

Whither Antitrust? The Uncertain Future Of Competition Law In Health Care

The recent lethargic performance of federal antitrust enforcement might be helped by sound judicial review and economic research.

BY THOMAS L. GREANEY

ABSTRACT: Although instrumental in ushering in competition to the health care industry and later in safeguarding the competitive structure of markets, antitrust law has come under attack. A series of questionable judicial decisions has clouded the standards applicable to analyzing health care markets. Legislative efforts to immunize conduct from antitrust challenge also have gathered support in recent years. This study finds scant economic or policy basis for these developments and concludes that anti-managed care

sentiments have diluted enthusiasm for applying competitive principles in health care. This phenomenon has resulted in outcome-driven judicial decisions and legislative activity geared to serving political expediency rather than sound policy tenets. The paper recommends heightened antitrust scrutiny of provider and insurer markets by federal and state enforcers and increased empirical research into the workings of imperfect health care markets and the effects of past antitrust decisions.

185

AS THE DOUBLE-EDGED TITLE of this paper suggests, the role of antitrust law in monitoring the health care industry faces an increasingly uncertain, and perhaps diminishing, future. Initially instrumental in removing professional- and payer-imposed barriers to competition, antitrust enforcement later preserved competitive market structures by policing consolidations by provider groups and health systems. Buffeted in recent years, however, by devastating losses in merger litigation and by legislative efforts to immunize conduct long regarded as illegal, government antitrust enforcers have shifted their focus away from traditional concerns about providers and payers in the health care industry. Although changes in the underlying competitive environment in health care account for some of the decline in legal activ-

ity, the political consensus and the legal firmament upon which antitrust enforcement in health care has long rested may have begun to erode. Segments of the judiciary are openly hostile toward applying traditional competition concepts to the health care sector, and renewed federal efforts to bring complex cases or to expand administrative and advisory efforts appear unlikely under the Bush administration.

This paper canvasses the changes in judicial and legislative attitudes about applying antitrust law and policy to health care and offers a normative assessment of that change. I have extensively surveyed and analyzed the decided cases and conducted interviews with dozens of private practitioners and government enforcers to gain perspective on trends in this area. I first trace and evaluate judicial

Thomas Greaney is professor of law and codirector of the Center for Health Law Studies at Saint Louis University School of Law.

decisions and prosecutorial policies affecting health care markets. I then analyze legislative proposals to immunize conduct from the reach of antitrust law. I observe that as faith in the competition paradigm has slipped, both judges and legislators have occasionally rejected traditional analyses and assumptions undergirding antitrust law. I conclude with recommendations to enhance antitrust scrutiny of health market structure and conduct by federal and state enforcers and to initiate more research so that judicial performance can be improved.

Judicial Retrenchment And Governmental Vacillation

The federal courts have dealt a number of important setbacks to government agencies and private plaintiffs litigating antitrust matters. A close examination of these cases reveals an admixture of factors ranging from plain judicial error, to subtle changes in legal doctrine, to a shifting jurisprudence that is increasingly deferential to professionalism in health market interactions. An undercurrent has been that a backlash against managed care has contributed to decisions that shield providers from the antitrust laws.

The unfavorable reception to antitrust cases in court appears to have had a corresponding chilling effect upon federal enforcement efforts. The Department of Justice (DOJ) has filed only three health care antitrust cases in federal court since 1998 (one involving the manufacture of false teeth), and the Federal Trade Commission (FTC) has redirected much of its enforcement agenda toward the pharmaceutical industry. Cases involving serious misconduct have resulted in mild civil sanctions rather than criminal prosecutions, and the overall level of investigatory and advisory activity appears to have declined. Moreover, the Bush administration's antitrust enforcers, particularly the DOJ's Charles James, are understood to be unenthusiastic about continuing the health care enforcement agenda of prior administrations.

From a policy standpoint, this is a worrisome trend. Since the early 1980s the nation

has trusted that decentralized, competitive markets in health services and insurance would enhance innovation and quality while constraining costs. Although it is true that a more "mature" competitive environment may reduce the extent of blatant cartel activity, there remains a strong need for close surveillance of the health care industry, as local markets for provider services and managed care become more concentrated.

■ **Hospital mergers.** The most pronounced change in the law has been in merger enforcement. Unlike other areas of antitrust litigation, legal doctrines and practical considerations severely limit private lawsuits challenging mergers; as a result, enforcement is almost exclusively the province of government agencies. The box score for government enforcement is telling. Between 1984 and 1994 the FTC and DOJ won five of six cases challenging hospital mergers decided on the merits.¹ Many others were settled by consent decree or abandoned after government inquiries spotlighted potential antitrust claims. Recently, however, the tide has turned: Since 1995 federal and state enforcers have lost all seven cases litigated in federal court.

Although economic factors have slowed the pace of merger activity, the government's failures in court have undoubtedly encouraged consolidation across the health care industry. Because they may supply precedent on issues such as market definition, the hospital merger decisions are likely to have a profound impact in other areas of antitrust concern such as physician consolidation, network formation, and restraints of trade. Experienced attorneys giving advice to physicians and hospitals see a judicial imprimatur for consolidation. As one practitioner put it, the cases "make almost any merger worth trying."

By any standard, however, the results in several cases have been startling. Courts have drawn geographic markets extending 70–100 miles for basic acute care services. Even in cases viewed as a "slam dunk," prosecutors have failed. For example, in *Federal Trade Commission and State of Missouri v. Tenet Healthcare Corporation*, a merger involving the only two

hospitals in Poplar Bluff, Missouri, a federal appeals court reversed the trial court's finding of a local market in favor of one extending some seventy miles.² Making this decision even more emblematic of judicial disdain for applying antitrust doctrine to health care providers is the appellate court's failure to extend customary deference to the findings of the lower court and its flat refusal to accept credible testimony from market participants. Most health care antitrust practitioners concede that the extraordinarily broad markets drawn in these cases have little basis in the economic realities of local competition and that the judiciary has exhibited confusion over the implications of the interplay of managed care organizations (MCOs), employers, and insured persons in selecting hospitals.

The courts' erroneous reasoning in these cases can be traced to a series of mistakes, all stemming from a tendency to apply simplifying economic models to markets that do not fit the mold. A principal flaw in the case law rests with judges' tendency to ignore the highly idiosyncratic nature of decision making by health care consumers. For example, courts have accepted economic testimony that the mere presence of some patients on the fringe of the market, willing to travel to more distant locales for hospital services, suggests the willingness of others to do so in response to higher prices.³ This approach ignores the fact that a myriad of factors other than price—personal, logistical, and other considerations—shape purchasing decisions for highly differentiated services. Recent economic studies confirm that it is impossible to accurately predict patients' travel for hospital care using simplified economic models.⁴ Also, litigation to date has failed to produce workable doctrinal norms that ensure predictability and economic rationality, since the facts in each case have differed greatly.

A second flaw in the courts' approach to geographic markets is a propensity to overlook the importance of agency relationships in determining consumers' responses. For example, in evaluating consumer demand, courts have failed to appreciate that the selection of

hospitals occurs in two distinct phases. First, hospitals vie for inclusion in networks selected for beneficiaries by MCOs and employers. Second, hospitals also compete at a second stage for the business of insured persons who choose among hospitals both in and out of network. Patients' migration patterns might be very different at each of these two stages. A careful economic analysis by Greg Vistnes demonstrates that anticompetitive effects may be realized at either stage, even though considerable migration might occur across tentative market boundaries.⁵

Finally, many of the decided cases fail to take into account that hospital services are highly differentiated. For example, buyers' perceptions of qualitative differences among hospitals and of certain hospitals (such as those affiliated with teaching institutions) that occupy a special niche position may change the competitive dynamic in a given market. Some hospitals may constitute a separate market or be able to exercise "unilateral" market power despite the presence of numerous less sophisticated or prestigious rivals. However, the one litigated case in which a plaintiff attempted to demonstrate a market for "anchor hospitals" was unsuccessful.⁶ Perhaps now gun-shy from this defeat and failures in more conventional cases, the government has not assayed a second case based on unilateral-effects analysis in the hospital market.

Controversy also surrounds court decisions rejecting challenges to hospital mergers on grounds other than the market definition issue. In a widely noted case, *FTC v. Butterworth Health Corp.*, a federal court invoked the non-profit status of the merging hospitals and their voluntary commitments to restrain future pricing to approve a merger creating a monopoly in Grand Rapids, Michigan.⁷ Despite prior case law to the contrary, the court relied on limited economic evidence and expert testimony that not-for-profit hospitals operate differently in highly concentrated markets than do profit-maximizing firms.⁸ This view, and the economic research upon which the decision rests, has been contested in the economic literature, and its present vi-

ability appears to be in doubt.⁹

Other factors cited in the *Butterworth* decision are equally suspect. Observing that the merged hospital would comprise “business leaders who have a direct stake in maintaining high quality and low cost hospital services,” the district court held that the governing structure of the merged hospitals provided an effective deterrent to the exercise of monopoly power. It also relied on a “community commitment” of the defendant hospital that it would benignly exercise its market power, pledging to freeze list prices or charges and managed care prices at premerger levels and limit profit margins. Finally, the decision refused to credit hospital discounting to MCOs that existed prior to the merger, viewing it as “cost shifting” and not benefiting “consumers as a whole.”

These factors are notable not only for their questionable economic premises but also for the underlying rejection of conventional norms that guide competition law. There is, for example, no empirical support for the proposition that outside board membership will temper the behavior of managers who effectively control “commercial” nonprofit organizations. Moreover, regulating devices such as *ex ante* rate freezes appear unlikely to be able to curb a hospital’s ability to reap the benefits of its market power through quality adjustments, cost shifting, or other means. Indeed, a recent retrospective analysis of the performance of the merged hospital in the *Butterworth* case found that although prices were kept within promised parameters, the defendant failed to achieve promised efficiencies and may have used its dominant position in the hospital services market to secure a competitive advantage for its HMO subsidiary.¹⁰

In preferring quasi-regulatory controls over the market and dismissing the dynamic benefits of managed care competition, the *Butterworth* decision turned antitrust law on its head. Private regulation by supposedly benign nonprofit boards and governmental regulation in the form of the judicially approved controls over prices and profits are dubious substitutes for interfirm rivalry.¹¹ Unfortu-

nately, the Michigan court’s experiment with regulatory relief is not unique. State attorneys general have settled many hospital merger cases by allowing the merger to go forward, subject to a commitment to restrain pricing and various payments by the hospital.¹²

Finally, the hospital merger opinions betray a strong undercurrent of suspicion about the role of managed care and perhaps competition in general in health care markets. The Eighth Circuit decision in *Tenet*, for example, quoted Judge Richard Posner’s hyperbolic dictum that “the HMO’s incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible.”¹³ Other courts have gone further, explicitly downplaying testimony from managed care buyers or suggesting that competition resulting from rivalry among such entities was not in consumers’ interest.¹⁴

■ **Cartels and professional restraints of trade.** A staple of antitrust enforcement over the past twenty years has been the government’s close monitoring of collective actions by health care professionals that thwart competition. Following a landmark decision by the Supreme Court in 1975, the FTC and DOJ challenged a variety of ethical codes prohibiting contracting and affiliation with HMOs as well as dozens of private physician boycotts that sought to deter innovative financing plans, block competition from alternative-care providers, or organize collective bidding.¹⁵

Schemes that overtly stifle competition recur despite the large number of cases brought in this area. In the past two years the FTC has uncovered and punished several cartels comprising physicians and other health professionals that sought to prevent managed care entities from securing discounts. For example, the FTC charged Texas Surgeons, P.A., an independent practice association (IPA), with restraining competition among general surgeons in the Austin, Texas, area; the IPA’s actions raised costs for surgical services by more than \$1 million.¹⁶ According to the complaint, the IPA collectively refused to deal with two

health plans, terminated contracts with Blue Cross of Texas, and threatened to terminate contracts with United HealthCare of Texas if the payer did not comply with the association's demand for rate increases. Perhaps the most notable fact about this line of cases is the lack of criminal prosecution of the offenders. Abuses of this kind are routinely the subject of criminal prosecutions in other industries. Although government officials have on several occasions announced that they would not hesitate to pursue flagrant abuses in health care in criminal courts, their reluctance to do so bespeaks the atmosphere of caution in the new era.

A variety of more subtle devices that may limit the vigor of market rivalry among providers and payers also merit close scrutiny. Because these activities often implicate concerns about quality of care, they have proved vexing for the courts and regulators. Unfortunately, decided cases have failed to give clear guidance as to legal analysis, and regulatory attempts to clarify matters have foundered.

In an important case decided in 1999, *FTC v. California Dental Association*, the Supreme Court squarely faced the issue of the role of professionals in the competitive marketplace. Unfortunately, its decision failed to clarify the doctrinal issues posed by such restraints and may have muddied the analytical waters governing the latitude to be given to quality-based justifications in antitrust analysis. The case involved a restriction imposed by a private dental association on advertisements by dentists conveying either price or nonprice information. (The latter category included ads making claims of "gentle" dentistry or other qualitative assertions.) The Supreme Court concluded that the lower court and the FTC had erred in impermissibly applying an abbreviated analysis to strike down the restrictions. It held that a more searching examination was necessary, one that took into

account the imperfections of the health care market and the possibility that professional screens on advertising would shield the public from confusing or misleading information. On remand, the Court of Appeals followed the Supreme Court's instructions to conduct a more complete review and concluded that the government had failed to establish an "empirical" basis for concluding that the California Dental Association's restriction would raise prices or lower the quality of dentistry.¹⁷

The courts' insistence on *ex ante* empirical proof of competitive impact undoubtedly has raised the bar for antitrust enforcers attempting to control physician cartels. While the decision mandates a richer economic analysis of the underpinnings of health care market interactions involving professionals, at the same time it imposes enormous barriers for the government to meet the standard. The Supreme Court's requirement that antitrust

analysis incorporate consideration of market imperfections is appropriate and, according to many commentators, long overdue.¹⁸

The *California Dental* decision is problematic from a doctrinal standpoint because of the Supreme Court's failure to adopt judicially manageable tools for performing the complex inquiry it mandates. Lower courts may well find themselves at sea in assaying a detailed economic inquiry into cause-effect relationships between professional restraints and economic outcome (especially if effects on quality are to be counted). In a notable dissent, Justice Stephen Breyer, joined by three other justices, offered a means of cabin-ing the inquiry that would have served future courts dealing with professional restraints well by allowing consideration of legitimate claims that market failures distorted market outcomes and were corrective by professional actions. Unfortunately, the Court's 5-4 majority opinion opted for a far looser standard that leaves courts free to roam about, essen-

"Private litigation has inherent limitations that make it an inadequate substitute for active government enforcement."

tially trying to referee economic analyses of market behavior. Some attorneys believe that the *California Dental* opinion leaves a wide opening for professionals to assert that a broader inquiry is almost always required because quality claims can be broadly made.

■ **Networks and joint ventures among providers.** Physician networks and other joint ventures among health care providers are of particular importance in antitrust enforcement, as the size and practices of joint enterprises have a critical impact on the competitive performance of health care markets. Antitrust doctrine in this area requires a careful balancing of anticompetitive harms resulting from enhanced provider power and pro-competitive benefits arising from new entry or enhanced efficiency. Government agencies have attempted to clarify the applicability of broad antitrust doctrine to many kinds of health care ventures by issuing more than ninety advisory opinions on health industry conduct, a series of guidelines on provider joint ventures, and joint venture guidelines of general applicability.¹⁹ Although these policy statements have had a commendable impact in clarifying an agency's enforcement posture, they lack the force of law and have not been supplemented by binding court precedent.

Several concerns may be noted about the development of antitrust law governing joint ventures. First, the federal enforcement agencies have been slow to challenge physician or other provider networks or vertical linkages between payers and providers. Generally, they have targeted only near-monopolies and outright cartels. Further, the agencies' advisory opinions in many cases have generously extended the safe-harbor limits contained in their own policy statements. Consequently, many private attorneys advise clients that it is a relatively low risk proposition to form networks that encompass large segments of a market. In sum, agencies' failure to back up their advisory opinions with enforcement actions may have undermined the prophylactic potential of their advisories.

■ **Private litigation.** Antitrust law provides strong incentives for private litigation.

Persons injured by actions covered by the statutes may receive treble damages or seek injunctive relief. Although cases brought by private plaintiffs are in general less meritorious than litigation initiated by government agencies, such cases have resulted in a number of seminal antitrust precedents.²⁰

There has been a recent upsurge in cases challenging the exercise of market power by hospitals and MCOs.²¹ This trend reflects the increasing concentration of local hospital and insurance markets caused by consolidation, as physicians and hospitals have claimed that they have been foreclosed from competing by the actions of those entities. For example, in several cases physicians desiring to open outpatient surgery facilities have alleged that dominant hospital rivals effectively barred them from competing by entering into exclusive agreements with MCOs or by engaging in other predatory actions designed to bar new entrants.²² Hospitals are likewise bringing cases charging that powerful competitors have used their leverage with managed care or are tying up physician resources so as to inhibit their ability to compete.²³ The underlying theories of these cases require courts to assess and balance justifications and raise complex issues as to the extent of the defendants' market, the degree of market power, and the legitimacy of business justifications for the challenged conduct.

Although as yet these cases have resulted in few decisions, a favorable court ruling might create an influential precedent. However, private litigation has inherent limitations that make it an inadequate substitute for active government enforcement. Despite the incentives of treble damages, private parties generally cannot be counted on to police competitive abuses, as countervailing business, financial, and practical considerations often outweigh potential rewards. Second, legal doctrines of standing and antitrust injury and those barring "indirect purchasers" from bringing suit limit the field of potential plaintiffs. Finally, private plaintiffs often have incentives to settle cases for limited relief that might not vindicate the public interest.

Legislative Proposals To Immunize Providers From Antitrust Law

Although a number of proposals have been put forward over the years to curtail antitrust laws' applicability to the health care industry, only a few, relatively minor, adjustments have been enacted.²⁴ Recently, however, Congress and the states have given close attention to proposals to legalize collective bargaining by independent physicians or physician groups. A proposed federal law would essentially extend an antitrust exemption applicable to labor unions to cover independent physicians; however, an important distinction is that the bill did not require any regulatory supervision of physician unions or their collective bargaining activities by the National Labor Relations Board as is required of all other unions. Such legislative initiatives are in part a reaction to legal decisions concluding that existing law prohibits collective bargaining by "independent contractors," essentially allowing only physicians who are employees of HMOs or hospitals to jointly negotiate.²⁵

Hospitals have likewise sought legislative protection for collaboration.²⁶ Although hospitals have had some success in obtaining passage of state legislation easing antitrust review of joint ventures, these laws have not been widely used, because of strict regulatory oversight imposed at the state level and uncertainty as to whether these laws will supplant federal scrutiny.

At the federal level, H.R. 1304, the Quality Health-Care Coalition Act, which would have immunized physician collective bargaining from attack under antitrust law, won House approval in 2000 by an overwhelming 276-136 margin. (The bill did not reach the floor of the Senate.) Proponents contend that market concentration among health plans and the growing public dissatisfaction with their operations necessitate "leveling the playing field" to permit physicians to respond collectively. Free to bargain as a union, they argue, physician groups would negotiate to obtain contractual commitments and reimburse-

ment levels adequate to assure better quality of care. Opponents of the bill point to economic studies estimating that the legislation may raise annual medical costs by as much as \$29-\$141 billion over a five-year period as a result of higher physician fees, changes in practice patterns, and the ripple effect on government program costs.²⁷ Critics of immunity proposals also point out that the bill gives no assurance that the physician fee enhancements will result in higher-quality care. Moreover, professionals are not without means to influence the market: They are free to collaborate on matters of quality, to communicate dissatisfaction with plans, and to form their own group practices and IPAs to negotiate or compete with health plans or HMOs. Finally, the controversy has ethical dimensions. Although the American Medical Association (AMA) has endorsed collective bargaining, some of its leaders have cautioned that such efforts could damage public perceptions of professional norms and might entail serious questions about medical ethical standards.²⁸

States also have commenced legislative action designed to permit collective bargaining. Texas, the first state to enact such a law, allows competing physicians to meet and communicate for the purpose of jointly negotiating with health plans concerning both nonprice and, under specified conditions, fee-related terms.²⁹ More than twenty other states and jurisdictions are considering similar bills based on a model act drafted by the AMA. The impact of state legislation depends on whether it satisfies criteria established by the Supreme Court for effectively immunizing conduct approved by states from federal antitrust challenges. To qualify for such immunity, the state law must explicitly and intentionally displace competition, and the state must actively supervise the conduct through administrative regulation.³⁰

Legislators' newfound interest in exempting collective bargaining is startling not only because it represents a substantial reversal of long-standing public policy and legal precedent endorsing competitive approaches to health care, but also because of the thin justi-

fications on which exemption rests. One is hard-pressed to find a principled economic or quality-of-care rationale for provider collective bargaining or hospital cooperation statutes. Although advocates cite the need to “level the playing field” between payers and providers, an examination of local market structures reveals that few managed care markets are highly concentrated. In eighteen of the nation’s twenty largest metropolitan statistical areas (MSAs), the largest single HMO plan in the area covers fewer than 20 percent of its residents.³¹ Further, physicians face no serious obstacles to forming their own networks or sharing information about unacceptable managed care practices.³² If organized medicine is correct that such networks are capable of delivering cost-effective care in a more patient-centered manner than entities controlled by managed care can, then they should find success in the marketplace.

Although market failure can justify legislative action to improve the functioning of health markets, it is not apparent how collective bargaining would do so. It is not obvious, for example, how it would enhance patients’ access to information or improve physicians’ functioning as their agents. Moreover, there is no clear nexus between improved quality of care and collective bargaining: The dynamic of labor negotiations concerning a myriad of issues—including practice conditions and reimbursement levels for a large numbers of physicians—seems ill-suited for advancing patients’ interests.

New Directions For Antitrust Enforcement

To say that antitrust litigation involving the traditional targets of concern—physicians and hospitals—has come on hard times does not mean that the government agencies have been entirely dormant. Indeed, they have directed their resources in a number of new directions that may have important ramifications for consumers. The government recently filed its first challenge to a merger of MCOs when it sought to enjoin Aetna’s acquisition of Prudential based on the effect on the HMO

market and physician services market in Dallas and Houston.³³ The suit ultimately was settled by a consent decree requiring a spin-off of business in the contested market areas. However, the underlying theories of this case were, to say the least, controversial and would have faced considerable difficulty had the case gone to litigation.³⁴

Although government enforcers are likely to pay close attention to the structure and practices of managed care, it is important to remember that the focus of antitrust policy is on harm to consumers, not competitors. Thus, practices that irritate or inconvenience physicians or drive down their incomes may not constitute an antitrust violation unless it can be shown that they also impair consumers’ welfare. For example, an insurer’s insistence that contracting physicians participate in all plans offered by that insurer (so-called all-products clauses) may benefit insured persons. They may avoid disruptions of care because they can change plans without having to change physicians. Consumer injury is likely to arise only if the insurer has market power or is able to use the all-products clauses to inhibit competition by other insurers. It will probably be rare for an insurer to control such a large proportion of the physician market so as to be able to exert such power.

Without doubt, the most prominent sector of late has been the pharmaceutical industry, which had been the subject of a variety of governmental actions, several of which resulted in extremely large settlements. For example, Mylan, the nation’s second-largest generic drug manufacturer, agreed to pay \$100 million to disgorge overcharges on two widely used antianxiety drugs.³⁵ The FTC alleged that Mylan had entered into exclusive licensing and supply agreements for the active ingredients in these drugs to prevent other generic manufacturers from obtaining the ingredients at a competitive price. Mylan’s resulting monopoly power enabled it to raise the wholesale price of one drug, clozapate, from \$11.36 to \$377.00 for 500 tablets.

The FTC also has challenged strategic behavior in the pharmaceutical industry that

has had adverse competitive repercussions. These cases incorporate recent developments in economics that identify competitive problems that may arise from the ability to manipulate rivals' cost structures in ways that disadvantage them in the marketplace and ultimately harm consumers' welfare.³⁶ In a series of administrative complaints, the FTC has charged that brand-name drug manufacturers have effectively bought off rival generic drug manufacturers, paying them large sums of money to stay out of the market. This litigation involved novel claims of misuse of the FDA approval process through litigation settlements that, according to the FTC, have increased costs to consumers by \$100 million per year. In one case recently settled by the FTC, the agency charged that Hoechst (now Aventis) entered into an illegal conspiracy with Andrx pursuant to which Hoechst agreed to pay Andrx to delay bringing to market a generic version of Hoechst's heart drug Cardizem-CD.³⁷ The FTC also has undertaken a broad survey of seventy-five firms, seeking to learn more about patent disputes involving generic drug makers, and Congress has held hearings to reconsider the regulatory framework that may have encouraged these anti-competitive agreements.³⁸ Finally, federal enforcers have closely scrutinized pharmaceutical mergers, many involving large international firms, and in some cases have broken new ground in merger law.³⁹

The FTC's pharmaceutical industry initiative is certainly an appropriate and fruitful application of its resources in the health sector. Like Willie Sutton, the commission understandably is interested in going where the money is, not to mention chasing down politicians' current *bête noire*. At the same time, however, many in the private sector perceive this new emphasis as reflecting a disinclination to aggressively challenge structural problems in provider and payer markets.

Prognosis And Policy Recommendations

The law governing competition in health care faces challenges in both legislative and judi-

cial arenas. Case law has constrained enforcers' ability to control concentration and has given overly permissive signals to providers who are contemplating further consolidation. Moreover, doctrine has developed erratically, failing to find a coherent approach to analyzing the complex nature of health care markets, and conveying the impression that decisions are more driven by outcomes than by sound analysis of precedent and economic policy. On the other hand, there are suggestions in the case law that if pursued could strengthen the hand of enforcers. The *California Dental* decision could open the door for closer examination of the imperfections of health markets. This development coincides with recent scholarship that focuses on the need to assess directly market failures and the dimension of quality of care when gauging competitive effects of agreements or market structures.⁴⁰

In the political context, support for antitrust's role in monitoring providers' activities has eroded amid rising skepticism about the efficacy of markets in serving consumers' needs. While valid concerns about consumer protection should not legitimize provider monopolies, the political community appears ready to accept such outcomes.⁴¹ Recent trends such as the lethargic performance of the federal antitrust agencies are a reminder that political undercurrents influence the development of antitrust law in health care.

What might policymakers do to address the lack of coherence in the case law? One step would be to encourage the the legal system's self-correcting forces. Through judicial review, appellate courts can consider the precedents supplied by lower courts and sort out the doctrinal and methodological problems that conflicting approaches present. The preferred means of obtaining greater attention to competitive conditions in health markets would be to revitalize (that is, redirect resources to) federal enforcement. If, however, political will is lacking at the federal level, state attorneys general could shoulder greater enforcement responsibilities. Antitrust reviews and litigation are costly, how-

ever, and a means must be found to fund the understaffed state units. Increased revenues might be found in transaction and merger filing fees as well as various fee-shifting arrangements.

For its part, the judiciary could improve its performance by developing presumptions and precedents that will make the law more predictable and sensitive to the peculiar economics of health care markets. For example, the opinions of knowledgeable market participants—representatives of MCOs and employers who purchase hospital services on behalf of others—can supply a workable gauge of future demand responses necessary to delineate antitrust markets. Several courts have inexplicably rejected such testimony, implying that such opinion evidence might be biased.⁴² Academic research might supply some support in this area by conducting retrospective analyses of the economic outcomes of consummated mergers and refining the methodologies used for gathering and testing opinion evidence used in these cases. In the longer run, empirical methods of evaluating unilateral effects and the nature of competition in differentiated hospital markets holds out great promise for improving the reliability of judicial inquiries into these questions.⁴³

A more controversial approach would be to allow state attorneys general to conduct antitrust reviews of specified transactions and combinations as part of an administrative process. The attorney general of California is empowered to undertake such evaluations in connection with mergers involving charitable hospitals.⁴⁴ This approach raises legitimate concerns as to whether the administrative process is suitable for such examinations, the degree of transparency that will be afforded, and the need to safeguard against creating a system in which competition concerns are diluted by other policy objectives. Nevertheless, a properly designed process might be a

second-best policy option where the alternative is a health care marketplace open to cartels and tight oligopoly.

What antitrust needs most, however, is sound economic and policy research. Antitrust law relies heavily on presumptions, rules, and norms based on neoclassic microeconomic theory. Where market imperfections intrude, however, judicial fact finders often find themselves at sea. Research into the way health care purchasing is done, as described in this paper, is beginning to clarify understanding of the factors that courts should stress. Importantly, the findings of these investigations can eventually lead to the much-needed establishment of presumptions and rules of thumb that make the judicial process manageable.

Finally, continued empirical inquiry into the impact of competition on health care costs, quality, and outcomes is of central importance. If there is proof that competition does

not benefit consumers in specified circumstances, antitrust doctrine is flexible enough to countenance conduct that might be impermissible in other settings. On the other hand, evidence that competition advances consumer welfare can serve to stiffen the spines of judges and enforcers who must take on the unpopular responsibility of occasionally saying “no” to prominent local interests.

“Continued empirical inquiry into the impact of competition on health care costs, quality, and outcomes is of central importance.”

NOTES

1. B. Furrow et al., *Health Law*, 2d ed. (St. Paul: West Publishing Company, 2000), sec. 14-48.
2. *Federal Trade Commission and State of Missouri v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999). The author served as consultant to the State of Missouri in this litigation.
3. See, for example, *FTC v. Tenet*, 186 F.3d 1045.
4. C.S. Crapps et al., “The Silent Majority Fallacy of the Elzinga-Hogarty Criterion: A Critique and New Approach to Analyzing Hospital Mergers,” NBER Working Paper no. 8216 (April 2001); J. Langenfeld and W. Li, “Critical Loss Analysis in Evaluating Mergers,” *Antitrust Bulletin*, Vol. XLVI (2001): 299–337; and K.L. Danger and H.E. Frech,

- “Critical Thinking about ‘Critical Loss’ in Antitrust,” *Antitrust Bulletin*, Vol. XLVI (2001): 339–355.
5. G. Vistnes, “Hospitals, Mergers, and Two-Stage Competition,” *Antitrust Law Journal* 67, no. 3 (2000): 671–692.
 6. *U.S. v. Long Island Jewish Medical Center*, 983 F. Supp. 128 (E.D. N.Y. 1997).
 7. 946 F. Supp. 1285 (W.D. Mich. 1996), *aff’d* 121 F.2d 708 (6th Cir. 1997).
 8. See W. Lynk, “Non Profit Hospital Mergers and the Exercise of Market Power,” *Journal of Law and Economics* (October 1995): 437–461. Decisions declining to treat nonprofit hospitals differently include *Federal Trade Commission v. University Health, Inc.*, 938 F.2d 1206, 1225 (11th Cir. 1991); and *United States v. Rockford Memorial Corporation*, 898 F.2d 1278, 1286 (7th Cir. 1990).
 9. D. Dranove and R. Ludwick, “Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk’s Analysis,” *Journal of Health Economics* 18, no. 1 (1999): 87–98 (applying different model to the same data used by William Lynk and concluding that “nonprofit mergers are associated with higher prices”); and E. Keeler et al., “The Changing Effect of Competition on Nonprofit and For-Profit Hospital Pricing Behavior,” *Journal of Health Economics* 18, no. 1 (1999): 69–86. For Lynk’s response, see W. Lynk and L.R. Naumann, “Price and Profit,” *Journal of Health Economics* 18, no. 1 (1999): 99–116.
 10. D. Balto and M. Geertsma, “Why Hospital Merger Antitrust Enforcement Remains Necessary: A Retrospective on the Butterworth Merger,” *Journal of Health Law* (Spring 2001): 129–170.
 11. Technically, the court itself did not issue a decree or supervise the defendants’ “community commitment.” The court’s opinion did, however, rely on the parties’ pledge to restrain prices and profits in concluding that the merger would not lessen competition.
 12. See, for example, *Commonwealth of Pennsylvania v. Capital Health System Services*, 1995–2 Trade Cases (Commerce Clearing House, para. 71,205 [M.D. Pa. 1995]), in which the hospitals agreed to supply to the community \$56 million in free or low-cost services in return for approval of their merger.
 13. *Tenet*, quoting *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1412, 1410 (7th Cir. 1995).
 14. See Notes 8 and 11 and accompanying text.
 15. In *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), a case involving professional restrictions on competition by lawyers, the Supreme Court clarified that collective actions by professionals were not excused from the antitrust law because they were local in character or because they involved “learned professionals.” Later cases overturning professional codes and challenging car-
 - tel schemes include *American Medical Association*, 94 F.T.C. 701 (1979), *aff’d as modified*, 638 F.2d 443 (2d Circuit 1980), *aff’d by equally divided Court*, 452 U.S. 676 (1982); and *Michigan State Medical Society*, 101 F.T.C. 191 (1983). See generally, Furrow et al., *Health Law*, sec. 14-10.
 16. *Texas Surgeons, P.A.*, FTC Docket C-3944 (consent order issued 18 May 2000). See also *Alaska Healthcare Network, Inc.*, FTC Docket C-4007 (consent order issued 25 April 2001); and *Wisconsin Chiropractic Association*, FTC Docket C-3943 (consent order issued 18 May 2000).
 17. *California Dental Association v. Federal Trade Commission*, 224 F.3d 942 (9th Cir. 2000).
 18. See, for example, P.J. Hammer, “Medical Antitrust Reform: Arrow, Coase, and the Changing Structure of the Firm,” in *The Privatization of Health Care Reform*, ed. G. Bloche (New York: Oxford University Press, forthcoming); T. Greaney, “Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation,” *Connecticut Law Review* (Spring 1989): 605–665; and P. Areeda, *Antitrust Law*, Vol. 4 (New York: Aspen Publishers, 1998), para. 1504.
 19. Department of Justice and Federal Trade Commission, “Statements of Antitrust Enforcement Policy in Health Care,” <www.usdoj.gov/atr/public/guidelines/1791.htm> (12 December 2001). Advisory opinions of the FTC are available at <www.ftc.gov/bc/advisory.htm>, and business review letters of the DOJ can be found at <www.usdoj.gov/atr/public/busreview/letters.htm>. See also FTC and DOJ, *Antitrust Guidelines for Collaboration among Competitors* (2000), reprinted in *Trade Regulation Reporter*, 4, para. 13,160.
 20. See, for example, *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); and *Patrick v. Burget*, 486 U.S. 94 (1988).
 21. “Hospital Litigation: More Hospitals Sue Other Hospitals, Claim Antitrust Breaches, Network Exclusion,” *BNA Health Law Reporter* (5 April 2001): 529.
 22. See, for example, *Surgical Care of Hammond v. Hospital Services District*, 2001WL8586 (E.D. La. 2001) (dismissing plaintiff’s claim that defendant hospital attempted to drive its ambulatory surgery center out by entering into exclusive contracts with managed care firms and refusing to enter into patient transfer agreements with the center and other allegedly predatory acts); and *Rome Ambulatory Surgery Center LLC v. Rome Memorial Hospital, Inc.* (N.D. N.Y., No. 01-CV-002) (Complaint filed 1 January 2001).
 23. See, for example, *St. Luke’s Hospital v. California Pacific Medical Center* (Calif. Super. Ct., No. 300518), in which a San Francisco hospital sued the Sutter Health system claiming that the exclusive arrangement between Sutter and the city’s largest medical group restricted its ability to com-

- pete. The case was settled on terms that permitted the plaintiff hospital to affiliate with Sutter.
24. See *Health Care Quality Improvement Act*, 42 U.S.C.A., sec. 11101–11152 (1995) (antitrust immunity for certain peer review actions).
 25. See *AmeriHealth, Inc./AmeriHealth HMO*, Case 4-RC (Reg'l Director Decision) (24 May 1999).
 26. J. Entin et al., "Hospital Collaboration: The Need for an Appropriate Antitrust Policy," *Wake Forest Law Review* (Spring 1994): 107–167.
 27. See Congressional Budget Office, *Amended Cost Estimate, H.R. 1304* (Washington: CBO, 2000) (estimating costs of \$29 billion over 2001–2005); and H.E. Frech III and J. Langenfeld, "The Impact of Managed Care on Medical Costs and Access to Health Insurance" (Monograph, prepared for the Health Benefits Coalition, May 2000) (estimating costs of \$141 billion over the same period based on different assumptions about effects on utilization management, percentage of physicians that would take advantage of the legislation, and spillover effects). See also Charles River Associates, *Antitrust Waivers for Physicians: Costs and Consequences* (Boston: Charles River Associates, 2000).
 28. "AMA Delegates Decide to Create Union of Doctors," *New York Times*, 24 June 1999, A1.
 29. Texas Insurance Code, sec. 29.06(a).
 30. *Federal Trade Commission v. Ticor Insurance Company*, 504 U.S. 621 (1992).
 31. Testimony of the Antitrust Coalition for Consumer Choice in Health Care, Judiciary Committee, U.S. House of Representatives, on H.R. 1304, "The Quality Health-Care Coalition Act of 1999" (compiling InterStudy MSA Profiles, 1998), 22 June 2001, <www.healthantitrust.org/written testimony.htm> (12 December 2001).
 32. On the latitude provided by antitrust law, see Testimony of Robert Pitofsky, Judiciary Committee, U.S. House of Representatives, on H.R. 1304, "The Quality Health-Care Coalition Act of 1999." On the limited impact of physician gag clauses, see V. Bonham, "Much Ado about Nothing? Gag Clauses in Managed Care Physician Contracts," *Journal of Health and Hospital Law* (Winter 1998): 61–69.
 33. *United States and State of Texas v. Aetna Inc.*, Civil Action no. 3-99 CV 1398-H (N.D. Tex., filed 21 June 1999); and *Federal Register* 64 (1999): 44946 (consent decree and competitive impact statement).
 34. See R. Bloch, "A New and Uncertain Future for Managed Care Mergers: An Antitrust Analysis of the Aetna/Prudential Merger," *Antitrust Report* (New York: Matthew Bender and Company, October 1999); and T. Greaney, "Antitrust and the Healthcare Industry: The View from the Three Branches," *Journal of Health Law* (Summer 1999): 391–416.
 35. *FTC v. Mylan Laboratories, Inc. et al.*, Order and Stipulated Permanent Injunction, District Court for the District of Columbia, Civil No. 1:98CV03114, <www.ftc.gov/os/2000/11/mylan orderandstip.htm> (24 January 2002).
 36. See T.G. Krattenmaker and S. Salop, "Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price," *Yale Law Journal* (December 1986): 209–293.
 37. *Hoechst Marion Roussel, Inc., Carderm Capital L.P., and Andrx Corp.*, FTC Docket no. 9293 (filed 16 March 2000). The case was settled 1 April 2001. See also *In the Matter of Abbott Laboratories and Geneva Pharmaceuticals, Inc.*, FTC Docket no. C-3945; and *In the Matter of Schering-Plough Corporation, Upsher-Smith Laboratories and American Home Products Corporation*, FTC Docket no. 9297 (filed 2 April 2001).
 38. See FTC, "FTC to Study Generic Drug Competition," Press Release, 11 October 2000, <www.ftc.gov/opa/2000/10/genericdrug.htm> (12 December 2001); and statement of the Federal Trade Commission on "Competition in the Pharmaceutical Marketplace: Antitrust Implications of Patent Settlements," before the Senate Judiciary Committee, 24 May 2001, <www.ftc.gov/os/2001/05/pharmtstmy.htm> (12 December 2001).
 39. For example, the FTC has challenged pharmaceutical mergers linking potential products in the "pipeline," that is, where competition threatens to harm a "market for innovation." A complete listing of the FTC's actions involving the pharmaceutical industry is available at <www.ftc.gov/bc/rxupdate.htm> (12 December 2001). See Remarks of Sheila Anthony, Federal Trade Commission, "Riddles and Lessons from the Prescription Drug Wars: Antitrust Implications of Certain Types of Agreements Involving Intellectual Property," 1 June 2000, <ftc.gov/speeches/anthony/sfp000601.htm> (2 November 2001).
 40. See P. Hammer, "Antitrust and Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intermarket Second Best Trade-offs," *Michigan Law Review* (February 2000): 849–925; W. Sage and P. Hammer, "Competing on Quality of Care: The Need to Develop a Competition Policy for Health Care Markets," *University of Michigan Journal of Law Reform* (Summer 1999): 1069–1118; and Greaney, "Quality of Care and Market Failure Defenses."
 41. See C.C. Havighurst, "American Health Care and the Law—We Need to Talk!" *Health Affairs* (July/Aug 2000): 84–106.
 42. See, for example, *FTC v. Tenet Healthcare*, 186 F.3d 1045. See generally, T. Greaney, "Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law," *American Journal of Law, Medicine, and Ethics* 23, nos. 2 and 3 (1997): 191–220.
 43. See Crapps et al., "The Silent Majority Fallacy."
 44. *Cal. Corp. Code* sec. 5213 (2000); and *Cal. Admin. Code*, title 11, sec. 999.2.