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HEALTHCARE

Affordable Care Act Signals New Direction for Antitrust Enforcement in Healthcare



By Douglas E. Rosenthal, Axel Bernabe and Daniel Vitelli

The enactment of the 2010 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, represents the most significant and comprehensive attempt to manage healthcare coverage for Americans since the creation of the Medicare program in 1965.

The main goal of the Act is to reform the delivery of healthcare services by changing the way healthcare providers are paid and by providing incentives toward greater integration between healthcare providers to use resources more efficiently. The Act seeks this goal through implementation of a Medicare Shared Savings Program that encourages provider groups to come together as Accountable Care Organizations (''ACOs'') and qualify for the Program's new payment structure.

By virtue of its emphasis on integration and cooperation between otherwise competing providers, the Act has generated considerable debate in the antitrust community as to the proper role of antitrust law in the healthcare sector. Proponents of the reforms have argued that absent a relaxing of antitrust scrutiny the Act's desired efficiencies cannot be achieved. Similarly, some of the county's largest health systems that were supposed to be spearheading the push towards greater

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integration have stated that they will not participate in the ACO framework absent a reduction of bureaucratic oversight, including of antitrust scrutiny.[1]

The purpose of this article is to review recently proposed regulations by the agencies tasked with antitrust enforcement to determine whether the new ACO framework does in fact weaken the traditional role antitrust law plays in the healthcare sector. Two important regulations under the Act were proposed in March of this year. The first, by the Centers for Medicare & Medicare Services (''CMS'') — the administrative agency chiefly tasked with implementing the Shared Savings Program — sets out a Proposed Rule on how the new ACO framework will be structured. The second, issued jointly by the Department of Justice (''DOJ'') and Federal Trade Commission (''FTC''), sets out a Proposed Statement of their policy for antitrust enforcement regarding the ACOs participating in the new Program.[2]

As set out below, an initial review of the Proposed Rule and Statement does indeed suggest a shift in focus by the Administration in the regulation of concerted activities by healthcare providers. First, the traditional analysis of whether cooperating providers are sufficiently medically integrated to avoid per se treatment under the antitrust law has broadly been taken from the agencies — the FTC in particular — and given to CMS. Second, there appears to be a greater willingness than in the past to allow provider cooperation among entities with a degree of market power. Indeed, both the Proposed Rule and Statement explicitly afford room for significant ACO growth — the former by encouraging ACOs to expand their footprint and grow their membership through their joint ventures and the latter by expanding the agencies' traditional antitrust ''safety-zone'' to include larger entities. Third, the Proposed Statement exhibits and reinvigorates focus on abuse of market power by dominant entities, particularly the use of vertical restraints such as exclusive dealing or contracting arrangements between large ACOs and insurance companies. As demonstrated in the final section of this article, this appears to be broadly consistent with recent Agency enforcement decisions.

In sum, our preliminary review of both the CMS and Agencies' proposals suggests an Administration willing to encourage ACO consolidation and tolerate greater market power with the goal of cutting and streamlining healthcare costs.[3] The Act's priorities do reflect a significant shift away from the Agencies' traditional role in the healthcare sector and a partial surrendering of antitrust oversight, particularly as it relates to joint ventures between competing entities with market power.

Such a shift raises concerns from an antitrust perspective. However, particularly in certain healthcare markets that are fragmented, it may be that cooperation between providers in an ACO could limit duplicative medical services without causing adverse economic consequences. To the extent that such a limited relaxing of traditional antitrust standards can lead us to an effective and much needed reform of the healthcare system, it may be a path worth considering.

Moreover, as set out in the Proposed Statement, and as demonstrated by recent enforcement activity, the Agencies have made it a priority to ensure that ACOs or other entities with significant economic power will be unable to exercise such power in an anticompetitive fashion. They have done so by stepping up enforcement of abuse of dominance, particularly of vertical restraints such as exclusive dealing or contracting arrangements between large providers and insurance companies.

One overarching concern does remain. That the quest towards increased efficiency and cost containment will disproportionally negatively impact the quality of patient care. While the CMS Proposed Rule does place a heavy emphasis on maintaining high quality standards, a reduction of competition in the delivery of medical services — combined with the Act's emphasis on shared savings to be achieved by reducing redundant care — carries significant risk that providers will short change innovation and quality care. The success of the Affordable Care Act's ability to reform healthcare will necessarily hinge on the Administration being able to encourage cooperation and cost savings while at the same time being able to supervise the quality of care being delivered.

I. BACKGROUND

On March 23, 2010, the Affordable Care Act was made law.

The goal of the Affordable Care Act is to reform health care by making higher quality care available to a greater number of individuals while simultaneously decreasing total health care expenditures. The government hopes to achieve this goal by realizing efficiencies through the development of value-based purchasing models, increased innovation, expanded reporting and evaluation programs and, most pertinently, the integration of healthcare providers. The Affordable Care Act's Medicare Shared Savings Program (or the ''Program'') and the development of the ACO model is the primary example of such legislative goals and the means by which to achieve them.

Implementation of the new law requires coordination by multiple agencies. The United States Department of Health and Human Services (''HHS'') is the primary entity responsible for the execution and administration of the ACO program. Section 1899(1) of the Affordable Care Act directs the Secretary of HHS to establish the Medicare Shared Savings Program no later than January 1, 2012, to ''promote[] accountability,'' ''encourage[] investment in infrastructure and rede-

[1] *See, e.g.* http://www.beckershospitalreview.com/hospital-physician-relationships/mayo-geisinger-cleveland-clinic-may-not-participate-in-acos.html; http://www.fiercehealthcare.com/story/mayo-forgoes-aco-rejects-participation/2011-06-13.

[2] See Robert E. Bloch and Scott P. Perlman, *Analysis of DOJ/FTC Proposed Policy on Accountable Care Organizations* (100 ATRR 441), for a foundation on the similarities and differences between the recent Proposed Statement and the existing FTC/DOJ 1996 *Statements of Antitrust Enforcement Policy in Health Care*.

[3] This conclusion and concern is shared by Robert E. Bloch and Scott P. Perlman in their analysis. As they state, ''[t]he Policy Statement in its present form appears to allow additional provider consolidation while at the same time relaxing integration requirements, creating a serious risk that it will encourage and condone the formation of ACOs with a greater ability to exercise market power against health plans than would ACOs formed under the principles in the 1996 Health Care Statements.'' *Id*. at 5.

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signed care processes,'' and attain ''high quality and efficient service delivery.''[4]

The HHS has delegated this task to CMS,an operating division of HHS. To this end, CMS submitted its Proposed Rule entitled ''Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations'' (''Proposed Rule'') on April 7, 2011.[5] This Proposed Rule sets out the specific standards that must be met by entities wishing to quality as an ACO and participate in the Shared Savings Program. Comments that were submitted before June 6, 2011, in response to the Proposed Rule will be considered by CMS before it issues its Final Rule.

In addition to HHS and CMS, the DOJ and the FTC (collectively the ''Agencies'') are involved in the execution and oversight of the Medicare Shared Savings Program. The DOJ, as an administrative agency, is responsible for implementing the administration's priorities with respect to antitrust enforcement related to the Program. The FTC, an independent agency, has historically taken the lead in considering issues of clinical integration in the health care sector and will continue to be involved in the review and enforcement of ACOs.[6] Notwithstanding traditional allocations of tasks between the Agencies, it appears that both will simultaneously be involved in the review and enforcement of the ACO Program.[7]

Historically, the DOJ and FTC have provided active oversight with respect to innovations in health care delivery systems, often by issuing advisory opinions, guidelines and policy statements. The FTC/DOJ 1996 *Statements of Antitrust Enforcement Policy in Health Care* (''1996 Health Care Statements'') have been the primary source of antitrust guidance for multiprovider networks[8] and more specifically for physician network joint ventures[9]. On March 31, 2011, the Agencies responded to the Medicare Shared Savings Program and the ACO framework by issuing their *Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* (''Proposed Statement'').[10] The Proposed Statement, discussed in detail below, is an extension of the DOJ/FTC analysis under the 1996 Health Care Statements.

II. CMS PROPOSED RULE REGARDING ACOs

CMS's Proposed Rule sets out the Administration's goal for the Shared Savings Program: ''(1) better care for individuals; (2) better health for populations; and (3) lower growth in expenditures.''[11] To achieve this, HHS and CMS attempt to generate incentives for providers to significantly invest in health care infrastructure through the establishment of ACOs, by allowing eligible ACOs that meet quality and savings requirements to share in Medicare savings as prescribed by the Affordable Care Act and the Proposed Rule.[12]

The Proposed Rule is relevant from an antitrust perspective in two primary ways. First, there is an implicit belief that ACOs will need to achieve a substantial size — not only in the Medicare market but also in the commercial market — in order to realize the necessary efficiencies to benefit from the Shared Savings Program. Second, the Proposed Rule sets out a new role for CMS concerning antitrust law in the new ACO framework.

1. ACO Size Matters

With respect to the potential size — and potential market power — of new ACOs, the Affordable Care Act and the Proposed Rule recognize that, in order to maximize clinical and financial efficiency-enhancing integration, the ACO will effectively need a substantial footprint in their relevant market. First, an ACO is required to have at least 5,000 Medicare fee-for-service beneficiaries assigned to it to participate in the Shared Savings Program.[13] Although such a threshold may not be challenging for urban and suburban ACOs, it may not be practicable in rural areas with dispersed populations.[14] By setting a minimum beneficiary limit, the Proposed Rule identifies a minimum ACO size as an indispensible element to a successful program.

Second, the Proposed Rule explicitly provides incentives for ACO growth by making shared savings under the Program more lucrative the larger the ACO. As explained in the Proposed Rule, ''as the number of assigned beneficiaries increases, the minimum savings rate (MSR) gets smaller. Conversely, as the number of assigned beneficiaries decreases, the MSR expands thus making it significantly more difficult for an ACO to obtain shared savings.''[15]

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[4] Affordable Care Act, § 1899(a)(1).

[5] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528 (proposed April 7, 2011) (to be codified at 42 C.F.R. pt. 425).

[6] *See* J. Thomas Rosch, Comm'r, Fed. Trade Comm'n, Statement of J. Thomas Rosch Respecting Proposed Regulations Implementing the Affordable Care Act 1 (Mar. 3, 2011), *at* http://www.ftc.gov/speeches/rosch/110303acostatement.pdf (''For the last decade, the FTC has not only taken the lead in reviewing and enforcing the antitrust laws respecting clinically-integrated health care providers, but has done so nearly exclusively.'')

[7] *See* Thomas Catan, *This Takeover Battle Pits Bureaucrat vs. Bureaucrat*, The Wall Street Journal (April 12, 2011), http://online.wsj.com/article/SB10001424052748703784004576221100894386950.html.

[8] ''Multiprovider networks'' are defined by the 1996 Health Care Statements as ''ventures among providers that jointly market their health care services to health plans and other purchasers.'' 1996 Health Care Statements, 134.

[9] ''Physician network joint ventures'' are defined by the 1996 Health Care Statements as ''a physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services.'' 1996 Health Care Statements, 76.

[10] Available at http://www.justice.gov/atr/public/guidelines/269155.pdf (last visited April 11, 2011).

[11] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528 (proposed Apr. 7, 2011) (to be codified at 42 C.F.R. pt. 425) at 19531.

[12] Questions remain as to what shape ACOs will take and whether health care providers will be willing to spend the necessary resources to meet the program's requirements.

[13] Affordable Care Act, § 1899(b)(2)(D).

[14] For instance, in certain rural service areas that simply do not have 5,000 Medicare beneficiaries to assign to an individual ACO, providers may be excluded from participation in the Program. Affordable Care Act, § 1899(b)(2)(D).

[15] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528 (proposed Apr. 7, 2011) (to be codified at 42 C.F.R. pt. 425) at 19545; *see also Id.* (''Thus, the amount of the incentive payment would be scaled to the number of beneficiaries in the

Third, the Proposed Rule recognizes that the patients covered by the ACOs will not be limited to Medicare beneficiaries but that ACOs will likely also be negotiating collectively with commercial insurers.[16] Although the current Program itself applies only to savings in the Medicare fee-for-service market,[17] it is understood that providers are more likely to form ACOs if they can simultaneously or subsequently reap the benefits of increased efficiencies in the provision of care for commercially insured patients. In short, if the Program ultimately is successful, it will result in a permanent shift in the health care delivery paradigm for a much larger category of patients — regardless of payment source.

2. Role of Antitrust Law in ACO Framework

The Proposed Rule is also relevant from an antitrust perspective in that it specifically sets out CMS' position concerning the role of antitrust law in the new ACO framework. The Rule does so in two ways. First it addresses the question of potential *per se* liability for collaboration between competing providers. Second, it sets out CMS' position for limiting the exercise of ACO market power.

The Proposed Rule clearly recognizes that the incentives provided by the ACO framework will necessarily involve competing provider collaboration. Pursuant to both the CMS Proposed Rule and the FTC/DOJ Proposed Statement, it is CMS, not the Agencies, that will be responsible for determinations of whether the members of the ACO are sufficiently integrated to protect against antitrust scrutiny — a role traditionally reserved for the FTC.

Citing several FTC Advisory Opinions, the Proposed Rule clarifies that in order to avoid such *per se* condemnation as ''shams'' that ''facilitate price fixing or other per se illegal activities,'' ACOs must show that they are ''integrated ventures that are likely to, or do, enable their participants jointly to achieve cost efficiencies and quality improvements in providing services.''[18]

Indeed, according to the Proposed Rule, the CMS eligibility criteria that must be met by ACOs to participate in the Shared Savings Program are broadly harmonized with ''the similar antitrust criteria on clinical integration.''[19] While such harmonization suggests that an ACO meeting the CMS eligibility criteria would likely have shown itself to be a pro-competitive entity, it is not clear from the Rule whether CMS will also require prospective ACOs to meet any additional integration requirements set out in the FTC Advisory Opinions specifically referenced or otherwise issued by the FTC. Nor is it clear to what extent any decision by CMS to deviate from such requirements will provide protection from subsequent enforcement Agency investigation.

The Proposed Rule also specifically addresses the question of potential ACO market power. Here, CMS makes clear its intent to ''preserve the benefits of competition for Medicare beneficiaries by precluding newly formed ACOs with market power from participating in the Shared Savings Program.''[20] Specifically, the Proposed Rule aims to maintain competition by promoting the ''formation of two or more ACOs in an area . . .''[21] To achieve its goal of limiting ACO market power, the Proposed Rule would require any ACO with a market share of more than 50% to obtain a ''letter from the reviewing Antitrust Agency confirming that it has no present intent to challenge or recommend challenging, the proposed ACO.'' [22],[23] Absent such a letter, the ACO would not be able to participate in the Shared Savings Program.

Notably, the stated goal of requiring that ACOs undergo such a mandatory antitrust review is to ''ensure that there are sufficient providers to allow the formation of competing ACOs to serve Medicare beneficiaries.'' As will be seen below, however, the Proposed Statement issued by the Antitrust Agencies does not appear to condition the granting of approval to such dominant entities on the existence of a sufficient number of competing providers. Rather, the agencies will ''consider any substantial procompetitive justification for why the ACO needs that proposed share to provide high-quality, cost-effective care . . . .''

As the Proposed Rule is silent with respect to whether CMS will be implementing its own criteria to limit ACO size — over an above those set out in the Agency Proposed Statement — the extent of their ability to limit ACOs with market power from participating in the Shared Savings Program remains to be seen.

III. DOJ/FTC PROPOSED STATEMENT REGARDING ACOs

The Agencies' Proposed Statement sets out the dual purpose of (1) giving providers increased confidence in the program by clarifying how the antitrust agencies will scrutinize collaborations of providers, and (2) coordinating the efforts between the antitrust agencies and CMS.

The Affordable Care Act's overall priority of encouraging provider collaboration, integration and ACO size is reflected in the Agencies' Proposed Statement. First, the Agencies indicate that they will defer to CMS in de-

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ACO during the performance year. However, since the MSR adjusts with the number of assigned beneficiaries, there is a built-in incentive for ACOs to increase their beneficiary population.'').

[16] *Id.* at 19630 (''A concern with potential ACO market power in the commercial (as well as the Medicare) market is warranted, because recent commentary suggests that health care providers are more likely to create ACOs under the Shared Savings Program if they can use the same ACOs to serve both Medicare beneficiaries and patients covered by commercial insurance.'') (citation omitted); *see also* DOJ/FTC Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 1.

[17] *See* Affordable Care Act, § 1899(d)(1)(B)(i).

[18] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19,528 (proposed Apr. 7, 2011) (to be codified at 42 C.F.R. pt. 425) at 19542

[19] *Id.*

[20] *Id.* at 19628.

[21] *Id.* at 19630.

[22] *Id.*

[23] Interestingly, rather than designating a single antitrust agency to review ACO applicants and enforce the antitrust laws in the ACO model, as suggested by at least one of the FTC Commissioners, the Proposed Rule delegates these responsibilities to both Agencies. *See* J. Thomas Rosch, Comm'r, Fed. Trade Comm'n, Statement of J. Thomas Rosch Respecting Proposed Regulations Implementing the Affordable Care Act 1 (Mar. 3, 2011), available at http://www.ftc.gov/speeches/rosch/110303acostatement.pdf (stating that proposed regulations ''omit assignment of responsibility for antitrust review and enforcement'' as between FTC and DOJ and arguing that FTC should have responsibility for ACO Program).

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termining the level of clinical integration required by ACO to be considered a bona fide joint arrangement. Second, the traditional antitrust zone thresholds, including the threshold for the ''Antitrust Safety Zone,'' are expanded for newly formed ACOs compared to the similar zones identified under the Agencies' 1996 Health Care Statements. Finally, the Proposed Statement places specific emphasis on an Agency review of potential abuses of market power by large ACOs — specifically through vertical restraints entered into between ACOs and health insurance companies.

1. Clinical Integration of ACOs

As explained above, the Proposed Rule specifically identifies the Agencies as being responsible for reviewing any ACO that has a greater than 50 percent share of a market. That said, under the Agencies' Proposed Statement, *the determination of whether an ACO is sufficiently integrated to avoid an allegation of per se price fixing is left in the hands of CMS*. The Agencies' coordination efforts with CMS involved a review of CMS's proposed eligibility criteria for ACOs and a determination that such criteria are ''broadly consistent with the indicia of clinical integration that the Agencies previously set forth in the Health Care Statements'' they issued in 1996.[24]

This represents a significant shift from prior practice. The FTC previously specialized in making case-by-case determinations as to whether sufficient clinical integration was achieved for purposes of antitrust enforcement and issuing advisory opinions in that respect.[25] At least with respect to clinical integration determinations for ACOs, the decision is largely taken out of the Agencies' hands and placed within CMS' purview. As confirmed by the Proposed Statement, ''organizations meeting the CMS criteria for approval as an ACO are reasonably likely to be bona fide arrangements intended to improve the quality, and reduce the costs, of providing medical and other health care services through their participants' joint efforts.''[26]

Significantly, the Agencies broaden the conclusion to what essentially amounts to an ex ante finding of sufficient integration — and procompetitive justification — to their analysis of commercial markets:

> Further, if a CMS-approved ACO provides the same or essentially the same services in the commercial market, the Agencies have determined that the integration criteria are sufficiently rigorous that joint negotiations with private-sector payers will be treated as subordinate and reasonably related to the ACO's primary purpose of improving health care services.[27]

It appears that the Agencies are satisfied with CMS's criteria at the front-end with regard to clinical integration. The Agencies' focus, rather, as set out in Section IV of the Proposed Statement, would now be limited to an ''analysis of ACOs that meet CMS eligibility criteria,'' as a matter of competition policy, and specifically whether any anticompetitive effects outweigh the procompetitive benefits of integration.

2. Antitrust Zone Thresholds Relaxed

As with their 1996 Health Care Statements, the Agencies set out to provide the health care community with predictability of review by designating discrete zones, each calling for different antitrust scrutiny, based primarily on the entity's share of an identified relevant market. Notably, rather than using the relevant geographic and product market to determine an entity's market position, the Proposed Statement details an analysis of an ACO's market position by considering the ACO's share of services in each ACO participant's Primary Service Area (''PSA'').[28, 29, 30]

Pursuant to Section IV of the Proposed Statement, the Agencies direct a competitive analysis of three classes of ACOs: those that fit within the proposed ''Safety Zone,'' those that require mandatory review by the Agencies, and those that neither fit the Safety Zone nor require review. Critically, the thresholds identifying these three distinct zones are enlarged and relaxed when compared with the 1996 Health Care Statements. This supports the notion that the Agencies recognize the importance of size to the success of health care reform and will adjust antitrust scrutiny accordingly.

A. ACOs In The Safety Zone

The first distinct zone contemplated by the Proposed Statement is the Antitrust Safety Zone. ACOs must satisfy the following two requirements to fall within the Antitrust Safety Zone: (1) ''independent ACO participants . . . that provide the same services . . . must have a combined share of 30 percent or less of each common service in each participant's PSA, wherever two or more ACO participants provide that service to patients from that PSA''; and (2) ''Any hospital or ambulatory surgery center . . . participating in an ACO must be nonexclusive[31] to the ACO . . . regardless of its PSA share.''[32] If the ACO falls within the Antitrust Safety Zone, the ACO has no obligation to contact the antitrust agencies during the application process for participat-

[24] Proposed Statement, 4.

[25] *See* Proposed Statement, 4 (citing *generally* FTC Staff Advisory Opinions (2002-present), *available at* http://www.ftc.gov/bc/healthcare/industryguide/opinionguidance.htm) (‘‘ [T]he Agencies have . . . responded to detailed proposals from health care providers who have decided how they wish to integrate their health care delivery systems to improve quality and lower costs.'')

[26] Proposed Statement, 4.

[27] Proposed Statement, 4.

[28] The Proposed Statement discusses an entity's share in its respective PSA, but is careful not to equate this concept to market share of a relevant geographic market under traditional antitrust analysis. Proposed Statement, 5 n.22 (''While a PSA does not necessarily constitute a relevant geographic market, it nonetheless provides a useful tool for evaluating potential competitive effects.'').

[29] Proposed Statement, 5. Although a granular analysis of the method used to calculate an ACO's PSA Shares is beyond the scope of this article, the authors direct readers to the Proposed Statement, 12-15 for an explanation of how to calculate PSA shares.

[30] ''The PSA for each service is defined as 'the lowest number of contiguous postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients]' for that service.'' Proposed Statement, 6 (quoting Medicare Program: Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 16094 (Mar. 26, 2004)).

[31] ''Non-exclusive'' in this context means the hospital or ambulatory surgery center ''is allowed to contract individually or affiliate with other ACOs or commercial payers'' and ''nonexclusive in fact and not just in name.'' Proposed Statement, 6.

[32] Proposed Statement, 6.

ing in the Shared Savings Program. These ACOs are presumed to be ''highly unlikely to raise significant competitive concerns.''[33]

The Agencies' Proposed Statement diverges from its 1996 Health Care Statements in two important respects. It increases the safety zone threshold to ACOs with independent ACO-participants combining for a 30 percent PSA share from the previous 20 percent share of a traditionally defined relevant market (which could use concepts of market definition other than PSAs).[34] It also introduces a new ''Dominant Provider Limitation'' clause to the safety zone analysis, whereby an ACO with a provider-participant with a greater than 50 percent share in its PSA of any service that no other ACO participant provides to patients in that PSA may fall within the safety zone so long as (1) the dominant provider-participant contracts with the ACO on a non-exclusive basis, and (2) the ACO does not require commercial payers to contract exclusively with the ACO or otherwise restrict the commercial payer's ability to deal with other provider networks.[35] These provisions tacitly acknowledge both the potential need for ACOs to have larger footprints in their respective markets as well as the fact that many provider markets already suffer from high levels of provider concentration.

The Proposed Statement also appears to echo the growth incentives in the CMS's Proposed Rule by shielding organic growth from antitrust review where it is driven by business acumen rather than anticompetitive considerations. For instance, an ACO starting below the 30 percent share mark that later exceeds that threshold solely because it attracts more patients will not lose its safety zone status and protection.[36] Indeed, even an ACO with a share greater than 50 percent will be permitted to grow if solely by attracting more patients without attracting additional review by the Agencies[37]—so long as it does not abuse that dominant position under antitrust laws.

B. ACOs That Require Mandatory Review

The second distinct zone contemplated by the Proposed Statement is the Antitrust Mandatory Review Zone for ACOs with PSA shares exceeding the 50 percent threshold for any common service that two or more independent ACO participants provide to patients in the same PSA, unless the ACO qualifies for the narrow Rural Exception.[38] If the ACO is of sufficient size to reach the Mandatory Review Zone, during the application process the ACO must provide CMS a letter from the FTC or DOJ indicating that it has no intention to challenge or recommend challenging the ACO.[39]

Here, the Agencies recognize that while the 50 percent share threshold provides ''a valuable indication of the potential for competitive harm,'' it will consider ''any substantial procompetitive justification for why the ACO needs that proposed share to provide high-quality, cost-effective care.''[40, 41]

The Agencies also provide specific guidance as to the type of conduct that may raise flags in their review. They state that ACOs with greater than a 50 percent PSA share can reduce the likelihood of antitrust concern by avoiding such conduct, which is identified in the Proposed Statement's description of its review of ACOs falling within the ''Gray Zone'' (below).

C. ACOs In the Antitrust Gray Zone

The final distinct zone contemplated is for ACOs that do not qualify for the Antitrust Safety Zone and are below the 50 percent threshold. We call this the Gray Zone. If the ACO falls within the Gray Zone, mandatory review by the Agencies is not necessary, but available.[42]

More importantly, this section sets out ''additional antitrust guidance'' for ACOs fitting within the Gray Zone–as well as those with greater than a 50 percent share—including specific examples of potentially anticompetitive conduct that ACOs should avoid in order to ''reduce significantly the likelihood of antitrust investigation.''[43] These examples of conduct, discussed below, provide valuable insight into the Agencies' focus on the exercise of market power through the implementation of vertical restraints.

3. Potentially Anticompetitive Conduct

The recent Proposed Statement indicates that the agencies will devote substantial attention to anticompetitive vertical restraints. In contrast to the Agencies' 1996 Health Care Statements that simply warned against attempts by providers to exclude competitors from the market by, for example, ''pressur[ing] other market participants to refuse to deal with such competitors or deny them necessary access to key facilities,''[44] the Proposed Statement provides significantly greater specificity regarding conduct to be avoided. This includes:

1. Preventing or discouraging commercial payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through ''anti-steering,'' ''guaranteed inclusion,'' ''product participation,'' ''price parity,'' or similar contractual clauses or provisions
2. Tying sales (either explicitly or implicitly through pricing policies) of the ACO's services to the commercial payer's purchase of other services from providers outside the ACO (and vice versa), including providers affiliated with an ACO participant (e.g., an ACO may not require a purchaser to

[33] Proposed Statement, 6.
[34] 1996 Health Care Statements, 64-65 (''The Agencies will not challenge, absent extraordinary circumstances, an exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market.'').
[35] Proposed Statement, 7.
[36] Proposed Statement, 7.
[37] Proposed Statement, 9 n.36.
[38] Proposed Statement, 8.
[39] Proposed Statement, 8.
[40] Proposed Statement, 8.
[41] What remains unclear from the Proposed Statement is whether the Agencies will coordinate their review of ACOs with a greater than 50 percent share with CMS's review of ACOs with a less than 50 percent share. As it stands, it is conceivable that an ACO with a 49 percent share will be subject to a different clinical integration (antitrust) analysis by CMS than an ACO with a 51 percent share whose ''substantial procompetitive justification'' for dealing with its competitors will be reviewed by the Agencies.
[42] Proposed Statement, 10-11.
[43] Proposed Statement, 10.
[44] 1996 Health Care Statements, 104.

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contract with all the hospitals in the same network as the hospital that belongs to the ACO)

3. With an exception for primary care physicians, contracting with other ACO physician specialists, hospitals, ASCs, or other providers on an exclusive basis, thus preventing or discouraging them from contracting outside the ACO, either individually or through other ACOs or provider networks
4. Restricting a commercial payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan, if that information is similar to the cost, quality, efficiency, and performance measures used in the Share Savings Program
5. Sharing among the ACO's provider participants competitively sensitive pricing or other data that they could use to set prices or other terms for services they provide outside the ACO.[45]

Notably, of the five types of conduct identified, 4 are aimed at the vertical relationship between the ACO and insurance companies and are stated to be ''important to facilitate payers' ability to offer insurance products that differentiate among providers based on cost and quality.''[46] Only one is aimed at conduct typically targeted by the Agencies when reviewing *horizontal* agreements between competitors, namely avoiding collusion on pricing or other competitively sensitive data.

The five types of anticompetitive conduct highlight the Agencies' particular concern with vertical restraints between health care providers and insurance companies. While the Proposed Statement is aimed specifically at ACO conduct in this regard, the Agencies enforcement record—as well as recent actions brought by private plaintiffs—suggests that such practices will also be subject to investigation when initiated by independent providers or large insurance companies. The Proposed Statement's emphasis on a review of vertical restraints appears consistent with the Agencies' recent enforcement activity. In particular, both the Proposed Statement and the enforcement activity suggest that vertical restraints, including exclusive dealing arrangements and other vertical exclusionary contracting practices, will receive special attention from the Agencies as the ACO framework unfolds.

IV. RECENT ANTITRUST CASES IN THE HEALTH CARE SECTOR

1. United States v. United Regional Health Care System

On February 25, 2011, the DOJ and the State of Texas filed a complaint against United Regional Health Care System alleging a violation of Section 2 of the Sherman Act.[47] The complaint provides an indication of the DOJ's position on certain types of conduct in the health care environment mere weeks before the DOJ/FTC Proposed Statement was issued. Here, the DOJ claimed that the defendant, an alleged ''must-have''[48] hospital in the region, had monopoly power in the markets for ''(1) the sale of general acute-care inpatient hospital services to commercial health insurers, and (2) the sale of outpatient surgical services to commercial health insurers,'' maintaining unlawfully a market share of approximately 90% and 65%, respectively.[49]

Critically for present purposes, the DOJ alleged that United Regional entered into exclusive contracts with commercial health insurance companies, whereby the insurance companies had to pay a ''substantial pricing penalty,'' ranging from 13% to 27%, if the insurers also contracted with competing providers.[50] The DOJ claimed that pricing penalties took the form of discounts:

> Specifically, the contracts provide for a higher discount off billed charges (*e.g.*, 25%) if United Regional is the only local hospital or outpatient surgical provider in the insurer's network. The contracts provide for a much small discount (*e.g.*, 5% off billed charges) if the commercial health insurer adds another competing local health-care facility, such as Kell West or Maplewood. A penalty that reduces an insurer's discount from 25% to 5% (for adding a rival facility) increases the insurer's price from 75% to 95% of billed charges—a 27% increase over the discounted price.[51]

These ''discount'' pricing penalties allegedly made it commercially unreasonable for an insurance company to enter into a contract with competing hospitals, unless the competing hospital would agree to prices below United Regional's marginal cost.[52] Accordingly, competitors were foreclosed from the most profitable health insurance contracts.[53] Additionally, the DOJ pressed the argument that no valid procompetitive justifications supported the conduct.[54]

On the same day the complaint was filed, the DOJ filed a Proposed Final Judgment prohibiting United Regional from (1) conditioning pricing discounts for commercial insurers on insurer's agreement not to contract with other providers; (2) prohibiting a commercial insurer from entering into contracts with other providers; (3) engaging in retaliatory or discriminatory action against a commercial insurer because the insurer deals with other providers; (4) offering its services to commercial insurers at a ''Conditional Volume Discount,'' unless the discounted prices are above cost; and (5) offering to or agreeing to terms with a commercial insurer that prohibits the insurer from offering products that encourage subscribers to use other in-network provid-

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[45] Proposed Statement, 10-11.

[46] Proposed Statement, 10.

[47] *United States v. United Regional Health Care System*, No. 7:11-cv-00030-O (N.D. Tex. filed Feb. 25, 2011), Complaint ¶ 86.

[48] A ''must-have'' hospital is a term used to describe a hospital with such a significant presence in the relevant market that payers effectively must contract with this hospital. Here, the DOJ's Complaint stated ''Commercial health insurers that offer health insurance within the [relevant geographic market] consider United Regional a 'must have' hospital because it is by far the largest hospital in the region and the only provider of some essential services, such as cardiac surgery, obstetrics, and high-level trauma care.'' Complaint ¶ 28.

[49] Complaint at ¶ 1, *United States v. United Regional Health Care System*, No. 7:11-cv-00030-O (N.D. Tex. filed Feb. 25, 2011).

[50] Complaint at ¶ ¶ 2, 44.

[51] Complaint at ¶ 44.

[52] Complaint at ¶ 79.

[53] Complaint at ¶ 55.

[54] Complaint at ¶ 80.

ers.[55] These prohibitions highlight the kind of conduct that will be targeted by the Agencies and reflect the prohibitions set out in the Proposed Statement. The matter was settled on the same day and is awaiting final judgment from the court after the 60-day comment period.[56]

2. Texas v. Memorial Hermann Healthcare System

In a similar vein, the Office of the Attorney General of Texas entered into an Agreed Final Judgment and Stipulated Injunction with Memorial Hermann Healthcare System (''Memorial'') on January 15, 2009.[57] Texas claimed that Memorial ''engaged in practices that discouraged health insurers . . . from entering contracts with certain of its competitors.''[58] In particular, Texas claimed that Memorial was the largest hospital system in Houston, maintaining a market share of approximately 20% during the time at issue.[59] The anticompetitive conduct targeted by the State of Texas in this case is similar to the vertical conduct identified by the Proposed Statement. As alleged, Memorial discouraged health insurers from contracting with competitors by (1) notifying an insurer that contracted with a competitor that Memorial would terminate its contract with that insurer; (2) substantially renegotiating its contract with an insurer that contracted with a competitor, resulting in ''substantial rate concessions'' from the insurer; and (3) notifying other insurers of Memorial's intention to terminate its contract with an insurance company that contracted with a competitor; and (4) notifying an insurance company that a 25% rate increase would result if the insurance company contracted with a competitor.[60]

The terms of the Order indicate that Memorial is enjoined from ''requiring, requesting, entering into, continuing, or maintaining any agreement with any Health Plan that the Health Plan will, alone or with other Health Plans, boycott or refuse to deal with one or more specifically identified competing hospitals or category of competing hospitals,'' among other things.[61] However, the Order does specifically note that ''Seeking or entering into contracts with Health Plans in which Memorial Hermann is designated as the exclusive provider or one of a limited number of providers of services for such Health Plans'' shall not violate the Order, subject to the possible application of another provision.[62] Digested, these provisions provide that Memorial may operate as an exclusive provider for an insurance company; however, it cannot achieve exclusivity by affirmatively requesting or requiring that the insurance company refuse to deal with other providers. This dividing line, albeit blurry in practice, mirrors the distinctions taken by the DOJ as outlined in the above case law and the five types of conduct referenced in the DOJ/FTC Proposed Statement, particularly Conduct Type 1.

3. United States v. Blue Cross Blue Shield of Michigan

In addition to bringing exclusive dealing claims against large providers, the DOJ has also brought claims against large insurance companies for exclusive contracting arrangements. In *United States v. Blue Cross Blue Shield of Michigan*,[63] the DOJ, on October 18, 2010, alleged that Blue Cross Blue Shield of Michigan (''Blue Cross'') included anticompetitive ''most favored nation'' (''MFN'') clauses in its contracts with hospital providers, thus violating Section 1 of the Sherman Act.[64] With respect to market position, the DOJ alleged that Blue Cross covers more than 60% of the commercially insured population of Michigan, leading to claims of market shares ranging from 40% to 80% in each of the relevant markets provided.[65]

In the health insurance context, an MFN clause requires that the hospital contract with rival insurance companies such that the hospital receives rates at least as high as, or higher than, the rates paid to the hospital by Blue Cross.[66] Such a provision effectively ensures that Blue Cross will pay the least amount to the hospital for health care services when compared to its rival insurance companies. Generally, Blue Cross would agree to pay a relatively higher price to the hospital in exchange for the MFN provision.[67] Accordingly, the DOJ claims that Blue Cross's MFN clauses bear an effective penalty feature insofar as a hospital would receive decreased revenue from Blue Cross enrollees, who represent a significant portion of hospital patients, if a hospital did not accept the MNF provision.[68] The anticompetitive effects alleged include (1) raising rivals' costs; (2) establishing a price floor, thereby deterring cost competition; (3) raising the price floor once established; and (4) increasing barriers to entry and expansion.[69] The DOJ claims that all of these anticompetitive effects ultimately resulted in an increase in the price of hospital services and health insurance prices.[70] Moreover, the DOJ alleges that the MFN clauses force hospitals to demand higher prices from insurers, ''effectively excluding [the insurers] from the market.''[71] A motion to dismiss was filed by defendants on December 17, 2010 and a memorandum in opposition was filed by the

[55] *United States v. United Regional Health Care System*, No. 7:11-cv-00030-O (N.D. Tex. filed Feb. 25, 2011), [Proposed] Final Judgment 5-6.

[56] United States Department of Justice, *Justice Department Reaches Settlement with Texas Hospital Prohibiting Anticompetitive Contracts with Health Insurers* (Feb. 25, 2011), http://www.justice.gov/opa/pr/2011/February/11-at-249.html (last visited Apr. 21, 2011).

[57] *Texas v. Mem'l Hermann Healthcare Sys.*, No. 2009-04609 (Tex. Dist. Ct., Filed Jan. 26, 2009), Agreed Final Judgment and Stipulated Injunction, *available at* http://www.oag.state.tx.us/newspubs/releases/2009/012609hermann_judgment.pdf (last visited Apr. 14, 2011).

[58] *Id.* at 1.

[59] *Texas v. Mem'l Hermann Healthcare Sys.*, No. 2009-04609 (Tex. Dist. Ct., Filed Jan 26, 2009), Plaintiff's Original Petition, ¶ 6.1 *available at* https://www.oag.state.tx.us/newspubs/releases/2009/012609hermann_pop.pdf (last visited May 4, 2011).

[60] *Id.* at ¶¶ 6.6-6.9.

[61] *Id.* at 4.

[62] *Id.* at 6.

[63] No. 2:10-cv-14155-DPH-MKM (E.D. Mich. filed Oct. 10, 2010).

[64] *United States v. Blue Cross Blue Shield of Michigan*, No. 2:10-cv-14155-DPH-MKM (E.D. Mich. filed Oct. 18, 2010) Complaint at ¶¶ 1-6.

[65] Complaint at ¶¶ 1, 28, 33.

[66] Complaint at ¶ 36.

[67] Complaint at ¶ 44.

[68] Complaint at ¶ 45.

[69] Complaint at ¶¶ 41, 45

[70] Complaint at ¶ 44.

[71] Complaint at ¶ 6.

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DOJ.[72] On June 7, 2011, the court denied Blue Cross Blue Shield's motion to dismiss.[73]

4. West Penn Allegheny Health System, Inc. v. UPMC

In a recent private[74] case, *West Penn Allegheny Health System, Inc. v. UPMC*, 627 F.3d 85 (3d Cir. 2010), the second-largest hospital system in Pittsburgh sued Pittsburgh's dominant hospital system and dominant insurer claiming that both defendants violated Sections 1 and 2 of the Sherman Act by conspiring to protect one another from competition.[75] As alleged, the defendant University of Pittsburgh Medical Center (''UPMC'') established a 55% market share of the Allegheny County market for hospital services and a market share greater than 50% for tertiary and quaternary care services; similarly, the plaintiff claimed defendant Highmark, Inc. maintained a market share of between 60% and 80% in Allegheny County market for health insurance since 2000.[76]

The plaintiff alleged vertical exclusionary conduct similar to the vertical conduct referenced in the DOJ/FTC Proposed Statement. For example, the plaintiff claimed that UPMC (1) ''refused to enter into competitive provider agreements with Highmark's rivals,'' and (2) ''shrunk [the] UPMC Health Plan (Highmark's main competitor in the insurance market),'' while Highmark (i) ''paid UPMC supracompetitive reimbursement rates . . . by increase[ing] its insurance premiums,'' (ii) ''vowed not to offer a health plan that did not include UPMC as an in-network provider,'' (iii) ''leaked confidential financial information regarding West Penn to UPMC,'' and (iv) ''maintained West Penn's reimbursement rates at artificially depressed levels and repeatedly refused to increase them.''[77] Moreover, the court noted that UPMC unilaterally pressured other hospitals in the community to enter into joint ventures taking the shape of exclusive-dealing arrangements whereby the other hospitals had to refer their oncology patients to UPMC-owned facilities.''[78] These allegations provide real-world significance to the otherwise abstract guidance from the Agencies. Indeed, it appears this is precisely the type of conduct the DOJ and FTC envisioned when emphasizing vertical restraints in the Proposed Statement.

Here, the plaintiff's complaint was dismissed by the district court.[79] On appeal, the Third Circuit determined that the complaint properly alleged sufficient direct evidence of an unlawful agreement producing anticompetitive effects in relevant markets, which lead to antitrust injury as to certain claims.[80] Therefore, the Third Circuit reversed in part and vacated in part the district court's opinion and remanded for further proceedings.[81]

5. Heartland Surgical Specialty Hospital v. Midwest Division, Inc.

In *Heartland Surgical*,[82] the District Court of Kansas considered a physician-owned provider's Section 1 claims that hospitals horizontally conspired, and that insurance companies and hospitals vertically conspired, in furtherance of a group boycott of the plaintiff that prevented the plaintiff from entering into in-network managed care contracts.[83] In denying the majority of defendants' motions for summary judgment, the court analyzed the market at issue, the evidence presented, the proffered economic theory and motive and procompetitive justifications offered to justify the conduct at issue. Therefore, this case not only demonstrates the increased opportunity for large insurance companies and large providers to engage in exclusionary vertical conduct, but also provides additional insight regarding the method by which courts will analyze such conduct.

Heartland held itself out as a specialty hospital, claiming to offer ''a higher standard of care with lower costs.''[84] In the relevant market pleaded, the insurance defendants accounted for approximately 90% of the managed care enrollment and the hospital defendants accounted for approximately 74% of patient revenues.[85] Heartland alleged both direct and circumstantial evidence that a conspiracy existed between traditional hospital providers and insurance companies for the purpose of denying specialty hospitals the ability to contract with the managed care organizations.[86]

In considering the summary judgment motions, the court considered the plausibility of the claims asserted. The court found it plausible that hospital defendants would conspire in order to quell the competitive threat of specialty hospitals, thereby protecting profitability and market share.[87] In short, the court was persuaded that it was economically believable that the hospitals would band together to pressure the insurance companies to deny entities like Heartland in-network status. The power to provide this pressure is driven largely from the market position the hospitals achieved.

From the insurance defendants' perspective, the court found it plausible that the insurance companies would agree to include exclusionary network configuration clauses, which excluded specialty hospitals while allowing competing hospitals to add new facilities, in provider agreements in exchange for lower reimbursement rates paid to hospitals.[88] As alleged, the insurance

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[72] http://www.justice.gov/atr/cases/f266300/266327.pdf; http://www.bcbsm.com/pdf/BCBSM_Motion_and_Brief.pdf.

[73] http://detnews.com/article/20110608/BIZ/106080325/Judge-allows-case-against-Blues-to-proceed.

[74] Although the case was ultimately brought by a private plaintiff, the antitrust agencies maintained a strong interest in this arrangement as noted by Judge Smith in the opinion of the Third Circuit: ''The conspiracy ended in 2007, when the Antitrust Division of the Department of Justice began investigating Highmark's and UPMC's relationship.'' *West Penn*, 627 F.3d at 94-95.

[75] *West Penn*, 627 F.3d at 91 (''The plaintiff says that pursuant to the conspiracy, the dominant hospital system used its power in the provider market to insulate the health insurer from competition, and in exchange the insurer used its power in the insurance market to strengthen the hospital system and to weaken the plaintiff.'').

[76] *West Penn*, 627 F.3d at 91-92.

[77] *West Penn*, 627 F.3d at 93-94.

[78] *West Penn*, 627 F.3d at 96.

[79] *West Penn*, 627 F.3d at 97.

[80] *West Penn*, 627 F.3d at 100-01, 105 (''Having concluded that paying West Penn artificially depressed reimbursement rates was an anticompetitive aspect of the alleged conspiracy, it follows that underpayments constitute an antitrust injury.'').

[81] *West Penn*, 627 F.3d at 110.

[82] *Heartland Surgical Specialty Hospital v. Midwest Division, Inc.*, 527 F.Supp.2d 1257 (D. Kan. 2007).

[83] *Heartland Surgical*, 527 F.Supp.2d at 1263.

[84] *Id.* at 1267.

[85] *Id.* at 1266.

[86] *Id.* at 1298.

[87] *Id.* at 1302-03.

[88] *Id.* at 1302-03.

companies essentially acted as the conspiracy's sword in exchange for reduced rates. The court further construed the individual network configuration agreements between a single hospital and a single insurance company to constitute circumstantial evidence of a horizontal conspiracy among the insurance companies.[89]

When weighing possible procompetitive justifications for the alleged behavior, the court was not convinced that they justified summary judgment disposition, particularly given the direct evidence of an agreement and the plausible economic motive.[90] In light of the condition of the relevant market, the direct and circumstantial evidence of an agreement and the economic theory, the court largely denied the defendants' motions for summary judgment. The matter was settled upon confidential terms in early 2008.[91]

6. Little Rock Cardiology Clinic PA v. Baptist Health

In *Little Rock*, the Eighth Circuit affirmed the district court's decision to grant a motion to dismiss for failure to state a claim under Sections 1 and 2 of the Sherman Act.[92]

Here, the plaintiff, a professional association of cardiologists, alleged that defendants worked together to protected Baptist Health from competition by terminating plaintiffs' provider agreements with Blue Cross & Blue Shield of Arkansas.[93] The plaintiffs alleged that for a number of years, plaintiff had clinical and staff privileges at Baptist Health and were in Blue Cross's preferred-provider network.[94] However, shortly after plaintiff opened a separate hospital specializing in cardiology services, Blue Cross terminated plaintiff's provider agreements.[95] The plaintiff alleged that this termination was effectuated by Baptist Health in order to protect Baptist Health from the new competition.[96]

The linchpin of the decision was that the plaintiff failed properly to allege a relevant market.[97] The court held that the plaintiff alleged a product market limited to patients covered by private insurance, yet did not clearly articulate whether the relevant product is (a) one conjoined service, cardiology services obtained in hospitals; or (b) two complementary services, hospital services and cardiology services.[98] Additionally, the court took issue with the plaintiff's claim that the relevant market was limited to commercial insurance payers, arguing that ''a product market cannot be limited to a single method of payment when there are other methods of payment that are acceptable to the seller.''[99] As an alternative ground, the court found that the plaintiff's alleged geographic market, Little Rock, was overly narrow as plaintiffs failed to allege that ''a low percentage of its patients enter its proposed geographic market.''[100]

In light of these failures, the court affirmed the district court's order to dismiss the antitrust claims with prejudice.[101] The Supreme Court denied the writ of certiorari, leaving a conflict as to whether patients covered through government insurance programs should be included in the relevant market. Of note, the DOJ's relevant market in the *United Regional* case discussed above excluded government payers from the relevant market primarily because ''The federal government sets the rates and schedules at which the government pays health-care providers for services provided to individuals covered by [government programs]. [Unlike commercial insurance programs, t]hese rates are not subject to negotiation.''[102]

V. ANALYSIS AND CONCLUSION

The DOJ/FTC Proposed Statement as well as the above cases demonstrate that abuses of market power through vertical restraints such as exclusive dealing arrangements and other exclusionary contracting practices in the provider-insurer relationship are likely to receive substantial attention in the antitrust analysis of health care markets. This is particularly true given the market integration and consolidation that will continue to occur as the ACO program is rolled-out.

Vertical restraints have been called into question by the Agencies not only when there is a clear, traditional exclusive dealing contract between an insurer and a provider, but also where contractual provisions indicate questionable nuances in the entities' relationship. Indeed, exclusionary arrangements come in many forms: the ''anti-steering, guaranteed inclusion, product participation or price parity'' provisions, as referenced in the DOJ/FTC Proposed Statement; or the discounting practices or penalty provisions, as implicated in the above *United Regional Health System* and *Blue Cross Blue Shield of Michigan* cases.

Vertical restraints can thus be the product of unilateral action by a dominant insurer or provider or the product of concerted action between one or more insurers and one or more providers. While antitrust law has traditionally deems concerted anticompetitive conduct more nefarious, the above cases demonstrate that the Agencies and private plaintiffs can and will use Section 2 of the Sherman Act to allege monopolization claims in instances of unilateral action.[103] Moreover, as the Agencies' actions reveal, with the increased concentration of both the provider and insurer markets, Section 2 cases against provider systems or insurers with substantial market power are likely to increase as the ACO framework is implemented.

The Shared Savings Program and the ACO model will hopefully provide opportunities to increase efficiencies in the ailing health care industry. However, entities wishing to be a part of the new Program must be sure to consider the warnings and guidance provided by the CMS' Proposed Rule, DOJ/FTC Proposed Statement, and recent antitrust actions. These documents and the recent case law emphasize the importance of business conduct and possible anticompetitive vertical restraints,

[89] *Id.* at 1301-02.
[90] *Id.* at 1308.
[91] http://www.stuevesiegel.com/CM/Press/Kansas-Clinic-Settles.asp (last visited Apr. 26, 2011).
[92] *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 594 (8th Cir. 2009).
[93] *Id.* at 594.
[94] *Id.* at 594.
[95] *Id.* at 594.
[96] *Id.* at 594.
[97] *Id.* at 594.
[98] *Id.* at 596-97.
[99] *Id.* at 598.
[100] *Id.* at 599.
[101] *Id.* at 601.
[102] Complaint at ¶ 14, *United States v. United Regional Health Care System*, No. 7:11-cv-00030-O (N.D. Tex. filed Feb. 25, 2011).
[103] *See, e.g.*, *United States v. United Regional Health Care System*, No. 7:11-cv-00030-O (N.D. Tex. filed Feb. 25, 2011).

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particularly exclusive dealing and other exclusionary contracting practices that fail to ensure competition. A serious economic analysis on a case-by-case basis of the net benefits to market competition and consumer welfare of such vertical restraints in the health care context is necessary to determine whether or not to permit such arrangements given the concerns with anticompetitive effects.

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