

Critical Issues In Hospital Antitrust Law

Ensuring that hospital competition produces social benefits depends much more on regulators and legislators than on courts.

by **Peter J. Hammer and William M. Sage**

ABSTRACT: Antitrust litigation involving hospitals is common. This paper describes recent developments and underlying issues in antitrust law with respect to hospital–hospital relations, hospital–physician relations, and hospital–payer relations. A key unanswered question in each of these areas is how government regulation and public purchasing affect competitive markets for hospital services.

ANTITRUST LAW HAS PLAYED A CRITICAL ROLE in shaping modern medical markets. For better or for worse, antitrust law helped usher in the era of medicine as (big) business.¹ Lawsuits against hospitals constitute the lion's share of antitrust litigation. Between 1985 and 1999 hospitals were defendants in 61 percent of 394 medical antitrust disputes that led courts to issue formal opinions (hospitals were plaintiffs in only 6 percent).² These numbers underscore the burden of hospital antitrust litigation because most filed claims do not result in a published judicial opinion.

From an antitrust perspective, hospitals are simply business firms organized to provide medical services. Undeniably, these services involve complicated combinations of physical facilities, advanced technology, and specialized human capital. However, modern antitrust law focuses on a firm's behavior, not its objectives. Therefore, nonprofit status and similar hallmarks of good intentions are largely irrelevant to antitrust analysis. Hospital-firms can follow whatever "objective function" they like (maximization of profits, or output, or quality), as long as each enterprise pursues its objectives independently and avoids becoming a monopoly. Antitrust leaves it to the market to determine whether the achievements of a hospital-firm have social value.

The Achilles' heel of medical antitrust law is not its indifference to hospitals' (or physicians') ethical commitments and charitable impulses, but rather its inability to coherently address the role of government itself as regulator and purchaser.³ The federal antitrust laws represent default rules for the private economy; they readily yield to specific state and federal controls. Some government enact-

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ments formally supersede antitrust law under the “state action” doctrine or related doctrines of express and implied federal repeal. Typically, such instances reflect conscious public choices to replace private markets with nonmarket institutions. Ironically, the legions of well-intentioned government policies with market-distorting effects that fall short of formal preemption may be more destructive of social welfare. These regulatory schemes can invite unnecessary business transactions, impair organizational efficiency, and hamper the negotiation of mutually advantageous arrangements by willing buyers and sellers. Government is intensively involved in hospital care through Medicare and Medicaid and through state oversight of health, public safety, and the professions. Medicare policies and state requirements strongly influence both the objectives and the conduct of hospitals as competitive firms and may have unintended consequences.

Harmonizing health policy and competition policy is not an easy task. Antitrust law is designed to control the behavior of private actors, not public ones, and government purchasers may believe, erroneously, that the public and private sides of medical markets are distinct. Without careful attention to these interactions, however, neither public programs nor private competition will benefit society as much as their proponents intend.

This paper examines critical aspects of antitrust law as it affects hospital-hospital, hospital-physician, and hospital-payer relations. Each section reviews recent antitrust developments and identifies unresolved issues that underlie them, focusing on the nexus between government controls and private incentives in determining the structure of medical markets and the organization of the hospital as a rational economic firm.

Hospital-Hospital Relations

Business transactions involving hospitals are numerous, but only a few raise antitrust concerns. Strictest scrutiny is reserved for agreements between direct competitors—what antitrust lawyers call “horizontal restraints.” Because the ability to raise price unilaterally (“market power”) is a prerequisite for most antitrust violations—price fixing being an important exception—medical antitrust law may have its sharpest bite in small and medium-size communities that can support only a handful of hospitals. A transaction involving two local freestanding hospitals may well get more antitrust attention than the merger of two national hospital chains.

Attempts to prevent hospital mergers are simultaneously the most visible and the least successful aspect of public antitrust enforcement. Justice Potter Stewart once quipped that the “sole consistency” to be found in merger cases was that “the government always wins.”⁴ In health care, the government does not always win. The Federal Trade Commission (FTC) and Department of Justice (DOJ) have actively prosecuted hospital mergers since the mid-1980s. In terms of cases resulting in published court opinions, hospital mergers account for nearly half of govern-

ment enforcement activities in health care.

After initial victories by the FTC against for-profit hospitals in *American Medical International* (1984) and *Hospital Corporation of America* (1986), and by the DOJ against nonprofit hospitals in *Rockford Memorial* (1990), state and federal antitrust enforcers suffered an unprecedented series of defeats, losing all seven prosecutions they have attempted since 1995.⁵ By and large, federal enforcers brought cases that from a textbook perspective should have prevailed. The failure of these cases confirms the practical limits of law and economics in health care, as well as the continued importance of hospitals as social institutions.

■ **Recent developments.** *Market power and nonprofit hospital pricing.* Defendants have persuaded some courts to abandon traditional antitrust presumptions about the adverse effects of market power by offering expert economic testimony regarding the pricing behavior of nonprofit hospitals. In a typical (nonhospital) merger challenge, the government wins if it has properly defined the product and geographic markets and has demonstrated that the merged entity would have market power. In hospital cases, however, proving these elements seems necessary but not sufficient. At least two courts have ruled that nonprofit hospitals will not raise prices in the same manner as would for-profit hospitals or businesses outside health care with comparable market shares.⁶

Geographic boundaries of hospital markets. By any criteria, the law concerning hospital market definition is in shambles. Common sense suggests that health care, like politics, is local. In the words of Judge Richard Posner, “People want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges.”⁷ However, courts have stretched the geographic boundaries of markets to strip merging hospitals of market power and thereby shield them from antitrust liability.⁸

In *United States v. Mercy Health Services*, the court defined a geographic market around Poplar Bluff, Missouri, that included hospitals 70–100 miles away.⁹ In *United States v. Carilion Health Systems*, the court held that the market for primary and secondary services included a sixteen-county area surrounding Roanoke, Virginia, and that the market for tertiary services reached Charlottesville, Richmond, and Winston-Salem and Durham, North Carolina.¹⁰ While economists are developing new methods for measuring hospital competition and market power, these approaches have yet to be tested in major litigation.¹¹

Studying and perhaps unwinding hospital mergers. Having better empirical data about market power, nonprofit status, efficiencies of scale and scope, and coordination between competing hospitals would help antitrust lawyers, judges, and policy-makers.¹² Indeed, the FTC’s research and policy staff is studying hospital markets that had undergone mergers, to assess their economic effects. This work has strategic motives as well. No new merger case has been initiated by the FTC or DOJ since 1998, a fact that cannot be explained solely by declining numbers of corporate combinations.¹³ Studies confirming anticompetitive consequences in merger

cases lost by the government would reinvigorate their enforcement campaign. The government also could return to court seeking to unwind some transactions it failed originally to enjoin. For the FTC, challenging a consummated merger has a special advantage. Stopping a merger requires obtaining a preliminary injunction from a federal judge in the hospital's home district, but reversing a merger can be done "in house" before an administrative law judge, with appeals going first to the full commission and then to federal courts of appeals. The principal difficulty with this approach is fashioning a remedy to reestablish competition, a process described as akin to unscrambling an egg.

■ **Underlying issues.** *Structure of hospitals and other firms.* In the general economy, consumer demand and the costs of production guide firm structure, creating incentives at different times and in different places for traditional department stores, specialty retail shops, or Wal-Marts. Antitrust law takes market structure largely as given and has limited ability to ask if restructuring the market would improve competitiveness, particularly when other public actors play constitutive roles.

In earlier generations, hospitals were financed mainly through internal sources of capital such as charitable contributions. When today's hospitals "follow the money," they are primarily responding to distant health insurers, particularly government programs for the elderly and disabled.¹⁴ Nothing in Medicare policy takes explicit account of the connection between insurance reimbursement and hospital competition. The relative generosity of this revenue stream, as well as its remoteness, can easily distort firms' structure and behavior. Because of health insurance, most hospitals today are able to support a full range of specialized services and attendant technology, whereas more parsimonious funding would require hospitals in all but the largest communities to approach many projects as joint ventures. It is little wonder that merger cases scatter throughout middle America, with the FTC and DOJ viewing as market manipulation what the communities themselves see as "rationalizing" investment in expensive technology.

Hospitals as social institutions. The courtroom dynamic of nonprofit hospital merger challenges—accusations leveled by lawyers representing the federal bureaucracy against defendants with long-standing roots in the community—reflects an unusual feature of hospital markets. For the public as well as federal district judges, the question is often "Who can be trusted?" and not "What Hirfindahl-Hirschmann Index will result from the merger?" In other words, this is a battle for hearts as well as minds. Local hospitals are both market actors and important social institutions, a fact increasingly in evidence as communities deal with high rates of uninsurance, as well as concern over bioterrorism and other public health threats. Again, however, the regulatory mandates that help define the social obligations of hospitals rarely get incorporated into antitrust analysis. Instead, district judges unwilling to make rulings that contradict their gut instincts either abandon traditional economic assumptions about the adverse effects of market power or embrace strained definitions of the hospital market and

make the underlying antitrust question go away.

Quality and access as competitive goals. The foregoing factors suggest that antitrust oversight of hospital–hospital relations is a problem largely of the government’s own making. Money has poured into hospitals, mostly from taxpayers. At the same time, explicit health planning has receded, leaving competitive forces to generate not only appropriate price and output, but also appropriate clinical quality and access to hospital services. Antitrust law is poorly equipped to monitor this process without help from other public actors. For example, Medicare could do much to sharpen private incentives for quality-based competition (such as by disseminating information about comparative hospital quality) and to broaden access by improving productive efficiency (such as by subjecting specialized services to competitive bidding). At the same time, greater sensitivity on the part of antitrust enforcers and courts to how reimbursement policies influence the hospital-firm and the overall market could help legislators and regulators make more effective social choices in the first instance.

Hospital–Physician Relations

In general, agreements between parties at different levels in the chain of production or distribution—so-called vertical restraints—provoke less antitrust concern because such agreements hold the promise of increased economic efficiency without direct threats to competition. From an economic perspective, the modern hospital can be seen as organizing the production of medical services, using physician labor as both a supply input and a distribution network to patients. These are familiar vertical arrangements. However, few physicians would accept this description. The formal relationship between physicians and hospitals has historically been cast in coproduction terms, with corporate ownership of hospitals’ physical assets strictly separated from control over physicians’ specialized human capital. Physicians typically were neither employees nor investor-owners of hospital facilities but participated in self-governing medical staffs with exclusive responsibility for many aspects of hospital quality. In practice, physicians were also hospitals’ real customers, since they acted as largely unconstrained purchasing agents for patients and health insurers.

The peculiarities of this decision-making structure create challenges for economists theorizing about the nature of the firm and for judges trying to understand the competitive meaning of hospital–physician relations. For example, most antitrust violations require proof of an agreement between independent economic entities, giving legal significance to the question of whether a hospital acts as a single integrated firm or an association of autonomous actors. If a hospital is merely a gathering place for physicians, then agreements between the medical staff and the hospital (or between individual physicians on the medical staff) could constitute conspiracies in restraint of trade. On the other hand, if the hospital is a single firm, then component parts of the firm are legally incapable of conspiring with each

other under the *Copperweld* doctrine.¹⁵

In recent years horizontal consolidation and internal restructuring in response to changes in government reimbursement and private insurance purchasing have moved the hospital away from serving as a doctors' workshop and toward becoming a more integrated producer of medical care. Antitrust law has been comfortable with this transformation because it brings physician-hospital relations closer to vertical models that are familiar from other industries. As a result, current challenges relate mainly to the logical extremes of these models—situations where physicians are either employees or direct competitors of the hospital—and to the interplay of antitrust law and other health care regulation.

■ **Recent developments.** *Resident matching system.* A major development in antitrust relations between physicians and hospitals is the private challenge to the National Resident Matching Program (NRMP).¹⁶ In a class-action suit against the Association of American Medical Colleges (AAMC) and many prominent U.S. teaching hospitals, a group of resident physicians and applicants for residency allege that the NRMP and related accreditation standards for residency programs unlawfully limit training choices, lower pay, and worsen conditions of employment.¹⁷ Because the creation of a market is a lawful purpose for collective private activity under antitrust law, it is doubtful that the core of the NRMP will be held illegal even if the case reaches trial.¹⁸ By using a single algorithm to bring graduating medical students together with the training programs that value them most highly, and vice versa, the NRMP increases allocative efficiency in the labor market for residents. However, specific details of the NRMP, such as prohibitions on negotiating terms of employment prior to matching, are troubling because they go beyond the type of ancillary restriction necessary to achieve the program's legitimate goals. A twist that might prove important to the NRMP litigation is that two markets are involved simultaneously: teaching hospitals acting as buyers of residents' clinical services, and residents acting as buyers of graduate medical education.¹⁹ This is problematic for antitrust purposes because the "market" for medical education is influenced more by Medicare subsidies, other government policies, and the allocation of slots by professional self-regulatory processes than by competition.

Specialty hospitals. Changes in medical technology have blurred the boundary between inpatient and outpatient services, rendering contestable the very definition of a "hospital" and increasingly turning physicians and hospitals into direct competitors. These trends are illustrated by the emergence of specialty hospitals, which may be formed exclusively to serve cardiac patients or perform orthopedic surgery—often with physicians in leadership roles.²⁰ Proponents of specialty hospitals argue that they are better suited to use new technology and that they provide higher-quality care. Antitrust disputes can arise when a general hospital attempts to discipline physicians on its medical staff for diverting patients to newer, more specialized facilities. Although antitrust law encourages organizational innovation and market entry, it generally does not require existing competitors to

cooperate with each other or with new entrants. Just as General Motors has no obligation to cooperate with Ford or facilitate Ford's market expansion, a hospital that lacks market power may lawfully prohibit physicians associated with it from referring patients to, investing in, or accepting staff privileges at a specialty hospital. On the other hand, collective action by hospitals or by groups of otherwise independent physicians to boycott the specialty hospital and its medical staff might well violate the antitrust laws.

■ **Underlying issues.** *The physician-hospital "firm."* The transformation of general hospitals into rationally organized firms accords well with the economic principles underlying antitrust law. This is evident in cases challenging exclusive contracts to staff specific hospital departments, where courts clearly recognize hospitals' competitive interest in managing both the cost and the quality of physician services.²¹ In this respect, medical antitrust law follows the same pattern as the law governing contracts between manufacturers and distributors of branded goods in other industries: Courts accept limits on competition within brands to improve competition between brands.²² However, history militates against the smooth evolution of physician-hospital "firms."²³ While explicit legal barriers to employing physicians exist in only a handful of states, the practice-acquisition bubble of the 1990s may have sapped many hospitals of confidence in their ability to integrate physicians into hospital operations. Within antitrust law, staff privileges cases not involving exclusive contracts demonstrate continued ambivalence with respect to quality control. Although physician-plaintiffs seldom prevail, courts do not typically regard quality-based medical staff decisions as a part of hospitals' competitive strategies.²⁴ Rather, courts take refuge in older notions of hospital quality as a physician self-regulatory matter apart from competition, an approach made easier by the Health Care Quality Improvement Act of 1986, which immunized bona fide peer-review activities from antitrust liability.²⁵

Risk selection and cross-subsidization. The unequal distribution of illness affects hospitals as well as health insurers. Competitive success that is achieved through managing risk rather than improving medical services might not improve social welfare if ultimate financial responsibility is simply transferred to other payers in various forms. Medical antitrust law has yet to confront the public policy implications of risk selection.²⁶ Because physicians know the most about patients' clinical needs and financial resources and also have the greatest control over where care is rendered, these issues are likely to arise in cases involving hospital-physician relations. For example, critics argue that specialty hospitals are simply the latest scheme of cherry-picking high-end consumers. Significantly, market trends being subjected to antitrust scrutiny often represent efforts to exploit regulatory discrepancies rather than true comparative advantage. For example, specialty hospitals sidestep costly federal mandates to provide emergency care by not having emergency departments.²⁷ Similarly, the NRMP litigation follows a larger pattern of isolating and eliminating historic cross-subsidies in health care markets. Per-

haps the strongest public policy argument that can be made for the current extent of coordination in resident hiring is that keeping trainees' salaries low allows teaching hospitals to subsidize patient care. However, these considerations are anathema to conventional antitrust analysis, which assumes that unfettered markets, not the collective assertion of public objectives by private actors, will produce socially optimal outcomes.²⁸

Fraud-and-abuse law. Federal fraud-and-abuse oversight—made necessary by the public policy decision to use administered rather than negotiated or bid prices in government health programs—interacts constantly with antitrust law, although the connection is seldom mentioned explicitly. Both antitrust and antifraud enforcers generally prefer conduct by single entities to agreements entered into collectively, but their different goals have produced conflicting standards. Modern antitrust law focuses on anticompetitive effect, not evil intent, whereas most fraud-and-abuse enforcement depends on proof of unlawful motive. Antitrust law concentrates on horizontal agreements between competitors that relate to core issues of pricing and market division, tolerates other horizontal agreements unless market power exists, and permits nearly all vertical arrangements along the supply chain, but it reserves the right to condemn single entities that grow large enough to exercise monopoly power unilaterally. By contrast, the anti-kickback statute and the self-referral (Stark) prohibitions of federal fraud-and-abuse law are more critical of vertical than horizontal agreements because the likelihood of a quid pro quo involving Medicare referrals is higher; they lack a threshold principle analogous to market power for distinguishing economically harmful from economically harmless conduct; and they rely instead on specific exceptions and “safe harbors” that can be strategically manipulated.

These government policies could have unintended economic consequences. For example, fraud-and-abuse considerations could prevent hospitals from entering into efficient transactions with physicians short of actual employment—for example, bringing physicians who cannot afford commercial malpractice insurance into the hospital's coverage program at favorable rates. Similarly, staff-privileges decisions made by hospitals on economic grounds, which plausibly enhance competition, could be second-guessed under the anti-kickback statute.²⁹ On the other hand, specialty hospitals exploit a loophole in fraud-and-abuse law that allows physicians to maintain financial interests in “whole hospitals” but not specific departments.³⁰ If the department is the entire hospital, physicians can be investor-owners and make whatever referrals they want.

Hospital-Payer Relations

When buyers confront sellers in the marketplace, antitrust law expects active, often fierce bargaining. Competition in health care purchasing is complicated by multiple agency relationships on both sides. Because of physician “ordering” and health insurance, users of hospital services are different from choosers, and nei-

ther users nor choosers typically pay the bill. Managed care wrought two additional changes, with implications in each case for antitrust law. First, managed care brought explicit contracting for the sale of hospital services into the mainstream, not only directly between payers and specific facilities but also indirectly as hospitals saw the advantages of entering into business agreements with physicians, other hospitals, and nonhospital providers such as home health agencies. Second, managed care revolutionized the buyer side of transactions, creating a new class of purchasing agents for patients who were more powerful and more demanding than physicians had been, but also more clearly self-interested.

The dynamics of bargaining dominate debates over hospital-payer relations. The balance of negotiating power between hospitals and payers is largely determined by the amount of “excess” capacity in the market.³¹ In the early 1990s hospital markets were overhung with substantial underused capacity, which payers were able to parlay into large price concessions. Predictably, hospitals had strong incentives to reduce capacity through merge, exit from the market, or unilaterally reduce the number of beds.³² With diminishing capacity, power in hospital-payer negotiations shifted to hospitals in many markets. This coincided with a consumer backlash against tightly managed networks, further eroding insurers’ ability to credibly threaten hospitals with exclusion. Not surprisingly, hospital price concessions have eased, and cost trends have reversed. Hospital care again exceeds pharmaceuticals as the principal driver of health insurance premium increases.³³

Increased bargaining power does not by itself raise antitrust issues. As long as capacity reductions are the result of hospitals’ independent decisions and do not produce concentration ratios that suggest monopolization, there is no antitrust violation. However, there is a direct relationship between hospitals’ capacity and their incentives to engage in active price competition. From a policy perspective, then, the trade-off is between preserving capacity to improve competitive bidding and eliminating capacity in the name of operational efficiency.

■ **Recent developments.** *Monopsony and countervailing power.* Health care restructuring has not been limited to hospitals. Health insurers have also undergone a series of mergers, with corresponding increases in concentration in many parts of the country. Hospitals and physicians argue that buyer-side monopolies—what economists call *monopsony*—should be scrutinized for anticompetitive effects. In theory, antitrust law is concerned about monopsony as well as monopoly, since both can depress output and impair allocative efficiency. In practice, however, monopsony power is seldom the subject of antitrust enforcement.³⁴ This is particularly true in health care markets, because courts traditionally assumed that payer activism enhanced price competition, benefiting insured patients.

There are also technical obstacles to bringing successful claims against insurers. First, the geographic market for insurance is often considered national or regional rather than local, making it hard for any insurer to achieve dominance as defined by antitrust law.³⁵ Second, barriers to entry by new competitors in insurance

markets are thought to be low, making it hard to prove that even a dominant insurer will abuse its position. Third, physicians and hospitals may not have the legal right to challenge conduct by insurers that harms consumers (a direct suit by policyholders would avoid this problem, but such a suit is unlikely). For these reasons, providers concerned about insurers' negotiating power more often urge the FTC and DOJ to take action than file lawsuits themselves. They also lobby legislatures for the right to bargain collectively.³⁶ Although this approach has superficial appeal on fairness grounds, economists generally believe that the exercise of countervailing power (also called "bilateral monopoly") typically harms rather than helps consumers.

"Anchor" hospitals. Hospital markets exhibit product differentiation, meaning that consumers have clear preferences for some competitors' services over others'. Antitrust law does not prohibit a single firm from gaining a monopoly by virtue of having a superior product. However, a merger between hospitals representing consumers' clear first and second choices could have serious anticompetitive effects even if the merged hospitals' overall market share remained moderate.³⁷ In *United States v. Long Island Jewish Medical Center*, the DOJ claimed that the defendant hospitals were sufficiently prestigious to constitute must-haves for managed care networks. However, the court rejected the government's "anchor hospital" theory, in essence viewing all acute care hospitals as interchangeable.³⁸ This issue could be revisited as economic concentration increases and overall capacity falls in hospital markets, if accompanied by more explicit patterns of interdependent oligopoly behavior by the largest or most acclaimed institutions. For example, the "terminate and then negotiate" tactics used in the fall 2000 showdown between Partners HealthCare and Tufts Health Plan in Boston could be a harbinger of things to come.³⁹

Bundling and tying. Hospital-payer negotiations in differentiated markets also raise questions about multihospital systems' bundling hospitals together in all-or-nothing deals, not unlike the "all-product" clauses that some health insurers ask participating physicians to sign. Antitrust law forbids tying arrangements, situations in which a seller with market power over one product refuses to sell that product unless buyers also purchase a second, unrelated product. In health care, the fear is that a hospital system could force insurers to include less desirable hospitals in their networks, to gain access to the system's more desirable hospitals.⁴⁰ Tying prohibitions have been widely criticized by antitrust theorists on the grounds that the "tie" ordinarily does not permit the seller to do anything that it could not simply do by demanding a higher price for the more desired product in the first instance.⁴¹ However, resolving the issue in hospital antitrust litigation is likely to depend on empirical data.

■ **Underlying issues.** *Identifying buyers and buyers' agents.* Health care markets are rife with principal-agent relationships.⁴² In early cases, courts tended to assume that health insurers stood in the shoes of patient-beneficiaries, a position made tena-

ble by a strict regulatory climate that monitored the passthrough of savings to the public and prevented health insurers from exercising control over medical care itself.⁴³ Courts were slow to recognize that deregulation changed the competitive analysis of insurers' conduct. Eventually, however, the public backlash against managed care increased judicial skepticism, and courts have begun to question whether private insurers adequately advance the interests of consumers generally, or whether they represent narrower constituencies such as their enrollees, the employers who sponsor coverage, or merely themselves.⁴⁴

In the short term, distrust of insurers could rehabilitate physicians as patients' economic as well as clinical agents. In the longer term, antitrust law requires a clearer framework for evaluating agency failures, and the regulatory response to them, as a source of overall market failure in health care. Should "consumer welfare," which remains the formal touchstone of antitrust analysis, mean the interests of actual patients or the interests of healthy enrollees who are at most potential patients? Are there circumstances where the economic interests of actual payers should prevail over the interests of end users?

Contracting with government. Antitrust oversight of hospital-payer relations has seldom extended to public insurance programs such as Medicare or Medicaid, for the simple reason that those programs pay administered rather than negotiated rates. Still, private market structure has important implications for Medicare beneficiaries, particularly in terms of quality and other nonprice attributes of hospital care that are not explicitly regulated. Health policy experts often criticize politicians for handcuffing large government insurers and preventing them from exercising the leverage their size would allow in a typical market.⁴⁵ For example, several attempts to introduce competitive bidding to Medicare as demonstrations have been aborted for political reasons.⁴⁶ In the future, however, factors such as the continued growth of Medicare managed care, the likely introduction of a Medicare prescription drug benefit, and renewed interest by the Bush administration in moving federal entitlements to a Federal Employees Health Benefits Program (FEHBP)-like model will magnify the importance for government insurance programs of assuring vigorous competition in hospital markets.

HOSPITALS ARE COMPLEX and changing institutions, with a range of legal, professional, and social responsibilities. They are also economic competitors. Effective private markets often require thoughtful public sponsorship. Making sure that hospital competition remains active, and that it produces socially beneficial outcomes, therefore depends on establishing a closer and clearer connection between health care regulation and financing on the one hand and antitrust law on the other. Courts can play only a limited role in this process. Regulators and legislators must take the lead.

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NOTES

1. C.C. Havighurst, "Health Care as (Big) Business: The Antitrust Response," *Journal of Health Politics, Policy and Law* 26, no. 5 (2001): 939–955.
2. P.J. Hammer and W.M. Sage, "Antitrust, Health Care Quality, and the Courts," *Columbia Law Review* 102, no. 3 (2002): 545–649.
3. W.M. Sage and P.J. Hammer, "A Copernican View of Health Care Antitrust," *Law and Contemporary Problems* 65, no. 4 (2002): 241–290.
4. *United States v. Von's Grocery Co.*, 384 U.S. 270, 301 (1966) (Justice Potter Stewart dissenting).
5. *In re American Medical International, Inc.*, 104 F.T.C. 1 (1984); *in re Hospital Corporation of America*, 106 F.T.C. 361 (1985), affirmed, 807 F.2d 1381 (7th Cir. 1986); *United States v. Rockford Memorial*, 898 F.2d 1278 (7th Cir. 1990); and T.L. Greaney, "Whither Antitrust? The Uncertain Future of Competition Law in Health Care," *Health Affairs* (Mar/Apr 2002): 185–196.
6. *United States v. Carilion Health Systems*, 707 F. Supp. 840 (W.D. Va. 1989); and *F.T.C. v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996). William Lynk's research suggests that nonprofit hospitals with market power do not charge higher prices. W. Lynk, "Nonprofit Hospital Mergers and the Exercise of Market Power," *Journal of Law and Economics* 38, no. 2 (1995): 437–461; and W. Lynk and L. Neumann, "Price and Profit," *Journal of Health Economics* 18, no. 1 (1999): 99–116. This claim has been criticized. See D. Dranove and R. Judwick, "Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis," *Journal of Health Economics* 18, no. 1 (1999): 87–98; and E. Keeler, G. Melnick, and L. Zwanziger, "The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior," *Journal of Health Economics* 18, no. 1 (1999): 69–86. More recent studies further support the proposition that market power results in higher prices for both nonprofit and for-profit hospitals. See M. Gaynor and W.B. Vogt, "Competition among Hospitals," NBER Working Paper no. 9471 (Cambridge, Mass.: National Bureau of Economic Research, 26 November 2002). There is some evidence that locally controlled nonprofit hospitals raise prices to a lesser extent than nonprofit hospitals that are affiliated with larger hospital systems. See G.J. Young, K.R. Desai, and F.J. Hellinger, "Community Control and Pricing Patterns of Nonprofit Hospitals: An Antitrust Analysis," *Journal of Health Politics, Policy and Law* 25, no. 6 (2000): 1051–1081.
7. *United States v. Rockford Memorial* (1990).
8. B. Furrow et al., *Health Law*, 2d ed. (St. Paul, Minn.: West Publishing Company, 2000), sec. 14-49.
9. *United States v. Mercy Health Services*, 902 F. Supp. 968, 972 (N.D. Iowa 1995), vacated, 107 F.2d 632 (8th Cir. 1997).
10. *United States v. Carilion Health Systems*, 707 F. Supp. 840 (W.D. Va. 1989), affirmed, 892 F.2d 1042 (4th Cir.).
11. Gaynor and Vogt, "Competition among Hospitals"; and M.W. Sohn, "A Relational Approach to Measuring Competition among Hospitals," *Health Services Research* 37, no. 2 (2002): 457–482.
12. W.M. Sage, "Judge Posner's RFP: Antitrust Law and Managed Care," *Health Affairs* (Nov/Dec 1997): 44–61.
13. Hospital mergers in 1994–1998 were frantic, with more than 1,000 deals involving nearly 3,500 facilities. M.E. Guerin-Calvert et al., "Economic Analysis of Healthcare Cost Studies Commissioned by Blue Cross Blue Shield Association," 25 February 2003, www.hospitalconnect.com/aha/press_room-info/content/EconomistReport030225.pdf (11 August 2003) (data derived from the AHA Annual Survey and *Modern Healthcare*). Merger activity has declined markedly. Compared to a high of 235 deals in 1996, only 60 deals were reported in 2002.
14. In 2001 Medicare and Medicaid paid \$212.4 billion for hospital services; private insurers paid \$152.1 billion. K. Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (Jan/Feb 2003): 154–164.
15. *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984). Even in situations where the unity of interest between the medical staff and the hospital administration was questionable, antitrust courts in the 1980s were quick to invoke *Copperweld* as a convenient means of dismissing staff-privileges cases. Medical markets have changed sufficiently that today most hospitals would comfortably fall within the *Copperweld* requirements without stretching the truth.
16. *Jung v. Association of American Medical Colleges* (D. D.C.) (1:02CV00873) (7 May 2002).
17. F.H. Miller and T.L. Greaney, "The National Resident Matching Program and Antitrust Law," *Journal of the American Medical Association* 289, no. 7 (2003): 913–918.

18. *Chicago Board of Trade v. United States*, 246 U.S. 231 (1918).
19. Medicare Payment Advisory Commission, *Report to the Congress: Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals* (Washington: MedPAC, August 1999); and J.P. Newhouse and G.R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs* (Mar/Apr 2001): 136–147.
20. K.J. Devers, L.R. Brewster, and P.B. Ginsburg, "Specialty Hospitals: Focused Factories or Cream Skimmers?" Issue Brief no. 62 (Washington: Center for Studying Health System Change, April 2003).
21. Hammer and Sage, "Antitrust, Health Care Quality, and the Courts."
22. P.J. Hammer, "How Doctors Became Distributors: A Fabled Story of Vertical Relations," *Loyola Consumer Law Reporter* 14, no. 4 (2002): 411–438.
23. P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); and R. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).
24. Hammer and Sage, "Antitrust, Health Care Quality, and the Courts."
25. 42 U.S.C., secs. 11,101–11,152 (2003).
26. Sage and Hammer, "A Copernican View of Health Care Antitrust"; and W.M. Sage, D.A. Hyman, and W. Greenberg, "Why Competition Law Matters to Health Care Quality," *Health Affairs* (Mar/Apr 2003): 31–44.
27. The Emergency Medical Treatment and Active Labor Act (EMTALA, 42 U.S.C.A., sec. 1395dd) requires all hospitals participating in Medicare that have emergency rooms to provide screening exams and to stabilize the emergency conditions of any patient coming to their emergency room.
28. A variant of the argument succeeded in *United States v. Brown University*, 5 F.3d 658 (3d Cir. 1993), a case that eventually settled but remains the closest analogy to the NRMP challenge. In *Brown University*, a group of prominent colleges claimed that avoiding bidding wars for individual applicants by setting financial aid packages collectively allowed them to offer financial aid to a greater number of incoming students.
29. R.L. Nagele, "Hospital Privileges as Kickbacks? The Economic Credentialing Debate Commands Renewed Attention," in 2003 *Health Law Handbook*, ed. A.G. Gosfield (St. Paul, Minn.: West Group, 2003), 315–381.
30. 42 U.S.C., sec. 1395nn(d)(3).
31. "Redefining Hospital Capacity," *AHA Trend Watch* (September 2000): 1–8.
32. B.C. Strunk, P.B. Ginsburg, and J.R. Gabel, "Tracking Health Care Costs," 26 September 2001, www.healthaffairs.org/WebExclusives/Strunk_Web_Excl_092601.htm (11 August 2003).
33. *Ibid.*
34. In 542 judicial opinions published between 1985 and 1999, monopsony power was addressed on only two occasions. Hammer and Sage, "Antitrust, Health Care Quality, and the Courts."
35. *Ball Memorial Hosp., Inc. v. Mutual Hosp., Inc.*, 784 F.2d 1325 (7th Cir. 1986).
36. F.J. Hellinger, "An Analysis of Physician Antitrust Exemption Legislation," *Journal of the American Medical Association* 286, no. 1 (2001): 83–88.
37. C.S. Capps et al., "The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers," NBER Working Paper no. 8216 (Cambridge, Mass.: NBER, April 2001).
38. *United States v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (E.D. N.Y. 1997).
39. "Managed Care Crunch," *Boston Globe*, 25 October 2000.
40. J. Blumstein, "Framing Presentation" (DOJ/FTC Hearings on Health Care Competition Law and Policy, 27 February 2003), www.ftc.gov/ogc/healthcarehearings/030327trans.pdf, 17–40 (11 August 2003).
41. R.H. Bork, *The Antitrust Paradox* (New York: Free Press, 1978).
42. L. Casalino, "Managing Uncertainty: Intermediate Organizations as Triple Agents," *Journal of Health Politics, Policy and Law* 26, no. 5 (2001): 1055–1068.
43. *Kartell v. Blue Shield*, 749 F.2d 922 (1st Cir. 1984).
44. *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996).
45. B.C. Vladeck, "The Political Economy of Medicare," *Health Affairs* (Jan/Feb 1999): 22–36.
46. L.M. Nichols and R.D. Reischauer, "Who Really Wants Price Competition in Medicare Managed Care?" *Health Affairs* (Sep/Oct 2000): 30–43.