party operates: the presence and qualities of competitors, regulatory and market barriers to entry, actual prices charged, leverage due to economic and non-economic factors alike, and the overall economic impact of the party in question on competition.

By identifying those parties that have substantial amounts of market power—not just high percentages of market share—and challenging any anticompetitive behaviors in which they are engaging, it may be possible to realign the health care market to give consumers leverage to demand the services they need at fair prices. In an effort to discern the link between increased health care prices and market power, the California Attorney General's office has recently been examining health care consolidation practices and "probing whether mergers of hospitals and doctor groups are pushing up prices."[60] This attention puts a spotlight on issues including "hospital systems' reimbursement from . . . insurers" and "whether the systems' tie-ups with physicians, as well as ownership of hospitals, have given them the market power to boost prices in a way that violates antitrust law."[61] However, hospital leverage is driven by many factors, not just consolidation.[62] Thus, instead of waiting for the threat of consolidation, these enforcement efforts should be aimed at *all* restrictive practices in

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58 Letter from Blue Shield of California to Federal Trade Commission dated May 27, 2011, at 3. Blue Shield explains some of these factors in a section of its letter to the FTC titled "Need for Stricter Market Share Screens":

[M]arket shares of providers located in areas near Kaiser facilities are understated because Kaiser's large network is included when their market shares are calculated even though the Kaiser facilities are not available to competing payers. In addition, health plans must obtain advance permission from the Department of Managed Health Care to transfer members from a provider that is being removed from a network. These providers often insist, and sometimes persuade the Department, that alternative providers are not adequate substitutes, leaving the health plan with no choice but to negotiate with the incumbent provider who has been given significant leverage.

Id. Blue Cross also describes hospital systems' practices of negotiating on an "all-or-nothing" basis as contributing to certain providers' market power, despite having "shares well below the 30 percent primary service area" threshold set by the FTC. *Id.*

59 Berenson et al., *supra* note 2, at 702.

60 Anna Wilde Mathews, *Doctor, Hospital Deals Probed*, WALL ST. J., Sept. 14, 2012, at B1.

61 *Id.*

62 Berenson et al., *supra* note 5, at 975.

order to more effectively prevent and correct for the continued aggregation of market power among dominant parties.

In particular, the negotiation process between providers and insurers, though often hidden from the public eye, is a crucial point at which powerful parties can leverage their power to artificially raise prices. Because it is all but invisible to health care consumers, it creates an opportunity for anticompetitive behavior to transpire. The resulting contracts may include provisions that either directly make accurate price information about services unavailable or indirectly contribute to powerful parties' maintenance of their market power by protecting their position in the market. The next two parts elaborate on several ways in which antitrust law can address the inefficiencies created during this process.

II. HEALTH INSURANCE CONTRACT PROVISIONS: UNREASONABLE RESTRAINTS OF TRADE

In negotiations for health plan contracts, powerful parties sometimes seek to include contractual language that preserves their dominance. Under Section One of the Sherman Act, some of these terms in contracts between insurers and providers may rise to the level of being anticompetitive. Because insurers and providers do not compete with each other, however, it can be difficult to prove that agreements between the two, which otherwise might appear to restrain trade under Section One, cause harm to competition instead of simply being smart business tactics.[63] As such, the terms that pose potential antitrust issues are those that affect the prices that competitors of the agreeing parties can set.[64] That is, if a transaction between a provider and an insurer depends on the "specifics of a different buyer-seller relationship involving at least one of the same parties," or if either party needs to "know the details of a rival's contract" to determine the final price or terms of the contract, the clause is potentially anticompetitive.[65]

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63 *See* Royal Drug Co. v. Group Life & Health Ins. Co., 737 F.2d 1433 (5th Cir. 1984) (finding no horizontal restraint of trade in an agreement between an insurer and pharmacies, despite the appearance of collusion between the pharmacies as a result of the insurer-pharmacy agreements). In *Royal Drug*, the court rejected the plaintiffs' argument that the insurer, "by engaging in procompetitive conduct in the insurance business, . . . bec[a]me a price-fixer in the retail drug business because its method of competition [sought] to bring its customers the maximum insurance reimbursement." *Id.* at 1438. Rather, the court found that the insurer and the pharmacies "sit on opposite sides of the bargaining table. Absent any evidence of the presence and abuse of monopoly power, [the insurer] has the clear right to bargain for the lowest price and best deal for itself and its customers/insureds." *Id.*

64 *See* Jonathan M. Jacobson & Daniel P. Weick, *Contracts That Reference Rivals as an Antitrust Category*, THE ANTITRUST SOURCE (Apr. 2012), http://www.wsgr.com/publications/PDFSearch/jacobson-0412.pdf.

65 FIONA SCOTT-MORTON, DOJ, CONTRACTS THAT REFERENCE RIVALS 3 (Apr. 5, 2012), *available at*

Perhaps the most notable of these contract provisions is the most-favored nation ("MFN") clause. MFN clauses, a form of payment parity agreement, guarantee insurers that they are receiving a provider's best rates and limit the prices that providers can charge to other insurers—a practice that opens the door to the possibility of antitrust liability. MFN clauses allow insurers to pay certain providers higher rates "in return for the hospitals' charging competing plans even higher rates, potentially raising prices for everyone."[66] As prices rise, consumers suffer a competitive harm in the form of higher prices that they would not have paid if not for the provision. In addition, the provider loses any incentive it might have had to offer lower prices, because it must offer that same low price to all insurers. The result is an increased equilibrium price.[67] MFN clauses therefore not only force higher prices upon consumers, but they also reduce any incentive to make prices transparent, which, in many cases, exacerbates the harm to consumers.[68] Where this harm can be shown, antitrust law may offer a remedy.

In Massachusetts, the state Attorney General has argued that MFN clauses have the potential to harm competition by locking in payment levels, thwarting innovation, and preventing price competition.[69] The Massachusetts Attorney General's report describes how these contracts can harm competition:

> Parity clauses may decrease competition among providers by reducing their incentive to offer lower prices to insurers. Likewise, parity clauses may reduce insurers' incentive to bargain with providers, since rival insurance companies with parity provisions would obtain any price savings. Parity clauses may also deter entry to the marketplace since any discount would have to be passed on to insurers already in the market. . . . [T]hese agreements may have the net effect of allowing insurers to increase payment to providers without concern that they will be at a competitive disadvantage to other insurers.[70]

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http://www.justice.gov/atr/public/speeches/281965.pdf.

66 Berenson et al., *supra* note 5, at 978.

67 *See* SCOTT-MORTON, *supra* note 65, at 12.

68 *See* Muir et al., *supra* note 1, at 359.

69 OFFICE OF MASS. ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L.C. 118G, § 6½(b), at 40–41 (2010), *available at* http://www.mass.gov/ago/docs/
healthcare/2010-hcctd.pdf.

70 *Id.* at 41; *see also* SCOTT-MORTON, *supra* note 65, at 12–13.

Applying a rule of reason analysis, if these competitive harms are not outweighed by counterbalancing pro-competitive effects, the use of an MFN clause to unfairly raise prices would lay the groundwork for a strong argument that this practice constitutes an unreasonable restraint of trade under Section One of the Sherman Act or under a comparable state statute.

Recently, the DOJ challenged Blue Cross Blue Shield of Michigan's use of MFN clauses on this theory, alleging that it has reduced competition in the market.[71] Aetna subsequently brought a private suit alleging that it was harmed by the reduction of market competition,[72] which was followed by a consumer class action seeking "overcharges paid by purchasers of Hospital Healthcare Services directly to hospitals in Michigan that resulted from the anticompetitive acts of Blue Cross."[73] In the class action, the plaintiffs describe how they have been harmed by the MFN scheme as follows:

> In exchange for the MFNs, Blue Cross agreed to pay higher hospital charges to many hospitals throughout Michigan. Instead of using its market position as Michigan's largest commercial health insurer to negotiate against a hospital's proposed price increases, Blue Cross accepted these increases as a means to secure the MFN provisions. . . . As a result of this anticompetitive scheme, prices for Hospital Healthcare Services in Michigan rose, and members of the Class of direct purchasers . . . paid artificially inflated prices.[74]

Although all three lawsuits survived the defendant's initial motions to dismiss,[75] on March 25, 2013, a week after the enactment of a Michigan law prohibiting MFNs in contracts between health insurers and providers, the DOJ and Blue Cross filed a joint motion to dismiss the DOJ's case.[76]

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71 United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. 2011) (denying defendant's motion to dismiss). According to the DOJ's complaint, Blue Cross Blue Shield dominates the Michigan insurance market with anywhere from 40% to 80% market share across different geographic areas. *See* Complaint, United States v. Blue Cross Blue Shield of Mich., No.2:10-cv-14155-DPH-MKM, at 13 & 28. (E.D. Mich. Oct. 18, 2010).

72 Aetna Inc. v. Blue Cross Blue Shield of Mich., 2012-1 Trade Cas. (CCH) ¶ 77,937, U.S. Dist. LEXIS 82621 (E.D. Mich. June 14, 2012) (denying defendant's motion to dismiss).

73 The Shane Group, Inc. v. Blue Cross Blue Shield of Mich., 2012-2 Trade Cas. (CCH) ¶ 78,156, ¶ 125,625, No. 10-14360, 2012 U.S. Dist. LEXIS 170201 (E.D. Mich. Nov. 30, 2012) (denying defendant's motion to dismiss).

74 *Id.* ¶ 125,625–26.

75 To survive a motion to dismiss, an antitrust complaint must allege enough facts so that the court will find the claim plausible and "raise a reasonable expectation" that, in the course of the lawsuit, evidence of an unlawful agreement will be uncovered. Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 556 (2007).

76 Press Release, Dep't of Justice Office of Public Affairs, Justice Department Files Motion to Dismiss

The state law, which was set to go into effect on January 1, 2014,[77] in combination with a February 2013 order from the Michigan Insurance Commissioner making MFNs in health insurance contracts unenforceable, rendered "the injunctive relief sought by the DOJ and State of Michigan . . . unnecessary."[78] The private suits, however, are still proceeding through discovery as of the date of this writing. To prevail, the plaintiffs will eventually need to prove that any alleged pro-competitive benefits of the MFN clauses outweigh the anticompetitive aspects thereof.

Other types of contractual provisions might also make providers or insurers susceptible to antitrust liability if they harm consumers. For example, a firm that uses its market power to demand exclusionary discounts has the potential to impact competition and therefore can lead to antitrust liability.[79] As with MFN clauses, courts will carefully analyze these contractual provisions to determine if their pro-competitive impact outweighs their anticompetitive effect. Where a provision's anticompetitive impact is greater than its benefits, it may be viewed as an unreasonable restraint of trade that will be subject to antitrust enforcement.

Many antitrust cases based on contractual provisions end in consent decrees enjoining enforcement of the terms in question rather than threatening offenders with treble damages.[80] This threat, therefore, may not be a sufficient incentive to lead to any measurable change. Regulatory measures forbidding such clauses, like the one recently enacted in Michigan, may be equally effective as, and less costly than, litigation that can drag on for years. Thus, although antitrust law offers a potentially useful legal tool to end anticompetitive contract terms, regulatory change may be the preferable approach in these cases.

Antitrust Lawsuit Against Blue Cross Blue Shield of Michigan After Michigan Passes Law to Prohibit Health Insurers from Using Most Favored Nation Clauses in Provider Contracts (Mar. 25, 2013), http://www.justice.gov/opa/pr/2013/March/13-at-345.html.

77 *Id.*

78 Press Release, Blue Cross Blue Shield Blue Care Network, Blue Cross Blue Shield of Michigan, U.S. Department of Justice and State of Michigan Jointly File to Dismiss Antitrust Case (Mar. 25, 2013), http://www.bcbsm.com/content/microsites/blue-cross-blue-shield-of-michigan-news/en/index/news-releases/2013/march-2013/bcbsm-doj-dismiss-antitrust.html.

79 United States v. United Regional Health Care System, Case No. 7:11-cv-0030-O, at 5 (Sept. 29, 2011) (final judgment prohibiting exclusionary conduct).

80 Jacobson & Weick, *supra* note 64, at 3–4 (citing United States v. Or. Dental Serv., No. C95-1211 FMS, 1995 U.S. Dist. LEXIS 21042 (N.D. Cal. July 17, 1995); RxCare of Tenn., Inc., 121 F.T.C. 762 (1996)). A consent decree is simply a stipulation by the offending party that it will cease its illegal conduct, in exchange for withdrawal of the lawsuit.

III. LINKED HEALTH CARE SERVICES: UNLAWFUL TIES, (ATTEMPTED) MONOPOLIZATION, AND UNFAIR COMPETITION

Contract language, of course, is not the only place where potential antitrust violations can arise. Enforcers should also look to parties' behavior for evidence of unfair business practices. Specifically, this part considers the application of antitrust law to the unreasonable use of leverage during contract negotiations. In certain areas, hospital networks—especially those that include hospitals that dominate particular markets—have significant negotiating power over even the most dominant insurers.[81] When networks actively seek to increase the leverage they already have by engaging in anticompetitive practices such as linking hospitals in distinct geographic locations or bundling unrelated services without legitimate business justifications, they artificially inflate prices and contribute to the inefficient market conditions that make health care so unaffordable for many consumers. These practices allow hospital networks to condition an insurance contract within one product or geographic market on the purchase of services in a separate market, and consequently they at least raise the question of legality under the antitrust laws. This part describes several potential antitrust challenges to address these practices under the laws of unlawful tying, monopolization or attempted monopolization, and unfair competition.

A. Unlawful Tying

One way to challenge these behaviors is as examples of unlawful tying under Section One of the Sherman Act. A tie is prohibited when a company uses its market power in one product to coerce the purchase of a second, separate product.[82] An unlawful tie exists when there are (1) two separate products involved, (2) a tie requiring the purchase of the tied product as a condition of buying the tying product, (3) sufficient market power in the tying product to make the coercion possible, and (4) a not insubstantial effect on interstate commerce in the tied product's market.[83] For example, if a supermarket sold flour to customers only if they also bought sugar, that would clearly satisfy the first two elements: (1) flour

81 Berenson et al., *supra* note 5, at 974. "[A] leading form of consolidation is the multihospital system extending across large geographic areas, which in most cases does not lead to antitrust scrutiny. *Id.* at 978–79.

82 Times-Picayune Publ'g Co. v. United States, 345 U.S. 594, 605 (1953).

83 IMPROVING HEALTH CARE, *supra* note 44, ch. 4, at 40; *see also* Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451 (1992); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984).

and sugar are two separate products, and (2) the purchase of sugar (the tied product) is a condition of the purchase of flour (the tying product). However, a plaintiff must also show that the store has (3) sufficient market power in flour, and that the tie creates (4) a significant impact on the sugar market to establish that the tie is an unreasonable and unlawful restraint. If such a tie is present, it can be challenged by either a purchaser who has been forced to buy the tied product or a competitor who has been prevented from competing in the tied product's market as a result of the illegal tie.[84]

Most cases, however, are not as cut-and-dry as the example of flour and sugar. Each element requires careful consideration. Courts analyze the first element using the separate products test, which asks whether there is sufficient consumer demand for each of the two products such that a supplier would provide each product separately.[85] The second and third elements require a factual determination of the presence of market power and its use to coerce the purchase of the tied product. These elements measure to what extent the seller had and exploited its dominance "to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms."[86] Finally, to determine whether there was a serious enough effect on interstate commerce to satisfy the fourth element, the plaintiff must allege evidence showing the foreclosure of a substantial amount of competition.[87] All four of these elements must be met in order for a court to hold a party liable for unlawful tying.

Moreover, modern courts tend to analyze the market realities using the rule of reason to determine if the tie might be pro-competitive, because a tie may be an effective and efficient means of competition and therefore "entirely consistent with the Sherman Act."[88] That is, the party challenging the tie must demonstrate that the arrangement aims to foreclose competition in the tied market and that it is not outweighed by pro-competitive benefits. This approach recognizes the distinction between engaging in legal business practices to maximize return on the tying product and actually imposing restraints that insulate a "potentially inferior

84 Abraham v. Intermountain Health Care Inc., 461 F.3d 1249, 1266 n.10 (10th Cir. 2006).

85 *Jefferson Parish*, 466 U.S. at 21–22.

86 *Id.* at 12.

87 Gordon v. Lewiston Hosp., 272 F. Supp. 2d 393, 447 (M.D. Pa. 2003), *aff'd*, 423 F.3d 184 (3d Cir. 2005) (affirming dismissal in part because plaintiff "failed to present any evidence regarding either the patient volume effect or the dollar volume of business that has been affected by the tied market").

88 *Jefferson Parish*, 466 U.S. at 12.

product" from competition.[89] For example, there is economic evidence that integrating or bundling health care services can sometimes be efficient, so courts analyze factors such as whether there is a business justification for the tie or whether there is a less restrictive alternative.[90] Only after considering these arguments will a court find a tying arrangement unlawful. This section analyzes to what extent hospital networks' negotiation tactics satisfy the elements of an unlawful tie and whether any justifications exist for those business practices.

1. Geographic Tying

One application of antitrust law's prohibition against tying is on the link between hospital services in one geographic market where the hospital has market power (the tying product) to its services in a second market (the tied product). Insurance company Blue Shield points out that "an increasing number of provider networks in multiple geographic areas in California have insisted Blue Shield contract with them on an 'all-or-nothing' basis—meaning that Blue Shield must contract with their providers in every geographic location or none at all."[91] Blue Shield argues that this harms competition by allowing the provider network to increase rates and impose non-price requirements that prevent cost-containment and price transparency.[92] Similarly, the Massachusetts Special Commission on Provider Price Reform has recommended prohibiting "any contracting practices that require insurers to contract with all provider locations for a multi-location provider, rather than contracting only with the individual provider locations with which an insurer may wish to contract," as well as "any contracting practices that require payers to pay the same or similar prices to all provider locations for a multi-location health care provider where geographic differences in the provider's site do not support charging the same or similar prices."[93] To date, no plaintiff has won a lawsuit alleging this behavior as a violation of antitrust law.[94] However, to the extent that it falls under the authority of

89 *Id.* at 14.

90 IMPROVING HEALTH CARE, *supra* note 44, ch. 3, at 39–40; Berenson et al., *supra* note 5, at 977; Mathews, *supra* note 60, at B1.

91 Letter from Blue Shield of California to Federal Trade Commission dated May 27, 2011, *supra* note 58, at 3.

92 *Id.* at 4.

93 Mass. Exec. Office of Health & Human Servs., RECOMMENDATIONS OF THE SPECIAL COMMISSION ON PROVIDER PRICE REFORM 25 (Nov. 9, 2011). The Special Commission is made of members including public health officers, legislators on health committees, officers of insurance and hospital organizations, and health economists. *Id.* at i.

94 This track record may change, however, depending on the outcome of the class action *Sidibe v. Sutter Health*. *See* Third Amended Complaint and Demand for Jury Trial, Sidibe v. Sutter Health, No. 3:12-cv-

the antitrust laws, courts should recognize geographic tying as a practice that harms competition.

Importantly, hospital networks that take advantage of their leverage to raise prices are distinct from the provider networks created under the Affordable Care Act known as Accountable Care Organizations ("ACOs"). ACOs aim to coordinate care between providers and thereby increase efficiency on a systematic level.[95] Some economists, however, have expressed concerns that the increasing numbers of ACOs could encourage consolidation and give the resulting organizations leverage to "drive up health costs and limit patient choice."[96] Recognizing this possibility, the DOJ and the FTC issued an antitrust enforcement policy to guide the application of antitrust law to ACOs.[97] The policy statement clarifies that the rule of reason will be used to analyze "[j]oint price agreements among competing health care providers . . . if the providers are financially or clinically integrated and the agreement is reasonably necessary to accomplish the procompetitive benefits of the integration."[98] Specifically, it notes that ACOs that meet the eligibility requirements put forth by the Centers for Medicare and Medicaid ("CMS") are "reasonably likely to be bona fide arrangements intended to improve the quality, and reduce the costs, of providing medical and other health care services through their participants' joint efforts."[99] Thus, although some ACOs may still give rise to concerns about consolidation, those that meet CMS criteria are outside the scope of this article, both because of their likely pro-competitive benefits and because of the antitrust agencies' explicit policy statement.

Therefore, the geographic tying claims described in this section apply only to networks of hospitals that cause actual economic harm. To warrant a finding of liability, each element of an unlawful tie must be present. This means that a court must (1) be willing to view the same health service offered in the two geographic markets as separate products that may be

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4854-LB (N.D. Cal. Dec. 9, 2013).

95 Jenny Gold, *FAQ on ACOs: Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Aug. 23, 2013), http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx.

96 *Id.*

97 "The Agencies recognize that not all such ACOs are likely to benefit consumers, and under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality of care." Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, at 3, *available at* http://www.justice.gov/atr/public/health_care/276458.pdf.

98 *Id.* at 4. The DOJ and FTC have specified the standards for financial and clinical and integration elsewhere in a range of statements and opinions.

99 *Id.* at 5.

tied together, (2) find evidence of a coercive tie, (3) find market power in the tying market, and (4) determine that the alleged anticompetitive harms create a substantial amount of harm in the secondary market and are neither legal business tactics nor outweighed by pro-competitive effects. Proving each of these elements will be a challenge and will require significant economic and legal analysis.

The first element may be the most difficult to prove. If two separate geographic regions attract entirely different groups of consumers, with very few patients traveling to the other location, it seems apparent that health services in each region constitute distinct products—an argument that aligns with the general justifications for prohibiting tying.[100] Still, the case law is unclear as to whether an unlawful tie can exist where the two products constitute the same services but in different geographic markets. In *Jefferson Parish*, a seminal tying case, the Court wrote that it "follows from the underlying rationale of the rule against tying" that "two distinguishable product markets" must be involved.[101] This definition does not clarify whether the differentiation between product markets can include geographic distinctions, and courts have not directly addressed this question in the context of tying. Furthermore, it is possible that a court might view a hospital network's geographic market as a single, broad market—perhaps covering the entire State of California or even the entire United States—if the hospital proves that a broad market "reflects the reality of the way in which [it] built and conduct[s] [its] business."[102] In spite of each hospital's local activities, if the network is viewed as operating on a larger scale, courts may see it as a single entity, simply negotiating to get the best deals possible and therefore not engaging in unlawful tying.[103] Nonetheless, if there is economic proof of distinct consumer demand for each geographic market—which may exist as employers putting together a health plan often demand providers within a specific geographic region—there is an argument that that should be sufficient to prove the existence of two separate, tie-able products under the separate products test.[104]

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100 Tying arrangements are forbidden because "[t]hey deny competitors free access to the market for the tied product . . . . [and] buyers are forced to forego their free choice between competing products." N. Pac. Ry. Co. v. United States, 356 U.S. 1, 6 (1958).

101 Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 21 (1984).

102 United States v. Grinnell Corp., 384 U.S. 563, 576 (1966).

103 *See id.* at 575. In *Grinnell*, the Court found that an accredited central station service operated in a national geographic market because its planning, inspection, certification, rate-making, pricing, and terms were all set on a national level—despite the fact that "rates may be varied to meet local conditions." *Id.*

104 *See Jefferson Parish*, 466 U.S. at 21–22.

The Supreme Court has found similar—though not entirely analogous—situations to be violations of antitrust law. In *United States v. Griffith*, four affiliated movie theater companies vastly increased their market share over a period of five years in the late 1930s, seeing an increase from having theaters in 37 towns—57% of which had only a single theater and thus no competition—to 85 towns—62% of which were without competition.[105] The corporations faced allegations that they had used their market power in the closed markets (that is, those without competition) to gain exclusive privileges from movie distributors in other markets.[106] The Court found that this behavior violated antitrust law, but it did so under the (presently disfavored) theory of monopoly leveraging rather than under a theory of unlawful tying.[107] This was likely due to the fact that the companies did not appear to have threatened not to deal with the distributors in the towns where they had a monopoly subject to their dealing with them in the competitive markets. Nonetheless, the Court's reasoning is useful:

> A man with a monopoly of theatres in any one town commands the entrance for all films into that area. If he uses that strategic position to acquire exclusive privileges in a city where he has competitors, he is employing his monopoly power as a trade weapon against his competitors. It may be a feeble, ineffective weapon where he has only one closed or monopoly town. But as those towns increase in number throughout a region, his monopoly power in them may be used with crushing effect on competitors in other places. . . . When the buying power of the entire circuit is used to negotiate films for his competitive as well as his closed towns, he is using monopoly power to expand his empire.
>
> The consequence of such a use of monopoly power is that films are licensed on a non-competitive basis in what would otherwise be competitive situations. That is the effect whether one exhibitor makes the bargain with the distributor or whether two or more exhibitors lump together their buying power, as appellees did here.[108]

105 United States v. Griffith, 334 U.S. 100, 101–02 (1948).
106 *Id.* at 103–04.
107 *See infra* notes 154–156 and accompanying text (discussing the monopoly leveraging theory).
108 *Griffith*, 334 U.S. at 107–08.

The Court went on to note that, though "[l]arge-scale buying" is not unlawful per se because of the potential efficiencies it can create, such conduct for the purpose of either monopolization or "stifl[ing] competition by denying competitors less favorably situated access to the market" is unlawful.[109] This indicates that, despite finding liability under Section Two of the Sherman Act in *Griffith*, the Court might be willing to view similar conduct as a restraint of trade under Section One.[110]

However, another well-known tying case, *Times-Picayune Publishing Co. v. United States*, provides an argument that two distinct markets for the same hospital network's services may not be separate products because they belong to the same network. In that case, the Court found that a morning and evening newspaper constituted the same product in the eyes of advertisers; despite the fact that "readers consciously distinguished between these two publications," the advertisers did not differentiate between the customers but rather generally sought to increase their customer coverage by advertising in both newspapers.[111] Thus, because "two newspapers under single ownership at the same place, time, and terms [sold] indistinguishable products to advertisers," there were no separate tying and tied products.[112] Even if different *readers* might purchase the two newspapers, the Court seemed to view the relevant customer base as the *advertisers* seeking simply to expand their reach and increase the number of (in their view) fungible consumers, without regard for differences between those consumers. This could be analogous to an insurer contracting with a hospital network to expand its reach; the insurer does not distinguish between consumers based on geographic location but only seeks to sell to more customers.[113] Under this reasoning, depending on how inherently different a court determines the two markets to be, it might view all of a hospital network's services as a single product in the eyes of insurers seeking to expand their consumer base.

Another illustrative example is the unreported case *Austrian v. UnitedHealth Group, Inc.*[114] In that case, individual physicians challenged a dominant insurer's practice of imposing an all-or-nothing requirement

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109 *Id.* at 108.

110 Although the *Griffith* Court did not expand on its statement, it suggested that the companies, "having combined with each other *and with the distributors* . . . formed a conspiracy in violation of §§ 1 and 2." *Id.* at 109 (emphasis added).

111 Times-Picayune Publ'g Co. v. United States, 345 U.S. 594, 613 (1953).

112 *Id.* at 614.

113 Insurance companies do in some cases distinguish between customers with different health expectations, which may be influenced by geography. The connection to geography, however, is tenuous and is not the crux of the coverage decision, and thus it is largely irrelevant for purposes of this discussion.

114 Austrian v. UnitedHealth Group, Inc., 2007 Conn. Super. LEXIS 1949 (July 17, 2007).

that the physicians accept all of its health plans.[115] The court held that the tying allegation was too general and that there was no proof of a foreclosure of competition in a distinct product market, finding that "only one market [was] involved."[116] The market in that case included "managed care organizations operating in the [same geographic] market;" despite having different contractual terms, the court decided that their services were "legally indistinguishable."[117] This case offers insight into how difficult it is to prove a tying claim between two similar products—but it leaves open the question of whether two managed care organizations operating in *different* markets would be indistinguishable. Because this issue has not been thoroughly vetted by the courts, to justify a finding of liability a court would have to carefully analyze the pro- and anticompetitive aspects of an all-or-nothing arrangement, as well as the market power and coercive tactics of the defendant.

The second element of a tying claim, coercion, may also be difficult to prove. Even if a court finds there are two separate products capable of being tied, there must be evidence that the tie actually coerced the health plan to purchase the tied product. This is a difficult feat when the purchase is the result of negotiations. In one health care case alleging that a hospital required third party payers "to contract for outpatient surgery services on an exclusive basis as a condition for contracting for general inpatient acute care hospital services on a discounted basis," the court found that there was no coercion because "the exclusive contracts, unreasonably restrictive or not, were the product of negotiation."[118] The court based this decision on testimony that the insurer had agreed to the contracts, in spite of their restrictive nature, as a business decision to avoid severing its relationship with the hospital.[119] Consequently, if a health plan might have purchased the product even without the tie—the difference being only the amount it paid—there may be a strong argument against the existence of coercion. However, studies of provider-insurer negotiations in several metropolitan areas throughout the country have demonstrated that networks with dominant hospitals often exercise significant leverage over health plans, making their negotiations one-sided and forcing the health plans to contract with their non-dominant hospitals as well.[120] If empirical research demonstrated a similarly anticompetitive impact in the market under

115 *Id.* at *5.
116 *Id.* at *32.
117 *Id.* at *32–33.
118 Rome Ambulatory Surgical Ctr. v. Rome Mem. Hosp., 349 F. Supp. 2d 389, 407–08 (N.D.N.Y. 2004).
119 *Id.* at 408.
120 *See generally* Berenson et al., *supra* note 5.

scrutiny, there would be a stronger argument that these ties are coercive. Performing such a study may be a logical starting point to build evidence of the anticompetitive effects of this conduct in individual states.

The third element, market power, will require intense analysis of the control a certain provider has in the alleged tying market. As discussed above, this analysis must not only clearly define the relevant geographic market, but it must also take note of factors beyond just market share such as market-based and regulatory barriers to entry.[121] Given the difficulty in measuring market power in the health care market, there must be thorough economic analysis of the actual power held by any given network-defendant.

Finally, the fourth element asks whether a substantial amount of commerce in the tied product has been affected in a way that is harmful to competition. The answer to this question will depend on the balance of pro- and anti-competitive effects in the secondary market. Such pro-competitive effects may include the fact that these arrangements enable an entire system of hospitals to negotiate with insurers rather than just the ones the insurers find "important."[122] Additional benefits may be found in the efficiency and quality improvements that arise from an integrated system.[123] These improvements often arise from cross-subsidization between hospitals and better coordination between physicians and administrators at multiple locations.[124] For example, the Massachusetts Special Commission noted that its recommendations to prohibit these contracting practices "may not apply" in situations where those practices allow for more efficient delivery and better-managed costs, so they "should be reevaluated" in light of market changes.[125]

Still, the anticompetitive effects of these ties are vast, and the DOJ and FTC's guidelines on enforcement against ACOs draw a line in the sand to help distinguish between efficient and harmful business practices. Geographic ties force health plans to accept hospital networks' rates and thereby cut short the negotiation process; as a result, health plans lose the ability to set market-rate prices for distinct services. They pass this loss on to consumers, who lack knowledge about the prices they pay. On this basis, a strong argument can be made that these practices are more harmful

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121 *See supra* Part I.C.

122 Berenson et al., *supra* note 2, at 702 (describing how hospital networks leverage the fact that health plans seek out their "must-have" hospitals to negotiate beneficial rates).

123 *Id.* at 5.

124 *See, e.g.*, IMPROVING HEALTH CARE, *supra* note 44, ch. 3, at 39–40; Berenson et al., *supra* note 5, at 977.

125 Mass. Exec. Office of Health & Human Servs., *supra* note 93, at 25.

than efficient. If a claim on these grounds is successful, it may help illuminate the true market value of hospital services and alleviate these market inefficiencies.

A geographic tying claim holds the potential to break down the market power that certain dominant hospital networks use to control prices, and a successful lawsuit could pave the way for a price transparency initiative to mandate the revelation of prices without the worry of unintended collusion. However, due to the challenges inherent in alleging a new variation on an old legal theory, an allegation of geographic tying will require serious dedication if it is to succeed. Currently, one group of litigants has raised this claim (among others), in the California lawsuit *Sidibe v. Sutter Health*.[126] As *Sidibe* progresses, it will be a case to watch to see just how willing courts will be to address the harm caused by these business practices using the framework provided by the antitrust laws.

2. Bundling Services

Another potentially unlawful tie in the health care market is hospitals' bundling of services in their negotiations with payers, which effectively masks the prices of individual services. It should be noted, of course, that bundling services has been one of the leading cost-saving techniques proposed in discussions about health care reform, and rightly so: Bundling can save consumers money when it appropriately "align[s] incentives for providers."[127] By grouping, for example, all services that are a part of a single course of treatment or episode of care into a single payment, such a payment structure can encourage a team of providers to strive for *quality* care rather than *quantity* of care, thus simultaneously lowering costs and improving quality.[128]

These same benefits, however, do not arise when services that are *not* related to a single illness are grouped together for payment purposes. Instead, that grouping makes it impossible for purchasers to distinguish discrete services to arrive at their fair market value. Thus, a bundling challenge should focus on revealing how a tie between *unrelated* services harms consumer welfare and increases the provider's market power.[129] If

126 Third Amended Complaint and Demand for Jury Trial, Sidibe v. Sutter Health, No. 3:12-cv-4854-LB, at 12 (N.D. Cal. Dec. 9, 2013).

127 Ctrs. for Medicare & Medicaid Servs., Fact Sheet: Bundled Payments for Care Improvement Initiative (Aug. 23, 2011), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2011-Fact-Sheets-Items/2011-08-23.html.

128 *Id.*

129 *See* Havighurst & Richman, *supra* note 5, at 876 n.86. This ensures that the products are viewed as two

services are not used together by consumers, the arguments in favor of pricing them together decrease significantly, leaving little justification for a coercive tie.

It is often profitable for a dominant provider to bundle unrelated services, because doing so allows it to "make a precommitment to tie" that strengthens its hold on the tied market.[130] Bundling has the potential to harm competition by concealing the prices of individual services; separating the prices of discrete services would allow insurers to negotiate the reimbursement rate for each service individually, thereby enabling competitive pricing for services for which good substitutes exist rather than forcing insurers to accept a bundled rate.[131] As a result, as Professors Havighurst and Richman argue, hospitals that want to "fully exploit [their] various monopolies" would be forced to reveal prices for individual services to insurers and to the marketplace.[132] Insurers could then use this information to adopt policies and create incentives that would encourage consumers to seek out lower costs for specific procedures.[133]

As with the geographic tying claim proposed above, however, this theory of bundling as a potential antitrust violation will face many speed bumps if alleged in court. The first bump in the road is the first element of the test for tying: the separate products test. Hospital services are often viewed as a single product rather than as individual products.[134] Thus, proving the existence of two separate products capable of being tied together would be a significant legal hurdle. To prevail on this claim would require economic analysis of the markets for each hospital service (or set of related hospital services) and of consumers' demands for those services to establish that they are distinct products.

A second challenge is proving the element of coercion—that is, clear evidence that the insurer would not have purchased the tied product but for the unlawful restraint. As with geographic tying, the fact that the health plan might have entered into a contract whether or not the services were bundled could prove problematic for a plaintiff.[135] Similarly, the third

distinct products. Economic analysis suggests that it is not profitable for a monopolist to tie a complementary product to its monopolized product, therefore making such a claim unlikely to succeed; however, "where the monopolized product is no longer essential for all uses of the non-monopolized components, tying once again emerges as a profitable exclusionary strategy." Michael D. Whinston, *Tying, Foreclosure, and Exclusion*, 80 AM. ECON. REV. 837, 840 (1990).

130 Whinston, *supra* note 90, at 839 ("By bundling components of its system together . . . firms can precommit to their marketing strategy.").

131 Havighurst & Richman, *supra* note 5, at 876.

132 *Id.* at 876–77.

133 *Id.* at 877.

134 *See supra* notes 39–42 and accompanying text.

135 *See supra* notes 118–120 and accompanying text.

element, market power, will require the same kind of thorough economic analysis of the provider's market share and control over the tying service.[136]

Finally, to establish the tie has a harmful effect on a substantial amount of commerce, it is necessary to overcome the argument that bundling is often pro-competitive and therefore not unlawful. Arguments about the pro-competitive character of bundling arrangements center on the economic efficiencies they create that allow providers to bargain for lower prices that they can then pass on to consumers.[137] For instance, bundling may allow for the cross-subsidization of services that otherwise might be prohibitively expensive.[138] It also helps avoid the problem of fee-for-service payment that can incent overtreatment.[139] In fact, bundling was a focus of the Affordable Care Act due to its ability, at least in some cases, to reduce fragmentation in health care and thereby improve the coordination of health care—in turn lowering overall costs.[140]

But if, on the other hand, these ties create barriers that prevent competitors from introducing better, cheaper competing products, to the detriment of consumers, they should be considered anticompetitive.[141] If health plans were better able to distinguish between the prices of different services, they would be able to provide better coverage for patients willing to accept narrower networks.[142] Together with price transparency, this could give consumers significantly more power in the health care market than they have now. Analyzing the impact of bundling on consumer costs in a specific market, the availability of alternatives, and the ease of entry into the market—in addition to the initial determination of whether the provider has market power in the relevant market—will therefore provide crucial facts in laying out a case for antitrust liability under this theory.

3. Full-Line Forcing

A slightly different way to frame the ties between health care services and/or markets is as a form of tying known as full-line forcing. Often used in the context of retail distribution, full-line forcing occurs when a seller

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136 *See supra* Part I.C.

137 IMPROVING HEALTH CARE, *supra* note 44, at 100.

138 *Id.* at 39–40.

139 *See generally* SHANNON BROWNLEE, OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER (2008).

140 *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., *supra* note 127.

141 *See id.*; *see also* ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 96 (Apr. 2007) (describing a de facto tying arrangement as one where the bundled products are priced such that it is better for consumers to purchase them together than separately, resulting in higher consumer costs).

142 Havighurst & Richman, *supra* note 5, at 877.

requires a retailer to "take and display a full or 'representative' line of the seller's products in order to obtain a desired product."[143] This is arguably analogous to the practice of forcing a health plan to purchase all of a provider's services or to contract with all of its hospitals in a region, although most full-line forcing cases involve retail distribution and therefore may be distinguishable from the provision of health care services through insurance plans. Courts tend to uphold full-line forcing arrangements, particularly when the arrangements are not exclusive, because of the benefits in distribution efficiency they provide.[144] If the products that the retailer is forced to purchase are unrelated to those it initially wanted, however, "the reasonableness of this requirement to buy the whole line would be suspect."[145] For example, in a case involving ties between tractors and haying equipment, the court rejected the defendant's argument that full-line forcing is always permissible, finding that the circumstances under which such an arrangement does not violate the law "probably do not include cases in which coercion is applied to secure compliance with the full-line requirement."[146]

If hospital networks' practice of leveraging their power in one service or market is viewed as full-line forcing, the justification for allowing the practice does not hold. As discussed above, when hospital systems coerce the purchase of their services, the factual and economic evidence suggests that full-line forcing does not produce the efficiencies that it does in analogous distribution arrangements. On the contrary, if there were proof that these practices result in "higher prices and outlays for medical services," there would be a strong argument that they are anticompetitive and harmful to consumers.[147] Therefore, in addition to a classical tying argument, full-line forcing may—in spite of its disfavor in some courts—be another potential argument to use to challenge hospital network ties.[148]

B. Monopolization and Attempted Monopolization

Alternatively, if this behavior is not enough to constitute an illegal tie, it may give rise to liability under Section Two of the Sherman Act if it represents willful maintenance of monopoly power and/or a willful attempt

143 1-22 ANTITRUST LAW AND TRADE REGULATION *Tying Arrangements* § 22.05(2) (Matthew Bender & Co., 2d ed. 2012).

144 *Id.*

145 *Id.*

146 Earley Ford Tractor, Inc. v. Hesston Corp., 556 F. Supp. 544, 550–51 (W.D. Mo. 1983).

147 AM. BAR ASS'N, ANTITRUST HEALTH CARE HANDBOOK 266 (4th ed. 2010).

148 *Id.* ("There are no decisions discussing this issue, but full line forcing policies such as this may become a fertile ground for future health care antitrust litigation.").

to monopolize.[149] This is most relevant in the context of geographic tying where a hospital network with a monopoly in one market attempts to gain market power in a separate market while simultaneously seeking to maintain its monopoly in the first market. As alleged in *Sidibe v. Sutter Health*, this could represent both willful maintenance of monopoly power (in the tying market) and attempted monopolization (in the tied market).[150] The monopolization claim would require proof that the hospital network had a monopoly in the tying market, which could be shown by analyzing market share and ability to control prices in the relevant market, as discussed above,[151] and that it willfully maintained that monopoly.[152] Proving willful maintenance would require evidence that the ties were created in order to preserve the monopoly and not for another valid business purpose.[153] Any allegedly valid business purposes would likely mirror the pro-competitive benefits described as potential responses to a Section One claim.

Alternatively, to prove an attempted monopolization claim, there must be evidence of anticompetitive conduct, specific intent to monopolize, and a "dangerous probability" that the attempt will succeed. However, even if the tying arrangements are found to be anticompetitive and made with the requisite specific intent, proving a "dangerous probability" of success will be a challenge—though not an insurmountable one—without compelling economic data that the tied hospital poses a serious threat of becoming dominant in the tied market. This practice may alternatively be viewed under a monopoly leveraging theory, under which liability can arise from using one's monopoly power in one market to gain a competitive advantage in another market.[154] However, circuit courts are split as to whether monopoly leveraging can exist without the monopolization or attempted monopolization of the second market.[155] On this issue, the Supreme Court recently wrote that proving a monopoly leveraging claim requires evidence that there is a dangerous probability of

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149 *See, e.g.*, SmithKline Corp. v. Eli Lilly & Co., 427 F. Supp. 1089, 1129 (E.D. Pa. 1976), *aff'd*, 575 F.2d 1056 (3d Cir. 1978) (finding that, although there was no illegal tie, the defendant engaged in behavior that constituted a willful maintenance of monopoly power and violated Section Two of the Sherman Act).

150 Third Amended Complaint and Demand for Jury Trial, Sidibe v. Sutter Health, No. 3:12-cv-4854-LB, at 12 (N.D. Cal. Dec. 9, 2013).

151 *See supra* Part I.C.

152 United States v. Grinnell Corp., 384 U.S. 653, 570–71 (1966).

153 *See* Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451, 482–83 (1992).

154 United States v. Griffith, 334 U.S. 100, 107–08 (1948).

155 2-25 ANTITRUST LAWS AND TRADE REGULATION *Actual Monopolization* § 25.04 (Matthew Bender & Co., 2d ed. 2012). Notably, the Ninth Circuit has rejected the monopoly leveraging theory, requiring instead that there be an actual or attempted monopoly in the second market. *See* Alaska Airlines, Inc. v. United Airlines, Inc., 948 F.2d 536, 548–49 (9th Cir. 1991).

success of monopolization in the second market.[156] Thus, this claim would need the same evidence as a stand-alone Section Two claim for monopolization or attempted monopolization, which would require the difficult factual showing of monopolization or a "dangerous probability of success" thereof in the second market, not just in the first. Therefore, this claim could be feasible but may be met with limited success.

C. Unfair Competition

Finally, even if these practices of linking unrelated services to build up leverage during negotiations fail to satisfy one or more of the elements of the claims described above, a plaintiff could still find refuge in state unfair competition law. In California specifically, "any unlawful, unfair or fraudulent business act or practice" could give rise to a claim under the UCL,[157] if that practice "threatens an incipient violation of an antitrust law, or violates the policy or spirit of one of those laws."[158] Therefore, a technical failure to meet the separate products test or to prove coercion may not be fatal if a court is willing to view these practices as violative of the "spirit" of the antitrust laws, depending on the relevant state law. In light of the substantial harm to competition evidenced by the unpredictable and out-of-control prices of health care, in combination with the unfair and unethical approach that some dominant firms have taken to raise and maintain those prices, a court could be justified, particularly in some of the most egregious cases, in making a finding of liability.

CONCLUSION: BEST APPROACHES TO LITIGATION, REGULATION, AND PUBLIC POLICY

Regulators have many options when it comes to choosing a legal strategy to address the inefficiencies in the health care market. Using antitrust law, they can challenge anticompetitive contract terms like MFN clauses as unreasonable restraints of trade enacted by dominant insurers. Alternatively, they can tackle the geographic ties that hospital networks leverage to expand their market power into more and more locales, relying either on a theory of tying or attempted monopolization, or bringing suit under a state unfair competition law. Bundled services that are not functionally related pose yet another risk to market efficiency, for many of the same reasons as geographic ties, although there may be policy

156 Verizon Commc'ns, Inc. v. Law Offices of Curtis V. Trinko, LLP, 540 U.S. 398, 415 n.4 (2004).
157 CAL. CIV. CODE § 17200.
158 Cel-Tech Commc'ns, Inc. v. L.A. Cellular Tel. Co., 973 P.2d 527, 565 (1999).

arguments in favor of grouping these services together. Of these practices, geographic ties seem to present the greatest anticompetitive concerns with the fewest pro-competitive benefits, due to their ability to grant greater power and market expansion to already-dominant hospital networks—which economic evidence suggests are some of the biggest causes of high health care prices—while offering no clear benefit to patients. Thus, this would be a logical focal point for regulators or consumers who are seeking a way to break down the market power that allows these hospital networks to keep the true price of their services not only high, but also hidden from consumers.

Given the trepidation with which courts have approached issues of competition in health care, it is not clear whether any of the litigation strategies described in this article will succeed. But the lack of a clear precedent does not mean that legal efforts are in vain. Take, for example, the challenges against Blue Cross of Michigan's MFN clauses. Though the DOJ's lawsuit will not result in a courtroom victory, the litigation spurred the passage of regulatory measures to prohibit MFN clauses. By highlighting these kinds of problematic behaviors, the antitrust agencies can raise awareness of unfair business practices and motivate legislators to do something about them. In California, the recently filed class action against Sutter Health may similarly heighten legislative concerns about geographic tying. If state government officials pay attention to these allegations, they may supplement the private lawsuit with a state antitrust challenge or legislative efforts to increase competition. And as private companies see these lawsuits play out, perhaps they will see that their current practices are not sustainable in a regulatory environment that views fair pricing practices as a critical element of health care ethics.

Moreover, to improve the possibility of success and accuracy in breaking down market power, economists and policy analysts can also offer their expertise. As a starting point, one group of researchers studied twelve U.S. communities to understand how some hospital systems have used their leverage to negotiate high rates from insurers.[159] This kind of research should be repeated in target markets where there is evidence suggestive of similar practices. In doing so, researchers will be able to build the strong economic evidence of competitive harm that is necessary to succeed in an antitrust suit.

By taking steps to bring targeted lawsuits, to spur action from local and state governments, and to conduct empirical studies, it is possible to heighten the discourse about anticompetitive behaviors in the health care

159 *See generally* Berenson et al., *supra* note 5.

market—and perhaps, in doing so, to gain additional policy attention and financial resources. In light of the U.S. health policy community's focus on reducing wasteful health care spending generally, and improving price transparency specifically, there should be plenty of room for a pinpointed focus on the harmful business practices that are driving these inefficiencies.

Even if a lawsuit is ultimately unsuccessful, the discordance between the justifications behind antitrust law (the protection of the consumer) and the realities of the health care market (the near-total lack of consumer power) makes it clear that there is a need for action. Whether that action is ultimately a litigation strategy or a regulatory or policy effort, or a combination thereof, it should address the inefficient and harmful practices that powerful players in the health care market use to artificially drive up the cost of health care—not only for individual patients, but also for the entire nation. Bringing attention to this serious competitive harm can reduce the consolidation of market power and lower prices for consumers. At the same time, it can make way for price transparency and other important policy initiatives that would be difficult to implement under current market conditions. Antitrust law thus offers a first step toward making U.S. health care affordable, efficient, and fair for everyone.