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Competition as Policy Reform: The Use of Vigorous Antitrust Enforcement, Market-Governance Rules, and Incentives in Health Care

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COMPETITION AS POLICY REFORM: THE USE OF VIGOROUS ANTITRUST ENFORCEMENT, MARKET-GOVERNANCE RULES, AND INCENTIVES IN HEALTH CARE

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ABSTRACT

In health care, the increase in market concentration on both the insurer side and the provider side has led to insurers and providers acquiring market power. Insurers and providers, in turn, have used that market power to charge higher prices to employers providing employees with medical care without corresponding increases in the quality of that care. Responding more generally to the increase in market concentration in many industries in the United States with a range of inimical effects for the nation's economy, the Obama Administration suggested a range of policy solutions that this article groups under the term "Competition as Policy Reform." These solutions included the use of vigorous antitrust enforcement to restore competition, the use of market incentives to stimulate existing competition, and the promulgation of market-governance rules to jumpstart new competition. This article explores in detail whether and how competition as policy reform can be instituted in health care. It first discusses what vigorous antitrust enforcement can and cannot do to combat the use of market power by health care actors in more concentrated markets. Recognizing that the enforcement of antitrust law can, at best, restore the status quo ante in terms of competition in a market victimized by anti-competitive conduct, this article also explores two other solutions: (1) the use of market incentives to stimulate competition and (2) the promulgation of market-governance rules to jumpstart competition. This article finds that competition as policy reform can be instituted in health care as an alternative to other proposed policy solutions, such as applying the regulated utility model. Ultimately, it also finds that the individual states—as laboratories for experimentation in our federalist system—can play a key role in the endeavor to use competition as policy reform in health care.

* Senior attorney in state public service in California. The author thanks Robert Berenson, Kathleen Foote, Thomas Greaney, and Bruce Hinze for their insights. This law review article sets out the personal views of the author only and so should not be ascribed to the California Attorney General's Office, any other state attorney general's office, or any other organization or individual.

I. INTRODUCTION

Competition as policy reform starts with issues involving the exercise of market power—and in its extreme form, monopoly power—excepting covert price-fixing conspiracies. Market power is the ability to charge a price higher than the one prevailing in competitive markets.[1] As it consists in effect of the power to control prices or exclude competition, it is interchangeable with monopoly power.[2] A significant driving escalator of costs in our health care system is the acquisition of market power or monopoly power by participants in that system—be they health care providers such as hospital systems, or insurance companies.[3] This matches more generalized concerns that increases in market concentration—an indicator of possible market power or monopoly power—in many industries since the Great Recession of 2008 may be causing strong negative impacts on the national economy involving less consumer choice, less quality, and higher prices, as well as higher profits that are not reinvested into higher wages or into additional research and development.[4]

1. *See, e.g.*, Eastman Kodak Co. v. Image Tech. Serv., Inc., 504 U.S. 451, 464 (1992); *see also, e.g.*, *In re* Cipro Cases I & II, 348 P.3d 845, 863 (2015); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 14 (1984); PHILLIP E. AREEDA ET AL., ANTITRUST LAW 109 (3d ed. 2007).

2. *See* Thomas G. Krattenmaker et al., *Monopoly Power and Market Power in Antitrust Law*, 76 GEORGETOWN L.J. 241, 247 (1987). The case law takes a similar view as to market power and monopoly power. *See In re* Cipro Cases I & II, 348 P.3d at 863. Other cases and sources, however, distinguish between market power and monopoly power, finding that the latter applies only when a firm is restrained by its own costs, i.e., any fringe competitors left in the market do not appreciably impact the market power. *See, e.g.*, Broadcom Corp. v. Qualcomm, Inc., 501 F.3d 297, 307 (3d Cir. 2007); *see also* ABA SECTION OF ANTITRUST LAW, MARKET POWER HANDBOOK: COMPETITION LAW AND ECONOMIC FOUNDATIONS 19–20 (2d ed. 2012) (Monopoly power requires "'something greater' than a finding of market power.").

3. Several sources discuss this issue of health care costs as being a serious problem in delivering health care in the United States as well as attempts that are under way to bring reform to health care pricing, such as by switching from fee-for-service pricing to risk-based pricing. *See, e.g.*, Kenneth W. Field & Douglas E. Litvack, *Health Care Merger Analysis in the Era of Payment Reform*, *Competition*, J. ANTITRUST, UCL & PRIVACY SEC. STATE BAR CAL., Fall 2015, at 42, 44–47. For a discussion on how the increase in health care costs may be attributed in part to market concentration, see, for example, Brief of Amicus Curiae of the States of Cal. et al. at 8-12, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775 (9th Cir. Aug. 20, 2014) (No. 14-35173) (collecting studies from California, Massachusetts, and Connecticut on the threat to health care posed by increased costs and the role of market concentration in increasing those costs).

4. *See, e.g.*, *Benefits of Competition and Indicators of Market Power*, COUNCIL OF ECON. ADVISERS 7, 14 (Apr. 2016), https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160414_cea_competition_issue_brief.pdf; *see also, e.g.*, *Too Much of a Good Thing*, ECONOMIST, Mar. 26, 2016, at 21–22. What constitutes a concentrated market and how much the degree of market concentration reflects a diminution of competition as opposed to other factors such as scale economies may require a more discerning analysis. *See* Maureen K. Ohlhausen, Comm'r, Fed. Trade Comm'n, Remarks at Hogans Lovells, Hong Kong: Does the U.S. Economy Lack Competition, and If So What To Do About It? 2, 5–6 (June 1, 2016), https://www.ftc.

As measured by a number of studies, such as those concerning the regions established by the California Legislature for individuals[5] and small employers,[6] to purchase health insurance under the Patient Protection and Affordable Care Act (ACA),[7] health care providers (e.g., hospitals and physician medical groups) who acquire market power are able to increase the prices charged to health insurers.[8] Those prices are in turn passed through: first, directly as an increase in costs for self-insured employers ("self-insureds"—those who assume the financial risk for their employees' use of medical providers and then contract with insurers for administrative services and the "rent" of those insurers' provider networks)[9] and second, indirectly to individuals and fully insured businesses in the form of higher premiums and cost-sharing obligations.[10] This increase in prices has not led to an increase in the quality of medical care,[11] but

gov/system/files/documents/public_statements/952273/160601doesuseconomylackcomp.pdf. However, a more discerning analysis may lead to the concluision that the increase in market concentration corresponds to increased prices and not to increased efficiencies such as economies of scale. *See* BRUCE A. BLONIGEN & JUSTIN R. PIERCE, DIVS. OF RESEARCH & STATISTICS & MONETARY AFFAIRS, EVIDENCE FOR THE EFFECTS OF MERGERS ON MARKET POWER AND EFFICIENCY (2016), https://www.federalreserve.gov/econresdata/feds/2016/files/2016082pap.pdf.

5. *See* CAL. HEALTH & SAFETY CODE § 1399.855 (2013); *see also* CAL. INS. CODE § 10965.9 (2013).

6. *See* CAL. HEALTH & SAFETY CODE § 1357.512 (2013); *see also* CAL. INS. CODE § 10753.14 (2013).

7. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

8. *See, e.g.*, Richard M. Scheffler et al., *Covered California: The Impact of Provider and Health Plan Market Power on Premiums*, 40 J. HEALTH POL., POL'Y, & L. 1179, 1184–87 (2015); T. Scott Thompson, *ACA Exchange Premiums and Hospital Concentration in California*, ANTITRUST HEALTH CARE CHRON., June 2015, at 27–28, 33.

9. *See* David Dranove, *The Anthem-Cigna Merger: A Post-Mortem*, HEALTH AFF. BLOG (Sept. 5, 2017), http://www.healthaffairs.org/do/10.1377/hblog20170905.061802/full/ (last visited Nov. 6, 2017). Self-insured employers constitute a quite sizeable portion of the employment picture in the states. *See, e.g.*, STATE HEALTH ACCESS DATA ASSISTANCE CTR., STATE-LEVEL TRENDS IN EMPLOYER-SPONSORED HEALTH INSURANCE: A STATE-BY-STATE ANALYSIS 10 (2013), http://www.shadac.org/sites/default/files/Old_files/shadac/publications/ESI_Report_2013.pdf (noting that in 2011, almost sixty percent of employers, with more than fifty employees, offered self-insured coverage).

10. *See* Scheffler et al., *supra* note 8 at 1189, 1192.

11. *See, e.g.*, JOHN KWOKA, MERGERS, MERGER CONTROL, AND REMEDIES: A RETROSPECTIVE ANALYSIS OF U.S POLICY 100, 245 (2015); *see also, e.g.*, N.Y. STATE HEALTH FOUND., WHY ARE HOSPITAL PRICES DIFFERENT? AN EXAMINATION OF NEW YORK HOSPITAL REIMBURSEMENT 8 (Dec. 2016), https://nyshealthfoundation.org/uploads/resources/an-examination-of-new-york-hospital-reimbursement-dec-2016.pdf; Martin Gaynor et al., *The Industrial Organization of Health Care Markets* 53 J. ECON. LITERATURE 235, 247 (2015). ("[B]oth mortality and expenditures are lower in less concentrated markets . . . ."); Bob Kocher & Ezekiel J. Emmanuel, *Overcoming the Pricing Power of Hospitals*, 308 JAMA 1203, 1214 (2012) ("Moving from [a model of] hospitals [as] price setters to a market in which patient demand drives hospital prices and quality improvement" requires "systems that [concentrate on] outcomes as opposed to activity, [and that] are focused on service and quality" as opposed to volume.).

it has slowed wage increases as employers and their workers have to bargain for the coverage of these increased costs.[12]

However, the increase in costs accompanying the acquisition of market power in the health care industry is not limited to health care providers. The market concentration of insurers has also resulted in premium increases—though California's use of an active purchaser model for selecting insurance products for individuals and small businesses who shop for health care plans on its exchange has in the *current* market appeared to have acted as a counterweight.[13]

These developments all raise the question of how to address issues arising from the gain or maintenance of market power flowing from market concentration in health care. Is that the job of antitrust law exclusively? Or is there a role to play for other options working in tandem with antitrust law to, in effect, use competition norms as the spearhead of policy reform? This article answers these questions by stating that there is a role in implementing competition as policy for vigorous antitrust law enforcement, for incentives to increase competition, and for market-governance rules that address the gaps in vigorous antitrust enforcement and in the use of incentives.

This article then concludes with thoughts on the often-overlooked role of the states in furthering competition in health care markets as the reason why states need to consider the use of competition as policy reform.[14] Given that providing health care services amounts to one-sixth of the nation's economic output,[15] the answers to the questions posed above assume a special importance in terms of addressing the more general questions involved in remedying inimical effects from market concentration arising from 2008. And ultimately, how these questions can be answered will determine whether competition itself as policy

12. *See* MARTIN GAYNOR ET AL., THE BROOKINGS INST., MAKING HEALTH CARE MARKETS WORK: COMPETITION POLICY FOR HEALTH CARE, ACTIONABLE POLICY PROPOSALS FOR THE EXECUTIVE BRANCH, CONGRESS, AND THE STATES 3 (2017), https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf.

13. *See* Richard M. Scheffler et al., *Differing Impacts of Market Concentration on Affordable Care Act Marketplace Premiums*, 35 HEALTH AFF. 880, 881, 883–87 (2016); *see also Health Insurance Industry Consolidation: What Do We Know from the Past, Is It Relevant in Light of the ACA, and What Should We Ask?: Hearing Before the S. Comm. on the Judiciary, Subcomm. on Antitrust, Competition Pol'y, & Consumer Rights*, 114th Cong. 12 (2015) (testimony of Leemore S. Dafny); Leemore Dafny et al., *Paying a Premium on your Premium: Consolidation in the U.S. Health Ins. Industry* 3 (Nat'l Bureau of Econ. Res. Working Paper No. 15434, 2009), http://www.bu.edu/sph/files/2010/10/Dafny-Duggan-Ramanarayanan.pdf.

14. *See, e.g.*, Brief of Amicus Curiae of the States of Cal. et al., *supra* note 3, at 5.

15. Natalie Jones, *Health Care in America: Follow the Money*, NPR (Mar. 29, 2012, 4:58 PM), http://www.npr.org/sections/health-shots/2012/03/19/148932689/health-care-in-america-follow-the-money (last visited Oct. 26, 2017).

reform is a superior alternative to other non-competition based options, such as a regulated utility model.[16]

II. BACKGROUND ON ANTITRUST LAWS AND REMEDIES

To understand the role that vigorous antitrust enforcement can play in executing competition as policy, it is necessary to begin by noting that the scope of antitrust law and the reach of the remedies that it provides rests on two issues: (1) the conduct at issue, and (2) whether a firm has market power (absent certain narrow exceptions). Because the analysis of market power under antitrust law, in turn, rests on economics, including specific studies and models relating to health care, this section will first discuss how economics has contributed to the assessment of antitrust issues. Next, it will discuss how economics has informed the definition of markets and hence the assessment of market power in the health care context. Then this section will discuss how the antitrust laws classify business conduct into one of three categories: (1) joint conduct, (2) unilateral conduct, or (3) mergers and acquisitions.

A. Use of Economics in Antitrust Law

The United States (U.S.) Supreme Court has expressly recognized that developments in economic thinking can lead to changes in antitrust analysis.[17] The California Supreme Court has articulated the presumptions to be applied to the review of pharmaceutical settlements between brand drug manufacturers and generic drug manufacturers based on economics.[18] Thus, to understand how the courts determine the metes and bounds of health care markets, the touchstone for assessing market power, it is helpful to start with the economic studies and analysis of these markets to which courts increasingly refer.

B. Economic Measurement of the Metes and Bounds of Health Care Provider and Insurer Markets and the Implications for Prices

In looking at why challenges by federal and state antitrust authorities to horizontal provider acquisitions generally failed through the early 2000s—erroneously so as it led to court approval of acquisitions that caused anti-competitive effects[19]—health care economists developed the so-called two-

16. *See* Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 129 (2015); *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, 979 (2012).

17. Kimble v. Marvel Entm't, LLC, 135 S. Ct. 2401, 2404 (2015) (The U.S. Supreme Court stated that it has "felt relatively free to revise [its] legal analysis as economic understanding evolves and . . . to reverse antitrust precedents that misperceived a practice's competitive consequences.").

18. *See In re* Cipro Cases I & II, 348 P.3d 845, 850–51 (Cal. 2015).

19. *See, e.g.*, Cory S. Capps, *From Rockford to Joplin and Back Again: The Impact of Economics on Hospital Merger Enforcement*, 59 ANTITRUST BULL. 443, 460 (2014); *see also, e.g.*, Steven Tenn, *The Price Effects Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, 18 INT'L J. ECON. BUS. 65, 69–70 (2011).

stage model of health care markets. The first stage—and the key one for purposes of determining market shares—involved providers bargaining with insurers for inclusion in those insurers' networks at a set price.[20] Once an employer selected an insurer, the second stage would involve the employees of that employer choosing an individual provider[21]—a choice that would largely be based on non-price factors such as referrals, word-of-mouth, and reputation, though employers and insurers are making efforts to change that dynamic.[22] Because choices made in the second stage were based on non-price factors, the second stage would not play the same role as the first stage in assessing the scope of relevant health care markets from the perspective of antitrust law.[23]

As far as the markets for large employers directly purchasing insurance or self-insured employers "renting" a network (with the insurer serving as an Administrative Service Organization (ASO)) may be concerned, this two-stage model set out how those networks had to be broad and deep enough to be attractive to the employees of these large companies. This means that if a network was missing key components necessary to making these networks attractive to such employees, such as the existence of providers for most kinds of medical care close to where employees live and work,[24] the existence of such holes would, all else being equal, make that network less desirable. Accordingly, as providers grow by acquiring hospitals ("horizontal acquisitions") and setting up affiliations with physician groups that can direct referrals to those hospitals ("vertical acquisitions"),[25] they can expand these network holes, enhancing their bargaining leverage vis-a-vis insurers even if the market share of an individual hospital or an individual physician group of that provider group was otherwise modest.[26]

20. *See* Capps, *supra* note 19, at 460.

21. *See id.*

22. *See* Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 682 (2000).

23. *See, e.g.*, Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 784 (9th Cir. 2015); *see also* Fed. Trade Comm'n v. Penn State Hershey Med. Ctr., 838 F.3d 327, 342 (3d Cir. 2016); United States v. Anthem, Inc., 236 F. Supp. 3d 171, 193 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017). A good synopsis of the two-stage model, based on evidence and economic analysis submitted by the U.S. Federal Trade Commission in such cases as the St. Luke's case, can be found at Field & Litvack, *supra* note 3, at 43–44.

24. That employees demand the availability of health care services close to where they live and work has been recognized in the case law. *See, e.g.*, *Penn State Hershey Med. Ctr.*, 838 F.3d at 342*; Saint Alphonsus Med. Ctr.-Nampa, Inc.*, 778 F.3d at 784–85; In the Matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, at 10 (F.T.C. 2007); *Anthem, Inc.*, 236 F. Supp. 3d at 204.

25. *See* Roger D. Blair et al., *Hospital Mergers and Economic Efficiency*, 91 WASH. L. REV. 1, 6 (2016).

26. *See, e.g.*, UAS Mgmt., Inc. v. Mater Misericordiae Hosp., 87 Cal. Rptr. 3d 81, 90 (Cal. Ct. App. 2008); *see also, e.g.*, In the Matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, at 57–58 (F.T.C. 2007).

Applying this two-stage model, economists have found the following: (1) horizontal acquisitions can and have increased market power—leading to increases in prices charged to insurers even if there is a significant group of employees who travel far for medical care;[27] and (2) vertical acquisitions can and have increased market power—leading to increases in prices due to referral effects, e.g., the increased steering of patients by a formerly independent physician group to an acquiring hospital or hospital system at the expense of competing hospitals.[28] Furthermore, using this model, there are studies finding that cross-market provider acquisitions, e.g., health care provider systems in a given county entering a new market in a different county by acquiring a provider, can result in price increases.[29]

As far as insurers are concerned, there are two aspects to the economic analysis of their health insurer markets. One aspect is calculating the insurers' shares of the markets for the sale of products for fully insured employers and self-insureds (whether those products are viewed as being sold in one market or in two markets) to assess market power. The determination of the metes and bounds of this aspect of insurer markets is influenced by three factors: (1) the

27. *See, e.g.*, Fed. Trade Comm'n v. Advocate Health Care Network, 841 F.3d 460, 470–72, 475 n.5 (7th Cir. 2016); Brief of Amicus Curiae Submitted by 33 Economists in Support of the FTC and State of Illinois at 7, 9, 12, Fed. Trade Comm'n v. Advocate Health Care Network, 841 F.3d 460 (7th Cir. 2016); *Penn State Hershey Med. Ctr.*, 838 F.3d at 343; Consent Brief of Amici Curiae Economics Professors in Support of Plaintiffs/Appellants Urging Reversal at 6, 8–9, Fed. Trade Comm'n et al. v. Penn State Hershey Med. Ctr. et al., 838 F.3d 327 (3d Cir. 2016) (No. 1:15-cv-02362); *St. Alphonsus Medical Ctr.-Nampa, Inc.*, 778 F.3d at 784 n.10; Motion for Leave to File Brief of Amici Curiae Economics Professors at 7, St. Alphonsus Medical Ctr.-Nampa, Inc. v. St. Luke's Health System, Ltd. et al., 778 F.3d 775 (9th Cir. 2015) (No. 1:12-cv-00560-BLW); ProMedica Health Sys., Inc. v. Fed. Trade Comm'n., 749 F.3d 559, 564 (6th Cir. 2014) (relying on insurer testimony as to the two-stage market).

28. *E.g.*, Laurence C. Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 HEALTH AFF. 756, 756–57 (2014); Julie A. Carlson et al., *Economics at the FTC: Physician Acquisitions, Standard Essential Patents, and Accuracy of Credit Reporting*, SPRINGER 303, 306, 311–12 (Nov. 22, 2013), https://www.ftc.gov/sites/default/files/documents/reports/economics-ftc-physician-acquisitions-standard-essential-patents-accuracy-credit-reporting/carlsonetal-physicianacquisitions2013.pdf; Ann S. O'Malley et al., *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?*, ISSUE BRIEF, Aug. 2011, at 1–2, 4 (increasing hospital employment of physicians in turn leads to an increase in referrals that can raise costs without increasing quality absent reform of the payment structure); Robert S. Huckman, *Hospital Integration and Vertical Consolidation: An Analysis of Acquisitions in New York State*, 25 J. HEALTH ECON. 58, 77 (2006).

29. *See* Leemore Dafny et al., *The Price Effects of Cross-Market Hospital Mergers* 25 (Nat'l Bureau of Econ. Research, Working Paper No. 22106, 2017); Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power*: *Evidence from Out-of-Market Acquisitions*, 48 RAND J. ECON. 579, 581 (2017); Matthew S. Lewis & Kevin E. Pflum, *Diagnosing Hospital System Bargaining Power in Managed Care Networks*, 7 AM. ECON. J. 243, 244 (2014); Gregory S. Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L.J. 253, 259 (2013).

specialization of insurers, with some insurers gearing their products for the individual and small group market, and others designing their products for large group and ASO markets;[30] (2) the role of state agencies as gatekeepers regarding entry into their insurance markets, which can impose general requirements such as financial stability as well as specific requirements that depend on the nature of the market in question;[31] and (3) whether certain insurers will never be able to obtain anything more than a slice of business in a given market because of limitations in demand for their particular business model, with Kaiser—an integrated, closed system that provides insurance and has its own providers—being such an example in California.[32] Studies have found that the acquisition of market share by insurers in employer markets (large group and ASO) has led to higher prices for employers.[33]

Another aspect in market analysis is calculating the market share of an insurer purchase of health care services from health care providers to assess its market power vis-a-vis those providers. The determination of the scope of such upstream or supply markets focuses on how an anti-competitive reduction in upstream prices can reduce downstream services, e.g., reducing the quality or output of medical care or limiting provider availability.[34] For this reason, the economic literature refers to this set of circumstances as monopsony to distinguish it from the more familiar monopoly situation.[35]

Cases do exist in which insurers were seen to have monopsony power.[36] Studies have found that insurers can exercise monopsony power.[37] Indeed, while a monopsony analysis focuses on the negative incentives for upstream markets by an anti-competitive reduction in price, to the extent that providers perceive

30. United States v. Anthem, Inc., 236 F. Supp. 3d 171, 188, 194 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017). More broadly, the determination of the relevant market for health care purposes can either focus on the services being provided such as acute in-patient services or primary care physician services, s*ee Saint Alphonsus Med. Ctr.-Nampa, Inc.*, 778 F.3d at 784–85; Cal. v. Sutter Health Sys., 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001), or on the nature of the payors who are receiving or furnishing services, *see, e.g.*, *Anthem, Inc.*, 236 F. Supp. 3d at 194; In the Matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, at 55 (F.T.C. 2007).

31. *See, e.g.*, *Anthem, Inc.*, 236 F. Supp. 3d at 187–88.

32. *See id.* at 205.

33. *See, e.g.*, Scheffler et al., *supra* note 13, at 886; Thomas Greaney, *New Health Care Symposium: Dubious Health Care Merger Justifications—The Sumo Wrestler & 'Government Made Me Do It' Defenses*, HEALTH AFF. BLOG (Feb. 24, 2016), http://healthaffairs.org/blog/2016/02/24/dubious-health-care-merger-justifications-the-sumo-wrestler-and-government-made-me-do-it-defenses/ (last visited Oct. 4, 2017); Dafny et al., *supra* note 13, at 1, 3.

34. *See Anthem, Inc.*, 236 F. Supp. 3d at 237.

35. *See, e.g.*, COUNCIL OF ECON. ADVISORS, *supra* note 4, at 2.

36. *See* Joseph M. Miller & Brian C. Lewis, *Monopsony and Health Plan Mergers: Does Anthem-Cigna Signal a Shift in Policy?*, COMPETITION POLICY INT'L (Sept. 2017), https://www.competitionpolicyinternational.com/wp-content/uploads/2017/09/North-America-Column-September-Full.pdf.

37. *See, e.g.*, Dafny et al., *supra* note 13, at 29.

the acquisition of leverage by insurers to be present, that perception can encourage providers to combine—via conduct or merger—and thus ultimately increase prices.[38] But, as a general matter, the courts struggle with when exactly coordinated reductions in upstream prices by downstream purchasers can be viewed as being anti-competitive precisely because they believe that consumers still benefit from lower prices.[39]

C. Analysis of Joint Conduct by Independent Firms: Per Se, Quick Look or Structured Rule of Reason, and Full Rule of Reason

Joint conduct by independent firms can be analyzed via one of three different paths: (1) per se illegality, (2) quick look or structured rule of reason, or (3) full rule of reason. These paths fall along a spectrum rather than being mutually exclusively categories.[40] For example, in the so-called eBooks case in which Apple was ultimately found guilty of having orchestrated a per se illegal price-fixing conspiracy with four out of five book publishers, there were factual disputes over the purpose of the conspiracy (e.g., to thwart Amazon's low-cost pricing of eBooks versus introducing a new Apple iBooks product to compete with Amazon) and over the degree of coordination involved.[41] To buttress the treatment of this conspiracy as being per se illegal, the federal government and several states therefore introduced evidence of actual price increases in the eBooks market because of Apple's conduct.[42] While that kind of check can be germane to a quick look analysis or structured rule of reason analysis (the concept of which is explained below) and certainly is relevant to a full rule of reason analysis (also explained below), it is not supposed to be required for a per se illegal analysis of joint conduct.

Moreover, it can be tricky to determine which category may be appropriate for addressing certain types of business conduct. This can be illustrated by thinking about the formation of independent physician medical groups as opposed to those groups entering price-fixing arrangements with their competitors or affiliating with large provider systems. The formation of an independent physician medical group as a venture of formerly independent physicians to deliver coordinated care most likely presents competitive concerns only in their initial formation. However, when that medical group then enters price-fixing arrangements with their competitors to obtain bargaining leverage with plans, or when it affiliates with a hospital provider system to that end, then

38. *See* Miller & Lewis, *supra* note 36.

39. *Compare, e.g.*, Knevelbaard Dairies v. Kraft Foods, Inc., 232 F.3d 979, 989 n.6, 990 (9th Cir. 2000), *with, e.g.*, Energy Conversion Devices Liquidation Trust v. Trina Solar Ltd., 833 F.3d 680, 689 (6th Cir. 2016), *cert. denied*, 137 S. Ct. 1582 (2017).

40. *See* Cal. Dental Ass'n v. Fed. Trade Comm'n, 526 U.S. 756, 779 (1999).

41. *See* United States v. Apple, Inc., 791 F.3d 290, 291, 327 (2d Cir. 2015), *cert. denied*, 136 S. Ct. 1376 (2016).

42. *See id*. at 310.

issues can arise. And as far as provider systems themselves are concerned, a case from the U.S. Court of Appeals for the Sixth Circuit stated that a dominant hospital provider system in a town in Ohio, whose hospitals still were independent for some purposes, could be functionally treated as if it were an agreement between independent actors rather than as an integrated entity.[43]

For certain types of joint conduct, e.g., secret price-fixing agreements among competitors known as cartels, market power need not be shown collectively or individually, and it is conclusively presumed (and thus cannot be rebutted) that excuses or justifications do not exist for that kind of conduct. Hence that kind of conduct is referred to in legal terminology as per se illegal or hardcore conduct.[44] For other types of joint conduct, e.g., the eBooks price-fixing conspiracy or an agreement among independent physicians to fix the fees charged to insurers, such conduct can still be treated as per se illegal, with no showing of market power required and no excuses or justifications accepted, so long as a check is performed to make sure that such conduct should be treated as being equivalent to a cartel.[45] That check can involve ascertaining if any asserted pro-competitive efficiencies supporting that joint conduct are plausible or if there are factual indicia, such as a market-wide increase in prices, supporting the treatment of that joint conduct as per se illegal.[46]

However, joint conduct cannot be shielded from treatment as being per se illegal, or even be found to be legal in a quick look, a structured rule of reason, or a full rule of reason context, if the justifications in question are related to non-competition related goals. For example, the courts have rejected justifications based on the asserted need to create private intellectual property rights[47] or to combat low pricing or predatory pricing by a competitor.[48] Rather, the achievement of those goals, or the balancing of those goals with competition-related concerns, is left to government agencies and the enactment of additional laws by state legislatures or the U.S. Congress.[49] This is an important point for

43. Med. Ctr. at Elizabeth Place, LLC v. Atrium Health Sys., 817 F.3d 934, 936, 945 (6th Cir. 2016).

44. *See* ORG. FOR ECON. CO-OPERATION & DEV., COMPETITION AND BARRIERS TO ENTRY 2 (Jan. 2007), http://www.oecd.org/competition/mergers/37921908.pdf.

45. *Apple, Inc*., 791 F.3d at 327–28.

46. *See, e.g.*, *id.* at 328–30.

47. *See, e.g.*, Fashion Originators' Guild of Am., Inc. v. Fed. Trade Comm'n, 312 U.S. 457, 467–68 (1941).

48. *See, e.g.*, *Apple, Inc.*, 791 F.3d at 331–33.

49. For example, under federal antitrust law, if physicians form a venture solely to bargain jointly with insurers on fees, i.e., there is no evidence of any *plausible* pro-competitive efficiency, that venture is treated as per se illegal. *See, e.g.*, Arizona v. Maricopa Cty. Med. Soc'y, 457 U.S. 332, 354–55 (1982); Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,025, 67,027 (Oct. 28, 2011). In a reaction to the *Maricopa* decision, the California Legislature proceeded down a different path in allowing providers to create "efficient[ly]-sized" contracting units. CAL. BUS. &

health care: Issues regarding the adequacy of provider networks and corresponding provider pricing raise concerns closely similar to these cases involving non-competition related issues and as such should be addressed by government actors rather than by private entities who may otherwise use these issues as an excuse to engage in anti-competitive conduct.[50]

Joint conduct that is not per se illegal can be struck down as being illegal under either a quick look, a structured rule of reason analysis, or a full rule of reason analysis. A quick look analysis involves conduct that an observer with just a rudimentary understanding of economics can view as anti-competitive; in such an eventuality, not only is a showing of market power not required but also the burden shifts to defendants to proffer pro-competitive reasons justifying that conduct.[51] Conversely, a reverse quick look analysis may also be employed to dismiss cases where the conduct in question is obviously pro-competitive to an observer with just a rudimentary understanding of economics.[52]

However, in such circumstances the courts have increasingly turned to a structured rule of reason—though they have not forbidden the use of quick look analysis altogether.[53] A structured rule of reason allows a court to *presume* conduct to be anti-competitive if certain facts are shown without having to do the full market analysis to determine market power, or alternative analysis of market-wide effects, required in a full rule of reason context.[54] However, in contrast to quick look, the presumption of anti-competitive effects can be rebutted.[55] And while justifications or excuses for business conduct may be offered by defendants, a structured rule of reason can enable courts to disallow the assertion of certain justifications—if supported by economics—while allowing for the possibility that other justifications may exist to which a court should give more detailed consideration.[56]

One example of the application of a structured rule of reason is tying, which is the forced sale of one product together with another separate product (though alternatively tying has been characterized as being subject to a quasi-per se illegal mode of analysis).[57] Another example of such an application would be

PROF. CODE § 16770(d)(e); CAL. HEALTH & SAFETY CODE § 1342.6; CAL. INS. CODE § 10133.6. Nonetheless, such contracting units can still be struck down under the same antitrust standards applicable to other presumptively legal enterprises, such as the rule of reason. *See* CAL. HEALTH & SAFETY CODE § 1342.6.

50. *See, e.g.*, United States v. Anthem, Inc., 236 F. Supp. 3d 171, 252 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017).

51. *See, e.g.*, Cal. Dental Ass'n v. Fed. Trade Comm'n, 526 U.S. 756, 770–71 (1999).

52. *See, e.g.*, Am. Needle, Inc. v. Nat'l Football League, 560 U.S. 183, 203 (2010).

53. *See, e.g.*, *Apple, Inc.*, 791 F.3d at 329–330.

54. *See, e.g.*, *In re* Cipro Cases I & II, 348 P.3d 845, 862 (Cal. 2015).

55. *See, e.g.*, *id.*

56. *See id.* at 869–70.

57. *See, e.g.*, Einer Elhauge, *Rehabilitating* Jefferson Parish: *Why Ties Without a Substantial Foreclosure Share Should Not Be Per Se Legal*, 80 ANTITRUST L.J. 463, 463, 466 (2016); *see also,*

reverse payments in the pharmaceutical context, i.e., a large monetary or non-monetary payment by a brand manufacturer to a generic manufacturer (or vice versa) to limit competition in a market for a certain drug.[58]

If conduct is subject to a full rule of reason analysis, a plaintiff must show either anti-competitive effects arising from that conduct—or show that such effects are likely to arise—before the burden shifts to a defendant to proffer pro-competitive reasons for that conduct.[59] A plaintiff may show such effects in one of two ways: (1) by showing directly that anti-competitive effects have arisen from the conduct in question, e.g., an increase in market prices or a decrease in output, such that market power may be presumed in what is known as a direct effects analysis,[60] or (2) by showing that a defendant has a sufficient market share from which market power may be presumed[61] in combination with a showing that the conduct in question is likely to cause anti-competitive effects if a firm has market power.[62]

e.g., C. Scott Hemphill, *Less Restrictive Alternatives in Antitrust Law*, 116 COLUM. L. REV. 927, 939, 981–82 (2016) (noting that tying is "tilted in favor of plaintiffs by dispensing with the need to show foreclosure as to the tied product.").

58. *See In re Cipro I & II*, 348 P.3d at 850.

59. *See id.* at 862.

60. *See, e.g.*, Fed. Trade Comm'n v. Ind. Fed'n of Dentists, 476 U.S. 447, 460–61 (1986) (noting that direct effects evidence is enough under the rule of reason); Toys-R-Us v. Fed. Trade Comm'n, 221 F.3d 928, 937 (7th Cir. 2000) (stating that one way to prove market power is "through direct evidence of anticompetitive effects"); Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of Univ. of Okla. 468 U.S. 85, 109–10 (1984); *cf.* In the Matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, at 63–67 (F.T.C. 2007) (showing actual price increase by merged entity in post hoc merger analysis was enough to demonstrate anti-competitive analysis where regression analysis, pre- and post-merger documents of the merged entity, and testimony from insurers all supported the conclusion that the price increase arose from the market power of the combined entity and not from any competitively-benign factors).

61. *E.g.*, Tops Market, Inc. v. Quality Market, Inc., 142 F.3d 90, 98 (2d Cir. 1998) (explaining that market power "may be proven directly by evidence of the control of prices or the exclusion of competition, or it may be inferred from one firm's large percentage share of the relevant market").

62. *E.g.*, K.M.B. Warehouse Distributors, Inc. v. Walker Mfg. Co., 61 F.3d 123, 129–30 (2d Cir. 1995) (noting that allegation of defendant's market power was not enough where plaintiff failed to meet burden under rule of reason of showing that restraint was likely to lead to anti-competitive effects); Gen. Leaseways, Inc. v. Nat'l Truck Leasing Ass'n, 744 F.2d 588, 596 (7th Cir. 1984) ("[I]f it seems that the defendant does have the power to restrain trade substantially, then inquiry proceeds to the question whether the challenged practice was likely . . . to help rather than hurt competition."); *see also* Cal. Dental Ass'n v. Fed. Trade Comm'n, 526 U.S. 756, 775 n.12 (1999) ("[T]here must be some indication that the court making the decision has properly identified the theoretical basis for the anticompetitive effects and considered whether the effects actually are anticompetitive. Where . . . the circumstances of the restriction are somewhat complex, assumption alone will not do.").

Insofar as market shares are concerned, though more than a fifty percent market share is normally required for an antitrust conduct action to prevail,[63] the courts have both avoided requiring a set market share to prevail and have carefully emphasized that the market share required for joint conduct need not be as high as for a monopoly cause of action (discussed in more detail below), as witnessed by case law involving tying[64] or exclusive dealing.[65] Indeed,

63. *E.g.*, AREEDA ET AL., *supra* note 1, at 249–50 (noting that although some courts have found less than fifty to sixty percent market shares can still create a jury question as to market power, commentators recommend that "[b]ecause it would be rare indeed to find that a firm with half of a market could individually control price over any significant period, we would presume that market shares below 50 or 60 percent do not constitute [market] power."). But even those commentators, who have had a lot of influence on antitrust law, note that the market shares required to show market power may, as a practical matter, depend upon the degree of confidence that a market has been properly defined: "If the court's confidence is high that a relevant market has been identified that properly groups close substitutes, excludes non substitutes, and is protected by high entry barriers, then market shares along the lower range of acceptability are permissible." *Id.* at 243.

64. Tying arrangements condition the sale of one distinct product or service (the "tying product") on the sale of another distinct product or service (the "tied product") or the agreement not to purchase the tied product or service from any other supplier. Ill. Tool Works, Inc. v. Indep. Ink, Inc., 547 U.S. 28, 31 (2006); Eastman Kodak Co. v. Image Tech. Serv., Inc., 504 U.S. 451, 461–62 (1992); *see also* Int'l Bus. Machines Corp. v. United States, 298 U.S. 131, 135 (1936). The U.S. Supreme Court has held that tying can be per se illegal if the defendant has market power in the market for the tying product. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 15–17 (1984). Market power is the "ability of a single seller to raise price and restrict output." *Eastman Kodak Co.*, 504 U.S. at 464 (quoting Fortner Enters., Inc. v. U.S. Steel Corp., 394 U.S. 495, 503 (1969)). The U.S. Supreme Court has held that market power in the tying product market will be inferred if "the seller's share of the market is high." *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. at 17. In determining what market share of the tying product market is sufficiently high to infer market power, the Court has rejected a thirty percent market share as being sufficient. *Id.* at 26–27. However, the Court has never defined a specific market share threshold for inferring market power, *id.* at 37 n.6 (O'Connor, J., concurring), and has held that a firm need not have a monopoly or dominant position in the tying product market for it to have market power, United States Steel Corp. v. Fortner Enters., Inc., 429 U.S. 610, 620 (1977) ("[T]hese decisions do not require that the defendant have a monopoly or even a dominant position throughout the market for a tying product.").

65. Exclusive dealing agreements, in which a distributor agrees to distribute only the goods of a certain manufacturer to the detriment of other manufacturers, are subject to full rule of reason treatment because these "agreements can achieve legitimate economic benefits (reduced cost, stable long-term supply, predictable prices)." Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of R.I., 373 F.3d 57, 65–66 (1st Cir. 2004). To draw an inference of anti-competitive effects under this full rule of reason analysis, plaintiffs must show a significant enough foreclosure share in the relevant market, i.e., that the exclusive agreement covers a significant percentage of the relevant market for a sufficiently long enough a period that these agreements may give the defendants market power and drive rivals out of the market, all other factors being equal. *See, e.g.*, *Jefferson Parish Hosp. Dist. No. 2*, 466 U.S. at 45 (O'Connor, J., concurring); Sterling Merch., Inc. v. Nestle, S.A., 656 F.3d 112, 123–24 (1st Cir. 2011); *Stop & Shop Supermarket Co.*, 373 F.3d 57 at 66; Eastern Food Servs. v. Pontifical Catholic Univ. Servs. Ass'n, 357 F.3d 1, 8 (1st Cir. 2004); Omega

recently a lower court accepted a market share as low as 26.4% as being sufficient to demonstrate market power given other market factors. [66] Although that case was reversed on appeal, the appellate court left undisturbed the notion that a set minimum market share is *not* required for a showing of market power.[67] In the realm of health care, this is an important point for both providers and insurers because modest market shares may, as discussed above, still allow for the exercise of market power.

Moving on from the assessment of market shares, once a plaintiff makes the requisite showing of direct effects or of a sufficient market share from which a presumption of market power may be made, a defendant can then show the existence of pro-competitive justifications or excuses as a defense.[68] If a defendant can make such a showing, the question is then raised of whether a plaintiff may show the existence of substantially less restrictive practical alternatives to the conduct in question that would achieve the same goals as those

Envtl, Inc. v. Gilbarco, Inc., 127 F.3d 1157, 1162–64 (9th Cir. 1997); Twin City Sportservice, Inc. v. Charles O. Finley & Co., Inc., 676 F.2d 1291, 1302 (9th Cir. 1982). The foreclosure market screen requires a minimum market share for these agreements of twenty percent to forty percent. *See, e.g.*, *Stop & Shop Supermarket Co.*, 373 F.3d at 68; *Twin City Sportservice, Inc.*, 676 F.2d at 1301 (holding twenty-four percent foreclosure sufficient). The use of this foreclosure market screen does not involve only the exclusive dealing agreement under consideration but also other exclusive dealing agreements in the relevant market, *see Stop & Shop Supermarket Co.*, 373 F.3d at 66, as well as any tying agreements, *see Twin City Sportservice, Inc.*, 676 F.2d at 1301, as well as any tying agreements, *see id.*

66. United States et al. v. Am. Express Co. 88 F. Supp. 3d 143, 190–91 (E.D.N.Y. 2015), *rev'd on other grounds*, 838 F.3d 179 (2d Cir. 2016), *cert. granted sub nom.* Ohio v. Am. Express Co, No. 16-1454, 2017 WL 2444673 (U.S. Oct. 16, 2017). The actual criteria for proving a relevant market, either for rule of reason purposes or for monopoly purposes, are beyond the scope of this article but can be traced back to a trio of cases, United States v. E.I. du Pont Nemours & Co., 351 U.S. 377, 380–81 (1956), Brown Shoe Co. v. United States, 370 U.S. 294, 326 (1962), and United States v. Grinnell Corp., 384 U.S. 563, 571–72 (1966). For purposes of this article, it is important to note that the question of what constitutes the relevant market is a highly fact-dependent one. *See, e.g.*, Broadcom Corp. v. Qualcomm, Inc., 501 F.3d 297, 307 (3d Cir. 2007) ("The scope of the market is a question of fact as to which the plaintiff bears the burden of proof."); United States v. Microsoft Corp., 253 F.3d 34, 81 (D.C. Cir. 2001) ("[T]he determination of a relevant market is a factual question to be resolved by the District Court."); In the Matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, at 57 n.67 (F.T.C. 2007) ("However, market definition fundamentally is a question of fact."). Because appellate courts can, and have, reversed ill-supported factual determinations adverse to the government, including in the health care merger context, *e.g.*, Fed. Trade Comm'n v. Penn State Hershey Med. Ctr., 838 F.3d 327, 339 (3d Cir. 2016) ("[T]he District Court erred in both its formulation and its application of the proper legal test" for determining the relevant geographical market.), the highly fact-dependent nature of defining a market does not preclude this article's call for vigorous antitrust enforcement even as it suggests that such vigorous enforcement has inherent limits.

67. United States v. Am. Express Co., 838 F.3d 179, 201 n.47 (2d Cir. 2016), *cert. granted on other grounds sub nom*. Ohio v. Am. Express Co., 2017 WL 2444673 (U.S. Oct. 16, 2017).

68. *See, e.g.*, *id.* at 195.

for which the defendant engaged in the conduct in question in the first place.[69] Under a full rule of reason, a plaintiff may make such a showing, but the plaintiff carries the burden of showing that such an alternative, in fact, would apply; under a structured rule of reason, a plaintiff has to plead the existence of such alternatives but a defendant may be the one to bear the burden of showing that such alternatives do not, in fact, apply, as in the tying context.[70] Assuming for the sake of argument that substantially less restrictive, practical alternatives do not exist, the court (or the jury) must then balance pro- and anti-competitive effects.[71]

To this point, this analysis has assumed that the firms participating in the joint conduct are all willing participants. If one of the participants is not willing, e.g., that participant was coerced into the conspiracy because of another participant's market power, the case law unequivocally recognizes the necessary predicate of joint conduct in the context of tying.[72] Outside of the context of tying, the case law is split as to whether the necessary predicate of joint conduct is present if one of two participants was coerced into participating by the market

69. *See, e.g.*, Emilio E. Varanini & Jonathan M. Eisenberg, Jr., *Antitrust Restrictions on Technology Companies and Electronic Commerce*, *in* E-COMMERCE AND INTERNET LAW 27 (Ian Ballon ed., 2014).

70. *See, e.g.*, Elhauge, *supra* note 57, at 515 (acknowledging presumption against accepting justifications for tying based on less-restrictive alternatives but then criticizing the Supreme Court for not considering the incentives and monitoring cost problems that those alternatives raised "in some cases"); Hemphill, *supra* note 57, at 981–82 (making same point but advocating that the defendants have the burden of producing evidence supporting their justification for the tying). Both articles, which are generally supportive of applying presumptions in the tying context, do illustrate nonetheless the limits of such presumptions in the minds of commentators when faced with fact-dependent circumstances. Thus, while both articles support this article's call for increased antitrust enforcement, they also illustrate the limits of such enforcement to the extent that even noted commentators in the antitrust field who are sympathetic to antitrust plaintiffs may be uncomfortable with overly broad presumptions. *See* Eastman Kodak Co. v. Image Tech. Servs. Inc., 504 U.S. 451, 466–67 (1992) ("Legal presumptions that rest on formalistic distinctions rather than actual market realities are generally disfavored in antitrust law. This Court has preferred to resolve antitrust claims on a case-by-case basis, focusing on the 'particular facts disclosed by the record.'") (quoting Maple Flooring Mfrs. Assn. v. United States, 268 U.S. 563, 579 (1925)).

71. Atlantic Richfield Co. v. USA Petrol. Co., 495 U.S. 328, 342 (1990); *see* Cal. Dental Ass'n v. Fed. Trade Comm'n, 526 U.S. 756, 771 (1999) (goal of analysis is to identify "net procompetitive effects"). The full balancing step of pro- and anti-competitive effects—to determine if anti-competitive effects outweigh pro-competitive effects—has been left to the finder of fact at trial without any guardrails at the trial level on how that balancing should be done or who carries the burden of proof. *See, e.g.*, Eastman Kodak Co. v. Image Tech. Servs., 504 U.S. 451, 486–87 (1992) (Scalia, J. dissenting); Capital Imaging Assoc., P.C. v. Mohawk Valley Med. Ass'n, 996 F.2d 537, 543 (2d Cir. 1993) (citing and quoting Chi. Bd. of Trade v. United States, 246 U.S. 231, 238 (1918); AM. BAR ASS'N SECTION OF ANTITRUST LAW, MONOGRAPH 23, THE RULE OF REASON 174 (1999).

72. *See, e.g.*, *Eastman Kodak Co.*, 504 U.S. at 461.

power of the other participant, though at least under state law, the balance of the cases tends toward recognizing the existence of a conspiracy.[73]

This leaves the question of what kind of conduct has been, or may be thought to, violate antitrust laws in the health care context as to insurers and providers. Under federal law, the formation of a venture of physicians for the sole purpose of bargaining for higher prices with insurers has been found to be a per se illegal violation.[74] The U.S. Department of Justice (DOJ) and the State of Michigan alleged that an insurer violated antitrust laws by insisting on most favored nation clauses in provider contracts where providers could not offer a better deal to rival insurers; that case ultimately was dismissed after the State of Michigan passed a law outlawing such clauses.[75] And there was a lawsuit against a provider system, comprising four out of the five total hospitals in Toledo, Ohio, which alleged the provider system pressured insurers to exclude the fifth hospital from their networks so as to increase prices.[76]

There is other health care related conduct on which discussion has taken place as to whether that conduct violates the antitrust laws. Examples of such conduct (on the part of providers) include all-or-nothing clauses, forcing insurers to include all components of a provider system on pain of including none,[77] and anti-tiering/anti-steering clauses, which prevent insurers from charging higher prices for higher cost individual providers or from steering patients to lower cost, equal or higher quality providers.[78]

Recent studies have shown that provider systems with market power can use such clauses to increase prices and deprive patients of choices.[79] Courts, commentators, and the federal antitrust agencies have noted that such conduct

73. *See, e.g.*, Kathleen Foote & John F. Cove, Jr., *Monopolization*, *in* CALIFORNIA ANTITRUST AND UNFAIR COMPETITION LAW 6–8 (Cheryl Lee Johnson ed., 2016).

74. *See* sources cited *supra* note 49.

75. United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665, 668–69, 676 (E.D. Mich. 2011) (denying motion for summary judgment); Order of Dismissal Without Prejudice at 1–2, United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. Mar. 28, 2013) (No. 2:10-cv-14155-DPH-MKM).

76. Med. Ctr. at Elizabeth Place, LLC, v. Atrium Health Sys., 817 F.3d 934, 936–38 (6th Cir. 2016) (involving a provider system of independent hospitals that orchestrated a group boycott of a competing hospital by insurers). There are other cases involving similar, exclusionary conduct. *E.g.*, Agreed Final Judgment & Stipulated Injunction Between the State of Tex. & Mem'l Hermann Healthcare Sys. at 1, Tex. v. Mem'l Hermann Healthcare Sys., No. 2009-04609 (Tex. Dist.—Harris Cty. [281st Dist.] Jan. 26, 2009).

77. *E.g.*, Sidibe v. Sutter Health, No. C 12-04854 LB, 2013 WL 2422752, at *14 (N.D. Cal. June 3, 2013); *see also* Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564, 1565 (2017).

78. *See, e.g.*, MARTHA COAKLEY, MASS. OFFICE OF ATTORNEY GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS 41 (2010), http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf; *see also* Greaney, *supra* note 77, at 1565.

79. *See, e.g.*, COAKLEY, *supra* note 78, at 41.

can be treated as tying and hence can constitute a violation of the antitrust laws.[80] This is true whether that conduct is carried out directly (via contract) or indirectly (via coercive pricing).[81] Furthermore, a district court recently rejected a motion to dismiss for a case brought by the U.S. DOJ and the State of North Carolina alleging that a dominant health care provider system in Charlotte violated federal antitrust law by imposing express contractual conditions that barred steering by insurers.[82]

This discussion thus illustrates that vigorous antitrust enforcement can address an extremely wide range of joint anti-competitive conduct by individual firms. However, it also begins to shed light on the limits of such enforcement in implementing competition as policy, a theme to which this article will return.

D. Analysis of Unilateral Conduct by Individual Firms: Illegal Acquisition or Maintenance of a Monopoly

A monopoly, for purposes of antitrust law, has generally been found to be present when a single firm has a market share of greater than sixty to sixty-five percent.[83] The courts are more reluctant to find a violation of antitrust laws based on actions by an individual firm, as opposed to joint conduct, because of the greater risk of penalizing legitimate business conduct[84]—which is why a higher market share is required for a monopoly finding.

Moreover, it is not illegal to be a monopolist.[85] Rather it is only illegal when a company uses illegal means to acquire or maintain a monopoly, i.e., conduct that the law considers exclusionary[86] or predatory.[87] Exclusionary or predatory conduct where monopolies are concerned includes tying, exclusive dealing,

80. *See, e.g.*, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026, 67,030 (Oct. 28, 2011); FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 34 (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723 healthcarerpt.pdf.

81. *See, e.g.*, Cascade Health Solutions. v. PeaceHealth, 515 F.3d 883, 912 (9th Cir. 2008); Einer Elhauge, *Tying, Bundling, and the Death of the Single Monopoly Profit Theory*, 123 HARV. L. REV. 397, 402–03 (2009).

82. United States v. Charlotte-Mecklenburg Hosp. Auth., No. 3:16-cv-00311-RJC-DCK, 2017 WL 1206015, at *1, *9 (W.D.N.C. Mar. 30, 2017).

83. *See, e.g.*, Image Tech. Servs., Inc. v. Eastman Kodak Co., 125 F.3d 1195, 1206 (9th Cir. 1997); Varanini & Eisenberg, *supra* note 69, at 48. A firm can also be liable for attempted monopolization as well as monopolization itself, *see* Spectrum Sports, Inc. v. McQuillan, 506 U.S. 447, 456 (1993), though a discussion of that concept is beyond the scope of this article.

84. *See* Am. Needle, Inc. v. Nat'l Football League, 560 U.S. 183, 190 (2010).

85. *See, e.g.*, United States v. Aluminum Co. of Am., 148 F.2d 416, 429–430 (2d Cir. 1945).

86. *See* Varanini & Eisenberg *supra* note 69, at 55–56.

87. *See id*. at 62–63.

certain kinds of bundled pricing,[88] and below-cost pricing where the losses in question can be recouped at a later date.[89] And while arbitration itself is not inconsistent with the antitrust laws, even if it does not involve the more formal process of the courts or facilitate class actions, a dominant firm's coercive antitrust arbitration clauses—with terms that make remedying such a violation more difficult, if not impossible—is a different kettle of fish.[90] Indeed, the antitrust laws can view behavior committed by a monopolist as anti-competitive that would be seen as pro-competitive if committed by a non-monopolist.[91]

As with the rule of reason, a plaintiff must show that a firm has a monopoly and that its actions have, or will likely lead to, an anti-competitive result such as increased prices, lower output, lower quality, or lower choice. A defendant can offer a pro-competitive justification for its conduct, though a plaintiff may show a substantively less restrictive alternative. And if both anti-competitive and pro-competitive effects flow from a company's unilateral acts, those effects are to be balanced by the ultimate trier of fact.[92] Such monopoly cases have been brought in health care.[93]

More vigorous antitrust enforcement going forward would allow for monopoly cases to be brought to remedy the same kind of anti-competitive conduct discussed above in the joint conduct section of this article: where an individual firm has market power approaching monopoly levels and where its coercion of its counterparties (e.g., a monopolist insurer coercing providers or a monopolist provider coercing insurers) may make a court reluctant to infer joint conduct.

But while litigation can blaze the way for addressing such anti-competitive conduct, ultimately legislation may be a far more effective tool for carrying out competition as a policy goal.[94] The reason for this is that courts, proceeding on

88. *See, e.g.*, Cascade Health Solutions. v. PeaceHealth, 515 F.3d 883, 901, 903, 912 (9th Cir. 2008).

89. *See* Brooke Group, Ltd. v. Brown & Williamson Tobacco Corp., 509 U.S. 209, 224 (1993).

90. *See* Mark A. Lemley & Christopher R. Leslie, *Antitrust Arbitration and Merger Approval*, 110 NW. U. L. REV. 1, 3–4, 42 (2015). This same logic may apply in markets that involve market concentration with only a few firms but do not actually involve a monopoly as such. *See id.* at 42.

91. *See e.g.*, Eastman Kodak Co. v. Image Tech. Servs., Inc., 504 U.S. 451, 488 (1992) (Scalia, J., dissenting).

92. *See, e.g.*, United States v. Microsoft, 253 F.3d 34, 58 (D.C. Cir. 2001). Whether certain conduct committed by a monopolist such as exclusive dealing should be presumed anti-competitive does not affect the points made in this article and is therefore beyond its scope.

93. *E.g.*, Complaint at 14, United States & Tex. v. United Reg'l Health Care Sys., No. 7:11-cv-00030 (N.D. Tex. Feb. 25, 2011) (alleging monopolization of hospital services market through loyalty "discounts").

94. For example, the U.S. DOJ and the State of Michigan brought a lawsuit against Blue Cross Blue Shield, alleging that its use of most favored nation clauses in its contracts was anti-competitive. United States v. Blue Cross Blue Shield of Michigan, 809 F. Supp. 2d 665, 668 (E.D. Mich. 2011). After this lawsuit survived a motion for summary judgment, *id.* at 679, Michigan

a case-by-case basis, must act prudently in each individual case to ensure that they are not inappropriately second-guessing individual business decisions.[95] Legislation does not suffer from that same need as it reflects public value judgments on the utility of business conduct as a general matter.

Of considerable importance to assessing the limits of vigorous antitrust enforcement in this area, is the consideration of whether parallel but *independent* anti-competitive conduct by market participants—that taken together have monopoly power—can constitute a violation of antitrust law. Commentators have made the interesting argument that such conduct may constitute a *shared* monopoly and hence should be treated as a de facto monopoly under the antitrust laws,[96] but no court has accepted such an argument to date.[97] Moreover, while older case law exists treating such conduct as a violation of unfair competition law in circumstances where the market is an oligopoly (generally four or fewer firms with entry being difficult), the perceived skepticism on the part of the courts regarding this concept has apparently inhibited the bringing of such cases by federal enforcers.[98] This is an important point: Worries about anti-competitive conduct have involved more than one participant in a given health care market,[99] and studies have found aggregate anti-competitive effects from multiple participants in health care markets.[100] It is a point that is thus suggestive of an independent need for legislation in carrying out competition as a policy goal.

passed a law banning such most favored nation clauses, *see* Order of Dismissal without Prejudice 1, United States v. Blue Cross Blue Shield of Mich., No. 10-cv-14155-DPH-MKM (E.D. Mich. Mar. 28, 2013). This lawsuit was then dismissed due to the passage of that legislation. *Id.* at 2.

95. *See* Am. Needle, Inc. v. Nat'l Football League, 560 U.S. 183, 190 (2010).

96. *See* C. Scott Hemphill & Tim Wu, *Parallel Exclusion*, 122 YALE L.J. 1182, 1187 (2013).

97. *See, e.g.*, JOHN MILES, HEALTH CARE & ANTITRUST L. § 5:17, Westlaw (database updated July 2017). The theory of shared monopolies needs to be distinguished from conspiracies to monopolize, which is viable as a legal theory. *Id.*

98. *See, e.g.*, SUSAN A. CREIGHTON ET AL., PRESENTATION AT WORKSHOP ON SECTION 5 OF THE FTC ACT AS A COMPETITION STATUTE: SOME THOUGHTS ABOUT THE SCOPE OF SECTION 5 4–5 (Oct. 17, 2008), https://www.ftc.gov/sites/default/files/documents/public_events/section-5-ftc-act-competition-statute/screighton.pdf.

99. *See, e.g.*, Vistnes & Sarafidis, *supra* note 29, at 255.

100. *See* Glenn A. Melnick & Katya Fonkych, *Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-Hospital Systems*, 53 J. HEALTH CARE ORG., PROVISION, & FIN. 1, 6 (2016).

E. Antitrust Analysis of Mergers and Acquisitions

A merger of two firms, or the acquisition of one firm's assets by another firm, violates antitrust law where there may be a substantial lessening of competition or where there is a tendency towards the creation of a monopoly.[101] Applying this standard, antitrust law has barred acquisitions or allowed the retroactive unwinding of otherwise completed acquisitions involving horizontal acquisitions of competitors[102] and vertical acquisitions of upstream suppliers or downstream retailers.[103]

A substantial lessening of competition is presumed under the law where the merger or acquisition significantly increases market concentration in a relevant market.[104] This is because the state of competition is a proxy for consumer welfare under the antitrust laws and because competition itself involves not only price but also quality, output, innovation, and choice.[105] However, federal and state antitrust agencies as well as the courts will look at a variety of other factors, such as the innovator status of a firm being acquired or whether the merging firms were previously close competitors, either to establish that an anti-competitive effect is in fact likely or to address a rebuttal by defendants of the market concentration presumption.[106]

101. 15 U.S.C. § 18 (2012) (commonly referred to as Section 7 of the Clayton Act). Congress used this phraseology to indicate that it was concerned with probable effects arising out of mergers rather than effects provable to a certainty, *e.g.*, Fed. Trade Comm'n v. H.J. Heinz Co., 246 F.3d 708, 713 (D.C. Cir. 2001), thus supporting the ability of federal and state government agencies to block mergers and acquisitions before their consummation.

102. *See, e.g.*, United States v. Phila. Nat'l Bank, 374 U.S. 321, 369–71 (1963).

103. *E.g.*, Ford Motor Co. v. United States, 405 U.S. 562, 571–79, (1972); Brown Shoe Co. v. United States, 370 U.S. 294, 323–24, (1962). A discussion of the history of the proscription of vertical mergers and of allowing vertical mergers after the imposition of certain conditions, can be found at Jaime Stilson, et al., *Reading the Tea Leaves: Evaluating Potential Antitrust Concerns in Vertical Mergers Between Insurers and Health Care Providers*, 30 ANTITRUST 11, 11–16 (2015).

104. *See, e.g.*, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 785–86 (9th Cir. 2015).

105. *See* AYESHA BUDD ET AL., CONTRIBUTION TO INT'L COMPETITION NETWORK'S 10TH ANNUAL CONFERENCE: COMPETITION ENFORCEMENT AND CONSUMER WELFARE SETTING THE AGENDA 10 (May 17–20, 2001), http://www.internationalcompetitionnetwork.org/uploads/library/doc857.pdf.

106. *See, e.g.*, U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 3–4 (Aug. 19, 2010), https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf; Field & Litvack, *supra* note 3, at 43. Speaking generally, the method for proving a relevant market for assessing the competitive effect of a merger or acquisition is the same as it is for rule of reason or for monopoly purposes. *See, e.g.*, PHILIP AREEDA et al., *supra* note 1, at 107. But this extended inquiry does not obviate the importance of market share presumptions in the merger context. *See, e.g.*, Harry First & Eleanor M. Fox, *Philadelphia National Bank: Globalization, and the Public Interest*, 80 ANTITRUST L.J. 307, 326 (2015) (noting that the shift from eschewing tests for competitive effects to the market share presumptions in *Philadelphia National Bank* "made effective enforcement more likely" because of the focus on both economics and administration).

There are limits to what sort of factors may be considered. Most notably in health care, many economists and others have been skeptical that a merger of insurance companies may be justified because the merged insurance companies may be able to get a better price from any provider system; even if the merged entity can obtain lower prices (which is open to doubt), those lower prices may not be passed on to customers[107] and may result in reduced provider availability or reduced quality of medical care. These themes all emerged in the Anthem-Cigna merger in the district court's skeptical take on this justification.[108]

If this market concentration presumption is not rebutted, it is generally accepted (albeit with considerable court skepticism) that the merging parties can assert the defense that a merger is likely to lead to pro-competitive effects, such as the production of a new product or an improvement in product quality.[109] However, the more concentrated the market, the greater the efficiencies must be, with a two-to-one merger requiring truly "extraordinary efficiencies."[110] Moreover, those efficiencies must be merger-specific: The defendants must show that those efficiencies could not be achieved in other ways, such as by the formation of a joint venture, and that these efficiencies will benefit consumers rather than shareholders or managers by showing, for example, that any cost savings from the merger will be passed on, in whole or in part, to consumers of their products.[111] Further, these efficiencies must also be verifiable, that is to say not speculative.[112] Consequently, when merging health care providers have argued that the merger would allow them to engage in risk-sharing pricing that will benefit consumers through lower costs and higher quality, the courts have required those parties to show that such a result could not be achieved through a looser affiliation.[113]

Although historically the courts have been unwilling to block horizontal provider mergers,[114] that situation changed with the development of new economic modes of analyzing the competitive effects of these mergers, such as the two-stage model discussed above. For example, in a recent case in the Ninth Circuit, the appellate court upheld the decision of the lower court blocking a horizontal merger of a provider system, which included physicians and

107. *See, e.g.*, Greaney, *supra* note 33.

108. *See* United States v. Anthem, Inc., 236 F. Supp. 3d 171, 249–51 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017).

109. *See, e.g.*, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 789 (9th Cir. 2015).

110. *E.g.*, *id.* at 790; *Anthem, Inc.*, 236 F. Supp. 3d at 236.

111. *E.g.*, *Saint Alphonsus Med. Ctr.-Nampa Inc.*, 778 F.3d at 790–91; *Anthem, Inc.*, 236 F. Supp. 3d at 236–37.

112. *See, e.g.*, *Anthem, Inc.*, 236 F. Supp. 3d. at 236.

113. *E.g.*, *Saint Alphonsus Med. Ctr.-Nampa Inc.*, 778 F.3d at 790–92.

114. *See, e.g.*, Fed. Trade Comm'n v. Advocate Health Care Network, 841 F.3d 460, 464, 468–73 (7th Cir. 2016).

hospitals, with a physician group in Nampa, Idaho.[115] And there have been even more recent decisions from the Seventh Circuit[116] and Third Circuit[117] also barring horizontal provider mergers under this two-stage model.

Similarly, district courts have blocked two blockbuster horizontal insurer mergers: Aetna-Humana[118] and Anthem-Cigna.[119] Although the merging parties appealed the Anthem-Cigna merger decision to the District of Columbia Circuit, that appellate court upheld the district court in a two-to-one decision, forcing Anthem to abandon the merger.[120]

Additionally, as to vertical mergers, the courts have imposed serious behavioral conditions on vertical provider acquisitions such as instituting a mandatory arbitration procedure for provider-insurer disputes[121] or pursuant to a recent decision of the Federal Trade Commission providing incentives to doctors to allow them to switch medical groups.[122] Antitrust public enforcers generally have not yet sought to bar these vertical acquisitions because of other considerations, such as the financial solvency of the providers to be acquired.[123]

But with the review of mergers as with the review of conduct, there are important limitations under antitrust law. Principally, antitrust law does not address the question of whether a merger should be allowed in the absence of benefits to competition or to consumers, e.g., if the merger's competitive effects

115. *Saint Alphonsus Med. Ctr.-Nampa Inc.*, 778 F.3d at 792.

116. *E.g.*, *Advocate Health Care Network*, 841 F.3d at 464, 456–66.

117. *E.g.*, Fed. Trade Comm'n v. Penn State Hershey Med. Ctr., 838 F.3d 327, 333–34 (3d Cir. 2016).

118. United States v. Aetna Inc., 240 F. Supp. 3d 1, 8–9 (D.D.C. 2017).

119. United States v. Anthem, Inc., 236 F. Supp. 3d 171, 179 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017).

120. United States v. Anthem, 855 F.3d 345, 348–49 (D.C. Cir. 2017) (rejecting Anthem's contention that the district court erred in rejecting Anthem's claims of efficiencies from the merger).

121. *See, e.g.*, Amended Final Order at 2, 8–9, *Penn. v. Geisinger Health Sys. Found.*, No. 1:13 CV-02647-YK (M.D. Pa. Nov. 1, 2013); Unopposed Motion to Approve and Enter Final Order at 7, Penn. v. Urology of Cent. Penn., Inc., No. 1:11-cv-01625-JEJ (M.D. Pa. Sept. 1, 2011); *see also* RANDALL R. BOVBJERG & ROBERT A. BERENSON, URBAN INST., CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER? 19–20 (2015), https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf.

122. Decision and Order at 7, In re CentraCare Health Sys., Docket No. C-4594 (F.T.C. Jan. 6. 2017).

123. *See generally* KWOKA, *supra* note 11, at 140 (noting that antitrust authorities might have to resort to conduct remedies in extreme circumstances where a provider may fail or where the merger may result in substantially large merger-specific efficiencies that would otherwise be lost). But the reluctance to challenge vertical mergers is beginning to change. *See* State of Cal. v. Valero Energy Corp. et al., 2017 WL 3705059 (N.D. Cal. Aug. 28, 2017). How this will play out in the health care space remains to be seen.

are neutral[124] or are otherwise difficult to ascertain. This is an important point: The correlation between substantial increases in market concentration in an industry and increases in price[125] suggests that the toll on the general economy from allowing certain mergers could be greater than one would think, which is a point supported by recent evidence that mergers cannot simply be presumed to be efficient as a general rule.[126] Finally, as with coordinated reductions in input prices by downstream purchasers, the courts struggle with whether reductions in input prices arising from the merger of two downstream purchasers of that input are anti-competitive even if those reductions are not market wide or even if those reductions could translate into, or do translate into, lower quality or provider availability.[127]

In summary, whether to allow mergers in certain areas already subject to extensive regulation can involve social trade-off issues that in involving non-competition related goals go beyond antitrust law. Correspondingly, these points, when all taken together, do support a call for a more systematic legislatively-imposed process for reviewing mergers in an industry, specifically where that industry may be highly regulated and difficult to enter to begin with,[128] that would supplement the more case-by-case competition-based focus of antitrust law.

F. Antitrust Remedies

Ultimately, while antitrust law can be quite supple in the conduct remedies that can be imposed through settlements and court actions, there are limitations in how far conduct remedies can go.[129] If an action is brought based on illegal

124. *Cf.* Cal. Dental Ass'n v. Fed. Trade Comm'n, 526 U.S. 756, 771 (1999) (explaining that conduct is not illegal under a rule of reason analysis if the agreement on its face "might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition").

125. *See* Peter C. Carstensen, *The* Philadelphia National Bank *Presumption: Merger Analysis in an Unpredictable World*, 80 ANTIRUST L.J. 219, 247 (2015).

126. *See, e.g.*, at 252; *Philadelphia National Bank at 50: An Interview with Judge Richard Posner*, 80 ANTITRUST L.J. 205, 216–17 (2015).

127. *See* Carstensen, *supra* note 125, at 254.

128. *See, e.g.*, United States v. Anthem, Inc., 236 F. Supp. 3d 171, 221–22 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017).

129. *See, e.g.*, New York v. Microsoft Corp., 224 F. Supp. 2d 76, 152, 178, 183–84 (D.D.C. 2002). The *Microsoft* case is an interesting example as to the ill-understood efficacy of conduct remedies in many cases. *See id.* While the district court rejected the "structural" kind of remedies proposed by California and several other states (the California Group), the conduct remedies obtained by the U.S. DOJ and other states, as modified by certain provisions obtained by the California Group, involved extensive conduct remedies, including remedies involving related markets and ongoing monitoring of new technologies developed by Microsoft to ascertain compliance. *See id.* at 183–84, 186. Those measures had a much more salutary effect than they get credit for in restoring competition to technology and software markets that are intertwined with the internet even if they may not have been as effective as structural relief would have been. *See* Varanini & Eisenberg, *supra* note 69, at 95. For a fuller analysis see, for example, *id.* at 94–117.

conduct, remedies may involve a cessation of the illegal conduct in question, disgorgement of profits, compliance training, and other measures in the affected markets or closely related markets designed to restore competition going forward.[130] However, the courts have become more reluctant to order structural remedies, such as the divestment of assets or the breakup of a firm in the case of a monopoly.[131] This is important because structural relief can be viewed by courts as being easier to implement than conduct relief, as the latter requires ongoing judicial supervision.[132]

If an action is brought to block a merger, remedies may include blocking the merger, even retrospectively (after the fact)[133] or implementing measures that fall short of outright blocking it. That latter set of measures can include the divestment of assets to a third party and the imposition of conditions with ongoing monitoring from the court and from government agencies.[134]

The divestment of assets in a merger context can be a preferred option where there is a willing third party, where the assets to be divested are complete enough that the third party can viably compete, and where the negative competitive effects of the merger would be eliminated or substantially mitigated by such a divestment.[135] However, there are two questions with such a divestment: (1) Are the issues involved, such as the assignment of contracts, back office support, monetary resources, access to technology, and government approvals of such complexity that a divestment would likely fail to create a viable competitor?;[136] and (2) Would the third party use the divested assets to become a viable competitor?

130. *See, e.g.*, *Attorney General Kamala D. Harris Announces Settlements Totaling $4.95 Million with LG, Hitachi, Panasonic, Toshiba and Samsung over Price-Fixing Scheme*, ST. CAL. DEP'T JUSTICE (Mar. 30, 2016), https://oag.ca.gov/news/press-releases/attorney-general-kamala-d-harris-announces-settlements-totaling-495-million-lg (last visited Nov. 14, 2017).

131. *See* United States v. Microsoft Corp., 253 F.3d 34, 105–07 (D.C. Cir. 2001) (imposing structural relief via a retrospective Clayton Act case to remedy anti-competitive effects of an acquisition is easier than imposing such relief for monopolistic conduct).

132. *See* KWOKA, supra note 11, at 133–34.

133. *See, e.g.*, Ford Motor Co. v. United States, 405 U.S. 562, 571–72, 578 (1972) (affirming comprehensive relief—divestiture, supply requirements, behavioral requirements, and protections for divested assets and employees—to ensure the restoration of competition on an acquisition that was several years old when challenged by the federal government); St. Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health Care Sys., Ltd., 778 F.3d 775, 792–93 (9th Cir. 2015) (holding that the district court's divestiture order was amply justified even though the merger took place prior to the district court's hearing because there was testimony from the acquired physician's group that they could compete independently because: (1) employees of the group had been told they would have their jobs no matter what, and (2) the acquiring system had agreed to pay nine million dollars to the acquired physician's group as part of the merger).

134. *See, e.g.*, KWOKA, *supra* note 11, at 128, 139.

135. *See e.g.*, *id*. at 128–30, 133.

136. *See, e.g.*, Complaint at 4–5, United States v. Haliburton Co, No. 1:16-cv-00233-UNA (D. Del. Apr. 6, 2016).

Accordingly, examples exist where such divestments in the past did not achieve the desired result of preventing an increase in prices.[137] The need for courts to ensure that viable third-party competitors arise out a divestment process also presents difficult questions for the courts to answer: (1) Can direct monitoring of such competitors ever take place once a divestment occurs and if so, when would it be appropriate?; (2) Is it easy to address a short-run exit problem if one, in fact, occurs even with such direct monitoring?; (3) How much due diligence can one do beforehand as to the viability of a third-party competitor, and should competitive commitments be required from such third parties beforehand?

That leaves behavioral conduct remedies that regulate or cabin the conduct of a firm in some manner but do not require the breakup of that firm itself or the spin-off of assets. As noted above, conduct remedies are quite common where vertical mergers are concerned,[138] such as in the telecommunications industry where a federal regulator, the Federal Communications Commission, is involved as well as state and federal antitrust agencies.[139] In that industry, though these conduct remedies—such as imposing net neutrality, non-retaliation, and/or equal access type of provisions to avoid content discrimination or disadvantaging competitors—can appear to be limited, but these remedies can, in fact, succeed in mitigating or preventing the negative anti-competitive effects of such mergers.[140]

In health care, the federal agencies prefer not to use such conduct remedies in the context of horizontal mergers, a stance validated by the courts.[141] However, the states—faced with hospitals that may fail unless they are acquired, hospitals for which continued community service is essential, or provider systems whose acquisitions may only enhance market power at the margins—have been more willing to use creative conduct remedies. For example, the Pennsylvania Attorney General has used conduct remedies to address provider acquisitions, including such remedies as barring higher hospital-based prices for services rendered by newly acquired physicians and requiring its newly acquired providers to have a separate and independent negotiating team to negotiate prices in good faith with insurers.[142] If insurers cannot negotiate what they believe to be a fair price from the provider, they may request arbitration with certain guaranteed processes to ensure a fair outcome.[143]

137. *See, e.g.*, KWOKA, *supra* note 11, at 107–08, 120.

138. *See supra* notes 121–23 and accompanying text.

139. *See* Varanini & Eisenberg, *supra* note 69, at 152–53.

140. *See, e.g.*, *id.* at 79, 126–57.

141. *See, e.g.*, St. Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health Care Sys., 778 F.3d 775, 793 (9th Cir. 2015).

142. Amended Final Order at 14, *supra* note 121, at 8, 14.

143. *See, e.g.*, Final Order at 7–10, Commonwealth of Penn. v. Urology of Central Penn., Inc., No. 1:11-cv-01625-JEJ (M.D. Pa. Aug. 31, 2011). Albeit in a non-health care context, the

Those conduct remedies can be effective, but there are limits to how far one can go with them in the merger context. For example, the Massachusetts Attorney General, faced with the acquisition of two hospitals that she thought might fail by a provider system that already had market power, entered into a settlement allowing the acquisition to proceed in exchange for the imposition of several conditions applicable to the entire provider system, such as a six and one-half year price cap across the entire provider system, restrictions on future acquisitions, and an allowance for insurers to purchase a la carte access to the different components of that system.[144] Ultimately, that Massachusetts settlement, in contrast to the settlements in Pennsylvania, was disapproved by the state court because it involved complex provisions applicable to the entire provider system (such as the price cap) that required close ongoing judicial supervision.[145]

In short, as far as conduct remedies in the merger space are concerned, the more complex the remedies in combination with ongoing supervision required by the court, the more the courts may look askance at such remedies. The more those remedies are cabined so that they do not involve the courts directly making complex determinations such as pricing, and the more that violations can be resolved with minimal court processes such as the use of fair and voluntary arbitration processes in provider-insurer negotiations or the use of a court-appointed special master or monitor,[146] the more successful such conduct remedies can be.[147]

California Attorney General has used a similar, voluntary, and fair arbitration process to avoid judicial concerns over the supervision of potentially complex court terms. *See* Final Judgment and Order Pursuant to Stipulation at 5–6, State of Cal. v. Pratibha Syntex, LTD., No. BC499751 (Cal. Super. Dec. 15, 2015); *see also Attorney General Kamala D. Harris Announces Landmark Settlement with Pratibha Syntex Ltd.*, OFF. OF CAL. DEP'T OF JUSTICE (Dec. 28, 2015), http://oag.ca.gov/news/press-releases/attorney-general-kamala-d-harris-announces-landmark-settlement-pratibha-syntex (last visited Nov. 4, 2017).

144. Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgment by Consent at 3, 10, 12–13, 16, Commonwealth v. Partners Healthcare Sys., Inc., No. SUCV2014-02033-BLS2 (Sup. Ct. Mass. Jan. 29, 2015).

145. *Id*. at 15–16, 46–48.

146. It has been suggested to the author of this article that state agencies could serve in such a role along with special masters and monitors. While state agencies would need to have the statutory authority necessary to serve in such a role, one could imagine cases involving joint jurisdiction by both a court and a state agency in which they may both work together to craft and supervise otherwise complex remedies over a long period of time until new competition emerges. *See e.g.*, BOVBJERG & BERENSON, *supra* note 121, at 1–2, 4–5, 11, 20–23 (discussing the exercise of joint jurisdiction of a state agency and the Attorney General of North Carolina over a provider system pursuant to the certificate of public advantage process).

147. As far as *Microsoft* involved the use of monitors by the two separate government enforcer groups, it too fits the pattern of using out-of-court methods to enable the enforcement of an otherwise complex court decree to occur in a manner that would not ensnare the court in determinations that either would be difficult or would involve minutiae. *See* New York v. Microsoft

Ultimately, however, the discussion in this section illustrates the practical limitations that can adhere to antitrust remedies in the judicial setting while facilitating competition as policy. Correspondingly, the discussion of antitrust principles and remedies—and their limits—raises the question of whether other measures exist that can go beyond antitrust in implementing competition as policy. It is to that question that this article now turns.

III. CONTRASTING ANTITRUST ENFORCEMENT WITH INCENTIVES TO INCREASE COMPETITION

Antitrust enforcement's goal, in the first instance, is not to increase competition over what prevailed in the status quo ante, i.e., what prevailed prior to the commission of anti-competitive conduct or an anti-competitive acquisition.[148] However, providing incentives can result in such an increase in competition. To give one relatively simple example, a serious and credible suggestion has been made that prizes be awarded to further development of pharmaceutical alternatives.[149] This could have a substantial impact on the development of drugs for which conventional incentives may not suffice, such as improved antibiotics, cheaper insulin, or medications to treat rare diseases.

Significant, albeit more complex, examples of such pro-competitive incentives abound in health care. For example, California has passed a series of laws over the past couple of years to increase price transparency in the selection of providers on one's health insurance; that transparency is designed to give consumers the tools necessary to select lower cost providers of quality health care.[150] Covered California, the agency that runs the intrastate regional exchanges for the sale of insurance policies in the individual and small group markets under the ACA,[151] promulgated regulations requiring insurers to report on those providers who provide either the costliest service or the lowest quality services (measured based on benchmarks set by Covered California) and then either provide a remedial plan or explain the circumstances as to why insurers continue to contract with those providers.[152] These regulations give insurers an

Corp., 224 F. Supp.2d 76, 86 (D.D.C. 2002); United States v. Microsoft, 253 F.3d 34, 81–82 (D.C. Cir. 2001).

148. *See, e.g.*, U.S. DEP'T. OF JUSTICE, ANTITRUST DIVISION POLICY GUIDE TO MERGER REMEDIES 1 (June 2011), www.justice.gov/sites/default/files/atr/legacy/2011/06/17/272350.pdf.

149. *See* Bryan P. Schwartz & Marhi Kim, *Economic Prizes: Filling the Gaps in Pharmaceutical Innovation*, COMM'N ON INTELL. PROP. RTS., INNOVATION & PUB. HEALTH 1, 47–48 (2005), http://www.who.int/intellectualproperty/submissions/CIPIHSubmissionsBryanSchwartz.pdf?ua=1.

150. *See, e.g.*, *Health Care Coverage: Provider Contracts: Hearing on S.B. 751 Before the Assembly Comm. on Health*, 2011–12 Leg. Sess. 4 (Cal. 2011).

151. *What is Covered California?*, COVERED CAL., https://www.coveredca.com/what-is-covered-california/ (last visited November 4, 2017).

152. *See, e.g.*, *Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy*, COVERED CAL. 3–4 (Feb. 18, 2016), http://board.coveredca.com/meetings/

incentive to contract with low-cost providers that can provide quality medical care, and are reasonably accessible, over those higher-cost providers that may not be better in terms of quality medical care or accessibility. Additionally, incentives exist on the federal level, such as those encouraging the formation of risk-sharing Accountable Care Organizations (ACOs) involving an arrangement between various providers and insurers.[153]

While these incentives can and do encourage competition, they can also be gamed or hindered such that their goals of furthering competition are not partly or fully realized. A provider with market power can form an ACO that does nothing more than reduce monopoly profits, possibly in exchange for a grant of exclusivity to safeguard those profits.[154] Even an insurer desiring to fulfill the goals of Covered California cannot force providers with market power to allow for steering, tiering, and all-or-nothing contracting—given Covered California may arguably lack direct authority over providers.[155] As illustrated by these examples, there is thus a need in thinking about competition as policy to go

2016/2-18/2017%20QHP%20Issuer%20Contract%20Attachment%207_February%2018_2016_CLEAN.pdf; *Cal. Health Benefit Exchange Board Minutes*, CAL. HEALTH BENEFIT EXCHANGE BD. (Jan. 21, 2016), http://board.coveredca.com/meetings/2016/2-18/January%2021%202015%20Minutes%20FINAL.pdf; *Cal. Health Benefit Exchange Board Minutes*, CAL. HEALTH BENEFIT EXCHANGE BD. (Feb. 18, 2016), http://board.coveredca.com/meetings/2016/4-07/HBEX%20Board%20Meeting%20February%202016.pdf; *Cal. Health Benefit Exchange Board Resolution No. 2016-09*, CAL. HEALTH BENEFIT EXCHANGE BD. (Apr. 7, 2016), http://board.coveredca.com/meetings/2016/4-07/HBEX%20Board%20Meeting%20February%202016.pdf. A somewhat parallel example exists in Massachusetts—with efforts having been made to encourage insurers to enter global or capitated pricing arrangements with providers to share upside and downside risk that have had success—though more remains to be done. MASS. OFFICE OF ATTORNEY GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS 1, 14 (Sept. 18, 2015), http://www.mass.gov/ago/docs/healthcare/cctcd5.pdf.

153. *See, e.g.*, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026, 67,027–67,028 (Oct. 28, 2011); *see also, e.g.*, United States v. Anthem, Inc., 236 F. Supp. 3d 171, 230 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017).

154. *See* Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. at 67,029.

155. *See* ERIN C. FUSE BROWN, NAT'L ACADEMY FOR STATE HEALTH POLICY, STATE STRATEGIES TO ADDRESS RISING PRICES CAUSED BY HEALTH CARE CONSOLIDATIONS 7 (2017), http://www.nashp.org/wp-content/uploads/2017/09/Consolidation-Report.pdf; COVERED CALIFORNIA, COVERED CALIFORNIA QUALIFIED HEALTH PLAN INSURER CONTRACT FOR 2016 BETWEEN COVERED CALIFORNIA, THE CALIFORNIA HEALTH BENEFIT EXCHANGE ("THE EXCHANGE") AND ("CONTRACTOR") 36–40 (2016), http://hbex.coveredca.com/PDFs/2016_QHP_Issuer_Model_Contract_and_Attachments.pdf. These incentives need not necessarily be subsidies. That being said, subsidies can be awarded and disbursed in a neutral administrative manner to jumpstart competition in new industries or enable research and development to create new markets. *See* ORG. FOR ECON. CO-OPERATION & DEV., TAX INCENTIVES FOR RESEARCH AND DEVELOPMENT: TRENDS AND ISSUES 7, http://www.oecd.org/sti/inno/2498389.pdf.

beyond the use of incentives as well as beyond vigorous antitrust enforcement, thus setting the stage for this article's discussion of market-governance rules.

IV. THE USE OF MARKET-GOVERNANCE RULES AS A COMPLEMENT TO ANTITRUST ENFORCEMENT AND THE USE OF INCENTIVES TO ENHANCE COMPETITION

Market-governance rules fill the gaps in otherwise vigorous antitrust enforcement and in incentives to foster competition, thereby complementing these measures in facilitating competition as policy reform. To understand this supplemental but important role that market-governance rules play in fostering competition as policy reform, this article will first discuss the use of public interest review of mergers in other industries and next the use of market-governance rules in health care in Massachusetts as well as in a limited regulatory way in California. This section will turn to legislation proposed in California in the 2015 to 2016 legislative year and re-introduced in the current 2017 to 2018 legislative year.

A. Public Interest Review of Mergers and Acquisitions

In regulated industries, mergers and acquisitions go through a public interest review process that takes place in front of the federal or state agencies responsible for supervising those industries.[156] That process does not ignore or obviate the competition-related analysis inherent in antitrust law; indeed, a review of these mergers or acquisitions for competition-related concerns takes place as part of this public interest process.[157]

However, a public interest review process can go beyond antitrust law in important ways. First, it can help guarantee that a merger will have beneficial effects on competition by guaranteeing continued, vigorous competition in existing markets and/or by requiring expansion into new markets, all as

156. INT'L COMPETITION POLICY ADVISORY COMM., U.S. DEP'T OF JUSTICE ANTITRUST DIV., TO THE ATTORNEY GENERAL AND ASSISTANT ATTORNEY GENERAL FOR ANTITRUST: FINAL REPORT 87, 148 (2000).

157. In California, the Antitrust Section of the California Attorney General's Office conducts such an analysis as part of the public interest review process for telecommunications (on the state level), CAL. PUB. UTIL. CODE § 854 (effective Jan. 1, 1996), and for not-for-profits, *see, e.g.*, Uniform Supervision of Trustees for Charitable Purposes Act, CAL. GOV'T CODE § 12588, *repealed and added by* 1959 Cal. Stat. 1258. In contrast, in the federal process for reviewing telecommunications mergers and acquisitions, the Antitrust Division of the U.S. DOJ plays an important role in reviewing such mergers and acquisitions for competition-related concerns. *See, e.g.*, Varanini & Eisenberg, *supra* note 69, at 152, 155. While state and federal antitrust agencies can play an important role in providing a competition analysis to their sister regulatory agencies, it is noteworthy—and important—that they retain the right to conduct an independent investigation and bring their own action in court because there are cases where mergers need to be blocked out of the gate due to substantial actual or likely inimical effects on competition. *See, e.g., id.* at 153–55.

buttressed by financial and other resource commitments.[158] Examples of these guarantees would include the commitments obtained by the Department of Managed Health Care and the Department of Insurance (though neither has an express public interest review process) from the parties to the Centene-Health Net merger.[159] Second, a public interest process can better ensure the viability of a third-party acquirer of assets from the merging party to ensure that competition will continue to take place in a state, as witnessed again by the example of financial and resource commitments obtained from the parties to the Centene-Health Net merger by the Department of Managed Health Care and the Department of Insurance.[160] Third, this public interest review process may provide an easier path than antitrust law to address monopsony issues in the context of already highly-regulated industries[161]—even though antitrust law can and should continue to vigorously address these issues.[162]

In fact, market regulators not only have great experience with the ongoing supervision of businesses in their markets but also have administrative subpoena and enforcement tools if businesses should violate their commitments. And while administrative enforcement actions are ultimately reviewed by the courts, such a review can take place under a deferential standard.[163]

B. Legislative and Regulatory Market-Governance Measures

As noted above, antitrust law may have limits in addressing conduct that, when adopted in whole or in part on an independent basis by several participants, can inhibit competition on a market-wide scale. However, state legislatures can

158. *See* Leemore Dafny et al., *More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces*, 1 AM. J. HEALTH ECON. 53, 57, 79 (2015) ("[P]remium[s] [on the Exchanges] would have been reduced by 5.4 percent had United entered all markets.").

159. *See, e.g.*, In re Application of Centene Corp., Chopin Merger Sub I, Inc., & Chopin Merger Sub II, Inc., No. APP-2015-00889 2–3, 7–8 (Cal. Ins. Comm'r Mar. 22, 2016), http://www.insurance.ca.gov/0400-news/0100-press-releases/2016/Centene/upload/DecisionOrderHealthNet Centene.pdf; Undertakings at 10, In the Matter of Centene Acquisition of Health Net (Cal. Dept. Managed Health Care Mar. 18, 2016), http://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/u032216.pdf.

160. *See, e.g.*, In re Application of Centene Corp. et al., *supra* note 159. at 7–8; Undertakings, *supra* note 159, at 2–10.

161. *See, e.g.*, United States v. Anthem, Inc., 236 F. Supp. 3d 171, 252 (D.D.C. 2017), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017) ("Supreme Court precedent indicates that courts should not be in the business of making policy determinations about the appropriate allocations of healthcare dollars; those are value judgment that are better directed to the legislature.").

162. *See, e.g.*, Mandeville Island Farms, Inc. v. Am. Crystal Sugar Co., 334 U.S. 219, 235–36 (1948); West Penn Alleghany Health Sys., Inc. v. Univ. of Pittsburgh Med. Ctr., 627 F.3d 85, 103 (3d Cir. 2010); Knevelbaard Dairies v. Kraft Foods, Inc., 232 F.3d 979, 988–89, 989 n.6 (9th Cir. 2000); *Anthem, Inc.*, 236 F. Supp. 3d at 252–53.

163. *See* CAL. CIV. PROC. CODE § 1094.5(a)–(c) (2012); CAL. EVID. CODE § 664 (2012); *see also* JKH Enters., Inc. v. Dep't. of Indus. Relations, 48 Cal. Rptr. 3d 563, 573–75, 81 (Ct. App. 2006).

and have passed laws that can, in supple or targeted ways, proscribe such conduct and in so doing enhance competition.[164] Similarly, state regulators can also play such a role where authorized to do so by state legislatures.[165]

As also noted above, antitrust law may be inhibited from addressing social trade-offs, such as balancing competition goals against consumer protection goals or determining what qualifies as an insurance product suitable for health care markets. However, addressing such social trade-offs is better suited for the legislature and for regulators in lieu of the courts applying antitrust law, as remarked by the district court in the Anthem-Cigna merger trial.[166]

Most notably, the Massachusetts Attorney General conducted a study of the health care markets on how large provider systems used all-or-nothing and anti-tiering/anti-steering contractual provisions to force insurers to increase prices[167] to the determinant of self-insured companies and of consumers forced to pay higher premiums. Based on that study, the Massachusetts Legislature passed laws that barred such contractual conditions.[168] Those laws, in turn, successfully increased demand for tiering products though work remains to be done in Massachusetts on price transparency and tiered-product design to take full advantage of these laws.[169]

In addition, the California Department of Insurance and the California Department of Managed Health Care had to wrestle with balancing competition and consumer protection goals in setting out network adequacy standards.[170] These standards had to include default rules to govern the adequacy of provider networks provided by insurance companies as part of their insurance products so that users of these products would have reasonable assurances that they would have close-by alternatives for their medical care.[171] At the same time, these

164. That same point was made recently, for example, by the White House under the Obama Administration. *See* COUNCIL OF ECON. ADVISORS, *supra* note 4, at 2, 6, 8.

165. *See* Martin Gaynor, *Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze*, 33 HEALTH AFF. 1088, 1090 (2014). For a discussion of examples at the federal level, *see* COUNCIL OF ECON. ADVISORS, *supra* note 4, at 11–12.

166. *Anthem, Inc.*, 236 F. Supp. 3d at 252 ("Supreme Court precedent indicates that courts should not be in the business of making policy determinations about the appropriate allocations of healthcare dollars; those are value judgments that are better directed to the legislature.").

167. COAKLEY, *supra* note 78, at 3–5, 41–42.

168. MASS. GEN. LAWS ch. 176J, § 11 (2017); MASS. GEN. LAWS ch. 176O, § 9A (2017).

169. MASS. OFFICE OF ATTORNEY GEN., *supra* note 151, at 7–13, 28.

170. *See* Deborah Reidy Kelch, *Health Insurance Oversight in California:Observations on the Post-ACA Environment*, HEALTH INS. ALIGNMENT PROJECT 4, http://www.kelchpolicy.com/sites/default/files/insert/Health%20Insurance%20Oversight%20in%20California-Post%20ACA%20June%202015.pdf; STATE OF CAL. DEP'T OF INS., *Network Adequacy Regulation (Permanent): Initial Statement of Reasons*, CAL. HOSP. ASS'N 2 (Sept. 25, 2015), https://www.calhospital.org/sites/main/files/file-attachments/init_statement_of_reasons.pdf.

171. *See Medicaid Managed Care Final Rule: Network Adequacy Standards*, STATE OF CAL.—HEALTH AND HUMAN SERVS. AGENCY, DEP'T OF HEALTH CARE SERVS. 9, 31 (July 19, 2017), http://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf.

standards also had to allow for the consideration of circumstances—including in principle competition-related issues—under which these default standards could be waived.[172]

C. Proposed Additional Market-Governance Laws in California

It has been suggested that enacting laws in California like those enacted in Massachusetts, as discussed in the prior section of this article, would have a salutary effect on restoring more symmetrical bargaining power between provider systems and insurers; in particular, such laws would mitigate the negative effects of provider market concentration on pricing for products sold on Covered California's regional exchanges.[173] Moreover, for reasons discussed above, the extension of public interest review to insurance mergers in the health care space in California would seem to be a natural extension of the current use of that review in telecommunications and the not-for-profit sector.

As it turns out, to achieve these goals, legislation was proposed in the California Senate in the 2015 to 2016 legislative year[174] and again in the 2017 to 2018 legislative year.[175] The current draft of this legislation in the 2017 to 2018 legislative year involves two bills: Senate Bill 538 and Assembly Bill 595.[176]

172. *See, e.g.*, CAL. CODE REGS. tit. 28, § 1300.51(d)(H) (2017).

173. *See* Thompson, *supra* note 8, at 34; *see also* Fuse Brown, *supra* note 16, at 112–13 (arguing that market approaches based on patient information or active purchasing by insurers cannot work "where there is little choice or competition between providers"); *id.* at 140 (referencing the need for private insurers and employers to "bargain aggressively"); Berenson et al, *supra* note 15, at 976 (referencing one reason for the growth of health care systems via cross-market mergers as the desire of providers to acquire leverage over insurers).

174. S. COMM. ON HEALTH REPORT, S.B. 538, at 6 (Apr. 17, 2017) (discussing S.B. 932), http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201720180SB538 (last visited Nov. 21, 2017).

175. S.B. 538, 2017-2018 Leg., Reg. Sess. (Cal. 2017); Assemb. B. 595, 2017-2018 Leg., Reg. Sess. (Cal. 2017).

176. Senate Bill 538 is on the California Legislature's two-year cycle such that it can be taken up again in the Assembly in January 2018 after having passed the Senate on May 31, 2017. *See* S.B. 538, *supra* note 175; *The California Legislative Process*, CAL. STATE UNIV., http://www.calstate.edu/AcadSen/Records/Agenda/documents/The_California_Legislative_Process.pdf. Assembly Bill 595 was placed into the suspense file by the Assembly Committee on Appropriations after having passed the Assembly Committee on Health, *AB-595 Health Care Service Plans: Mergers and Acquisitions.*, CAL. LEGIS. INFO., http://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=201720180AB595 (last visited Nov. 21, 2017), which had indicated that it is most likely dead for the rest of the 2017 to 2018 legislative session, *see* Laurel Rosenhall, *The Suspense Files: California Bills Vanish Almost Without a Trace*, CALMATTERS (Sept. 6, 2017), https://calmatters.org/articles/capitol-suspense-california-bills-vanish-almost-without-trace/, although it can always be reintroduced in the new legislative session. However, Assembly Bill 595 was just resurrected in January 2018 and passed by the Assembly, after first being amended, and is now in front of the Senate. Assemb. B. 595, 2017-2018 Leg., Reg. Sess. (Cal. 2018).

Senate Bill 538 is designed to prohibit contracts between hospitals (defined as including general acute care hospitals, acute psychiatric hospitals, and specialty hospitals) and insurers from including certain terms: (1) requiring an insurer to contract with any one (or more) of a hospital's affiliates (with a significant exception for physician medical groups affiliated with that hospital), (2) setting payment rates for affiliates of the hospital that are not participating in that insurer's network, (3) requiring insurers and self-insureds to agree to arbitration of state and federal antitrust claims as a condition for a hospital's entering into a contract (but with an exception for consensual agreements), and (4) requiring that services provided by a hospital and its affiliates not have to be compensated at the same rate as all other in-network hospitals and their affiliates.[177] The bill also contains certain provisions designed to avoid creating an asymmetrical bargaining relationship favoring insurers and self-insureds over providers; in addition to the carve outs mentioned just above, these provisions include a requirement that insurers not disclose contract rates to self-insureds without reasonable non-disclosure agreements.[178]

Assembly Bill 595 would require insurance companies (including hospital providers that offer insurance plans) to obtain prior approval from the Department of Managed Health Care before merging with, acquiring, or obtaining direct or indirect control over another insurance plan (referred to in this paragraph as *proposed acquisition*).[179] That department can grant approval if it finds the following: the proposed acquisition "[p]rovides short-term and long-term benefits in the form of lower prices, better quality, improved access to care, and reduced health disparities"; the proposed acquisition "[d]oes not adversely impact competition"; the proposed acquisition "[d]oes not jeopardize the financial stability of the parties"; the proposed acquisition "[d]oes not result in a significant effect on the availability or accessibility of existing health care services"; and the proposed acquisition is not being undertaken by a party that fails to follow state and federal laws and regulations, including those of that department.[180] In reaching these findings, that department would be required to review an assessment by the California Attorney General as to "whether

177. S.B. 538, 2017-2018 Leg., Reg. Sess. (Cal. 2017).

178. *Id.* This bill presently includes a provision that does not allow providers to bind "payors" (i.e., self-insureds) to the terms of provider contracts. *Id.* This article does not take a position on the underlying issues being addressed by this provision except to note that the author's personal view is that such a provision is not needed to address those issues already addressed by the ban on coerced antitrust arbitration clauses in provider contracts with insurance companies. *See infra* note 186 and accompanying text.

179. Assemb. B. 595, 2017-2018 Leg., Reg. Sess. (Cal. 2017). The bill was amended on April 3, 2017 to remove the Department of Insurance as a state agency that would also have authority over proposed mergers and acquisitions involving health care insurers. *Id.* The effects of this amendment are beyond the scope of this article.

180. *Id.*

competition would be adversely affected and what mitigation measures could be adopted" to avoid that result in what the bill labels an advisory opinion.[181]

The Department of Managed Health Care would not, however, be required to vote up or down on the proposed acquisition.[182] Rather, it could accept mitigation measures proposed by the parties, or impose its own, to remedy deficiencies it may find in the proposed acquisition, specifically adverse effects on cost, quality, access to services, or health disparities.[183]

Together these two market-governance rules can address potential gaps in antitrust enforcement and in the use of incentives in the health care space in California without displacing either of those alternatives. Senate Bill 538 proposes pro-competitive rules, of immediate impact, that could restore symmetrical bargaining power between insurers and providers.[184] First, it bars out anti-competitive conduct by providers akin to tying such as all-or-nothing, anti-steering, and anti-tiering conduct.[185] Second, it bars coerced antitrust

181. *Id.* The bill was amended on January 22, 2018 to remove the provision allowing the Attorney General to submit an assessment as to the adverse effect of the merger on competition. *Id.* Instead, it requires the Department of Managed Health Care to engage in that exercise with the Department now having the power to hire consultants to assist it in that exercise. *Id.* The removal of the Attorney General's role in issuing an advisory opinion on the adverse competitive effects of these mergers, which is unexplained in the legislative history, lessens the benefits of this bill's enhancement of competition as far as it fails to take advantage of an agency with considerable experience on the anti-competitive effects arising from mergers. Nonetheless, the Attorney General retains the power to investigate, and if appropriate seek to enjoin, these mergers under state and federal antitrust law. *See, e.g.*, California v. American Stores Co., 495 U.S. 271, 283–85, 296–97 (1989); Stop Youth Addiction, Inc. v. Lucky Stores, Inc., 950 P.2d 1086, 1097 (Cal. 1998) (finding that a prior holding of the California Supreme Court—that state Unfair Competition Law could not be applied to a merger—was overruled by a subsequent statutory amendment of that law), *superseded by statute on other grounds as stated in* Californians for Disability Rights v. Mervyn's, LLC, 138 P.3d 207, 209 (Cal. 2006).

182. *See id.*

183. *Id.*

184. S.B. 538, 2017-2018 Leg., Reg. Sess. (Cal. 2017).

185. *See id.*; *see also* Thompson, *supra* note 8, at 34.

arbitration clauses,[186] which raise issues that go beyond the theoretical.[187] Thus, Senate Bill 538 provides market-wide relief that goes beyond what antitrust law can provide, while strengthening federal and state incentives to enhance competition, such as those put into place by Covered California to encourage insurers to reduce costs and improve quality of care in their contracts with providers.[188]

186. S.B. 538, 2017-2018 Leg., Reg. Sess. (Cal. 2017). As noted above, firms with market power can use antitrust arbitration clauses essentially to shield anti-competitive conduct from antitrust scrutiny—adding arbitral requirements that procedurally and substantively disadvantage challenges to their market power versus what the antitrust laws themselves may provide. *See* Lemley & Leslie, *supra* note 90, at 41, 47. Although preemption issues under the Federal Arbitration Act are beyond the scope of the paper, this proposed provision may not, in fact, be preempted under that act. First, as far as it is one provision of a comprehensive legislative scheme to address alleged abuses of market power by health care systems, it does not single arbitration out for disparate treatment as was the case in *Kindred Nursing Centers Ltd. Partnership v. Clark.* Kindred Nursing Ctrs. Ltd. P'ship v. Clark, 137 S. Ct. 1421, 1426–28 (2017) (voiding a Kentucky Supreme Court rule preventing individual with general power of attorney from agreeing to arbitration clauses in contract unless the representative with that power obtained a specific waiver of the right to go to court and the right of trial by jury; such rulings did not put arbitration provisions on an equal footing with other contractual provisions or require specific waivers of other constitutional rights). In that sense, this proposed requirement functions as a safeguard akin to the unconscionability doctrine under state law; that latter doctrine of which in turn survives federal preemption because it focuses on whether a party lacked meaningful choice on an arbitration term or provision that is *one-sided*, rather than on whether that arbitration term or provision was more informal than what would obtain in court. *See, e.g.*, In re Checking Account Overdraft Litig. MDL No. 2036, 685 F.3d 1269, 1278–79 (11th Cir. 2012); Sanchez v. Valencia Holding Co., LLC, 353 P.3d 741, 748 (Cal. 2015) (unconscionability "is concerned not with a 'simple old-fashioned bad bargain' but with terms that are 'unreasonably favorable to the more powerful party'") (first quoting Schnuerle v. Insight Commc'ns Co., L.P., 376 S.W.3d 561, 575 (Ky. 2012); then quoting 8 Williston on Contracts §18:10 (4th ed. 2010)); *Sanchez*, 353 P.3d at 741 (finding that this standard applies as equally to arbitration provisions as to non-arbitration provisions); *see also* McGill v. Citibank, N.A.**,** 393 P.3d 85, 97 (Cal. 2017) (quoting Volt Info. Scis., Inc. v. Bd. of Trs. of Leland Stanford Junior Univ., 489 U.S. 468, 479 (1989) for the proposition that arbitration "is a matter of consent, not coercion"). Second, even if that provision could be viewed in isolation, it is still not preempted because it only addresses coerced arbitral clauses that have been effectively and impermissibly used to strip statutory rights set out in federal and state antitrust laws. *See e.g.*, Am. Exp. Co. v. Italian Colors Rest., 133 S. Ct. 2304, 2311 (2013); *id.* at 2313–14 (Kagan, J., dissenting); *McGill*, 393 P.3d at 97.

187. *See, e.g.*, Chad Terhune, *Big California Firms Take On Health-Care Giant over Cost of Care*, NPR (Apr. 7, 2016, 5:00 AM), www.npr.org/sections/health-shots/2016/04/07/473253558/big-california-firms-take-on-health-care-giant-over-cost-of-care (last visited Oct. 12, 2017).

188. In addition to the Thompson study cited above, Thompson, *supra* note 8, other noted health care economists who led a distinguished task force examining market concentration issues in health care have just called directly for states both to invigorate antitrust enforcement and to enact such laws to bring more competition into the health care sector. *See* Gaynor et al., *supra* note 11, at iii, 2. The need for such anti-tying rules as part of a combined strategy also arose, albeit more indirectly, in the analysis of whether changes should be imposed to the regulatory framework applicable under the certificate of public advantage accorded in North Carolina to the combined

Assembly Bill 595 mandates that no proposed acquisition can be approved if it would be found anti-competitive,[189] thus cementing the primacy of satisfying the competitive analysis required by antitrust. But it also goes beyond antitrust in requiring that the proponents of that acquisition also show how consumers would, in fact, benefit from this acquisition—as measured both by pricing *and* non-pricing metrics.[190] And it allows for the institution and supervision of ongoing requirements as a condition for approving a proposed acquisition by agencies who are experts in the health care industry either to remedy any anti-competitive effects or to ensure pro-consumer benefits,[191] a task that is arguably more suitable for those agencies than for the courts.

As noted above, market studies in Massachusetts paved the way for market-governance rules like those proposed in Senate Bill 538. Market studies paved the way for the successful use by antitrust public enforcers of merger laws to bar horizontal provider mergers and insurer mergers. Here, too, economic studies support the institution of California's and Massachusetts's efforts in market-governance rules with respect to insurer-provider contracting is concerned. Even aside from examples previously discussed in this article, one study analyzing data from 2004 to 2013 found that in California, multi-county hospital systems *as a system* could and had charged far higher prices than other providers.[192] Another earlier study came to the same conclusion regarding California in comparing per-patient costs for being treated in multi-hospital systems to per-patient costs for being treated in single hospitals.[193] The findings of such anti-competitive effects arising from the conduct of health care systems are not limited to California.[194]

V. CONCLUSION

Our political system is structured to give the states an incubator role in instituting differing approaches to the enactment and enforcement of laws.[195] Over time, the successes and failures of these various approaches inform federal and state policy-making. Massachusetts served as the model for the ACA[196] and is now serving as the touchstone for suggested legislation outside of California

Mission-St. Joseph hospital system. *See* BOVBJERG & BERENSON, *supra* note 121, at 14, 15, 27 n.18, 28 n.29.

189. Assemb. B. 595, 2017-2018 Leg., Reg. Sess. (Cal. 2017).

190. *See id.*

191. *See id.*

192. Melnick & Fonkych, *supra* note 100, at 5–6.

193. James C. Robinson & Kelly Miller, *Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California*, 312 JAMA 1666–67 (2014).

194. *See, e.g.*, N.Y. STATE HEALTH FOUND., *supra* note 11, at 60, 62–63.

195. *See, e.g.*, New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

196. Sharon K. Long et al., *Coverage, Access, and Affordability Under Health Reform: Learning from the Massachusetts Model*, 49 INQUIRY 303, 303 (2012).

to remedy the anti-competitive effects of that provider conduct discussed in the previous section of this article.[197] Looking through a wider lens, Alaska has experimented with a reinsurance program that has helped to safeguard insurer competition in that state and may be a model for other states.[198]

In general, health care has been viewed as a quintessential local issue calling for such experimentation by such diverse sources as the U.S. Supreme Court,[199] regulations under the ACA,[200] and at least one prior Republican proposal in the U.S. Senate allowing states freedom to keep the ACA regime if they so wished.[201] And this role of states in experimenting with different local solutions that can impact federal policy-making not only involves new, market-governing laws, but also involves the vigorous enforcement of antitrust laws; here the states will continue to play integral roles in such areas as challenges to insurer and provider mergers.[202]

Thus, what states choose to do with competition as policy reform is important for American health care. This article sets out how competition as policy within a given state need not involve just a single option such as vigorous antitrust enforcement. Rather, it can include a medley of options that include increasing not just antitrust enforcement but also incentives to encourage competition and market-governance rules. The states instituting such a medley of options to carry out competition as policy reform can substantially improve consumer welfare. And this combined approach is a sensible one for the American states in the twenty-first century for health care: it follows an approach

197. *See, e.g.*, N.Y. STATE HEALTH FOUND., *supra* note 11, at 6–8, 11–12, 35–39.

198. *See* Sarah Kliff, *How Alaska Fixed Obamacare*, VOX.COM (Apr. 13, 2017), https://www.vox.com/policy-and-politics/2017/4/13/15262614/obamacare-alaska-reinsurance (last visited Oct. 14, 2017).

199. *See* Medtronic, Inc. v. Lohr, 518 U.S. 470, 475 (1996).

200. Patient Protection and Affordable Care Act, 78 Fed. Reg. 13,406, 13,435 (Feb. 27, 2013) (Health Insurance Market Rules); Patient Protection and Affordable Care Act, 77 Fed. Reg. 18,310, 18,413, 18,417–19, 18,443 (Mar. 27, 2012) (Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers).

201. *See* Patient Freedom Act of 2017, S. 191, 115th Cong. (2017) ("To improve patient choice by allowing States to adopt market-based alternatives to the Affordable Care Act that increase access to affordable health insurance and reduce costs while ensuring important consumer protections and improving patient care.").

202. *See* Eric Kroh, *Health, Pharma Sectors Will Be FTC Focus, Ohlhausen Says*, LAW360 (Mar. 31, 2017, 2:53 PM), https://www.law360.com/competition/articles/908609/health-pharma-sectors-will-be-ftc-focus-ohlhausen-says?nl_pk=5ce9b545-d29e-40e4-a79a-5b83b95f36ff&utm_source=newsletter&utm_medium=email&utm_campaign=competition (last visited Oct. 14, 2017) (setting out the remarks of the chair of the antitrust task force of the National Association of Attorneys General that "state AGs have shown they can step up when needed.").

that not only was encouraged under the Obama Administration in the U.S.[203] but also is being undertaken more widely elsewhere.[204]

203. *See Benefits of Competition and Indicators of Market Power*, *supra* note 4, at 1, 14; *see also* Jason Furman, *Beyond Antitrust: The Role of Competition Policy in Promoting Inclusive Growth*, OBAMA WHITE HOUSE 1 (Sept. 16, 2016), https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160916_searle_conference_competition_furman_cea.pdf (remarks at the Searle Center Conference on Antitrust Economics and Competition Policy in Chicago, Illinois).

204. *See, e.g.*, Yong Huang & Baiding Wu, *China's Fair Competition Review: Introduction, Imperfections and Solutions*, COMP. POL'Y INT'L ANTITRUST CHRON., Mar. 2017, at 2, 3.