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Dominant Hospitals, Dominant Insurers, and Exclusionary Conduct

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While the FTC has focused on hospital mergers, the Antitrust Division seems more concerned with conduct by which dominant hospitals or health plans implement conduct to exclude their competitors from the market. By doing so, they may obtain or maintain substantial market power in their respective markets. In recent times, the Division has brought two particularly interesting enforcement actions, which, in a sense, are mirror images of each other.

In its case against United Regional Health Care, a dominant hospital in Wichita Falls, Texas, the Division alleged in a February 25, 2011 complaint that the hospital monopolized the market for inpatient hospital services by inducing health plans not to contract with the only other hospital in the city. It allegedly entered into agreements with a number of health plans by which it accepted drastically lower prices from them if they refused to add the town's second hospital to their networks. Many health plans took the lower price and refused to contract with the competing hospital. The exclusionary effect, thus, was in the market for hospital services, but the ultimate effect, according to the complaint, was to increase the price of health insurance by the defendant's maintaining its monopoly power. United Regional chose to enter into a consent decree with the Division rather than litigating the case.

In its earlier case against Blue Cross Blue Shield of Michigan, filed on October 18, 2010, the Division sued Michigan's Blue Cross Blue Shield, a dominant insurer, alleging that its most-favored-nations provision in contracts with hospitals resulted in agreements unreasonably restraining competition. Some of the contracts not only prohibited the hospitals from granting lower prices to Blue Cross's competitors than they granted Blue Cross, but required that they charge other health plans significantly more than they charged Blue Cross. These provisions, the complaint alleged, had significant exclusionary effects in the market for health insurance by

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increasing the cost of Blue Cross's competitors or preventing them from contracting with some hospitals, permitting Blue Cross to maintain supracompetitive prices. This case on ongoing; Blue Cross filed a motion to dismiss for failure to state a claim, which the court has under advisement.

Exclusionary contracts between providers and payers—vertical agreements that may or may not adversely affect competition—can take numerous forms: exclusive contracts where one party expressly agrees not to contract with competitors of the other; price inducements, as in the United Regional case, resulting in a party's not dealing with the competitors of the other party; and others. From the standpoint of antitrust analysis, the form really doesn't matter and the basic antitrust analysis is the same. The contracts can be initiated by either providers or payers to protect their markets against competitors. And in some situations, dominant hospitals and health plans may enter into arrangements with each other that help maintain market power of both by each engaging in agreements that exclude their competitors. But these types of arrangements, depending on the circumstances, can generate procompetitive effects as well as anticompetitive effects, so they are always analyzed under the rule of reason rather than the per se rule.

Very generally, three factors must be present before an exclusionary arrangement between a provider and health plan raises antitrust concern. First, the party initiating the arrangement must have significant market power or the arrangement result in its obtaining significant market power. Absent that factor, rarely will the arrangement have a significant adverse effect on competition. The party's degree of market power depends on several variables, but the most important is its market share. Typically, a market share of 35 or 40 percent begins to raise concern. The Antitrust Division alleged that United Regional had a 90 percent market share of inpatient hospital services, clearly enough to raise concern. In the *Blue Cross* case, the Antitrust Division alleged that, in may different relevant geographic markets, Blue Cross's market share was between 45 and 75 of the commercial insurance market—certainly sufficient to raise antitrust concern about its market power.

Second, the arrangement must exclude or weaken competitors of the party subjected to the arrangement; it must foreclose them from a significant percentage

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of available business (as under the United Regional arrangement) or significantly raise their cost of doing business (as the Blue Cross MFNs allegedly did), which prevents or significantly inhibits them from constraining the market power of the firm that initiated the restraint. In sum, for the arrangement to violate the antitrust laws, it must permit the firm in question to obtain, or to maintain, market power. No specific percentage of foreclosure is determinative, but the courts indicate that, all else equal, the percentage of the market foreclosed to competitors should be at least in the 35 to 40 percent range. Smaller percentages may suffice, however, if the plaintiff can show that arrangement significantly weakens the ability of the firm's competitors to combat its market power.

The *United Regional* complaint does not allege the percentage of business from which the competing hospital was foreclosed as a result of that hospital's contracts with payers. But the complaint does allege that the health plans refusing to contract with the competitor constituted some 35 percent of United Regional's profits and that if just 10 percent of their patients switched to the competing hospital had the health plans contracted with it, its profits would have increased by at least 40 percent, increasing its ability to challenge United Regional's market power. In the *Blue Cross* case, the MFNs prevented Blue Cross's competitors from challenging its market power by raising the prices they paid for hospital services (allegedly up to 40 percent higher than the prices Blue Cross paid for hospital services) and thus forcing their premium prices significantly higher than Blue Cross's.

Finally, there must be no procompetitive justification for the arrangement that more than offsets its anticompetitive effects. In *United Regional*, the Division alleged specifically that "United Regional did not use the contracts to achieve any economies of scale or other efficiencies as a result of any additional patient volume that it obtained from the contracts." Similarly, in its *Blue Cross* complaint, the Division claimed that "[t]here are no likely procompetitive or efficiency-enhancing effects of the MFNs that would outweigh the . . . anticompetitive effects . . . . The MFNs have not led, and will likely not lead, to lower hospital prices for Blue Cross or other insurers."

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The primary lesson from the Division's attacks on exclusionary arrangements is that both dominant providers and health plans must carefully consider the likely effects on competition of their provider/payer contracts. They have every right under the antitrust laws to get the best price they can in selling or purchasing health care services as long as they do not tie those prices to the other party's excluding their competitors. If they do, the party initiating the contract had better determine and be ready to prove that procompetitive effects of the arrangement justify its exclusionary effect.

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