Editorial

Sham Peer Review: Antitrust Concerns

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In recent decades, hospitals have increasingly merged, acquired other hospitals, acquired physician practices, and employed physicians. Predictably, this monopolistic trend has led to increased costs. This translates to higher co-pays and higher insurance premiums for patients. For the uninsured and underinsured, these increased costs often result in burdensome debt and forgoing medical care in some cases.

Loss of physician autonomy has accompanied the trend of hospitals employing physicians, and has led to more decisions being made by non-physician administrators. This has negatively impacted the quality of care. The patient-physician relationship has been harmed as independent physicians are increasingly being replaced with shift workers (hospital-employed hospitalists). Continuity of care for hospitalized patients is disappearing.

In the quest to create larger and more robust monopolies, some hospitals are using sham peer review to remove the last remnants of independent physicians practicing in hospitals, thus eliminating competition and enhancing their monopoly power.

The creation of large hospital monopolies, with hospitals influencing the care provided by its employed physicians, has led to antitrust concerns.

The information presented below is not intended as legal advice or opinion. It derives from my extensive study of court documents and relevant literature, and from my own experience. Physicians should seek legal advice and opinion from their attorneys.

Patrick v. Burget: the Antitrust Case That Led to the Passage of HCQIA

The use of sham peer review to eliminate competition is not new. The precedential case that led to the passage of the Health Care Quality Improvement Act (HCQIA) of 1986 is *Patrick v. Burget*.[1] HCQIA is the federal law that applies to peer review.

As reviewed by the U.S. Supreme Court, Dr. Timothy A. Patrick became an employee of the Astoria Clinic in Astoria, Oregon, in 1972. Dr. Patrick was a general and vascular surgeon. Astoria is a small town in Northwest Oregon that had one hospital—Columbia Memorial Hospital (CMH). The majority of medical staff members there were either employees or partners of the Astoria Clinic. Thus, the Astoria Clinic physicians exerted substantial power over committees in the hospital, including those involved in peer review.[1]

In 1973, Dr. Patrick was invited to become a partner in the Astoria Clinic. Dr. Patrick declined that offer and decided to establish his own independent practice, in competition with Clinic surgeons. Thereafter, relations between Dr. Patrick and the Clinic physicians deteriorated. As reviewed in *AAPS News*:

> Astoria Clinic physicians consistently refused to have professional dealings with Dr. Patrick. Dr. Patrick received virtually no referrals from the physicians at the Astoria Clinic, who frequently referred patients to surgeons as far as 50 miles away. Clinic physicians were also reluctant to assist Dr. Patrick with his patients, declined to give consultations, and refused to provide back-up coverage for patients under Dr. Patrick's care. Meanwhile, Clinic physicians criticized Dr. Patrick for [allegedly] failing to obtain outside consultations and to provide adequate back-up coverage.[2]

Unfortunately, that was just the beginning of Dr. Patrick's difficulties. In 1979, a partner at the Clinic complained to the hospital's medical executive committee (MEC) about an incident in which Dr. Patrick allegedly left a patient in the care of a recently hired associate, who then allegedly left the patient unattended.[1] The MEC referred the matter to the State Board of Medical Examiners (BOME), and included other cases handled by Dr. Patrick. Another partner at the Clinic chaired the committee of the BOME that investigated Dr. Patrick's cases. The BOME subsequently issued a letter of reprimand to Dr. Patrick.[1] A law review article provided further details about this letter of reprimand:

> [Dr. Patrick] objected to the letter and requested a new hearing. Dr. Tanaka, BOME chairman, agreed the letter was erroneous but refused to withdraw it. Only after Dr. Patrick filed a petition for judicial review did the BOME retract the letter.[3]

As reported by *AAPS News* in July 1988:

> In 1981, one of the surgeons at the Clinic asked the MEC to initiate a review of Dr. Patrick's privileges. The MEC recommended that Dr. Patrick's privileges be terminated. A five member hearing committee, chaired by the same surgeon that initially requested the review of Dr. Patrick's privileges heard the charges, but the members of the committee refused to testify as to their personal bias against Dr. Patrick. Dr. Patrick resigned from the medical staff of Columbia Memorial Hospital rather than risk termination of his hospital privileges.[2]

Neither HCQIA nor the National Practitioner Data Bank (NPDB) existed at that time, so Dr. Patrick could resign his privileges without ruining or ending his career. Today a resignation while under investigation triggers a mandatory report to the NPDB.

> Dr. Patrick filed a lawsuit in U.S. District Court for the District of Oregon while the hospital peer review was still ongoing. Dr. Patrick alleged that the partners of the Astoria Clinic had violated 1 and 2 of the Sherman Act (ch. 647, 26 Stat. 209, 15 U.S.C. 1,2). Specifically, Dr. Patrick claimed that Clinic partners "had initiated and participated in the hospital peer-review proceedings to reduce competition from petitioner rather than to improve patient care." Respondents denied this assertion, and the District Court submitted the dispute to the jury with instructions that it could rule in favor of petitioner only if it found the respondents' conduct was the result of a specific intent to injure or destroy competition.[1]
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> The jury returned a verdict against respondents Russell [Dr. Franklin Russell chaired the BOME committee that investigated Dr. Patrick's cases], Boelling [Dr. Gary Boelling,

who had complained to the MEC about an incident where Dr. Patrick's associate allegedly left a patient unattended], and Harris [Dr. Richard Harris, is the surgeon who asked the MEC to review Dr. Patrick's privileges] on the 1 [Section 1] claim and against all of the respondents on the 2 [Section 2] claim. It awarded damages of $650,000 on the two antitrust claims taken together. The District Court, as required by law, see 15 U.S.C. 15(a), 38 Stat. 731 trebled the antitrust damages.[1]

Defendants appealed to the Ninth Circuit Court of Appeals, which reversed (800 F.2d 1498 (1986)). The Ninth Circuit found:

> that there was substantial evidence that respondents had acted in bad faith in the peer review process [i.e., had conducted a sham peer review]. The court held, however, that even if respondents had used the peer review process to disadvantage a competitor rather than to improve patient care, their conduct in the peer review proceedings was immune from antitrust scrutiny. The court reasoned that the peer review activities of physicians in Oregon fall within the state-action exemption from antitrust liability because Oregon has articulated a policy in favor of peer review and actively supervises the peer review process. The court therefore reversed the judgment of the District Court as to petitioner's antitrust claims.[1]

Dr. Patrick appealed to the U.S. Supreme Court, and in 1987 the Supreme Court granted certiorari (484 U.S. 814 (1987).[1]

The Association of American Physicians and Surgeons (AAPS) and the Semmelweis Society filed an amicus brief in support of Dr. Patrick, while the American Medical Association (AMA), the American Hospital Association (AHA), the Joint Commission on the Accreditation of Health Care Organizations (JCAHO, now known as the Joint Commission), the Oregon Medical Association, the Oregon Association of Hospitals, and the American Medical Peer Review Association filed an amicus brief supporting those who the 9th Circuit found had conducted a bad-faith peer review against Dr. Patrick. The question presented to the Supreme Court was "…whether the state-action doctrine of *Parker v. Brown*, 317 U.S. 341 (1943), protects physicians in the State of Oregon from federal antitrust liability for their activities on hospital peer review committees."[1]

AAPS Amicus Brief—*Patrick v. Burget*

In testimony to its longstanding opposition to bad faith, sham peer review, the AAPS brief stated:

> The bad faith use of the hospital peer review process to deprive a competent doctor of medical staff privileges at the only hospital in his community should not be exempt from antitrust liability.[4]

The AMA et al. argued in their brief that the Columbia Memorial Hospital was exempt from antitrust liability because it was a "state actor," where the peer review was subject to state policy and was "actively supervised" by the state.[5]

The AAPS amicus brief provided the following analysis based on the Midcal test:

> In *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.* 445 U.S. 97 (1980), this Court adopted [a] two-pronged test for determining when state regulation of private parties exempted them from federal antitrust laws: (1) the challenge restraint must be "clearly articulated and affirmatively expressed as state policy" and (2) the policy must be "actively supervised" by the State itself. The conduct of respondents in this case satisfies neither prong of Midcal.
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> The State Action Exemption to the Federal Antitrust Laws does not apply to the malicious, anticompetitive conduct demonstrated in the record of this case.[4]

AMA Amicus Brief—*Patrick v. Burget*

The AMA et al. argued in their amicus brief that imposing liability under federal antitrust laws discourages physicians from participating in effective peer review. They also advanced the "angry doctor" argument, noting that when adverse actions are taken against a doctor's privileges, it naturally provokes anger in the physician who then pursues "retaliatory" litigation to address his grievance. The AMA's amicus brief stated:

> *Amici's* interest in this case arises from their shared commitment to high quality medical and hospital care. They believe that this commitment can best be met when physicians conduct effective peer review according to their clinical judgment and professional standards, uninhibited by the threat of retaliatory litigation and the fear of uninsurable risks.
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> The judgment of the district court, imposing liability and awarding treble damages under the Sherman Act against individual physicians engaged in peer review, discouraged many physicians from participating in peer review. See Curran, *Law-Medicine Notes: Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 New Eng. J. Med. 597 (1987). The holding of the court of appeals conferring immunity upon the respondents allayed many fears and thereby promoted rigorous peer review.
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> Peer review recommendations denying, restricting or revoking privileges can provoke anger and can have a significant adverse economic impact on the affected physician. Consequently, physicians who are denied staff privileges or who have their privileges restricted or revoked often vigorously challenge that action through litigation. As one court noted in the early 1980's, "[a]ntitrust suits grounded on the denial, termination, or limitation of hospital staff privileges have proliferated in recent years." *Pontius v. Children's Hospital*, 552 F. Supp. 1352, 1362 (W.D. Pa. 1982). This threat of retaliatory litigation has become a substantial impediment to effective peer review.[5]

The underlying assumption is that all peer review is done in good faith by physicians whose only motive is the furtherance of quality medical care.

AMA et al. also argued: "In mandating peer review, the Oregon legislature effectively mandated some anticompetitive effects in the market for health care services."[5]

Dr. Patrick Prevails

On May 16, 1988, the Supreme Court rendered a decision in favor of Dr. Patrick. The Supreme Court adopted many of the arguments and analysis provided in the AAPS amicus brief. The Supreme Court held:

> Because we conclude that no state actor in Oregon actively supervises hospital peer-review decisions, we hold that the state-action doctrine does not protect the peer-review activities challenged in this case from application of

the federal antitrust laws. In so holding, we are not unmindful of the policy argument that respondents and their amici have advanced for reaching the opposite conclusion. They contend that effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability will prevent physicians from participating openly and actively in peer-review proceedings. This argument, however, essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care, and as such is properly directed to the legislative branch. To the extent that Congress has declined to exempt medical peer review from the reach of the antitrust laws, peer review is immune from antitrust scrutiny [486 U.S. 94, 106] only if the State effectively has made this conduct its own. The State of Oregon has not done so. Accordingly, we reverse the judgment of the Court of Appeals.[1]

Legal Arguments Impacting Liability under Federal Antitrust Laws

An excellent law review article, published a couple of years after the Supreme Court decision in *Patrick* and following the passage of HCQIA, provided an in-depth analysis of legal arguments impacting liability under federal antitrust laws. It noted that "*Patrick* represents the first United States Supreme Court case in which antitrust liability was extended to peer review committee members in a private hospital."[3] It noted that all 50 states have passed immunity for physicians who serve on peer review committees. However, unlike HCQIA, state laws generally require that peer reviewers act in good faith, without malice and with reasonableness.[3]

In discussing the jurisdictional test that applies to antitrust litigation, the article noted that peer review at hospitals is inherently local and thus does not affect interstate commerce. The Sherman Act, as a federal law, prohibits activities that restrict interstate commerce and competition in the marketplace. However, an indirect effect on interstate commerce can be sufficient to demonstrate an effect on interstate commerce. Citing *Hospital Building Co. v. Trustees of Rex Hospital* (425 U.S. 738 (1976), the article noted:

> [T]he fact that an effect on interstate commerce might be termed "indirect" because the conduct producing it is not "purposely directed" toward interstate commerce does not lead to a conclusion that the conduct at issue is outside the scope of the Sherman Act. The Court's holding merely stated that conduct may affect interstate commerce and thus satisfy the jurisdictional requirement of the Sherman Act even if it was not "purposely directed" toward interstate commerce. In other words, an indirect effect on interstate commerce may be sufficient. It follows that if the action was not purposely directed at interstate commerce and in addition did not have even an indirect effect on interstate commerce, the jurisdictional defense may still be valid. Defendants continue to raise this defense. Clearly, the peer review process utilized by hospitals in making staff privilege decisions often implicates the antitrust laws.[3]

After passing the jurisdictional test, a court must evaluate the reasonableness of a peer review action or agreement in terms of restraining competition. "Only those agreements [or peer review actions] which unreasonably restrain trade are held to violate section 1 of the Sherman Act."[3] Two methods of evaluating whether or not a peer review action unreasonably restricts competition include the *per se* analysis and the Rule of Reason analysis. As explained in the law review article:

> Several classes of behavior constitute *per se* violations. One example of a *per se* violation is a concerted refusal to deal or a group boycott. Other examples of *per se* violations are price-fixing agreements and territorial restrictions.
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> Under the Rule of Reason analysis, "the factfinder weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition." … Because a restrictive practice may have both anticompetitive and procompetitive effects, a court will find an antitrust violation only if the anticompetitive effects predominate.[3]

Identifying a relevant market is also required in antitrust litigation and can be a difficult and contentious issue.

Hospitals took note of the *Patrick* decision and got the message that bad-faith, sham peer review may no longer be tolerated, and if the sham peer review resulted in an unreasonable anticompetitive effect in the market, they could be liable for treble damages under antitrust laws. As noted in *AAPS News* in July 1988: "In the wake of the Patrick decision, some hospitals are admonishing their executive committees to take steps to ensure that peer review proceedings are conducted in a fair and reasonable manner." [2] Unfortunately, following the passage of HCQIA, which provides nearly absolute immunity to hospitals and peer reviewers, abuse of the peer review process has continued.

AMA and Sham Peer Review

As noted in the Supreme Court decision in *Patrick*, "The Court of Appeals for the Ninth Circuit…found that there was substantial evidence that respondents had acted in bad faith in the peer-review process."[1] Thus, the *Patrick* case was a case involving sham peer review.

Following the *Patrick* decision, the AMA remained skeptical about the existence of sham peer review. In a 2008 Report of the AMA Board of Trustees on Inappropriate Peer Review, they wrote:

> A sanction by a peer review body can be a devastating blow to a physician, emotionally, financially, and professionally. Those who have been so sanctioned frequently claim to be victims of "sham" peer review.
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> Abuse of peer review is easy to allege but, for the reasons discussed above, can be difficult to prove. Considering the nature of the proceedings, it is to be expected that such charges will be raised by physicians who disagree with the results. In fairness, though, those who raise such claims should have the burden of proving them. Since the passage of HCQIA in 1986, the AMA has been aware of only exceptional, isolated instances of peer review determinations that have resulted from improper motivations, rather than a good faith desire to improve patient care.
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> This may partly be explained by the difficulties in proving such a case and the legal disincentives against bringing this type of lawsuit. More likely, though, is that peer review abuse is a rarity…. If abusive peer review were indeed "epidemic," there would probably be a more substantial record of definitive and proven malfeasance. The absence of such a record suggests that the claims of widespread or frequent "sham peer review" are speculative.[6]

Then, at an AMA Interim Meeting in November 2012, the AMA quietly and abruptly changed its view of sham peer review.[7] At that meeting it was reported:

> As a member benefit, the AMA offers information and advice to doctors on matters pertaining to their relationship with hospitals, health systems and other entities on issues such as breaches of contract, medical staff bylaws, sham peer reviews, economic credentialing and the denial of due process.[7]

Sham peer review was apparently considered to be more than a "rarity" at that point; otherwise there would be no need to provide physician victims with information and advice.

Horizontal Consolidation: Creation of Hospital Monopolies

Horizontal consolidation occurs when hospitals merge or acquire other hospitals to form larger hospital conglomerates, or when physician practices merge to form larger physician groups.[8] As noted by one author:

> Healthcare consolidation is a problem. Large hospital conglomerates are expanding, purchasing smaller hospitals and independent clinics. This isn't market- or patient-driven consolidation. It isn't bottom-up emergence of economies of scale. This is government regulation putting a finger on the scale and giving larger institutions an unfair advantage over their competition. It's cronyism for tax-exempt systems that already rake in large revenues. Ninety percent of metropolitan statistical areas are considered highly concentrated by antitrust standards.[9]

And, unfortunately, "Hospital mergers and monopolies are increasingly the norm in the United States."[10] "Between 1998 and 2012, there were 1,113 mergers and acquisitions involving a total of 2,277 hospitals."[11] "In 2018, 91 percent of hospital beds were in system-affiliated hospitals—an increase from 88 percent in 2016."[12] From 2015 to 2020, health systems controlled 24 percent of market share, and "their revenue grew at twice the rate of the rest of the market."[13]

Between 2013 and 2020, hospitals in geographically separated areas have increasingly merged in what is known as cross-market mergers. The market in these cross-market hospital mergers depends on specialty and type of service. As one article noted:

> The definition of what is a "market" in a cross-market merger matters greatly, as different types of services may have different geographic hospital referral patterns that reflect different market sizes. For example, a patient may be willing to travel much farther for a hematopoietic stem cell transplant than for a primary care visit or elective knee replacement hospitalization. This would mean that a merger covering primary care or orthopedics across organizations located 75 miles apart may be "cross market," while a merger covering tertiary cancer centers across 75 miles distance may be "within market"….. The number of hospital systems in urban areas that could potentially exert cross-market power increased from 37 systems in 2009 to 57 systems in 2019."[14]

Another author noted that, in general, "patients have little motivation to travel far in search of competitors offering the same care at lower prices; if there is only a single hospital nearby that is able to provide that care, it can dictate high reimbursement fees."[11] This lack of incentive to travel to find lower cost care derives from the fact that most patients are insulated from the true cost of care.[11]

In many states, state universities have developed "hub and spoke" arrangements whereby the state university medical school acquires numerous small hospitals in the state. One article noted:

> Many health systems in the market today generally have 1 or more academic medical center "hubs," surrounded by other community or short-term acute hospital "spokes," and ownership interest or close affiliations with physicians, clinics, rehabilitation facilities, and other health care practitioners and organizations.[8]

Federal Government-Created Hospital Monopoly Problem

As noted by U.S. Representative Victoria Spartz (R-Ind.):

> The federal government created this hospital monopoly problem…. Growing up in the Soviet Union, I witnessed firsthand how damaging full government control of health care can be. Regrettably, I see many of the same socialist concepts in our own health care system today. Government interventions have contributed to a monopoly problem in every corner of the market leading to increased consolidation, elimination of competition and rising prices…. In my home state of Indiana, 91 percent of the hospital market is controlled by the largest hospital systems and over half of physicians are directly employed by the largest three hospital systems.[15]

Nonprofit Status

According to Zack Cooper, an economist at Yale School of Public Health:

> The bizarre part of all this is that many of these monopolizing hospitals are technically considered "nonprofits." There are apparently, "a lot of nonprofits to be made in the healthcare industry," Cooper jokes. He doesn't take their "nonprofit" status very seriously. He sees it more like a game where instead of making profits that are distributed to shareholders, nonprofit hospitals take the extra money they make and use it for executive compensation and buying shiny stuff.[10]

ObamaCare

ObamaCare has greatly worsened the hospital monopoly problem. One recent article noted:

> Consolidation and lack of competition are not new phenomena, but they have been greatly exacerbated through policies targeted at health systems reform included in the 2010 Affordable Care Act (ACA), also known as ObamaCare. In fact, increased consolidation was a specific goal of the ACA, with President Obama's top health care advisers writing that "these reforms will unleash forces that favor integration across the continuum of care."[15]

Another article similarly reported: "The Affordable Care Act (ACA), often called ObamaCare, accelerates the pernicious growth of market consolidation in American health care."[11]

Yet another article noted that ObamaCare incentivized the growth of "hub and spoke" systems dominated by academic medical centers.

A large reduction in the use of inpatient care combined

with the incentives in the Affordable Care Act is leading to significant consolidation in the hospital industry. What was once a set of independent hospitals having arms-length relationships with physicians and clinicians who provide ambulatory care is becoming a small number of locally integrated health systems, generally built around large, prestigious academic medical centers.[8]

And, as noted in yet another article, the reduction and eventual elimination in competition was not an unintended consequence of ObamaCare—it was a primary goal.

> The shackling of competition is an essential feature of ObamaCare, not a bug. The health care system it establishes relies on unfunded mandates to raise revenue, seeks to cross-subsidize care with regulations, and views genuine competition as a threat to its funding structure.[11]

The specific mechanisms in ObamaCare used to squash competition include:

- Closing off alternatives to paying for health care by requiring individuals to purchase comprehensive insurance.
- Reducing the ability of insurers to compete with innovations in benefit design by requiring standardized benefit packages.
- Increasing the discriminatory subsidies that protect dominant hospitals from competition.
- Limiting patient choices by using Medicare payment policies to drive doctors into a small number of integrated hospital systems.[11]

The article further described these discriminatory payments by Medicare, favoring large hospital systems and disfavoring independent physicians.

> Payment methods also inflate the marginal costs of care (the expense involved in treating each additional patient), as Medicare reimburses the same treatments at substantially higher rates if they are performed in general hospitals.[11]

The 340B Scam—Hospitals Gaming the System for Huge Profits

A law passed in 1992, 340B, was intended to help subsidize hospitals that served vulnerable populations.[9] It was a law that strongly favored large hospital systems at the expense of smaller practices. The law required manufacturers to sell their medications at deep discounts to qualifying hospitals and safety net clinics. One article noted that "hospitals now account for 87 percent of drug sales at the 340B price."[9] In order to be eligible to receive these discounted drug prices, hospitals must meet a certain minimum threshold for serving Medicaid and low-income patients. Hospitals game the system by seeking to meet the bare minimum threshold but not exceed it. "These institutions are gaming the system, which collectively totaled about $50 billion in 2021."[9] The article further explains how this 340B program has increased hospital consolidation and specifically benefitted the "hub and spoke" hospital arrangement.

> This has led to consolidation because administrative guidance dating back to 1994 allows 340B hospitals to also obtain 340B discounts for patients treated at their satellite clinics. A large hospital hub can meet its minimum Medicaid and low-income Medicare inpatient share, and then buy drugs at the 340B discount for all the clinics it owns, even if those clinics don't see a single Medicaid patient.
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> These cheaper drugs these 340B eligible clinics purchase give a large competitive advantage to hospital-affiliated clinics. The independent clinic can't compete. This advantage allows hospitals to purchase those independent clinics, increasing consolidation.[9]

The article also noted that large hospital systems that game the 340B program can make huge profits by reselling drugs that they bought at highly discounted prices to patients with private insurance or Medicare at much higher prices.[9]

Certificate of Need (CON)

Another government intervention that has increased the monopoly power of hospitals is the certificate of need (CON). Requiring new facilities, including physician-owned facilities, to obtain a certificate of need from the state has provided hospitals with an effective mechanism for keeping new competitors out of the market.[11]

Consequences of Increased Hospital Consolidation

Monopolies always result in higher prices. At a recent hearing of the House Energy and Commerce Committee's Subcommittee on Health, the anticompetitive effects of consolidation in the healthcare industry and hospital non-compliance with price transparency rules were cited as causes of increasing healthcare costs. The Centers for Medicare and Medicaid services (CMS) was specifically criticized for lacking in enforcement efforts with respect to the requirement that hospitals post some of their prices.[16]

One article noted:

> While the consolidation of hospitals has often generated cost efficiencies, in hospital markets dominated by only a few providers, mergers have enabled hospitals to retain the savings rather than passing them on to consumers.[11]

Like the windfall profits hospitals obtain from their non-profit status, this savings from cost efficiencies may also go to higher executive compensation. Contrary to hospital claims that their non-profit status means they will not increase their prices, "the data demonstrate that ownership status is not a deterrent to price increases, and prices are just as high in nonprofit as in for-profit organizations."[8] A recent study reported price increases in the 10–40 percent range due to mergers.[8]

In addition to higher prices, hospital consolidation has resulted in poorer quality care. As one article noted:

> Heart attack patients are more likely to die when treated by hospitals in markets with less competition. Indeed, better outcomes for heart attack, and pneumonia patients in more competitive markets appear to be associated with the relative prevalence of private payers, who are able to vary payments to reward higher quality.[11]

Yale economist Zack Cooper likewise noted: "We have evidence that death rates are literally higher in markets where hospitals face less competition."[10]

Yet another article stated: "Intramarket [hospital] mergers come with a cost—evidence clearly demonstrates that they raise prices, without significant improvement in quality…. To be clear, there is empirical evidence that cross-market mergers increase prices by 10% to 17%."[14]

Hospital consolidation has also resulted in less innovation in products and processes. As one article noted:

Process innovations, however, seem to decline with market power consolidated in a few institutions. Organizations with market power often lack the incentive to develop simple items such as checklists and uniform protocols that deliver services in newer, more efficient ways. Such changes are difficult, and managers of large, profitable organizations might conclude that they do not need to undertake them.[8]

President Biden's Executive Order Promoting Competition

Although as vice president under President Obama, Mr. Biden fully supported the anticompetitive goals of ObamaCare, he apparently now recognizes that the Affordable Care Act has made care less affordable largely due to hospital consolidation that ObamaCare incentivized.

On July 9, 2021, President Biden issued an executive order on Promoting Competition in the American Economy.[17] The executive order stated:

> [E]xcessive market concentration threatens basic economic liberties, democratic accountability, and the welfare of workers, farmers, small businesses, startups, and consumers…. Hospital consolidation has left many areas, particularly rural communities, with inadequate or more expensive healthcare options."[17]

Some have noted that these are "mostly words on paper that 'encourage' federal agencies to do something about it. We'll need congressional action and more work at the FTC [Federal Trade Commission] to do something real about this issue."[10] The article noted that the FTC is "outgunned and undermanned and they're struggling to keep up with the tidal wave of mergers and acquisitions we've seen."[10] Another recent article noted that the FTC has failed to take action to curtail cross-market hospital mergers.[14]

Vertical Integration

"The term vertical integration is used to describe the merging of hospitals with physician groups, ambulatory surgery centers, rehab centers, ancillary services, or other health care service providers."[18] There are a number of reasons why vertical integration has become a prominent feature of the current healthcare environment. These include:

> [T]he implementation of new care delivery models, implementation of Accountable Care Organizations [ObamaCare] and value-based cuts in Medicare and Medicaid rates, and pricing incentives such as higher reimbursements for hospital-based services relative to those provided in physician offices.[19]

The pernicious effects of Accountable Care Organizations (ACOs) are well documented.

> If an ACO controls a large percentage of the available providers, it gets a lot easier to reduce patient utilization. If an ACO wants to, say, try to limit patients to 12 specialty visits a year, it's much easier if they "own" most of the specialists in the area. If an ACO includes many of the major hospitals, and a significant number of physicians in every major practice area—including, say, imaging facilities and labs (possibly a hospital outpatient lab), then it becomes a lot easier to guide patients to the level and type of utilization desired—which is, for purposes of the Medicare Shared Savings Program, always less utilization. And of course, it is much easier to enforce referral and utilization policies on physicians who are employees of a group running the ACO, rather than simply independent businesses who happen to join an ACO at a given moment in time…. It is highly ironic that a law [ObamaCare] proposed, in part, because of the allegation health insurance companies were increasing their profits by denying care to patients—is now the means by which the federal government pays physicians to, in effect, deny care to patients.[20]

Other causes include increasing demands foisted on physicians by insurers and hospital administrators.[21]

The Faustian bargain of increased income and fewer hassles with third-party payers in exchange for giving up professional autonomy is becoming evident to both physicians and patients. The professional and moral imperative to "First Do No Harm" is being violated. One article noted:

> As more physicians are subsumed under fewer and larger corporate entities, the ability of physicians to maintain professional autonomy and clinical independence is being severely compromised…. Final decision-making power over crucial health priorities has been consolidated among relatively few non-clinical executives, representing a major shift in power from physicians to administrators…. Many patients also recognize that third parties (i.e. insurance and pharmaceutical companies, administrators and policymakers/politicians) have been intruding on the physician-patient relationship. These intrusions can negatively impact patient care, increase moral injuries physicians face and result in sub-optimal and morally ambiguous care.[22]

Vertical integration has dramatically increased over the past ten years with a negative impact on independent physician practices. One article described this trend:

> The trend of local hospitals merging into massive health systems has significantly affected private practices. According to Avalere Health and Physicians Advisory Institute, between 2016 and 2018 hospitals acquired 8,000 medical practices and 14,000 physicians left private practice to work in hospitals…. Ever-larger health systems affect the flow of patient referrals a private practice needs to stay in business. They change the competitive dynamic for independent physicians, who aren't left with many choices at this point.[23]

Another article reported:

> The consolidation of physicians into vertically integrated health systems increased substantially from 2016 to 2018. The share of physicians affiliated with health systems increased by 11 percentage points, from 40 percent in 2016 to 51 percent in 2018. In 2018, 49 percent of primary care physicians were affiliated with systems—an increase from 38 percent in 2016.[12]

The trend has continued:

> [H]ospital consolidation has drastically reduced the number of independent physician practices. Between 2019 and 2021, hospital systems acquired 36,200 additional physician practices across the country, to the point where in January 2022, 74 percent of physicians were employed by hospitals, health systems or corporate entities. This consolidation reduces competition and allows a few large

systems to dictate prices. We know that physician prices increase by an average of 14 percent after being acquired by a hospital system, according to a Northwestern University study, with no improvement in quality.[15]

With the lure of windfall profits, private equity firms have gotten into the vertical integration business. One article aptly described this trend and the Faustian bargain some physicians have adopted in embracing this trend.

> These troubling trends for doctors have spelled "opportunity" for private equity firms, which entered the healthcare picture a little over a decade ago. From 2013 to 2016, private equity firms acquired 355 physician practices (many with hundreds of doctors). In the four years that followed, private equity acquired 578 additional physician practices. Those numbers continue to grow…. To doctors, PE firms offer an attractive value proposition: promising to ease physician dissatisfaction by increasing income and reducing insurance hassles. In exchange, physicians agree to relinquish significant control of their practice. Once the deal is done, PE firms leverage that control to generate sizable profits…. Researchers estimate 25% to 40% of ERs are now staffed by private-equity companies…. A recent study concluded that "high intensity billing" for expensive emergency services has gone up 400% in the past 15 years.[21]

In addition to the loss of physician autonomy, the article noted that physicians recognize that patients are harmed when they sign on to a private equity firm.[21] The article also noted that private equity firms charge 20 percent more per insurance claim than independent physicians.[21]

According to a 2020 American Medical Association Survey, a majority of physicians now work outside of physician-owned practices, often working directly for hospitals. And 4 percent of physicians work for private equity firms.[24]

The Purge of Independent Physicians from Hospital Practice—Sham Peer Review

Hospitals have been engaged in an active effort to "purge" the last remnants of independent physicians from hospitals so as to achieve total control over the practice of medicine in hospitals.[25] As one article noted:

> Across their practices, independent physicians are being buffeted by the unchecked power of hospital monopolies threatening their ability to remain afloat and making the continued practice of medicine increasingly difficult…. The growing power of hospitals achieved through system consolidations and the purchase of independent physician practices not only eliminates competition but systematically reduces the quality of care—all the while driving costs skyward.[26]

Sham peer review has increasingly played a key role in purging independent physicians from hospital practice so as to further enhance hospital monopoly power. If an independent physician refuses to give up his professional autonomy and become a hospital employee, and continues to compete with the hospital, the risk of sham peer review is high. If successful, a sham peer review not only eliminates the competing independent physician from the hospital, but often ends the physician's career so that he will not pose a competitive threat to any hospital ever again.

The nearly absolute immunity provided to hospitals and their peer reviewers under the HCQIA of 1986 and the formidable resources of hospital monopolies incentivizes hospitals to utilize sham peer review to eliminate competition. Patients, as always, suffer the consequences when good competent physicians are eliminated from the hospital.

Antitrust Scrutiny of Physician Practice Acquisitions

Recently, the Federal Trade Commission (FTC) has taken an interest in analyzing the impact vertical integration is having on competition in the healthcare marketplace.

> In early January 2021, the FTC announced that it was conducting a retrospective study of physician practice acquisitions. The FTC issued subpoena-like data demands to many major health insurers, ordering them to produce their last six years' volumes of detailed, patient-level claims data for provider services in 15 states. The agency said the data would "help the FTC assess the impact of physician consolidation during this period, including physician practice group mergers and hospital acquisitions of physician practices," as well as healthcare facility consolidation…. FTC staff have said publicly that one of the purposes of this initiative is to enable the FTC to learn how prices for physician services within specialties and for outpatient procedures have changed since 2015, relative to the pace and sizes of horizontal and vertical provider consolidation over that period.[27]

Another article noted that antitrust scrutiny of hospitals acquiring physician practices is also intensifying at the state level.

> The accelerating pace of health care transactions involving physician practices has been met with intensified antitrust scrutiny from both federal and state enforcers over the past few years. That scrutiny now extends to physician-group transactions and relies on both horizontal and vertical theories of harm.[19]

Antitrust Lawsuits

Recent antitrust lawsuits may give hospitals pause for thought when engaging in anticompetitive conduct. When physicians are harmed by the anticompetitive conduct of hospitals, the Sherman Act (15 U.S.C. §§ 1-7) and the Clayton Act (15 U.S.C. §§ 12-27) provide the means to hold monopolistic hospitals accountable. However, some hospitals may be so addicted to lucrative revenues hospital monopolies generate that, despite the risks, they may be reluctant to abandon anticompetitive conduct.

Health First Settled $346 Million Antitrust Lawsuit

In 2016, Health First, a large integrated health system in Florida, agreed to settle an antitrust lawsuit that sought $346 million in damages.[28] Plaintiffs in the federal antitrust lawsuit included OMNI Healthcare, the Interventional Spine Institute of Florida, a group of physicians, and a physician's assistant.[28] An article by HealthcareDive, reported:

> Health First used its market control to unfairly influence referral patterns by pressuring physicians to refer patients almost exclusively to Health First hospitals and specialists, according to allegations. Those who didn't play along lost admitting privileges to Health First hospitals and were

denied contracts with Health First plans.[28]

Despite the settlement, Health First is facing a class action antitrust lawsuit 5 years later, *Colucci et al. v. Health Care First, Inc.*, filed on Apr 19, 2021.[29] According to an article published by Newswire,

> Three plaintiffs allege Health First, Inc. has engaged in "pervasive and long-term exclusionary conduct" as a means to maintain and strengthen a monopoly in the market for acute care in Florida, even after a settlement over similar allegations roughly five years ago…. The 35-page proposed class action claims Health First, "unchastened" after agreeing in 2016 to a settlement with a multi-specialty physician group over alleged anticompetitive conduct, has picked up where it apparently left off by suppressing and injuring competition in the market for acute care services…. As of 2014, Health First held an 86.8 percent share of the market for acute care services in Southern Brevard County…[and] per the suit, Health First's share of the same product market in the broader Brevard County is currently estimated at more than 90 percent, which the case attributes to the defendant's abilities to exclude rival providers of acute care services and raise prices on patients and health plans "well above competitive levels."[29]

Vasquez v. Indiana University Health, Inc. et al.

Like Dr. Patrick, Dr. Vasquez was an independent vascular surgeon. He practiced in Bloomington, Indiana, for many years. His case is a tale of expanding hospital mergers and health system acquisition of physicians.

In 1997, Clarian Health was formed by a merger of three local hospitals. In 2010, Indiana University Health (IU Health) entered the Bloomington market. In 2011, Clarian Health was rebranded as IU Health. In 2017, IU Health acquired Premier Healthcare, a group of independent physicians based in Bloomington. Premier employed many physicians in the region, especially primary care physicians (PCPs). Dr. Vasquez's troubles began after the acquisition of Premier.[30]

The details of the Vasquez case, as reviewed by the Seventh Circuit, are well worth reviewing as they typify how hospitals are carrying out the agenda to purge independent physicians from hospitals. The Seventh Circuit decision also provides basic principles that courts apply in evaluating antitrust lawsuits.

> Vasquez alleges that, as a consequence of the Premier acquisition, IU Health now employs 97% of PCPs in Bloomington and over 80% of PCPs in the wider region….
>
> Vasquez contends that in "[a]pproximately 2017," around the time of the acquisition, IU Health launched "a systematic and targeted scheme" to ruin his reputation and practice. The scheme was motivated by Vasquez's commitment to independent practice. IU Health preferred to employ the region's doctors directly, an agenda which Vasquez resisted.[30]

In 2018, IU Health threatened to revoke his privileges, and in 2019 IU Health followed through on its threat, revoking Vasquez's Bloomington admitting privileges.[30]

The key issue in the case is the hypothetical monopolist test, i.e., what is a relevant market?

> Vasquez's complaint needed to allege only one plausible geographic market to survive a motion to dismiss. See *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007). A rational jury could find that Bloomington is such a market, as we now explain.[30]

In *FTC v. Advocate Health Care Network*, 841 F.3d 460 (7th Cir. 2016) (*"Advocate"*), a case concerning a hospital merger, we endorsed the use of the "hypothetical monopolist test" to analyze geographic healthcare markets…. [T]hat test asks, "what would happen if a single firm became the only seller in a candidate geographic region." *Id*. at 468. "If that hypothetical monopolist could profitably raise prices above competitive levels, the region is a relevant geographic market." *Id*. But, if instead, "customers would defeat the attempted price increase by buying outside the region, it is not a relevant market; the test should be rerun using a larger candidate region." *Id*. In this sense, the inquiry "is iterative meaning it should be repeated with ever-larger candidates until it identifies a relevant geographic market." *Id*. Importantly, the determination of the area of effective competition poses a question of fact, not one of law." See *Fishman v. Estate of Wirtz*, 807 F.2d 520, 531 (7th Cir. 1986).[30]

Vasquez first posits that the vascular-surgery market in Bloomington is inherently local. This is because "vascular surgery patients need ongoing care, oftentimes lifetime care." So, Vasquez reasons, if a Bloomington patient "is sent to Indianapolis, that patient must continue to travel for a lifetime if he or she wants continuity of care." And because most patients would consider that a bad deal—as *Advocate* recognized, see 841 F.3d at 470—insurers (the most directly affected buyers here) face pressure to provide vascular surgery in or near Bloomington.[30]

We note in this connection that the antitrust laws confer a right of action on "any person…injured in his business or property," see 15 U.S.C. § 15, and that the Supreme Court has confirmed that both consumers, such as the insurers here, and competitors, such as Vasquez, fall within the scope of the law. See *Assoc. Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters*, 459 U.S. 519, 538 (1983). ("[T]he Sherman Act was enacted to assure customers the benefits of price competition, and [the Court's] prior cases have emphasized the central interest in protecting the economic freedom of participants in the relevant market").[30, footnote 1]

It follows that a hypothetical monopolist over vascular surgery in Bloomington would be able to abuse its market power considerably by jacking up payor prices and freezing out potential competitors. In particular, because much vascular surgery is performed in a hospital setting with special equipment, a hypothetical vertically integrated monopolist that controlled the hospital, the equipment, and most of the surgeons would be well-positioned to engage in anticompetitive practices.[30]

All agree that vascular surgeons, who are specialists, get most patients by referral from primary-care providers. Thus, a hypothetical monopolist over primary-care services in Bloomington would control not only that market but also the flow of patients to vascular surgeons. By cutting off the flow of new patients to its vascular-surgery competitors, the monopolist could capture the entire market, thereby positioning itself to raise payor prices without repercussion.[30]

With regard to vascular surgery itself, Vasquez contends that IU Health controls the hospital with the most advanced

equipment and, other than him, all the vascular surgeons. And regarding upstream referrals, he alleges without contradiction that IU Health employs 97% of the primary care physicians in Bloomington, meaning that virtually every patient sees an IU Health PCP. (That is one reason why the existence of other hospitals in the Bloomington area does not necessarily defeat Vasquez's claim.)[30]

The Seventh Circuit also noted that rural patients and urban patients may behave differently: "[There are] two different groups of people—urban and rural patients—with different expectations, motivations, and market behaviors."[30]

The Seventh Circuit rendered its decision on Jul 8, 2022: "The district court's grant of IU Health's motion to dismiss is REVERSED and the case is REMANDED for further proceedings consistent with this opinion."[30]

Conclusion

Hospital consolidation and vertical integration have continued for years and are getting worse. This monopolist trend has resulted in higher prices, loss of physician autonomy, and poorer quality care. Government has created and exacerbated the hospital monopoly problem.

Sham peer review is increasingly being used by hospitals to purge independent physicians from hospital practice and thereby further enhance the power and control hospital monopolies exert.

Antitrust lawsuits are an option for physicians who have suffered harm as a result of anticompetitive conduct of hospitals.

As patients continue to experience higher prices, higher insurance premiums, higher deductibles, higher co-pays, and poorer care as a result of the anticompetitive conduct of hospitals, Congress may face pressure to take action to halt the hospital monopoly juggernaut.

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