

# Antitrust policy and health care reform

BY JOHN J. FLYNN\*

## I. Introduction

Among the economic and political challenges facing the United States today, none is more significant—yet difficult to resolve—than the complex puzzle of how to reform the delivery of health care services. A consensus appears to have been reached that reform should extend health care coverage to all Americans, while restraining the growth of costs, maintaining the quality of care and continuing the high level of innovation in the industry. Although the estimates vary, the American health care system is claimed to cost in excess of \$800 billion per year, over 14% of the gross

---

\* Hugh B. Brown Professor of Law, University of Utah College of Law.

AUTHOR'S NOTE: *The author is grateful to Arthur M. Strong, a Staff Attorney with the Bureau of Competition of the Federal Trade Commission, who provided useful comments on preliminary drafts of this article. Neither Mr. Strong nor his employer is responsible for the analysis or conclusions reached in this article. They are the sole responsibility of the author.*

national product.<sup>1</sup> Between 35- and 37-million Americans are estimated to be without health care insurance at one time or another during a calendar year and employers and governments labor under a growing burden to pay for the health care benefits they underwrite and their employees expect.<sup>2</sup> Inflation in health care costs has been constant and excessive, while efforts to restrain inflation have been sporadic and ad hoc rather than consistent and comprehensive. In view of these facts, it is surprising that it has taken so long to arrive at a consensus for fundamental reform.

Many of the proposals for reform now being proposed would sanction joint conduct and levels of cooperation between competitors in health care that have often been questioned or condemned under the antitrust laws in other contexts and levels of government intervention and regulation that pose complex issues concerning the relation of antitrust policy to the regulation imposed. Other proposals contemplate a relaxation of antitrust standards for health care activities without explaining how the public interest in fair and efficient resource allocation at reasonable prices is to be achieved absent antitrust enforcement or affirmative government

---

<sup>1</sup> See Hilary Stout, *Delicate Decisions*, WALL ST. J., Apr. 22, 1993, § A, at 1, col. 1. See also V. R. Fuchs, *The Health Care System's Share of the Gross National Product*, 247 SCIENCES 534-38 (1990).

<sup>2</sup> See Paul B. Ginsburg, *Alternative Approaches to Health Care Cost Containment*, 30 JURIMETRICS J. 447, 448 (1990) (reporting that in 1988, employer contributions to health insurance equaled almost 5% of total compensation and that U.S. health care spending is 38% higher than in Canada and 85% and 87% higher than in France and West Germany respectively). 57 CONSUMER REP. 435, 436 (July 1992) reported that in 1960 the United States spent 5.3% of GNP on health care. In 1992 it estimated that the United States spent 14% of GNP on health care; that 16% of state and local budgets are spent on health care; that three of four businesses with ten or fewer employees did not provide health care benefits for employees; and the health care costs of businesses that must compete on world markets far exceed those of their foreign competitors. Estimates of the number of uninsured range from 13%-15% and the "woefully" underinsured at 13% of the total population. See Robert M. Veatch, *Physicians and Cost Containment: The Ethical Conflict*, 30 JURIMETRICS J. 461, 462 (1990).

rate and service regulation. Still other proposals contemplate a single payor system without spelling out how rates for specific services are to be established, what role competition policy should play in such a system, and how limited resources are to be rationed among competing demands while maintaining quality and incentives for innovation. Little attention has been given the question of the role of antitrust policy in the reform of health care financing and the delivery of health care services in pending legislative reform proposals.

As discussion of health care reform and distribution of health care resources has escalated in the early 1990s, the status of antitrust policy as a central premise of government economic and regulatory enforcement appears to be reemerging from the libertarian days of nonenforcement of the 1980s. Ever since the adoption of the Sherman Act in 1890, explicit reliance upon antitrust policy as the basic organizing principle for our economy has waxed and waned. Eras of a laissez-faire enforcement policy are usually—but not always—followed by periods of activist antitrust enforcement as a remedy for the excesses of markets and governmental regulatory schemes not subject to meaningful antitrust scrutiny.<sup>3</sup> On occasion, economic crises like that which prevailed during the Great Depression, cause government to flirt with economy-wide regulatory alternatives, such as cartelization of the

---

<sup>3</sup> Louis B. Schwartz has aptly observed: "There is relatively little useful predictive value in the cycle theory of antitrust. The regularities we perceive are largely subjective projections. There is some synchronicity with major politicoeconomic trends, but who can predict those with any reliability? The waves of antitrust zeal are composites of many ideological oscillations: federalism vs. states' rights, business vs. political leadership, judicial supremacy vs. executive and legislative powers, judicial activism vs. deference to administrative decisions, respect for jury trial etc. Moreover, there are no 'leading indicators' such as those sometimes relied on with notorious fallibility of financial forecasters. The periods of the antitrust pendulum and the interrelated political pendulum differ from each other and each is quite variable." Louis B. Schwartz, *Cycles of Antitrust Zeal: Predictability?*, 35 ANTITRUST BULL. 771, 799 (1990).

economy, on the assumption that reliance upon a government-enforced policy of a competitive process can no longer work in a complex modern society. On other occasions, most notably over the past two decades, reliance upon government-enforced antitrust policy has been undermined by an ideology hostile to government interference in the functioning of markets presumed to be governed by the invisible hand of perfect competition, the reality of particular cases to the contrary notwithstanding.<sup>4</sup> It is an ideology that gained the upper hand in the academy, the judiciary, and the executive branch of the federal government in the 1980s.<sup>5</sup> Some consequences of that hostility include the fact that the staff of the Antitrust Division was cut nearly in half during the Reagan

---

<sup>4</sup> The most extreme judicial exercise of applying the neoclassical model without regard to the facts of an individual case during the 1980s was *Matsushita Electric Industrial Co. Ltd. v. Zenith Radio Corp.*, 475 U.S. 574 (1986), approving the grant of summary judgment on the grounds that the plaintiff's claim of predatory pricing was "implausible"—with plausibility determined by the dictates of the neoclassical model rather than the facts of the case. For a factual critique of the decision, see Steven F. Bene, *Below-Cost Sales and the Buying of Market Share*, 42 STAN. L. REV. 695 (1990). For a critique of the Court's methodology see John J. Flynn, *An Antitrust Allegory*, 38 HASTINGS L. REV. 517 (1987).

The Court's simplistic positivism in *Matsushita*, has been placed in question by *Eastman Kodak Co. v. Image Technical Services, Inc.*, 112 S. Ct. 2072 (1992) stressing the need to have a trial of the facts and circumstances of antitrust cases rather than summarily dismiss a case on the basis of the predictions of an economic model of what might happen in a world abiding by the unrealistic factual assumptions behind the model. The *Kodak* case, however, has been followed by *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 113 S. Ct. 2578 (1993), where the majority employed *Matsushita's* "plausibility" standard, 113 S. Ct. at 2590, to justify an extensive review of a jury's finding of fact and uphold the trial court's reversal of the jury's finding of a violation of the Robinson-Patman Act in a predatory pricing case.

<sup>5</sup> See John J. Flynn, *Legal Reasoning, Antitrust Policy and the Social Science of Economics*, 33 ANTITRUST BULL. 713 (1988); Frederick M. Rowe, *The Decline of Economics and the Delusions of Models: The Faustian Pact of Law and Economics*, 72 GEO. L.J. 1511 (1984).

years,<sup>6</sup> private antitrust enforcement actions suffered a noticeable decline during the 1980s<sup>7</sup> and markets like health care not conforming to the two-dimensional model of perfectly competitive neoclassical markets were generally ignored by government enforcement officials and policymakers devoted to promoting the libertarian political ideology of the neoclassical model.<sup>8</sup>

---

<sup>6</sup> 52 *Antitrust & Trade Reg. Rep.* (BNA) No. 1300, at 157 (Jan. 29, 1987). Even the ABA's Antitrust Section recognized that the staff and budget cuts of the 1980s "had an adverse effect on antitrust enforcement." Report of the Section of Antitrust Law of the American Bar Association, *Task Force Report on Competition Policy*, 64 *ATTR* (BNA) No. 1604, at 1 (Spec. Supp., Mar. 4, 1993).

<sup>7</sup> In the decades of the 1970s, over 1000 private actions were filed annually. See John E. McClatchey, *Introduction: Private Enforcement in the New Antitrust Era*, 58 *ANTITRUST L.J.* 271, 272 (1989). In 1977, 1611 private cases were filed. *Id.* Ten years later, in 1987, a total of 758 private cases were filed. *Id.* See also Steven C. Salop & Lawrence J. White, *Economic Analysis of Private Antitrust Litigation*, 74 *GEO. L.J.* 1001 (1986). It is possible, but highly improbable, that the private sector became far more law abiding in the go-go 1980s than in prior years. It is also possible that the cow did, in fact, jump over the moon.

<sup>8</sup> The appeal of this form of law and economics analysis to law professors is thoughtfully explored by Mark Cooney in *Why Is Economic Analysis So Appealing to Law Professors?*, 45 *STAN. L. REV.* 2211 (1993). Among other reasons, Professor Cooney (a lawyer-sociologist) concludes that adoption of economic analysis of legal problems enables legal scholars to "embrace science without undertaking empirical investigation." *Id.* at 2229. Cooney also observes that "the greater the commitment to investigating the facts of legal behavior, the less dominant economic analysis is likely to be." *Id.* at 2230. The difficulty with an exclusive reliance upon economic analysis, at least those forms of economic analysis emphasizing a rigid deductive use of a model to determine both fact and law, is that it shuts off an intense empirical analysis of facts inconsistent with the assumptions of the model as in the *Matsushita* case or it confines empirical analysis to understandings of only those facts consistent with the model as in the *Brooke Group* case. Legal analysis requires a constant reexamination of the rules found relevant in light of the facts of the dispute before the Court as in the *Kodak* decision, *supra* note 4.

The 1992 election has generated an interesting confluence of change—change in the emphasis that will be placed on antitrust enforcement to regulate the economy and change in the political concern with the legal and economic regime governing the delivery of health care services. Whether these two developments will take place in harmony or in conflict is, however, unclear. It shall be the purpose of this article: 1. To examine case law developments over the past decade in applying antitrust policy to health care markets; and 2. To suggest how antitrust policy as it presently stands relates to legislative proposals for reform of health care markets.

## II. Recent antitrust litigation in health care

### A. *The current status of antitrust doctrine*

Despite oscillations in ardor for antitrust policy and its enforcement, certain fundamental doctrines endure through one analytical fad and the next to be applied to activities not previously subjected to consistent antitrust enforcement like health care.<sup>9</sup> For example, antitrust policy is assumed to be the basic organizing principle for the economy of a democratic society relying primarily upon government defined and enforced private ownership of property and contract rights to allocate resources, distribute wealth, set prices, reward efficiency, and stimulate innovation.<sup>10</sup> Justice Black's description of the Sherman Act as "a comprehensive charter of economic liberty . . . providing an environment conducive to the preservation of our democratic political and social institutions"<sup>11</sup> is a recognition of the deeper normative reasons for establishing a competitive process as the presumed method for organizing our economic affairs in the

---

<sup>9</sup> See Rowe, *supra* note 5.

<sup>10</sup> See John J. Flynn, *The Chicken and the Egg*, in *FUNDAMENTALS OF THE ECONOMIC ROLE OF GOVERNMENT* 69 (W. Samuels ed., 1989).

<sup>11</sup> *Northern Pac. Ry. v. United States*, 356 U.S. 1, 4 (1958).

absence of a clear legislative statement to the contrary.<sup>12</sup> The meaning and scope of federal legislation imposing some degree of regulation on an industry, including health care,<sup>13</sup> is still determined by courts in light of an assumption that antitrust policy is presumed to apply to the activity in question unless the conduct is expressly exempted or an intent to exempt can be divined from the regulatory scheme imposed.<sup>14</sup> Similarly, as the Supreme Court

---

<sup>12</sup> Recognition of the need to establish antitrust policy as the *sine qua non* or *primus inter pares* of a democratic society's economic policy is being reaffirmed by nations newly emerging from a Marxist tradition. Many of these nations adopted antitrust laws as one of their first steps toward economic liberalization as an indispensable ingredient of privatizing property ownership and establishing a system of private contracting. Poland, Hungary, Bulgaria and the former Czechoslovakia have all recently adopted antitrust laws in recognition of the necessary connection between establishing a private enterprise-based economy and the need to protect the economic liberty of the state, people and businesses in that economy from private aggregations of power that displace a competitive process determining economic success and failure and a political process protecting individual liberty and equality of access to economic opportunity. Asian nations like Korea and Taiwan, with the tradition of wedding private economic power with the political power of the state, have also recently adopted antitrust laws as a necessary step toward economic liberalization and political democratization. Japan, whose original antitrust laws, like those of Germany, were adopted under the pressure of U.S. occupation authorities as a necessary step to foreclosing the reestablishment of a fascist state, has substantially increased its antitrust enforcement in recent years. See Harry First, *Three Cheers for Antitrust* (1993) (unpublished manuscript, on file with the author).

<sup>13</sup> The Supreme Court upheld the application of the Sherman Act to health care 50 years ago in *American Medical Association v. United States*, 317 U.S. 519 (1943), discussed *infra* note 34 and accompanying text.

<sup>14</sup> The doctrines of express and implied exemptions from antitrust policy, and the related concept of "primary jurisdiction," are reviewed in LOUIS B. SCHWARTZ ET AL., *FREE ENTERPRISE AND ECONOMIC ORGANIZATION: ANTITRUST* 800, *et seq.* (6th ed. 1983); see also Louis B. Schwartz, *Legal Restrictions of Competition in the Regulated Industries: An Abdication of Judicial Responsibility*, 67 HARV. L. REV. 436 (1954); Robert S. Balter & Christian C. Day, *Implied Antitrust Repeals: Principles for Analysis*, 86

recently reasserted in *FTC v. Ticor Title Insurance Co.*,<sup>15</sup> before principles of federalism may be held to oust federal antitrust jurisdiction over activity subject to some level of state regulation, it must be shown that the anticompetitive conduct in question is specifically authorized and affirmatively regulated by independent state authority.<sup>16</sup> The Court majority in *Ticor* was reaffirming a long-standing political value of antitrust policy important to health care reform proposals: the presumption that antitrust policy applies to all economic activity in society unless otherwise exempted by the Congress or state governments; and, in the case of state governments, the conduct in question must be specifically exempted and independently and objectively regulated by the

---

DICKINSON L. REV. 447 (1982). One of the more careful and significant recent applications of this fundamental principle may be found in Judge Greene's opinion finding that Congress had not committed exclusive regulation of AT&T to the FCC and therefore, the government's antitrust suit seeking to break up AT&T could proceed. *United States v. American Tel. & Tel. Co.*, 461 F. Supp. 1314, 1320-30 (D.D.C. 1978).

The principle has been maintained in analyzing the effect of regulatory action in the health care field. *See, e.g., National Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross*, 452 U.S. 378 (1981) (holding that Blue Cross' refusal to deal is not immune from antitrust review because of failure of plaintiff hospital to secure approval of construction under the National Health Planning & Resources Development Act of 1974, 42 U.S.C. § 3001, *et seq.*).

<sup>15</sup> 112 S. Ct. 2169 (1992).

<sup>16</sup> 112 S. Ct. at 2175. The question presented in *Ticor* was what is required by way of "active supervision" for a state regulatory regime to be found to be adequate to displace the presumed application of antitrust policy. Beginning with the assumption that "[t]he preservation of the free market and of a system of free enterprise without price fixing or cartels is essential to economic freedom," 112 S. Ct. at 2176, the Court held that there must be sufficient state involvement and supervision to insure that the anticompetitive policies or programs adopted are those of the state and not those of the private interests involved. Simply authorizing the anticompetitive conduct or having in place an authority with the power to supervise was found not to be enough. *See also California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

state before an exemption from federal antitrust policy will be recognized by the judiciary.<sup>17</sup>

Other fundamental principles have either reemerged or, sometimes and surprisingly, not been ignored during the past two decades. For example, the inherent obligation of legal reasoning to analyze the reality of disputes in the context of the industry and circumstances presented with a due regard for the constitutional right to a jury trial, placed in great jeopardy by the simplistic positivism of *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*,<sup>18</sup> reemerged in *Eastman Kodak Co. v. Image Technical Services, Inc.*<sup>19</sup> The Court in *Eastman Kodak* required the analysis of the reality of the dispute in the circumstances unique to the dispute before it could be concluded that antitrust policy had not

---

<sup>17</sup> Anticompetitive conduct engaged in by local governments pursuant to express grants of regulatory authority from the state, need not be subject to active state supervision for immunity to obtain under the pre-*Ticor* decision, *City of Columbia v. Omni Outdoor Advertising, Inc.*, 111 S. Ct. 1344 (1991). Although the opinion is a confused and poorly written one, it could be rationalized on the grounds that the remedy for an anticompetitive misuse of the delegated state regulatory power by a local governmental entity lies with the local electorate or, if the misuse is a product of corruption, with traditional criminal law sanctions for corruption. It could have been held, as the dissenters argued, that local governments should be required to meet the "active state supervision" requirement for anticompetitive conduct before immunity is obtained. The risk of locally authorized anticompetitive conduct escaping control by antitrust policy or independent regulatory authority can be significant and of long-term damage to the political system as well as the economic one. It is not possible to reconcile *City of Columbia* with the holdings of *Community Communications Co., Inc. v. City of Boulder*, 455 U.S. 40 (1982), and the policy underlying *Ticor's* holding that active supervision is required for immunity of conduct under state regulatory programs except by claiming that state supervision of the local government's supervision of anticompetitive conduct is sufficient. While it is possible that state supervision of the local supervision may be sufficient, it should only be found to be sufficient where the supervision is "active."

<sup>18</sup> 475 U.S. 574 (1986).

<sup>19</sup> 112 S. Ct. 2072 (1992).

been violated and the plaintiffs could be summarily denied their right to a trial of the facts.<sup>20</sup> An important principle of legal and every other form of inductive analysis was being reasserted after flirting with the method of simplistic positivism followed in *Matsushita*: that the relevance, meaning, and applicability of the facts of a dispute and the law governing a dispute, must be analyzed in light of each other and the normative goals underlying antitrust policy and the particular and general consequences of the decision made.<sup>21</sup> *Eastman Kodak's* insistence that rules be interpreted and applied in light of the facts unique to the dispute, is a demand of

---

<sup>20</sup> Companies supplying service for Kodak photocopy and micrographic equipment claimed that Kodak engaged in a pattern of conduct unlawfully excluding them from the service markets for Kodak machines by adopting a policy of selling parts only to customers who either repaired their own equipment or took service from Kodak, agreeing with Kodak parts manufacturers that they would only sell parts for Kodak machines to Kodak and engaging in eliminating the market for used Kodak equipment in order to eliminate a secondhand market for parts. Kodak claimed it was "implausible" to argue it had power to impose a tying arrangement because it lacked power in the parts market and it was "implausible" that it could monopolize the service market because it lacked monopoly power in the equipment and parts markets. The Justice Department supported Kodak and argued further that Kodak's pricing strategy should be presumed to be a valid competitive strategy of pricing the equipment market low and the parts and service market high, thereby spreading the cost of the equipment over the lifetime of the equipment. And, that it should be presumed that competition from other suppliers of equipment would constrain any conduct by Kodak restraining trade.

The Court refused to be seduced into a methodology that sought to conform the facts of the case to the predictions of a model premised upon assumptions that may or may not equate with the reality of the case. The Court reversed for a more extensive examination of the circumstances unique to the case, the reality of consumer knowledge and ability to obtain it and proof of justifications Kodak offered for its conduct.

<sup>21</sup> *Matsushita's* summary judgment standard may not have been significantly altered by *Kodak* after all in view of the Court's opinion in *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 113 S. Ct. 2578 (1993) sustaining a judgment NOV in a Robinson-Patman Act case on the ground that the jury verdict was based on findings of fact that were not "plausible."

legal reasoning that should have particular force in the analysis of health care antitrust disputes in light of the unique characteristics of health care financing and methods for delivering the service.

Other basic principles of particular relevance to the regulation of health care continue to have vitality: that concepts like relevant markets are analytical means to the end of determining whether the policy of the law has been violated, not objectively definable ends unto themselves;<sup>22</sup> that the central concern of section 2 of the Sherman Act is a qualitative one as well as a quantitative one—the control of economic power displacing a competitive process determining success or failure in the marketplace;<sup>23</sup> that “a combi-

---

<sup>22</sup> See *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985). The *Eastman Kodak* case also reasserted the role of market analysis as a means to the end of determining whether the policy of the law was violated in the circumstances of the case by treating the markets involved as those for service and replacement parts for Kodak machines despite Kodak's argument that it lacked power in the general equipment market. The Court observed: “Legal presumptions that rest on formalistic distinctions rather than actual market realities are generally disfavored in antitrust law. This Court has preferred to resolve antitrust claims on a case-by-case basis, focusing on the ‘particular facts disclosed by the record.’ . . . In determining the existence of market power, and specifically the ‘responsiveness of the sales of one product to price changes of the other’ . . . this Court has examined closely the economic reality of the market at issue.” *Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 112 S. Ct. 2072, 2082 (1992).

<sup>23</sup> *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985). The Court may have taken a step back from a qualitative approach to § 2 in *Spectrum Sports v. McQuillan, Inc.*, 113 S. Ct. 884 (1993) in favor of a quantitative test. That case involved the Ninth Circuit's approach to the “attempt to monopolize” prohibition and whether one must prove a dangerous probability of gaining a monopoly over a market before being held to have committed the offense of an unlawful attempt to *monopolize*. The Supreme Court held “yes” and required proof of a dangerous probability of gaining a monopoly of the markets defined. The opinion converts the “attempt to monopolize” offense into one of attempting to gain a “monopoly,” rather than attempting to “monopolize.” The decision converts the offense from a behavioral offense into a structural one despite the literal meaning of the statutory language prohibiting unilateral conduct fixing prices or excluding competition the

nation formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing” prices remains “illegal per se”;<sup>24</sup> that horizontal territorial and customers divisions continue to be per se illegal;<sup>25</sup> that the regime of a competitive process determining market entry and price may not be displaced by the privately determined ethical codes of professions claiming to follow some higher calling and claiming to be motivated solely by quality of care considerations;<sup>26</sup> that horizontal boycotts seeking to fix prices or exclude competitors are per se illegal even where there may be socially desirable ends or other justifications for the joint conduct;<sup>27</sup> that vertical price fixing, maximum as well as minimum, remains per se illegal;<sup>28</sup> that tying arrangements remain

---

Ninth Circuit’s *Lessig* test, *Lessig v. Tidewater Oil Co.*, 327 F.2d 459 (9th Cir. 1964), *cert. denied*, 377 U.S. 993 (1965).

<sup>24</sup> *Palmer v. BRG of Georgia, Inc.*, 498 U.S. 46, 49 (1990) (quoting and relying upon, *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940)).

<sup>25</sup> *Palmer v. BRG of Georgia*, 498 U.S. 46 (1990) (quoting with approval, *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1972)).

<sup>26</sup> *National Soc’y of Professional Eng’rs v. United States*, 435 U.S. 679 (1978); *FTC v. Indiana Fed’n of Dentists*, 476 U.S. 447 (1986); *Ballard v. Blue Shield of S.W. Va., Inc.*, 543 F.2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977). *See generally*, Thomas L. Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 CONN. L. REV. 605 (1989).

<sup>27</sup> *FTC v. Superior Court Trial Lawyers Ass’n*, 493 U.S. 411 (1990). This case reaffirms a basic principle of antitrust policy, but raises questions about the wisdom of the allocation of FTC enforcement resources during the Reagan-Bush years. While it may have been politically satisfying for libertarians to seek to enjoin publicly funded lawyers representing indigents from striking the government of the District of Columbia to increase their wages to \$35 an hour, one wonders if there were not more pressing matters for the FTC to pursue with its limited resources. It appears to be a case reaffirming Anatole France’s observation: “The majestic egalitarianism of the law, which forbids rich and poor alike to sleep under bridges, to beg in the streets, and to steal bread.” LE LYS ROUGE ch. 7 (1894).

<sup>28</sup> *Atlantic Richfield Co. v. USA Petroleum Co.*, 496 U.S. 325 (1990); *Arizona v. Maricopa County Medical Soc’y*, 457 U.S. 332 (1982).

illegal where the seller has “appreciable economic power” in the tying product and the arrangement affects a substantial volume of commerce in the tied market;<sup>29</sup> that legitimate objectives of joint ventures necessary to produce a product must follow the least restrictive alternative to that end when doing so;<sup>30</sup> and, that denial of market access to a single competitor by means that displace the competitive process determining market access, the controversial *Klor’s* rule, remains per se unlawful whether done by collaboration,<sup>31</sup> or by the unilateral exercise of monopoly power.<sup>32</sup> These are the fundamental policies and rules of antitrust law that have not only survived but have been reaffirmed by the courts during the past several years of judicial and executive branch skepticism about the need for antitrust enforcement; and, they are central principles and rules that should shape the alternatives considered in government’s coming response to malfunctions in health care markets and the financing of health care.

### *B. Health care antitrust issues*

The continuing vitality of antitrust policy and its fundamental role as the presumed method for ordering otherwise unregulated economic activity, even during the Reagan-Bush years, is well demonstrated by the significant recent antitrust activity relating to the health care industry. As one particularly thoughtful observer has stated, “antitrust litigation helped remove a complex set of

---

<sup>29</sup> *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 112 S. Ct. 2072 (1992).

<sup>30</sup> *National Collegiate Athletic Ass’n v. Board of Regents*, 468 U.S. 85 (1984).

<sup>31</sup> *Summit Health, Ltd. v. Pinhas*, 111 S. Ct. 1842 (1991); *Klor’s, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959).

<sup>32</sup> *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985).

firewalls that had for many years shielded health care providers from market discipline."<sup>33</sup>

Fifty years ago the Supreme Court held that the antitrust laws are fully applicable to the practice of medicine and the delivery of health care services. In *American Medical Association v. United States*,<sup>34</sup> the United States Supreme Court upheld a Sherman Act criminal indictment and conviction of the American Medical Association, the Medical Society of the District of Columbia, and others for obstructing the operations of a nonprofit group health plan in the District of Columbia offering prepaid health care services. The indictment charged the defendants with conspiring to prevent physicians from accepting employment with the group health plan and preventing hospitals from providing facilities to patients of doctors practicing in the employment of the group health plan. The Supreme Court held: (1) the practice of medicine to be "trade" under the Sherman Act, (2) that the defendants' conduct was shown to have "restrained" trade within the meaning of the Sherman Act, and (3) that the defendants' conduct did not fall within the labor exemptions from the antitrust laws.

Despite these clear holdings broadly applying antitrust policy to health care, relatively little antitrust litigation took place in the health care industry until the 1970s. A 30-year period of ignoring the antitrust laws and growing anticompetitive practices ensued until a gradual and then a galloping increase in the cost for all forms of health care began its seemingly inexorable rise.<sup>35</sup> Like most industries long ignored by antitrust enforcement, anticompetitive structures were put in place, anticompetitive practices became common, and widespread distortions in the availability and price of health care services became extreme. In particular,

---

<sup>33</sup> Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE J. REG. 179, 182 (1988).

<sup>34</sup> 317 U.S. 519 (1943).

<sup>35</sup> The yearly trend is summarized in Stephen Martin & John Goddeeris, *Policy and Structural Change in the Health Care Industry*, 30 ANTITRUST BULL. 949 (1985).

the medical profession's continued insistence upon the fee-for-service method for paying for health care and opposition to pre-paid contract service resulted in "the creation of a monopoly in medical practice through the exclusion of alternative practitioners" and the prevention of customer cost and quality controls.<sup>36</sup>

Increased antitrust attention over the past decade began to uncover a number of areas where industry structure and accepted practices have contributed significantly to the current crises of a misallocation of health care resources, excessive pricing and exclusionary practices. While gradually dismantling a large number of barriers to competition, antitrust litigation over the past two decades has also opened up the debate over how to reform the health care industry to insure access to all, efficiency in the delivery of care, and quality in the care delivered. What follows is a summary review of recent antitrust litigation dealing with health care financing, boycotts, price fixing, exclusive dealing and tying arrangements, and mergers and joint ventures—activities central to health care reform proposals.

1. HEALTH CARE FINANCING Today, consumers, or more accurately employers offering health care benefits to employees, can choose between several different plans for financing health care on behalf of their employees. One method is traditional indemnity insurance that reimburses providers on a fee-for-service basis and makes no attempt to encourage patients or providers to lower costs or control prices. A second method is to enroll consumers in health maintenance organizations (HMOs) whereby consumers give up some of their freedom to choose health care providers by agreeing to use services provided by the HMO in exchange for full insurance coverage at predetermined prices for the service provided.<sup>37</sup> Preferred provider organizations (PPOs) offer a middle

---

<sup>36</sup> PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 21 (1982).

<sup>37</sup> For a description of HMOs and PPOs see, Francis H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care*, 51 *LAW & CONTEMP. PROBS.* 195, 200-01 (1988).

ground, with consumers allowed to select from a list of competing providers who have agreed to limit their charges for most services to a predetermined fee schedule. The growth of HMOs and PPOs has been a relatively recent phenomenon because of long-standing and effective opposition of organized medicine to financing mechanisms other than fee-for-service medicine.<sup>38</sup>

Despite the *AMA* case of 1943, the underlying practice of the medical and hospital establishments of insisting upon "free choice" for patients in the employment of their physician and hospital on a fee-for-service basis and without the intervention of a contract buyer of the service on behalf of the patient continued until the 1980s. In what has been aptly characterized as the "Guild Free Choice" approach to buying health care services,<sup>39</sup> the *AMA* and state and local medical societies prohibited members on "ethical" grounds from providing "contract service" by selling health care services prospectively on a prepaid basis to persons belong-

---

<sup>38</sup> The growth of HMOs and PPOs controlled by insurance companies has begun to raise serious issues for physicians excluded from serving patients in the HMO or PPO. See Ron Winslow & Edward Felsenthal, *Physicians Fight Back as Insurers Cut Them From Health Networks*, WALL ST. J., Dec. 30, 1993, at 1, col. 1. Some states have been passing statutes precluding insurers and employers from excluding physicians and hospitals willing to provide service at the same price as the PPO from receiving payment from the insurer. See VA. CODE § 38.2-2407 (1950). The statute has been upheld over claims that it is preempted by ERISA. See *Blue Cross & Blue Shield of Virginia v. St. Mary's Hospital*, 245 Va. 24, 426 S.E.2d 117 (1993); *Stuart Circle Hospital v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993).

State laws requiring insurers and employers to deal with all providers willing to provide service at the same price as the negotiated price a PPO is willing to provide the service wipe out the advantage of the PPO. On the other hand, an exclusive arrangement between a PPO and an employer or insurer excluding competing providers from providing the service has earmarks of a concerted refusal to deal or boycott. See Edward Felsenthal, *Recent Rulings May Threaten Health Plans*, WALL ST. J., Nov. 3, 1993, at B1, col. 1.

<sup>39</sup> Charles D. Weller, "Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance, 69 IOWA L. REV. 1351 (1984).

ing to the group covered by the contract. In the name of keeping control over medical decisions in the hands of the medical profession in general and the treating physician in particular, the profession obtained a monopoly over economic decision making in, access to, and the method for financing health care.<sup>40</sup> Third-party insurers under an obligation to pay the bill for all services provided by the doctor and hospital in accord with the medical profession's definition of acceptable practice, had no control over what services were provided, the quantity of care ordered, the quality of the care offered, and the price of the care chosen.

The consequences of third-party insurer payment on a fee-for-service basis for health care services chosen by patients and their physicians have been obvious. Consumer choice of providers and treatments have not been constrained by price considerations. Suppliers of services have not been constrained by a competitive process in determining their fees and choices of services where a third-party payor is present and obligated to pay for all or most of the services chosen by the insured patient and the provider. Under what has been a cost-plus regime for financing health care expenditures, total health care costs have escalated dramatically; those

---

<sup>40</sup> Professor Havighurst has observed: "Centralization of medical-economic decisions in the hands of the medical profession imparts to the highly diverse and fragmented health care industry an essentially monopolistic character and should raise further doubts about its economic efficiency."

Professor Havighurst astutely notes that the health care system exercises monopoly power not by reducing output but by preventing those paying for services from "acting as independent decision makers competing to provide more cost-effective coverage to consumers. . . ." While the welfare loss in the typical monopoly circumstance results from an underallocation of resources to the activity, in health care "the welfare loss attributable to noncompetitive conditions . . . has taken the form of an overallocation, rather than an underallocation, of resources to the industry." Clark C. Havighurst, *Decentralizing Decision Making: Private Contract Versus Professional Norms*, in MARKET REFORMS IN HEALTH CARE 22, 26 (J. Meyer ed., 1983).

who cannot afford the price, have had to forego insurance and, often, care; public health care services for the uninsured have both been strained to capacity and have deteriorated in the quality of care provided; cross-subsidies have multiplied geometrically; and the cost of health care benefits has become a serious problem for individuals, employers and governments.

On the supply side of the market, excess capacity has been growing in both hospital space and equipment; distortions in provider markets have been growing with practitioners gravitating to high income specialties and understaffing low income ones; insurers and employers have been attempting to monitor more closely health care provider decisions by establishing bureaucratic, expensive and time-consuming monitoring systems; and, individuals, employers, insurers and governments have been straining to meet ever-increasing costs of providing health care insurance or shedding the responsibility for doing so wherever possible.

In a little noticed Ford-Carter era FTC proceeding culminating in a 1979 cease and desist order,<sup>41</sup> the FTC found that the AMA's ethical rules—followed by state and local medical societies at that time—constituted an agreement to prevent members from soliciting business by advertising, to fix prices and to restrain members from engaging in competitive practice formats. The Commission found that the ethical rules prohibited advertising and the solicitation of patients;<sup>42</sup> that methods of delivering health care services

---

<sup>41</sup> American Medical Ass'n, 94 FTC 980, 1015 (1979), *enforced sub nom.*, American Medical Ass'n v. FTC, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982). The opinions are thoroughly and perceptively reviewed in Weller, *supra* note 39.

<sup>42</sup> The Commission found: "This evidence is susceptible to no interpretation other than that ethical principles of the medical profession have prevented doctors and medical organizations from disseminating information on the prices and services they offer, severely inhibiting competition among health care providers. Because prepaid health care plans and other alternative providers depend heavily on advertising to announce their existence and explain their programs, the advertising restrictions

through systems other than the traditional fee-for-service method (particularly through prepaid plans) had been harshly impacted by the advertising and solicitation prohibition; that the purpose and effect of the prohibition was to suppress competition among physicians; and that an ethical rule providing that a physician "should not dispose of his services under terms and conditions which interfere with or impair the free and complete exercise of medical judgement and skill" was enforced for the purpose of preserving the traditional fee-for-service method of payment for medical services and to prevent the development of prepaid contract mechanisms for the payment for medical services.<sup>43</sup>

The net effect of the AMA's ethical rules, and similar policies followed by hospitals,<sup>44</sup> was the channeling of health care financing down the path of fee-for-service payment only, a cost-plus system of health care financing that conferred immunity from the development of competitive methods for financing and delivering

---

have had an even harsher impact on such organizations." 94 FTC at 1005-06.

<sup>43</sup> The FTC found that the effect of the enforcement of this policy was to prevent the development of (1) contractual arrangements that affect the adequacy of fees by underbidding where they precluded the free choice of a physician by a patient; (2) the prevention of financing methods that compensated physicians on other than a fee-for-service basis; and (3) financing mechanisms that involved physician arrangements with nonphysicians. See 94 FTC at 1011-17.

<sup>44</sup> In 1933, the American Hospital Association adopted a policy expressly providing that competition among hospitals was to be avoided and that fees for hospital services under group insurance plans should be available to all hospitals in an area and be available to any subscriber to which his physician has access. The policy expressly provided that control of any plan must not be transferred to an "enrolling agency" and that hospitals should "decline to enter into contracts with any business agency which controls or seeks to control the finances or management of the plan." Quoted in Weller, *supra* note 39, at 1365. The effects of this policy were to maintain the fee-for-service or cost-plus method for financing hospital services, prevent the development of prepaid plans where the insurer retained some control over cost and utilization, and make staff privileges with peer review at a hospital a crucial entry factor to hospital utilization and competition between both providers and hospitals.

health care services. Fee-for-service compensation financed by third-party insurance became the root cause of inflation in health care costs and the misallocation of health care resources that we are now struggling to change.<sup>45</sup> Following the FTC's antitrust action enjoining the AMA's ethical rules, consumers and employers paying the insurance bill began to have a choice between the traditional fee-for-service insurance plans<sup>46</sup> and a variety of pre-paid or contract plans, primarily different forms of HMOs<sup>47</sup> and

---

<sup>45</sup> At the beginning of the 1980s, approximately 10 million consumers belonged to HMOs. By 1992, membership in HMOs had grown to over 40 million. Greg Seinmetz, *New Treatment*, WALL ST. J., May 18, 1993, at 1. It is estimated at the end of 1993 that over 90 million belong to either HMOs or PPOs. See Winslow & Felsenthal, *supra* note 38. The dramatic growth in group buying of health care services during the 1980s and 1990s followed the FTC's action enjoining the AMA's ethical rules mandating fee-for-service delivery of health care. For an excellent review of the significance of the FTC's action against the AMA, see Weller, *supra* note 39. Professor Weller aptly describes the consequences of the fee-for-service model as: making each hospital and practitioner a "self-contained market" insulated from economic competition like in a horizontal market division, *id.* at 1373; making each provider a "financial island unaccountable to anyone but himself at a time when scientific medicine was weaving a pattern of clinical interdependence," *id.* at 1374; "isolating each provider from financial responsibility for the overall cost of health care services" while eliminating "private incentives for efficiency"; and, making providers ignorant of the financial impact of their decisions and the public damage done thereby, *id.* at 1374.

<sup>46</sup> The traditional cost-plus financing of health care was also maintained by the medical profession since the 1930s through devices like setting up doctor or hospital controlled insurance programs like Blue Cross-Blue Shield. See Weller, *supra* note 39, at 1367.

<sup>47</sup> A general description of how HMOs function is as follows: "Health maintenance organizations . . . are the prototype prepaid plans, and in traditional closed-panel HMOs, insurance and provider functions are technically merged. Salaried physicians and allied health personnel provide basic medical services freed from temptation to receive extra income from superfluous care. Hospitalization takes place either in HMO-owned facilities or in hospitals contracting to comply with the HMOs cost-containment directives. In open-panel HMOs, on the other hand, the independent contractor physicians who provide medical serv-

PPOs<sup>48</sup> permitting choice on the basis of price, quality and benefits before service is provided. Competition among prepaid plans requires that they closely monitor costs because "they risk financial catastrophe if they underwrite comprehensive but unmonitored medical expenses for a single fixed premium."<sup>49</sup> In the 1980s, a fundamental policy of antitrust finally began to be applied to health care financing: that the option of intelligent consumer choice *before* a service is provided is essential if competition is to determine price, quality, allocation of resources and innovation in health care markets.

## 2. PEER REVIEW, CREDENTIALING AND OTHER HEALTH CARE PROVIDER EXCLUSIONARY PRACTICES

A large number of health care antitrust

---

ices are unsalaried. Doctors are usually compensated either on a capitation basis for each HMO patient in their care, or on a discounted fee-for-service basis, with incentives to discourage excess utilization built into the reimbursement formula." Miller, *supra* note 37, at 200.

<sup>48</sup> PPOs may be described as follows: "Preferred provider organizations . . . are an important variation on the prepaid health insurance theme, and combine features of both HMO and fee-for-service insurance coverage. If the PPO insured receives care from a 'preferred' provider, who has contracted with the PPO to render services subject to managed care constraints, the insurance premium covers the full costs of care. If instead the insured chooses to obtain care from a non-contractive provider, PPO coverage functions as indemnity insurance. This means that insured patients have to pay their non-PPO provider bills directly. They will usually be reimbursed for only a part of that expense, however, because non-preferred provider charges ordinarily exceed those allowed by the PPO." *Id.* at 200-01.

A PPO gives subscribers a financial incentive to get medical care from preferred providers approved by the plan because they render service at a discount. See *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986) (describing various PPO plans in a case by Indiana hospitals challenging Blue Cross decision to offer a PPO plan in the face of declining market share for Blue Cross' traditional reimbursement on a fee-for-service basis). The court's opinion, by Judge Easterbrook, finding no violation, is extensively criticized in Miller, *supra* note 47, at 226-30.

<sup>49</sup> Miller, *supra* note 47, at 200.

cases in the past decade have involved peer review—joint action usually by members of a specialty or by a hospital staff passing upon the qualifications and fitness of a practitioner to remain in the specialty or hospital, or to join it. Credentialing concerns a large array of private and public mechanisms for both carving out and certifying institutions and personnel as qualified for providing health care services and specialties.<sup>50</sup> Both forms of entry control can be of great significance to the level of competition among providers of a service and between providers of competing services,<sup>51</sup> as well as to the success or failure of an individual provider

---

<sup>50</sup> See *Daniel v. American Bd. of Emergency Medicine*, 802 F. Supp. 912 (W.D.N.Y. 1992) (finding jurisdiction over complaint that Board illegally denied plaintiff right to sit for exams leading to certification as a “specialist” in emergency medicine).

Professional specialties may also be involved in issuing public statements concerning the safety, validity, or effectiveness of a particular service or medical procedure. In *Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 397 (7th Cir. 1989), the Academy had labeled the procedure of radial keratotomy, corneal surgery designed to remedy nearsightedness, as “experimental,” thereby precluding insurance reimbursement for the treatment. Plaintiffs brought an unsuccessful antitrust suit claiming the press release was the product of a conspiracy by Academy members to restrain trade. The case was tried to a jury for 1 month and the jury found for the defendants; a decision affirmed on appeal by the Seventh Circuit. Judge Easterbrook, author of the opinion, could see no justification for the suit, although labeling the procedure “experimental,” rather than “investigational” made surgery not reimbursable under Medicare and limited the number of surgeries done. For an earlier antitrust action against a federal advisory council on eye care, finding immunity for limiting those who could provide the surgery, see *Vest v. Waring*, 565 F. Supp. 674 (D.N.D. Ga. 1983).

<sup>51</sup> Compare *Weiss v. York Hosp.*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985) with *Ballard v. Blue Shield of S.W. Va., Inc.*, 543 F.2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977).

A boycott organized by almost all the major health care credentialing and trade associations of chiropractic services on the ground that it was a “cult” and not scientifically legitimate is described and analyzed in *Wilk v. American Medical Ass’n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984); see also *Ballard v. Blue Shield of S.W. Va.*, *supra* (finding a combination of medical associations and insurers to deny reimbursement for chiropractic services unlawful).

“whose business is so small that his destruction makes little difference to the economy.”<sup>52</sup> Such conduct, as well as horizontal agreements among providers refusing to provide cost information to insurers<sup>53</sup> and refusals by insurers to reimburse particular providers,<sup>54</sup> have earmarks of a boycott,<sup>55</sup> a joint refusal to deal

---

<sup>52</sup> *Klor's Inc. v. Broadway Hale Stores, Inc.*, 359 U.S. 207 (1959). For an application of the Sherman Act to cases involving a minimal connection to interstate commerce in the health care field, see *Summit Health, Ltd. v. Pinhas*, 111 S. Ct. 1842 (1991) (stressing judicial focus on the potential harm of a conspiracy to interstate commerce); *Sweeney v. Athens Regional Medical Center*, 709 F. Supp. 1563 (M.D. Ga. 1989) (finding a hospital and staff boycott of nurse midwife offering at-home birthing services in which jurisdiction was upheld). For a perceptive review of antitrust jurisdictional questions in light of *Summit*, see Andrew I. Gavil, *Reconstructing the Jurisdictional Foundation of Antitrust Federalism*, 61 GEO. WASH. L. REV. 657 (1993).

<sup>53</sup> *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986) (agreement by dentists refusing to supply x-rays to insurers seeking to control costs is an unlawful restraint similar to a boycott under the rule of reason); see also *Commonwealth v. Cahill*, 1993-1 Trade Cas. (CCH) ¶ 70,109 (D. Mass) (finding a conspiracy by physicians to refuse to deal with Blue Cross).

<sup>54</sup> See *National Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross*, 452 U.S. 378 (1981) (reversing dismissal of Sherman Act §§ 1 & 2 claims by a new hospital against Blue Cross for refusing to enter into a reimbursement agreement with the new hospital). Blue Cross sought to justify its refusal on the ground that construction of plaintiff's new hospital addition had not been approved by the local Hospital Systems Agency established pursuant to the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 3001, *et seq.* The Court found that the Act did not contain an implied repeal of the antitrust laws and stated: “The record discloses no formal request from the Missouri MAHSA to Blue Cross to refrain from accepting petitioner as a new participating hospital. Even if such a request had been made, it could not have been more than the advice of a private planning body—albeit a planning body created and funded by the Federal Government. This fact is crucial because antitrust repeals are especially disfavored where the antitrust implications of a business decision have not been considered by a governmental entity.” 452 U.S. at 390.

<sup>55</sup> See *Hartford Fire Insurance Co. v. California*, 113 S. Ct. 2891 (1993) (discussion of the meaning of the concept “boycott” and related

for purposes of fixing prices or the adoption of regulatory power by a private group to determine who may enter a market.<sup>56</sup>

Supreme Court concern with the political value of preserving the right of an individual to enter or remain in a market without regard for how much commerce is affected, or whether the displacement of a competitive process causes a measurable impact on price or resource allocation, is well demonstrated by the case of *Summit Health, Ltd. v. Pinhas*.<sup>57</sup> The elimination of a single ophthalmological surgeon from the Los Angeles market for such services by revocation of hospital privileges because of a refusal to require the presence of a second surgeon during surgery was found to meet the interstate commerce requirements of the Sherman Act. The Court held that the essence of a Sherman Act conspiracy violation was the agreement itself, not the amount of commerce affected.<sup>58</sup> Consequently, the potential harm of the con-

---

concepts for purposes of defining the exception to the McCarran-Ferguson Act exemption from antitrust for the "business of insurance").

<sup>56</sup> For a comprehensive review of peer review in the hospital context see James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, 51 LAW & CONTEMP PROBS. 7 (1988).

<sup>57</sup> 111 S. Ct. 1842 (1991). See Roxane C. Busey & Peter B. Freeman, *The View From the Summit: Jurisdiction and Beyond*, 60 ANTITRUST L.J. 725 (1992); Gavil, *supra* note 52.

<sup>58</sup> The Court's assertion that the essence of a § 1 violation is the contract or conspiracy to displace the competitive process determining price and related matters like entry is not new doctrine. See *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 224-26 n.59 (1940): "[I]t is . . . well settled that conspiracies under the Sherman Act are not dependent on any overt act other than the act of conspiring. . . . It is the 'contract, combination . . . or conspiracy in restraint of trade or commerce' which § 1 of the Act strikes down, whether the concerted activity be wholly nascent or abortive on the one hand, or successful on the other. . . . And the amount of interstate or foreign trade is not material . . . since § 1 of the Act brands as illegal the character of the restraint not the amount of commerce affected."

The conduct of the defendants combining to deny the plaintiff the opportunity to succeed or fail pursuant to a competitive process determines both the jurisdictional base for the application of the Sherman Act

spiracy if successful was the measure of whether commerce clause jurisdiction had been established over the conspiracy.<sup>59</sup> The Court found that if the conspiracy were successful, there would be a reduction in ophthalmological services in the Los Angeles market and a restraint on that market generally would be threatened vis-a-vis other surgeons subject to the same threat in the market for providing ophthalmological services.

Nor did the state action doctrine stave off antitrust review of the termination of hospital privileges of a single surgeon in Astoria, Oregon in *Patrick v. Burget*.<sup>60</sup> Patrick was originally employed by a clinic in Astoria located in the only hospital in the area, a hospital that had also granted Patrick staff privileges. After Patrick established an independent practice in competition with the surgical practice of the clinic, physicians associated with the clinic refused to deal with him. Several years later proceedings were begun to terminate Patrick's hospital privileges on the ground that his care of patients was below the standards of the hospital. Patrick maintained that the proceeding to revoke his hospital privileges was for the purpose of reducing competition from his surgery practice rather than to improve patient care, a proposi-

---

to their conduct and the issue of whether their conduct violates the statute.

<sup>59</sup> *Citing* *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232 (1980) (finding that under the Sherman Act, proof of either an unlawful purpose or effect is sufficient to establish jurisdiction). The case is interestingly reviewed in Andrew I. Gavil, *supra* note 52, suggesting that the original intent of the framers of the Sherman Act was to focus on "the nature of the predator, not the prey . . . to define the needed federal antidote in terms of jurisdiction." 61 GEO. WASH. L. REV. at 714.

<sup>60</sup> 486 U.S. 94 (1988); *see also* *Shahawy v. Harrison*, 875 F.2d 1529 (11th Cir. 1989) (finding active state supervision of peer review process inadequate to create a state action defense); *Miller v. Indiana Hosp.*, 930 F.2d 334 (3d Cir. 1991) (holding no active state supervision, means no antitrust immunity); *Lancaster Community Hosp. v. Antelope Hosp. Dist.*, 940 F.2d 397 (9th Cir. 1991), *cert denied*, 112 S. Ct. 1168 (1992) (holding that local hospital districts are not specifically authorized to act anticompetitively by state law).

tion, the jury agreed with in awarding Patrick antitrust damages for the termination of his hospital privileges. The Ninth Circuit agreed that the evidence supported a finding that the peer review process was invoked in bad faith, but held the defendants immune from antitrust liability because of the state action doctrine. In reversing, the Supreme Court held that the state action defense was not available because there was no active supervision of the peer review process by the state, a requirement for state action immunity reenforced in the Court's most recent state action decision, *FTC v. Ticor Title Insurance Co.*<sup>61</sup>

In rejecting the state action defense by requiring that there be active and objective state supervision of the state-exempted conduct, the Court took note of the benefits of peer review as a process for the "provision of quality medical care" and the enactment of the Health Care Quality Improvements Act of 1986,<sup>62</sup> providing a level of antitrust treble damage immunity for peer review actions executed in conformity with the Act.<sup>63</sup> The Act's grant of antitrust immunity is carefully circumscribed however, and does not provide immunity from antitrust injunctive actions, government antitrust actions, and possibly treble damage liability for peer review actions not taken "in the furtherance of quality health care" and ones not conforming to the lengthy list of procedural requirements set forth in the Act.<sup>64</sup> Consequently, peer review activity remains subject to potential antitrust liability, in government actions, private injunction cases and in circumstances like

---

<sup>61</sup> 112 S. Ct. 2169 (1992).

<sup>62</sup> 42 U.S.C. § 11101, *et seq.* The action in *Patrick* was filed prior to enactment of the statute. For a review of the statute see Joan M. Roediger, *Antitrust Implications of Peer Review Organizations*, 39 MED. TRIAL TECH. Q. 389 (1993).

<sup>63</sup> For an application of the statute holding a peer review proceeding immune, see *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992).

<sup>64</sup> See *Decker v. IHC Hosps., Inc.*, 982 F.2d 433 (10th Cir. 1992); *Manion v. Evans*, 986 F.2d 1036 (6th Cir. 1993). The Act is reviewed in *Blumstein & Sloan, supra* note 56; *Roediger, supra* note 62.

those of the *Patrick* case, when it is done “not in the reasonable belief in the furtherance of quality health care,” nor in conformity with the extensive due process requirements set forth by the Act.<sup>65</sup>

Another form of joint action having the earmarks of an antitrust boycott are arrangements between HMOs and similar provider collectives and insurers excluding providers not admitted to membership in the provider organization from reimbursement for treating plan beneficiaries. As medical practitioners, hospitals and clinics become collectivized to a greater or lesser degree to bargain collectively<sup>66</sup> through HMOs, PPOs, and other joint sellers of services with large collectives of potential patients managed by private or public insurers, complex antitrust issues raising exclusive dealing, boycott, concerted refusals to deal and tying arrangement issues can and have arisen.<sup>67</sup> One issue is the degree to which individual practitioners, hospitals or clinics must be organized into some form of recognized legal entity in order to avoid a finding that joint action by the individuals constitutes a

---

<sup>65</sup> 42 U.S.C. § 11112(a)(1).

<sup>66</sup> In some instances, unincorporated groups of providers have sought, unsuccessfully, to analogize their activities to a labor union. See *Colorado v. Colorado Union of Physicians & Surgeons*, 1990-1 Trade Cases ¶ 68,968 (D. Colo. 1990).

<sup>67</sup> For example, in *Capital Imaging Ass'n v. Mohawk Valley Medical Ass'n*, 725 F. Supp. 669 (N.D.N.Y. 1989), one of the two diagnostic imaging services group practices in the Albany, New York area claimed that its competitor's exclusive arrangement for magnetic resonance imaging (MRI) services with an HMO constituted an antitrust violation. The defendants were an independent practice association (IPA) of practicing physicians and an insurer contracting with IPAs for physicians' services to provide service to the insurer's customers. Physician members of the plaintiff radiological firm were denied membership in the IPA and were therefore excluded from providing services for the members of the HMO. The court held the arrangement between the HMO and the IPA was not a “boycott” but would be analyzed under the rule of reason as a vertical exclusive dealing arrangement. The case was subsequently dismissed for failure to prove a conspiracy and an unreasonable restraint of trade. 791 F. Supp. 956 (S.D.N.Y. 1992).

contract, combination or conspiracy for antitrust purposes.<sup>68</sup> While current litigation is splitting in several different directions on this issue, it is an issue that confronts reform proposals with difficult choices if we are to avoid creating a loophole from effective regulation by the competitive process and antitrust policy or

---

See also *Beard v. Parkview Hospital*, 912 F.2d 138 (6th Cir. 1990); *All Care Nursing Service, Inc. v. Bethesda Memorial Hospital, Inc.*, 887 F.2d 1535 (11th Cir. 1989); *Coffey v. Healthhurst, Inc.*, 955 F.2d 1388 (10th Cir. 1992); *Fuentes v. South Hills Cardiology*, 946 F.2d 196 (3d Cir. 1991); *In Re Workers' Compensation Insurance Antitrust Litigation*, 867 F.2d 1552 (8th Cir. 1989), *cert. denied*, 492 U.S. 920; *Chiropractic Co-op Ass'n v. American Medical Ass'n*, 867 F.2d 270 (6th Cir. 1989); *Action Ambulance Service, Inc. v. Atlanticare Health Services, Inc.*, 815 F. Supp. 33 (D. Mass. 1993); *Swathmore Radiation Oncology, Inc. v. Lapes*, 812 F. Supp. 517 (E.D. Pa. 1992).

Physicians excluded from HMOs and PPOs have begun to file lawsuits challenging their exclusion on a number of grounds other than antitrust, including interference with the physician-patient relationship. See Winslow & Felsenthal, *supra* note 38.

<sup>68</sup> Compare, *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1991), *cert denied*, 112 S. Ct. 973 (1992) (declaring that physicians holding staff privileges at hospital and hospital incapable of conspiring), with *Bolt v. Halifax Hospital Medical Center*, 891 F.2d 810 (11th Cir. 1990), *cert denied*, 495 U.S. 924, and *Boczar v. Manatee Hospitals & Health Systems, Inc.*, 993 F.2d 1514 (11th Cir. 1993) (holding that hospital medical staff independent entrepreneurs may conspire with each other for Sherman Act purposes and staff members may be found to have conspired with hospital). The split in the circuits on this issue is analyzed in Murray S. Monroe, *Health Care: Current Antitrust Issues*, 20 N. Ky. L. REV. 365, 367-68 (1993).

Group actions by hospitals to bargain collectively through their trade association for temporary nursing services with several competing nursing agencies was attacked in *All Care Nursing Service, Inc. v. Bethesda Memorial Hospital*, 887 F.2d 1535 (11th Cir. 1989) (holding that temporary injunction granted plaintiff nursing agencies reversed for failure of trial court to hold a hearing). For a comprehensive review of the concepts of contract, combination and conspiracy see William E. Kovacic, *The Identification and Proof of Horizontal Agreements Under the Antitrust Laws*, 38 ANTITRUST BULL. 5 (1993).

by the imposition of affirmative government regulation to prevent abuse where antitrust policy is held not to apply and joint action generates anticompetitive effects.

Whatever form is chosen to organize providers into bargaining units to deal with insurers, those excluded from the bargaining group will no doubt consider antitrust policy as a remedy for their exclusion. If the organization is not labeled a boycott or other section 1 per se violation,<sup>69</sup> a central question in such conduct will no doubt be the degree to which the organized group possesses "power" in the affected markets, an elusive and multipurpose concept in antitrust analysis. The Supreme Court's decision in *Eastman Kodak Co. v. Image Technical Services, Inc.*,<sup>70</sup> requires a fact-based determination as opposed to a theoretical one, in determining whether a firm has market "power." Even though Kodak was found to have a relatively small share of the market for photocopying and micrographic equipment, that finding did not preclude the possibility that Kodak possessed power in the markets for parts and repair service for Kodak's equipment because of information and switching costs incurred by buyers of the equipment. A realistic approach to the question of "power" in antitrust analysis treats the concept as a functional tool for connecting the facts of the dispute to the policies behind the law, not as an objec-

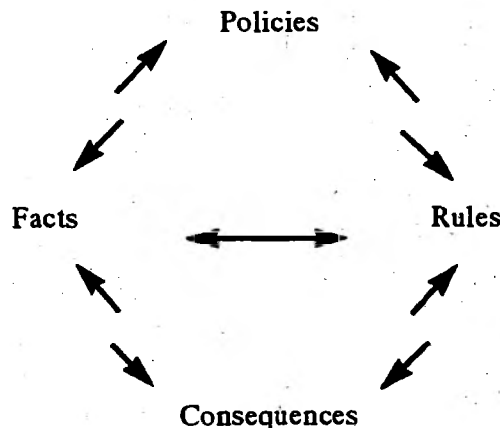
---

<sup>69</sup> The degree of formality required for a group to escape being found to be a combination of competitors rather than a single legal entity, is crucial in determining whether to analyze the arrangement as a § 1 boycott or a § 2 case of unlawful monopolization or attempt to monopolize. Forming an "association" is not enough to escape being found to be a § 1 contract combination or conspiracy. See *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447 (1986); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982). If the parties are found to be a combination of competitors, power is not relevant in determining whether their joint conduct amounts to a per se violation or an unreasonable restraint of trade.

<sup>70</sup> 112 S. Ct. 2072 (1992).

tive thing in physical reality to be identified by an abstract model or physical measurements of size or weight.<sup>71</sup>

<sup>71</sup> Legal positivists and many economists assume the reasoning involved in analyzing a legal dispute is deductive logic where Rules  $\times$  Facts = Right Decision. Reaffirming unexamined assumptions underlying fixed premises by a simplistic form of deductive logic may be useful for impressing naive students by manipulating models to produce "truth" or for generating seemingly "scientific" papers producing "truth," but has little value in the real world for resolving disputes in light of the normative policies underlying the law in the context of the facts and circumstances of the dispute. Extreme legal realists view the process of legal reasoning as one of rationalizing a decision one comes to for political or other reasons independent of definable rules and principles capable of objective verification or systematic application. Legal reasoning must grapple with the reality of disputes on a far more complex basis than that assumed by positivists and on a more constrained level than admitted by the extreme realists. Law and legal reasoning implementing "the law" is a complex inductive process where determinations of the (1) relevance, (2) meaning, and (3) application of rules and facts are dependent upon the policies behind the law and the consequences of the decision made, as well as the words of the rules and the circumstances of the dispute. The process, one of inductive, not deductive reasoning constantly confronts the assumptions of fact and policy underlying premises at each of the three analytical steps of deciding relevance, meaning and application of both the rules and the facts, and may be diagrammed as follows for those who find two-dimensional diagrams of the multidimensional complexities of reasoning helpful:



It is a reasoning process surrounded by several institutional constraints as well. One restraint is the role definition of judges mandating

The implications of *Kodak* for antitrust analysis of the power of legally recognized entities created for bargaining purposes in health care may indeed be significant.<sup>72</sup> Providers excluded from such entities and unable to claim a section 1 violation, may still be able to claim a violation of section 2 of the Sherman Act where the entity possesses "power" and consumers locked into a provider group are precluded from dealing with competing providers. It is a significant issue generating health care litigation on antitrust and other grounds, and an issue legislative reform of health care must address.

3. PRICE FIXING A closely related issue concerns the degree to which providers organized into groups and insurers and other entities bargaining on behalf of consumers with provider organizations may set prices they will offer on behalf of the group of providers or insureds in the bargaining between them. As health insurers have become more price conscious and better at negotiating discounts and capitation fees, providers increasingly claim

---

that they follow legislative intent and be limited generally by evidence presented in open court and by the arguments of the parties in their determination of facts and law. Also, constitutional limitations, like the right to jury trial, as well as procedural and other limitations upon the process of factfinding and the use of precedent and other sources of law significantly confine judicial discretion. Finally, there are inherent limitations upon language and the concepts it generates to carry the "freight" of meaning many simplistically assume language can carry with little or no attention paid to distinctions like those between connotation and denotation and the complex process by which the mind comes to understand the meaning of words in the context of their use and in the application of words and the concepts they generate to specific facts in the particular circumstances of a dispute. See John J. Flynn, *Antitrust Policy and the Concept of a Competitive Process*, 35 N.Y.L. SCH. L. REV. 893 (1990). The legal analysis of disputes is intensively empirical and the more one is immersed in facts, the less relevant abstract models become. See Mark Cooney, *Why Is Economic Analysis So Appealing to Law Professors?*, 45 STAN. L. REV. 2211 (1993).

<sup>72</sup> See Michael S. Jacobs, *Recent Developments in Antitrust Law and Their Implications for the Clinton Health Care Plan*, 21 J.L. MED. & ETHICS 163 (1993).

that they lack the bargaining power individually to negotiate fair fees and therefore need to band together to negotiate collectively with large insurers. Often, health care providers that otherwise operate independently have discussed and agreed upon fees for certain services offered to powerful buyers. These fee schedules bear many of the earmarks of prohibited price fixing, much like the practices of organized labor bargaining collectively with employers. Ultimately, legislative exemptions from the antitrust laws were required for collective bargaining by officially recognized unions before the courts finally yielded in their hostility to collective bargaining as a prohibited form of horizontal price fixing.<sup>73</sup> In the absence of having the legally recognized status of a labor union or the single entity status of a corporation or other legally recognized single business entity, there is no antitrust immunity for joint or collaborative activity by otherwise competitive economic actors.<sup>74</sup>

---

<sup>73</sup> Section 6 of the Clayton Act declares that the "labor of a human being is not a commodity or article of commerce" and that the existence of labor, agricultural or horticultural organizations formed for mutual self help, "not having capital stock or conducted for profit" shall not "be held or construed to be illegal combinations or conspiracies in restraint of trade under the antitrust laws." 15 U.S.C. § 17. Section 20 of the Clayton Act, 29 U.S.C. § 52, precludes the issuance of injunctions in any case involving disputes over terms and conditions of employment unless necessary to prevent irreparable injury. Due to judicial hostility against unions engaging in coercive strikes, Congress adopted the Norris-LaGuardia Act of 1932, 29 U.S.C. § 104, further confining the exercise of judicial power to order injunctions in labor disputes and establishing the National Labor Relations Board to regulate labor-management relations. The history and status of the relationship between antitrust policy and labor legislation is reviewed in LOUIS B. SCHWARTZ, et al., *supra* note 14, at 1070, *et seq.*

<sup>74</sup> See *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990) (denying antitrust immunity to an association of lawyers "striking" the District of Columbia government for higher fees for representing indigent criminal defendants in the District of Columbia Superior Court).

Horizontal price fixing by the agreement of legally independent persons or entities, maximum or minimum, is the classic per se violation of the Sherman Act.<sup>75</sup> In *Arizona v. Maricopa County Medical Society*,<sup>76</sup> this basic rule of antitrust was extended to joint efforts by medical practitioners establishing "medical foundations" to set the maximum price that members of the foundations would charge insurance carriers for specified medical procedures. The purpose of establishing "foundations" was to promote fee-for-service medicine and to block the development of HMOs and PPOs as alternatives to fee-for-service financing.<sup>77</sup> The Court rejected defenses that the arrangement fixed maximum rather than minimum prices,<sup>78</sup> that the "industry was one with which the judi-

---

<sup>75</sup> Although it is beyond the scope of this article to explore the nature of per se rules, the legal status of the rules of per se illegality is ambiguous. While cases like *F.T.C. v. Superior Court Trial Lawyers*, 493 U.S. 411 (1990) and *Arizona v. Maricopa Medical Society*, 457 U.S. 332 (1982) suggest that the per se rules of antitrust are substantive rules of law, cases like *Broadcast Music, Inc. v. CBS*, 441 U.S. 1 (1979) and *NCAA v. Board of Regents of the University of Oklahoma*, 468 U.S. 85 (1984) proceed on a basis that assumes that per se rules are rules of evidentiary presumptions of varying levels of rebuttability. See John J. Flynn, *Rethinking Sherman Act Section 1 Analysis: Three Proposals for Reducing the Chaos*, 49 ANTITRUST L.J. 1593 (1980); John J. Flynn, *The Function and Dysfunction of Per Se Rules in Vertical Market Restraints*, 58 WASH. U. L.Q. 727 (1980); John J. Flynn, *The "Is" and "Ought" of Vertical Market Restraints After Monsanto Co. v. Spray-Rite Service Corp.*, 71 CORNELL L. REV. 1095 (1986).

<sup>76</sup> 457 U.S. 332 (1982). For a recent case dealing with an agreement by hospitals to limit advertising and disclosure of quality comparisons between the hospitals, see *United States v. Hospital Ass'n of Greater Des Moines*, 1993-1 Trade Cas. (CCH) ¶ 70,160 (S.D. Iowa 1993).

<sup>77</sup> PPOs do not assume responsibility for all the costs the insured may incur, as do HMOs. For a comparison of PPOs and HMOs, see Spies et al., *Alternative Health Care Delivery Systems: HMOs and PPOs*, in HEALTH CARE COST MANAGEMENT: PRIVATE SECTOR INITIATIVES (P. FOX et al. eds., 1984); ABA ANTITRUST COMMITTEE, *MANAGED CARE AND ANTITRUST: THE PPO EXPERIENCE* (1990).

<sup>78</sup> The Court rejected this argument on the grounds that the per se rule is "grounded on faith in price competition as a market force," that

ciary had little experience,<sup>79</sup> that the arrangement was by members of a learned profession<sup>80</sup> and that there were procompetitive justifications.<sup>81</sup> The assumption of the power to set prices for

---

the price restraint imposed provides the same economic reward to all regardless of their individual abilities, the restraint may deter entry and experimentation with new methods of delivering the service and it may be a masquerade for fixing uniform prices. 457 U.S. at 348.

<sup>79</sup> The Court rejected this argument by citing *Socony-Vacuum* for the proposition that so far as price fixing is concerned, the Sherman Act "establishes one uniform rule applicable to all industries alike and that the elimination of so-called competitive evils . . . is no justification" for price-fixing agreements. 457 U.S. at 349. This holding overruled the implication of *United States v. Oregon Medical Soc'y*, 343 U.S. 326, 336 (1952), that the medical profession was immune from the normal rules of antitrust policy. Since the decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), it has become increasingly clear that the Court is becoming less and less sympathetic to claims of some level of immunity for the professions based on traditional ethical norms of a profession limiting competition. See Clark C. Havighurst, *The Contributions of Antitrust Law to a Procompetitive Health Policy*, in *MARKET REFORMS IN HEALTH CARE* 295 (J. Meyer ed., 1983).

<sup>80</sup> The Court cited *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), and *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1978) for the proposition that price fixing in a profession unrelated to enhancing professional norms or which facilitate customer payments is no defense. 457 U.S. at 349.

<sup>81</sup> The Court rejected this defense on the grounds that the per se rules foreclose justifications being offered because the rule is premised on the anticompetitive potential of all price-fixing agreements, that a guarantee of complete coverage required agreement on the price to be charged and the price was being fixed by agreement of doctors participating in the plan, and that it was up to Congress to change the law not the courts. The Court distinguished *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), on the grounds that in that case the insurer fixed the price, not the providers, in order to guarantee full reimbursement for prescriptions. The claim that the practice involved only "price fixing in a literal sense," relying on *Broadcast Music, Inc., v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1 (1979), was rejected on the ground that the doctors' combination in the form of "foundations" was a combination of competitors selling medical care in competition with one another and not a combination creating a new product. The combination

medical services by competitors providing that service, as opposed to an arrangement between insurers and insureds setting the price at which they would be reimbursed for medical services,<sup>82</sup> was found to be the essential factor causing the conduct in question to fall into the per se category of "price fixing."<sup>83</sup>

---

in *Broadcast Music* was characterized as one creating a new product, the blanket license, for which a price had to be set.

<sup>82</sup> See *Hassan v. Independent Practice Ass'n, P.C.*, 698 F. Supp. 679 (E.D. Mich. 1988) (distinguishing *Maricopa* on the grounds that the defendant HMO incorporated and assumed the role of an insurer rather than formed a confederation of competitors in the form of a "foundation" to administer the price and payments made by independent insurers). Such an arrangement did not save the policy of a physician-administered insurance plan involving 90%–93% of eligible physicians in Oregon refusing to allow podiatrists and other nonphysicians to join the plan. *Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022 (9th Cir. 1988), *cert. denied*, 493 U.S. 846 (1989). Members were reimbursed up to 90% of their charges, while nonmembers were reimbursed up to 60% of their charges. Since physicians controlled the insurer and operated it on a PPO basis, the court held there was sufficient evidence for a jury to determine whether the arrangement constituted a horizontal agreement by competitors to fix prices and boycott podiatrists. See also *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).

<sup>83</sup> The status of vertical price-fixing agreements in health care is unsettled. In *Group Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), the Court was presented with a cost-control program adopted by Blue Cross, in which it agreed to reimburse pharmacies filling prescriptions for Blue Cross members on a predetermined fee of cost plus \$2 for each prescription filled. The insurer reimbursed insured's dealing with nonparticipating pharmacies at 75% of the price charged. Pharmacists not agreeing to the plan sued, claiming the plan constituted price fixing and a boycott. The lower courts dismissed the claim on the grounds that the conduct was exempt conduct under the McCarran-Ferguson Act, a holding the Supreme Court reversed on the ground that dealings between an insurance company and third parties supplying services to insureds was not "the business of insurance" and was therefore not exempt. The majority did not reach the merits of the price-fixing claim.

On remand, the Fifth Circuit affirmed dismissal of the claims of price fixing and boycott, rejecting arguments that the individually negotiated contracts with each pharmacy constituted either horizontal price fixing

The thin line between what constitutes per se illegal price fixing and legitimate bargaining between health care providers and insurers, is illustrated by *United States v. Alston*,<sup>84</sup> a criminal price-fixing case charging three dentists with fixing prices for insurance reimbursement and co-payment schedules. The defendants met with fifty other dentists to discuss insurance reimbursement schedules and co-payment schedules and wrote individual but identical letters to insurance carriers demanding an upward revision in both schedules. A jury found the defendants had agreed to fix the price of co-payment fees and had mailed identical letters to insurers as part of a conspiracy. In reversing the trial court's judgment of acquittal overruling the jury verdict, the Ninth Circuit found sufficient evidence of a conspiracy or agreement,

---

between the pharmacies, or vertical price fixing between the insurance company and individual pharmacies. No evidence of agreement among competing pharmacies to fix prices was found, and coerced conformity by a powerful buyer was found insufficient to infer conspiracy on a conscious parallelism theory. Also, a claim of vertical price fixing was rejected on the ground that the relationship between Blue Cross and the pharmacies was the product of independent bargaining, rather than conspiracy to fix prices, and that there was no agreement to maintain resale prices. *Royal Drug Co. v. Group Life & Health Ins. Co.*, 737 F.2d 1433 (5th Cir. 1984), *cert. denied*, 469 U.S. 1160 (1985). *See also* *Zinser v. Rose*, 868 F.2d 938 (7th Cir. 1989) (holding that parallel conduct by insurance companies fixing chiropractor reimbursement not sufficient to prove horizontal or vertical agreement); *Austin v. Blue Cross & Blue Shield of Alabama*, 903 F.2d 1385 (11th Cir. 1990) (consumers lacked "standing" to challenge agreements between Blue Cross and hospitals giving Blue Cross lower rate than that charged plaintiff).

<sup>84</sup> 974 F.2d 1206 (9th Cir. 1992). There are usually two closely connected issues: (1) Is the conduct pursuant to a contract, combination or conspiracy; and (2) Is the joint action conduct "price fixing" within the legal meaning of that concept. The *Alston* case raises the issue of what kind and how much evidence is required to prove joint action amounts to a contract, combination or conspiracy. The second issue is raised by cases like *Anesthesia Advantage, Inc. v. Metz Group*, 759 F. Supp. 638 (D. Colo. 1991) (standards for sufficiency of the evidence on motion for summary judgment to prove price fixing); *American Soc'y of Internal Medicine*, 105 FTC 505 (1985) (advisory opinion rejecting use of "relative value scales" on the ground that they lead to "price fixing").

that it was one to fix prices, and that it resulted in the fixing of prices. The court found that *FTC v. Superior Court Trial Lawyers Ass'n*,<sup>85</sup> holding a “strike” by defense lawyers representing indigents in the District of Columbia, forcing the local government to raise fees, per se illegal price fixing, and established the per se rule as “a substantive rule of antitrust law, not merely a rule of administrative convenience.”<sup>86</sup>

The case points up what could be troubling issues for any reform of health care financing based on collective bargaining between health care providers and insurers. While individual insurers may use the collective power of their policyholders to establish or bargain for lower prices, to what extent may providers join together to bargain with insurers? The *Alston* court noted:

But health care providers who must deal with consumers indirectly through plans such as the one in this case face an unusual situation that may legitimate certain collective actions. Medical plans serve, effectively, as the bargaining agents for large groups of consumers; they use the clout of their consumer base to drive down health care service fees. Uniform fee schedules—anathema in a normal competitive market—are standard operating procedure when medical plans are involved. In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or a group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules. Thus health care providers might pool cost data in justifying a request for an increased fee schedule. . . . Providers might also band together to negotiate various other aspects of their relationship with the plans such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanisms for adjusting disputes. Such concerted actions, which would not implicate the per se rule, must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals from the plans.<sup>87</sup>

---

<sup>85</sup> 493 U.S. 411 (1990).

<sup>86</sup> 974 F.2d at 1208.

<sup>87</sup> 974 F.2d at 1214.

Left unanswered was the degree to which providers must be organized into a legally recognizable entity to escape the label of independent parties engaging in a contract, combination, or conspiracy to fix prices and the degree to which independent parties may bargain over elements affecting pricing collectively, without crossing the line into conduct that will be identified legally as "price fixing." These are issues that any reform of health care relying upon "managed competition" or other forms of collective bargaining between providers and insurers must confront and resolve if difficult antitrust issues are to be avoided.<sup>88</sup>

4. HEALTH CARE EXCLUSIVE DEALING AND TYING ARRANGEMENTS  
Institutional health care providers, such as hospitals, frequently condition the purchase of some services with a requirement that the patient also use other services offered by the hospital. For example, hospitals typically require patients and admitting physicians to use radiology, anesthesiology and medical laboratory services provided by the hospital. Similarly, insurers (particularly HMOs and PPOs) require insureds to use only specified providers or forfeit some or all insurance benefits, and may limit a provider's right to treat patients other than those belonging to the insured group. Similar practices in other industries raise antitrust issues analyzed under the labels of "exclusive dealing" and "tying arrangements."

Although section 3 of the Clayton Act regulating exclusive dealing arrangements that might tend to lessen competition or create a monopoly in any line of commerce is limited to transactions involving "goods or commodities,"<sup>89</sup> the practice may also come within the Sherman Act<sup>90</sup> and the Federal Trade Commission Act<sup>91</sup>

---

<sup>88</sup> For an extensive analysis of the issue of "capacity to conspire" in health care cases, see Blumstein & Sloan, *supra* note 56, at 39-52.

<sup>89</sup> 15 U.S.C. § 14.

<sup>90</sup> See *Twin City Sportservice, Inc. v. Charles O. Finley & Co.*, 676 F.2d 1291 (9th Cir. 1982), *cert. denied*, 459 U.S. 1009.

<sup>91</sup> *FTC v. Brown Shoe Co.*, 384 U.S. 316 (1966).

which apply to exclusive dealing in services as well as goods and commodities. Tying arrangements, a variety of exclusive dealing whereby a consumer is forced to buy one product or service to obtain another, may raise issues under section 3 of the Clayton Act, section 1 of the Sherman Act and section 5 of the Federal Trade Commission Act. Both practices have raised complex issues in the context of antitrust review of conduct involved in providing health care services and are likely to raise difficult issues for resolution by legislation promising reform.

For example, in *Jefferson Parish Hospital District No. 2 v. Hyde*,<sup>92</sup> the plaintiff challenged the denial of his application to provide anesthesiology services at the defendant hospital. The hospital had entered into an exclusive dealing contract with a firm of anesthesiologists to provide anesthesiology services for all patients at the hospital, thereby foreclosing competing providers of the service from offering the service at the hospital. The Court analyzed the effect of the contract in two "markets": first, the market for consumers of medical service, and second, the market for providers of anesthesiology services. In the first market, the contract was analyzed as a tying arrangement because patients at the hospital needing the service were forced to use the services of the firm the hospital had contracted with. In the second market, the case was analyzed as an exclusive dealing case. In both markets, the Court found no violation because the hospital lacked market power for hospital services in the geographic market and a substantial volume of commerce was not foreclosed by the restraint.<sup>93</sup> Whether described as a tying arrangement or a packaged sale, the requirement that patients at the hospital use the serv-

---

<sup>92</sup> 466 U.S. 2 (1984).

<sup>93</sup> The hospital had approximately 30% of the general hospital market in the East Bank area of Jefferson Parish. Under the Clayton Act, a 23% market share was considered sufficient to raise the risk that an exclusive dealing arrangement may tend to lessen competition. See *Standard Oil Co. v. United States*, 337 U.S. 293 (1949). The *Jefferson Parish* case had to be brought under the Sherman Act because the products involved were services, not goods or commodities.

ices provided by the contract provider was found not to injure competition because patients were free to use the services of other hospitals using other anesthesiologists.<sup>94</sup> In the absence of evidence demonstrating an injury to competition in anesthesiology services, the Court was unwilling to infer that the practice unreasonably restrained trade.<sup>95</sup>

---

<sup>94</sup> 466 U.S. at 25. The presence of market power can result in a finding of violation. See *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440 (9th Cir. 1988) (excluding a nurse anesthesiologist found unlawful where hospital had 84% of general surgical market in Helena, Montana). The absence of market power in the hands of an HMO was found to undermine claims of an unlawful boycott by allergists terminated by the HMO for ordering excessive tests in *Hassan v. Independent Practice Ass'n, P.C.*, 698 F. Supp. 679 (E.D. Mich. 1988). The definition of product and geographic markets is considered crucial to the determination of "power." See *Collins v. Associated Pathologists, Ltd.*, 844 F.2d 473 (7th Cir. 1988), *cert. denied*, 488 U.S. 852 (upholding dismissal of exclusive dealing case for pathology services at a hospital by defining the product market as competition between pathologists and the geographic market as national market for pathologists). The problem is more complex however than a deductive process of first defining markets and then measuring "power" in the markets involved by a measurement of market share or some other quantitative standard. In *Eastman Kodak Co. v. Image Technical Services, Inc.*, 112 S. Ct. 2072 (1992), the Court approached the problem of identifying "power" inductively by requiring a factual analysis of the reality of the industry and practices involved, rather than presuming the concept of "power" could be determined by the dictates of a model divorced from the reality of the business involved in the case. The concepts of "market" and "power" should be understood as analytical means to the end of determining whether the policies of the law have been violated. See John J. Flynn, *Antitrust Policy and the Concept of a Competitive Process*, 35 N.Y.L. SCH. L. REV. 893 (1990).

<sup>95</sup> The conclusion in *Jefferson Parish* that patients were free to use the services of other hospitals if they wished to use anesthesiologists other than those given the exclusive right to provide such services at Jefferson Parish Hospital, assumes that consumers knew of the exclusive dealing contract at the hospital and were free to choose some other hospital for their surgery. The latter assumption includes the assumption that the patient's surgeon was able to practice at competing hospitals. Assuming both facts may no longer be permissible after the *Eastman Kodak* case requiring a trial of the facts of the dispute rather than the assumptions of fact a particular judge may hold.

*Jefferson Parish* did not immunize exclusive dealing and tying arrangements in health care from antitrust review,<sup>96</sup> particularly where one can show that the anticompetitive effect of the arrangement is due to market power of the party imposing the restraint. In *Key Enterprises of Delaware, Inc. v. Venice Hospital*,<sup>97</sup> the court of appeals reinstated a treble damage verdict awarded to a vendor of home medical equipment that claimed that an exclusive dealing arrangement between the dominant local hospital (approximately 80% of hospital admissions in the area) and a vendor steering home medical equipment supply business<sup>98</sup> to the joint venturer violated sections 1 and 2 of the Sherman Act. The court likened the arrangement to a reciprocal dealing arrangement and held "that where a plaintiff's evidence shows that one party has sufficient market power to unduly influence a second party to treat the first more favorably than the free market would otherwise dictate,

---

Market failure due to imperfect information, as well as third-party payment, make tying practices in health care both attractive to providers and pernicious for consumers and third-party payors. See R. Craswell, *Tying Requirements in Competitive Markets: The Consumer Protection Issues*, 62 B.U. L. REV. 661, 671 (1982) (tying and imperfect information).

<sup>96</sup> See *Blue Shield of Va. v. McCready*, 457 U.S. 465 (1982) (upholding standing of a consumer to sue for Blue Shield's refusal to reimburse plaintiff for psychotherapy services provided by a psychologist unless the treatment was provided by a psychiatrist or was billed through and supervised by a physician). The underlying claim in this case alleged a conspiracy between Blue Shield and physicians to exclude and boycott clinical psychologists from receiving compensation under Blue Shield plans.

<sup>97</sup> 919 F.2d 1550 (11th Cir. 1990), *vacated and reh'g granted*, 979 F.2d 806 (11th Cir. 1992).

<sup>98</sup> The market involved is called a "durable medical equipment" (DME) market and includes prosthetic devices, hospital beds, oxygen equipment, wheelchairs and walkers. The joint venturer supplier was given exclusive access to its co-venturer hospital's patients needing such services, and hospital personnel were instructed to steer DME business to the defendant supplier. After 2 years of the joint venture operation, plaintiff's market share had dropped from 72.8% of the DME market to 30% and the defendant supplier had jumped from a 9.2% market share to 61% of the market, despite providing inferior service. 919 F.2d at 1555.

and the second party acts in conformity with the reciprocal arrangement, the plaintiff has proved the existence of an arrangement which unreasonably restrains trade."<sup>99</sup> The court also sustained findings of a conspiracy to monopolize and an attempt to monopolize the market involved through use of the reciprocal dealing arrangement effectively displacing the competitive process for determining success or failure in the market for home medical equipment.<sup>100</sup>

Cases have also arisen challenging exclusive dealing arrangements imposed by insurance carriers on providers.<sup>101</sup> For example, in *Reazin v. Blue Cross & Blue Shield of Kansas*,<sup>102</sup> the Tenth Circuit upheld a treble damage verdict against the defendant Blue Cross for cutting off a large Wichita hospital from participating provider status with Blue Cross after the hospital was acquired by Hospital Corporation of America (HCA). HCA also operated a highly successful HMO in the area and competed with Blue Cross in the health care insurance business. The jury found that Blue Cross had conspired with competing hospitals to cut off the HCA hospital's participating provider status in violation of section 1 of the Sherman Act and that the defendant had violated section 2 of the Act by using its power in the health insurance market (approximately 60% in Kansas) to injure a competing insurance carrier.<sup>103</sup> The Tenth Circuit affirmed, finding sufficient evidence

---

<sup>99</sup> 919 F.2d at 1562.

<sup>100</sup> For similar cases involving alleged restraints in medical equipment markets, see *M & M Medical Supplies & Services, Inc. v. Pleasant Valley Hospital, Inc.*, 981 F.2d 160 (4th Cir. 1992); *Advanced Health-Care Services, Inc. v. Radford Community Hospital*, 910 F.2d 139 (4th Cir. 1990).

<sup>101</sup> For a thoughtful review of the cases and the issues involved in such circumstances, see Miller, *supra* note 37.

<sup>102</sup> 899 F.2d 951 (10th Cir. 1990).

<sup>103</sup> *Reazin v. Blue Cross & Blue Shield, Inc.*, 663 F. Supp. 1360 (D. Kan. 1987), *aff'd and remanded*, 899 F.2d 951 (10th Cir. 1990), *cert. denied*, 497 U.S. 1005 (1991).

to support the section 1 finding of conspiracy and that Blue Cross' 60% share of the insurance market in Kansas was sufficient to establish market power. The court also found that Blue Cross' practice of dealing only with hospitals unaffiliated with competing insurers did in fact injure competition.<sup>104</sup>

While other cases have refused to find that exclusive dealing contracts in the health care field injure competition in either health care insurance markets or the providing of health care services,<sup>105</sup> it is likely that more cases will arise in the future with the growth of HMOs and PPOs and the drive toward "managed competition" in health care markets. The crucial analytical concept in both exclusive dealing and tying cases is "power"; a functional concept in the analysis of several categories of antitrust disputes linking the normative goals underlying antitrust policy to the facts of particular cases,<sup>106</sup> the language of the particular law

---

<sup>104</sup> "We have little difficulty in concluding that Blue Cross' total conduct in this case—threatening to terminate Wesley's contracting provider agreement and reducing the maximum allowable payments for the remaining . . . hospitals, thereby coercing other hospitals into not doing business with Blue Cross competitors—constitute wilful maintenance of its monopoly power. A general intent to do so is amply supported by the record." 899 F.2d at 973.

<sup>105</sup> See, e.g., *Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985); *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986).

<sup>106</sup> Determining the relevance, meaning and application of the words of rules and the concepts they invoke to the facts of disputes cannot be sensibly accomplished without first determining—among other things—the purpose of the rules. Robert Bork correctly observed in *THE ANTI-TRUST PARADOX*, 50 (1978): "Antitrust policy cannot be made rational until we are able to give a firm answer to one question: What is the point of the law—what are its goals? Everything else follows from the answer we give." On the other hand, Bork's advocacy of the narrow goal of "maximization of consumer welfare" as defined by neoclassical economic theory and the use of a formalistic methodology for analyzing antitrust disputes, is inconsistent with the legislative history of the antitrust laws establishing broader purposes for the law than maximizing "consumer welfare" and modern understandings of the is and ought of legal reasoning. See Flynn, *supra* note 94.

invoked<sup>107</sup> and the practical consequences of finding or not finding the existence of power in the particular case and generally.<sup>108</sup> Depending on the theory of liability, the concept of power can be either a quantitative concept requiring proof of markets and a large market share<sup>109</sup> or it can be used as a qualitative concept for determining whether, under the facts and circumstances unique to a dispute, the competitive process is being displaced as the means for determining entrepreneurial success or failure in the private economic realm and consumer freedom to choose goods and services free of coercion displacing the competitive process determining choice.<sup>110</sup> Health care antitrust cases frequently involve

---

<sup>107</sup> The concept of "power" may have different meanings depending upon whether the action is a structural case brought under § 2 of the Sherman Act or a behavioral case brought under § 1 of the Sherman Act or § 3 of the Clayton Act. While the majority opinion in *Kodak* defined power as "the ability of a single seller to raise price and restrict output," 112 S. Ct. 2081, the concept is often used in the context of practices excluding competitors as well. See *Klor's, Inc. v. Broadway Hale Stores, Inc.*, 359 U.S. 207 (1959).

<sup>108</sup> Some of the particular and general consequences of the *Kodak* decision are explored in George A. Hay, *Is the Glass Half-Empty or Half-Full? Reflections on the Kodak Case*, 62 ANTITRUST L.J. 177 (1993); Robert H. Lande, *Chicago Takes It on the Chin: Imperfect Information Could Play a Crucial Role in the Post-Kodak World*, 62 ANTITRUST L.J. 193 (1993); Gordon V. Spivack & Carolyn T. Ellis, *Kodak: Enlightened Antitrust Analysis and Traditional Tying Law*, 62 ANTITRUST L.J. 203 (1993).

<sup>109</sup> *Northern Pacific Ry. Co. v. United States*, 356 U.S. 1 (1958); *International Salt Co. v. United States*, 356 U.S. 1 (1947).

<sup>110</sup> Thus in *Kodak*, Kodak could be found to have economic power over the customers of its machines if it could be found to "force a purchaser to do something he would not do in a competitive market." 112 S. Ct. at 2080. The concept "power" is being used in such circumstances to link the goals underlying antitrust policy to the facts of the case and the consequences of permitting or not permitting the practice in question. As in other practices denominated "per se" violations, the inquiry is directed to whether the practice is one displacing a competitive process determining the success or failure of competitors or the freedom of consumers to choose goods and services on the basis of price and quality.

restraints demonstrating the use of both meanings of power to find that conduct constitutes an unlawful exclusive dealing, tying arrangement or other form of anticompetitive conduct.<sup>111</sup> Consequently, any reform of health care financing and delivery of services must be sensitive to both forms of power and the variety of contexts where antitrust policy is said to be violated by the unjustified exercise of power displacing the competitive process.

5. HEALTH CARE MERGERS AND JOINT VENTURES In most areas of the country there is a significant excess supply of hospital space;<sup>112</sup> an excess caused in part by many decades of paying for

---

It is an example of antitrust policy being loyal to its roots. For example, in *United States v. Addyston Pipe & Steel Co.*, 85 Fed. 271 (6th Cir. 1898), defendant manufacturers of cast-iron pipe engaged in a price-fixing contract sought to justify their agreement as a "reasonable" contract on the ground that it only applied to 30% of the capacity for cast-iron pipe in the country and that such a partial restraint was for the legitimate purpose of preventing ruinous competition. Justice Taft held that "no conventional restraint of trade can be enforced unless the covenant embodying it is merely ancillary to the main purpose of a lawful contract, and necessary to protect the covenantee in the enjoyment of the legitimate fruits of the contract, or to protect him from the dangers of an unjust use of those fruits by the other party. . . . [T]he covenant must be one in which there is a main purpose, to which the covenant in restraint of trade is merely ancillary." 85 Fed. at 282.

Kodak's insistence that purchasers of its machines use Kodak supplied parts and repair services, was a covenant imposed on purchasers of machines without justification and denying them the freedom to use other suppliers of services and parts and excluded competing suppliers of service and parts. As such it is a case where market definitions and "power" are being used as tools for a qualitative analysis to explore the facts and circumstances of the dispute in view of a broader complex of goals than that admitted by analyzing the case in light of the narrow goals of a model. See Lande, *supra* note 108.

<sup>111</sup> Compare *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984), with *Summit Health, Ltd. v. Pinhas*, 111 S. Ct. 1842 (1991).

<sup>112</sup> There has been a significant decline in hospital occupancy rates from a 72%–76% rate in the 1970s to rates running from 50%–63% in the 1980s. See Jonathan B. Baker, *The Antitrust Analysis of Hospital Merg-*

hospital costs on a fee-for-service reimbursement insurance system thereby providing little or no incentive for doctors or patients to minimize or limit the use of hospital facilities and services being paid for by third-party insurance. In the 1970s, it was believed that the incentives to build excess hospital capacity could be controlled by requiring governmental approval before construction projects or major equipment purchases were undertaken by requiring Certificates of Need (CON).<sup>113</sup> Federal incentives for state CON regulation were abandoned in the 1980s with the shift to reimbursement for federally funded health care programs on a prospective payment basis instead of a fee-for-service one.<sup>114</sup>

The combination of excess capacity, the growing shift from cost-plus reimbursement to prospective payment for services and a growing overcapacity with the removal of government limitations upon new hospital construction by abolishing CON regulation triggered a hospital merger movement during the 1980s.<sup>115</sup> The trend of the 1980s appears to be building into a "surge" in the 1990s in light of the prospects of a major overhaul of health care financing accompanied by significant cost controls threatening the earning power of hospitals operating at less than efficient capacity.<sup>116</sup>

---

*ers and the Transformation of the Hospital Industry*, 51 LAW & CONTEMP. PROBS. 93, 98 n.27 (1988).

<sup>113</sup> The National Health Planning & Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

<sup>114</sup> See Baker, *supra* note 112, at 97-98.

<sup>115</sup> *Id.*: "Hospital mergers, once rare in the United States, have grown commonplace in the current decade. During the early 1980s, acquisitions or consolidations occurred at the rate of roughly two hundred per year, dramatically higher than the yearly rates of fifty in 1972 and five in 1961."

<sup>116</sup> See George Anders, *Merger of Hospitals Surge Amid Pressures to Cut Costs*, WALL ST. J., Dec. 1, 1993, at B1, col. 1, stating that "[m]erger mania is sweeping through the nation's 5,400 acute-care hospitals" in light of the need to "avoid the costs of duplicating services" and be more

While there has been some controversy over the Clayton Act's section 7 jurisdiction of the FTC over asset acquisitions by non-profit entities,<sup>117</sup> to the extent that section 7 of the Clayton Act

---

responsive to "the needs of managed-care entities. . . ." It should be noted, that there is also a trend of mergers by suppliers of health products and services raising antitrust issues. See *Roche Holding Ltd.*, 5 Trade Reg. Rep. (CCH) ¶ 22,879 (F.T.C. 1990) (holding that a pharmaceutical company acquisition of Genentech, Inc., a biotechnology company, required divestiture of certain product lines); *E-Z-EM, Inc.*, 5 Trade Reg. Rep. (CCH) ¶ 22,859 (F.T.C. 1990) (finding that an acquisition of one barium diagnostic product firm by another required divestiture); *Amer-sham International plc*, 5 Trade Reg. Rep. (CCH) ¶ 22,838 (F.T.C. 1990) (deciding that acquisition of firm manufacturing radioactive compounds for use in brain scanning technologies requiring divestiture).

<sup>117</sup> See Baker, *supra* note 112, at 112-13; Miles, *Hospital Mergers and the Antitrust Laws: An Overview*, 29 ANTITRUST BULL. 253 (1984); Note, *Antitrust and Nonprofit Entities*, 94 HARV. L. REV. 802 (1981). In *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va. 1989), *aff'd, unpublished opinion*, 892 F.2d 1042 (4th Cir. 1989), the district court held that § 7 does not apply to the merger of two nonprofit hospitals. The argument is based on the fact that there is no stock acquisition in acquisitions of nonprofits and the acquisition is usually a pure asset acquisition. Section 4 of the FTC Act excludes FTC jurisdiction over nonprofits and it was argued that this means the language of § 7 limiting jurisdiction over asset acquisitions to those by persons "subject to the jurisdiction" of the FTC deprived the FTC of jurisdiction. The unpublished circuit-court opinion in *Carilion* affirmed the lower court finding of no violation on other grounds and did not reach the question of whether § 7 applies to asset acquisitions by nonprofit hospitals.

Judge Posner, in *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990), *cert. denied*, 498 U.S. 920, was confronted with the same issue and rejected the argument that the FTC lacks jurisdiction over asset acquisitions by nonprofits. He found that the language in § 7 referring to FTC jurisdiction was referring to the FTC's jurisdiction defined by § 11 of the Clayton Act, 15 U.S.C. § 21, and not that defined in § 4 of the FTC Act, 15 U.S.C. § 44. Posner held, however, that since the government failed to raise the argument and analysis of statutory language that Posner discovered, the government waived the argument and could not proceed on a Clayton Act § 7 theory, but could rely only on a Sherman Act § 1 claim that the merger constituted an unreasonable restraint of trade. The Eleventh Circuit subsequently upheld FTC jurisdiction over nonprofit asset acquisitions on the theory suggested by Judge Posner in *FTC v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991).

does apply, it is a potentially significant barrier to hospital mergers and acquisitions.<sup>118</sup> In a hospital merger or acquisition case, geographic and product markets are narrowly defined due to the localized nature of hospital services<sup>119</sup> and the tendency of most hospitals to provide overlapping services or a "cluster" of overlapping services.<sup>120</sup> Many local health care markets are concentrated to begin with, and further acquisitions are likely to meet

---

<sup>118</sup> In the *Rockford* case, *supra* note 117, the market share of the two merged hospitals in the Rockford area amounted to between 64% and 72% and the estimated three-firm market share was 90%; concentration ratios clearly sufficient to prove a § 7 violation if the court had applied the incipiency standard found in § 7. Judge Posner upheld a finding that this large percentage of market share for the merged firms and the concentration ratio in the market constituted a violation of § 1 of the Sherman Act because it made it easier for the firms "to collude." In the course of reaching this conclusion, Posner suggested that the test for proving a violation of § 1 of the Sherman Act and the test for proving a violation of § 7 of the Clayton Act were the same: "Both statutes as currently understood prevent transactions likely to reduce competition substantially," 898 F.2d at 1283, and that the claim that § 7 prevents "*probable* restraints and section 1 *actual* ones is word play." *Id.* (emphasis in original). Such a holding, equating § 7's incipiency standard with ease of collusion, appears contrary to the purpose for amending § 7 in 1950 and to the express wording of the statute. See *Brown Shoe Co. v. United States*, 370 U.S. 294, 311-23 (1962); DAVID MARTIN, *MERGERS AND THE CLAYTON ACT* (1959).

<sup>119</sup> See Baker, *supra* note 112, at 141-48; Michael A. Morrisey et al., *Defining Geographic Markets for Hospital Care*, 51 *LAW & CONTEMP. PROBS.* 165 (1988).

<sup>120</sup> See *Hospital Corp. of America v. FTC*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987) (holding that an acquisition of four hospitals in Chattanooga, Tennessee measured in terms of the hospital market in Chattanooga reduced number of competitive hospitals from 11 to 7 and raised the acquiring firm's market share from 14% to 26%; raised the four-firm concentration ratio from 79% to 91%; FTC finding that the acquisition may tend to lessen competition, upheld in opinion by Posner, J.). The "cluster of services" approach for defining product markets first arose in *United States v. Philadelphia Bank*, 374 U.S. 321, 356-57 (1963). While it is an attractive approach for dealing with product market definitions in hospital acquisitions, it does pose some difficulties. See Baker, *supra* note 112, at 123-40.

whatever standard is relied upon to prove a particular acquisition heightens concentration and facilitates collusion.<sup>121</sup> Consequently, in undoing the incentives to overbuild capacity and increase the efficient use of local hospital facilities, section 7 may become a significant factor in constraining mergers and acquisitions, unless defenses like the failing firm defense come into play, or specific federal legislation mandates otherwise and specifically exempts hospital mergers from section 7 of the Clayton Act.<sup>122</sup>

---

<sup>121</sup> See *Ukiah Valley Medical Ctr. v. FTC*, 911 F.2d 261 (9th Cir. 1990) (court refused to enjoin FTC decision to proceed with a complaint against an asset acquisition by one hospital (43 beds) in Ukiah, California of the assets of another (51 beds) in the same area giving the acquiring firm a 90% plus market share in acute hospital services in Mendocino and Lake Counties); *FTC v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991), 5 Trade Reg. Rep. (CCH) ¶ 23,218 (1992) (upholding proposed consent order barring acquisition (630-point rise in Herfindahl-Hirschman index (HHI) to 3200) in acute care hospital market in Augusta, Georgia area as result of merger challenged by the FTC); *Columbia Hospital Corp.*, 5 Trade Reg. Rep. (CCH) ¶¶ 23,333, 23,450, 23,475 & 23,476 (F.T.C. 1993) (complaint challenging acute care hospital acquisition in three-county area of Florida and consent order divesting control of hospital); *Maine v. Cardiovascular & Thoracic Associates*, 1992-2 Trade Cas. (CCH) ¶ 69,985 (Sup. Ct., Kennebec Co. 1992) (consent decree in state case to enjoin conduct by merged firm providing 60% of the cardiac surgery in only medical facility in southern Maine). See also *Nelson v. Monroe Regional Medical Ctr.*, 925 F.2d 1555 (7th Cir. 1991), *cert. denied*, 112 S. Ct. 285 (upholding standing of treble damage claimant denied service after acquisition of clinic where plaintiff was treated in the past in a highly concentrated local health care market).

<sup>122</sup> A complex state action issue may be arising with the adoption of state laws authorizing horizontal agreements by hospitals and other health care providers for sharing or allocating facilities or programs, laboratories, etc., between competing hospitals. See 12 M. REV. STAT. title 22, §§ 1881-1888 (1991); 7 MINN. STAT. ANNOT. § 62J.29 (1992); OHIO REV. CODE ANN. title 37, § 3727.21-.24 (Page 1992); WASH. REV. CODE title 70, § 70.44.450 (1992); 1992 Wis. Legis. Serv., Act 250 (West). North Dakota recently adopted a similar law permitting cooperative agreements among health care providers subject to review by the State Department of Health and Consolidated Laboratories. See 65 ATRR (BNA) No. 1622, at 63 (July 8, 1993).

To date, the enforcement agencies have used section 7 sparingly except where acquisitions raise significantly concentration ratios in local acute care hospital markets.<sup>123</sup> Adoption of federal health care legislation mandating "managed care" and the collectivization of providers and consumers into bargaining groups, however, should accelerate the trend to eliminate excess hospital capacity and excessive duplication of services and equipment either by mergers or by joint ventures. In anticipation of the growing pressure to rationalize excess hospital, medical equipment and physician service capacity, the enforcement agencies have issued *Enforcement Policy Statements in the Health Care Area*<sup>124</sup> spelling out "safety zones" for six areas: (1) hospital mergers; (2) hospital joint ventures sharing expensive high technology or equipment; (3) the collection and dissemination of information by physicians designed to influence practice parameters; (4) exchanges of price and cost information by hospitals; (5) joint purchasing arrangements by health care providers; and (6) physician joint ventures establishing independent practice associations

---

In order to escape the application of overriding federal antitrust policy, such state laws must "expressly authorize" the private agreements put in place and "actively supervise" the market divisions adopted. Most retain jurisdiction in the state's attorney general to review agreements and to revoke the arrangement. Whether "active supervision" must include supervision of the rates charged by what may become a monopoly over certain categories of care upon an agreement dividing up local hospital services, is unclear. It is doubtful that legislative statements, like Ohio's, of an intent that state officials provide "direction, supervision and control over approved cooperative agreements," OHIO REV. CODE ANN. title 37, § 3727.24, is "supervision" of the sort required for state action immunity. Intending supervision and providing active and objective supervision are quite different things after the *Ticor* case, *F.T.C. v. Ticor Title Insurance Co.*, 112 S. Ct. 2169 (1992). The issue may be coming to a head with the proposal of the three major hospitals in Portland, Maine to combine operations under supervision of a holding company and eliminate duplicative services. See *Hospital Plan in Maine Tests Antitrust Law*, WALL ST. J., Aug. 25, 1993, at B1.

<sup>123</sup> See cases cited *supra* note 121.

<sup>124</sup> The policies may be found in 64 ATRR (BNA) No. 1631 Special Supplement (Sept. 16, 1993).

(IPAs), PPOs and similar joint ventures to market services to group insurance and similar plans. Although well intended, it is difficult to assess the utility of the "policy statements" other than to suggest that mergers and joint ventures on their face are not illegal unless they threaten to or actually tend to lessen competition or tend to create a monopoly—in other words, violate the standards of section 7 presently in place.

Overcapacity and duplication of services has also led to a widespread and growing use of joint ventures in health care markets.<sup>125</sup> While joint ventures may make economic and practical sense in many circumstances, they may also become the vehicle for fixing prices, dividing customer and geographic markets or the monopolization of a category of goods or services.<sup>126</sup> Cases have arisen, for example, where hospitals have entered into "joint ven-

---

<sup>125</sup> The concept of a "joint venture" is surely a friendlier label than the concept "combination in restraint of trade," although joint ventures are "combinations" and may well "restrain trade" in some or all of their activities. See, e.g., *NCAA v. Bd. of Regents of the University of Oklahoma*, 468 U.S. 85 (1984); *Citizens Publishing Co. v. United States*, 394 U.S. 131 (1969); *Associated Press v. United States*, 326 U.S. 1 (1945). The "joint venture" label is usually applied where the joint action produces a new product or service. The combination or conspiracy in restraint of trade label is usually applied where there is no new product or service being provided by virtue of the joint activity. Both concepts have the potential to mask the factual differences underlying their appropriate uses.

Concepts should be recognized in law as functional tools of analysis to link facts to rules in light of policies and practical consequences and not as wooden premises of deductive logic to dictate results without regard for facts. See generally Flynn, *supra* note 94; Felix S. Cohen, *Transcendental Nonsense and the Functional Approach*, 35 COLUM. L. REV. 809 (1935).

<sup>126</sup> See Kevin Grady, *A Framework for Antitrust Analysis of Health Care Joint Ventures*, 61 ANTITRUST L.J. 765 (1993). For a broad review of antitrust regulation of joint ventures, see Joseph Brodley, *Joint Ventures and Antitrust Policy*, 95 HARV. L. REV. 1523 (1982); Donald I. Baker, *Compulsory Access to Network Joint Ventures Under the Sherman Act: Rules or Roulette?*, 1993 UTAH L. REV. 999.

tures" or exclusive dealing arrangements with suppliers of home medical equipment needed by patients discharged from the hospital unlawfully excluding competing suppliers from the market.<sup>127</sup> Although the parties labeled their practice a "joint venture," no new product or service was created by the joint effort. The market power of the hospital over its patients was being used to steer patients to its partner in the home health care market, a combination in restraint of trade in home health care markets rather than a laudable "joint venture" producing some new service or product.

Despite antitrust concerns with combinations in restraint of trade masking as "joint ventures" and competition reducing joint ventures, there is considerable discussion concerning the legitimation of the widespread use of joint ventures. Some states have sought to exempt local joint ventures from federal antitrust scrutiny by special legislation affirmatively authorizing health care joint ventures.<sup>128</sup> Some states have adopted legislation imposing rate regulation on hospitals, presumably a way of controlling monopoly pricing power that might arise out of hospital mergers or joint ventures monopolizing particular categories of treatment or equipment.<sup>129</sup> State legislation simply exempting local joint ven-

---

<sup>127</sup> See *Key Enterprises of Delaware, Inc. v. Venice Hospital*, 979 F.2d 806 (11th Cir. 1990); *Advanced Health-Care Services, Inc. v. Radford Community Hospital*, 910 F.2d 139 (4th Cir. 1990); *M & M Medical Supplies & Serv., Inc. v. Pleasant Valley Hospital, Inc.*, 981 F.2d 160 (4th Cir. 1992).

<sup>128</sup> See state statutes cited *supra*, note 122.

<sup>129</sup> The degree and methodology of rate regulation imposed varies considerably in those states adopting this approach to controlling hospital costs. See 6 CONN. GEN. STATS. ch. 368c, §§ 19a-145, *et seq.* (1993); 1992 Fla. Sess. Law Serv., ch. 92-33, §§ 408.001, *et seq.* (West); 12 M. REV. STAT. ANN. tit. 22, §§ 381, *et seq.* (1992); MD. CODE ANN. §§ 19-201, *et seq.* (1990); MASS. LAWS ANN., ch. 6A, §§ 31, *et seq.* (1988); N.J. STAT. ANN. §§ 26-2H-1, *et seq.*; N.Y. LAW ANN. §§ 2897, *et seq.* (Consol. 1993); 8 OR. REV. STAT. §§ 442.400, *et seq.* (1990); 5 W. VA. CODE ANN. §§ 16-29B-1 (1991). Hospital rate regulation authority in Washington and Wisconsin has been repealed. The complexities of rate regulating hospitals and the different approaches followed in other countries are extensively reviewed

tures from antitrust policy is not sufficient to immunize the anti-competitive consequences of a state-authorized joint venture from federal antitrust policy. In *Federal Trade Commission v. Ticor Title Insurance Co.*,<sup>130</sup> the Supreme Court held that for a state regulatory policy to exempt conduct from federal antitrust policy, it must specifically exempt the anticompetitive conduct in question from antitrust policy and the state must “actively supervise” the exempted conduct. The Court defined “active supervision” as requiring determination of:

whether the state has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties. . . . [T]he analysis asks whether the State has played a substantial role in determining the specifics of the economic policy. The question is not how well state regulation works but whether the anticompetitive scheme is the State’s own.<sup>131</sup>

The mere potential of state supervision by way of a veto of the privately set rates is not sufficient supervision of the conduct to make it the state’s own.<sup>132</sup> Consequently, state laws authorizing

---

in WILLIAM A. GLASER, *PAYING THE HOSPITAL: THE ORGANIZATION, DYNAMICS AND EFFECTS OF DIFFERING FINANCIAL ARRANGEMENTS* (1987).

<sup>130</sup> 112 S. Ct. 2169 (1992).

<sup>131</sup> 112 S. Ct. at 2177. The Court explained its insistence upon “active supervision” as necessary to insure that the states “accept political responsibility for actions they intend to undertake” and that where states “choose to displace the free market with regulation, our insistence on real compliance with both parts of the . . . [state action] test will serve to make clear that the State is responsible for the price fixing it has sanctioned and undertaken to control.” *Id.* at 2178.

<sup>132</sup> In *Ticor*, the Court held: “Where prices or rates are set as an initial matter by private parties, subject only to a veto if the State chooses to exercise it, the party claiming the immunity must show that state officials have undertaken the necessary steps to determine the specifics of the price-fixing or ratesetting scheme. The mere potential for state supervision is not an adequate substitute for a decision by the State.” 112 S. Ct. at 2179.

In two of the state regulatory programs under review in *Ticor*, state “review” of the rates set was by a “negative option” by which the rates

health care joint ventures having anticompetitive effects must include a mechanism for active and independent state supervision of the conduct restraining trade rather than just a potential veto by state officials to escape review under federal antitrust standards.

An analogous issue may arise at the federal level with the adoption of health care reform legislation under the doctrines of primary, concurrent and exclusive jurisdiction where federal health care legislation authorizes conduct impinging upon the ideal of a competitive process without spelling out how antitrust policy is altered or amended.<sup>133</sup> A key part of "managed competition" proposals is the collectivization of providers into groups to bargain with organized consumer buying groups. A major set of issues that will need to be spelled out in some detail by any reform proposal is the degree to which provider groups may be organized as joint ventures and engage in exclusive dealing arrangements and the extent to which such joint ventures will

---

came into effect if the state regulatory agency did not veto them within a specified time. There was no evidence of independent state review of the rates set for anything other than mathematical accuracy in the two states having a negative option scheme of review. In two states where there was some evidence of independent review by a state regulatory authority, the Court remanded for further proceedings on the question of whether the "supervision" was "active supervision."

<sup>133</sup> The doctrines of primary, exclusive and concurrent jurisdiction in such circumstances are explored in LOUIS B. SCHWARTZ ET AL., *supra* note 14, at 798-809. The analogy to the judicially created state action defense should not be pressed too far because the issues do not involve a weighing of federalism concerns but involve questions of legislative intent to displace competition where Congress has not clearly addressed the circumstances at issue. The courts have fashioned a process of reconciling the particular scope of regulation imposed with the generalized policy of relying upon a competitive process found in the antitrust laws under the concepts of primary, exclusive and concurrent jurisdiction. For an excellent example of the analytical process followed, see Judge Greene's opinion in an early phase of the AT&T antitrust case leading up to the breakup of AT&T, *United States v. American Telephone & Telegraph Co.*, 461 F. Supp. 1314, 1320-30 (D.D.C. 1978), excerpt quoted *infra* note 136.

be subject to antitrust constraints or some form of affirmative regulatory supervision.<sup>134</sup>

### III. Health care reform legislation

It is an understatement to observe that there is a general consensus, at least among the public, that the financing, structure, and operation of the health care delivery system is in need of significant reform.<sup>135</sup> Whichever framework for reform is put in place must take account of the assumption that either antitrust policy regulates the structure of and conduct in the health care industry, or that affirmative regulation of both is imposed, or some combination of antitrust and regulation are imposed on the industry. The interrelationship of antitrust and affirmative regulation must be spelled out and sensitively supervised, lest it be held that antitrust policy applies in the absence of a clear intent to provide otherwise or a gap is opened up where neither the antitrust laws nor affirmative government regulation applies.<sup>136</sup> It is doubt-

---

<sup>134</sup> An excellent beginning point for an analysis of many of the issues raised by health care joint ventures is Grady, *supra* note 126. See also Robert J. Enders, *An Introduction to Special Antitrust Issues in Health Care Provider Joint Ventures*, 61 ANTITRUST L.J. 805 (1993).

<sup>135</sup> Theodore R. Marmor & Michael S. Barr, *Making Sense of the National Health Insurance Reform Debate*, 10 YALE L. & POL'Y REV. 228, n.5 (1992) (reporting that 89% of the public agree that the U.S. health care system is in need of "fundamental change" or "complete rebuilding"); see also Edward A. Goetas III, *Health Care: The Issue for the Nineties*, 10 YALE L. & POL'Y REV. 220 (1992).

<sup>136</sup> Judge Greene in *United States v. American Tel. & Tel. Co.*, 461 F. Supp. 1314, 1320-30 (D.D.C. 1978), holding FCC regulation did not oust antitrust jurisdiction over alleged monopolization of the telephone industry by AT&T, spelled out the analytical methodology as follows: "Broadly speaking the antitrust laws are rooted in the proposition that the public interest is best protected by competition, free from artificial restraints such as price-fixing and monopoly. The theory of regulation, on the other hand, presupposes that with respect to certain areas of economic activity the judgment of expert agencies may produce results supe-

ful that the public or segments of the industry would long put up with a gap where neither antitrust policy nor regulation control pricing discretion, resource allocation or market access by providers. The failure of a competitive process to function in several areas of health care and subject those failures to regulation by the competitive process or some form of affirmative regulation has led to rapid inflation of costs. In addition, the failure to enforce competition or impose regulation has led to inequities in the distribution of resources and the rapid growth of health care antitrust litigation over the past decade reviewed in the first part of this article.

A fundamental issue with widespread antitrust-regulatory implications is how will health care be financed to balance goals of equity reflected by the now widely held assumption that universal access to health care be provided for all and the demand for efficiency in the delivery of health care services if we are to

---

rior to those of the marketplace, and that for this reason competition in a particular industry will not necessarily serve the public interest.

. . . . .

“The Supreme Court has repeatedly noted that ‘repeals of antitrust laws by implication from a regulatory statute are strongly disfavored, and have only been found in cases of plain repugnancy between the antitrust and regulatory provisions.’

“Regulated industries are not per se exempt from the Sherman Act, and they are not necessarily exempt even if the conduct complained of in an antitrust context has been expressly approved by the agency charged with regulating the particular industry.

. . . . .

“Regulated conduct is, however, deemed to be immune by implication from the antitrust laws in two relatively narrow instances: (1) when a regulatory agency has, with congressional approval, exercised explicit authority over the challenged practice itself (as distinguished from the general subject matter) in such a way that antitrust enforcement would interfere with regulation, and (2) when regulation by an agency over an industry or some of its components or practices is so pervasive that Congress is assumed to have determined competition to be an inadequate means of vindicating the public interest.”

afford universal access without curbing innovation or imposing undue and expensive bureaucratic burdens upon the delivery of services. While the various options from traditional fee-for-service to total socialization of health care are too complex to explore fully here, the outlines of some of the options likely to be considered in the United States and the interplay of antitrust policy with them can be tentatively explored.

After extensive review of health care financing options and in light of a fundamental commitment to provide universal access to health care services, the Clinton administration has proposed adoption of a "managed competition" Health Security Act;<sup>137</sup> a method for financing and regulating the supply of health care services first suggested by Professor Alain C. Enthoven.<sup>138</sup> Under the proposed Clinton plan, consumers would be guaranteed comprehensive health care coverage,<sup>139</sup> and be required to join a health

---

<sup>137</sup> Health Security Act, H.R. 3600, S. 1757 (103d Cong., 1st Sess. 1993). The President's message sending the Bill to Congress may be found in U.S. CODE CONG. & AD. NEWS, December 1993, No. 10, at D. 37. Alternative bills have been introduced in the first session of the 103d Congress, including: a single payor bill, H.R. 1200; a conservative Democratic bill avoiding mandated payments by employers, H.R. 3222; a bipartisan bill, S. 1579; a moderate Republican bill, S. 1770; and conservative Republican bills, H.R. 3080 and S. 1743.

<sup>138</sup> Professor Alain Enthoven's critique of the existing system, its faults, and the remedy of managed competition are fully explored in his book: *THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE* (1988). See also D. Yao, *Health Care Managed Competition—FTC Member's View*, 7 Trade Reg. Rep. (CCH) ¶ 50,100 (1993).

<sup>139</sup> Section 1001 of the Act guarantees every eligible individual a "comprehensive benefit package." Section 1101 of the Health Security Act, defines the scope of coverage plans must provide as including: Hospital services (defined in § 1111); services of health professionals (described in § 1112); emergency and ambulatory medical and surgical services (described in § 1113); clinical preventive services (described in § 1114); mental health and substance abuse services (described in § 1115); family planning services and services for pregnant women (described in § 1116); hospice care (described in § 1117); home health care (described in § 1118); extended care services (described in § 1119);

plan<sup>140</sup> offered through a state-created "regional alliance"<sup>141</sup> that will contract with providers organized through the intermediary of

---

ambulance services (described in § 1120); outpatient laboratory, radiology, and diagnostic services (described in § 1121); outpatient prescription drugs and biologicals (described in § 1122); outpatient rehabilitation services (described in § 1123); durable medical equipment and prosthetic and orthopedic devices (described in § 1124); vision care (described in § 1125); dental care (described in § 1126); health education classes (described in § 1127); and investigational treatments (described in § 1128).

The definitions of each category of care and § 1141 of the Act defines several exclusions from coverage like services not medically necessary or appropriate, custodial care and cosmetic surgery. A National Health Board, created by §§ 1501–06, is to further define the scope of plan coverage set forth by § 1151. Implicit in this grant of authority is the power to ration health care paid for by approved plans. See Ronald Dworkin, *Is Clinton's Plan Fair?*, N.Y. REV. BOOKS, Jan. 13, 1994, at 20.

<sup>140</sup> Section 1002 of the proposed Act provides:

(a) In General. In accordance with this Act, each eligible individual (other than a medicare-eligible individual)

- (1) must enroll in an applicable health plan for the individual, and
- (2) must pay any premium required, consistent with this Act, with respect to such enrollment.

(b) Limitation on Disenrollment. No eligible individual shall be disenrolled from an applicable health plan until the individual

- (1) is enrolled under another applicable health plan, or
- (2) becomes a medicare-eligible individual.

<sup>141</sup> Section 1202 of the Act requires each state to establish one or more regional alliances. Section 1301 of the proposed Act defines a regional alliance as: "In this Act, the term 'regional alliance' means a non-profit organization, an independent state agency, or an agency of the State. . . ."

It is envisioned that regional alliances will be of two types: state sanctioned multi-employer alliances and large employer alliances. Under § 1321 of the Act, alliances will contract with state approved health plans to offer health care services to employees electing a particular plan offered by the alliance. Section 1322 of the proposed Act provides:

Each health alliance must provide to each eligible enrollee with respect to the alliance a choice of health plans among the plans which have contracts in effect with the alliance under section

state approved HMOs, PPOs, and similar group provider plans.<sup>142</sup> Plans are required to accept all eligible applicants<sup>143</sup> and are pre-

---

1321 (in the case of a regional alliance) or section 1341 (in the case of a corporate alliance).

(b) Offering of Plans by Alliances.

(1) In general. Each regional alliance shall include among its health plan offerings at least one fee-for-service plan (as defined in paragraph (2)).

(2) Fee-for-service plan defined.

(A) In general. For purposes of this Act, the term "fee-for-service plan" means a health plan that

(i) provides coverage for all items and services included in the comprehensive benefit package that are furnished by any lawful health care provider of the enrollee's choice, subject to reasonable restrictions (described in subparagraph (B)), and

(ii) makes payment to such a provider without regard to whether or not there is a contractual arrangement between the plan and the provider.

<sup>142</sup> Section 1202 of the Act provides for certification of health care plans eligible for inclusion in the offerings by regional alliances:

(a) Criteria for Certification.

(1) In general. For purposes of this section, a participating State shall establish and publish the criteria that are used in the certification of health plans under this section.

(2) Requirements. Such criteria shall be established with respect to

(A) the quality of the plan,

(B) the financial stability of the plan,

(C) the plan's capacity to deliver the comprehensive benefit package in the designated service area,

(D) other applicable requirements for health plans under parts 1, 3, and 4 of subtitle E, and

(E) other requirements imposed by the State consistent with this part.

(b) Certification of Health Plans. A participating State shall certify each plan as a regional alliance health plan that it determines meet the criteria for certification established and published under subsection (a).

<sup>143</sup> Health Security Act, § 1402(a) provides:

(1) In general. Subject to paragraph (2), each health plan offered by a regional alliance or a corporate alliance must accept for enrollment every alliance eligible individual who seeks such

cluded from terminating coverage until the person is covered by another plan.<sup>144</sup> Health insurance coverage would be financed in most cases by employers paying 80% of the costs and employees contributing up to 20% of the costs and would be bought on a prospective basis for a period of 1 year, with consumers free to chose annually among presumably competing plans, including a fee-for-service option, based on quality and cost.<sup>145</sup>

Consumers choosing a group provider plan would be forced to limit their freedom of choice of doctors to those providing service

---

enrollment. No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics, such as health status, anticipated need for health care, age, occupation, or affiliation with any person or entity.

(2) Capacity limitations. With the approval of the applicable regulatory authority, a health plan may limit enrollment because of the plan's capacity to deliver services or to maintain financial stability. If such a limitation is imposed, the limitation may not be imposed on a basis referred to in paragraph (1).

<sup>144</sup> Health Security Act, § 1402(b).

<sup>145</sup> *Id.* § 1341. A variety of complex funding formulas are contained in the proposed Act in §§ 6021, *et seq.*, including a requirement for payments of part of the costs by families enrolled with a regional alliance plan found in §§ 6101, *et seq.* The mandate that all employers pay 80% of the funding costs has raised substantial opposition from small business interests opposed to paying employee health care costs and may prove to be a significant stumbling block to adopting the Clinton plan in its present form despite tax and other subsidies considerably reducing the burden for small business. See Rick Wartzman & Jeanne Saddler, *Motley's Crew: A Fervent Lobbyist Rallies Small Business to Battle Health Plan*, WALL ST. J., Jan. 5, 1993, at 1.

Professor Enthoven's plan, like the Clinton proposal, does not rely upon a totally free market, but requires "management" of the competition that can take place by inserting "active collective agents on the demand side, which I call sponsors, who contract with the competing health care plans and continuously structure and adjust the market to overcome its tendencies to failure." ENTHOVEN, *supra* note 138, at 82. Sponsors would serve as "the broker who structures the coverages, contracts with the health plan and beneficiaries regarding the rules of participation, manages the enrollment process, collects premium contributions from beneficiaries, pays premiums to health plans and administers cross subsidies among beneficiaries and subsidies available to the whole group." *Id.* at 83.

through the provider plan chosen by the consumer and would be limited to the coverage provided by the basic plan. Coverage over and above the basic plan would be available through supplemental plans consumers and/or employers would be required to finance on their own.<sup>146</sup>

The basic thrust of the Clinton proposal is to collectivize and make universal consumer access to health care through insurance purchasing groups financed by employers and/or government<sup>147</sup> to deal with collectivized provider groups competing with each other for the custom of the buyer groups. Competition among the plans for the business of purchasing groups, it is assumed, will drive down or keep in check the market failure of the traditional fee-for-service delivery system. However, if this approach is adopted the areas of recent significant antitrust litigation outlined above—health care financing, peer review, price fixing, exclusive dealing, and mergers and joint ventures—should be addressed in the legislation establishing the plan. Each area is in need of more explicit attention in the Clinton Health Security Act if competition is to be “managed” to secure both equity and efficiency.<sup>148</sup>

---

<sup>146</sup> Health Security Act, §§ 1421–23.

<sup>147</sup> One acronym gaining currency to describe one form of consumer collective is HIPC—Health Insurance Purchasing Cooperatives—a semigovernmental agency to contract with provider organizations on behalf of groups of small business purchasers and the otherwise uninsured.

<sup>148</sup> Professor Enthoven recognizes the need to enforce antitrust policy if a system of managed competition is to work. See ENTHOVEN, *supra* note 138, at 122. Aside from a general recognition of the need to regulate boycotts and price fixing, Enthoven does not spell out in any detail how antitrust policy and a system of managed competition would be integrated. For some of the complexities that will inevitably arise, see Rosemary Gibson & John B. Reiss, *Health Care Delivery and Financing: Competition, Regulation and Incentives*, in MARKET REFORMS IN HEALTH CARE 243 *et seq.* (Jack A. Meyer ed., 1983); Miller, *supra* note 37; Mark V. Pauly, *Competition in Health Insurance Markets*, 51 LAW & CONTEMP. PROBS. 237 (1988); Thomas Kauper, *The Role of Quality of Care Considerations in Antitrust Analysis*, 51 LAW & CONTEMP. PROBS. 273 (1988).

(footnote 148 continued)

While competition between plans for acceptance by a regional alliance is relied upon to control costs, the ability to control costs remains subject to cost inflation imposed by plan beneficiaries making excessive use of the plan. The underlying problem of market imperfections caused by third-party payment creates the risk, and the Health Security Act proposes complex premium caps<sup>149</sup> and family-share premiums,<sup>150</sup> in addition to competition among the plans offered, to control the risk. Whether premium caps will become bidding targets for plans or whether competition among plans will keep bids below the cap, is one of the major unknowns if the Clinton plan is adopted. From an antitrust perspective, it is clear that collusion among plans in the bidding process remains unlawful. On the other hand, the presence of a statutory method for setting price caps may be an invitation to make the cap the common bidding price without collusion.

---

The only explicit reference to the antitrust laws made in the Clinton proposal, Health Security Act § 5501, is an amendment of the McCarran-Ferguson Act, providing:

(a) In General. Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson Act, is amended by adding at the end the following:

(c) Notwithstanding that the business of insurance is regulated by State law, nothing in this Act shall limit the applicability of the following Acts to the business of insurance to the extent that such business relates to the provision of health benefits:

- (1) The Sherman Act (15 U.S.C. 1 et seq.).
- (2) The Clayton Act (15 U.S.C. 12 et seq.).
- (3) Federal Trade Commission Act (15 U.S.C. 41 et seq.).
- (4) The Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 21a et seq.), known as the Robinson-Patman Antidiscrimination Act.

(b) Effective Date. The amendment made by subsection (a) shall take effect on the first day of the sixth month beginning after the date of the enactment of this Act.

Section 1422 of the proposed Act prohibits tying the sale of a supplemental insurance plan to enrollment in a plan offered by a regional alliance.

<sup>149</sup> Health Security Act, §§ 6000–6041.

<sup>150</sup> *Id.* §§ 6101–6115.

Other issues requiring a sensitive and more explicit evaluation of the role of antitrust policy coexisting with the complex regulatory scheme involved in the Health Security Act need careful scrutiny if the cost of excessive antitrust litigation is to be minimized. For example, what terms and conditions will be imposed to establish a provider group as a single entity rather than a collection of independent providers fixing prices?<sup>151</sup> What standards

---

<sup>151</sup> Part 6 of the FTC and Antitrust Division *Enforcement Policy Statements in the Health Care Area*, *supra* note 124, defines a safety zone from antitrust review by the enforcement agencies (but not necessarily private parties) for physician joint ventures with 20% or less of a specialty and states that those outside of the safety zone will be reviewed on a rule of reason basis. The formality of organization is not spelled out and there remains the risk of finding implied agreements among and between joint ventures and their members. On the issue of implied agreements in health care, see, Anthony J. Dennis, *Hospitals, Physicians, and Health Insurers: Guarding Against Implied Agreements in the Health Care Context*, 71 WASH. U. L.Q. 115 (1993). Senators Hatch and Thurmond have introduced a complex bill, S. 1658, 103d Cong., 1st Sess. (1993) in response to physician concerns about antitrust liability for joint action by physicians to bargain collectively with insurers. See Edward Felsenthal, *Doctors Seek Easing of Antitrust Laws*, WALL ST. J., Jan. 3, 1994, at 12. The bill spells out in some detail the safety zone for doctor groups bargaining collectively with providers.

The Health Security Act, § 1203, delegates general authority to the states to certify plans without spelling out the legal structure of a plan; i.e., whether it must be in a corporate form or other legally recognized "person" for antitrust purposes.

At least for the fee-for-service plan, which must be offered by an alliance, specific mention of antitrust doctrine is made. Section 1322 of the Act authorizes states to set statewide fee for service schedules after negotiation with providers. Subsections (5) and (6) of § 1322 provide:

(5) Activities treated as State action or efforts intended to influence government action. The establishment of a fee schedule under this subsection by a regional alliance of a State shall be considered to be pursuant to a clearly articulated and affirmatively expressed State policy to displace competition and actively supervised by the State, and conduct by providers respecting the establishment of the fee schedule, including collective negotiations by providers with the regional alliance (or the State) pursuant to

will be applied to determine membership in a provider group and who will have the power to both include and exclude members?<sup>152</sup> What constraints will be imposed upon the formation of provider groups and buyer groups with monopoly power?<sup>153</sup> What limita-

---

paragraph (2), shall be considered as efforts intended to influence governmental action.

(6) No boycott permitted. Nothing in this subsection shall be construed to permit providers to threaten or engage in any boycott.

<sup>152</sup> The Health Security Act, § 1407 expressly authorizes plans to limit the number of providers belonging to the plan, requires enrollees in the plan to obtain services only from providers belonging to the plan and requires enrollees to receive specialized services from referrals made by participating providers in the plan. Providers excluded from membership in a plan will no doubt look to antitrust and other remedies where plans exclude them from membership, *see Winslow & Felsenthal, supra* note 38, at 1, or where membership in a plan forecloses membership in other plans. *See U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993) (holding that HMO employment contract offering doctors higher capitation payments in exchange for an agreement not to participate in other HMOs a lawful exclusive dealing contract, not a boycott).

While § 1407 of the Health Security Act preempts state laws prohibiting the exclusion of providers from belonging to a particular plan, some states have already adopted laws prohibiting insurers from excluding providers willing to meet the requirements of their group plans. Such laws undermine the reason for having a group plan if providers outside the plan are free to offer service at prices provided for by the plan and state law requires that insurers sponsoring a plan pay the fees of non-members abiding by the fees set. On the other hand, providers excluded from plans providing coverage for their patients will suffer a decline in income, and have been seeking various remedies for their plight. *See Winslow & Fesenthal, supra* note 38. The issue is a replay of the traditional battle between fee-for-service medicine and the shift to patients being bound to providers serving in their HMO, PPO or other form of collective practice.

<sup>153</sup> In many parts of the country there is not a sufficient base to provide for three or more competitive supplier plans. *See R. Kronick et al., The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition*, 328 *NEW ENG. J. MED.* 148 (1993). The Health Security Act, §§ 1221-1224, authorizes the establishment of single-payor systems which might meet objections of an insufficient base from which

tions will be imposed on hospitals and other providers merging or dividing up local product markets pursuant to state laws in the name of efficiency?<sup>154</sup> What limitations will be imposed on the

---

to establish competing plans so long as fees are set by an independent state agency. The general requirements for a valid state single-payor system are set forth in § 1222:

(1) Establishment by state. The system is established under State law, and State law provides for mechanisms to enforce the requirements of the plan.

(2) Operation by state. The system is operated by the State or a designated agency of the State.

(3) Enrollment of eligible individuals.

(A) Mandatory enrollment of all regional alliance individuals. The system provides for the enrollment of all eligible individuals residing in the State (or, in the case of an alliance-specific single-payer system, in the alliance area) for whom the applicable health plan would otherwise be a regional alliance health plan. . . .

Extensive regulations are imposed on single-payor systems with regard to medicare, corporate alliance and other plan beneficiaries, as well as in the supervision of the state single-payor system. The regulations imposed would probably satisfy the state action exemption from the antitrust laws where they are effectively administered by independent state authority.

<sup>154</sup> The Health Security Act does not deal explicitly with mergers and joint ventures among hospitals and health care providers other than to authorize 1-year exclusive dealing contracts between joint venture plans and consumers. The Antitrust Division and FTC statement of policy on mergers and joint ventures in health care, *supra* note 124 and accompanying text, only explain the existing antitrust constraints on such activities. Neither agency, of course, is authorized to amend the antitrust laws or establish standards to govern court interpretation of the statutes in government or private actions.

There is an extensive merger movement among hospitals in anticipation of some form of "managed competition" legislation being adopted. See Anders, *supra*, note 116. Widespread excess capacity and the risk of being excluded from having an exclusive dealing contract with large insurance plans, poses a serious risk to unaffiliated hospitals incapable of providing full service to all members of a plan. On the other hand, many mergers may raise local concentration levels for acute care hospital services well above the HHI index standards of the Merger Guidelines and pose serious enforcement questions for the FTC and Antitrust Division. Reform legislation should address the application of § 7 of the Clayton

bargaining power of powerful buyer groups and powerful supplier groups to insure that they do not use that power to exclude competitors, set artificially low or high prices or collude with competitors in concentrated markets?<sup>155</sup> What measures may be taken to insure that consumers locked into a particular HMO are not underserved in order to maximize the profits of the HMO or that the HMO will not take steps to minimize coverage of or exclude risky patients or expensive treatments?<sup>156</sup>

While the proposed Health Security Act has identified and sought to respond to some of these concerns,<sup>157</sup> many of the remedies for specific market failures lie with private bargaining (“managed competition”) between plan sponsors and providers or within these groups. Such bargaining, however, must take place within the limits of the legal regime that defines the scope of contract and property rights through basic laws like the state and federal antitrust laws. Tailoring this regulatory regime to the constraints of antitrust policy through legislation will be a challenging task—one of balancing the need for flexibility with the need to either constrain market failures and monopoly power with antitrust policy or by imposing some form of state or federal government affirmative regulation to curb the consequences of market failure.<sup>158</sup> Doing so, while also avoiding the costs of a complex

---

Act to hospital and other health care mergers, and if the incipiency standard is relaxed, substitute some form of regulatory oversight for what may otherwise become monopoly power in providing local hospital services by merged hospitals and hospital chains capable of supporting losses in one market from profits in another.

<sup>155</sup> See *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 899 F.2d 951 (10th Cir. 1990), *cert. denied*, 497 U.S. 1005 (1991); Yao, *supra* note 138.

<sup>156</sup> ENTHOVEN, *supra* note 138, at 87–90.

<sup>157</sup> See *supra* note 151.

<sup>158</sup> If an express statutory exemption for joint action by buyers and providers is to be considered at the federal level, the closest existing analogies that might provide a guide for drafting an exemption are those for agricultural cooperatives and organized labor. See, e.g., Clayton Act,

administrative bureaucracy to both negotiate constraints on market failures or to oversee the bargaining process envisioned and the monopoly power that might be created, raises the further question of whether there might be a cheaper and less complex alternative.<sup>159</sup>

---

§ 6, 15 U.S.C. § 17 (exempting formation of labor, agricultural and horticultural organizations “for the purpose of mutual help”); The Capper Volstead Act, 7 U.S.C. §§ 291–92 (authorizing agricultural associations to engage in joint marketing subject to regulation for monopolization by the Secretary of Agriculture); Clayton Act § 20, 29 U.S.C. § 52 (prohibiting injunctions in labor disputes “concerning terms and conditions of employment”); Norris-LaGuardia Act, 29 U.S.C. §§ 101–10 (protecting unilateral actions of labor and management in pursuit of their own goals from injunctions).

These exemptions were enacted in light of the unique characteristics of the activities involved and in light of the need to equalize bargaining power in what would be otherwise unequal bargaining circumstances. For an analysis of the exemptions, see, PHILLIP AREEDA, 1 ANTITRUST LAW 178–188 (agricultural exemption) & 188–222 (labor exemption) (1978); LOUIS B. SCHWARTZ ET AL., *supra* note 14, at 394–96 (agricultural exemption) & 1070–1165 (labor exemption). A managed competition system for regulating health care might also require an exemption authorizing limited joint buyer and seller conduct to equalize bargaining power through joint ventures, mergers or collective bargaining by otherwise independent competitors. Authority to control competitive abuses of the exemption, however, should be lodged in the Antitrust Division and the FTC rather than some specialized agency to minimize the risk of “regulatory capture” by powerful forces aligned on one or the other side of the market.

<sup>159</sup> One serious criticism of the Clinton proposal is that it would appear to add to the administrative bureaucracy presently plaguing health care. Gregg Easterbrook has observed: “In the name of cutting bureaucratic waste in health care Clinton proposes to abolish nothing, while creating an entirely new level of overhead in the form of large health-purchasing alliances; establishing the new National Health Board; and creating as many as 50 separate systems of medical care, since each state is to be free to devise its own approach to health administration.

“Excessive overhead is already the bane of American medicine, with studies estimating administrative expenses at around 20 percent of U.S. health care costs or a stunning \$168 billion in 1992—more than France and Germany combined spent of their entire health care systems in that

The principal alternative many advocate to managed competition is the Canadian system for financing health care. In Canada, the basic reform was to socialize insurance, but not the practice of medicine, by making provincial governments the primary third-party payor insuring all citizens of Canada. The provincial governments regulate the discretion of providers to charge what the traffic will bear by negotiation with provider groups.<sup>160</sup> The system is paid for through a series of provincial and federal taxes, much like our social security and welfare systems are financed. This reform achieves universal access, while leaving consumers free to select their own health care provider and method of treatment within the constraints of the limitations upon the negotiated plan and the willingness of providers to supply services at the pre-determined price. Doctors and other health care professionals are not made employees of the government and practice much as they do in this country, although there are province-mandated limits on charges for services (maximum rate regulation) and prohibitions on billing patients for any balance of the cost of providing them service over and above the government-negotiated fee. Proponents of this approach claim a major advantage over a managed competition approach is the minimizing of administrative overheads estimated by some to constitute 20% to 25% of total health care costs of the present system in the United States.<sup>161</sup> A single payor system, rather than a complex bargaining process by multiple pri-

---

year." *Major Surgery for Clinton's Health Care Plan*, WASH. POST W. ED., Oct 4-10, 1993, at 25.

<sup>160</sup> For reviews of the Canadian system see Marmor & Barr, *supra* note 135; Robert G. Evans, *The Canadian Health-Care Financing and Delivery System: Its Experience and Lessons for Other Nations*, 10 YALE L. & POL'Y REV. 362 (1992); Kaplan, *A Legal Perspective on National Health Insurance: Current Issues in Canada's Program*, 9 WIS. INT'L L.J. 515 (1991).

<sup>161</sup> See Eric Eckholm, *Study Links Paperwork to 25% of Hospital Costs*, N.Y. TIMES, Aug. 5, 1993, at A3; Robert G. Evans, *Tension, Compression, and Shear: Directions, Stresses, and Outcomes of Health Care Cost Control*, 15 J. HEALTH POL. POL'Y & L. 101, 115 (1990); Marmor & Barr, *supra* note 135, at 232-33.

vate parties and ongoing administration of the managed competition system by the parties and government, it is argued, would minimize what have become large administrative overheads.<sup>162</sup>

One overhead cost not often counted by proponents of the Canadian system is the cost of the method adopted for setting fees.<sup>163</sup> Fees are set through negotiation in each province between the provincial government and the provincial medical association. Fees are lower than in the United States although the volume provided by universal coverage and accessibility can make up for the lost physician income due to reduced fees for each procedure.<sup>164</sup> Consumers are free to select their own physician. With almost

---

<sup>162</sup> Evans, *supra* note 160, at 377-82. Among the costs avoided by a single-payor system are costs of monitoring competing private insurers and market failures like HMOs trying to escape insuring high-risk applicants in favor of maximizing profits. In addition, the current system of multiple insurers each using their own billing systems has created a paperwork nightmare. It is reported, for example, the Johns Hopkins Hospital is required to keep track of 18,000 different charge categories for 500 different insurance plans that pay bills for patients at the hospital. Billing procedures at the hospital are estimated to cost \$13 million per year. WASH. POST NAT'L WEEKLY, ED., May 17-23, 1993, at 9.

<sup>163</sup> In the United States we have had approximately 10 years of experience with prospective fee setting under Medicare and the establishment of DRGs specifying fees for specific treatments rendered individuals. See LOUIS B. SCHWARTZ ET AL., *FREE ENTERPRISE AND ECONOMIC ORGANIZATION: GOVERNMENT REGULATION* 591 *et seq.* (6th ed. 1985). For a critical empirical review of the program, see David Frankford, *The Medicare DRGs: Efficiency and Organizational Rationality*, 10 *YALE J. REG.* 273 (1993).

<sup>164</sup> Physicians in Canada continue to earn high salaries ranging in British Columbia from an average of \$300,000 for cardiologists, to \$240,000 for ophthalmologists, to \$128,000 for general practitioners. Robert G. Evans, *Health Care in Canada: Patterns of Funding and Regulation*, 8 *J. HEALTH POL'Y & L.* 1 (1983). A recent survey in the United States estimated the average yearly earnings of cardiovascular surgeons at \$574,769; diagnostic radiologists at \$309,556; anesthesiologists at \$253,511; and family practitioners at \$119,166. See Eric Eckholm, *Health Plan Is Toughest on Doctors Making Most*, *N.Y. TIMES*, Nov. 7, 1993, at 1.

50% of Canadian physicians engaged in family practice, as compared to 13% to 30%, depending on how one counts, in the United States, there is competition in Canada for providing family service and less of a tendency for patients to go to specialists first. Family physicians in turn, assume the primary responsibility for referring patients to specialists when needed.

Under the Canadian system there is also substantial government involvement in decisions to build additional hospital capacity and coordination of the purchase of expensive equipment, additional regulatory expenses not often counted by proponents of the system. Hospitals negotiate with provincial governments for an annual operating budget and through this mechanism, the government is able to control the building or retention of excess capacity, the acquisition of unnecessary and duplicative equipment and the pressure on hospitals to specialize in every possible procedure. Since government funding provides 95% of a hospital's funds in Canada, control of those purse strings can be used to prevent actions like those we see in many places in the United States—building more and more bed space when some hospitals are operating at 60% or less of capacity, the buying of expensive equipment duplicating that at other facilities, and trying to specialize in everything to compete with other hospitals doing the same.

If merger and monopolization regulation are to be reduced in the health care field by adopting the Canadian approach to financing and regulation, a complex issue of how hospital rates will be set must be confronted. States are beginning to enact legislation authorizing hospitals and other health care facilities to enter into "cooperative agreements" with other hospitals and facilities "for the sharing, allocation or referral of patients, personnel, instructional programs, support services and facilities or medical, diagnostic and laboratory services or procedures or other services."<sup>165</sup>

---

<sup>165</sup> 22 M. REV. STAT. ANN. § 1882 (1991). North Dakota adopted similar legislation in the spring of 1993. See 65 ATRR (BNA) No. 1622, at 63 (July 8, 1993). State Certificate of Need (CON) laws can be used to

This specific authorization for local hospitals to divide markets in the name of avoiding a costly competitive race duplicating facilities, specialties and equipment has much to commend it if one ignores the monopolistic potential of such arrangements. Simply authorizing the conduct without objective and ongoing supervision of the arrangement and the prices charged by the participants would obviously not meet the requirements of the state action exemption from the antitrust laws. One must confront the further question that if this kind of exemption for clearly per se illegal conduct is to be sanctioned, whether it must be accompanied by the further step of affirmative rate regulation of the activity in question where the market division creates a monopoly or unreasonable restraint of trade. If affirmative rate regulation is to be adopted, the form of rate regulation—cost of service, value of service, operating ratios, or some other method—that would be the preferred system of rate regulation in such circumstances must also be addressed.

Adoption of the Canadian approach in the United States is still a possibility although politically less likely than is the adoption of some version of managed competition.<sup>166</sup> If the Canadian system is adopted in the United States—and the administrative costs of the existing system and the costs and complexity of the proposed Health Security Act may drive us to it—considerable thought would have to be given to the establishment of a mechanism for setting fees of doctors, hospitals, and related activities, and how these price-setting mechanisms would relate to antitrust policy. If done by the federal or state governments, the challenge of estab-

---

control the proliferation of hospital programs in order to provide across the board services in light of likelihood that there will be group purchase of service on a fixed fee basis. *See Blood Feud—Heart-Surgery Battle in Michigan Is Struggle Over Cost, Care, Profit*, WALL ST. J., May 24, 1993, at 1 (CON regulation used to preclude establishment of new open heart surgery facilities; state has 28 hospitals offering the service and no need of additional facilities).

<sup>166</sup> See Hilary Stout & David Rogers, 'Single Payer' Concept for Health-Care Plan Is Alive and Well Despite Downgrading by Clinton, WALL ST. J., Dec. 31, 1993, at 32.

lishing specific fees for the hundreds of different services and procedures available without undue damage to the allocation of resources and innovation, may be overwhelming. We have experience with establishing fees for Medicare Diagnosis Related Groups (DRGs),<sup>167</sup> but would no longer have the flexibility of cross-subsidizing mistakes in setting DRG prices by raising prices in the third-party insured fee-for-service market.

While adoption of the Canadian system does offer the attractions of minimizing administrative costs and retaining freedom of patient choice, it must also be recognized that it suffers from relying upon a maximum price-fixing regime to control fees where maximum fees will likely become minimum ones; it requires the establishment of a centralized decision-making regime on how resources are to be allocated among different medical procedures and over capital investment decisions; and, it may impact seriously upon a central goal of antitrust policy—the stimulation of innovation.

In addition, adoption of the Canadian system would raise complex issues for integrating antitrust policy with the details of the plan adopted. For example, if family practitioners are to be relied upon as gatekeepers to control access to specialists, what antitrust standards will be applicable to the exercise of this discretion? To what extent will mergers of hospitals and other health care facilities be permitted where government is setting a cap on hospital fees and regulating hospital expansion and equipment acquisitions? To what degree will providers be permitted to band together to negotiate the terms and conditions of fees and to what extent will joint conduct be permitted to spill over into other areas of competitive concerns like credentialing and peer review? It is in the details and practical operation of the plan that difficult antitrust and regulatory alternative issues must be anticipated and provided for before legislation adopting some form of “managed

---

<sup>167</sup> For an overview of the use of prospective rate setting on an average cost basis used in setting fees for DRGs, see LOUIS B. SCHWARTZ ET AL., *supra* note 163, at 591–609; Frankford, *supra* note 163.

competition" or the Canadian single payor system can be made final.<sup>168</sup>

#### IV. Conclusion

Antitrust policy is not in need of resuscitation when it comes to the health care industry. It is in need of being more consistently used, not just for litigation purposes, but for purposes of determining which health care financing system and activities ought to be affirmatively regulated in lieu of antitrust policy and how best to implement the regulation found necessary. Health care is an industry that has too long been immune from rigorous review on fundamental legal and economic grounds, a fact for which we are now paying a heavy price in both extensive litigation and a major legislative effort to restructure the entire industry. The complexities of sorting out which road to follow in reforming health care are in large part due to the fact that the industry has evolved without being subject to serious and consistent antitrust or regulatory review. Anticompetitive practices and structures have evolved in the context of third-party payment on a fee-for-service basis, embedding in the public mind a right of access to health care services without realizing the ultimate individual responsibility to pay for them. Health care practitioners have also been operating on the assumption that they will be reimbursed without regard for the cost of what they do for the patient and without regard for the costs of the exercise of their discretion in determining a course of care. It is an industry structure and pattern of behavior that society has finally concluded we can no longer afford and one that must be reformed. And, it is an industry now in the course of

---

<sup>168</sup> There are other models from which the United States health care reform may borrow. See, e.g., Kirkman-Liff, *Physician Payment and Cost Containment Strategies in West Germany: Suggestions for Medical Reform*, 15 J. HEALTH POL. POL'Y & L. 69 (1990); Dukakis, *Hawaii and Massachusetts: Lessons from the States*, 10 YALE L. & POL'Y REV. 397 (1992); Garland, *Light on the Black Box of Basic Health Care: Oregon's Contribution to the National Movement Towards Universal Health Insurance*, 10 YALE L. & POL'Y REV. 409 (1992).

change as all concerned search for a new industry financing mechanism and standards for behavior capable of delivering service to all efficiently and fairly, without undue compromise of quality and innovation.

The goals of antitrust policy provide a guiding light for both suggesting paths of reform and measuring the wisdom of the reforms proposed, including the wisdom and consequences of any affirmative regulation that may be proposed in lieu of antitrust enforcement to address areas of market failure. Antitrust and affirmative regulation are not two incompatible regimes, but constitute two different means for achieving and insuring the common economic, social and political objectives gained by subjecting economic activity to a competitive process or government regulation seeking to mimic the consequences of a competitive process where competition is not possible.<sup>169</sup> Leaving the industry and reform proposals to continue along a path of no accountability to the political, social and economic goals sought by antitrust policy and responsible affirmative regulation is a solution we have been following for too many decades in health care and one that has created the plight we now find ourselves in. Finding the right mix of market and regulatory remedies is the great challenge of health care reform and one that may well take, and should take, decades to resolve in light of the complexities of the issues.

The proposals pending before Congress provide contrasting beginning points to the debate. While the Clinton administration deserves credit for the great strides that have been made in securing consensus on universal access, requiring cost containment and the need for legislative reform of financing methods for health care, neither the Health Security Act nor any of the other plans proposed to date appear to address adequately the details of how antitrust and regulatory policy should fashion reform and govern the future operation of the health care delivery system. The one

---

<sup>169</sup> Modern rationales for imposing affirmative government regulation on an industry or activity are summarized in LOUIS B. SCHWARTZ ET AL., *supra* note 163, at 64-66.

alternative society cannot afford is reform that allows the industry to escape accountability to the social, political and economic goals of antitrust policy whether they are to be realized by reliance upon a competitive process or by the imposition of an affirmative regulatory process seeking to achieve the goals antitrust enforcement and responsible regulation secure by maintaining or mimicking a competitive process. If Congress does not expressly address the issue of securing these goals by affirmative regulation in the areas of health care financing, peer review and credentialing, pricing for services, exclusive dealing, tying and mergers, the courts will be left with the complex task of reconciling antitrust policy with the ambiguities of whatever system is adopted. While the incomes of antitrust and regulatory lawyers may benefit, consumers, the industry, health care reform, antitrust policy and the courts will not be served well by such a state of affairs.