CHAPTER 5

HEALTH CARE ANTITRUST DEVELOPMENTS

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§ 5.01 INTRODUCTION TO HEALTH CARE ANTITRUST CONCERNS

Since 2015, the Federal Trade Commission (FTC), the U.S. Department of Justice (DOJ), and state Attorneys General (state AG) (collectively, the agencies) have continued their string of successful challenges to health plan, hospital, and physician practice mergers. The DOJ and FTC also have increased their scrutiny of market allocation agreements, wage fixing and no-poaching agreements between competing health care providers. In addition, the DOJ is challenging provider anti-steering and related provisions in payer contracts, which are relatively common in health plan—hospital agreements. The past three years also witnessed several court decisions resolving private hospital litigation involving significant doctrinal points. This chapter discusses the past three year's' key developments in these areas.[1]

§ 5.02 HOSPITAL, PHYSICIAN, AND HEALTH PLAN MERGER ENFORCEMENT

From 2016 to 2017, antitrust law practitioners watched closely as the federal courts analyzed the two largest insurance mergers in history. The proposed merger between Anthem, Inc. ("Anthem") and Cigna Corp. ("Cigna")—valued at $54 billion—and the $37 billion combination of Aetna Inc. ("Aetna") and Humana Inc. ("Humana") would have significantly consolidated an already condensed national insurance market and would have significant repercussions across multiple industries.

[A] Insurance Mega-Mergers

[1] Anthem/Cigna

On February 8, 2017, the U.S. District Court for the District of Columbia blocked the proposed $54 billion merger between Anthem and Cigna.[2] This ruling came on the heels of the court's decision to block another insurance mega-merger—the $37 billion deal between Aetna and Humana. Anthem subsequently appealed the decision to the United States Court of Appeals for the District of Columbia ("DC Circuit"), which, in a 2-1 decision, upheld the injunction by U.S. District Judge Amy B. Jackson, enjoining the industry's largest-ever deal because it would create an unlawful concentration of market power and Anthem's claims

[1] The authors dedicate this chapter to the memory of their colleague, Clifford "Cliff" E. Johnson.

[2] United States v. Anthem, Inc., 236 F. Supp. 3d 171 (D.D.C. 2017).

that the merger would provide $2 billion in efficiencies were dubious and could not be verified.[3]

On July 21, 2016, eleven states and the District of Columbia joined the DOJ's challenge of Anthem's acquisition of Cigna. The deal, which would have combined two of the "big four" largest health insurers and two of the few remaining commercial health insurance options in the individual and employer markets throughout the country,[4] would have been the largest merger in the history of the health insurance industry. In its complaint, the government argued that the merger would substantially lessen competition in numerous markets throughout the country, raise prices, reduce benefits, and deprive consumers and health care providers of the ability to improve care outcomes. The government further argued that, post consolidation, the "big four" would become the "big three" and each would have twice the revenue of the next largest insurer.

The DOJ's case against Anthem/Cigna focused on three distinct areas: national accounts, large group employers, and a monopsony claim.

- *National Accounts*. National accounts are those employer plans with more than 5,000 employees across multiple states (*i.e.*, those that require national coverage to insure their employees). The DOJ argued that the proposed merger would have harmed national accounts in two geographic markets: (1) the 14 states where Anthem sells under a Blue Cross Blue Shield Association ("Blue") license; and (2) the United States, generally. According to the DOJ, the merger would have eliminated a substantial competitor for Anthem, further consolidating an already consolidated market, resulting in market shares exceeding 50 percent (50%) in the relevant geographic markets. In addition, since Blue affiliates each enjoy an exclusive license to market insurance under the Blue brand within their individual territories, no two Blue companies would ever bid on the same large group or national account and no Blue licensee could bid on an account headquartered in another licensee's state without receiving a "cede" from that carrier.
- *Large Group Employers*. The DOJ argued that the proposed merger would have harmed competition in 35 metropolitan areas across the United States. In these areas, Anthem and Cigna were either the only, or two of the very few, large group employer insurance options. In these metropolitan areas, they competed based on reimbursement rates, customer service and innovation, all of which would presumably have been affected by the proposed merger. Indeed, the record revealed that Anthem's business model was to compete on the basis of low price (the "Walmart" model according to one witness). In contrast, the Cigna model

[3] United States v. Anthem, Inc., 855 F.3d 345 (D.C. Cir. 2017).
[4] United States v. Anthem, Inc., No. 1:16-cv-01493 (D.D.C. July 21, 2016).

was to compete on the basis of lowering employer medical spending through innovative provider collaboration and population health management programs.

- *Monopsony Claim*. The DOJ claimed that the proposed merger would have resulted in a monopsony whereby Anthem would be able to dictate market terms, resulting in lower reimbursement rates, reduced access to medical care, reduced quality and fewer value-based provider collaborations. The government argued that, post-merger, Anthem would gain significant leverage in rate negotiations with physician practices, hospitals and physician groups, allowing Anthem to impose "take-it-or-leave-it" terms. These lower rates would have, in turn, forced physician groups to reevaluate their employment and operations practices, effectively reducing patients' access to care and dis-incentivizing physicians to engage in collaborative, value-based care.

In reaching its decision, the court primarily focused on the anticompetitive harm to national accounts in the 14 states where Anthem operates as the Blue licensee. While the court did not directly address the DOJ's monopsony claim (which would have been of keen interest to providers) during its detailed discussion of Anthem's claimed $2 billion of efficiencies, the court did address the harm the merger would have caused to providers, even noting that Anthem's own witness offered his view that the merged company would ultimately be able to achieve even larger discounts from providers. In addition, the court noted Anthem's efficiency claims were premised upon its ability to exercise the muscle it had already obtained by virtue of its size. Therefore, with no corresponding increase in value or output, the court found the "efficiency" claims were better characterized as an application of market power rather than a cognizable beneficial effect of the merger.[5]

The court found that the merger would likely result in an anticompetitive impact on the market for the sale of national accounts within the 14 states where Anthem operates as a Blue licensee. According to the court, the evidence demonstrated that the merger was likely to result in higher prices to employers and individuals, eliminate competition between the two companies for national accounts, reduce the number of national carriers available to respond to solicitations, and diminish innovation.[6]

After confirming the relevant geographic and product markets, the court used the Herfindahl-Hirschman Index (HHI) metric to measure market concentration in the 14 states in question. The government argued, and the court found, that the market concentration resulting from the merger would have been presumptively anticompetitive as it eliminated the existing head-to-head competition

[5] *Anthem*, 236 F. Supp. 3d, at 192.
[6] *Anthem*, 236 F. Supp. 3d at 192.

between Anthem and Cigna and reduced the number of national accounts carriers from four to three. Further, the resulting entity's market power would not have been mitigated by new market entrants, the expansion of the markets in question, or the sophistication and bargaining power of the surviving competitors.[7]

In an effort to rebut the DOJ's case, Anthem argued that national account customers would enjoy over $2 billion in medical cost savings. Because many national accounts are self-insured and sign "administrative services only" (ASO) contracts, Anthem argued these $2 billion in medical cost savings would flow directly to large employers. In order to recognize these medical cost savings, Anthem's plan post-merger was to unilaterally invoke the "affiliate clause" provision in its provider contracts to require providers to extend Anthem's discounted fee schedules to the newly acquired Cigna accounts.[8] The court was not impressed with this argument, stating the medical cost savings were primarily the result of increasing market power and were not even necessarily an "efficiency" at all. In addition, the court specifically noted that Anthem's internal documents reflected that the company had been actively considering ways to capture the medical cost savings for itself, including by raising ASO fees.[9]

Because Anthem's plan was to use the "affiliate clause" and merely provide lower Anthem reimbursement to the Cigna accounts, the court found that "[n]ot one penny of these savings derives from anything new, improved, or different . . . to the contrary, the medical network calculation is specifically based on pricing that one or the other of the companies has already achieved alone."[10] In addition, the court found that Anthem's own witness specifically opined that Anthem had already achieved the benefits of scale in its dealings with providers and that increased volume would not enable it to obtain greater discounts, stating, "Anthem's already past the threshold of having enough size to do what it needs to do in terms of offering volume to providers." Essentially, the court found national accounts could already obtain the lower Anthem rates if they wanted to by simply switching carriers, so the medical cost savings were not merger-specific.[11]

Interestingly, the court also found that the medical cost savings were not verifiable. Citing internal Anthem memos and emails, the court found that Anthem was expecting strong provider push back in moving Cigna members to the lower Anthem rates. In one internal email, an Anthem executive stated, "I would expect strong provider resistance, as they view this as an incremental discount with no corresponding incremental value (no new members)."[12] Even

[7] *Anthem*, 236 F. Supp. 3d at 206.
[8] *Anthem*, 236 F. Supp. 3d at 231.
[9] *Anthem*, 236 F. Supp. 3d at 237.
[10] *Anthem*, 236 F. Supp. 3d at 238.
[11] *Anthem*, 236 F. Supp. 3d at 241.
[12] *Anthem*, 236 F. Supp. 3d at 243.

Cigna's CEO testified that Anthem's predicted medical cost savings were unreliable because they were based on an unproven assumption that providers will not react and negotiate their fee schedules upwards. The court also questioned whether the medical cost savings were even a true "efficiency" at all. Finding that the medical cost savings do not result from either company doing anything better, or from the elimination of duplication or the creation of new demand, the court was reticent to even call the medical cost savings an "efficiency."[13]

The court made particular effort to point out that Anthem and Cigna offered different products and utilized different strategies in the health insurance market. Anthem's strategy of leveraging its market power to command substantial discounts in provider contracts was directly opposed to Cigna's value-based strategy of collaborating with providers to reduce costs through innovation. As part of its "affiliate clause" strategy, Anthem's post-merger plan would have forced providers to increase collaboration (similar to Cigna's pre-merger strategy) but do so at lower rates (similar to Anthem's pre-merger strategy). Internal emails between Anthem executives showed the conflict between Anthem's stated plans to increase provider collaboration and to "drop the hammer" on providers with lower rates. Additionally, Cigna's CEO testified that imposing lower fee structures post-merger would unravel the collaborative relationships with providers that are essential to accountable care and better clinical outcome, leading to the destruction of the Cigna value proposition. The court noted that Anthem's own experts found that people "like something Cigna offers." Further, the court noted that providers have been very clear that one cannot ask them to do more but pay less at the same time.

In a rather bizarre twist, the court noted the "elephant in the courtroom": Anthem and Cigna's relationship had deteriorated throughout the merger and that the two were clearly not aligned. Not only did Cigna's executives provide compelling testimony that undermined the medical cost savings, but Cigna's counsel cross-examined Anthem's expert and refused to sign Anthem's Findings of Fact and Conclusions of Law on the grounds that they "reflect(ed) Anthem's perspective" and that some of the findings "are inconsistent with the testimony of Cigna's witnesses." All of this led the court to question whether the medical cost savings could be achieved and whether there was any basis to "believe in the rosy vision being put forward by Anthem."

Almost immediately following the court's decision, Anthem appealed the decision to the DC Circuit, asking for and receiving an expedited hearing set for March 24, 2017. On February 14, 2017, Cigna ended the merger agreement with Anthem and filed suit against Anthem in the Delaware Court of Chancery seeking $13 billion in damages for its shareholders on top of a $1.85 billion break-up fee outlined in the transaction agreement. The suit alleged Anthem "willfully breached" the merger agreement in a way that made it unlikely the deal would be

[13] *Anthem*, 236 F. Supp. 3d at 243.

approved.[14] On April 28, 2017, the Court of Appeals confirmed the court's decision blocking the merger. Anthem and Cigna continue to contest the break-up fee and damages in court.[15]

[2] Aetna/Humana

On January 23, 2017, following a 13-day trial, the U.S. District Court for the District of Columbia ruled in favor of the DOJ in the government's suit to block the $37 billion insurance mega-merger between Aetna and Humana.[16] Following the decision, the parties decided to abandon the merger and did not appeal.[17]

On July 21, 2016, the Antitrust Division of the DOJ, eight states, and the District of Columbia challenged Aetna's acquisition of Humana, two of the nation's largest providers of Medicare Advantage plans and two major competitors on the health insurance exchanges established by the Affordable Care Act.[18] The government alleged that Aetna's acquisition of Humana would substantially harm consumers in 364 counties across the United States and would have "enhance(d) Aetna's power to profit at the expense of seniors who rely on Medicare Advantage and individuals and families who rely on the public exchanges for affordable health insurance."[19] The DOJ differentiated Medicare Advantage plans as a distinct product market from traditional Medicare on the provision of additional benefits—such as prescription drug, dental, vision and hearing coverage, as well as care management and wellness programs—at a reduced cost under Medicare Advantage plans. In 70 of the 364 counties identified as the relevant geographic market, the government alleged that the proposed merger would have given Aetna and Humana a monopoly over the Medicare Advantage market. In approximately 100 additional counties, Aetna and Humana were the two largest competitors in those markets. Additionally, the proposed merger would have stunted expansion plans by the two companies that would have otherwise generated competition in additional markets.[20]

Aetna proposed to divest limited pieces of its or Humana's Medicare Advantage plans in counties throughout the United States where the court believed the merger would have an anticompetitive effect. The government argued that this plan would have failed to replicate the competition between Aetna and Humana and would have resulted in lower sales volume and market shares, would have

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[14] Anthem, Inc. v. Cigna Corp., No. 2017-0114-JTL (Del. Ch. Feb. 17, 2017).

[15] *Anthem*, 855 F.3d at 345

[16] United States v. Aetna, Inc., 240 F. Supp. 3d 1 (D.D.C. 2017).

[17] *Aetna and Humana Mutually End Merger Agreement*, Aetna (Feb. 14, 2017), *available at* https://news.aetna.com/news-releases/aetna-and-humana-mutually-end-merger-agreement/.

[18] *See generally,* United States v. Aetna, Inc., Case 1:16-cv-01494 (July 21, 2016).

[19] *Aetna*, Case 1:16-cv-01494 at 3.

[20] Anthem v. Cigna, No. 2017-0114-JTL at 1.

been less efficient and of lower quality, and would have provided fewer opportunities for innovation. Additionally, the government argued the proposed divestiture would have required significant additional government oversight to ensure compliance and to maintain the competitive balance in the relevant geographic markets.[21]

The DOJ identified public health insurance exchanges as a relevant product market in 17 geographic markets located across three states: Florida; Georgia; and Missouri. The DOJ argued that the further consolidation of the market would have harmed patients and increased the burden on taxpayers as additional funding would have been required to supplement the exchanges.[22]

The court's analysis of the Aetna/Humana merger centered on three distinct issues: (1) Medicare Advantage; (2) the Public Health Insurance Exchanges formed under the Affordable Care Act; and (3) potential efficiencies resulting from the merger.[23]

The court concluded that the proper product and geographic markets for evaluating this merger were the individual Medicare Advantage plans in the 364 counties identified by the government. Using the HHI metric to measure market concentration, the government argued, and the court found, that the merger would create "364 (very) highly concentrated markets, including 70 county-level monopolies" and was, therefore, presumptively anticompetitive. Additionally, the court determined that neither government regulation nor new entry by competitors into the relevant product and geographic markets would offset the loss of competition resulting from the merger.[24]

One of Aetna and Humana's key arguments was that the proposed divestiture of certain assets to Molina Healthcare would counteract any anticompetitive effects of the merger. Relying on arguments advanced by the government, historical analysis of Molina's attempts to expand into the Medicare Advantage market, and the internal comments made by the Molina leadership, the court found that Molina would struggle to put together a competitive provider network in the available time frame and that the divestiture of those certain assets would not counteract the anticompetitive effects of the merger.[25]

The government also alleged that the effect of the merger would be to substantially lessen competition in the public exchange markets in 17 counties across the United States, and specifically, in three contested counties in Florida. However, shortly after the complaint was filed, Aetna, making headlines nationwide, announced that it would no longer offer exchange plans in any of those 17 counties, citing financial losses. The government contested this position and the court, expressing skepticism, stated that they would grant the evidence the weight it

[21] Anthem v. Cigna, No. 2017-0114-JTL at 9.
[22] *Aetna*, Case 1:16-cv-01494.
[23] *See generally Aetna*, 240 F. Supp. 3d.
[24] *Aetna*, 240 F. Supp. 3d at 47.
[25] *Aetna*, 240 F. Supp. 3d at 59.

deserved—"less if Aetna withdrew for the purpose of improving its litigation position; more if Aetna withdrew for sound business reasons."[26] Troublingly, the court reviewed the evidence and determined that Aetna had in fact withdrawn from the 17 counties to improve its litigation position and chose to disregard this action and instead to analyze the competitive landscape as it existed in 2016.

The court concluded that the merger would substantially lessen competition in the public exchange markets in the three counties in Florida. Using the same HHI metric used to analyze the Medicare Advantage product markets, the court determined that the proposed merger would lead to presumptively anticompetitive levels of market concentration. Additionally, the government presented evidence that Aetna and Humana compete head-to-head in Florida on prices and product design and that the merger would have hurt competition following the removal of a key competitor in the respective markets.[27]

Aetna and Humana defended the merger on the grounds that it would have created substantial, procompetitive efficiencies, including efficiencies that would have accrued directly to the consumer. In particular, Aetna and Humana asserted that the proposed merger would have resulted in: (1) savings associated with moving Aetna's Medicare Advantage business onto Humana's more cost-efficient Medicare Advantage business; (2) pharmacy cost reductions through the consolidation of contracts, pharmacy rebate maximization and moving Aetna's outsourced pharmacy to Humana's in-house pharmacy; (3) network medical cost savings associated with the selection of the most favorable provider contracts; and (4) clinical cost savings, including the benefits of moving Humana's claims review process to Aetna's proprietary technology. Aetna and Humana alleged that the proposed merger would have produced $2 billion in annual efficiencies to the combined company every year after 2020 and an additional $300 million in cognizable efficiencies that would have flowed directly to the government and consumers.[28]

The court was unpersuaded by these efficiency arguments, stating that Aetna and Humana must present "extraordinary efficiencies" to rebut the presumption of illegality resulting from the merger's high market concentration measures—a standard, in the court's view, they failed to meet.[29] The court stated "Aetna and Humana put forward very little evidence that would tempt a consumer in one of the challenged markets to choose the merger over continued competition."[30]

[26] *Aetna*, 240 F. Supp. 3d at 80.
[27] *Aetna*, 240 F. Supp. 3d at 90.
[28] *See generally*, Aetna, 240 F. Supp. 3d.
[29] *Aetna*, 240 F. Supp. 3d.
[30] *Aetna*, 240 F. Supp. 3d at 98.

[3] Practical Takeaways for Antitrust and Health Care Practitioners

The courts' decisions in the Anthem/Cigna and Aetna/Humana mergers provide a number of lessons and practical takeaways for antitrust and health care practitioners:

- Where possible, providers should attempt to remove or revise "affiliate clauses" to limit the payer's ability to pass along a negotiated discount in the event of a merger or the addition of new affiliates. For example, the inclusion of a notice and acceptance process allows the provider to have greater control over whether the agreement can be passed on to new affiliates.
- As more care moves to the value-based model, providers should be mindful of the various products and services offered by payers and understand how these various products and services affect a provider's payer strategy. Recognizing that in many markets providers cannot simply walk away from the dominant payer, providers should carefully consider the financial risks and rewards of the various payer products and services.
- These cases emphasize the importance of ensuring proper intent and alignment between the parties, particularly as the DOJ and FTC depose leadership and review ordinary course documents in an attempt to determine the competitive impact.
- In this era of the Affordable Care Act (and its potential repeal and replacement), courts are cautious about wading into the policy discussion of rising health care costs even though certain cases might be squarely on point, deferring instead to the legislature to make such policy determinations.

[B] Hospital Mergers

Recent years have seen a roller coaster of activity for hospital merger enforcement. After a decade of success by the FTC, 2015 saw a number of ultimately short-lived victories for providers as hospitals and health systems attempted to position themselves in an ever-evolving health care landscape. In merger enforcement actions across the country, the FTC challenged the mergers, and ultimately won injunctions seeking to halt provider mergers.

[1] Penn State Hershey Medical Center/Pinnacle Health System

In the first significant court victory for hospitals over the FTC in more than 10 years, on May 9, 2016, U.S. District Judge John E. Jones III of the Middle District of Pennsylvania denied the FTC and the State of Pennsylvania's request for

a preliminary injunction to temporarily block the merger between Penn State Hershey Medical Center ("Hershey") and Pinnacle Health System ("Pinnacle"). Judge Jones rejected the government's definition of the relevant geographic market as too narrow and admonished the FTC for their opposition to mergers in an evolving health care environment that "virtually compels institutions to seek alliances such as the hospitals intended here." Disagreeing with Judge Jones, the FTC appealed to the Third Circuit, arguing that the decision failed to correctly apply the "hypothetical monopolist" test in determining the geographic market by only considering whether patients, and not insurers, would use hospitals outside the FTC's defined geographic market.

The Third Circuit found that Judge Jones erred in both the formulation and application of the hypothetical monopolist test. Judge Jones originally ruled that, in using the hypothetical monopolist test to define the relevant geographic market, the FTC constructed the market too narrowly because consumers regularly travel to Hershey from outside of the four-county geographic market proposed by the government.[31] The Third Circuit took issue with the district court's reliance on patient inflow data and found that the FTC presented undisputed evidence showing that 91 percent of patients in Harrisburg receive care in that area, supporting its contention that the market is inherently local.[32] The Court went on to say that the District Court failed to take the likely response of commercial health plans into account, choosing instead to focus on patient migration and neglecting the realities of a two-stage health care market.[33] Shortly thereafter, the parties announced they would abandon the proposed merger.

[2] Advocate Health Care Network/NorthShore University Health System

In September 2014, Advocate Health Care ("Advocate") and NorthShore University Health System ("NorthShore") announced their intention to merge and become the largest integrated health care delivery system in Illinois and the 11th largest not-for-profit system in the country.[34] One year later, the FTC and the State of Illinois sued to block the merger, claiming the companies would have had a virtual monopoly on general acute care hospitals in the suburban area of Chicago known as the North Shore.[35]

District Court Judge Jorge L. Alonso denied the FTC's motion for a preliminary injunction to block the proposed merger. In his decision, Judge Alonso

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[31] FTC v. Penn State Hershey Med. Ctr., 185 F. Supp. 3d 552 (M.D. Pa. 2016).

[32] FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327 (3d Cir. 2016).

[33] *Penn State Hershey Med. Ctr.*, 838 F.3d 327, at 342.

[34] *Advocate and NorthShore Combine to Create Preeminent Health Care System*, NorthShore University HealthSystem, *available at* https://www.northshore.org/newsroom/press-releases/northshore-advocate-merger/ (last visited June 14, 2018).

[35] FTC v. Advocate Health Care Network, No. 1:15-cv-11473 (N.D. Ill. Dec. 22, 2015).

found that the government had not "shouldered their burden of proving the relevant geographic market" and that, absent that showing, had not demonstrated a likelihood of succeeding on their claim. In rejecting the FTC's market definition, Judge Alonso highlighted the growing influence of outpatient facilities as a key driver of hospital admissions and the FTC economist's exclusion of so-called "destination hospitals" from the market definition.[36] The FTC disagreed with the district court's decision and appealed the decision to the Seventh Circuit. On October 31, 2016, the Seventh Circuit overruled the district court noting that Judge Alonso did not appropriately consider the FTC's evidence that Chicago's northern suburbs would be negatively affected by the Advocate-NorthShore consolidation.

The Seventh Circuit found the district court incorrectly interpreted and applied the hypothetical monopolist test as circular reasoning, arguing in favor of a more insurer-centric analysis, and further erred in not recognizing the differences between community hospitals and academic medical centers for purposes of analyzing the geographic market. The Seventh Circuit highlighted evidence that witnesses, including commercial health plan executives, differentiated academic medical centers from community hospitals in terms of the complexity of services provided and in patients' willingness to travel further for care. Additionally, the Seventh Circuit found that the district court erred in (1) finding the evidence "equivocal" that patients generally choose hospitals close to their homes; and (2) focusing on hypothetical patients who might travel further for their care to avoid higher prices post-merger rather than on those patients who would remain close to home for their care.[37] The Seventh Circuit remanded the case back to the district court.

On remand, the district court applied the Seventh Circuit's reasoning regarding an insurer-centric analysis and upheld the FTC expert's market definition. Advocate and NorthShore abandoned their attempted merger after the adverse ruling, and the FTC dismissed the administrative complaint.[38]

[3] Practical Takeaways for Hospital Mergers

The FTC's approach to hospital transactions and the court's rulings in these cases provide a number of practical takeaways and compliance best practices to consider when evaluating a potential hospital transaction:

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[36] FTC v. Advocate Health Care Network, No. 15 C 11473, 2016 BL 196331 (N.D. Ill. June 20, 2016).

[37] FTC v. Advocate Health Care Network, 841 F.3d 460 (7th Cir. 2016).

[38] *Advocate Health Care Network, Advocate Health and Hosp. Corp., NorthShore Univ. HealthSystem, In the Matter of*, FTC, *available at* https://www.ftc.gov/enforcement/cases-proceedings/141-0231/advocate-health-care-network-advocate-health-hospitals (last updated Mar. 20, 2017).

- The decisions in Hershey/Pinnacle and Advocate/NorthShore represent a strong endorsement by the courts for the FTC's analytical approach to hospital merger antitrust enforcement. The FTC has consistently tried to narrowly define geographic markets based on the views of the commercial health plans and self-insured employers in the area.
- Merger challenges are occurring in urban areas with competitive, saturated health care markets as well as in nonurban areas with only a handful of hospitals. Hospitals considering mergers with competitors even in large, populous metropolitan areas should undertake an antitrust analysis early in the transaction process to assess potential antitrust risk. Hospitals should consult numerous sources of evidence in conducting their initial analysis, including internal documents, managed care contracting history, network configuration, patient preferences and economic data, among other sources, to help determine the correct geographic and products markets that antitrust enforcers will analyze.
- Increasingly, antitrust enforcers are analyzing and using provider's ordinary course documents to help make the case for the competitive effects of a given transaction. These documents include email correspondence, consultants' reports, presentations, and other documents that document or evaluate a potential transaction. While not necessarily fatal to any given transaction, the parties' internal views on the competitive effects of a transaction may bear some influence on antitrust enforcers and ultimately a court's evaluation of a transaction.

[C] Physician Practice Acquisitions

Hospital acquisitions of physician practices have ebbed and flowed over the years as a result of different economic climates and regulatory environments. Hospitals and health systems have been majorly impacted by health care and payment reform, including the impact of the Affordable Care Act, various bundled payment initiates, the move toward quality-based and site-neutral payment systems, and the movement toward the enhanced use of electronic health records and technology in the delivery of care. Consequently, hospitals and health systems have prioritized the acquisition of primary and specialty care physician practice groups. Both the FTC and states AGs have taken a close look at the competitive impact of these transactions with a variety of different outcomes and analyses.

[1] Sanford/Mid Dakota

On June 22, 2017, the FTC and the Attorney General of North Dakota filed a complaint in the U.S. District Court for the District of North Dakota challenging the proposed acquisition of Mid Dakota Clinic, P.C. ("Mid Dakota") by Sanford

Health ("Sanford"). The complaint alleged that the proposed transaction would cause substantial harm to competition. On December 15, 2017, the United States District Court for the District of North Dakota granted the FTC and Office of the Attorney General of North Dakota's motion for a preliminary injunction, halting the proposed acquisition.[39] The parties have appealed the decision to the Eighth Circuit Court of Appeals.

Sanford is a 40-hospital, 250-clinic health care system headquartered in Sioux Falls, South Dakota that operates a 217-bed general acute care hospital and a network of primary care and specialty clinics and employs 160 physicians and 100 non-physician providers in the Bismarck-Mandan, North Dakota area. Sanford also sells health insurance in four states, including North Dakota. Mid Dakota is a for-profit, multispecialty medical practice employing 61 physicians and 19 advanced practice practitioners. Mid Dakota also operated six clinics, a Center for Women and an ambulatory surgery center primarily in Bismarck, North Dakota.

The government alleged the resulting entity would be able to impose a small but significant and non-transitory increase in price ("SSNIP") in four relevant service markets: (1) adult primary care physician (PCP) services; (2) pediatric services; (3) OB/GYN services; and (4) general surgery physician services—in the relevant Bismarck-Mandan, North Dakota geographic market—a four-county geographic region covering a population of more than 125,000 people. Using the Herfindahl-Hirschman Index (HHI) to analyze the number of physicians in the Bismarck-Mandan market and to measure market concentration, the court found the proposed transaction was presumptively illegal, further concentrating an already highly concentrated market.

In addition to the HHI analysis, the government analyzed a number of other qualitative and quantitative metrics including diversion, upward pricing pressure, and willingness to pay analyses. The government argued, and the court agreed, that Sanford and Mid Dakota are each other's closest substitutes and the proposed transaction would generate the ability for Sanford to use increased bargaining leverage to negotiate increases in reimbursement from commercial payers for primary care, pediatric, OB/GYN, and general surgery services.[40]

The parties did not challenge the government's market concentration analysis, but instead advanced a number of efficiencies arguments asserting that the transaction would benefit consumers and that the presence of a large insurer would preclude any anticompetitive effects that might otherwise result from the transaction. Sanford claimed that the transaction would have generated efficiencies in clinical care, ancillary services, and non-clinical areas including: (1) financial savings attributable to the federal 340B program; (2) a program incorporating genetic medicine into primary care; (3) embedding behavioral health therapists

[39] FTC v. Sanford Health, No. 1:17-cv-133, 2017 BL 473364 (D.N.D. Dec. 15, 2017).
[40] *Sanford Health*, No. 1:17-cv-133, 2017 BL 473364.

into primary care clinics; (4) cancer-care trials and community outreach; (5) electronic medical record ("EMR") system efficiencies; and (6) increased subspecialty recruitment.[41] The court spent significant time discussing the parties' dispute over the financial benefits attributable to the federal 340B program efficiencies, ultimately finding the defendants' analysis was flawed and insufficient to meet the required burden for claimed efficiencies.[42]

The government did not contest the claimed efficiencies impact on patient quality, but the court concluded that many of the claimed efficiencies were non-merger specific and insufficient to overcome the presumption of illegality. Quoting the Horizontal Merger Guidelines, the court stated that "efficiencies almost never justify a merger to monopoly or near-monopoly."[43]

Sanford and Mid Dakota argued that the presence of Blue Cross Blue Shield of North Dakota (BCBSND) in the market would mitigate any potential anticompetitive impact. Historically, antitrust law has been skeptical in applying a "powerful buyer" defense to merger analysis. Here, the court highlighted BCBSND's declining market share in the commercial health insurance market. Sanford also operates a health insurance plan—the Sanford Health Plan (SHP) —and their entrance into the commercial health insurance market further weakened the parties' "powerful buyer" argument. SHP was the second largest commercial insurer in the state and had already demonstrated the ability to compete aggressively against BCBSND, earning the contract with the North Dakota Public Employees Retirement System in a competitive bidding process over BCBSND.[44]

BCBSND expressed concern Sanford would have post-merger bargaining leverage to issue an ultimatum resulting in increased reimbursement for Sanford because Sanford would have the market power to be able to terminate its network agreement with BCBSND and cover individuals under SHP. The parties argued they could not issue an ultimatum to BCBSND because BCBSND is Sanford's largest payer and critical to their financial success. The court ultimately rejected the parties' "powerful buyer" argument, finding that the transaction would create a "near monopoly" in the relevant service areas, giving Sanford market negotiating leverage with BCBSND.[45]

[2] CentraCare Health/St.Cloud Medical Group

On February 29, 2016, CentraCare Health ("CentraCare"), a non-profit health system in central Minnesota that includes a multi-specialty physician practice group, and St. Cloud Medical Group P.A. ("SCMG"), a physician-owned,

[41] *Sanford Health*, No. 1:17-cv-133, 2017 BL 473364, at 2.
[42] *Sanford Health*, No. 1:17-cv-133, 2017 BL 473364, at 18.
[43] *Sanford Health*, No. 1:17-cv-133, 2017 BL 473364, at 21.
[44] *Sanford Health*, No. 1:17-cv-133, 2017 BL 473364, at 2.
[45] *Sanford Health*, No. 1:17-cv-133, 2017 BL 473364, at 21.

multi-specialty practice group that operates four clinics in and around St. Cloud, entered into an acquisition agreement. Under the agreement, CentraCare would acquire all outstanding shares of SCMG and directly employ all of SCMG's physicians and advanced practice providers. This transaction would be too small to be reportable under the Hart-Scott-Rodino Act. On January 9, 2017, almost a year after an anonymous tipster notified Minnesota's Office of the Attorney General about a possible combination between CentraCare and SCMG, the FTC and Minnesota Attorney General filed an administrative complaint challenging the transaction as anticompetitive alleging that the acquisition would substantially increase CentraCare's market share to over 80 percent in three specific physician service markets: adult primary care, pediatric primary care and OB/GYN care. In the complaint, the government acknowledged certain factors affecting the transaction—namely, that SCMG was a financially failing firm.[46]

CentraCare and SCMG argued for a "failing firm" defense in order to justify the proposed transaction. Under a failing firm defense, the parties had to prove: (1) that SCMG was unlikely to improve its financial condition; (2) physicians were leaving SCMG and more would depart both the group and the geographic area if the acquisition was not consummated; and (3) that SCMG made a good-faith effort to find an alternative buyer. In reviewing the facts at hand, the FTC found that SCMG was "financially failing, with no access to credit, and that physicians [were] and [would] continue to leave the practice. [That] they had shown that no alternative purchasers other than CentraCare were interested in acquiring the entire SCMG practice group."[47]

To resolve the competitive issues, the FTC and the parties entered into a settlement order that the FTC said would mitigate likely anticompetitive effects of the deal. Under the order, CentraCare promised to provide financial payments to incentivize the expansion of competition after the acquisition, to suspend noncompete agreements to facilitate the ability of up to 14 physicians from the SCMG group to accept other employment opportunities in the St. Cloud area, and to provide $100,000 "departure payments" to five physicians who leave CentraCare to create or join a small third-party medical practice in the St. Cloud area.[48]

This settlement outcome, however, does not appear to signal a return of the failing firm defense as a means of avoiding federal antitrust scrutiny. Instead, in this instance, the FTC believed that the practical realities of SCMG's financial health combined with the settlement provisions addressing physician noncompetes would offset the potential anticompetitive consequences of the transaction. In Commissioner Maureen Ohlhausen's concurring statement, she explained

[46] *CentraCare Health*, Docket No. C-4594, *available at* https://www.ftc.gov/system/files/documents/cases/170109centracarecomplaint.pdf.

[47] *CentraCare Health*, Docket No. C-4594, at 2.

[48] *CentraCare Health System*, Docket No. C-4594, *available at* https://www.ftc.gov/system/files/documents/cases/170109centracarefinalorder.pdf.

that SCMG failed to meet the required failing firm defense, but that the proposed settlement represented the best opportunity to ensure competition.[49]

[3] CHI Franciscan—WestSound Orthopaedics and the Doctor's Clinic

On August 31, 2017, the Washington state Attorney General (Washington state AG) sued CHI Franciscan Health (CHI) in federal court seeking to undo two recent transactions the suit claims were undertaken to increase prices on patients in the Kitsap Peninsula area west of Seattle. According to the Attorney General, the two 2016 deals, in which CHI obtained assets and contracted for ancillary services from The Doctors Clinic ("TDC"), a 54-physician multi-specialty practice, and acquired WestSound Orthopaedics, P.S. ("WestSound"), a seven-member orthopedic group, amounted to a conspiracy to reduce competition in the region.

The state's lawsuit seeks to undo the two transactions on two different legal theories. The Washington state AG's complaint alleged that the affiliation between CHI and TDC is a price-fixing agreement in violation of the antitrust laws. CHI acquired TDC's ambulatory surgery center, imaging and laboratory services. CHI then shuttered TDC's imaging services, as well as a large portion of the services provided at the ambulatory surgery center, and shifted that care to Harrison Medical Center—a CHI facility. CHI did not acquire TDC's medical practices. CHI and TDC entered into a Professional Services Agreement (PSA) whereby CHI would contract with TDC as a group, as opposed to individual physicians, compensating TDC based on an aggregate of TDC's RVU production which would then be distributed as income to the individual physicians by TDC. Under the PSA, TDC would retain governance and management rights over the practice. The only centralized functions under the PSA would be billing and collecting and information technology (IT).[50]

Citing to interrogatories, TDC admitted that it "remains [a] separate entity, and TDC's physicians remain under their own physician governance structure" and that in conducting the affiliation with CHI Franciscan, it was "absolutely" trying to remain as independent as possible operationally, while still affiliating with a large health organization.[51] According to the Washington state AG, CHI and TDC are separate economic actors, with independent economic incentives, that

[49] Maureen K. Ohlhausen, *Concurring Statement of Maureen K. Ohlhausen In the Matter of CentraCare Health System*, FTC (Oct. 6, 2016), *available at* https://www.ftc.gov/system/files/documents/public_statements/988633/161006centracarestatement.pdf.

[50] Washington v. Franciscan Health Sys., No. C17-5690 BHS, 2018 BL 83793 (W.D. Wash. Mar. 12, 2018).

[51] Washington v. Franciscan Health Sys., No. 3:17-cv-05690 (W.D. Wash. Aug. 31, 2017).

have come together under the PSA for the exclusive purpose of jointly negotiating reimbursement rates with payers in violation of federal and state antitrust laws.[52]

Conversely, the Washington state AG's complaint analyzed the WestSound acquisition under a more traditional horizontal merger analysis alleging that the resulting entity was presumptively illegal and resulted in demonstrable anticompetitive effects. Using an HHI analysis, the Washington state AG argued that the transaction moved the market from "unconcentrated" to "highly concentrated" and enhanced Defendants' market power for orthopedic services.[53] Using additional economic analyses (ex. Diversion Analysis), and analyzing the parties ordinary course documents found that before the WestSound acquisition, CHI and WestSound were each other's closest competitors for Orthopedic physician services.[54]

In its complaint, the Washington state AG sought to "unscramble the egg" and requested that the court undo CHI's acquisitions and enjoin the companies from entering into similar service agreements. Additionally, the state sought disgorgement of profits, alleging the transactions had caused monetary damages to citizens of the state, in addition to any applicable civil penalties.[55]

[4] Practical Takeaways and Compliance Best Practices for Physician Practice Acquisitions

The FTC's and state AGs' varied approach to physician acquisitions provides a number of practical takeaways and best practices to consider:

- State AGs can and do independently challenge transactions they consider anticompetitive with or without support from the FTC. State and local governments can and will continue to be aggressive in pursuing enforcement actions where health systems either acquire physician practices or use other agreements, such as professional services agreements, to charge higher rates for physician and ancillary services.
- Health systems should consider that even non-reportable transactions under the Hart-Scott-Rodino Act may trigger a challenge from either the FTC or state AGs. Antitrust enforcers frequently monitor national and local news and may act on tips relating to transactions of all sizes. Authorities increasingly appear willing to challenge non-reportable transactions involving health care providers.

[52] Washington v. Franciscan Health Sys., No. 3:17-cv-05690, at 20.
[53] Washington v. Franciscan Health Sys., No. 3:17-cv-05690, at 30.
[54] Washington v. Franciscan Health Sys., No. 3:17-cv-05690, at 31.
[55] Washington v. Franciscan Health Sys., No. 3:17-cv-05690, at 38.

- Regardless of the size and scope of a transaction, ordinary course documents such as internal emails, consultants' reports, presentations, and documents discussing a transaction may eventually surface in an antitrust investigation. Parties considering any type of action that could be construed as anticompetitive should be wary of the discussions they have and how those documents portray the parties' motives and incentives for various transactions.
- As with hospital transactions, federal and state antitrust enforcers are increasingly relying on the views of insurers in determining the effect of a given transaction on the relevant market. Providers considering entering into a transaction should consider how the transaction will be viewed by local and national insurers, and, if possible, work to generate buy-in in favor of the transaction.

§ 5.03 DEPARTMENT OF JUSTICE SHERMAN ACT SECTION ONE CONDUCT ENFORCEMENT

[A] Market Allocation Agreements

In the past three years, the DOJ has investigated and/or sued competing hospitals for unlawfully agreeing to allocate territories or services, and has alleged more aggressive *per se* and even criminal claims for these types of arrangements.

[1] *United States v. Allegiance Health*

On June 25, 2015, the DOJ and the Attorney General of Michigan sued four hospital systems—Hillsdale Community Health Center, Community Health Center of Branch County, ProMedica Health System, and Allegiance Health, alleging that Hillsdale entered into agreements with each of the other hospitals not to conduct marketing activities in each other's respective counties.[56] The complaint alleged that the hospitals had for years maintained a "gentleman's agreement" not to advertise in one another's territories, which constituted a market allocation agreement in violation of Sherman Act Section 1.[57] The DOJ alleged that the agreement "deprived patients, physicians, and employers of information regarding their health care-provider choices," and "limited competition among defendants" and "eliminated a significant form of competition to attract patients," such as advertising, direct mailings, outreach to physicians and employers, health fairs and free screenings. In a break with its prior enforcement of market allocation

[56] United States v. Hillsdale Cmty. Health Ctr., No. 15-cv-12311, 2015 BL 396912 (E.D. Mich. June 25, 2015).

[57] *Hillsdale Cmty. Health Ctr.*, No. 15-cv-12311, 2015 BL 396912, at 10

claims, the DOJ also alleged that the arrangement had was unlawful under a *per se* or, alternatively, a "quick look" analysis.

Three of the hospital defendants settled with the DOJ at the time the complaint was filed; however, Allegiance continued to litigate the case. Allegiance filed for summary judgment arguing that the arrangement should be subject to analysis under the rule of reason rather than the *per se* rule. Allegiance also argued that no unlawful agreement existed because the hospitals' actions were unilateral and part of a strategy to secure referrals for higher acuity services. The DOJ cross-moved on the same points, arguing that there was undisputed evidence of a market allocation agreement, and these types of agreements are plainly anticompetitive and always *per se* violations. On May 31, 2017, the court ultimately denied both motions in favor of allowing the case to go to trial. The court, citing email communications relating to the alleged arrangement among the hospitals, ruled that "there remain questions of material fact as to whether defendant's actions were a legitimate business strategy instead of an agreement to unreasonably restrain trade."[58] Specifically, the court called out contradictory testimony of the Hillsdale CEO, which could be construed to refer to either an agreement or a unilateral strategy. The court concluded:

> Because the Court is unable to determine whether an agreement exists, and therefore how it may be structured, the Court also is unable to determine which antitrust principle should be used to analyze the legality of any agreement. Accordingly, the Court denies all parties' motions for judgment on the applicability of the per se rule, "quick look" standard, and rule of reason.[59]

Later, in July 2017, the parties briefed the novel issue of whether, in light of the settling defendants' agreement to refrain from the conduct challenged in the complaint, the matter was moot—essentially, Allegiance argued that there were no partners with which Allegiance could conspire.[60] The court held that because Allegiance was not "certain" to prospectively refrain from conduct "related" to the actions challenged in the complaint, the case was not moot and should proceed to trial.

On the eve of trial, Allegiance entered into a consent decree agreeing to restrictions on future collaborations and communications with competitors regarding marketing, as well as specific compliance program requirement, including hiring an antitrust compliance officer, engaging in extensive annual antitrust training for leadership, submitting to inspections and interviews relating to compliance, and reporting and preserving documents relating to any future violations of the decree. Notably, the consent decree imposed the same restrictions, but

[58] United States v. W.A. Foote Mem'l Hosp., No. 15-cv-12311-JEL-DRG 1, 9 (E.D. Mich. May 31, 2017).

[59] *W.A. Foote Mem'l Hosp.*, No. 15-cv-12311-JEL-DRG, at 13.

[60] *W.A. Foote Mem'l Hosp.*, No. 15-cv-12311-JEL-DRG 1, 9 (E.D. Mich. May 21, 2018).

greater monetary penalties, on Allegiance than the three hospitals that originally settled rather than litigate. The decree also provides that "in any civil contempt action, any motion to show cause, or any similar action brought by Plaintiffs regarding an alleged violation" of the decree, Plaintiffs may "establish a violation and the appropriateness of any remedy therefor by a preponderance of the evidence, and Allegiance waives any argument that a different standard of proof should apply."[61]

[2] *United States v. CAMC*

In April 14, 2016, in the U.S. District Court for the Southern District of West Virginia, the DOJ entered into an almost identical consent decree with two competing West Virginia health systems, Charleston Area Medical Center (CAMC) and St. Mary's Medical Center (SMMC), settling claims that the defendants had a "gentleman's agreement" not to place billboard or newspaper advertising in each other's counties.[62] The complaint alleged that the agreement among marketing staff "disrupted the competitive process and harmed patients and physicians," adding:

> Among other things, the agreement has deprived patients of information they otherwise would have had when making important healthcare decisions and has denied physicians working for the Defendants the opportunity to advertise their services to potential patients.

It further alleged that the agreement was a *per se* violation of Section 1 of the Sherman Act. Interestingly, SMMC was in litigation with the FTC at that time relating to its merger with Cabell Huntington Hospital, and the market allocation agreement was likely discovered in that litigation and referred to the DOJ. In settling the DOJ's claims, the hospitals agreed to prospective restrictions on competitor collaboration and communication, and also to institute comprehensive antitrust compliance programs.

[3] *Monmouth County v. Florida Cancer Specialists, et al.*

On March 26, 2018, Monmouth County, New Jersey, brought an action on behalf of a putative class of purchasers of "oncology services" against Florida Cancer Specialists ("FCS") and 21st Century Oncology ("21C"), two large oncology providers, and their principle physician executives, alleging an agreement to

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[61] United States v. W.A. Foote Mem'l Hosp., No. 15-cv-12311-JEL-DRG 1, 9 (E.D. Mich. May 21, 2018).

[62] United States v. Charleston Area Med. Ctr., Inc., No. 2:16-cv-03664 (S.D. W. Va. Apr. 14, 2016).

allocate the oncology services market.[63] 21C, which had previously filed for bankruptcy, was subsequently voluntarily dismissed as a defendant. In the earlier bankruptcy proceeding, 21C disclosed that the DOJ Antitrust Division was conducting a criminal investigation relating to the oncology services market in Southwest Florida.[64] Also, previously, in 2016, a False Claims Act complaint filed in the United States District Court for the Middle District of Florida was unsealed after the DOJ declined to intervene in a case alleging, among other claims, a conspiracy among 21C and FCS not to compete in each other's primary service lines in certain counties in Southwest Florida.[65]

Specifically, the complaint alleged that, according to the relators in the False Claims Act matter, FCS and 21C had entered into a "gentleman's agreement" to send each other referrals for medical oncology (provided by FCS) and radiation oncology (provided by 21C) and not to offer those services themselves—*i.e.,* the parties had unlawfully allocated services. As a result, class plaintiffs alleged that they paid more for oncology services than they would have had FCS and 21C competed in the named counties. FCS filed a motion to dismiss on May 24, 2018 and subsequently, the court appointed a mediator and set a January 31, 2019 mediation deadline.[66]

[4] Practical Takeaways and Compliance Best Practices for Market Allocation Agreements

Apparently, "gentleman's agreements" to not compete in each other's service areas or for employees, including for physicians (see Section 5.06[A] regarding non-poaching and wage-fixing agreements), are relatively widespread among health care providers. They are, however, unlawful under the antitrust laws and potentially subject to the most severe antitrust penalties— criminal liability and substantial fines. And a defendant provider cannot defend its conduct by asserting a procompetitive justification or arguing that it has a low market share and the allocation agreement had no anticompetitive effect. Proof of entering into the agreement is alone sufficient to support a violation.

In fact, in its recent cases challenging market allocation agreements, the DOJ has alleged per se violations of the antitrust laws, unlike in prior cases, and has even conducted at least one investigation (there may be more that are not public) as a criminal prosecution. The DOJ has not brought a criminal suit in over 20 years, so this is a significant change and it remains to be seen what distinguishing

[63] County of Monmouth, New Jersey v. Florida Cancer Specialists, P.L., No. 2:18-cv-00201 (M.D. Fla. Apr. 10, 2018).

[64] *Florida Cancer Specialists, P.L.*, No. 2:18-cv-00201.

[65] *Florida Cancer Specialists, P.L.*, No. 2:18-cv-00201.

[66] *Florida Cancer Specialists, P.L.*, No. 2:18-cv-00201.

factors the DOJ will apply to determine whether to challenge a market allocation arrangement criminally versus in a civil suit.

Even where the market allocation is challenged in a civil action, the defendant provider can face substantial defense costs. And where the defendant decides to litigate rather than enter into a consent decree at the outset, like Allegiance, it will face even more severe penalties. And regardless of whether or when the provider settles with the DOJ, it will be subject to ongoing oversight and compliance requirements.

[B] *United States v. Carolinas HealthCare System*: Hospital-Payer Contract Provisions

On June 9, 2016, the DOJ and North Carolina Attorney General (North Carolina state AG) filed suit against Carolinas HealthCare System (CHS) alleging that CHS used its market power illegally to prevent major health insurers from steering patients to low cost hospitals, under Section 1 of the Sherman Act.[67] DOJ alleged that CHS entered into agreements that harmed consumers, employers and insurers in the Charlotte, North Carolina area by prohibiting insurers from offering patients financial incentives to utilize CHS's competitors. The DOJ and North Carolina state AG requested the court enjoin CHS from enacting or enforcing any provision in any agreement that prohibits or restricts an insurer from engaging, or attempting to engage, in steering towards any health care provider.

Specifically, the DOJ alleged that CHS leveraged its 50-percent market share in acute inpatient hospital services and "must have" status for payer provider networks to coerce insurers to include various steering restrictions in its insurance agreements, including agreements with Aetna Health of the Carolinas, Inc., Cigna Healthcare of North Carolina, Inc., Blue Cross Blue Shield of North Carolina and United Healthcare of North Carolina, Inc.—insurers that collectively control 85 percent of the commercially insured patient population in the relevant geographic market.[68]

The ability of insurers to steer patients away from one contracted provider to another in-network provider, the DOJ contended, can give providers a powerful incentive to be as efficient as possible, maintain low prices and offer high quality, innovative services. According to the complaint, CHS negotiated steering restrictions into its insurer contracts preventing insurers from providing financial incentives to patients to encourage them to consider utilizing purportedly lower cost but comparable or higher quality alternative health care providers and limit an insurer's ability to offer tiered networks that feature hospitals that compete

[67] United States v. The Charlotte-Mecklenburg Hosp. Auth., No. 3:16-cv-00311-RJC-DCK (W.D.N.C. June 9, 2016).

[68] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, at 7.

with CHS in the top tiers. The complaint further alleged that these provisions prevent steering *directly* by preventing insurers from offering either narrow networks that exclude CHS or tiered networks that incentivize patients to use CHS' competitors. The provisions also *indirectly* restrict steering by preventing the insurers from providing information to their enrollees about where they can obtain lower-cost or higher-quality health care services.[69] According to the DOJ, these provisions prevent insurers from offering narrow networks that include only CHS's competitors. The DOJ's complaint acknowledged that CHS offered discounts to encourage insurers to steer patients towards itself, but the DOJ apparently afforded little weight to those discounts (which it characterized as "modest") in its analysis.[70] The DOJ further claimed that CHS charged "premium" prices that were above "competitive levels."

In August 2016, CHS filed a motion for judgment on the pleadings arguing that its anti-steering provisions are not an exercise of market power, but instead allow CHS to lower rates by ensuring access to a larger patient population.[71] CHS also argued that there is no evidence of anticompetitive effects from these provisions, noting that the complaint failed to show that the provisions actually lessened competition or lacked procompetitive effects. Subsequently, while CHS' motion was pending, the Second Circuit issued an opinion in *United States v. American Express* finding that similar steering restrictions imposed by American Express were not anticompetitive.[72] Specifically, the court determine that American Express' use of "nondiscriminatory provisions" did not prevent merchants from encouraging customers to use credit cards that charge lower fees, and thus did not have any anticompetitive effect. Previously, in response to CHS' motion, the DOJ had relied heavily on the underlying district court decision in *American Express*. Both CHS and DOJ then submitted supplemental briefing on the *America Express* decision. CHS described the decision as a "major blow" to the DOJ's arguments and urged that the same reasoning be applied in this lawsuit. DOJ responded that the Second Circuit's decision was distinguishable and was based on an extensive factual record, while here CHS was seeking to dismiss the case prior to any fact discovery.

On March 30, 2017, the court denied CHS' motion to judgment on the pleadings, finding that the DOJ and the North Carolina state AG's claims alleged plausible antitrust violations and should continue to discovery.[73] The court found that DOJ plausibly alleged that steering restrictions drive up insurance prices and

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[69] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, at 5.

[70] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK (W.D.N.C. Aug. 31, 2016).

[71] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK (W.D.N.C. Aug. 31, 2016).

[72] United States v. Am. Express Co., Docket No. 15-1672 (2d Cir. Sept. 26, 2016).

[73] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK (W.D.N.C. Mar. 30, 2017).

limit choice for health care consumers.[74] The court also pointed to allegations that the restrictions can result in higher out-of-pocket costs for consumers and hamper their ability to comparison shop. In addition, the court gave little weight to the Second Circuit's decision in *United States v. American Express*. The court specifically stated that it was not bound by the precedent, and that the Second Circuit only reached its decision after extensive discovery and a seven-day bench trial rather than on a motion on the pleadings, stating, "[i]mportantly, this court has not been presented with facts yet enabling it to conclude whether CHS' steering restrictions have pro-competitive or anti-competitive effects."[75] The court also found that the Second Circuit's analysis involved the loyalty of credit card holders to specific cards, which the court described as an entirely "different product and a different market" that has little applicability to the health care industry.[76] But the court also noted, however, that "CHS has raised serious and robust questions about the purposes, effects, and legality of its contractual steering restrictions and steering restrictions generally, but those questions are best resolved after the benefit of discovery."[77] Two weeks later, a state court ruled that a proposed class action could proceed under a similar theory.

The specifics of the alleged anti-steering mechanisms and evidence elicited during discovery supporting these allegations of market power and "premium" prices will be important to the outcome of this case because it is not uncommon and, presumably, not illegal for providers to reduce inpatient or outpatient prices relative to market rates in exchange for full inclusion by payers in their network configuration decision-making or to offer lower prices in exchange for excluding a key competitor to which the provider might otherwise lose patients (*i.e.*, "discount for volume" contracting). Nor is it uncommon to negotiate anti-discrimination provisions so that the provider is treated fairly by the payer in comparison with the treatment of similarly situated network providers. Finally, it is not uncommon for health systems to negotiate with payers for all hospital locations as a system to obtain lower rates in the aggregate in exchange for anti-steering provisions that minimize system leakage. However, a system with market power or "must have" facilities generally cannot use its leverage to foreclose or restrict competitor's access to insurers, or to obtain or maintain above-market prices. The ultimate issue is whether anti-steering provisions result from the exercise of market power or, conversely, are among the many price and non-price terms negotiated by the parties in good faith bargaining.

[74] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, at 15.
[75] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, at 18.
[76] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, at 16.
[77] *The Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, at 14.

[1] Practical Takeaways and Compliance Best Practices for Hospital-Payer Contract Provisions

The DOJ's challenge provides some new practical takeaways and reinforces others for any provider already utilizing or contemplating agreements with payers that include various forms of steering restrictions or requirements for full-system contracting:

- Given the DOJ's clear opposition and willingness to litigate its challenge to the steering restrictions here, providers with significant market share should be cautious about negotiating such provisions into their managed care agreements since this challenge signals a new focus in DOJ antitrust enforcement.
- In the FTC/DOJ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, the government indicated that an entity with "high PSA shares or other indicia of market power" may want to avoid "preventing or discouraging private payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through 'anti-steering,' 'anti-tiering,' 'guaranteed inclusion,' 'most favored-nation' or similar contractual clauses or provisions." In the present instance, the DOJ challenged CHS's arrangements even though it possessed only 50 percent of the market for acute inpatient services, indicating that the DOJ has set a relatively low threshold as to what constitutes "high PSA shares or other indicia of market power."
- Absent additional evidence being revealed during discovery indicating anticompetitive intent, or actual price and foreclosure effects in the CHS case, it is unclear whether the relatively low market share (50 percent) and the mere act of negotiating steering restrictions alone will be sufficient to ultimately persuade the court that the arrangements negotiated by CHS rise to the level of an antitrust violation, especially if adequate alternatives exist to meet network coverage requirements for health plans and CHS establishes procompetitive benefits.
- That said, if a health system is able to demand and obtain anti-steering or similar provisions over an insurer's objection, that fact, in and of itself, may demonstrate the market power necessary to "coerce" the insurer in the DOJ or court's view. Similarly, the prices offered by health systems in exchange for the steering restrictions are very important to, if not dispositive of, the analysis; using such provisions to obtain or maintain above-market prices raises substantial antitrust risk.

§ 5.04 PRIVATE PLAINTIFF HOSPITAL LITIGATION

[A] Ohio JOA Case Takes Numerous Twists and Turns; Sixth Circuit Provides Troubling Single Entity Guidance

On October 20, 2014, a district court in Ohio granted a motion for summary judgment to the defendant, Premier Health Partners ("Premier"), in a case brought by The Medical Center at Elizabeth Place ("Medical Center"), a competing, physician-owned, 26-bed acute care hospital.[78] The Medical Center claimed Premier violated Section 1 of the Sherman Act[79] by designing and implementing an unlawful plan to deny the Medical Center access to supply (managed care contracts and physicians) and demand (physician referrals) that the Medical Center needed to compete as a small acute care hospital in the Dayton, Ohio area.[80] The district court found Premier and its members were a single entity under *Copperweld Corp. v. Independence Tube Corp.*[81] ("Copperweld"), and therefore, unable to conspire in violation of Section 1 of the Sherman Act.[82]

The Medical Center appealed the district court's decision to the Sixth Circuit and on March 22, 2016, the Sixth Circuit in a 2-1 opinion that many antitrust practitioners find to be troubling, reversed and remanded, holding that there was a genuine issue of material fact as to whether Premier constituted a single entity or concerted action.[83]

In an interesting twist, on August 9, 2017, while on remand, the district court dismissed with prejudice the Medical Center's claims, finding that the Medical Center only pled a *per se* claim, but that the rule of reason standard should be applied.[84] The Medical Center appealed again to the Sixth Circuit and oral arguments were heard on April 25, 2018.

Premier is a joint operating agreement (JOA) between Catholic Health Initiatives (CHI), MedAmerica Heath Systems Corporation (MedAmerica), Atrium Health System (Atrium), and Upper Valley Medical Center (UVMC). Each of these four members own and operate various health care facilities within the Dayton area, including a number of acute care hospitals that compete directly with the Medical Center. Premier is controlled by a Board of Directors and manages most, though not all, of the health care operations of its members. While each member continues to own its facilities, the operational decision making is handled

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[78] Med. Ctr. at Elizabeth Place, LLC v. MedAmerica Health, No. 3:12-cv-26, 2014 WL 7739356, 9 (S.D. Ohio Oct. 21, 2014).

[79] 15. U.S.C. § 1.

[80] *Med. Ctr*., 2014 WL 7739356, at 1.

[81] Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 767–68 (1983).

[82] *Med. Ctr*., 2014 WL 7739356, at 1–2.

[83] Med. Ctr. at Elizabeth Place, LLC v. Atrium Health Sys., 817 F.3d 934 (2016).

[84] Med. Ctr. at Elizabeth Place, LLC v. Premier Health Partners, No. 3:12-cv-00026-WHR, 2017 WL 3433131, at 2 (S.D. Ohio Aug. 9, 2017).

at the Premier level, and all of the money goes to one bottom line that is divided among the members based on an agreed-upon formula.

The Medical Center claimed the four Premier members entered into a group boycott of the Medical Center through Premier that was a *per se* violation of the Sherman Act.[85] Specifically, the Medical Center claimed Premier used its market power to: (1) compel the largest commercial payers to exclude the Medical Center from the commercial payers' network; (2) threaten punitive financial consequences to physicians who affiliated with the Medical Center; (3) compel physicians not to refer to the Medical Center; (4) hire away key physicians affiliated with the Medical Center then prohibiting them from referring to the Medical Center; and (5) compel the largest commercial payers to offer the Medical Center below market rates.[86] Of note, the Medical Center pled that these actions were a *per se* violation of the antitrust laws and disavowed any reliance on a rule of reason analysis.

In the initial stage at the district court, Premier argued it was a single entity, and therefore, incapable of conspiracy. The Medical Center claimed Premier was not a single entity for a number of reasons, chief among them, because the members of Premier did not share ownership of the assets. Under *Copperweld*, control comes from ownership not simply management of the assets the Medical Center claimed. But the district court disagreed, finding the Supreme Court stated in *Copperweld* that "substance, not form, should determine whether a separately incorporated entity is capable of conspiring under Section 1."[87] Further, the district court, citing *American Needle*[88] found that concerted action does not turn simply on whether the parties involved are legally distinct entities, but whether the concerted action joins together separate decision makers.[89] Using *Susquehanna*[90] as an example, the District Court found "contractual control is sufficient to demonstrate that [Premier is] a single entity."[91]

On appeal, a troubling opinion by a split panel of the Sixth Circuit reversed and remanded. The Sixth Circuit concluded that there was a genuine issue of material fact as to whether Premier was a single entity or concerted action among competitors for purposes of Section 1 of the Sherman Act based on "[Premier's]

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[85] Med. Ctr. at Elizabeth Place LLC v. MedAmerica Health, No. 3:12-cv-26, 2014 WL 7739356, 88 (S.D. Ohio, Oct. 21, 2014).

[86] Med. Ctr. at Elizabeth Place LLC v. MedAmerica Health, No. 3:12-cv-26, 2014 WL 7739356, at 74.

[87] *Med. Ctr.*, 2014 WL 7739356, at 4 (*citing* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 767–68 (1983)).

[88] Am. Needle Inc. v. Nat'l Football League, 560 U.S. 183 (2010).

[89] *Med. Ctr.*, 2014 WL 7739356, at 3 (*citing* Am. Needle Inc. v. Nat'l Football League, 560 U.S. 183 (2010)).

[90] Healthamerica Pennsylvania, Inc. v. Susquehanna Health Sys., 278 F.Supp.2d 423, 427–28 (M.D. Penn. July 2, 2003).

[91] *Med. Ctr.*, 2014 WL 7739356, at 3.

stated intent to keep [Medical Center] out of the Dayton market, the evidence of coercive conduct threatening both physicians and insurance companies with financial loss if they did business with [Medical Center], evidence of continued actual and self-proclaimed competition among the [Premier] hospitals, and evidence that the [Premier] hospitals' business operations are not entirely unitary."[92] Citing *American Needle*,[93] the majority found the Premier joint operating agreement brought together "independent centers of decisionmaking" that "remain separately controlled, potential competitors with economic interests that are distinct" and thus are capable of concerted actions.[94]

The majority focused its analysis on whether the intent of the Premier members was anticompetitive, quoting *Board of Trade of Chicago*[95] that "the true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition . . . [and] to determine that question the court must ordinarily consider the facts peculiar to the business . . . [and] knowledge of intent may help the court to interpret facts and to predict consequences." As the dissent correctly pointed out, the test articulated by the majority from *Board of Trade of Chicago* is the "rule of reason" standard, which should only be used in a Sherman Section 1 case to determine whether the parties unreasonably restrained trade, not to determine whether the parties are a single entity under *Copperweld* capable of conspiring as a matter of law.[96]

Using this lens, the majority found anticompetitive intent could be found from evidence that insurance companies were refusing to deal with the Medical Center at the behest of Premier.[97] In addition, the majority found the Premier joint operating agreement provided for some degree of unitary management, but questions remained as to whether "their general corporate actions are guided or determined by separate corporate consciousnesses."[98] The majority also focused on the fact that the Premier members owned their own assets, were separate legal entities, filed their own tax returns, and had their own CEOs and Boards of Directors, finding that ". . . the [Premier] hospitals clearly did not completely align their interests economic or otherwise."[99]

In addition, the majority found that the Premier members continued to view themselves as competitors in the market. In 2010, Premier hired a consultant to prepare a five-year strategic plan. The consultant report made a number of

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[92] *Med. Ctr.*, 817 F.3d 934, at 938.
[93] Am. Needle Inc. v. Nat'l Football League, 560 U.S. 183 (2010).
[94] *Med. Ctr.*, 817 F.3d 934, 940.
[95] Board of Trade of Chicago v. United States, 246 U.S. 231, 238 (1918).
[96] *Med. Ctr.*, 817 F.3d 934, at 947.
[97] *Med. Ctr.*, 817 F.3d 934, at 942.
[98] *Med. Ctr.*, 817 F.3d 934, at 943 (*quoting Am. Needle*, 560 U.S. at 196).
[99] *Med. Ctr.*, 817 F.3d 934, at 944.

findings, including that the Premier members did not collaborate or act like a system, often competed with each other, and did not think of themselves as an integrated organization.[100] The majority found this as evidence that the Premier members were driven to pursue individual hospital goals and that the Premier members were actually competitors attempting to eliminate another competitor (*i.e.*, the Medical Center) through concerted action.[101]

To win on a claim under Section 1 of the Sherman Act, a plaintiff must prove two elements: (1) that the defendants participated in an agreement that (2) unreasonably restrains trade. Many antitrust practitioners find the majority's opinion troubling because it focuses on the second prong of the analysis, skipping the first prong. Typically, in order to get to the second prong, you must initially prove the first prong. Instead, the majority focused on the intent of the Premier members to hinder another competitor in the market. As the dissent correctly stated, "[Premier's] intent to exclude others from the market is irrelevant to determining whether defendants themselves constitute a single entity."[102]

On remand, in an interesting turn of events, the district court dismissed the claim against Premier with prejudice not based on the single entity analysis, but because it found the Medical Center's claims were not subject to *per se* condemnation and the Medical Center had disavowed any reliance on a rule of reason analysis.[103] As previously mentioned, to win on a claim under Section 1 of the Sherman Act, a plaintiff must prove two elements: (1) that the defendants participated in an agreement that (2) unreasonably restrains trade. In determining whether the restraint is unreasonable under the second prong, courts have developed two methodologies: the *per se* standard, and the "rule of reason" standard. There are a handful of categories of actions that are found to be so particularly problematic that they are deemed *per se* unlawful. This includes "naked" pricing-fixing and market allocations. Once it is determined that the *per se* standard applies, the plaintiff need only prove an agreement existed among the plaintiffs, but does not need to prove anticompetitive effects. On the other hand, the vast majority of actions are analyzed under the rule of reason standard which requires a case-by-case evaluation of the effect on competition. Under a rule of reason analysis, the court must weigh all circumstances of the case and determine on balance whether the anticompetitive harms outweigh the procompetitive benefits.

In its initial complaint the Medical Center alleged a *per se* violation of Section 1 of the Sherman Act occurred as a result of Premier's orchestrated group boycott of the Medical Center.[104] Interestingly, it did not make any alternative

[100] *Med. Ctr.*, 817 F.3d 934, at 944.
[101] *Med. Ctr.*, 817 F.3d 934, at 945.
[102] *Med. Ctr.*, 817 F.3d 934, at 948.
[103] *Med. Ctr.*, 2017 WL 3433131, at 2.
[104] *Med. Ctr.*, 2017 WL 3433131, at 2.

pleadings under the rule of reason. Quoting the Third Circuit, the District Court stated, "[w]hile pleading exclusively *per se* violations can lighten a plaintiff's litigation burdens, it is not a riskless strategy. If the court determines that the restraint at issue is sufficiently different from the *per se* archetypes to require application of the rule of reason, the plaintiff's claims will be dismissed.[105]

Addressing the Sixth Circuit's opinion, the district court found that "the court's decision was specifically limited to 'the element addressed by the district court,' i.e., whether [Premier's] conduct was the result of two or more entities acting in concert or whether [Premier], based on their participation in the JOA, functioned as a single entity."[106] This allowed the district court to focus on whether the Medical Center's claim should be governed by the rule of reason or *per se* standard.[107]

After having deftly sidestepped the Sixth Circuit's opinion, the district court turned its attention to analyzing Premier to determine whether the *per se* or rule of reason standard should apply. The district court stated that only a handful of categories of restraints are deemed to be *per se* unreasonable, and that the vast majority must be assessed, on a case-by-case basis, under the rule of reason standard.[108] Citing *Dagher*,[109] the district court stated that a legitimate joint venture's *core* activities are subject to rule of reasons analysis, *non-core* activities that are naked restraints are subject to *per se* analysis, but restraints that are ancillary to the legitimate and competitive purpose of the joint venture may be deemed valid under the rule of reason.[110] Going further, the District Court found the application of the *per se* rule appropriate only if the restraint is of a *per se* character and not plausibly necessary to a legitimate joint venture.[111]

Starting with the undisputed premise that Premier was a legitimate joint venture, the District Court worked through the proper analytical framework for determining whether the *per se* or rule of reason should apply to the challenged restraints. Figure 5-1 is a diagram the district court utilized.[112]

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[105] *Med. Ctr.*, 2017 WL 3433131, at 21 (*quoting In re* Ins. Brokerage Antitrust Litig., 618 F.3d 300, 317) (3d Cir. 2010)).

[106] *Med. Ctr.*, 2017 WL 3433131, at 7.

[107] *Med. Ctr.*, 2017 WL 3433131, at 8.

[108] *Med. Ctr.*, 2017 WL 3433131, at 2.

[109] Texaco Inc. v. Dagher, 547 U.S. 1, 6 (2006).

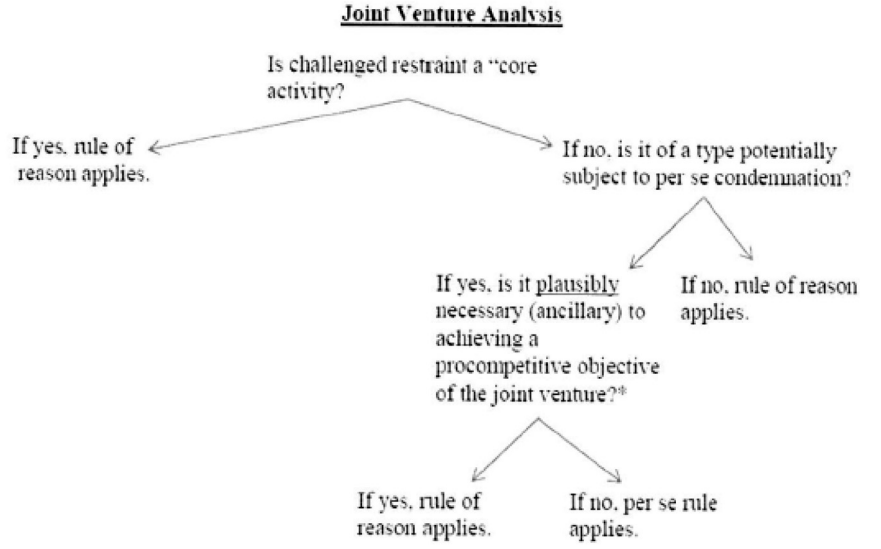
[110] *Med. Ctr.*, 2017 WL 3433131, at 4.

[111] *Med. Ctr.*, 2017 WL 3433131, at 14.

[112] *Med. Ctr.*, 2017 WL 3433131, at 14.

FIGURE 5-1.
JOINT VENTURE ANALYSIS

The following diagram shows the proper analytical framework:



*Whether the challenged restraint is actually necessary to achieve a procompetitive objective of the joint venture is a question of fact to be decided by the jury.

Using this analytical framework, the District Court focused on two challenged restraints: (1) rate-for-volume pricing/panel limitation clauses, and (2) noncompete clauses. With respect to the first challenged restraint, the Medical Center claimed that Premier negotiated "Panel Limitations" clauses into its managed care contracts, which had the effect of excluding the Medical Center from the market. These Panel Limitations clauses provided that if a payer added another hospital to its network (*i.e.*, the Medical Center), Premier had that option to terminate the contract or renegotiate the rates at which it would sell its services to the payer.[113] Using the analytical framework, the District Court found that joint venture pricing is a core activity under *Dagher* and to the extent that the Panel Limitations operate to ensure a certain volume of patients and that volume, in turn, forms the basis for the discount offered to payers (*i.e.*, rate-for-volume pricing), the Panel Limitations were intricately intertwined with internal pricing decisions, so the rule of reason would apply.[114] Taking the analysis a step further, the district court found that even if the Panel Limitations were not deemed to be a core activity, and even if the Panel Limitations were of the type typically subject

[113] *Med. Ctr.*, 2017 WL 3433131, at 14.
[114] *Med. Ctr.*, 2017 WL 3433131, at 15.

to *per se* analysis, the Panel Limitations would still be analyzed under the rule of reason because they were plausibly necessary to achieve a procompetitive objective of the joint venture.[115] The district court found that the Panel Limitations helped to ensure that patient volumes at Premier remained steady and that this *quid pro quo* (offering discounted rates for patient volumes) was the only way that Premier could protect the benefit of its bargain.[116] Interestingly, the district court specifically pointed out that it was possible a jury could find the Panel Limitations to be anticompetitive under the rule of reason analysis, but that the Panel Limitations were not subject to *per se* condemnation.[117]

Turning to the non-compete clauses, the district court also found that these challenged restraints should be analyzed under the rule of reason standard based on the *Dagher* framework.[118] Premier had certain non-compete clauses in leases and employment contracts with physicians who had also invested in the Medical Center. The district court found the non-compete clauses in the employment contracts to be core activities subject to the rule of reason.[119] But even if they were deemed non-core activities, the non-compete clauses would still be plausibly necessary to achieve a procompetitive objective of the joint venture because the non-compete clauses would allow Premier to operate more productively. Finding that Premier offered training and convenient office space to the physicians, it would make sense that Premier would not want the physicians to reap the benefits of the training and convenient office space, then refer patients to another hospital.[120]

Despite Premier's status as a legitimate joint venture, the Medical Center argued that the *per se* standard should still apply because Premier had led a group boycott against the Medical Center and group boycotts are always *per se* unreasonable restraints of trade.[121] The district court did not agree. Citing *Northwest Wholesale Stationers*,[122] the district court found that the Supreme Court said not all group boycotts are predominantly anticompetitive, but rather, there are three main characteristics of group boycotts that have been deemed *per se* illegal.[123] Focusing on the third characteristic—whether the group boycott was justified by plausible arguments that it was intended to enhance overall efficiency and make markets more competitive—the district court pointed to its prior reasoning, stating that the challenged restraints—Panel Limitations and non-compete clauses—were plausibly intended to enhance overall efficiency and make markets more

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[115] *Med. Ctr.*, 2017 WL 3433131, at 16.
[116] *Med. Ctr.*, 2017 WL 3433131, at 16.
[117] *Med. Ctr.*, 2017 WL 3433131, at 17.
[118] *Med. Ctr.*, 2017 WL 3433131, at 17.
[119] *Med. Ctr.*, 2017 WL 3433131, at 18.
[120] *Med. Ctr.*, 2017 WL 3433131, at 18.
[121] *Med. Ctr.*, 2017 WL 3433131, at 18.
[122] Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284 (1985).
[123] *Med. Ctr.*, 2017 WL 3433131, at 19 (*quoting* Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 294–98 (1985)).

competitive, so the group boycott was not subject to *per se* condemnation.[124] Again, the district court found that a jury may well find that the group boycott constituted an antitrust violation, but that it should be analyzed under the rule of reason and not condemned *per se*.[125]

[1] Practical Takeaways and Compliance Best Practices for Affiliation Arrangements

As providers continue to seek various affiliation arrangements, including JOAs, this case provides a number of practical takeaways, especially given the troubling Sixth Circuit opinion:

- Providers cannot assume that all JOAs will confer single-entity status; instead, when structuring a JOA, it is important to work with antitrust counsel to consider the single entity analysis. The fact that substance over form governs the antitrust analysis introduces a great deal of subjectivity into the single entity determination.
- Generally, the greater the level of financial, clinical, and administrative integration, and the more control given to the JOA entity, the more likely a court is to find that the JOA is a single entity incapable of conspiring in violation of the antitrust laws.
- Profit sharing via an agreed upon formula may not be considered sufficient financial integration to satisfy the single entity analysis, even with significant centralized administrative control; rather, some courts may require asset integration to be considered a single entity.
- Ordinary course documents detailing any type of anticompetitive intent to conspire or exclude competitors are likely to prove problematic even to JOAs, although technically not properly considered as a part of the single entity analysis.

[B] Judge Posner's Antitrust Swan Song Denies Hospital's Exclusive Contracts Harmed Rivals in Peoria, Illinois Area

On June 9, 2017, the Seventh Circuit in an opinion written by well-known antitrust jurist, Judge Richard A. Posner, affirmed an Illinois District Court's grant of summary judgment for the defendant, OSF Healthcare System d/b/a Saint Francis Medical Center ("Saint Francis"), against a claim brought by the plaintiff, Methodist Health Services Corporation ("Methodist"), alleging a host of antitrust

[124] *Med. Ctr.*, 2017 WL 3433131, at 19.
[125] *Med. Ctr.*, 2017 WL 3433131, at 20.

violations arising out of Saint Francis entering into payer contracts requiring the payers to exclude Methodist from the payers' provider networks.[126]

Saint Francis is the largest hospital in the Peoria, Illinois area with 616 beds. Methodist is the second largest hospital in the area with 330 beds. The two are located less than a quarter mile away from each other. In addition to being larger, Saint Francis is more advanced than Methodist, offering more extensive and advanced services. In an effort to drive volume to its hospital, Saint Francis entered into several exclusive contracts with different payers. Saint Francis had an exclusive contract with the largest commercial payer in the area, Blue Cross Blue Shield ("BCBS"), for its largest product in the area, the PPO product. In addition, Saint Francis had exclusive contracts with Humana, Health Alliance Medical Plans (HAMP), and Aetna. Interestingly, the second largest commercial insurance population in the area was Caterpillar, the area's largest employer. Until 2010, Caterpillar offered its employees a Saint Francis exclusive network. In 2010, Caterpillar opened its network to both Saint Francis and Methodist, but paid for it with a 38 percent price increase for Saint Francis's tertiary services and a 3.7 percent increase for non-tertiary services.[127]

Methodist filed a nine-count complaint against Saint Francis alleging that Saint Francis utilized its market power as a must-have hospital to coerce the payers into excluding Methodist from their provider networks.[128] Methodist claimed that it was foreclosed from competing for commercially insured patients.[129] The district court granted summary judgment for Saint Francis finding that a jury would not be able to conclude that Saint Francis's exclusive contracts substantially foreclosed competition in the Peoria inpatient market.[130] As in many exclusive dealing cases, the district court noted that courts typically require a foreclosure of at least 30 percent to 40 percent of the market to proceed with a claim.[131] Focusing on the various payer products and foreclosure calculations put forward by Methodist's economist, the district court found that the total foreclosure figures were less than Methodist claimed, coming in at less than 20 percent for 2009 and approximately 22 percent for 2012.[132] Additionally, the district court found that none of the contracts were for a very long duration, lasting one or two years, meaning that Methodist had the opportunity to compete for the contracts often.[133]

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[126] Methodist Health Servs. Corp., v. OSF Healthcare Sys., 859 F.3d 408, 410 (7th Cir. 2017).

[127] Methodist Health Servs. Corp., v. OSF Healthcare Sys., No. 1:13-cv-01054-SLD-JEH, 2016 WL 5817176, at 5 (C.D. Ill. Sept. 30, 2016).

[128] *Methodist*, 2016 WL 5817176, at 6.

[129] *Methodist*, 2016 WL 5817176, at 5

[130] *Methodist*, 2016 WL 5817176, at 11.

[131] *Methodist*, 2016 WL 5817176, at 9.

[132] *Methodist*, 2016 WL 5817176, at 14.

[133] *Methodist*, 2016 WL 5817176, at 14.

In a succinct opinion at only a few pages, the Seventh Circuit affirmed the district court's grant of summary judgment in favor of Saint Francis. Judge Posner, one of the most well-respected and renown antitrust jurists ever, wrote for the Seventh Circuit in what would be his final antitrust opinion after announcing a surprise and immediate retirement only three months after authoring this opinion. In a very straightforward opinion, Judge Posner asked, ". . . what is more common than exclusive dealing?"[134] Concluding that it is nothing more than a requirements contract which is common and legal. Further, in the context of health insurance, a requirements contract can be beneficial, allowing payers to get better rates for inpatient services in exchange for higher volume going to the provider.[135] Judge Posner admitted that some exclusive dealing arrangements are problematic, but given that these were short-term contracts Methodist had the ability to compete and outbid Saint Francis every year or two.[136] Taking this a step further, Judge Posner noted that Methodist could invest and duplicate special services only offered by Saint Francis, finding that if Methodist could not outbid Saint Francis, the logical inference was that Saint Francis offered the payer a better deal—broader and deeper services.[137] Finally, Judge Posner stated, "[a]s we've said before, 'competition-for-contract is a form of competition that antitrust laws protect rather than proscribe, and it is common.'"[138]

Another curious feature noted by Judge Posner was that Methodist brought this case in isolation.[139] Despite claiming that payers and providers alike were injured by Saint Francis's exclusive contracts, Judge Posner noted that no other payers or providers joined Methodist in its claim. Further, even after sending a copy of the complaint to the DOJ, Methodist was still the only plaintiff.[140] In Judge Posner's mind, this showed that Methodist was "simply an unsuccessful competitor with a hospital that offers patients insured by health insurance companies more health care than it does."[141]

[1] Practical Takeaways and Compliance Best Practices for Exclusive Contracts

Exclusive contracting, while common and legal, is not without antitrust risk depending on the specific facts and circumstances. As payers create more narrow

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[134] Methodist Health Servs. Corp., v. OSF Healthcare Sys., 859 F.3d 408, 410 (7th Cir. 2017).
[135] *Methodist*, 859 F.3d 408, 410.
[136] *Methodist*, 859 F.3d 408, 410
[137] *Methodist*, 859 F.3d 408, 411.
[138] *Methodist*, 859 F.3d 408, 411 (*quoting* Paddock Publ'n., Inc. v. Chicago Tribune Co., 103 F.3d 42, 45 (7th Cir. 1996).
[139] *Methodist*, 859 F.3d 408, 411.
[140] *Methodist*, 859 F.3d 408, 411.
[141] *Methodist*, 859 F.3d 408, 411.

network products and providers seek to use exclusivity to drive volume, providers must keep in mind a few key items when negotiating narrow network or exclusive contracts:

- The duration of the exclusive contract is of vital importance. Indefinite or long-term exclusive contracts will be looked at more suspiciously than short-term contracts. Long-term contracts have the potential to harm competition in the market by forcing competitors from the market, which may lead to less access to care and higher prices in the long run.
- Making sure there is competition for the contract matters. By keeping the duration of the contract short, health systems will keep competing every year or two to outbid its rivals for the contract. This has the potential to drive investment for greater services and gives payers the flexibility to negotiate larger discounts or more palatable networks.
- Providers should focus on how the exclusive contract will help competition and consumers. Providers must assess how the exclusive contract will benefit consumers. Obviously, an exclusive contract is going to harm a competitor in the short-term due to loss of volume, but as long as the competitor is not substantially foreclosed from the market and has the ability to compete for other patients and eventually the contract, then consumers likely will benefit in the long-run because providers will compete with each other vigorously to offer expanded services at lower prices.

§ 5.05 CERTIFICATES OF PUBLIC ADVANTAGE IN WEST VIRGINIA AND TENNESSEE/VIRGINIA

Beginning in the 1990s, several states passed Certificate of Public Advantage (COPA) laws intended to allow health care providers to enter into cooperative agreements that might otherwise be subject to antitrust scrutiny. These COPA laws purport to grant cooperative agreements state action immunity from the federal antitrust laws.[142] In order to obtain antitrust immunity for conduct that might otherwise violate the federal antitrust laws, the state action doctrine requires both a clear articulation of the state's intent to displace competition in favor of

[142] *FTC Staff Seeks Empirical Research and Public Comments Regarding Impact of Certificates of Public Advantage*, FTC (Nov. 1, 2017), *available at* https://www.ftc.gov/news-events/press-releases/2017/11/ftc-staff-seeks-empirical-research-public-comments-regarding (hereinafter *FTC Staff Seeks Empirical Research and Public Comments Regarding Impact of Certificates of Public Advantage*).

regulation and that the state provide active supervision over the regulatory scheme or body.[143]

In recent years, there has been a resurgence in COPAs as a means of immunizing transactions from federal antitrust scrutiny with providers arguing that they need an antitrust exemption because consolidation is the only way to achieve the size, scale, and degree of clinical integration necessary to participate in new delivery and payment models, such as population health initiatives and value-based payment models. On November 1, 2017, the FTC issued a public notice to encourage academic and industry research on the impact of certificates of public advantage regarding prices, quality, access, and innovation for health care services.[144] In this notice, the FTC sought information on the benefits and harms resulting from COPAs or other state-based regulatory approaches intended to improve health care quality and lower health care prices. The FTC's Office of Policy Planning, Bureau of Economics, and Bureau of Competition released this notice due to a lack of empirical research on the full competitive impact of COPAs on various health care services such as price, cost, and quality. Additionally, the notice was intended to gather information in preparation for a public workshop on COPAs anticipated for Fall, 2018. The workshop was billed as an opportunity for invited researchers to share their findings and encourage discussion among state policymakers, researchers, regulators, law enforcers, and stakeholders about COPAs.

Applied to different forms of provider collaboration, COPA laws have been utilized to shield provider mergers that otherwise might be suspect under antitrust laws. Although several state COPA laws extend to hospital mergers that might implicate antitrust concerns, only a few hospital mergers have been approved under COPA regulations.[145] The FTC has consistently taken the position that COPAs and similar state antitrust exemptions are unnecessary, and ultimately immunize activities that are most likely to cause harm. There have also been claims that some states are passing COPA legislation in response to political pressure to exempt specific hospital mergers from antitrust scrutiny.

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[143] *See* N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101,1114 (2015); FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1013 (2013).

[144] *FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments*, FTC (Nov. 1, 2017), *available at* https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/p181200_copa_assessment_comment_notice_11-1-17.pdf.

[145] The FTC has cited the following hospital mergers that have been permitted to proceed pursuant to COPA oversight: HealthSpan Hosp. Sys. (Minn., 1994); Mission Health Sys. (N.C., 1995); Benefis Health Sys. (Mont., 1996); Palmetto Health Sys. (S. C., 1998); Cabell Huntington Hospital/St. Mary's Med. Ctr. (W. Va., 2016); and Mountain States Health Alliance/Wellmont Health Sys. (Tenn. and Va., 2017).

FTC staff have issued several advocacy comments raising concerns about whether COPA regulations actually achieve the states' intended policy goals.[146] The FTC has opposed COPA applications because of the belief that the laws seek to immunize mergers and other collaborations among health care providers which would reduce competition and cause consumers to experience lower quality, reduced access, and higher prices of health care. Additionally, conduct remedies implemented by COPA statutes are difficult and costly to implement. Plus, the FTC has stated that conduct remedies are hard to monitor and susceptible to regulatory evasion.[147] Lastly, the FTC noted the lack of an effective mechanism to prevent the exercise of market power at the expiration of the COPA agreement or repeal of a COPA statute.

Thus, the FTC needs more evidence to demonstrate that COPA regulations produce better results for health care consumers. The FTC's public notice reflects its skepticism towards COPAs and dedication to opposing anticompetitive collaborations. Since a small number of COPAs have been issued and there is a limited amount of analysis on their impact, FTC is searching for more data to truly analyze if there is a detrimental anticompetitive impact of COPAs.

The FTC's varying approach to COPAs has been on display in their approach to numerous hospital transactions. Furthermore, the FTC has recommended denial of particular COPA applications in Tennessee and Virginia and an application in West Virginia.[148]

In Huntington, West Virginia the FTC challenged the proposed acquisition of St. Mary's Medical Center ("St. Mary's") by Cabell Huntington Hospital ("Cabell") in Huntington, West Virginia, despite the hospitals having entered into an agreement with the West Virginia Attorney General to limit certain conduct of the merged entity for a period of seven years following the merger. In response to the FTC's challenge, the West Virginia legislature passed a COPA law in March of 2016. Under the COPA law, certain hospital mergers are deemed exempt from

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[146] *FTC Staff Comment to the West Virginia House of Delegates*, FTC (Mar. 9, 2016), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf (concerning S.B. 597, intended to Exempt Health Care Providers Subject to Cooperative Agreements from the Antitrust Laws) (hereinafter *FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments*); *FTC Staff Comment to N.Y. State Dept. of Health*, FTC (Apr. 22, 2015), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf (concerning Certificate of Public Advantage Applications, Intended to Exempt Performing Provider Systems from the Antitrust Laws).

[147] *FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments*.

[148] Tenn. (November 2016, September 2015); Va. (October 2016; September 2015); W. Va. (March 2016); N.Y. (April 2015).

the federal antitrust laws if the West Virginia Health Care Authority approves the hospital merger.

On June 22, 2016, the West Virginia Health Care Authority approved the merger. In light of the ruling by the West Virginia Health Care Authority, on July 6, 2016, the FTC announced via press release that it had voted unanimously to abandon the challenge and dismiss their complaint without prejudice.[149] Although West Virginia's COPA law was the impetus for the FTC abandoning their challenge of the Cabell/Huntington transaction, the FTC expressed continued skepticism over the use of cooperative agreements and their ability to mitigate the anticompetitive effects of potential mergers. The FTC went so far as to say that the "decision to dismiss the complaint without prejudice does not necessarily mean that we will do the same in other cases in which a cooperative agreement is sought or approved."[150]

In Tennessee and Virginia, the FTC has taken an active lead in opposing the state's COPA being used to facilitate the merger of Wellmont Health System (Wellmont) and Mountain States Health Alliance (MSHA). In response to the proposed Wellmont-MSHA merger, the Tennessee and Virginia state legislatures amended their respective enabling legislation and the Tennessee Department of Health (TDH) sought an FTC advisory opinion.[151] In September 2014, the FTC sent non-binding public comment letters to each state, offering assistance to the Tennessee and Virginia health departments during their reviews of any COPAs. The FTC noted that its comments were intended to help ensure that any decision regarding the potential benefits and disadvantages of a proposal are based on a rigorous competitive analysis and reiterated the FTC's longstanding position that legislation intended to grant antitrust immunity would likely harm health care consumers.[152] The FTC further indicated its willingness to provide any expertise and information that it was authorized to share in connection with review of

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[149] *FTC Dismisses Complaint Challenging Merger of Cabell Huntington Hospital and St. Mary's Medical Center*, FTC (July 6, 2016), *available at* https://www.ftc.gov/news-events/press-releases/2016/07/ftc-dismisses-complaint-challenging-merger-cabell-huntington (hereinafter *FTC Dismisses Complaint Challenging Merger of Cabell Huntington Hospital and St. Mary's Medical Center)*.

[150] *FTC Dismisses Complaint Challenging Merger of Cabell Huntington Hospital and St. Mary's Medical Center*.

[151] *FTC Staff Submission to the Southwest Virginia Health Auth. and Virginia Dept. of Health Regarding Coop. Agreement Application of Mountain States Health Alliance and Wellmont Health Sys*., FTC (Sept. 30, 2016), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/submission-ftc-staff-southwest-virginia-health-authority-virginia-department-health-regarding/160930wellmontswvastaffcomment.pdf.

[152] *FTC Staff Comment to Susan Puglisis, Esq*., FTC (Sept. 17, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-virginia-department-health-regarding-virginias-rules-regulations-governing/151015virginiadoh.pdf; *FTC Staff Comment to Malaka Watson, Esq*., FTC (Sept. 17, 2015), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-tennessee-department-health-regarding-implementation-laws-relative-cooperative/151015tennesseedoh.pdf.

COPA applications, and in the concluding paragraph of each comment letter asked the state departments to incorporate concepts of permissible sharing of information and expertise between the state departments and the FTC in the rules to be promulgated.[153]

The FTC conducted its own investigation into the proposed merger and participated in TDH's COPA application process, ultimately issuing three rounds of commentary on the COPA application. The FTC determined that the transaction would substantially lessen competition in relevant health care markets and that the benefits claimed by Wellmont and MSHA would not exceed the likely harm to competition, citing numerous economic studies claiming that substantially reduced competition results in increased prices for health care services, as well as diminished quality. The FTC dismissed the parties' efficiency claims, noting that efficiencies almost never justify a merger that results in a monopoly or near-monopoly. The FTC also cautioned against reliance on a post-merger plan of separation, noting the difficulty of "unscrambling the egg" when it comes to merged entities.[154]

On September 19, 2017, the TDH announced that the request for a COPA from Wellmont and MSHA had been granted. Then, on January 31, 2018, the TDH announced the state would officially allow the Wellmont/MSHA merger by issuing a COPA to their parent company, Ballad Health.

§ 5.06 NON-COMPETE, WAGE-FIXING, AND OTHER EMPLOYMENT AGREEMENTS

[A] FTC and DOJ Joint Antitrust Guidance for Human Resources Professionals Regarding Hiring and Compensation

In October 2016, the DOJ and the FTC jointly issued "Antitrust Guidance for Human Resource Professionals" (the "Antitrust HR Guidance") for human resources (HR) professionals and others involved in hiring and compensation decisions, stating that the government would aggressively enforce antitrust laws against no-poaching agreements, wage-fixing agreements, and other anticompetitive employment agreements, including sharing competitively sensitive wage information.[155] The Antitrust HR Guidance outlines how the federal antitrust laws apply to the employment arena and also warns employers that the agencies will be investigating problematic agreements and information sharing between firms

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[153] *FTC Staff Comment to Susan Puglisis, Esq.*

[154] *FTC Staff Seeks Empirical Research and Public Comments Regarding Impact of Certificates of Public Advantage*.

[155] *Antitrust Guidance for Human Resource Professionals*, FTC, *available at* https://www.justice.gov/atr/file/903511/download. (The FTC and DOJ's joint guidance also contains a practical Q&A for HR professionals to reference when considering specific situations that may occur); *see also Antitrust Red Flags for Employment Practices*, FTC, *available at* https://

competing to hire similar employees, including bringing criminal enforcement actions against naked wage-fixing or no-poaching agreements.

The Antitrust HR Guidance explains that these anticompetitive agreements may be considered *per se* illegal, meaning that the conduct itself is inherently illegal and companies cannot escape liability by seeking to explain, defend, or justify their conduct. Importantly, wage-fixing and no-poaching agreements may be found illegal even if they are not in writing. That is, evidence of discussions and parallel behaviors (*e.g.*, gentleman's or handshake agreements) may be sufficient to implicate the federal antitrust laws. As such, companies competing to hire similar employees should avoid entering into agreements of any kind relating to terms of employment. The conduct is still considered illegal even if the agreements are through third-party intermediaries, and even if the invitation to enter into an illegal agreement goes unaccepted, the invitation itself may be considered an antitrust violation. Further, it makes no difference whether the companies compete to provide the same products or services. If they compete to hire and retain employees, then agreements, or solicitations to enter into agreements, to reduce competition in the employment marketplace are illegal under federal antitrust laws.

In particular, the Antitrust HR Guidance highlights two types of agreements that violate the antitrust laws: (1) wage-fixing agreements—agreements between competing companies about employee salary or other terms of compensation, either at a specific level or within a range; and (2) no-poaching agreements—agreements between competing companies to not solicit or hire the other company's employees. The Antitrust HR Guidance also makes clear that severe penalties may result from these agreements. As noted above, naked wage-fixing and no-poaching agreements among employers are *per se* illegal under the federal antitrust laws. As a result, such agreements can result in criminal felony charges against the participants in the agreement, both companies and individuals. In addition, private parties injured by an illegal agreement among potential employers can bring a civil lawsuit for treble damages (*i.e.*, three times the damages the party actually suffered). Potential liability increases significantly when damages are trebled and also asserted on behalf of a "class" of similarly situated plaintiffs.

The Antitrust HR Guidance provides several examples of problematic wage-fixing agreements in the health care industry. The first comes from a 2007 DOJ enforcement action in which the DOJ brought an enforcement action against a state hospital and health care association alleging that the association and its participating member hospitals jointly set prices and other terms governing the hospitals' purchases of per diem and travel nursing services, which resulted in lower

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www.ftc.gov/system/files/documents/public_statements/992623/ftc-doj_hr_red_flags.pdf?utm_source=govdelivery. (Additionally, the FTC and DOJ have developed a Reference Card outlining a number of antitrust "red flags" that HR professionals should be aware of so they can avoid engaging in anticompetitive conduct.)

"bill rates" than what the market would otherwise allow. That action resulted in a consent judgment.

Another example cited in the Antitrust HR Guidance of a problematic wage-fixing agreement in the health care industry comes from the widely publicized nurse wage-fixing cases. These cases began in 2006 and were brought as antitrust class action lawsuits against health systems in Albany, NY; Detroit, MI; Chicago, IL; Memphis, TN; and San Antonio, TX. In each instance, the nurses alleged that hospital executives shared confidential wage information and agreed on compensation levels for nurses, leading to below market pay. After years of incurring substantial defense costs while these cases made their way through the courts, many of these health systems either entered into large settlements or had large judgments levied against them.

The Antitrust HR Guidance also addresses agreements to share competitively sensitive wage information. While agreements to share information are not *per se* illegal, sharing information with competitors about the terms and conditions of employment or exchanging other competitively sensitive information could implicate the federal antitrust laws and even serve as circumstantial evidence of an illegal agreement. These violations may subject the company or individual to civil antitrust liability when they have, or are likely to have, an anticompetitive effect.

In a common circumstance for improper information sharing, participants in a merger, acquisition or joint venture often need to share information, for example, during due diligence or integration planning. However, there can be significant antitrust risk if the parties share competitively sensitive information about terms and conditions of employment prior to closing. Parties should take appropriate precautions in structuring information exchanges during due diligence to minimize their risk under the antitrust laws. As noted in the Antitrust HR Guidance, an example of problematic information sharing in the health care market occurred in 1994 when the DOJ sued the Utah Society for Healthcare Human Resources Administration for conspiring to exchange wage information about registered nurses. The exchange resulted in local hospitals matching wages, keeping the pay of registered nurses artificially low. This enforcement action resulted in a consent judgment to facilitate competition for registered nursing services.

[B] Recent Hiring and Compensation Policy Statements By DOJ and Recent Cases

On January 19, 2018, Makan Delrahim, Assistant Attorney General for the Antitrust Division of the DOJ, announced that the DOJ will soon announce criminal antitrust enforcement actions against companies that have entered into agreements not to solicit each other's employees—also known as "no-poaching agreements." Delrahim stated, "in the coming couple of months you will see some announcements [of criminal charges], and to be honest with you, I've been

shocked about how many of these [no-poaching agreements] there are, but they're real," confirming that the DOJ is currently involved in several active criminal investigations.

Delrahim's comments continue an initiative started near the end of the Obama Administration. Delrahim identified the issuance of the Antitrust HR Guidance as a clear line separating conduct the DOJ will pursue criminally from conduct it will pursue civilly. If companies that were engaging in no-poaching activity prior to the issuance of the Antitrust HR Guidance have continued such behavior, the DOJ will likely treat it as a criminal violation. If the illegal conduct stopped with the promulgation of the Antitrust HR Guidance, any enforcement action will be a civil proceeding.

Consistent with Delrahim's earlier policy announcements, on April 3, 2018, the DOJ announced that it reached a settlement with Knorr-Bremse AG and Westinghouse Air Brake Technologies Corporation, two large rail equipment suppliers.[156] The settlement resolves a lawsuit alleging the companies had maintained unlawful agreements not to compete for each other's employees for years. According to the terms of the settlement, the companies are prohibited from entering, maintaining, or enforcing no-poach agreements and must implement rigorous notification and compliance measures to prevent entry in anticompetitive agreements in the future. There are also several provisions in the settlement designed to improve the DOJ's ability to enforce the settlement. The parties agreed that the DOJ may prove any alleged violations of the decree by a preponderance of the evidence and the companies will reimburse for the costs of investigating and enforcing any violations. Interestingly, the DOJ did not allege criminal violations despite the earlier comments by Delrahim, presumably because the parties ceased their non-poaching agreement after the Antitrust HR Guidance. The court approved the settlement on July 11, 2018.[157] Since then, a number of private actions have been filed against the parties by former employees who allege they were paid less as a result of the alleged non-poaching agreements.[158]

In another recent example from the health care industry, on February 1, 2018, the U.S. district court for the Middle District of North Carolina certified a class action lawsuit seeking treble damages in which a physician alleged that the deans of two medical schools affiliated with the University of North Carolina and Duke University's health systems entered into a gentleman's agreement to forego hiring each other's medical facility faculty and staff. The court certified a class consisting of all persons employed as faculty members during the period beginning January 1, 2012, to the present at either medical school. The court declined to extend the class to include non-faculty physicians, nurses, or skilled medical

[156] United States v. Knorr-Bremse AG, No. 1:18-cv-00747 (D.D.C. Apr. 3, 2018).

[157] *See* U.S. v. Knorr-Bremse AG, Case No. 1:18-cv-00747-CKK (U.S. D.C. July 11, 2018).

[158] *See e.g.* May, Jeffrey, *Justice Department Settlement in "no-poach" Case Against Rail Equipment Suppliers Approved* Wolters Kluwer Antitrust Law Daily, July 13, 2018.

staff, but indicated that they could bring their own separate suit. One of the medical schools settled the case, but the other now has the onerous task of defending against a class action suit that may last for years and cost millions of dollars to defend.

Most recently, on July 31, 2018, the FTC and the Texas Attorney General challenged wage-fixing agreements between physical therapy staffing companies in Dallas, Texas, alleging that the companies unlawfully agreed, and invited other staffing companies to agree, to lower rates paid to therapists, exchanged rate information, and agreed to coordinate on rates to prevent therapists from switching to competing staffing companies paying higher rates.[159] Physical therapy staffing companies contract with physical therapists, and then contract with home health agencies to provide therapists and assistants to treat the agencies patients. The defendant staffing companies entered into settlements with the FTC and the Texas Attorney General, prohibiting them from entering into any agreement to lower, fix, or maintain rates in competing with each other for employees and exchanging wage information. The settlement also imposed reporting and certification requirements on the defendant staffing companies. Interestingly, the FTC did not expressly allege that the market allocation agreements were *per se* violations.

[1] Practical Takeaways and Compliance Best Practices for Hiring and Compensation

In order to avoid running afoul of the federal antitrust laws, employers should consider the following takeaways when structuring and implementing hiring and compensation practices:

- The FTC and DOJ intend to investigate and, in some circumstances, criminally prosecute companies and individuals for naked wage-fixing and no-poaching agreements. These arrangements can be formal or informal, written or unwritten or spoken or unspoken.
- Conduct that can constitute a *per se* violation and trigger felony criminal prosecutions includes, but is not limited to, agreements among firms to recruit or hire each other's employees, to set a pay scale or wage rates, to cap wage growth or to limit employee benefits.
- The DOJ emphasized, however, that traditional non-compete and non-solicitation agreements and other restrictive covenants in individual employment agreements remain legal if they have a legitimate business

[159] *See generally* In the Matter of Your Therapy Source, FTC File No. 171-0134 (July 11, 2018); *See also* In the Matter of Your Therapy Source, Agreed Final Judgment and Stipulated Injunction, Case. No. D-1-GN-18-003887 (July 31, 2018).

purpose and are narrowly tailored to conform to the purposes of the agreement.

- HR personnel and employers should review hiring and compensation practices to identify any potential violations. Companies should review all internal policies and practices to make sure human resources personnel are not engaging in conduct that could be considered a no-poaching or a wage-fixing agreement.
- Be careful when talking to other HR professionals in your industry at conferences or trade association meetings. Simple conversations that seem harmless could become the basis for a criminal or civil prosecution.
- Individuals and companies should completely avoid agreeing or coordinating with competitors about: (1) employee salary or other terms of compensation; or (2) refusing to solicit or hire another company's employees.
- Similarly, be wary of exchanging any wage information with a competitor or trade association. Unless properly structured, this exchange of information could be direct evidence of an unlawful wage-fixing agreement.
- Keep in mind that the cost to defend an FTC or DOJ investigation is incredibly high in terms of both money and time. In addition, any private party litigation may result in additional defense costs as well as trebled damages. Consult counsel if you have any questions related to current practices or if you have been or are approached by a competitor to enter into this type of arrangement.