THE APPLICATION OF ANTITRUST DOCTRINE TO THE HEALTHCARE INDUSTRY: THE INTERWEAVING OF EMPIRICAL AND NORMATIVE ISSUES

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INTRODUCTION

At present, much of healthcare policy is dominated by a debate about different ways of thinking about medical care—about different paradigms. On one hand, proponents of the traditional professional paradigm have argued, empirically, that the market cannot work well in medical care and, normatively, should not be permitted to work, at least in some situations.[1] Market-skeptics typically contend that medical care involves technical decisions that are beyond the ability of consumers to make. Professionals, with much training and a claim to scientific expertise, should be entrusted with medical care decision making because of what is characterized as the asymmetry of information—providers have it, consumers do not. In this account, consumers lack the knowledge to participate actively in decisions regarding medical care and, presumably, are incapable of becoming adequately informed, either directly or through use of information intermediaries.[2] Proponents of the professional paradigm claim that medical decision making is basically scientific, made by autonomous professional providers. They also claim that economic incentives should not significantly affect these professional, scientific decisions.[3]

In the last fifteen years, the normative and empirical premises of the professional paradigm have come under challenge. Patients have demanded to

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1. *See, e.g.*, Arnold S. Relman, *Practicing Medicine in the New Business Climate*, 316 NEW ENG. J. MED. 1150 (1987) (arguing that "the present trend toward market competition is clearly weakening values of our profession.").

2. Thomas L. Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 CONN. L. REV. 605, 633-35 (1989). This results either from incapacity or because of the high costs of becoming informed. For a classic description and analysis of the purported market failure in medical care, see Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). *See also* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 226-30 (1982) (arguing that professionalism, which Arrow regards as a response to market failure, is to some extent a cause of some market problems).

3. A classic statement of this adherence to the professional paradigm is Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980); *see also* Arnold S. Relman, *Medical Practice Under the Clinton Reforms—Avoiding Domination by Business*, 329 NEW ENG. J. MED. 1574 (1993). For a discussion of the professional culture and its hostility to financial incentives, see David M. Frankford, *Managing Medical Clinicians' Work Through the Use of Financial Incentives*, 29 WAKE FOREST L. REV. 71 (1994).

participate in decisions involving their own medical care,[4] and physicians increasingly seem to recognize the clinical significance of expanded patient participation in medical decisions affecting patients' own lives and health.[5] Studies have shown that there is a wide divergence in patterns of utilization among providers.[6] Perhaps the best-known of these studies was published in 1996 as the Dartmouth Atlas,[7] which demonstrated the wide variations of utilization in different regions without any ostensible scientific rationale. Further, earlier Rand experiments showed that financial disincentives significantly affected consumers' behavior,[8] and studies associated with the introduction of Diagnosis Related Groups (DRGs) in Medicare in the mid-1980s showed a considerable impact on hospital length of stay.[9]

The dramatic shift to outpatient medicine has undoubtedly been influenced by the incentives associated with DRGs. Evidence has also shown that different patterns of practice are associated with managed care (as contrasted with traditional fee-for-service medicine).[10] In short, it became clear that medical care, like other economic goods and services, responded to the economic realities and incentives of the marketplace.[11] The pure professional paradigm, which initially rejected such economic effects as a matter of empirical totem, has come to resist as a normative matter what is now seen as corruptive of medical practice.[12] Ignoring such economic realities, however, has resulted in extraordinary cost escalation when linked with third-party insurance, and has had

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4. *See generally* Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994).

5. *See* Joseph F. Kasper et al., *Developing Shared Decision-Making Programs to Improve the Quality of Health Care*, QUALITY REV. BULL., June 1992, at 183, 184.

6. *See, e.g.*, John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, HEALTH AFF., Spring 1984, at 6; Mark R. Chassin et al., *Variations in the Use of Medical and Surgical Services by the Medicare Population*, 314 NEW ENG. J. MED. 285, 287-89 (1986).

7. THE CENTER FOR THE EVALUATIVE CLINICAL SCIENCES, DARTMOUTH MEDICAL SCHOOL, THE DARTMOUTH ATLAS OF HEALTH CARE (1996).

8. *See generally* JOSEPH P. NEWHOUSE ET AL., FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT (1993).

9. *See generally* Judith R. Lave, *The Impact of the Medicare Prospective Payment System and Recommendations for Change*, 7 YALE J. ON REG. 499 (1990).

10. *See generally* Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980*, 271 JAMA 1512 (1994). For a discussion of physician attitudes towards managed care, see Gail Silverstein, *Physicians' Perceptions of Commercial and Medicaid Managed Care Plans: A Comparison*, 22 J. HEALTH POL., POL'Y & L. 5, 9-10 (1997).

11. *See* James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is A Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849, 852 (1981).

12. For an expression of this view in the context of a determination of liability, see *Muse v. Charter Hosp. of Winston-Salem, Inc.*, 452 S.E.2d 589 (N.C. Ct. App.), *aff'd per curiam*, 464 S.E.2d 44 (N.C. 1995).

to be reassessed from a policy perspective.[13]

Serious analysts do not call for the elimination of the professional paradigm. Rather, what is needed and what has occurred is an accommodation between elements of both models.[14] The pure professional paradigm is no longer feasible or appropriate, but the professionalism of physicians and other medical care providers is still an important component of the high quality of American medicine. While economics cannot be ignored, neither should the important professional contributions of medical care providers be underestimated or undervalued.[15]

An important contributor to the evolution of the healthcare marketplace—toward a more market-oriented focus—has been the application of the antitrust laws to the healthcare industry.[16] Elsewhere, I have observed that "[a]ntitrust law is the virtual engine of the market paradigm."[17] Antitrust focuses on the promotion of competition and evaluates conduct according to considerations of economic efficiency and consumer welfare. Because so much of policy in the healthcare arena has been driven by equitable concerns regarding access to quality medical care, the enforcement of antitrust in the healthcare industry raises an inevitable tension. Market efficiency may result in the more appropriate use of resources, and improved competition and efficiency may result in economies that benefit consumers who might otherwise not be able to afford those services. However, even with an efficient system, there will be persons whose income is just too low to pay for medical care.

Traditionally, the healthcare system has used cross subsidies to achieve "worthy purposes," such as the financing of services for those without the resources to pay for medical care on their own.[18] The funds for this cross subsidization have stemmed from the receipt (typically by hospitals) of supra-competitive returns in some areas; those supra-competitive returns reflect the ability of hospitals to exert a form of monopoly control in certain market niches, allowing for the receipt of revenues beyond a competitive return. By focusing on promoting competition and economic efficiency, and by barring anticompetitive conduct that leads to the earning of supra-competitive returns, antitrust laws constrain the ability of providers and provider institutions to achieve supra-competitive returns. That, in turn, compromises the ability of

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13. *See* Clark C. Hauighurst & James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 9-11 (1975).

14. *See* Randall R. Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965, 1001 (1981).

15. For a general discussion of these issues, see James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1463-86 (1994).

16. Thomas E. Kauper, *The Role of Quality of Health Care Considerations in Antitrust Analysis*, 51 LAW & CONTEMP. PROBS., Spring 1988, at 273.

17. Blumstein, *supra* note 15, at 1482.

18. David M. Frankford, *Creating and Dividing the Fruits of Collective Economic Activity: Referrals Among Health Care Providers*, 89 COLUM. L. REV. 1861, 1938 (1989).

healthcare institutions such as hospitals to cross subsidize.[19] The competing away of supra-competitive returns is a natural result of the introduction of competition; also, because antitrust circumscribes anticompetitive collusive or monopolistic conduct, it limits the ability of providers and provider institutions to restore their ability to cross subsidize by earning supra-competitive returns.[20] Many of the steps necessary to achieve those supra-competitive returns will subject an institution to antitrust enforcement scrutiny.

I. THE SUBSTANTIVE AND SYMBOLIC IMPORTANCE OF ANTITRUST

Antitrust law has both substantive and symbolic importance. "In very fundamental ways, application of antitrust principles to the medical care arena transforms thinking about certain issues." [21]

Application of the antitrust laws to healthcare alters the way that participants think about the services being provided and received—about the very nature of the healthcare enterprise. Thus, by changing the culture and the climate of the entire healthcare arena, the antitrust law is important in symbolic terms.

For example, under the health planning umbrella,[22] policymakers encouraged healthcare institutional managers to rationalize the "system" of healthcare delivery. Healthcare was considered a "system," with all that term connotes. Policymakers and planners would spend a good bit of time considering what institutional design structure would best achieve efficiencies and provide patients with accessible, high-quality services.[23]

Use of the term "system" suggests a social services delivery model. In that context, the term "non-system" is a pejorative, connoting that there should be an organized system, but that there is not one. Consistent with the health planning approach, much criticism was leveled at the American healthcare delivery "system" because it was insufficiently organized or inadequately structured.

Application of the antitrust laws to the healthcare arena makes it clear that issues involving "trade or commerce" are at stake.[24] That is, healthcare is an

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19. *See* Blumstein, *supra* note 15, at 1500-01.

20. *Id.* at 1482-86.

21. *Id.* at 1482.

22. *See generally* James F. Blumstein, *Effective Health Planning in a Competitive Environment*, *in* COST, QUALITY, AND ACCESS IN HEALTH CARE: NEW ROLES FOR HEALTH PLANNING IN A COMPETITIVE ENVIRONMENT 21 (Frank A. Sloan et al. eds., 1988); Randall R. Bovbjerg, *New Directions for Health Planning*, *in* COST, QUALITY, AND ACCESS IN HEALTH CARE, *supra*, at 206.

23. *See generally* DAVID D. RUTSTEIN, BLUEPRINT FOR MEDICAL CARE (1974) (considering how to best organize medical care under a putative national health insurance scheme).

24. Although the antitrust laws have been applied in some situations involving healthcare for a half-century, *see* AMA v. United States, 317 U.S. 519, 528 (1943), it was the *Goldfarb* decision in 1975 that definitively determined that there was no generalized antitrust exemption for the "learned professions." Goldfarb v. Virginia State Bar, 421 U.S. 773, 787 (1975). In *Goldfarb*, the Supreme Court recognized that the practice of law had business dimensions and was "trade or

"industry" to be policed through antitrust enforcement against anticompetitive conduct as are other economic sectors. In an "industry," principles of economics have application. Economic concepts such as supply and demand, incentives, and trade-offs become important terms for analysis and consideration. The "non-system" terminology has limited applicability in the context of an economic market, which is typically driven by decentralized decisions of individual households and firms.[25]

Viewing healthcare as an industry ("trade or commerce") rather than purely as a social services delivery system is truly transformative in terms of the culture of the actors within the industry. The very same activity that is considered appropriate or constructive under one behavioral framework (*e.g.*, the professional/planning model) is viewed as harmful and even illegal under another (*e.g.*, the competitive/antitrust model).

Under health planning, as influenced by the professional paradigm, institutional providers such as hospitals were encouraged to act collectively to eliminate "wasteful duplication."[26] Cooperation and coordination were seen as socially appropriate tools for rationalizing a "system" by participants in that system in pursuit of the common good. From an antitrust perspective, however, such conduct between or among competitors is far from the wholesome activity envisioned by its health planning proponents. Whereas "cooperation" or "coordination" seem like good things, antitrust enforcers are likely to see them in less glowing terms. "Cooperation" or "coordination" becomes the much more perverse "conspiracy;" the purported elimination of "wasteful duplication" looks like an illegal restraint of trade among competitors—a form of territorial market division that is so destructive to competition that the Supreme Court has labeled such restraints as per se illegal violations of the antitrust laws.[27]

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commerce" as required for coverage under the Sherman Anti-Trust Act, ch. 647, 26 Stat. 209 (1890) (current version at 15 U.S.C. § 1 (1994)). *Goldfarb*, 421 U.S. at 787-88. Following *Goldfarb*, the Court clearly indicated that the antitrust laws applied generically to professionals. *See* National Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978). Despite the existence of a federal regime of health planning at the time (since repealed), the Court also made clear that the antitrust laws applied to the healthcare arena. *See* National Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross, 452 U.S. 378, 391 (1981). Thus, Congress was forced to enact a limited exemption from antitrust coverage for hospital peer review activities, which were deemed essential for the maintenance of quality assurance procedures. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152. *See generally* James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, LAW & CONTEMP. PROBS., Spring 1988, at 7. It is now clear that the antitrust laws apply to conduct by professionals in the healthcare arena. *See* Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 329-30 (1991); Patrick v. Burget, 486 U.S. 94, 101-05 (1988).

25. James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal and Political Analysis*, 59 TEX. L. REV. 1345-1400 (1981).

26. *See* Clark C. Hauighurst, *Regulation of Health Facilities and Services by "Certificate of Need*," 59 VA. L. REV. 1143, 1148-51 (1973).

27. *See* United States v. Topco Assocs., Inc., 405 U.S. 596, 608-11 (1972). *Cf.* Hauighurst,

Clearly, then, the application of the antitrust laws to the healthcare industry has a critical symbolic function in altering the perception of how to think about the healthcare enterprise—from a social services delivery system to an industry in the economic marketplace. Accompanying the symbolic importance of antitrust is a critical substantive dimension as well.

One of the hallmarks of a profession is its sense of self-regulation. Professionals assume certain power by substituting their judgment on critical technical and economic matters for that of consumers.[28] The social quid pro quo for this empowerment is an understanding that professionals should not act in their own economic self interest at the expense of consumers. In theory, at least, self-regulation by the profession itself substitutes for the discipline of the marketplace, which normally determines price, quality, and level of services provided.

The frame of reference for professionals is the peer group of professionals. Members of the peer group establish ethical codes of conduct that govern standards of behavior within a profession. Professional peers set standards of quality[29] and, through various mechanisms of peer review, enforce standards of conduct within the profession. In short, it is entirely within the professional tradition for groups of peers to act collectively to establish and enforce professional norms. In some situations, this custom of joint conduct has been used to establish or retain professional hegemony or to resist threats against perceived inroads on providers' autonomy or financial well-being.[30]

For example, physicians have acted collectively against unwanted competition,[31] have engaged in group boycotts to resist fee pressures,[32] and have resisted alternative payment methods to combat the growth and development of prepaid plans such as health maintenance organizations (HMOs),[33] and dentists have acted in concert to resist cost-containment efforts by an insurer that threatened provider incomes and autonomy.[34] Antitrust norms call this type of collective behavior into question.

Further, the professional instinct for collective conduct to assert and to

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supra note 26, at 1149 ("[M]any of the activities undertaken in the name of planning were indistinguishable from such typical cartel practices as output restriction (collective determination of the bed supply) and market division (allocation of areas of responsibility both geographically and by activity.)"). *See also* Blumstein & Sloan, *supra* note 24, at 8-9 (discussing this dissonance).

28. *See* Greaney, *supra* note 2, at 633-35.

29. This is particularly true in the field of medicine, where liability standards for professional negligence are determined by reference to professional norms of conduct. *See* Blumstein & Sloan, *supra* note 24 and accompanying text.

30. *See, e.g.*, Patrick v. Burget, 486 U.S. 94 (1988); FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); AMA v. United States, 317 U.S. 519 (1943); Nurse Midwifery Assocs. v. Hibbett, 918 F.2d 605 (6th Cir. 1990), *modified*, 927 F.2d 904 (6th Cir.), *cert. denied*, 502 U.S. 952 (1991).

31. *See, e.g.*, *Patrick*, 486 U.S. at 94.

32. *See, e.g.*, *In re* Michigan State Med. Soc'y, 101 F.T.C. 191 (1983).

33. *See, e.g.*, *AMA*, 317 U.S. at 519.

34. *See, e.g.*, *Indiana Fed'n of Dentists*, 476 U.S. at 447.

enforce collectively determined norms of conduct is subject to challenge when confronted by the antitrust laws' norm against collective conduct to discipline the behavior of competitors. In the absence of Congressionally-conferred specific legislative exemptions,[35] courts applying the antitrust laws have expressed reluctance to weigh procompetitive virtues against other competing policy objectives. Thus, in an antitrust case, courts will routinely balance procompetitive against anticompetitive aspects of a restraint or a set of restraints. What antitrust courts tend to eschew, however, is the temptation to balance procompetitive values embodied in the antitrust laws with policy objectives other than those associated with competition.[36] If goals related to other policy values are to trump the procompetitive virtues of the marketplace protected by the antitrust laws, the courts have found that only Congress can carve out such an exception to antitrust coverage.[37]

This fundamental rule of antitrust law has been applied even to bar a group boycott aimed at disciplining illegal activity.[38] This, in many ways, is the essence of professional self regulation, yet the antitrust courts have typically been unwilling to allow that kind of concerted action because of fears of harm to the competitive process. The Supreme Court has applied this doctrine in the professional context, barring as illegally anticompetitive collective professional activity that assertedly promotes values other than competition (such as quality of services, a hallmark of professional self-regulation).[39] Indeed, in condemning challenges to antitrust enforcement actions based on the asserted worthiness of the pursuit of other, noncompetitive objectives—the "worthy purpose" defense—the Court has labeled such purported defense theories a "frontal assault" on the core values and policies of the antitrust laws themselves.[40]

Thus, from a substantive viewpoint, the antitrust laws are important in part because they eliminate non-efficiency-based criteria from consideration in deciding the legality of collective conduct. This comes into conflict with traditional professional norms, which recognize values other than competition as justifications for collective conduct.[41] Antitrust enforcement, therefore,

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35. *See Patrick*, 486 U.S. at 105 & 106 n.8.

36. *See, e.g.*, National Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679 (1978).

37. *See Patrick*, 486 U.S. at 105 & 106 n.8. *See generally* Blumstein & Sloan, *supra* note 24, at 28-32; Greaney, *supra* note 2; Kauper, *supra* note 16.

38. Fashion Originators' Guild of Am., Inc. v. FTC, 312 U.S. 457, 464 (1941).

39. *See, e.g.*, *Indiana Fed'n of Dentists*, 476 U.S. at 447; *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 679.

40. *See Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 680. *But see* United States v. Brown Univ., 5 F.3d 658, 661 (3d Cir. 1993); Wilk v. AMA, 719 F.2d 207, 222 (7th Cir. 1983).

41. The American Hospital Association (AHA), for example, advocated adoption of state laws that, making use of the antitrust exemption for state action under *Parker v. Brown*, 317 U.S. 341 (1943), would authorize collaborative activities among healthcare providers that might otherwise violate the federal antitrust laws. The rationale, in part, for that AHA initiative was dissatisfaction with antitrust doctrine that competition as a value cannot be offset, in an antitrust analysis, by other values such as improved access to or quality of medical care. *See* Fredric J. Entin

confronts the professional ideal that professionals control basic economic decisions regarding price, quality, and level of services provided and that professionals can act collectively to enforce those professional norms. Antitrust enforcers are notoriously skeptical of these professional claims; and antitrust enforcement in the healthcare arena compels professionals and providers to give more attention to traditional economic considerations of balancing quality and cost. Sensitivity on the part of providers to concerns of payors and consumers with regard to access, quality, and cost is a likely consequence. Accommodation to consumer desires to share in their medical care decision making may also be a result of enhanced attention to procompetitive considerations. From the perspective of market reform, it is important symbolically and substantively to maintain the role of the antitrust enforcement which has helped change the way that policymakers and market participants think about medical care.

II. THE SIGNIFICANCE OF EMPIRICAL ISSUES IN ANTITRUST ENFORCEMENT

Given the normative importance of the application of the antitrust laws to the healthcare environment, one could reasonably predict that there would be conflict regarding empirical issues that undergird the application of the antitrust laws to any industry. For example, conventional antitrust doctrine requires the use of empirical analysis to determine such issues as the existence or nonexistence of market power—the ability of an economic actor or set of actors to influence price or quantity in a market. Similarly, empirical evidence will often be sought regarding the competitive effects of various restraints in a particular market. That inquiry is necessary in a traditional rule-of-reason analysis to determine whether, on balance, a particular restraint is procompetitive or anticompetitive.[42]

To determine the issue of market power, an analyst must define a geographic market and a product market. After all, it is impossible to determine whether an economic actor or set of actors exerts market power without knowing what the market is. The determination of the market, in turn, is composed of a number of empirical considerations regarding geography and definition of the product involved. For example, in determining what the geographic market is, analysts must determine how far consumers will travel to consume a specific type of medical service when facing different levels of price or perceived quality.[43] This issue is nearly always an essential part of a rule-of-reason antitrust analysis and turns on empirical evidence specifically related to a particular market and set of services. There may be a difference in the scope of competition in different types of geographic markets depending on the nature of the medical services involved. For example, it is often suggested that the geographic market for primary care services is more narrowly circumscribed than the market for more specialized

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et al., *Hospital Collaboration: The Need For an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107, 127-28, 134 (1994).

42. *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 692.

43. *See, e.g.*, Michael A. Morrisey et al., *Defining Geographic Markets for Hospital Care*, LAW & CONTEMP. PROBS., Spring 1988, at 165.

tertiary care services.[44]

In defining the appropriate product market, analysts must determine what products or services compete with each other. That is, what products or services can be substituted for others. This is an empirical question that focuses on what economists call the cross elasticities of demand—what products or services can substitute for others and at what prices. For example, at what point do primary care physicians compete with specialists? Presumably, there is some continuum of quality and price at which payors and consumers will substitute primary care services for specialty services.

One important note of caution is necessary in evaluating empirical evidence in the context of antitrust policy. Empirical evidence is not developed in an institutional vacuum. Behavior is shaped by structural incentives, so observed consequences must be evaluated in the context of the institutional milieu in which the empirical observation is made. Thus, in considering the consequences of increased competition in a particular market, one must be aware of the institutional constraints on how competition is channeled before drawing policy conclusions. This insight will be important in the ensuing discussion of how empirical evidence should be evaluated in an antitrust policy context.

A. General

In definitively applying the antitrust laws to the professions, the Supreme Court recognized that the empirical effects of collective conduct in the context of the professions (such as medicine) might differ from that in other economic sectors.[45] The Court seemingly has rejected the "worthy purpose" defense in the context of the professions.[46] An example of this is disallowing the balancing of procompetitive values against non-competitive policy objectives designed to achieve worthy policy objectives through anticompetitive practices. The Court has steadfastly acknowledged, however, that not all doctrinal conclusions developed in other economic sectors will automatically transfer to the realm of the professions.

Thus, the Court has not been willing, as a matter of routine, to apply rules developed in other economic sectors to the professional context, preferring to allow defendants to proffer ostensible procompetitive justifications for independent judicial evaluation.[47] This is perhaps best illustrated in the area of

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44. *See, e.g.*, Blue Cross & Blue Shield United v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995); United States v. Long Island Jewish Med. Ctr., No. CV973412 (ADS), 1997 WL 662731 at *50 (E.D.N.Y. Oct. 23, 1997) (finding as a fact that different geographic markets existed for primary/secondary hospital services and for tertiary care services).

45. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 788-89 n.17 (1975).

46. *See* FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 463 (1986); *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 695-96; Blumstein & Sloan, *supra* note 24, at 28-32.

47. Some rules, such as the per se ban on price fixing, have been applied in the medical care and professional context. *See* FTC v. Superior Ct. Trial Lawyers, 493 U.S. 411, 432 (1990); Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 348 (1982).

the antitrust rules of per se invalidity under section 1 of the Sherman Act.[48]

Section 1 requires a threshold finding that there is concerted action by more than one party with the capacity to agree or conspire.[49] Once that threshold requirement is satisfied, the most fundamental practical analytical issue becomes which standard of antitrust to apply: the rule of per se invalidity or the rule of reason. Under traditional antitrust doctrine, the per se approach means that in carefully delineated situations an antitrust complainant need only establish the agreement itself to prevail in the litigation. Under a per se analysis, courts do not inquire elaborately into the precise nature or scope of the purported harm to competition or into the possible business justifications for use of the challenged practice.[50] Per se rules have developed from judicial experience, where courts conclude that a particular type of concerted conduct has a "pernicious effect on competition and lack[s] . . . any redeeming virtue."[51] Under such circumstances, use of per se rules is efficient, saving time and lowering complainant's cost of putting forward an expensive antitrust action. Because of their open-and-shut character, per se rules are carefully targeted, and the courts have been reluctant to be expansive in interpreting their scope.[52]

Practices that are subject to review under section 1 but that do not warrant per se treatment are anlyzed under the rule of reason. The test of legality under the rule of reason is "whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition."[53] A court must determine the "competitive significance of the restraint" and evaluate the "facts peculiar to the business, the history of the restraint, and the reasons why it was imposed."[54] The bottom line question a court must decide under the rule of reason is whether, on balance, a "restrictive practice should be prohibited as imposing an unreasonable restraint on competition."[55]

Application of the rule of per se invalidity does not allow a defendant to justify its conduct at all; proof of an agreement or a conspiracy that triggers a per se violation pretermits consideration of justifications. In the professional context, the Court normally has been willing to hear and consider purported

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48. 15 U.S.C. § 1 (1994).

49. *See* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984). *See* generally Blumstein & Sloan, *supra* note 24, at 39-53.

50. *See* United States v. Topco Assocs., Inc., 405 U.S. 596, 607 (1972); *see also National Soc'y of Prof'l Eng'rs*, 435 U.S. at 692.

51. Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958).

52. *See* Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 294-95 (1985).

53. Board of Trade v. United States, 246 U.S. 231, 238 (1918). "Under the rule of reason, the court must determine whether the consequences of the contested concerted conduct constitute contraindicated constraints on competition." Blumstein & Sloan, *supra* note 24, at 54.

54. *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 692.

55. Continental T.V., Inc. v. GTE Sylvania Inc., 433 U.S. 36, 49 (1977).

procompetitive rationales for restraints.[56] Indeed, the professional context has spawned a doctrinal accommodation: a third, intermediate level of scrutiny, in which plaintiffs need only demonstrate what appears to be a suspiciously naked restraint. While the defendants in these cases are afforded an opportunity to defend their collective conduct on the basis of a procompetitive rationale, the burden of justification rests with them, and plaintiffs need not present detailed evidence of market structure or particularized harm to competition.[57] Thus, professional defendants are usually afforded an opportunity to present procompetitive justifications for contested restraints, and that provides an opportunity for professionals to draw on theoretical or empirical evidence to rebut a claim that the challenged conduct should be held illegal.

In short, the federal antitrust laws, as applied to the healthcare arena, contemplate a careful evaluation of the competitive impact of various restraints on competition.[58] While the Court has warned against "fashioning a broad exemption under the Rule of Reason for learned professions" on the theory that "competition itself is unreasonable,"[59] it has also acknowledged that "by their nature, professional services may differ significantly from other business services" in their competitive impact.[60] Thus, "the nature of the competition in such services may vary."[61] A restraint on competition cannot be justified "on the basis of the potential threat that competition poses to the public safety" because that would be "nothing less than a frontal assault on the basic policy of the Sherman Act."[62] But antitrust enforcement must be sensitive to the particular context in which a restraint arises so that its competitive impact is fully understood. In sum, the federal antitrust laws "provide a great degree of flexibility for private collaborative efforts aimed at achieving more efficient and less costly delivery of health care services."[63] In the healthcare arena, empirical analysis will ultimately determine whether specific restraints peculiar to the healthcare industry will be vindicated as procompetitive or struck down as unwarranted restraints on competition.[64]

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56. *See* FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 693. While this is generally true, there are exceptions, notably the holding that the rule of per se invalidity applies to price fixing agreements among professionals. *See* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982); *see also* FTC v. Superior Ct. Trial Lawyers, 493 U.S. 411, 432 (1990).

57. *See Indiana Fed'n of Dentists*, 476 U.S. at 459; *see also* United States v. Brown Univ., 5 F.3d 658, 674 (3d Cir. 1993) (explaining intermediate standard of antitrust scrutiny).

58. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 788-89 n.17 (1975).

59. *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 696.

60. *Id*.

61. *Id*.

62. *Id*. at 695.

63. David L. Meyer & Charles F. Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 171 (1994).

64. *See Goldfarb*, 421 U.S. at 788-89 n.17. In recognition of the need for developing antitrust enforcement policy in the specific context of the healthcare industry, the Department of

B. The Case of Hospital Cooperation Laws

Many states have enacted laws designed to insulate conduct of hospitals or health care providers from scrutiny under the antitrust laws.[65] Although the rationales for these laws have been called into question,[66] their proponents claim that they are needed, in part, to promote economic efficiency.[67] While part of the rationale for these laws seems to be based on the desire to allow health care providers to cross subsidize to achieve worthy health policy objectives and to avoid the impetus toward efficiency of antitrust enforcement,[68] a substantial contributor to the enactment of these laws was an expressed concern with the ability of federal antitrust enforcement agencies to understand the economic realities of the healthcare marketplace.[69]

These so-called hospital cooperation laws are designed to make use of the *Parker v. Brown*[70] state-action immunity doctrine. Under general constitutional principles (the Supremacy Clause[71]), federal law supersedes state law that comes in conflict with it. In the realm of antitrust, however, the Supreme Court has construed the federal antitrust law to embrace a principle of federalism[72] which

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Justice and the FTC have adopted enforcement safety zones to provide guidance to industry participants of how the antitrust enforcement agencies interpret the antitrust laws in their application to the healthcare industry. U.S. Department of Justice & Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (Aug. 28, 1996) <http://www.ftc.gov/reports/hlth3s.htm>. The safety zones have been promulgated not as exceptions to, but as enforcement guidelines within, the framework of general antitrust policies. This point was made clear by a statement of Senator Howard Metzenbaum issued when the original safety zones were announced:

> We're going to solve a problem in the antitrust field without changing one word, one comma, or one semicolon of the antitrust laws. . . . We are here today to clear up confusion among doctors and hospitals about how these laws apply to them. We want to end their uncertainty. . . . These policy guidelines are proof positive that we can make our laws work to accommodate business when their concerns have logic and merit.

Statement by Senator Howard M. Metzenbaum (Sept. 15, 1993), *Press Conference with U.S. Att'y Gen. Janet Reno, First Lady Hillary Clinton, Janet Steiger, Chair, Federal Trade Commission*, Fed. News Service, Sept. 15, 1993, *available in* LEXIS, News Library, ARCNWS file.

65. For a list of these states as of October 1995, see James F. Blumstein, *Assessing Hospital Cooperation Laws,* 8 LOY. CONSUMER L. REP. 248, 253-54 (1996) (Table 1).

66. *See* Blumstein, *supra* note 15, at 1493-1501; Meyer & Rule, *supra* note 63, at 176-82.

67. *See generally* Entin et al., *supra* note 41.

68. *See* Blumstein, *supra* note 15, at 1498.

69. *Compare* Meyer & Rule, *supra* note 63, *with* Entin et al., *supra* note 41.

70. 317 U.S. 341 (1943).

71. U.S. CONST. art. VI ("This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.").

72. For a discussion of this principle of statutorily-mandated federalism, see James F.

authorizes states to overcome the effect of federal antitrust enforcement by substituting a regime of state regulation for competition.[73] Thus, federal antitrust law does not apply "to anticompetitive restraints imposed by the States 'as an act of government,'"[74] and is "subject to supersession by state regulatory programs,"[75] provided that the state must clearly articulate its policy to substitute regulation for competition and must actively supervise implementation of that policy.[76]

These hospital cooperation laws assume that "in the health care marketplace regulation may be preferable to competition in some circumstances."[77] To the extent that these laws are premised on the use of regulation to promote considerations of economic efficiency, they demonstrate a resistance to the application of antitrust as a vehicle for the enforcement of competition and thus economic efficiency. These laws reflect a "resistance to the shift in paradigms" from the professional to the market-oriented approach and assume that "features of the health care marketplace that impede the proper functioning of the market will remain in place."[78]

Importantly, advocacy of these laws was based on empirical evidence that competition among health care providers can result in the encouragement of wasteful practices.[79] This brings home a critical point regarding the use of empirical evidence in the analysis and evaluation of antitrust enforcement in the healthcare arena—empirical evidence will be shaped by the institutional structure of the industry. If avenues for competition are circumscribed, then competition can result in certain perverse or cost-escalating outcomes. But the policy implication of these studies must be evaluated in the context of possible institutional reform or redesign, which would change the nature and effect of competition. Similarly, antitrust enforcement authorities must be aware of the shifting nature of competition in the healthcare marketplace so that enforcement

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Blumstein, *Federalism and Civil Rights: Complementary and Competing Paradigms*, 47 VAND. L. REV. 1251, 1294-1300 (1994). *See generally* James F. Blumstein & Terry Calvani, *State Action as a Shield and a Sword in a Medical Services Antitrust Context*: Parker v. Brown *in Constitutional Perspective*, 1978 DUKE L.J. 389, 395-97, 400-03, 414-31.

73. *See* Frank H. Easterbrook, *Antitrust and the Economics of Federalism*, 26 J.L. & ECON. 23, 25 (1983) (describing *Parker* as a form of "inverse preemption"); *but see* Einer R. Elhauge, *The Scope of Antitrust Process*, 104 HARV. L. REV. 667, 717-29 (1991) (critiquing that view of the state-action doctrine).

74. City of Columbia v. Omni Outdoor Adver., Inc., 499 U.S. 365, 370 (1991) (Stevens, J., dissenting).

75. FTC v. Ticor Title Ins. Co., 504 U.S. 621, 632-33 (1992).

76. California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

77. Blumstein, *supra* note 15, at 1490.

78. *Id*. at 1494.

79. *See* James C. Robinson & Harold S. Luft, *The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and the Cost of Care*, 4 J. HEALTH ECON. 333, 353-54 (1985).

policies in fact, as well as in theory, promote competition rather than promote outdated rules of thumb that can, under the changed circumstances, stand in the way of appropriate procompetitive conduct.[80]

In the debate surrounding adoption of the hospital cooperation legislation, advocates of the legislation contended that the economic structure of the healthcare industry meant that price competition was not suitable.[81] Evaluation of that argument requires some consideration of the historical structure of the healthcare market.

Traditionally, physicians have been the most influential participants in the healthcare market.[82] This influence has stemmed from the expertise and knowledge physicians have obtained from their specialized training[83] and from their control of patients and patient referrals.[84] The professional dominance model[85] has both resulted from[86] and reinforced this asymmetry of information.[87] With professional dominance, patients tend to rely on the recommendations of their physician regarding referrals.

This traditional ability of physicians to channel patients has meant that hospitals have been dependent on physicians to admit patients to their facilities.[88] Understandably, in such circumstances and with the prevalence of third-party insurance for hospital stays offsetting most out-of-pocket patient expenses,[89]

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80. *See* Clark C. Hauighurst, *Are the Antitrust Agencies Overregulating Physician Networks?*, 8 LOY. CONSUMER L. REP. 78 (1995-96).

81. *See* Entin et al., *supra* note 41, at 122-38.

82. *See* STARR, *supra* note 2, at 226-27; Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 445-47 (1988).

83. *See* J. Michael Woolley & H.E. Frech, III, *How Hospitals Compete: A Review of the Literature*, 2 U. FLA. J.L. & PUB. POL'Y 57, 59-60 (1988-89).

84. *See* Harold S. Luft et al., *The Role of Specialized Clinical Services in Competition Among Hospitals*, 23 INQUIRY 83 (1986). *See generally* Blumstein & Sloan, *supra* note 24, at 17 ("Since doctors have traditionally referred patients to hospitals, they have controlled the hospitals' clientele. That power . . . has given physicians . . . considerable leverage over hospitals.").

85. *See* Blumstein, *supra* note 15, at 1463-64.

86. *See* STARR, *supra* note 2, at 226-27. Starr has argued that the dominance of professionals has perpetuated the imbalance in information available to patients, and, thereby, has perpetuated professional power vis a vis patients. In Starr's account, professionalism may in part be a cause, not exclusively a response, to market failure (the asymmetry of information between physician and patient).

87. *See* Arrow, *supra* note 2, at 947-49 (arguing that the professional paradigm is a response to the market failure in the medical care marketplace—the unpredictable nature of the need for medical care and the asymmetry of information (the knowledge of the physician and the ignorance of the consumer)). *But see* STARR, *supra* note 2, at 226-27 (noting that uncertainty and consumer ignorance may be promoted by the professional paradigm, thereby perpetuating the empowerment of professionals in medical care decisionmaking).

88. *See* Luft et al., *supra* note 84.

89. *See* Woolley & Frech, *supra* note 83, at 60-61.

competition among hospitals focused on attracting referrals of patients by physicians. In that type of competitive environment, still prevalent in many parts of the United States, emphasis among competing hospitals is on appealing to the physician-referrers; where third-party reimbursement is relatively automatic and cost-based,[90] neither the hospital nor the physician has much of an incentive to be particularly responsive to considerations of cost.

In an industry with such structural characteristics, it is surely no surprise to learn that increased competition would be associated with higher prices[91]—the so-called "medical arms race," where purchases of expensive equipment by one institution led to similar purchases by competitor institutions without regard for cost effectiveness and without regard to constraints of cost.[92] Since physicians controlled patient flow to hospitals through control of patient referrals, hospitals often competed for physician affiliations by providing expensive specialized clinical services[93] with the attendant escalation in capital expenditure, increases in overhead and the concomitant increase in operating costs.[94] In such an environment, empirical evidence suggested that hospitals in more competitive markets experienced higher costs.[95]

Although empirical evidence may have supported the "medical arms race" hypothesis in the presence of a particular market structure that channeled competition in certain ways, subsequent empirical research strongly suggests that, when the institutional structure of the healthcare marketplace changed, the impact of competition also changed. That is, when institutional and legal change altered the structure of the healthcare market[96] so that it reflected the kinds of economic incentives present in other markets, it seems that participants in the healthcare market behaved much like participants in other markets.[97]

For example, when selective contracting was broadly introduced into the

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90. In a cost-based mode of hospital reimbursement, greater competition may be associated with higher rather than lower costs. *See* Robinson & Luft, *supra* note 79, at 353-54.

91. *See, e.g.*, James C. Robinson & Harold S. Luft, *Competition and the Cost of Hospital Care, 1972 to 1982*, 257 JAMA 3241, 3244 (1987); Jack Zwanziger & Glenn A. Melnick, *The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California*, 7 J. HEALTH ECON. 301, 305 (1988). For a more generalized discussion of the relationship between the nature of competition and the containment of costs, see Thomas L Greaney, *Managed Competition, Integrated Delivery Systems and Antitrus*t, 79 CORNELL L. REV. 1507, 1513-14 (1994).

92. *See* Luft et al., *supra* note 84, at 92.

93. *See id*. at 83; Hall, *supra* note 82, at 506.

94. *See* Luft et al., *supra* note 84, at 93; Robinson & Luft, *supra* note 91, at 3241.

95. *See* Robinson & Luft, *supra* note 79, at 342 ("Hospitals in monopolistic positions within their local area produce[d] their services at significantly lower costs than hospitals in more competitive environments."). *See generally* United States v. Carilion Health Sys., 707 F. Supp. 840, 846 (W.D. Va. 1989).

96. The data for these subsequent studies derived largely from California.

97. *See* discussion *supra* notes 1-20 and accompanying text.

California market,[98] allowing private health plans and Medi-Cal[99] to channel patients to selected providers in exchange for price and other concessions, price competition was introduced into the California healthcare market.[100] With the broader introduction of cost-conscious payers into the healthcare market, incentives shifted, and, as a result, price competition as well as quality competition began to emerge.[101]

The altered payment policies in California in the early 1980s, and the resultant shift in economic incentives for participants in the healthcare marketplace substantially reduced the rate of increase in total hospital costs and revenues, and caused a shift to less expensive outpatient services.[102] With strong incentives to reduce costs,[103] hospitals experienced a lower growth rate in costs in the 1983-85 period than the 1980-82 period in all categories except for outpatient services.[104] For hospitals in highly competitive areas, total inpatient costs adjusted for inflation declined by 11.3% while remaining flat in low-competition markets.[105] From 1983 to 1988, high HMO penetration stimulated more price competitive behavior on the part of traditional health insurers. When those insurers were allowed to negotiate and contract with hospitals for discounts, they did so, with a reduction in costs.[106]

The empirical evidence from California strongly suggests that in competitive hospital markets, when appropriately structured, the traditional economic

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98. *See* Glenn A. Melnick & Jack Zwanziger, *Hospital Behavior under Competition and Cost-Containment Policies: The California Experience, 1980 to 1985*, 260 JAMA 2669, 2669 (1988); James C. Robinson, *HMO Market Penetration and Hospital Cost Inflation in California*, 266 JAMA 2719, 2719 (1991).

99. Medi-Cal is California's Medicaid program.

100. This allowed for bargaining on the part of private health plans and Medi-Cal with providers. *See* David Dranove & William D. White, *Recent Theory and Evidence on Competition in Hospital Markets*, 3 J. ECON. & MGMT. STRATEGY 169, 193-94 (1994); Melnick & Zwanziger, *supra* note 98, at 2669; James C. Robinson & Harold S. Luft, *Competition, Regulation, and Hospital Costs, 1982 to 1986*, 260 JAMA 2676, 2676 (1988); Robinson, *supra* note 98, at 2719; Zwanziger & Melnick, *supra* note 91, at 316-17; Jack Zwanziger et al., *Hospitals and Antitrust: Defining Markets, Settings Standards*, 19 J. HEALTH POL., POL'Y & L. 423, 424 (1994).

101. *See* Melnick & Zwanziger, *supra* note 98, at 2675; Robinson, *supra* note 98, at 2723; David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J.L. & ECON. 179, 180-81 (1993). The rate of increase in inpatient costs adjusted for inflation increased at an average rate of almost 5% in 1980-82 and decreased by almost 2% in the 1983-85 periods, after the introduction of selective contracting and the introduction of price negotiation. Melnick & Zwanziger, *supra* note 98, at 2672.

102. *See* Melnick & Zwanziger, *supra* note 98, at 2669.

103. *Id*. at 2670.

104. *Id*. at 2672.

105. *Id.* at 2673.

106. *See* Robinson, *supra* note 98, at 2723. While overall cost reductions were achieved during the period, there was a considerable rate of cost increase per hospital admission during the period. *Id.*

expectation holds true—competition results in lower prices or in lowering the price/cost margin.[107] In a payer-driven market, purchasers are motivated and capable price shoppers.[108] In such circumstances, margins, measured using the bargained-for price rather than the list price, have been shown to have fallen in competitive markets in the period 1983 to 1988 after the introduction of broadened selective contracting.[109] Similarly, California hospitals having more than ten other hospitals within a fifteen mile radius were found to have an adjusted inflation rate of 40.5%, whereas California hospitals having fewer than ten hospitals within a fifteen mile radius had an adjusted inflation rate of 62%. Hospitals in other states had a comparable overall rate of 58.4%.[110] And under selective contracting, the California Blue Cross Preferred Provider Organization (PPO) was able to secure lower prices for its patients in competitive markets.[111]

These empirical studies call into question the claim that antitrust policies are inappropriately applied to the healthcare marketplace because of some purported special characteristics of that market. Since hospitals and other providers apparently can be induced to compete on the basis of a variety of factors, including price, it would seem to be important to maintain potentially competitive markets so that consumers may realize the benefits of price and other forms of competition.[112]

These empirical studies also highlight the importance of evaluating empirical evidence by taking into consideration the structure of the market in which the empirical studies were conducted. These research findings caution against jumping to the conclusion that normal economic expectations are inapplicable in a market when economic theory would predict otherwise. One must be careful to evaluate and apply these empirical findings to situations sensitively, remembering that changes in institutional structure can have significant effects on how participants in the market conduct their affairs once incentives are altered.

Empirical evidence may well be useful in assuring that antitrust enforcement

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107. *See* Dranove et al., *supra* note 101, at 179, 182; Glenn A. Melnick, *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217, 231-32 (1992); Zwanziger & Melnick, *supra* note 91, at 316; Jack Zwanziger et al., *Cost and Price Competition in California Hospitals, 1980-1990*, HEALTH AFF. Fall 1994, at 118, 123; Zwanziger et al., *supra* note 100, at 429. For more recent data, see Alain C. Enthoven & Sara J. Singer, *Managed Competition in the California Health Care Economy*, HEALTH AFF., Spring 1995, at 105; Ron Winslow, *Is Victory in Sight in Health-Care War?*, WALL ST. J., Feb. 28, 1995, at 1 (attributing a 1.1% drop in average costs per employee from a Foster Higgins survey of employers' shifts to enrollment in managed care plans).

108. *See* Dranove et al., *supra* note 101, at 183; Zwanziger et al., *supra* note 107, at 120; Zwanziger et al., *supra* note 100, at 427-29.

109. *See* Dranove et al., *supra* note 101, at 201.

110. *See* Robinson & Luft, *supra* note 100, at 2679.

111. *See* Melnick, *supra* note 107, at 229, 231.

112. *See* Zwanziger et al., *supra* note 107, at 125; Zwanziger et al., *supra* note 100, at 442-44.

authorities understand what conduct threatens competition and what activities may be procompetitive. This is the Supreme Court's mandate as it has applied antitrust law to various components of the healthcare industry.[113] The doctrine itself seems sufficiently flexible to accommodate these concerns,[114] and the adoption and continued revision and updating of the antitrust enforcement guidelines (safety zones) in this area suggest that antitrust enforcement officials are quite aware of and sensitive to the need to conform enforcement efforts to an evolving understanding of the realities of the medical care marketplace.[115]

C. The Butterworth *Case*

A recent decision of a federal district court denying a preliminary injunction in a hospital merger case brings together the empirical and normative strands in the analysis of antitrust issues in the health care arena. *FTC v. Butterworth Health Corp.*[116] involved the merger of the two largest hospitals in Grand Rapids, Michigan, a four-hospital city.[117] The district court essentially accepted the analysis of the FTC as to the relevant product and geographic markets and concluded that "the proposed merger would result in a significant increase in the concentration of power in two relevant markets, and produce an entity controlling an undue percentage share of each of those markets."[118] Nevertheless, the district court declined to issue the requested preliminary injunction.

In setting forth the appropriate analytical standard, the district court in *Butterworth* stated that the defendant hospitals could defeat the FTC's *prima facie* case by showing that the "proposed merger is not likely to result in anticompetitive effects."[119] While that stated standard retains the proper focus of antitrust analysis—a balancing of procompetitive against anticompetitive effects[120]—it is far from clear that the district court avoided the prohibited pitfall of accepting the argument that the "special characteristics of a particular

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113. *See* FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1 986); National Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679 (1978); Goldfarb v. Virginia State Bar, 421 U.S. 773, 788-89 n.17 (1975). *See generally* William M. Sage, *Judge Posner's RFP: Antitrust Law and Managed Care*, 16 HEALTH AFF. 44 (1997) (noting need for better empirical evidence in managed care antitrust cases).

114. *See* Meyer & Rule, *supra* note 63, at 182-220.

115. U.S. Department of Justice & Federal Trade Commission, *supra* note 64.

116. 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd per curiam,* 121 F.3d 708 (Table), text at 1997 WL 420543 (6th Cir. July 8, 1997).

117. *Id*. at 1288.

118. *Id.* at 1294.

119. *Id*.

120. *See*, *e.g.*, FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 459 (allowing for consideration of "countervailing pro-competitive virtue[s]").

industry"[121] or organizational form[122] justify "monopolistic arrangements" on the ground that they "will better promote trade and commerce than competition."[123]

The district court purported to use empirical analysis to conclude that the merger should be allowed to proceed. The court seemed influenced by the work of an economist, Dr. William J. Lynk, whose studies concluded that market concentration among nonprofit hospitals was "positively correlated not with higher prices, but with lower prices."[124] Dr. Lynk's research tended to support the "medical arms race" hypothesis, which earlier research on California hospitals had supported.

The FTC criticized the Lynk research on the ground that it did not control for the effects of different levels of costs in concentrated and non-concentrated markets. The FTC argued that labor costs, in particular, were lower in rural areas, where levels of hospital concentration tended to be higher. The differences in observed prices, according to the FTC, could be attributable to differences in costs in concentrated and non-concentrated markets. Since the level of costs facing hospitals was so variable, the FTC argued, the Lynk research did not adequately distinguish among possible contributing elements. A raw correlation study, the FTC contended, was too crude a measure to determine whether it was concentration levels or cost factors that led to the observed pricing results.[125]

The district court noted that these methodological debates would probably continue long after the case was over, but that at the very least there was agreement that "high market concentration among nonprofit hospitals does not correlate positively with higher prices."[126] For the district court, that finding established a "good reason to question the applicability of the traditional presumption that a significant increase in market concentration will lead to higher prices in connection with the merger of nonprofit hospitals."[127]

The reliance of the court in *Butterworth* upon Dr. Lynk's empirical findings was placed within the framework of traditional antitrust analysis. In an earlier merger case, the Seventh Circuit Court of Appeals (per Judge Posner) had noted that antitrust merger cases are "decided on the basis of theoretical guesses as to what particular market-structure characteristics portend for competition," and urged empirical study of the issue.[128] The *Butterworth* court ostensibly viewed

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121. *See* National Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 689 (1978).

122. *See, e.g.*, American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp., 456 U.S. 556, 576 (1982) ("[i]t is beyond debate that nonprofit organizations can be held liable under the antitrust laws.").

123. *See National Soc'y of Prof'l Eng'rs*, 435 U.S. at 689.

124. *Butterworth*, 946 F. Supp. at 1296. *See* William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437 (1995).

125. *Butterworth*, 946 F. Supp. at 1295-96.

126. *Id*. at 1295.

127. *Id.*

128. United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1286 (7th Cir. 1990). *See generally* Sage, *supra* note 113.

the Lynk analysis as a response to that suggestion.

To the extent that the *Butterworth* decision rested on empirical findings related to the effect of concentration in a particular market, one could argue that its analysis was in accord with prevailing antitrust doctrine—it was just an attempt to secure a better understanding of how firms in a particular market and with a particular organizational form (nonprofit) would respond to concentrated market conditions. There might be legitimate methodological concerns, such as failing to control for geographical variation in costs,[129] or to consider how the change in market structure seemed to have altered the behavior of California hospitals (many of which were nonprofits) once they faced the reality of selective contracting.[130] Still, the analysis might be taken as within the traditional framework of rule of reason balancing of procompetitive and anticompetitive consequences of certain conduct.

When the two biggest hospitals in a four-hospital market merge, however, that necessarily reduces the number of independent decisionmakers in the market. In the Grand Rapids hospital market, the court acknowledged that there were "substantial barriers to new entry into the relevant market,"[131] thereby posing a significant risk of circumscribed consumer choice. Indeed, the district court found that the two small remaining hospitals' "ability to compete with the merged entity and defeat a small but significant price increase would be limited, especially for the foreseeable future."[132] This finding by the district court makes its purported reliance on empirical evidence within a traditional antitrust analytical framework troubling. It suggests that competition is concededly diminished, but that the institutions who have the capacity to raise price as a matter of market structure would not in fact exercise that power as a matter of noblesse oblige. At that point, the district court's decision subtly but unmistakably transmutes—from a traditional consideration of empirical evidence in a particular market and the structural effect of a merger on competition to a consideration of the much more amorphous question of how specific firms in a market will conduct themselves given their capacity to influence price and output in a market.

The district court's opinion does not, therefore, seem to be based on the procompetitive advantages of the hospital merger under review. Instead, the court implicitly seems to have shifted paradigms—from ascertaining the competitive impact of the proposed merger to determining the totality of overall benefit to the community derived from the merger. The latter inquiry is fundamentally at odds with core Supreme Court teaching on the appropriate analysis in antitrust cases; it impermissibly allows non-competitive values to be weighed against the virtues derived from competition, which is the core value of the antitrust laws.[133] In this sense, then, the court's mode of analysis subtly, but

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129. *Butterworth*, 946 F. Supp. at 1295.

130. *See supra* notes 82-113 and accompanying text.

131. *Butterworth*, 946 F. Supp. at 1297.

132. *Id.*

133. *See* Blumstein & Sloan, *supra* note 24, at 28-32.

definitively shifts from empirical to normative.

The first element of the court's normative approach is a focus on the nonprofit status of the two merging hospitals.[134] Previous cases had declined to give determinative weight to nonprofit status as a justification for anticompetitive consolidations.[135] For example, in *FTC v. University Health, Inc.*, [136] the Eleventh Circuit noted that, whatever present or past intentions, a nonprofit entity and its governing body would be "free to decide where to set prices and output."[137] Once a nonprofit entity enjoys concentrated authority, its "business decisions are not mandated by law."[138] In *Butterworth*, however, the court seemed to place greater emphasis on the finding that "a substantial increase in market concentration among nonprofit hospitals is not likely to result in price increases."[139] While disclaiming that the merging hospitals' status was dispositive in the matter, the court nevertheless placed considerable emphasis on noblesse oblige considerations associated with the leadership of the nonprofit institutions: "[T]he involvement of prominent community and business leaders on the boards of the hospitals can be expected to bring real accountability to price structuring,"[140] especially in view of the specific enforceable commitments that the hospitals were willing to make for contributions to community betterment.

This approach abandons reliance on the structural guarantees of a competitive marketplace in favor of reliance on alternative mechanisms of assuring accountability. Competition imposes market discipline and is designed to work by establishing a framework of incentives that does not rely on administrative or political mechanisms of enforcement. The antitrust law polices the process of competition, but it is the process of competition itself, accompanied by the economic incentives confronting the participants in the market, that results in a socially appropriate self-policing system.

There are mechanisms through which states can substitute a system of regulation for competition. The *Parker v. Brown*[141] state action doctrine allows

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134. The authority of the FTC to challenge mergers of nonprofit hospitals had been established in earlier cases. *See, e.g.*, FTC v. Freeman Hosp., 69 F.3d 260, 266-67 (8th Cir. 1995); FTC v. University Health, Inc., 938 F.2d 1206, 1214-15 (11th Cir. 1991); United States v. Rockford Mem'l Corp., 898 F.2d 1278 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990).

135. *See, e.g.*, NCAA v. Board of Regents, 468 U.S. 85, 101 n.23 (1984) ("Good motives will not validate an otherwise anticompetitive practice."); American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp., 456 U.S. 556, 576 (1982) ("It is beyond debate that nonprofit organizations can be held liable under the antitrust laws."); Hospital Corp. of Am. v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986) ("The adoption of the non-profit form does not change human nature."), *cert. denied*, 481 U.S. 1038 (1987).

136. *University Health*, 938 at 1206.

137. *Id.* at 1224.

138. *Id.*

139. *Butterworth*, 946 F. Supp. at 1297.

140. *Id.*

141. 317 U.S. 341 (1943).

states to confer immunity on private conduct that might otherwise run afoul of the federal antitrust law.[142] But *Parker* is a narrowly circumscribed doctrine, which requires that a state clearly articulate a policy to substitute regulation for competition and that the state actively supervise private conduct[143] on an ongoing basis[144] to assure that the policies being pursued by private parties are reflective of state policy and are not just reflective of private norms.[145] Actual, not just potential supervision by accountable state officials is required under *Parker*.[146] In addition, state officials not only must possess ultimate authority to review private decision making, they must exercise it.[147] Passive ratification is insufficient.[148]

The kind of evidence of self-abnegation on the part of the two nonprofit merging hospitals in *Butterworth* is a far cry from the stringent antitrust immunity standards of the *Parker* state-action doctrine. The district court did impose an obligation that the hospitals' commitment to the community to freeze prices and limit margins be embodied in a court decree,[149] presumably providing some enforcement vehicle for those commitments. But the very development of such a plan, which has the hallmarks of the hospital cooperation legislation discussed in Part II.B suggests an accountability framework in considerable tension with or even at odds with the accountability mechanism contemplated by the antitrust law—namely, competition. Further, the substitution of regulatory for competitive mechanisms is permitted to states because of principles of federalism. Yet, no responsible political actor in Michigan clearly articulated a policy to abrogate the norm of competition or actively supervised the private conduct in question.[150]

Perhaps the most troubling element of the district court's analysis is the court's treatment of the managed care issue. This may be the most clear-cut example of how the *Butterworth* analysis is really driven by normative rather than empirical concerns.

Apparently, the FTC contended that a significant impact of the merger in Grand Rapids would be on managed care organizations' ability to win price

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142. *See* Blumstein, *supra* note 15, at 1486-89.

143. *See* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980). The "clear articulation" requirement can be satisfied by a state policy of encouraging or authorizing, though not requiring, anticompetitive conduct. *See* Southern Motor Carriers Rate Conference, Inc., v. United States, 471 U.S. 48, 59-61 (1985).

144. *See* FTC v. Ticor Title Ins. Co., 504 U.S. 621, 633 (1992).

145. *See* Town of Hallie v. City of Eau Claire, 471 U.S. 34, 47 (1985) (With respect to private anticompetitive conduct, "there is a real danger that [the private party] is acting to further [its] own interests, rather than the governmental interests of the State.").

146. *See Ticor Title Ins. Co.*, 504 U.S. at 633.

147. *See* Patrick v. Burget, 486 U.S. 94, 101 (1988).

148. *See Ticor Title Ins. Co.*, 504 U.S. at 633.

149. *Butterworth*, 946 F. Supp. at 1298.

150. Michigan was not one of the states, in fact, that enacted a hospital cooperation law. *See* Blumstein, *supra* note 65, at 253-54.

concessions from the merging hospitals.[151] Greater concentration in the hospital market would allow the merging hospitals "to stem the growing influence of managed care organizations, whose growth has competitively secured discounts from hospitals."[152] The district court acknowledged that the merging hospitals "made no secret" of their desire to standardize managed care rates, resulting in price increases for some managed care organizations and price decreases for others.[153]

Quite understandably, the FTC contended that the hospitals' plan, which the court surrealistically labeled "level[ing] the managed care organization playing field,"[154] would create an anticompetitive result. In a competitive market, each exchange transaction between a willing buyer and a willing seller will reflect the bargaining power of the negotiating parties. It is irrational for a seller to price its product or service at below marginal cost, because such transactions are not profitable, even at large volumes. Thus, one can assume that the Grand Rapids hospitals were not pricing their services to managed care organizations at below marginal cost. However, it is possible that the hospitals were pricing their services to some powerful managed care organizations at below fully allocated average cost. That is, hospitals likely were not pricing their services so low that they were not recovering their variable costs—costs associated with delivering those services. At the same time, it is very possible that some purchasers were making smaller contributions to overhead than were others.

In response to the impetus toward cost containment that stems from increased competition, hospitals traditionally have sought to retain their revenues by shifting costs from some payers onto others.[155] But "[c]ost-shifting strategies can succeed only if (a) other buyers (onto whom costs are shifted) lack market leverage, or (b) transaction costs of prudent, aggressive purchasing by other buyers exceed potential benefits to those buyers in terms of cost savings."[156] This means that cost shifting cannot be a stable long-run condition because it "hinges on a passive payor community."[157] As buyers become more involved in administering their healthcare costs, and as those costs escalate, buyers have the ability and the incentive to manage those costs more effectively. Combining purchasing power through managed care organizations is an example of this phenomenon.

The district court in *Butterworth* was clearly unpersuaded about the virtues of managed care and the effect of tough bargaining by managed care

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151. *Butterworth*, 946 F. Supp. at 1299.

152. *Id.*

153. *Id.*

154. *Id.*

155. For a discussion of cost shifting, see Charles E. Phelps, *Cross-Subsidies and Charge-Shifting in American Hospitals*, *in* UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 108 (Frank A. Sloan et al. eds., 1986).

156. *See* Blumstein, *supra* note 15, at 1480. *See generally* MICHAEL A. MORRISEY, COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC 85-89 (1994).

157. Blumstein, *supra* note 15, at 1481.

organizations with the merging hospitals. The court accepted the cost shifting story and assumed that the hospitals could continue to shift costs into the future in a competitive environment. Yet the ability of hospitals to shift costs assumes the existence of unexercised market power over at least a segment of the market and, incidentally, undermines the court's view that nonprofit hospitals do not take advantage of their market leverage. Cost shifting is evidence of the contrary, as hospitals offset projected shortfalls in revenue from competitive purchasers by imposing additional costs on the less powerful, less knowledgeable, or less well-organized purchasers. But this assumption is questionable as a market becomes more competitive and purchasers become more sophisticated.

Because of cost shifting, the district court in *Butterworth* believed that the price discounts obtained by the managed care organizations were "illusory."[158] But those discounts could only be characterized as "illusory" in the sense that the district court is thinking of redistributive values that may be at stake. Relationships among consumers call into play traditional health policy concerns regarding equity and access to medical services of appropriate quality. Those concerns do not reflect considerations regarding efficiency, which is the hallmark or core value of the antitrust laws. The district court, it seems, was worried about the potential loss of cross subsidization from some purchasers to others. The assumption that such cross subsidization could occur over the long term in a competitive market is questionable. It is likely that the hospitals' concern about the stability of that traditional financing scenario led the hospitals to resist the leverage of the managed care purchasers and to seek out ways (such as the merger) to counterbalance the market power of the managed care organizations with market power of their own. Calling the ability of some consumers in a market to secure lower prices "illusory" because of the feared potential impact on other consumers, is nothing short of a challenge to the fundamental antitrust premise that worthy purposes unrelated to competition cannot justify collective conduct that is, on its own, anticompetitive.

In the Grand Rapids market, it was acknowledged that hospital over-capacity existed. Under such circumstances, theory would suggest that some erosion of capital infrastructure would be appropriate. To the extent that a hospital cannot recover its fully allocated average cost, which includes such indirect costs as depreciation, it might be induced to reduce its capacity. This is the market's method of bringing supply into equilibrium with demand. The court's assumption, however, must have been that the hospitals could not downsize as independent actors, but that assumption is unwarranted. Firms faced with overcapacity are frequently faced with the question of how to bring their capacity into synch with the realities of the market. This can be done through reduction in the cost or scope of services delivered and through developing more effective means of delivering services. Alternately, a hospital can seek to preserve or gain market share by developing a specialized niche or providing a superior or less costly service.

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158. *Butterworth*, 946 F. Supp. at 1299.

The essential point here is that institutions, faced with normal economic incentives, must often cope with overcapacity. The court did not explain satisfactorily why these firms should be able to cope with their overcapacity by exerting greater potential market leverage on purchasers of their service. It is here that the nonprofit status of the merging hospitals seems to have been important.

The district court acknowledged that the two merging hospitals, despite their excess capacity, were operating with above-average profit margins.[159] The FTC contended that the hospitals could cope with their excess capacity by reducing those margins and, implicitly, not seeking to exploit their market leverage by increased cost shifting. The court was unimpressed by this argument because it meant that, with smaller margins, the merging nonprofit hospitals would have less money to reinvest in their facilities. Yet, as the court noted, "[s]uch reinvestment necessarily results in benefits to consumers in the form of expanded and improved services."[160] The court observed that there was no evidence that the hospitals had wasted or otherwise misspent those extra funds.

The district judge himself toured the facilities and concluded that "the boards of both institutions have been responsible stewards of the resources available" and have "continuously reinvested substantial sums in their facilities to keep pace with medical and patient demands."[161] If there were a reduction in resources available to the facilities, that "could only have adverse effects on the quality of care provided."[162] This statement is quite important and warrants more detailed analysis.

Throughout this component of the opinion, the district court expressed concern about the overall quality of care and about consumers who are not members of managed care plans. But these are not the traditional concerns with economic efficiency that underlie antitrust analysis. With respect to consumers who are not members of managed care plans, the court assumed that the hospitals would continue to be able to exercise leverage over them indefinitely. This is far from clear, as the earlier discussion explained. Managed care organizations have arisen with considerable buying leverage; they typically are made up of many employer-groups, and they secure their bargaining power by aggregating demand from all those insured by their plans. There is no reason to believe that, as costs escalate and information about aggregation becomes more readily accessible, the buyers for whom the court expresses concern will not be able to defend themselves in the market. At any rate, it is far from clear that the remedy for that type of overcharging is to allow the overcharging party even more economic leverage.

The cost shifting story quickly gets interwoven with the concern for the fiscal well-being of the merging hospitals. One can reasonably assume that an institution worried about its long-term ability to cost-shift would seek to take

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159. *Id.*
160. *Id.*
161. *Id.*
162. *Id.*

measures to defend itself against those who have had the market clout to negotiate favorable prices. If cost shifting looms as an evanescent option, then the available alternative strategies for the hospital are all somewhat unattractive. These include reducing the level of cross-subsidized services, finding less costly ways of providing services through efficiencies (such as changing the skill mix among employees, reducing salaries of some of the higher paid employees, or reducing staff levels overall), or lowering the quality of services to approximate what the buyers are willing to pay for. The antitrust law has rejected a "worthy purpose" defense against anticompetitve conduct to achieve professionally desirable outcomes.[163] It is highly questionable whether the antitrust law should allow the compromising of effective competition for well-situated consumers to achieve such a worthy purpose as high quality medical care or to achieve other worthwhile goals pursued by nonprofit hospitals. In a market, levels of quality are driven by the purchasers, not by the professionals in charge of the hospital. This is an essential ingredient of the market system: purchasers control price, quality, and output. In medical care, however, under the professional model, the tradition has been otherwise: health care suppliers control price, quality, and output.

That is where the antitrust law's normative importance enters the analysis. The focus on the values of efficiency and purchaser control assures the primacy of market-oriented values. The district court opinion reflects an adherence to the professional paradigm and a willingness to bend the antitrust law to soften the impact of the economic marketplace with consideration of professional values such as quality of care without regard to cost and with consideration of traditional redistributive values of medical care concerning the plight of less organized consumers.[164]

A nice contrast with the revanchist approach of the district court in *Butterworth,*[165] is the district court's decision in *United States v. Long Island Jewish Medical Center (LIJ)*.[166] Whereas *Butterworth* seemed driven more by normative than empirical considerations and seemed to embrace a paradigm for the structure of the healthcare industry that is in tension with the enforcement of the antitrust laws, the district court in *LIJ* appeared to use empirical evidence in a more traditional antitrust analytical framework.

LIJ involved a proposed merger of two nonprofit teaching hospitals on Long Island, New York. In denying the FTC's request for a preliminary injunction to block the merger, the district court examined the empirical evidence regarding traditional criteria such as the definition of the product and geographic markets. The district court believed that the FTC had not established its market

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163. *See* Blumstein & Sloan, *supra* note 24, at 28-32.

164. For a comprehensive discussion of the different ways of thinking about medical care and the bulwarks and inroads on the professional model, see Blumstein, *supra* note 15, at 1463-86.

165. The truncated per curiam affirmance of *Butterworth* by the court of appeals, unfortunately, did not give the case the in-depth consideration it warranted. No. 96-2440, 1997 WL 420543 (6th Cir. July 8, 1997).

166. No. CV97-3412 (ADS), 1997 WL 662731 (E.D.N.Y. Oct. 23, 1997).

definitions given the expert and empirical information presented and concluded that there would not be an unwarranted lessening of competition from the merger.[167]

Although a number of the same arguments on behalf of the merging hospitals were made in *LIJ* and in *Butterworth*, the court's treatment of those arguments was much more in accord with the traditional antitrust framework. The district court's handling of *LIJ* is a better reflection of how empirical evidence should inform antitrust analysis, as the court appropriately took into account data regarding cross elasticity of demand and evidence regarding the scope of product and geographic markets. With regard to the difficult issue of nonprofit status, the court evaluated the evidence as part of its overall analysis of the competitive impact of the merger but clearly gave "only limited and non-determinative effect" to that factor.[168] And importantly, the court rejected on empirical grounds the FTC's claim that entry into the market was circumscribed.[169] The court found that, under appropriate government guidelines, one hospital fit the criteria as a likely entrant that would impose market discipline on the merging hospitals.[170]

The differences in analytical approach between *LIJ* and *Butterworth* led to the same result; in both cases, the courts denied the preliminary injunction that the FTC sought. Where the *LIJ* court used empirical analysis within a traditional antitrust framework, the *Butterworth* court seemed to push the envelope of antitrust enforcement with an adherence to a paradigm of the healthcare industry that is, at least, in tension with the pro-market mandate of antitrust law and, at most, fundamentally inconsistent with the dictates of antitrust law. Therefore, where *LIJ* may reflect a substantive doctrinal review of the tools and approaches for enforcement of the antitrust law, it does not threaten the procompetitive normative premises of the antitrust law itself. Unfortunately, the mixed messages that emanate from *Butterworth* may undermine the ability of the enforcement agencies to apply the procompetitive policies of the antitrust law—for all their substantive and symbolic importance—to an important component of the healthcare marketplace.

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167. *Id.* at *26.
168. *Id.* at *28.
169. *Id.* at *31.
170. *Id.*