NAVIGATING THE BACKWATER: VERTICAL MERGERS IN HEALTH CARE

BY THOMAS L. GREANEY[1]

1 Visiting Professor, University of California Hastings College of Law, Chester A. Myers Professor Emeritus, Saint Louis University School of Law. The author testified on a pro bono basis at the Investigatory Hearing on the Merger of Aetna Inc into CVS Health Corporation. conducted by the California Department of Insurance on June 19, 2018 and has been listed as a possible witness in the Tunney Act proceeding in the District Court for the District of Columbia in *U.S. v. CVS Health Corp. and Aetna Inc.* (Case No. 1;18-cv-02340-RJL).

CPI ANTITRUST CHRONICLE MAY 2019

Navigating Vertical Mergers in Healthcare Through a Shifting Enforcement Landscape
By Lisl J. Dunlop & Cristina M. Fernandez

Cross-Market Hospital Mergers: An Antitrust Theory Challenged by Facts and Law
By Jeffrey W. Brennan

Navigating the Backwater: Vertical Mergers in Health Care
By Thomas L. Greaney

A Stronger Second Competitor? Analyzing the Competitive Effects of the *Beth Israel-Lahey* Transaction
By Cory Capps, Kayuna Fukushima, Tetyana Shvydko & Zenon Zabinski

When Providers Merge, is Kaiser a Competitor?
By Douglas Ross, James Harlan Corning, David Maas & Douglas Litvack

Uncertainty in Pharmaceuticals Markets
By Henri Piffaut

To Settle or Not To Settle? An Analysis of the *Servier* Patent Settlement Case and it's Practical Implications
By Marie Manley & Anne Robert

The Commission's Paper on the Obligation of Continuous Supply of Medicines and it's Impact on Parallel Exporting Activities in The EU: A Paradigm Shift?
By Gonçalo Miguel Banha Coelho

www.competitionpolicyinternational.com

I. INTRODUCTION

Long a part of the backwaters of antitrust enforcement, vertical mergers have recently attracted the attention of academics and enforcers. The Federal Trade Commission's hearings on vertical merger policy and the issue of whether to publish new Vertical Merger Guidelines,[2] along with recent cases including the Department's unsuccessful challenge to AT&T's acquisition of Time Warner[3] and speeches by enforcement officials[4] illustrate a renewed focus on vertical combinations. It is widely recognized that the Department of Justice Non-Horizontal Merger Guidelines are out of date and do not reflect modern economic thinking or government enforcement policy. Indeed, a large body of theoretical and empirical work has served to undermine the economic foundations of the *laissez-faire* approach that has characterized government policies over the last thirty years.[5]

The health care sector, which has recently experienced significant vertical consolidation, exhibits textbook conditions of a market susceptible to consumer harm. Provider, payer, pharmaceutical, insurance, and intermediary management markets exhibit key pre-conditions for harm from vertical mergers: Most are highly concentrated, exhibit durable barriers to entry, and have historically performed poorly.[6] Applying contemporary economic analyses of health care markets, much derived from retrospective studies of hospital mergers, courts have closed the door on large horizontal mergers in the hospital, insurance, and physician sectors.[7] Over the last decade these cases clarified understanding about important characteristics of health care competition, such as the highly localized nature of provider and insurance markets, the two-stage competition characterizing provider networks, and the availability of alternatives to mergers to achieve integrative efficiencies.

2 Federal Trade Commission, HEARING #5 ON COMPETITION AND CONSUMER PROTECTION IN THE 21ST CENTURY (Nov. 1, 2018) https://www.ftc.gov/news-events/events-calendar/ftc-hearing-5-competition-consumer-protection-21st-century.

3 *U.S. v. AT&T*, 310 F.Supp 3d (D.D.C.2019); Federal Trade Commission, In the matter of Sycamore Ptns.II, Staples, Inc. and Essendant Inc. File No. 181-0180 (Jan. 28, 2019).

4 E.g. Makan Delrahim, Assistant Att'y Gen., Dep't of Justice, Harder Better Faster Stronger: Evaluating EDM as a Defense in Vertical Mergers. Remarks at George Mason Law Review 22nd Annual Antitrust Symposium (Feb. 15, 2019).

5 See Jonathan B. Baker et al., "Five Principles for Merger Enforcement Policy," (summarizing theoretical and empirical literature); Steven A. Salop, *Invigorating Vertical Merger Enforcement*, 127 Yale Law Journal 1962 (2018).

6 See Thomas L. Greaney, *The New Health Care Merger Wave: Does the "Vertical, Good" Maxim Apply?* 46 J. L., Medicine & Ethics 918 (2018); Martin Gaynor, "Examining the Impact of Health Care Consolidation," Statement Before the Energy and Commerce Oversight Committee, U.S. House of Representatives, February 14, 2018.

7 See, e.g. FTC v. Advocate Health Care Network, 841 F.3d 460 (7th Cir. 2016)(hospitals); FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327 (3d Cir. 2016)(hospitals); Saint Alphonsus Medical Center-Nampa & FTC v. St. Luke's Health System, 778 F.3d 775, 793 (9th Cir. 2015)(physicians); U.S. v. Anthem, Inc., 855 F. 3d 345 (D.C. Cir. 2017)(insurance); United States v. Aetna, Inc., 240 F. Supp. 3d 1 (D.D.C. 2017)(insurance).

Perhaps chastened by their experiences in court, and unwilling to risk litigation setbacks before an increasingly business-friendly judiciary, the FTC and Department of Justice have displayed no enthusiasm for taking on vertical issues involving health care delivery or payment. This essay argues that the agencies should learn the lessons of past lax antitrust enforcement in health care and undertake administrative and litigation policies designed to identify and curb excessive vertical consolidation. Detailing examples of unwise forbearance, this article will discuss the Justice Department's refusal to challenge the vertical aspects of the *CVS/Aetna* merger and the FTC's failure to tackle hospital acquisitions of physician practices.

II. THE CASE FOR PAYING CLOSE ATTENTION TO VERTICAL MERGERS IN HEALTH CARE

Contemporary economic analyses have sharply questioned the basis for a *laissez-faire* approach to vertical combinations. The modern account demonstrates that preconditions underlying Chicago School's analysis "rarely hold" and "can obscure how a particular merger may raise real competitive concerns."[8] While vertical mergers do not increase concentration they may enable conduct that limits rivalry at the horizontal level. Indeed, it is important to remember that harms from vertical consolidations arise from their effects on *horizontal* competition. That is, vertical mergers create "inherent exclusionary incentives as well as the potential for coordinated effects similar to those that occur in horizontal mergers."[9] By combining inputs with distribution, for example, a vertical merger can enhance incentives for the merged firm to exclude its downstream or upstream rivals, either by raising their costs or cutting off their access to critical resources. Professor Steven Salop's extensive body of work provides a sound economic model of foreclosure risks and maps the potential legal framework for applying the so-called "raising rivals' cost" principles to vertical mergers.[10] Unfortunately, owing to the disinclination of enforcement agencies in challenging vertical mergers, case law is sparse and precedent has failed to keep up with the economic learning.

Vertical mergers are proliferating in health care. Indeed, one can discern a reactive pattern, as unsuccessful horizontal mergers among the nation's largest commercial insurers has been followed by linkages between some of those same insurers with pharmacy benefit managers and one with the nation's largest pharmacy chain. Following suit, the nation's largest Medicaid managed care company has proposed to acquire a significant rival, and Medicare Advantage and Medicare prescription drug plan sponsors have become highly concentrated. In sum, the nation is only a few mergers away from having a very small contingent of vertically integrated middlemen responsible for insurance, benefit structure, and provider contracting across the entirety of public and private health care in the United States.

Market structure is an important starting point for analyzing vertical mergers.[11] Every sector of health care delivery and payment is characterized by high concentration. The data is striking: Over 90 percent of inpatient acute care hospital markets are concentrated and the four largest commercial insurers have over 80 percent of the nation's commercial insurance business, with half of all markets comprised of two insurers controlling over 70 percent of the market. Although physician markets are less concentrated, 65 percent of all MSAs have highly concentrated physician specialty markets and approximately 40 percent of local primary care markets are concentrated. The three largest pharmacy benefit management companies control over 70 percent of the business and two pharmacy chains control between 50 and 75 percent of the market in the nation's largest markets.[12]

Courts must evaluate the potential for competitive harm from vertical mergers arising from enhanced incentives of the merged firm to exclude its upstream or downstream rivals either by raising their costs or cutting off their access to critical resources. Not unlike horizontal merger analysis, that determination requires a probabilistic assessment based on incentives and experience. As economists have noted, highly concentrated markets protected by entry and mobility barriers create strong incentives to disadvantage rivals via exclusion or raising rivals' costs.

8 Steven A. Salop & Culley, *Potential Competitive Effects of Vertical Mergers: A How-To Guide for Practitioners* (Dec. 8, 2014), available at http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=2404&context=facpub.

9 Baker et al., *supra* note 5at 8.

10 Steven C. Salop, *Invigorating Vertical Merger Enforcement*, 127 Yale. L. J. 1962 (2018). Salop, *supra* note 8, *Invigorating Vertical Merger Enforcement.* Professor Salop offered a roadmap for developing presumptive rules and generally revising the government's vertical merger guidelines in his testimony at the FTC hearing on vertical mergers. See FTC Hearing #5, *supra* note 2.

11 Several participants in the FTC hearing proposed presumptions for vertical merger guidelines that employ among other factors market share concentration data. See e.g. Salop testimony, FTC Hearing #5, *supra* note 2.

12 For sources of these date, see Greaney, *supra* note 6; Gaynor, *supra* note 6. Leemore Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" Testimony before the Subcommittee on Antitrust, Competition Policy, and Consumer Rights of the Senate Committee on the Judiciary (2015).

In addition, conduct and context help inform the evaluation. While such inquiries are necessarily highly fact intensive, the need for vigilance over vertical consolidation in health care is particularly acute based on long experience demonstrating that market dominance achieved by mergers can give rise to anticompetitive conduct. The history of antitrust law in the health care sector is littered with examples of hospitals, physician organizations, and insurers that have taken advantage of their dominant market positions, barriers to entry, and the absence of effective regulatory oversight to undertake actions that disadvantage rivals and impair competition.[13]

The assessment of the likely competitive effect also requires evaluating the efficiency benefits that may flow from integration. However, as they have done in horizontal merger cases, courts evaluating such claims in vertical cases should be careful to scrutinize whether alleged efficiencies are plausible and merger specific. While there are undeniably potentially significant benefits resulting from vertical integration among health care providers, there is less evidence that such benefits flow from integration of payers and providers. Moreover, the assumption commonly made that cost saving and quality improvements inevitably flow from hierarchical structures is unwarranted. Analyses by Professor Lawton Burns and others illustrate that economic integration in health care has often failed to generate clinical integration that produces either cost savings or improved efficiency.[14] Not unlike horizontal mergers, vertical mergers are subject to problems associated with culture clashes, inadequate pre-merger information, and challenges inherent in management integration. As Martin Gaynor put it, "consolidation is not coordination."[15]

The bottom line is this: If antitrust is to undergo an "invigoration" of vertical merger law, the health care sector should be high on the agenda of enforcers. As noted above, the various sectors of the health care industry are uniquely susceptible to the risks of foreclosure and raising rivals' costs. Moreover, it should be remembered that as a general matter, antitrust law has been relatively lenient in dealing with exclusionary conduct and does little to curb extant market power.[16] Both conditions are prevalent in health care markets. As Professor Herbert Hovenkamp has contended, it is appropriate to apply the more demanding "incipiency" standard in cases such as vertical mergers, "where a merger is likely to lead to conduct that is both anticompetitive but also is difficult or impossible for antitrust law to reach once the merger has occurred."[17]

III. OVERLOOKED VERTICAL HEALTHCARE MERGERS

The absence of case law and agency guidance regarding vertical health care mergers is problematic because it sends an "all clear" signal to practitioners: As noted earlier, vertical mergers are proliferating in a number of sectors of healthcare delivery and payment. Two important cases in which enforcers have declined to pursue challenges illustrate the government's overly cautious approach.

Despite the extensive merger activity involving hospitals acquiring physician practices, government antitrust enforcers have never challenged such mergers. This is especially troublesome in view of economic evidence that such mergers result in higher prices and higher spending.[18] In its first litigated case involving a physician merger, *Saint Alphonsus Medical Center-Nampa & FTC v. St. Luke's Health System*,[19] the FTC prevailed in a challenge to a horizontal merger involving the acquisition of a physician group by a hospital system that would have increased the hospital's existing share of the primary care physician market to approximately 80 percent. Although the factual findings in the case tended to strongly support a finding of vertical foreclosure (which a rival hospital urged the court to consider), the FTC chose not to pursue that aspect

13 See Thomas L. Greaney & Barak D. Richman, Consolidation in Provider and Insurer Markets: Enforcement Issues and Priorities, Part I of the American Antitrust Institute White Paper Series on Competition in Payment and Delivery of Health Care Services (June, 2018), available at http://www.antitrustinstitute.org/content/aai-issues-part-i-new-white-paper-series-competition-delivery-and-payment-healthcare.

14 See, e.g. Lawton Burns, Testimony before the Investigatory Hearing on the Merger of Aetna into CVS Health Care Corporation, California Department of Insurance (June 19, 2018).

15 Martin Gaynor, "Examining the Impact of Health Care Consolidation," Statement Before the Energy and Commerce Oversight Committee, U.S. House of Representatives, February 14, 2018 at 11.

16 Jonathan B. Baker, *Exclusion as a Core Competition Concern*, 78 Antitrust L. J. 528 (2013).

17 Herbert Hovenkamp, *Prophylactic Merger Policy*, 70 Hastings L. J. 45 (2018).

18 Laurence C. Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 Health Aff. 756 (2014); Richard M. Scheffler et al., *Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices*, 37 Health Affairs (Sept. 2018); James C. Robinson & Kelly Miller, *Total Expenditures in Hospital-Owned and Physician-Owned Organizations in California*, 312 [J]AMA 1663 (2014), http://jama.jamanetwork.com/article.aspx?articleid=1917439 [https://perma.cc/4NS2-C3SP] (noting that groups owned by physicians have lower costs than groups owned by hospitals); Hannah T. Naprash et al., *Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices*, [J]AMA Online First (Oct. 19, 2015), http://archinte.jamanetwork.com/article.aspx?articleid=2463591 [https://perma.cc/M4QT-M469].

19 *Saint Alphonsus Medical Center-Nampa & FTC v. St. Luke's Health System*, 778 F.3d 775, 793 (9th Cir. 2015).

of the case. Ultimately, the district court and Ninth Circuit followed the FTC's lead and focused only on the merger's horizontal effects without addressing the vertical theory. This missed opportunity, coupled with the agency's failure to bring any vertical challenges to hospital/physician consolidation, provides a strong incentive to test the water with highly concentrative vertical acquisitions.

A second case, currently under review by the District Court for the District of Columbia, involves the challenge by the Department of Justice to the acquisition of Aetna by CVS. Although the Antitrust Division challenged the merger based on a horizontal overlap in a number of local, standalone Medicare prescription drug markets and accepted proposed divestitures to settle the case, it chose to ignore the much larger vertical aspects of the merger. The vertical aspects of the merger arise from the fact that Aetna is a buyer of important inputs — PBM services and pharmacies – that CVS sells. Competitive harms result from first the risk of "input foreclosure" i.e. the refusal to deal with competing health insurers on terms as favorable as those offered a merged Aetna. The potential harms identified by a number of parties including the American Medical Association, the AIDS Healthcare Foundation, and the California Department of Insurance were that the merged firm would raise the costs of rival insurers by advantaging its Aetna business by reducing the availability of PBM or retail and specialty pharmacy services, or by raising the price of these services to competing health insurers. In addition, the acquisition creates risks of "customer foreclosure" by CVS in that the merger would deprive competing PBMs and pharmacies of the markets for their services. Another notable vertical merger involving the same sector, Express Scripts, the second largest supplier of PBM services, acquired Cigna, the nation's fourth largest health insurer, was approved by the Department at approximately the same time. To the surprise of some, Judge Leon has ordered a hearing to evaluate the proposed consent decree in the CVS/Aetna consolidation under the Tunney Act public interest standard. While the Justice Department did not allege a vertical theory in settling the case it is possible the court could reject the narrowness of the challenge as not in the public interest.

IV. CONCLUSION

Forbearance has its costs. In the hospital sector, the government neglected to challenge any horizontal mergers over a period of approximately seven years. During that period, and afterwards, hospital markets across the country became highly concentrated. While not all of the increase is attributable to mergers, the implicit green light certainly contributed to the willingness to merge — an outcome that economic studies reveal has enabled the exercise of significant market power in local areas around the country.[20] Likewise the absence of precedent and standards regarding vertical mergers invites entities to test the outer reaches of concentration and potentially impose long term competitive harm.

20 Martin Gaynor & Robert Town, The Synthesis Project: The Impact of Hospital Consolidation, (Robert Wood Johnson Foundation 2012).

CPI COMPETITION POLICY INTERNATIONAL

CPI Subscriptions

CPI reaches more than 20,000 readers in over 150 countries every day. Our online library houses over 23,000 papers, articles and interviews.

Visit competitionpolicyinternational.com today to see our available plans and join CPI's global community of antitrust experts.