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ANTITRUST ISSUES IN HEALTH CARE REFORM

Janet L. McDavid*

INTRODUCTION

Health care has become an increasingly important part of the American economy. In 1993, the United States spent \$942.5 billion, over 14 percent of the Gross Domestic Product, on health care.¹ Expenditures for health care have grown much faster than the rate of inflation, and the Department of Commerce predicts an increase of 12.5 percent in 1994.² Although the United States spends record amounts on health care, there are still an estimated thirty-seven million people without any form of health insurance.³ These problems led President Clinton to include health care reform as a critical element of his campaign platform.⁴ It also led to the creation of the White House Health Care Task Force, which has proposed legislation that will revolutionize the way health care is delivered and paid for in the United States.⁵

At this point, no one can know exactly what kind of health care reform legislation Congress will enact. Legislators have introduced many different bills, ranging from House Bill 1200, a single-payor Canadian-type plan;⁶ to House Bill 3222, Congressman Jim

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1. Robert Pear, *\$1 Trillion in Health Costs Is Predicted*, N.Y. TIMES, Dec. 29, 1993, at A12. The Department of Commerce expects health care expenditures to exceed \$1 trillion in 1994. *Id.* Furthermore, health spending will account for a record 15 percent of the nation's total output of goods and services next year. *Id.*

2. *Id.*

3. George Anders & Ron Winslow, *Health Care Industry Is Now Restructuring; With It Comes Pain*, WALL ST. J., June 16, 1993, at A1.

4. *Rallying Around Reform*, 24 NAT. J. 2023, 2023 (1992).

5. The Health Security Act of 1993, H.R. 3600, 103d Cong., 1st Sess. (1993); see also Bonar Menninger, *Clinton Administration Has Started The Debate on U.S. Health Care; Pres. Bill Clinton's Health Care Reform Proposal*, BUS. J., Oct. 18, 1993, at 29 (describing the Clinton plan as "revolutionary").

6. The American Health Security Act of 1993, H.R. 1200, 103d Cong., 1st Sess. (1993).

Cooper's (D-Tenn.) bi-partisan plan;⁷ to House Bill 3600, the Clinton Administration's plan;⁸ to Senate Bill 1770, Senator John Chafee's (R-R.I.) plan;⁹ to House Bill 3080, Congressman Robert Michel's (R-Ill.) Republican plan.¹⁰ Nonetheless, based on the similarities between these proposals, it is possible to speculate about the broad outlines of the final plan.¹¹

The Clinton Administration describes its proposal as "managed competition."¹² Similarly, both House Bill 3222 and Senate Bill 1770 are premised on the "managed competition" concept, necessarily implying that these proposals include competition as part of their core.¹³ The concept of competition in a free market protected by vigorous antitrust enforcement is a cornerstone of the United States's economy, and should be a cornerstone of health care reform

7. The Managed Competition Act of 1993, H.R. 3222, 103d Cong., 1st Sess. (1993).

8. H.R. 3600, 103d Cong., 1st Sess. (1993).

9. The Health Equity and Access Reform Act of 1993, S. 1770, 103d Cong., 1st Sess. (1993).

10. The Affordable Health Care Now Act of 1993, H.R. 3080, 103d Cong., 1st Sess. (1993).

11. The various legislative proposals differ in many aspects. For example, the Clinton Administration's bill mandates employer contributions to health insurance (H.R. 3600, § 1006(b)), while House Bill 3222 (§§ 1001-07) and Senate Bill 1770 (§ 5003) rely on tax incentives as premium subsidies. However, while these differences are important to the overall economic and social consequences of the bills, they are not relevant to the antitrust issues raised by health care reform and will not be discussed in this article.

12. Dana Priest, *The Road to Health Care Reform*, WASH. POST, Jan. 26, 1993, § Z, at 12 (stating that President Clinton embraced the managed competition model as a way to structure the health care system).

13. Loretta McLaughlin, *The Mixed Motives of Health Reform Foes*, BOSTON GLOBE, Jan. 18, 1994, at 15 (stating that managed competition is the model for the three major plans, including President Clinton's, Sen. Chafee's, and Rep. Cooper's). These three bills, however, are different in the extent to which they rely on market-based reform or federal and state regulation. For example, the Clinton Administration's bill takes a highly regulatory approach: it establishes a national health care budget by imposing caps on health insurance premiums. H.R. 3600, § 1152(b). By 1999, increases in premiums would be limited to the same annual growth rate as the Consumer Price Index. *Id.* § 6001 (a)(3)(A). Also, it establishes a National Health Board to regulate the standard benefits package (*id.* § 1153), enforce the global budget (*id.* §§ 6011-12), monitor increases in drug prices (*id.* §§ 1503(i), 1572), and standardize measurements of quality (*id.* § 5003). The Administration's bill also calls for the establishment of Regional Health Alliances (*id.* §§ 1321-29) that will employ an estimated 50,000 people. *White House Expects 50,000 New Jobs in Health Alliances*, INSIDE WHITE HOUSE, Oct. 28, 1993, at 3. It also establishes fee schedules for fee-for-service plans. H.R. 3600, § 1322. The Clinton Administration's bill also allows states to establish single-payor, Canadian-style systems. *Id.* §§ 1221-24. In contrast, House Bill 3222 involves a less regulatory approach and relies more on market forces. Its proposed Health Care Standards Commission would establish a standard benefits package, develop factors for premium adjustments, and standardize information reporting requirements. H.R. 3222, §§ 1301-13. House Bill 3222, however, does not include a global budget or premium caps. *Id.* § 1311; *White House Sought to Dissuade Members from Supporting Cooper Bill, Sources Say*, Daily Rpt. for Execs. (BNA) No. 193, at G-3, G-6 (Oct. 7, 1993).

as well.¹⁴ The overall goals of health care reform equity and efficiency are completely consistent with the goals of antitrust laws.¹⁵ Therefore, using the antitrust laws to protect against the exercise of market power will be crucial to successful health care reform.

This Article begins by discussing the need for competition in any health care reform initiative. Next, it outlines a likely reform plan and discusses antitrust law and its application to health care reform. The Article then explains the various antitrust exemptions that may apply to different aspects of health care reform. Finally, the Article concludes by reiterating the critical role that competition and antitrust must play in the reform process.

I. THE NEED FOR COMPETITION IN HEALTH CARE REFORM

If managed competition is to succeed in cutting the costs of health care, it must restore normal economic incentives to the provision of care. One of the reasons for the current failure of the United States's health care system is that normal economic forces have been distorted, and the incentives that influence the behavior of health care providers and consumers are not set to enhance efficiency.¹⁶ For example, although the buyer in most markets must weigh the cost of a purchase, neither the health care consumer nor the physician who prescribes a course of treatment pays the direct price for purchasing decisions.¹⁷ The insurer typically bears these costs and ultimately passes them back to consumers and employers in the form of higher health insurance premiums. As a result, consumers have had little incentive to control health care expenditures, and providers have not competed on the basis of price.¹⁸ A key ele-

14. See Mitchell D. Raup, *Medicaid Boycotts by Health Care Providers: A Noerr-Pennington Defense*, 69 IOWA L. REV. 1393, 1414 (1984) (stating that antitrust laws seek to preserve the free market in which prices are set by competition and the interplay of supply and demand).

15. *Federal Agencies Set to Stay Course Pending Outcome of Health Care Reform*, Daily Rept. for Execs. (BNA) No. 97, at D-66 (May 21, 1993) (stating that a focus on traditional antitrust objectives will promote the goals of health care reform).

16. Charles A. James, Remarks Before the National Health Lawyers Association 3 (Jan. 31, 1992) (transcript on file with author) (stating that the distorted incentive system discourages efficiency and cost-containment while rewarding the over-utilization and over-provision of services).

17. *Id.* (noting that because of third-party payment, tax incentives, and subsidies, patients are insulated from the true marginal costs of their health care purchasing decisions).

18. *Id.* The current hospital overcapacity problem exemplifies the need for the restoration of normal economic principles. In response to patient demands, hospitals increased their capacity, although insurers paid the cost. The result has been substantial excess hospital capacity. Approximately one-third of the hospital beds in the United States are empty each day. Saad J. Allawi & Paul S. Levy, *Rx for Health Care*, VIEWPOINT, Winter 1993, at 59, 61.

ment in any effort to cut health care costs, therefore, will be to make both patients and providers more cost-sensitive.

Previous attempts to control health care costs have been unsuccessful. Federal Medicare and Medicaid¹⁹ programs attempted to reduce costs by cutting reimbursements; providers, however, simply shifted the unreimbursed costs to insured and private-pay patients.²⁰ Insurance companies also tried to cut costs through utilization reviews ("UR") designed to evaluate whether a course of treatment is necessary and cost-effective.²¹ However, while UR has had some moderating effect, it has not changed the economic incentives rooted in the current system.²²

While these attempts have been unsuccessful, recent evidence suggests that introducing competition into health care can restore normal economic incentives and restrain the growth rate of health care costs. A few states, such as Minnesota and California, have implemented some form of managed competition,²³ while other states, like Maryland and New Jersey, have attempted to control costs through government regulation.²⁴ Over the past three years, health care prices in states with competition have increased much more slowly than prices in regulated states.²⁵ For example, during the period from 1990 to 1992, health care prices in Baltimore increased more than 26 percent, while prices in Minneapolis increased only 13 percent.²⁶ Similarly, Calpers — the California state employees pension plan — recently introduced managed competition con-

19. Medicare is a program administered by the Social Security Administration, an agency of the United States Department of Health, Education, and Welfare. 42 U.S.C. § 1395 (1988). Medicaid is administered by individual states in accordance with a state-adopted plan that conforms to federal requirements. *Id.* § 1396.

20. *Further Cuts in Medicare, Medicaid Would Increase Cost-Shifting, CBO Says*, Daily Rept. for Execs. (BNA), at 99 (May 25, 1993).

21. *Managing Health Care*, COMPENSATION & BENEFITS REV., November 1993, at 65 (explaining that UR programs determine the appropriateness and necessity of health care and help determine where services should be provided).

22. Brian McCormick, *New Self-Referral Scrutiny: In-Office Arrangements*, AM. MED. NEWS, Jan. 18, 1993, at 1 (stating that while utilization review can help guard against unnecessary care, it would be foolish to think that economic motivations could be completely eliminated).

23. *See Impact of Provider Rate Regulation of HMOs*, PULSE (Sherlock Co., Gwynedd, Penn.), Jan. 1993, at 3 (stating that San Francisco and the Twin Cities have high HMO penetration and describing both areas as being driven by managed care).

24. *See id.* (stating that Baltimore and Newark do not have very high HMO penetration, but are highly regulated).

25. *Id.*

26. *Id.*

cepts into the Health Maintenance Organization ("HMO")²⁷ coverage it purchases for members.²⁸ Its premium rates for the 1993-1994 year increased only 1.5 percent from the rates in 1992-1993, and HMOs offered Calpers an average 1.1 percent premium reduction.²⁹

Antitrust enforcement³⁰ has already played a critical role in health care by paving the way for the development of lower-cost alternatives, such as HMOs.³¹ Without several court cases that extended antitrust law's application to professional practices,³² and the efforts of the Federal Trade Commission ("FTC") and the Department of Justice's ("DOJ") Antitrust Division to eliminate anticompetitive actions,³³ the health care reforms Congress is now considering would not be possible.³⁴ Therefore, the role antitrust law has played in the past will continue to be important to health care reform.

II. HEALTH CARE REFORM

Most proponents of health care reform hope to structure the

27. An HMO is an organization which assumes a contractual responsibility to deliver or assure the delivery of services to a defined population of enrolled persons in return for a fixed periodic prepayment made by or on behalf of enrollees. Josephine Gittler, *Hospital Cost Containment in Iowa: A Guide for State Public Policymakers*, 69 IOWA L. REV. 1263, 1270 (1984).

28. See Alain Enthoven, *Effective Cost Control in Comprehensive Health Care Reform: The Jackson Hole Approach*, VIEWPOINT, Winter 1993, at 47, 51 (stating that the Calpers plan provides the premier example of managed competition at work on a large scale).

29. Marilyn Chase & Carrie Dolan, *Calpers Proves Insurance Costs Can Be Reduced*, WALL ST. J., Feb 10, 1994, at B1.

30. The primary federal antitrust statutes are the Sherman Act (15 U.S.C. §§ 1-2 (1988)), the Clayton Act (15 U.S.C. §§ 12-14, 19-22, 27 (1988)), the Robinson-Patman Act (15 U.S.C. §§ 13-13(b), 21(a) (1988)), and the Federal Trade Commission Act (15 U.S.C. §§ 41-58 (1988)). The primary agencies that enforce the antitrust laws are the Federal Trade Commission and the Department of Justice's Antitrust Division. AMERICAN BAR ASSOCIATION WORKING GROUP ON HEALTH CARE REFORM, ANTITRUST IMPLICATIONS OF HEALTH CARE REFORM 1 n.2 (1993) (on file with author) [hereinafter ABA WORKING GROUP].

31. Caswell O. Hobbs III et al., *American Bar Association, Section of Antitrust Law, Report of the Special Task Force on Competition Policy*, 61 ANTITRUST L.J. 977, 979, 982 (1993); see also ABA WORKING GROUP, *supra* note 30, at 3-4 (describing how federal and state enforcement agencies have looked to antitrust laws to ensure that markets are open to alternative forms of health care delivery systems).

32. See *infra* notes 58-110 and accompanying text (discussing the application of antitrust law to health care).

33. See *infra* notes 71-81 and accompanying text (describing various actions to eliminate anticompetitive arrangements).

34. ABA WORKING GROUP, *supra* note 30, at 2-4 (noting that antitrust enforcement has opened markets to new forms of health care and has paved the way for the more innovative delivery systems contemplated by health care reform).

health care system so as to restore competition on all levels. This section outlines the likely elements that health care reform legislation will include. It then discusses how these elements will create competition and thus enhance quality and efficiency in the provision of health care.

A. Outline of Likely Reform

Health care reform premised on managed competition most likely will include four essential elements: (1) competitive provider markets to stimulate productive efficiency and innovation in delivery;³⁵ (2) competitive insurance markets to stimulate productive efficiency and innovation in financing;³⁶ (3) risk adjustment mechanisms to assure equity and discourage competition by risk selection;³⁷ and (4) financial incentives for consumers to stimulate informed shopping for insurance and medical care and to control utilization and costs.³⁸

These elements would work in the following ways. Large purchasing cooperatives — also called Health Alliances, Purchasing Alliances, Regional Health Alliances,³⁹ or Health Plan Purchasing Cooperatives⁴⁰ — will act as “power buyers” of health care services, using economies of scale to assure that services are purchased at the lowest possible price.⁴¹ They would purchase health care for individuals and small employers, while large employers would work outside the Health Alliance.⁴² These Health Alliances will collect premiums

35. H.R. 3600, §§ 1321-22; H.R. 3222, § 2.

36. H.R. 3600, § 6004; H.R. 3222, § 2.

37. H.R. 3600, § 1541; H.R. 3222, § 1204. Today, many insurers control costs largely by refusing to insure higher-risk patients. Health care reform, however, will minimize risk-based discrimination. Tom Morgenthau et al., *The Clinton Cure: Reinventing Health Care*, NEWSWEEK, Oct. 4, 1993, at 36.

38. H.R. 3600, §§ 1111-35; H.R. 3222, § 1104; *id.* §§ 1201-03. House Bill 3222 relies more strongly on market forces to control co-payment levels and deductibles. See H.R. 3222, § 1307 (discussing the National Health Data System, which would prepare analyses of the performance of Accountable Health Plans (“AHPs”) and publish annual reports in order to encourage AHPs to improve their delivery of care). However, the Clinton Administration’s bill prescribes co-payment levels and deductibles, which provide fewer financial incentives for consumers to control costs. H.R. 3600, §§ 1111-35.

39. H.R. 3600, §§ 1321-29 (describing Regional Health Alliances and their powers).

40. H.R. 3222, § 1701(b)(3).

41. *Summary of President Clinton’s “Health Security Plan,”* Daily Rept. for Execs. (BNA) No. 183, at D-94 (Sept. 23, 1993) (stating that Regional Health Alliances will benefit from economies of scale). This Article refers to these purchasing cooperatives by their most common term, “Health Alliances.”

42. The Clinton Administration’s bill allows employers with 5,000 or more employees to establish “corporate alliances” and opt out of Regional Health Alliances. H.R. 3600, § 1591. Under

and then purchase a basic package of health care benefits⁴³ from competing groups of providers.⁴⁴ In addition, they will publish a "scorecard" comparing the quality and price of the different providers' services, which will serve as the basis for purchasing decisions by both consumers and providers.⁴⁵

Health care providers, on the other hand, would come together as integrated groups to provide a broad range of health care services, and possibly financing as well.⁴⁶ These groups, which are termed Accountable Health Plans ("AHPs"), would manage all facets of the delivery of health care services, including selection of and contracting with providers, utilization review, quality assurance, and claims processing.⁴⁷ For example, an insurer may form an AHP by contracting with one or more hospitals, physicians, or nonphysician providers — such as physical therapists and psychologists — to provide a full range of health care services, claims processing, and administrative services.⁴⁸ A consumer would deal principally with a primary care physician, who would act as a gate-keeper in deciding what type of care a patient needs. For example, the primary care physician would decide whether to refer a patient to a specialist and whether a patient needs hospitalization. The existence of these groups and alliances creates a need for competition in the system in order to comply with antitrust law.

B. Restoring Competition

The reformed system would attempt to restore traditional economic incentives to health care. For example, it would penalize pa-

House Bill 3222, businesses with one hundred or more employees could opt out of the Health Plan Purchasing Cooperative. H.R. 3222, § 1701(c). The Clinton Administration's bill establishes special rules that would create disincentives for corporate alliances to opt out of regional alliances, including: eliminating payroll caps on insurance premiums (H.R. 3600, § 1385); eliminating subsidies for low wage employees (*id.* § 6131); and an additional payroll tax (*id.* § 7121).

43. The government is likely to mandate the provision of a basic package of health care benefits. See Marlene Cimons, *The Clinton Health Plan; Health Care Solutions: A Mixed Bag of Opinions*, L.A. TIMES, Sept. 22, 1993, at 45 (stating that President Clinton's plan promises a basic package of health care benefits).

44. H.R. 3600, §§ 6121, 6131.

45. *Id.* § 5012.

46. See Kevin Fickensher & David Kindig, *Elements of the American Health Security Act of 1993*, PHYSICIAN EXEC., November 1993, at 4 (explaining that AHPs are expected to evolve from insurance companies and existing health care organizations).

47. ABA WORKING GROUP, *supra* note 30, at 8.

48. See *id.* (stating that the formation of AHPs contemplates collaboration among health insurers and providers).

tients who choose care not recommended by a primary care physician, such as a visit to an orthopedic surgeon or cardiologist, or who choose a specialist outside the panel participating in the AHP.⁴⁹ In those instances, the consumer would be required to pay a significant portion of the specialist's fee.⁵⁰

In addition, most AHPs, including both physicians and hospitals, would be paid on a capitated basis, meaning that the entire integrated network would receive a per capita fee for each patient each year to provide all health care required under the basic plan.⁵¹ As a result, physicians and hospitals would be at risk if they did not provide efficient, cost-effective health care. Most bills contemplate offering consumers different options, including HMOs, Preferred Provider Organizations ("PPOs"), point of service options, and fee-for-service plans.⁵² Premiums, deductibles, and co-payments would be higher for plans that allow greater consumer choice of providers.⁵³

Multiple AHPs would compete with each other to provide the highest quality care at the lowest price. Consumers would have access to comparative information about quality and outcomes, thereby encouraging competition based on quality. Also, since consumers will have a choice of which AHP to join, AHPs will have an incentive to control costs by controlling both utilization and administrative costs.⁵⁴ The AHP would negotiate the lowest possible competitive rates or fee schedules with physicians and hospitals.

Because each physician and hospital would want to participate in one or more AHPs, this would lead to competition regarding the terms on which they contract with the AHP. Also, if both payors and providers are participants in the same AHP, they will have the same incentive to offer excellent health care at the lowest possible price, and utilization review and quality assurance will be directed toward those goals.⁵⁵ Today, in contrast, payors and providers have

49. See H.R. 3600, § 1134 (describing the cost-sharing schedule for in-network and out-of-network items and services).

50. *Id.*; see also *id.* § 1402(f) (defining in-network and out-of-network items and services).

51. Fickensher & Kindig, *supra* note 46, at 4. Other AHPs would compensate physicians through salaries or fee schedules. *Id.*

52. H.R. 3600, § 1322; H.R. 3222, § 1102.

53. See H.R. 3600, § 1131-34 (describing the various cost-sharing schedules each health plan may offer).

54. See *supra* notes 46-48 and accompanying text (describing how AHPs will manage the delivery and administration of health care).

55. Providers will evaluate practice patterns for specific procedures to choose the most cost-effective way of achieving the best outcome for a patient. Alan Enthoven & Sara J. Singer, *Per-*

opposing incentives. For example, hospitals and physicians want to justify long patient stays with many services and procedures, while payors want the shortest possible stay with the lowest possible level of treatment.

Thus, there will be competition among health care providers for participation in AHPs and competition among AHPs for contracts to provide services to consumers. There also will be competition between multiple Health Alliances and between Health Alliances and large employers.⁵⁶ Proponents of health care reform contemplate more integration and collaboration in order to produce this competition and other efficiencies. However, such integration can also create market power; for example, the power to raise prices to consumers.⁵⁷ Market power in the hands of providers, insurance companies, or any other single force will minimize competition, reduce health care choices, and increase the price of health care. Therefore, health care reform and antitrust enforcement must work together to achieve an efficient use of resources while minimizing the risk of creating market power for Health Alliances, AHPs, payors, or providers. The following section describes how this would occur.

III. ANTITRUST LAW AND ITS APPLICATION TO HEALTH CARE

Historically, antitrust law has promoted competition in health care. This next section will briefly discuss the principles of antitrust law and discuss their recent application to the health care industry.

A. *The Law of Antitrust*

The primary objective of antitrust law is to open the market to all competitors so that they can compete on the basis of price, quality, and service.⁵⁸ Its basic principle is "that the unrestrained interaction

spective on Health Care; Raise Quality By Lowering Costs, L.A. TIMES, Jan. 17, 1994, at B7.

56. House Bill 3222 calls for Health Alliances with exclusive territories. H.R. 3222, § 1101. However, because House Bill 3222 allows employers with as few as 100 employees to form a corporate alliance (*id.* § 1701 (c)), competition between corporate alliances and the Health Alliance may be possible. Senate Bill 1770 also establishes individual and small employer purchasing groups (S. 1770, §§ 1141-45), as well as large employer plans (*id.* §§ 1201-07).

Under the Clinton Administration's plan, however, there can be only one Health Alliance in each geographic area, and large corporations are discouraged from forming corporate alliances. H.R. 3600, tit. I, subtit. C, § 1202(b); *see supra* note 42 (discussing the disincentives that will discourage corporate alliances from opting out of Regional Health Alliances). This would effectively eliminate competition among multiple Health Alliances.

57. *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391 (1956).

58. *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 4 (1958).

of competitive forces will yield the best allocation of our economic resources"⁵⁹ Antitrust issues are analyzed according to either the "rule of reason"⁶⁰ or the *per se* standard.⁶¹

The rule of reason is a balancing test that considers all the facts and circumstances concerning a restraint to determine whether it is an "unreasonable" restraint on competition.⁶² Under this rule, the court considers the condition and nature of the business before the imposition of the challenged restraint, the nature of the restraint, and its effects.⁶³ The *per se* rule, on the other hand, is applied to restraints that are so antithetical to the principle of competition that they are "conclusively presumed to be unreasonable and therefore illegal"⁶⁴ These restraints are those that "always or almost always tend to restrict competition and decrease output,"⁶⁵ such as horizontal price fixing,⁶⁶ market division,⁶⁷ and group boycotts by firms with market power.⁶⁸ When the restraint is "essential if the product is to be available at all,"⁶⁹ however, the restraint is analyzed — as are other less pernicious horizontal restraints — under the rule of reason.⁷⁰

B. Application to Health Care

For many years, physicians and other professionals assumed that

59. *Id.*

60. *See, e.g., Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918) (stating that the rule of reason test considers all the relevant circumstances in determining whether the imposed restraint merely regulates or suppresses competition).

61. *Northern Pac. Ry. Co.*, 356 U.S. at 5.

62. *Chicago Bd. of Trade*, 246 U.S. at 238.

63. *Id.*

64. *Northern Pac. Ry. Co.*, 356 U.S. at 5.

65. *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1, 19-20 (1979).

66. *E.g., Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 348 (1982) (applying the *per se* rule to condemn horizontal price-fixing).

67. *E.g., Palmer v. BRG*, 498 U.S. 46, 48-49 (1990) (holding that a market allocation agreement is a *per se* violation of the Sherman Act); *United States v. Topco Assocs.*, 405 U.S. 596, 608 (1972) (holding that an agreement between competitors to divide a market is a *per se* violation of the Sherman Act).

68. *E.g., Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 293 (1985) (holding that group boycotts by firms with market power merit *per se* invalidation); *United States v. General Motors Corp.*, 384 U.S. 127, 145 (1966) (holding that group boycotts are a *per se* violation of the Sherman Act).

69. *NCAA v. Board of Regents*, 468 U.S. 85, 101-03 (1984); *see also Broadcast Music*, 441 U.S. at 24 (1979) (holding that where collective action is necessary if a product is to be offered at all, it should be evaluated under the rule of reason).

70. *NCAA*, 468 U.S. at 101-03; *Broadcast Music*, 441 U.S. at 24.

the antitrust laws did not apply to them.⁷¹ Any existing doubts were cast aside in 1975 when the Supreme Court held, in *Goldfarb v. Virginia State Bar Ass'n*,⁷² that the "learned professions" qualified as "trade or commerce" within the meaning of the Sherman Act.⁷³ Following that decision, the FTC and the DOJ's Antitrust Division brought enforcement actions in an effort to eliminate anticompetitive actions such as boycotts and thus prevent physicians and hospitals from contracting with managed care plans like HMOs and PPOs,⁷⁴ efforts to exclude nonphysician health care providers from hospitals or health insurance plans,⁷⁵ and even garden-variety price-fixing.⁷⁶ The FTC and DOJ also challenged a few hospital mergers, usually where they believed it was necessary to preserve competition amongst multiple hospitals.⁷⁷ In 1975, the FTC also began its landmark case against the American Medical Association ("AMA").⁷⁸ Since that time, antitrust enforcement has opened health care markets to innovative methods of delivering health care at lower prices, such as HMOs and PPOs,⁷⁹ and has provided market access to nonphysician health care providers like psychologists⁸⁰

71. Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1099 (stating that before active enforcement of the antitrust laws against the provision of health care began in the 1970s, the prevalent thought among providers was that they were justified in insulating themselves from competitive pressures).

72. 421 U.S. 773, 793 (1975) (holding that a minimum-fee schedule published by the County Bar Association violated § 1 of the Sherman Act).

73. *Id.* at 786-88.

74. *American Medical Ass'n v. United States*, 317 U.S. 519, 530 (1943) (holding that the AMA standards limiting physicians' ability to contract with alternative delivery systems are illegal).

75. *E.g.*, *Medical Staff of Mem. Medical Ctr.*, 110 F.T.C. 541 (1988); *Health Care Mgt. Corp.*, 107 F.T.C. 285 (1985).

76. *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 349 (1982) (holding that a price-fixing scheme among physicians was *per se* illegal).

77. *Health Care Industry Policies*, 4 Trade Reg. Rep. (CCH) ¶ 13,150, at 20,755 (Sept. 15, 1993) (stating that the agencies have challenged only eight of two hundred hospital mergers in the last five years); ABA WORKING GROUP, *supra* note 30, at 4 (stating that most hospital mergers have not been challenged because it is believed that they are unlikely to create sufficient market power to raise prices or exclude competition).

78. *See American Medical Ass'n*, 94 F.T.C. 701 (1979) (issuing an order in response to an FTC complaint that required, among other things, a medical association to cease engaging in any action that would restrict its members' solicitation of patients).

79. *American Medical Ass'n v. United States*, 317 U.S. 519, 530 (1943). In *American Medical Ass'n*, the AMA was convicted on criminal conspiracy charges of restraining an early HMO-type organization from doing business by enacting a plan that made it "unethical" for physicians to contract with certain types of alternative delivery systems. *Id.* at 530.

80. *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476, 485-86 (4th Cir. 1980) (holding that a Blue Shield policy which provided payment for psychologists only if billed through a physician violated § 1 of the Sherman Act).

who often provide lower-cost services. Indeed, antitrust enforcement enabled managed health care plans to gain a toe-hold in the market, making these innovative delivery options widely available.⁸¹

Antitrust enforcement in health care differs slightly from enforcement in other contexts. For example, while certain practices — such as horizontal price fixing by physicians⁸² — are *per se* illegal regardless of the professional context in which they arise,⁸³ some courts have been unwilling to apply the *per se* rule to other health care activities.⁸⁴ Courts instead have focused on several other key areas.

Antitrust enforcement agencies have vigorously applied antitrust laws to cases involving alleged price-fixing,⁸⁵ limitations on the development of new products, and restrictions on the practice of non-physician providers or physicians who practice in HMOs or clinics.⁸⁶

81. ABA WORKING GROUP, *supra* note 30, at 1-2.

82. *E.g.*, *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 349 (1982) (holding a physician horizontal price-fixing scheme to be *per se* illegal).

83. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 222 (1940) (stating that, as far as price-fixing agreements are concerned, the Sherman Act is a uniform rule applicable to all industries alike).

84. *See, e.g.*, *Wright v. Southern Mono Hosp. Dist.*, 631 F. Supp. 1294 (E.D. Cal. 1986) (holding that the *per se* rule was not applicable to either a group boycott of a staff member or a clinical privileges rule because of the court's lack of familiarity with regulation in the profession and because both practices related to the "public service" facet of the profession); *Pontius v. Children's Hosp.*, 552 F. Supp. 1352 (W.D. Pa. 1982) (holding that the refusal to refer patients to the plaintiff was not a *per se* violation since the boycott was based on ethical reasons); *McElhinney v. Medical Protective Co.*, 549 F. Supp. 121 (E.D. Ky. 1982) (holding that the *per se* rule did not apply to a physician since the action had a de minimis impact on the competitive market); *Medical Arts Pharmacy v. Blue Cross & Blue Shield*, 518 F. Supp. 1100 (D. Conn. 1981) (holding that a payment and reimbursement plan was not *per se* illegal since it had no effect on competition); *Everhart v. Jane C. Stormont Hosp. & Training Sch. for Nurses*, 1982-1 Trade Cas. (CCH) ¶ 64,703, at 73,895 (D. Kan. 1982) (holding that the denial of hospital staff privileges was not a *per se* illegal group boycott).

85. Antitrust laws prohibit conspiracy and collusion to keep costs artificially low or prices artificially high. *See Maricopa*, 457 U.S. at 349 (1982) (holding price-fixing in the health care context to be a *per se* violation of the Sherman Act). Price-fixing among competitors defeats the very purpose of competition by keeping prices to consumers artificially high. *Id.* at 344-49 (discussing the effects of price-fixing).

86. *See, e.g.*, *Diran Seropian, M.D.*, 57 Fed. Reg. 44,748 (1992) (prohibiting a physician from conspiring with a medical staff to prevent competition); *Debes Corp.*, 57 Fed. Reg. 39,205 (1992) (preventing a nursing home's boycott of certain nurse registries); *Medical Staff of Broward Gen. Medical Ctr. & Holy Cross Hosp.*, 56 Fed. Reg. 49,184 (1991) (prohibiting the medical staffs of Florida hospitals from entering or attempting to enter into any agreement which would prevent or restrict the offering or delivery of health care services by other providers); *Medical Staff of Doctors' Hosp.*, 110 F.T.C. 476 (1988) (banning the boycott of a hospital that was planning to open an HMO); *North Carolina Orthopedic Ass'n*, 108 F.T.C. 116 (1986) (prohibiting the boycott of podiatrists); *State Volunteer Mut. Ins. Co.*, 102 F.T.C. 1232, 1236-37 (1983) (prohibiting an insurance company from applying different underwriting criteria to physicians based on whether

Also, the DOJ recently brought criminal price-fixing charges against an association of Tucson dentists,⁸⁷ and both the FTC and the DOJ are currently investigating other possible price-fixing violations.⁸⁸ Limits on advertising expenditures and content also have recently been prohibited.⁸⁹ Thus, while antitrust law is generally applicable to health care, it is necessary to focus on specific aspects of the health care industry in order to understand the role antitrust can play in the reform process.

they were affiliated with nurse midwives); *Forbes Health Sys. Medical Staff*, 94 F.T.C. 1042, 1045 (1979) (banning the obstruction of hospital privileges for HMO physicians); *Medical Serv. Corp.*, 88 F.T.C. 906 (1976) (banning the denial of Blue Shield participation to HMO physicians).

87. *United States v. Alston*, 974 F.2d 1206, 1209 (9th Cir. 1992) (holding that dentists who met to determine fees had engaged in price-fixing in violation of the Sherman Act).

88. *FTC v. Indiana Fed. of Dentists*, 476 U.S. 447, 457-65 (1986) (enjoining a conspiracy that had resulted in a restraint on trade); *United States v. Massachusetts Allergy Soc'y, Inc.*, 1992-1 Trade Cas. (CCH) ¶ 69,846, at 68,006, 68,007-008 (D. Mass. 1992) (prohibiting fixed fees for allergy services by an HMO or by individual physicians with a third-party payor); *United States v. Burgstiner*, 1991-1 Trade Cas. (CCH) ¶ 69,422, at 65,711, 65,712 (S.D. Ga. 1991) (prohibiting the exchange of information concerning current or future medical fees for a period of ten years as well as any agreement to fix, raise, or maintain medical fees).

The FTC and DOJ have also filed civil cases involving efforts to increase prices or prevent cost-containment efforts. *McLean County Chiropractic Ass'n*, [Jan.-June 1994] *Antitrust & Trade Reg. Rep. (BNA) No. 1646*, at 11 (Jan. 13, 1994) (barring thirteen competing chiropractors from agreeing to set prices for patients and the terms of third-party payor contracts); *Southeast Colo. Pharmacal Ass'n*, 57 Fed. Reg. 52,631 (1992) (prohibiting a boycott in order to participate in reimbursement programs); *Peterson Drug Co., N.Y.*, 57 Fed. Reg. 21,290 (1992) (prohibiting a boycott in order to prevent cost containment); *Southbank IPA, Inc.*, 57 Fed. Reg. 2913 (1992) (prohibiting a physician from entering into any agreement with another physician to fix, stabilize, or tamper with any fee or price or any physician services); *Chain Pharmacy Ass'n*, 56 Fed. Reg. 9,223 (1991) (prohibiting two pharmacy chains from entering into any agreement with other pharmacies to withdraw from or to refuse to enter into any third-party payor prescription drug participation agreements); *Pharmaceutical Soc'y of Orange County*, 55 Fed. Reg. 31,441 (1990) (prohibiting, among other things, four pharmaceutical societies from organizing or entering into any agreement among pharmacy firms to withdraw from or refuse to enter into a third-party payor prescription drug plan); *Michigan State Medical Soc'y*, 101 F.T.C. 191 (1983) (prohibiting a medical society from entering into agreements with its members to affect the amount, manner of calculating, or terms of reimbursement for health care services).

The FTC recently charged manufacturers of infant formula with price-fixing by taking actions intended to coordinate pricing decisions. *FTC v. Abbott Labs.*, 1992-2 Trade Cas. (CCH) ¶ 69,996, at 68,832 (D.D.C. 1992); *FTC v. Mead Johnson & Co.*, No. 92-1366 (D.D.C. June 11, 1992) (complaint); *FTC v. American Home Prods. Corp.*, No. 92-1365 (D.D.C. June 11, 1992) (complaint).

89. See *United States v. Hospital Ass'n of Greater Des Moines, Inc.*, 1993-1 Trade Cas. (CCH) ¶ 70,160, at 69,733, 69,734 (S.D. Iowa 1993) (prohibiting a hospital association and its members from limiting or regulating the types or amount of advertising done by area hospitals); *National Ass'n of Social Workers*, 58 Fed. Reg. 17,441, 17,444 (1993) (prohibiting restrictions on the solicitation of and participation in patient referral services and truthful advertising); *Tarrant County Medical Soc'y*, 110 F.T.C. 119, 122 (1987) (prohibiting restrictions on the amount, size, and duration of physicians' advertising).

IV. ANTITRUST AS A TOOL TO ANALYZE HEALTH CARE ISSUES

Using an antitrust framework to analyze possible health care structures is useful since antitrust laws are centered around the interests of consumers.⁹⁰ Moreover, given the experience of antitrust enforcement agencies in the health care market and the courts' deference to health care professionals,⁹¹ antitrust enforcement will likely assist in achieving the goals of health care reform. This section analyzes the antitrust issues that health care reform presents by discussing certain activities that have long been the subject of considerable antitrust attention and analysis.

A. Monopsony

Large buying cooperatives, such as the proposed Health Alliances, may present issues of monopsony.⁹² Monopsony, also known as buyer power, involves purchasers who use their size, or market power, to drive prices down.⁹³ This conduct may be unlawful under

90. See Janet D. Steiger, Address Before the National Health Lawyers Association Program on Antitrust in the Healthcare Field 9 (February 19, 1993) (transcript on file with author) [hereinafter *Steiger Speech*] (stating that "[v]igorous antitrust enforcement can help ensure that change responds to market forces and thus reflects consumers' wants and needs").

91. See *supra* notes 82-84, *infra* notes 99-103 and accompanying text (discussing cases that exemplify how the courts have sparingly applied the *per se* rule in the health care context).

92. See *supra* notes 54-57 and accompanying text (describing how the proposed Health Alliances will act as "power-buyers" of health services).

93. Roger D. Blair & Jeffrey L. Harrison, *Cooperative Buying, Monopsony Power, and Antitrust Policy*, 86 Nw. U. L. Rev. 331, 331 (1992) (stating that "powerful buyers, whether acting individually, as a monopsonist, or in collusion with other buyers are capable of causing the same economic harm that the antitrust laws are designed to prevent").

Charges of monopsony in the health care area have been made against Blue Cross and Blue Shield. Providers have argued unsuccessfully that the market power of these payors allows them to demand noncompetitive prices from providers. *E.g.*, *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101, 1107 (1st Cir. 1989) (holding that a policy allowing an insurer to pay a provider more for a particular service than providers were accepting from an HMO was not a violation of the Sherman Act); *Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922, 927 (1st Cir. 1984) (holding that a legitimate buyer is entitled to use its market power to keep prices down); *Westchester Radiological Assoc., P.C. v. Empire Blue Cross & Blue Shield of N.Y., Inc.*, 707 F. Supp. 708, 714 (S.D. N.Y. 1989) (holding that antitrust laws do not prevent buyers from using market power to negotiate); *National Benefit Adm'rs, Inc. v. Blue Cross & Blue Shield of Ala., Inc.*, 1989-2 Trade Cas. (CCH) ¶ 68,831, at 62,370, 62,372 (M.D. Ala. 1989) (finding that monopoly power could not be inferred from a health insurer's alleged coverage of 37 percent of a state's population).

Several New Jersey hospitals recently challenged the formation of an integrated HMO network by Blue Cross & Blue Shield of New Jersey, claiming that it had utilized its market power to secure low prices from hospitals, had boycotted some hospitals, encouraged physicians to boycott hospitals, and fixed prices. *Beth Israel Hospital v. Blue Cross & Blue Shield of N.J., Inc.*, Civil Action No. 93-2952 (D.N.J. July 7, 1993) (complaint).

section five of the Federal Trade Commission Act,⁹⁴ and section two of the Sherman Antitrust Act,⁹⁵ which prohibit monopolization, conspiracies to monopolize, and attempted monopolization.⁹⁶

The mere pooling of buying power, however, is not *per se* illegal under antitrust laws.⁹⁷ Most purchasing groups are structured as legitimate joint ventures and thereby produce integrative efficiencies.⁹⁸ As the Supreme Court recognized in *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*,⁹⁹ group purchasing arrangements “are not a form of concerted activity characteristically likely to result in predominantly anticompetitive effects. Rather, such cooperative arrangements would seem to be ‘designed to increase economic efficiency and render markets more, rather than less, competitive.’ ”¹⁰⁰

In *Northwest Stationers*, the Supreme Court refused to apply the *per se* rule to the expulsion of a member from a purchasing cooperative of stationery retailers.¹⁰¹ According to the Court, “Unless the cooperative possesses market power or exclusive access to an element essential to effective competition, the conclusion that expulsion is virtually always likely to have an anticompetitive effect is not warranted. Absent such a showing . . . , courts should apply a rule-of-reason analysis.”¹⁰² Thus, group purchasing arrangements are analyzed under the rule of reason rather than the *per se* rule.¹⁰³ The recent DOJ/FTC joint Antitrust Enforcement Policy Statements in the Health Care Area create “safe harbors” for group purchasing

94. 15 U.S.C. § 5 (1988)

95. *Id.* § 2.

96. *Id.*

97. *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 297 (1985).

98. Charles F. Rule, Remarks at the “Antitrust and Health Care” Seminar of the Antitrust Section of the Connecticut Bar Ass’n and the Connecticut Health Lawyers Ass’n 12-13 (March 11, 1988) (transcript on file with author); see also Mark J. Horoschak, Remarks Before the American Bar Association Section of Antitrust Law 1-5 (August 11, 1992) (transcript on file with author) (discussing joint ventures in the health care context).

99. 472 U.S. 284 (1985).

100. *Id.* at 295 (citing *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1, 20 (1979)).

101. *Id.* at 297.

102. *Id.* at 296-97 (citations omitted); see also *NCAA v. Board of Regents*, 468 U.S. 85, 98-104 (1984) (holding that the application of the *per se* rule was inappropriate where horizontal restraints were necessary in the industry); *Broadcast Music*, 441 U.S. at 19-20 (holding that the *per se* rule was inapplicable to blanket licenses).

103. *Northwest Stationers*, 472 U.S. at 296-97.

arrangements that meet certain criteria.¹⁰⁴

If large buyer cooperatives such as Health Alliances are created as part of health care reform, they will try to obtain the best service at the lowest price. The risk in forming any large joint purchasing arrangement, including Health Alliances, however, is the potential misuse of monopsony power — such organizations may demand unreasonably low prices from providers that would eventually restrict output and harm consumers.¹⁰⁵ One good way to avoid an exercise of monopsony power by Health Alliances is to ensure that they are subject to the antitrust laws.

The Clinton Administration's plan poses a substantial risk of monopsony power because it allows only one Health Alliance in each geographic area and discourages the formation of corporate alliances.¹⁰⁶ Hospitals, physicians, and other providers will be forced to contract with the Health Alliance regardless of the terms and prices it offers.¹⁰⁷ The Clinton Administration's plan attempts to counter the market power of the Health Alliance by allowing providers to negotiate collectively with the Health Alliance to establish fee schedules.¹⁰⁸ The bill requires the Health Alliance to establish a fee schedule for fee-for-service plans, and it establishes an antitrust exemption for such collective fee negotiations by physicians and hospitals that would otherwise violate the antitrust laws.¹⁰⁹ House Bill

104. *Health Care Industry Policies*, *supra* note 77, at 20,755, 20,759-60. Joint purchasing arrangements are in a "safe harbor" if the members collectively account for less than 35 percent of purchases in the market and the cost of the input represents less than 20 percent of the price of the final product offered for sale by the purchasers. *Id.* The Justice Department had previously applied this standard in a series of business review letters. *See, e.g.*, Letter from Michael Boudin, Acting Assistant General, to Benjamin Seligman, Seligman & Seligman 3 (July 7, 1988) (stating in a business review letter that the DOJ would not challenge a proposal by FRA Shipper's Association since its membership had a total projected volume of less than 35 percent of available transportation capacity and its transportation costs represented no more than 20 percent of the landed cost of goods its members intended to ship) (on file with author).

105. A few cases have found that joint purchasing arrangements exercised monopsony power in violation of the Sherman Act. *E.g.*, *Kiefer-Stewart Co. v. Joseph E. Seagrams & Sons*, 340 U.S. 211, 213 (1951) (holding that distillers who had conspired to fix maximum prices above which wholesalers could not resell violated the Sherman Act); *Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219, 222-23 (1948) (holding that a purchasing arrangement between refiners who constituted the entire market violated the Sherman Act).

106. H.R. 3600, § 1202. Monopsony power is unlikely to occur if there are multiple competing Health Alliances. Jonathan M. Jacobson & Gary J. Dorman, *Joint Purchasing, Monopsony and Antitrust*, 36 ANTITRUST BULL. 1, 4 (1991).

107. *See* H.R. 3600, § 1406 (describing the role of providers in the Clinton Administration's bill).

108. *Id.* § 1322(c)(2).

109. *Id.* § 1322(c). The proposed antitrust exemption in House Bill 3600 did not appear in the

3222 is preferable because it allows some competition between the Health Alliance and corporate alliances.¹¹⁰ An even better approach would be a bill that permits the formation of multiple Health Alliances in a state or geographic area that could compete for contracts with AHPs. This would provide multiple contract opportunities for physicians, hospitals, and other providers, and obviate the need for the antitrust exemption proposed by the Clinton Administration.

B. Issues Raised By Integration

Under health care reform it is likely that there will be various kinds of integration among providers, and between providers and payors. It is also likely that there will be horizontal integration of competing or potentially competing physicians into groups, as well as integration among competing hospitals. There are also likely to be vertical integrations of hospitals, physicians, and nonphysician providers into provider networks offering a full array of health care services to consumers. Finally, there may be vertical integration among providers and payors who provide financing, claims processing, and other administrative services. Each of these types of integration raises possible antitrust issues, and each is discussed in this section.

1. Cooperative Agreements and Integration Among Competitors

Providers — both hospitals and practitioners — may integrate through mergers, joint ventures, or other contracting arrangements.¹¹¹ Horizontal integration and cooperative agreements among competitors result in fewer competitors in the market.¹¹² Such arrangements, therefore, are an archetype for antitrust concern. Anti-

outline of the Clinton Administration's plan on September 7, 1993. It was added at the last minute in response to pressure from the AMA. Anne Bingaman, the Assistant Attorney General in charge of the DOJ Antitrust Division, has defended the proposed exemption on the ground that it allows providers to band together to counteract the market power of the Health Alliance. W. John Moore, *Rough Ride*, 25 NATIONAL J. 2874, 2879 (1993).

110. See *supra* note 56 (describing how House Bill 3222 allows for competition between corporate alliances and the Health Alliance).

111. *Health Care Reform: Do Antitrust Laws Discourage Cost Cutters or Defeat Price Gougers?: Hearings Before the Subcomm. on Antitrust, Monopolies and Business Rights of the Senate Comm. on the Judiciary*, 103d Cong., 1st Sess. 23-32 (1993) [hereinafter *Hearings*] (prepared statement of Janet D. Steiger, FTC Chairman) (discussing possible exemptions for health care mergers, joint ventures, and other forms of concerted action).

112. See Horoschak, *supra* note 98, at 24 (describing how integration may lead to market power distribution in only one or a few competitors).

trust and economic principles hold that when competitors integrate, it often leads to a more efficient use of resources and creates new innovative and cost-effective products.¹¹³ At the same time, horizontal integration can concentrate market power in one or several competitors, enabling the newly integrated group to dominate the market, drive up prices, and eliminate choices.¹¹⁴

2. *Legitimate Venture or Sham*

In some cases, a joint venture is used to disguise a collusive horizontal agreement among competitors.¹¹⁵ As a result, one critical step in evaluating the legitimacy of an agreement among competitors is to determine whether the venture is a "sham" or legitimate.

The first step in this analysis is to assess whether the venture is provider-controlled. For example, in *Arizona v. Maricopa County Medical Society*,¹¹⁶ the Supreme Court found that two medical foundations, established by the local medical society for the purpose of "promoting fee-for-service medicine and [providing] the community with a competitive alternative to existing health insurance plans," were sham joint ventures that actually involved an illegal horizontal price-fixing agreement.¹¹⁷ A provider-controlled plan, however, is not necessarily illegal.¹¹⁸ As with all forms of exclusionary conduct, the conduct must produce unreasonable anticompetitive effects to be unlawful.¹¹⁹ However, once a venture or entity is determined to be provider-controlled, there is a greater risk that it will be subject to scrutiny under the *per se* rule.¹²⁰ The Supreme Court did exactly that in *Maricopa*, holding that the maximum fee schedules established by the foundations were *per se* illegal.¹²¹

When considering the control of a health care plan, courts look at

113. *Hearings*, *supra* note 111, at 23-26 (prepared statement of Janet D. Steiger, FTC Chairman); see also Horoschak, *supra* note 98, at 16-17 (discussing how many hospital joint ventures enhance efficiency and promote competition).

114. See Horoschak, *supra* note 98, at 24 (describing how a joint venture may have the ability to raise prices by concentrating market power in one or several competitors).

115. *Id.* at 7, 13-14.

116. 457 U.S. 332 (1982).

117. *Id.* at 336.

118. *Id.* (stating that in order to determine illegality under the Sherman Act, the actual purpose and effects of an agreement must be analyzed at a full trial).

119. Rule, *supra* note 98, at 6-7.

120. Horoschak, *supra* note 98, at 12-13 (discussing how inherently suspect agreements, absent a valid efficiency justification, are summarily condemned).

121. *Maricopa*, 457 U.S. at 357.

the substance of the venture rather than its form.¹²² The inquiry is whether providers "sharing substantially similar economic interests collectively exercised control of a plan under whose auspices they have reached agreements which work to the detriment of competitors."¹²³

Another issue evaluated in an analysis of a venture's legitimacy is the existence of integrative efficiencies.¹²⁴ Either or both of the following factors can indicate the existence of integrative efficiencies: the pooling of the participants' resources and the sharing of the risks associated with the joint activity;¹²⁵ or whether the venture leads to the creation of a new product.¹²⁶ Thus, joint ventures involving some potential efficiency-creating integration of the participants' re-

122. Virginia Academy of Clinical Psychologists, 624 F.2d 476, 481 (4th Cir. 1980).

123. Hahn v. Oregon Physicians' Serv., 868 F.2d 1022, 1029 (9th Cir. 1988) (holding that a prepaid health care plan comprised of between 90 to 93 percent of all eligible physicians and osteopaths was provider-controlled because a majority of the plan's governing board of trustees were physicians).

Courts consider several factors when evaluating whether a plan is provider-controlled. The key factor, however, is the composition of the venture's board of directors and other decision-making committees. See U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 594 (1st Cir. 1993) (finding that although the board of U.S. Healthcare was dominated by physicians, there was evidence indicating that the board played no role in the development of the exclusionary provision at issue); Barry v. Blue Cross of Cal., 805 F.2d 866, 868-69 (9th Cir. 1986) (finding that a physicians relations committee, consisting of sixteen doctors, that offered comments and suggestions before the plan was implemented did not establish physician control of organization); Pennsylvania Dental Ass'n v. Medical Serv. Ass'n, 745 F.2d 248, 256 (3rd Cir. 1984) (holding that the fact that dentists constituted the majority of two committees of directors did not establish a prima facie case of price-fixing); Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476, 481 (4th Cir. 1980) (finding that a Blue Shield plan was within the purview of the Sherman Act because its bylaws required a majority of the board of directors to be physicians); Michigan State Podiatry Ass'n v. Blue Cross & Blue Shield of Mich., 671 F. Supp. 1139, 1146 (E.D. Mich. 1987) (stating that a conspiracy may be found to exist when corporate directors, officers, or representatives are working on behalf of two or more entities); Human Resources Inst. of Norfolk, Inc. v. Blue Cross of Va., 498 F. Supp. 63, 66 (E.D. Va. 1980) (stating that although a subscriber majority on a board of directors did not preclude a finding of control by member hospitals, there was not any direct evidence of member hospital control).

124. See Rule, *supra* note 98, at 6-7 (discussing how economic efficiencies are considered in the analysis of effect on competition).

125. *Maricopa*, 457 U.S. at 356-57 (1982). In *Maricopa*, the Supreme Court found a venture among competing physicians to be a naked price-fixing cartel and, therefore, *per se* illegal. *Id.* The Court based this conclusion on the absence of any integrative efficiencies. *Id.* The Court also noted that partnerships — or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit — will be regarded as a single firm competing with other sellers in the market. *Id.*

126. See *NCAA v. Board of Regents*, 468 U.S. 85, 113 (1984) (holding that a television plan was not a new product); *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1, 20-23 (1979) (analyzing a blanket license covering broadcast rights as a new product); *SCFC ILC, Inc. v. VISA U.S.A., Inc.*, 819 F. Supp. 956, 973 (D. Utah 1993) (stating that if firms know they may be forced to share new products, they will be less likely to develop new products).

sources qualify for analysis under the rule of reason.¹²⁷

3. Mergers

If hospitals or physicians were to fully integrate, the merger would be subject to section seven of the Clayton Act.¹²⁸ Federal antitrust enforcement agencies would then apply the *Horizontal Merger Guidelines*¹²⁹ to define the markets involved, determine the resultant post-merger concentration, and evaluate the competitive effects of the transaction.¹³⁰ If the concentration is sufficiently high, antitrust enforcement agencies would then undertake more fact-specific studies to balance the actual effect the merger may have on the market against the efficiencies that may be created.¹³¹ The agencies would also consider forces that could constrain the merged entity's market power.¹³²

Between 1987 and 1991, the FTC and DOJ investigated only twenty-seven of 229 hospital mergers, and challenged only five.¹³³ As a result, antitrust challenges have barred relatively few hospital

127. The FTC/DOJ joint Antitrust Enforcement Policy Statements in the Health Care Area set forth criteria for analyzing such ventures and require that participants in the venture share substantial financial risks. *Health Care Industry Policies*, *supra* note 77, at 20,759-60. It does not create a safety zone for discounted or other fee-for-service arrangements, nor does it provide a safety zone for ventures involving equity investments by physicians. According to an earlier FTC policy statement, the coordination or joining of such functions as production, management, promotion, distribution, financing, and debt collection supported a finding of integration. Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48,982, 48,987 (1981).

128. Clayton Act, ch. 323, § 7, 38 Stat. 730, 731-32 (1914) (current version at 15 U.S.C. § 18 (1988)) (addressing the acquisition of stock of one corporation by another).

129. *Horizontal Merger Guidelines — 1993*, 4 Trade Reg. Rep. (CCH) ¶ 13,406, at 21,193 (April 13, 1993) [hereinafter *Horizontal Merger Guidelines*].

130. *Id.*

131. FTC Chairman Janet Steiger recently elaborated on the FTC's analysis of proposed hospital mergers:

A variety of other factors, including the experience of health care insurers and other buyers of hospital services (such as health care plans and large employers) and the transaction's effect on competition, influence the Commission's decisions as to whether to challenge a merger of hospitals. In analyzing likely competitive effects, the Commission considers the timeliness, likelihood, and sufficiency of new entry; the ability of smaller firms to expand services; the likelihood that the merged firm can exercise unilateral market power or act collusively with the other remaining firms in the market; and efficiencies that can be achieved only by the proposed merger.

Senate Hearings — Hospital Mergers, Trade Reg. Rep. (CCH) No. 268, at 3 (June 23, 1993).

132. *Horizontal Merger Guidelines*, *supra* note 129, at 21,194-195.

133. *Hearings*, *supra* note 111, at 27 n.23 (prepared statement of Janet D. Steiger, FTC Chairman). Between 1981 and 1992, the FTC investigated twenty-seven hospital mergers and issued complaints in only five. *FTC Reports Issuance of Complaints in 20% of § 7 Investigations of Hospitals*, [July-Dec.] Antitrust & Trade Reg. Rep. (BNA) No. 1629, at 289-90 (Aug. 26, 1993) [hereinafter *Investigations of Hospitals*].

mergers.¹³⁴ The recent FTC/DOJ joint Antitrust Enforcement Policy Statements in the Health Care Area create "safety zones" for mergers of small hospitals and provide for formation of physician networks that include 20 percent or less of the physicians in each specialty in the relevant geographic market.¹³⁵

4. Joint Ventures

Alternatively, providers may partially integrate for some purposes, such as contracting with AHPs, while maintaining separate, competing practices. In partial integrations, competitors form a joint venture to share the risk of economic gain or loss.¹³⁶ Hospitals, for instance, can share services — such as laundry and data processing — in which they do not compete.¹³⁷

Most joint ventures will be analyzed under the rule of reason.¹³⁸ Partial integrations that offer new services not previously offered by the participants independently are treated leniently under the antitrust laws.¹³⁹ This is particularly helpful in the health care field, where new technology may be too expensive for any provider to purchase alone.¹⁴⁰ Restrictions on competition that are reasonably ancillary to an integrated joint venture are likely to be upheld.¹⁴¹ As discussed above, where parties to a joint venture do not share economic risk, for example, where the joint venture is not integrated,

134. *Investigations of Hospitals*, *supra* note 133, at 289-90.

135. *Health Care Industry Policies*, *supra* note 77, at 20,755. The AMA has stated that the "safety zone" is "too narrow and does not reflect the needs of the market." Letter From Kirk B. Johnson, AMA, to Anne K. Bingaman and Janet D. Steiger 1 (Oct. 6, 1993) (on file with author).

136. *Doctor-Hospital Ventures Can't Fix Reimbursement Levels*, [Jan.-June] *Antitrust & Trade Reg. Rep. (BNA) No. 1508*, at 419 (Mar. 21, 1991) (stating that a joint venture allows physicians or hospitals to share risks of adverse financial results).

137. Horoschak, *supra* note 98, at 2.

138. See *Physician Agreements to Control Medical Prepayment Plans*, 46 *Fed. Reg.* 48,982 (1981) (describing the FTC's decision to proceed on a case-by-case basis in evaluating physician agreements regarding prepayment plans).

139. See *NCAA v. Board of Regents*, 468 U.S. 85, 113 (1984) (noting that although joint ventures have no immunity from the antitrust laws, a joint selling agreement may make possible a new product by reaping otherwise unattainable efficiencies); *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1, 22-24 (1979) (subjecting the issuance of blanket licenses to a rule of reason analysis, rather than declaring it *per se* unlawful price-fixing).

140. The FTC/DOJ Antitrust Enforcement Policy Statements in the Health Care Area provide a "safety zone" for such joint ventures, provided that no hospital could afford to purchase the equipment separately and that the venture includes no more than the number of hospitals whose participation is needed to support the equipment. *Health Care Industry Policies*, *supra* note 77, at 20,758.

141. See *Rothery Storage & Van Co. v. Atlas Van Lines*, 792 F.2d 210, 229 (D.C. Cir. 1986) (finding that restraints ancillary to a joint venture did not violate § 1 of the Sherman Act).

price or market allocation decisions will violate the antitrust laws.¹⁴²

Antitrust enforcement agencies are also concerned about partial integrations because the collaboration may result in "spillover" into areas in which the venture participants compete.¹⁴³ For example, several hospitals in a community can form a legitimate joint venture for the purpose of operating a Magnetic Resonance Imaging ("MRI")¹⁴⁴ clinic. The successful operation of this venture requires that the participants meet and discuss issues related to the venture. The hospital participants may, however, use these meetings to collude on aspects of services unrelated to the operation of the venture, such as which hospital will provide pediatric services and which will provide orthopedic services.¹⁴⁵ As a result, many joint venture agreements include safeguards to prevent spillover collusion.¹⁴⁶ An integration can also come under close scrutiny if it possesses market power, such as where a large proportion of area competitors participate in one venture.¹⁴⁷ If certain key competitors are represented in a joint venture, there are risks of price increases because the joint venture is the only means through which a buyer can obtain the services. Problems may also arise when physicians start a joint ven-

142. See *Palmer v. BRG*, 498 U.S. 46, 49 (1990) (finding that horizontal market allocation among actual or potential competitors is *per se* illegal); *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 345 (1982) (finding that price agreements among nonintegrated competitors are *per se* illegal); *State v. Wenatchee Valley Clinic*, 1988-1 Trade Cas. (CCH) ¶ 68,118, at 58,780 (E.D. Wash. 1988) (prohibiting a medical clinic from fixing prices). Partial integrations may also negotiate nonprice terms of a contract with third parties, but they may only serve as messengers to individual joint venturers for the price terms. *United States v. Alston*, 974 F.2d 1206, 1214 (9th Cir. 1992). Partial integrations should avoid the appearance of tie-in restraints if they may also have market power. See *Lancaster Community Hosp. v. Antelope Valley Hosp. Dist.*, 1991-1 Trade Cas. (CCH) ¶ 69,499, at 66,125 (9th Cir. 1991) (holding a hospital liable for its refusal to allow HMOs to contract for perinatal services at the hospital unless they also agreed to use the hospital for nonperinatal services).

143. U.S. DEP'T OF JUSTICE, ANTITRUST DIVISION, ANTITRUST ENFORCEMENT GUIDELINES FOR INTERNATIONAL OPERATIONS § 3.4 (1988); see also *Yamaha Motor Co. v. FTC*, 657 F.2d 971, 981 (8th Cir. 1981) (finding that various agreements between two competitors did not serve a legitimate purpose of a joint venture).

144. *Health Care Industry Policies*, *supra* note 77, at 20,758-59 (stating that this arrangement would usually fall within the antitrust safety zone).

145. See *Horoschak*, *supra* note 98, at 8 (stating that a "venture" in which hospital A provides one service and hospital B provides another does nothing more than restrain competition).

146. For cases imposing conditions to minimize the risk of spillover, see *United States v. Alcan Aluminum Ltd.*, 605 F. Supp. 619 (W.D. Ky. 1985); *General Motors Corp.*, 103 F.T.C. 374 (1984).

147. *Blue Cross of Wash. & Alaska v. Kitsap Physicians Serv.*, 1982-1 Trade Cas. (CCH) ¶ 64,590, at 73,211 (W.D. Wash. 1981); *Medical Serv. Corp.*, 88 F.T.C. 906, 908-09 (1976); see also *supra* notes 128-32 and accompanying text (describing the application of the Clayton Act to hospital or physician mergers).

ture to operate an oxygen supply business with enough referral power to monopolize the business and exclude competing oxygen suppliers.¹⁴⁸ Similarly, joint ventures by hospitals and durable medical equipment ("DME") providers have been challenged because the hospitals had unique access to patients, or coerced patients to use the DME partner.¹⁴⁹

5. Concerns for the Future

When considering health care reform, attention must be paid to the delicate balance between efficient integrations which can benefit consumers and anticompetitive concentrations of market power.¹⁵⁰ Rather than increase direct regulation, an efficient market-oriented health care system would encourage horizontal integrations that create efficiencies, but would prevent integrations that produce market power.¹⁵¹ Hospital merger enforcement by the DOJ and FTC is designed to achieve this objective.¹⁵² The federal antitrust agencies have attempted to ensure that more than one hospital is available in a geographic area to guarantee choices for consumers and payors and competition on price and quality.¹⁵³ In some ways, hospital merger enforcement has preserved the possibility that multiple AHPs, each anchored by a separate hospital, can be formed to compete in each geographic area.

148. The FTC recently challenged such ventures. *First Cases Emerge from FTC Examination of Doctor Referrals to Self-Owned Firms*, [July-Dec.] Antitrust & Trade Reg. Rep. (BNA) No. 1638, at 579-80 (Nov. 4, 1993).

149. In three recent decisions, courts concluded that the hospital at issue had market power in the inpatient acute care market and had demonstrated an intent to impair competition in the downstream DME market. See *Key Enters. of Del., Inc. v. Venice Hosp.*, 919 F.2d 1550, 1560 (11th Cir. 1990); *Advanced Health-Care Servs., Inc. v. Radford Community Hosp.*, 910 F.2d 139, 150 (4th Cir. 1990); *M & M Medical Supplies & Serv., Inc. v. Pleasant Valley Hosp., Inc.*, 1991-2 Trade Cas. (CCH) ¶ 69,618, at 66,760 (4th Cir. 1981). All three cases involved extraordinary efforts by hospitals to steer patients to affiliated DME suppliers. *Id.*

150. See *Former Division Official Discusses Antitrust Impact Under Clinton Plan*, [July-Dec.] Antitrust & Trade Reg. Rep. (BNA) No. 1639, at 630 (Nov. 11, 1993) (stating that legitimate joint ventures will be lawful unless they exercise excessive market power or engage in anticompetitive exclusionary conduct).

151. *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391 (1956) (stating that while integration can produce efficiencies, it can also create market power).

152. *Hearings*, *supra* note 111, at 28 (prepared statement of Janet D. Steiger, FTC Chairman) (noting that the FTC seeks to ensure that health care consumers have a sufficient selection of competing providers, and describing the different factors that hospital merger investigations consider so as to allow those that create efficiencies).

153. See *id.* at 26-28 (stating that the majority of hospital mergers do not endanger competition because they occur in markets with a substantial number of competitors) (prepared statement of Janet D. Steiger, FTC Chairman).

There is no magic number of AHPs that must be available to compete with one another.¹⁵⁴ Some major metropolitan areas may enjoy competition between five or even ten AHPs. But some cities may only have enough hospitals to support two or three competing AHPs.¹⁵⁵ Finally, in some rural areas there may be only one hospital, which would mean that there could be only one AHP in that area, unless the hospital participates in multiple AHPs.¹⁵⁶

Antitrust enforcement after health care reform should focus on ensuring active competition among providers.¹⁵⁷ The extent of that competition will vary by geographic area.¹⁵⁸ The antitrust agencies should attempt to maximize the competitive options available to consumers. Health care reform may also encourage the formation of other groups to counterbalance concentrations of market power. For instance, if several doctors merge their practices, their market power could be constrained by the buying power of the AHP that pays for their services.¹⁵⁹ Similarly, the power of a large AHP could be counterbalanced by the buying power of a Health Alliance.¹⁶⁰ This counterbalancing requires careful planning and the establishment of sufficient channels for individuals to express their choices about health care options, either politically or through their choice of a purchasing organization. Purchasing entities must also be able to choose among providers and to pick those that give quality care at a reasonable price.¹⁶¹

154. See Richard Kranick et al., *The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148, 149 (1993) (noting that the minimal number of plans needed to avoid a market with strong oligopolistic tendencies is not clear).

155. *Id.* at 150-51.

156. A recent report in the *New England Journal of Medicine* concluded that only 42 percent of the population lives in market areas capable of supporting three fully-integrated provider networks, while 29 percent of the population lives in thinly populated market areas that cannot support more than one integrated provider network. *Id.*

157. See *supra* notes 16-34 and accompanying text (discussing how the lack of competition has led to the failure of today's health care system).

158. See *supra* notes 105-10 and accompanying text (discussing the various bills' plans for the number of Health Alliances and corporate alliances in any given geographic area).

159. See *supra* note 47 and accompanying text (discussing how AHPs would manage the delivery of health care services, by contracting with providers, conducting utilization review, and assuring quality).

160. See *supra* notes 46-48 and accompanying text (discussing Health Alliances and how they will purchase a basic package of health care benefits from competing providers).

161. See *supra* note 16-34 and accompanying text (discussing how a lack of competition has led to the failure of today's health care system).

6. Vertical Integration

Vertical integration after health care reform is likely to include integration among physicians, hospitals, and other providers, as well as integration between providers and payors.¹⁶² Because vertical integration does not involve competitors, it typically raises fewer antitrust concerns than horizontal integration among competitors.¹⁶³ Nonetheless, vertical integration does involve some antitrust issues.

For example, vertical integrations between hospitals and providers or between providers and payors may pose antitrust problems if they foreclose access to a market.¹⁶⁴ This foreclosure could occur when one hospital possesses a high percentage of area physicians, making it difficult for other hospitals to compete for patients. Furthermore, if a hospital has exclusive contracts with a large percentage of physicians of a certain specialty, another hospital may be foreclosed from offering that specialty. If a major health insurer creates an integrated health care delivery system by contracting exclusively with one hospital in a community, other hospitals in that community are foreclosed from the subscribers of that insurer and other payors would be foreclosed from contracting with that hospital.

Typically, joint venture agreements contain ancillary vertical restraints on economic variables such as price, output, territories, customers, and access to the joint venture.¹⁶⁵ Many joint venture cases involve challenges to ancillary restraints, which must be analyzed to determine whether they will have any anticompetitive effects.¹⁶⁶

A restraint common to vertically-integrated ventures requires that the venture deal exclusively with the venture partners for certain goods or services, or that the venture partners deal exclusively with

162. ABA WORKING GROUP, *supra* note 30, at 8, 12-13.

163. *Id.*; see also ABA ANTITRUST SECTION, ANTITRUST LAW DEVELOPMENTS 99 (3d ed. 1992) (stating that vertical arrangements are typically permissible under the antitrust laws).

164. See Horoschak, *supra* note 98, at 23-24 (describing how the participation of a sufficiently high proportion of area physicians may create market power with respect to the provision of service).

165. *E.g.*, Northwest Wholesale Stationers, Inc. v. Pacific Stationary & Printing Co., 472 U.S. 284, 297 (1985); NCAA v. Board of Regents, 468 U.S. 85, 99, 103 (1984); Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1, 8-9 (1979); Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 59 (1977).

166. In general, vertical nonprice restraints such as exclusive distributorships, territorial clauses, and location clauses are analyzed under the rule of reason. See, *e.g.*, Business Elecs. Corp. v. Sharp Elecs. Corp., 485 U.S. 717, 724 (1988) (holding that vertical nonprice restraints are not *per se* illegal); Continental T.V. v. GTE Sylvania, 433 U.S. 36, 58-59 (1977) (holding that the *per se* rule does not apply to vertical restrictions).

the venture for certain services.¹⁶⁷ For example, a joint venture agreement among several hospitals for the purpose of operating an MRI might require the hospitals to use the venture MRI to the exclusion of other MRIs. These types of agreements are referred to as exclusive dealing arrangements.¹⁶⁸ Vertically-integrated ventures may also limit access to the venture. For example, a Preferred Provider Organization ("PPO")¹⁶⁹ created by an insurer may require that its subscribers utilize only PPO physicians or may require higher co-payment for non-PPO physicians, thereby effectively foreclosing non-PPO physicians from treating PPO subscribers.¹⁷⁰ This type of an exclusivity provision may give rise to claims that the venture is a vertical concerted refusal to deal.

Exclusive dealing arrangements can take two forms: (1) agreements requiring a buyer to purchase products or supplies for a significant period of time from only one supplier; or (2) agreements forbidding a buyer from purchasing from the supplier's competitors.¹⁷¹ The potential pro-competitive effects of exclusive dealing arrangements are well recognized:

In the case of the buyer, they may assure supply, afford protection against rises in price, [and] enable long-term planning on the basis of known costs From the seller's point of view, requirements contracts may make possible the substantial reduction of selling expenses, give protection against price fluctuations, and . . . offer the possibility of a predictable market.¹⁷²

167. See *Standard Oil Co. v. United States*, 337 U.S. 293, 295 (describing vertical restrictions in the form of exclusive dealing agreements as widespread); HERBERT HOVENKAMP, *ECONOMICS AND FEDERAL ANTITRUST LAW* 241 (1985) (defining an exclusive dealing agreement as a contract under which a buyer promises to buy its requirements of one or more products exclusively from a particular seller).

168. HOVENKAMP, *supra* note 167, at 241.

169. Preferred Provider Organizations are arrangements under which a group of health care providers contracts directly or through a broker with a third-party payor to provide designated services to a defined population. Josephine Gittle, *Hospital Cost Containment in Iowa: A Guide for State Public Policymakers*, 69 IOWA L. REV. 1263, 1272 (1984).

170. The courts, the FTC, and the DOJ recognize that, assuming sufficient market alternatives are available, such restrictions can encourage efficiency and will likely be pro-competitive by controlling costs. See Letter from Michael O. Wise, Acting Director, FTC, to Joseph P. Mazurek, Attorney General of the State of Montana 4 (Feb. 4, 1993) (on file with author) (discussing programs that limit the number of providers who participate in their programs and their popular success); see also *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 592 (1st Cir. 1993) (discussing an exclusivity provision in a doctor-HMO agreement where the physician agreed not to serve as a participating physician for any other HMO plan); *Barry v. Blue Cross of Cal.*, 1986-2 Trade Cas. (CCH) ¶ 67,367, at 61,953 (9th Cir. 1986) (noting the existence of certain pro-competitive elements in vertical agreements between Blue Cross and the doctors); James, *supra* note 16, at 10 (discussing an example of an exclusive dealing agreement).

171. HOVENKAMP, *supra* note 167, at 241.

172. *Standard Oil Co. v. United States*, 337 U.S. 293, 306-7 (1949).

In 1949, the Supreme Court enunciated the "quantitative substantiality" rule for determining whether an exclusive dealing arrangement is an unreasonable restraint of trade.¹⁷³ This rule measures the foreclosure of competition by focusing solely on the percentage of the relevant market impacted by the arrangement.¹⁷⁴ Later, in *Tampa Electric Co. v. Nashville Coal Co.*,¹⁷⁵ the Supreme Court adopted a rule that has been characterized as the "qualitative substantiality" test.¹⁷⁶ Instead of focusing exclusively on the percentage of the market that has been foreclosed, the Court also considers other factors, such as barriers to entry and the probable immediate and future effects of the arrangement on competition.¹⁷⁷

Exclusive dealing arrangements, therefore, are subject to a rule of reason analysis, with special emphasis on the nature, extent, and duration of market foreclosure.¹⁷⁸ As with all rule of reason analyses, the anticompetitive effects of the arrangement are weighed against

173. *Id.* at 314.

174. *Id.*; see also *Brown Shoe Co. v. United States*, 370 U.S. 294, 323-24 (1962) (holding that an important consideration in the evaluation of vertical arrangements is the market share foreclosed to the competitors of either party). The *Standard Oil* Court emphasized that other competitors in the market also used exclusive dealing arrangements and considered the collective effects of the multiple exclusive arrangements. *Standard Oil Co.*, 337 U.S. at 314.

175. 365 U.S. 320 (1961).

176. *Id.* at 331-32.

177. *Id.* at 328, 334-35; see also *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 29 (1984) (stating that in proving a violation of the Sherman Act, one must consider the actual effect on competition).

178. *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 594 (1st Cir. 1993) (stating that a common danger of exclusivity agreements is that they may foreclose so much of the available supply that existing competitors or new entrants are limited in a number of ways). Both the DOJ and the FTC consider the extent to which a market is foreclosed by provider ventures. See J. Paul McGrath, 60 *Minutes With J. Paul McGrath, Assistant Attorney, General Antitrust Division*, 54 ANTITRUST L.J. 131, 132 (1985) (stating that PPOs should not raise antitrust issues if they are not too all-inclusive in membership and are not anticompetitive); Horoschak, *supra* note 98, at 20 (noting that exclusivity arrangements that have obtained a large percentage of area physicians are likely to endanger competition by foreclosing market entry); James F. Rill, Remarks Before the National Health Lawyers Association 8-9 (Feb. 15, 1991) (transcript on file with author) (noting that the DOJ looks skeptically on the formation of a PPO among a large percentage of the providers in a community); Rule, *supra* note 98, at 13 (stating that a PPO containing all or most of the providers in a market can serve as a powerful vehicle for a protectionist boycott); see also *State v. Greater Cleveland Hosp. Ass'n*, 1983-2 Trade Cas. (CCH) ¶ 65,685, at 69,500, 69,501 (N.D. Ohio 1983) (enjoining a hospital from entering into any agreement which restrained competition among prepayment plans); Letter from Arthur M. Lerner, Assistant Director, FTC, to Gilbert Frimet (March 22, 1984) (on file with author) (informing an HMO that imposing an exclusivity requirement on their participating physicians, who accounted for 60 percent of the market, would raise concern since it could make it extremely difficult for a new or existing HMO to operate effectively).

the procompetitive effects.¹⁷⁹

Similarly, vertical "concerted refusal to deal" claims are usually analyzed under the rule of reason¹⁸⁰ and require that the plaintiff establish the existence of a contract, combination, or conspiracy, and the existence of an unreasonable restraint of trade resulting from the refusal to deal.¹⁸¹ To determine whether the restraint is unreasonable, a court balances the anticompetitive effects of the provision against its pro-competitive effects.¹⁸² There may be little or no adverse effect on competition if alternative sources of supply are available. Put another way, if the portion of the market foreclosed to the excluded entity is small, it is more likely that the restraint will be found to be reasonable. Thus, the analysis of a concerted refusal to deal claim is similar to the analysis of an exclusive dealing claim — the anticompetitive effect of the market foreclosure is then balanced against the procompetitive effects.

After health care reform, antitrust enforcement involving vertical integration should continue to focus on insuring that multiple choices are available to both consumers and purchasers of health care, like AHPs or Health Alliances. As a practical matter, there is likely to be little difference in how the antitrust laws are applied in this area after health care reform takes place.

D. Antitrust Exemptions

There are certain situations in which the antitrust laws do not apply to anticompetitive practices. Several of these antitrust exemptions are potentially applicable to health care reform. Additional exemptions have been proposed by health care providers, including the American Medical Association,¹⁸³ the American Hospital Associa-

179. *U.S. Healthcare*, 986 F.2d at 595 (stating that under the rule of reason, procompetitive effects of exclusive dealing can outweigh the anticompetitive effects of restraint).

180. Vertical refusals to deal designed to enforce resale price maintenance or tying arrangements have been held to be *per se* illegal. *E.g.*, *Business Elecs. Corp. v. Sharp Elecs. Corp.*, 485 U.S. 717, 724 (1988).

181. *See Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 760-61 (1984) (explaining the requirements for the existence of a contract, combination, or conspiracy, and discussing unreasonable restraints and their origins).

182. *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918).

183. *See Hearings*, *supra* note 111, at 93-94 (prepared statement of Dr. Richard F. Corlin, on behalf of the AMA) (requesting a statutory scheme permitting health care providers to join together to collectively negotiate with third-party payors with respect to the operation of a managed care plan).

tion,¹⁸⁴ and the Pharmaceutical Manufacturers Association.¹⁸⁵ As noted above, the Clinton Administration's plan also creates an anti-trust exemption.¹⁸⁶ This section discusses each of these exceptions in detail.

1. State Action Doctrine

In *Parker v. Brown*,¹⁸⁷ the Supreme Court held that when a state requires or regulates a practice, principles of federalism prevent federal laws from overriding these state laws.¹⁸⁸ Several recent Supreme Court cases have further refined the "state action doctrine."¹⁸⁹

Under the state action doctrine, a state must clearly articulate an affirmative policy to allow private parties to act anticompetitively.¹⁹⁰ In addition, the state must actively supervise the anticompetitive activity of the private parties.¹⁹¹ It must substitute an "adequate system of regulation" and exercise "significant control" over the anticompetitive behavior.¹⁹² Active supervision includes a review on

184. See *id.* at 95 (stressing the need for greater collaboration amongst hospitals and asking for change in the current governmental antitrust policy in order to facilitate cooperative action).

185. See Letter from John R. Ferguson, Counsel to Pharmaceutical Manufacturers' Ass'n, to John W. Clark, Acting Attorney General, Antitrust Division 2-3 (March 12, 1993) (on file with author) (proposing a self-imposed limitation that restricts member companies' upward pricing freedom to annual increases in the Consumer Price Index).

186. See H.R. 3600, § 1322 (c) (establishing an antitrust exemption for collective fee negotiations by physicians and hospitals). In contrast, House Bill 3222 creates no explicit antitrust exemptions. Instead, it requires that the federal government develop guidelines on the application of the antitrust laws to AHPs and promptly issue business review letters to AHPs. H.R. 3222, § 1231. House Bill 3222 also creates potential exemptions for collective action through certificates of public advantage from the Attorney General based on a weighing of the benefits of the venture against its anticompetitive effects. *Id.* § 1232. The certificate must be issued or denied in 30 days. *Id.* Senate Bill 1770 would establish "safe harbors" that largely parallel the DOJ and FTC exemptions. S. 1770, §§ 4202-08; *Health Care Industry Policies*, *supra* note 77, at 20,755.

187. 317 U.S. 341 (1943).

188. *Id.* at 362.

189. See *FTC v. Ticor Title Ins. Co.*, 112 S. Ct. 2169, 2177-80 (1992) (holding that actual state supervision of a practice is a precondition for the application of the state action doctrine); *Patrick v. Burget*, 486 U.S. 94, 99-106 (1988) (holding that the state action doctrine does not protect physicians from federal antitrust liability for their activities on hospital peer review committees); *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 55-66 (1985) (holding that collective rate-making activities, although not compelled by the state, were immune from federal antitrust liability under the state action doctrine); *California Retail Liquor Dealers Ass'n v. Midcal Aluminum Inc.*, 445 U.S. 97, 102-106 (1980) (holding that a state must actively supervise a practice in order to establish antitrust immunity).

190. *Southern Motor Carriers*, 471 U.S. at 65.

191. *Patrick*, 486 U.S. 100-101; *Town of Hallie v. Eau Claire*, 471 U.S. 34, 46-47 (1985); *California Retail Liquor Dealers*, 445 U.S. at 105.

192. *324 Liquor Corp. v. Duffy*, 479 U.S. 335, 345 n.7 (1987).

the merits of a decision, not just on the procedures.¹⁹³ The Supreme Court held in *FTC v. Tigor Title Insurance Co.*¹⁹⁴ that state action immunity is "disfavored" and that the state must in fact exercise its authority to supervise.¹⁹⁵ Staffing and funding an inactive state regulatory board is not sufficient.¹⁹⁶ Negative option schemes must show that state officials in fact took the necessary steps to supervise any price-fixing schemes.¹⁹⁷

The Clinton Administration's plan expands the state action doctrine. Section 1322(c) authorizes states to allow physicians and other providers to negotiate collectively on fees and other terms and conditions if the state "actively supervises" their conduct.¹⁹⁸ Thus, the Clinton Administration's bill creates a federal statute explicitly allowing application of the judicially-created state action doctrine.

The ostensible purpose of the Clinton Administration's proposed antitrust exemption is to counterbalance the possible market power of Health Alliances.¹⁹⁹ However, this rationale makes little sense. Providers are expected to contract with AHPs, who in turn will contract with the Health Alliance.²⁰⁰ Because there will likely be multiple AHPs in each area, an AHP is unlikely to have market power. Providers will have multiple AHPs from which to choose to contract, and there should be no need to counterbalance the market power of AHPs. Moreover, as discussed above, other market-based alternatives, such as multiple competing Health Alliances, are a preferable way to achieve this result.²⁰¹

In recent years, at least fifteen states enacted legislation to provide antitrust immunity to certain collaborative agreements among health care providers.²⁰² As a result, the state action doctrine may

193. *Patrick*, 486 U.S. at 105.

194. *FTC v. Tigor Title Ins. Co.*, 112 S.Ct. 2169, 2178 (1992).

195. *Id.*

196. *Id.* at 2179.

197. *Id.*

198. H.R. 3600, § 1322(c).

199. See *supra* notes 39-45 and accompanying text (discussing the market power of health alliances).

200. See *supra* notes 46-48 and accompanying text (describing AHP's).

201. See *supra* note 108-09 and accompanying text (discussing the Administration's plan to counter the market power of health alliances).

202. See Sarah Vance, *Immunity for State Sanctioned Provider Collaboration After Tigor*, 62 ANTITRUST L.J. 409 (1993) (describing the immunity provisions in Maine, Wisconsin, Minnesota, Ohio, Washington, and Kansas); see also, e.g., COLO. REV. STAT. ANN. §§ 24-32-2701 to 2715 (West Supp. 1993); FLA. STAT. ANN. §§ 408.0015-.604 (West 1992 & Supp. 1993); 1993 Iowa Legis. Serv. 158 (West); KAN. STAT. ANN. § 65-4929 (1992); ME. REV. STAT. ANN. tit. 22,

be an obstacle to effective health care reform by precluding the application of federal antitrust laws. The federal government should consider the dynamics of competition and antitrust enforcement when it structures its health care reform proposals. The state action doctrine could distort the market forces that are likely to be the basis for health care reform. Moreover, allowing states to exempt portions of the health care industry from federal antitrust oversight could lead to unequal health services according to an individual state's regulatory scheme.²⁰³

The federal government is best situated for a global evaluation of nationwide conditions and best able to compensate for possible market distortion on a systemic basis. This global, systemic perspective is necessary to achieve a coherent approach to health care issues. The federal government, therefore, should consider preempting state laws that purport to regulate health care and provide antitrust exemptions.²⁰⁴ Preemption is likely to be necessary to protect competitive forces that have been built into the reform plan and that are crucial to its success. Preemption also will ensure that health care regulation is as nearly uniform as possible throughout the country.²⁰⁵

2. *McCarran-Ferguson Act*

The McCarran-Ferguson Act exempts the "business of insurance" from the reach of the antitrust laws if a state regulates that industry.²⁰⁶ Excluded from the exemption are agreements to boycott, coerce, or intimidate as well as acts of boycotting, coercion, or

§ 405-D (West 1992); MINN. STAT. ANN. §§ 62J.29, 62J.2913 (West 1992); 1993 Mont. Laws 606; N.Y. PUB. HEALTH LAW § 2950 (Consol. 1993); N.C. GEN. STAT. §§ 131E-192.3 (1993); OHIO REV. CODE ANN. § 3727.24 (Baldwin 1994); TENN. CODE ANN. §§ 68-11-1301 to -1309 (1993); 1993 Tex. Sess. Law Serv. 638 (Vernon); WASH. REV. CODE §§ 39.34, 70.44 (1993); WIS. STAT. § 609.001 (1993).

203. See *supra* notes 71-89 and accompanying text (discussing examples of how federal antitrust law has promoted competition and equality in health care services).

204. There is a presumption that state regulation of health matters is primarily a matter of local concern. *Hillsborough County v. Automated Medical Labs., Inc.*, 471 U.S. 707, 714 (1985). Congress, however, may render state action in a particular area invalid if it decides that the interest of the federal government in that area is of national interest. *Hines v. Davidowitz*, 312 U.S. 399, 404 (1990); ABA ANTITRUST SECTION, ANTITRUST FEDERALISM: THE ROLE OF STATE LAW 11-15 (1988).

205. The power of preemption ensures that a state may not pass a law that is inconsistent with federal law. *McDermott v. Wisconsin*, 228 U.S. 115, 128 (1913).

206. 15 U.S.C. § 1012(b) (1988).

intimidation.²⁰⁷

If the federal government decides to regulate health insurance, the McCarran-Ferguson Act should be repealed to allow competition in all areas affected by health care reform. Repeal of the McCarran-Ferguson exemption as it applies to health care insurance would require Health Alliances and AHPs to operate procompetitively. The Administration's bill proposes repeal of the McCarran-Ferguson exemption.²⁰⁸ Senator Howard Metzenbaum (D-OH), Chairman of the Senate Subcommittee on Antitrust, Monopolies and Business Rights,²⁰⁹ and Anne Bingaman, Assistant Attorney General for the Antitrust Division, also support repeal of the exemption.²¹⁰

3. Proposed Exemptions For Health Care Providers

Physicians, hospitals, and pharmaceutical manufacturers have proposed various antitrust law exemptions or "clarifications" that would effectively exempt certain conduct from federal antitrust laws.²¹¹ However, not a single proponent of these proposed exemptions has been able to establish an adequate rationale supporting their existence. Since competition is the essential foundation of most health care reform proposals,²¹² antitrust exemptions for health care providers should not be enacted because they permit providers to avoid competition.

207. *Id.* § 1013(b). See generally *Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, 2916 (1993) (discussing examples of what does and does not constitute a boycott); *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126-34 (1982) (describing the relevant criteria for determining whether a particular practice is part of the "business of insurance" exempted by the McCarran-Ferguson Act); *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205, 210-11 (1979) (holding that § 2(b) of the McCarran-Ferguson Act exempts the business of insurance, not the business of insurers); *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 541-46 (1978) (holding that § 3(b) of the McCarran-Ferguson Act is broad and unqualified, covering any act or agreement amounting to a boycott, coercion, or intimidation); *SEC v. National Secur., Inc.*, 393 U.S. 453, 463 (1969) (holding that fraudulent misrepresentation in the "business of insurance" is not enough to exclude a company from the McCarran-Ferguson Act exemption).

208. H.R. 3600, § 5501.

209. *Antitrust Issues in the Health Care Industry: Hearings Before the Subcomm. on Medicare and Long-Term Care of the Senate Comm. on Finance*, 103d Cong., 1st Sess. 11 (1993) (statement of Sen. Metzenbaum).

210. *Insurance Competitive Pricing Act of 1993: Hearing on H.R. 9 Before the Subcomm. on Economic and Commercial Law of the House Comm. on the Judiciary*, 103d Cong., 1st Sess. 15-16 (1993) (statement of Anne Bingaman, Assistant Attorney General, Antitrust Division).

211. See *supra* notes 112-50 and accompanying text (discussing exemptions and clarifications proposed by the various groups).

212. See *supra* notes 16-34 and accompanying text (explaining the need for competition).

The AMA has proposed an antitrust law "clarification" to "assure that physicians can fulfill the role expected of them in the reform process."²¹³ According to the AMA, in order for physicians to respond to managed competition, they must be able to negotiate collectively with managed care plans without the threat of civil or criminal antitrust actions.²¹⁴ By "clarifying" the law as requested by the AMA, Congress would be granting the AMA an exemption and, in essence, allowing physicians to bargain collectively with managed care plans without a concomitant enhancement of efficiency.²¹⁵ As a result, price competition among physicians would be eliminated and consumers would face a greater risk of price increases or restrictions on choice.²¹⁶ In fact, the AMA proposal would exempt the precise conduct the Justice Department prosecuted in *United States v. Alston*.²¹⁷

Similarly, the American Hospital Association ("AHA") claims that competition has led to a "medical arms race" of costly duplication of services and facilities.²¹⁸ It has proposed legislation that would exempt certain collective or cooperative actions by hospitals from the application of antitrust laws.²¹⁹ Hospitals, the AHA argues, have been discouraged from forming advantageous mergers or joint ventures by fear of antitrust prosecution.²²⁰ Further, the AHA

213. *Hearings, supra* note 111, at 93-94 (prepared statement of Dr. Richard F. Corlin, on behalf of the AMA); see also AMA, POSITION ON ANTITRUST 2 (1993) (on file with author) [hereinafter AMA POSITION]; Edward Felsenthal, *Doctors Seek Right to Join Forces to Negotiate with Health Plans*, WALL ST. J., Jan. 3, 1994, at A12. Senator Orrin Hatch (R-Utah) and Cong. William Archer (R-Tex.) have introduced legislation to permit collective fee negotiations by physicians with less than 20 percent of the market. S. 1658, 103d Cong., 1st Sess. (1993).

214. AMA POSITION, *supra* note 213, at 2. The AMA has also requested an FTC Staff Advisory Opinion to permit the group to engage in professional peer review of physician fees. *Id.*

215. The AMA believes that physicians participating in managed care plans should have an opportunity for input into the plans about their policies. *Id.* The AMA contends that these physicians should have input in two ways. First, committees elected by participating physicians should be created to address medical review and quality assurance criteria. Second, participating physicians should be allowed to develop and present joint presentations to the health plan, provided that they do not threaten or implement a boycott. *Id.*

216. The DOJ and the FTC support this theory and have opposed physician input in managed care plans because of fears of possible price-fixing. *Id.* In recent Congressional testimony, the FTC opposed the exemption proposed by the AMA. *Antitrust Law Enforcement and Health Care Markets: Hearings Before the Sen. Finance Comm.*, 103d Cong., 1st Sess. 13-16 (1994) (prepared statement of Mary Lou Steptoe, Acting Director of the Bureau of Competition of the FTC).

217. 974 F.2d 1206 (9th Cir. 1992); see also *supra* note 87 and accompanying text (discussing the *Alston* case).

218. *Hearings, supra* note 111, at 79 (prepared statement of Fredric J. Enter, on behalf of the AHA).

219. *Id.* at 79-81.

220. *Id.* at 83-84.

claims that the antitrust laws are contrary to efforts to cut costs by consolidating facilities and services and eliminating duplication.²²¹

These arguments exaggerate the effects of antitrust enforcement actions in hospital mergers.²²² In the past decade, the FTC and DOJ have challenged less than one hospital merger per year from among fifty to one hundred mergers in a typical year.²²³ In addition, neither agency has challenged a single joint venture.²²⁴ Competition among health care providers is critical to the success of health care reform.²²⁵ Mergers and other joint actions by hospitals should continue to be subject to antitrust review.²²⁶ The antitrust agencies should evaluate whether, after a proposed merger or joint venture, competition among hospitals will be sufficient to support multiple, competing AHPs. If so, the merger should be allowed. If not, it should be challenged.

The Pharmaceutical Manufacturers Association ("PMA") has also sought an antitrust law "clarification."²²⁷ In March 1993, the PMA submitted a request for a business review letter from the DOJ exempting PMA members from prosecution for certain price agreements.²²⁸ Specifically, the PMA sought to "set out a pricing policy by which the member companies, acting individually and unilaterally, would agree to be bound."²²⁹ Each PMA member would "limit its price increases, if any, on the entire line of its prescription drug products in any calendar year to an amount not to exceed the increase in the CPI."²³⁰ In October 1993, Anne Bingaman advised the group that the DOJ would challenge the PMA's proposed coordi-

221. *Id.* at 79.

222. The recent FTC/DOJ Antitrust Enforcement Policy Statements in the Health Care Area create an extremely narrow "safe harbor" for hospital mergers involving hospitals with fewer than 100 beds and an average daily census of forty or fewer patients. *Health Care Industry Policies*, *supra* note 77, at 20,755.

223. *Hearings*, *supra* note 111, at 27 n.23 (prepared statement of Janet D. Steiger, FTC Chairman). During the period 1987-91, there were 229 hospital mergers, only twenty-seven of which were investigated by the FTC or DOJ, and only five of which were challenged. *Id.*

224. *Id.* at 27-28.

225. *See supra* notes 16-34 and accompanying text (explaining the need for competition in health care reform).

226. *See supra* notes 129-36 and accompanying text (discussing hospital mergers).

227. Letter from John R. Ferguson, Counsel for the Pharmaceutical Manufacturers' Association, to John W. Clark, Acting Assistant Attorney General, Antitrust Division 2 (March 12, 1993) (on file with author).

228. *Id.*

229. *Id.*

230. *Id.*

nated price cap.²³¹

There are several problems with the PMA's proposal. First, it is surprisingly similar to the maximum fee schedule condemned by the Supreme Court in *Maricopa*,²³² where the Court rejected claims that a maximum fee schedule was procompetitive and pointed out that maximum price schemes tend to "acquire all the attributes of an arrangement fixing minimum prices."²³³ Moreover, the PMA proposal could eliminate price competition between drug manufacturers, resulting in increased drug prices. In fact, such a fee agreement would threaten the aggressive price competition recently experienced by the pharmaceutical industry.²³⁴ Finally, it is difficult to understand why unilateral action by pharmaceutical firms could not achieve the PMA's desired effects.²³⁵

CONCLUSION

Even if Congress never enacts a health care reform proposal, the Clinton Administration has already achieved many of its objectives by stimulating debate on the issue and forcing everyone to focus on the problems in our current health care system. The market is already responding to this focus and changing in anticipation of reform.²³⁶ Providers and payors are restructuring to position themselves for a post-reform world.²³⁷ Hospital pre-merger filings with the FTC and DOJ in fiscal year 1993 were twice the number filed in 1992.²³⁸ Recent articles in many publications have described efforts by health care providers to position themselves for a post-reform

231. *Antitrust Division Would Challenge Drug Association Plan to Control Prices*, [July-Dec.] *Antitrust & Trade Reg. Rep. (BNA)*, No. 1634, at 462 (Oct. 7, 1993).

232. 457 U.S. 332 (1982).

233. *Id.* at 347.

234. See Elyse Tanouye, *Drug Prices Get Dose Market Pressure*, *WALL ST. J.*, March 11, 1993, at B1 (stating that "[f]or the first time in years, competition among drug makers is prompting some companies to try an aggressive marketing approach: lowering prices").

235. Indeed, several pharmaceutical firms have announced unilateral pricing plans that impose limits on future price increases. See Michael Waldholz, *Merck Releases Its Proposal on Linking Annual Price Boosts to Inflation Rate*, *WALL ST. J.*, April 19, 1993, at B8 (describing Merck's proposal calling for drug companies to sign contracts that tie annual price rises to the inflation rate, thereby reducing prescription drug spending by nearly \$7 billion over three years).

236. Jolie Solomon et al., *Why Wait for Hillary*, *NEWSWEEK*, June 28, at 38-40.

237. *Id.*

238. George Anders, *Mergers of Hospitals Surge Amid Pressures to Cut Costs*, *WALL ST. J.*, Dec. 1, 1993, at B1, B8; see also Sandy Lutz, *Mergers: Two-Hospital Towns Try Togetherness*, *MODERN HEALTHCARE*, Dec. 6, 1993, at 39 (discussing how mergers are sometimes necessary to remain competitive).

world.²³⁹ Some commentators have noted that competition in health care had already started a health care revolution in advance of the Administration's reform proposals.²⁴⁰ Hospitals and physicians are proposing mergers, joint ventures, and integrations that are changing the face of health care.²⁴¹ For example, in Minneapolis, large employers have formed a coalition to control costs while increasing the quality of care by stimulating competition between providers, requiring consumers to manage their own consumption of health care, forcing providers to engage in quality improvement programs, and minimizing administrative costs.²⁴²

Not all ventures that have been proposed will be accomplished, and not all will be successful. However, these changes are likely to produce some of the benefits the Administration hopes to achieve and to lead to increased support for health care reform. Competition and the antitrust laws should and are playing critical roles in this revolution in health care.

239. See, e.g., Anders & Winslow, *supra* note 3, at A1 (describing how the health care industry is preparing for change with increased mergers and the restructuring of large hospitals in order to become more efficient); Della de Lafuente, *Doctors' Orders: Integrate*, MODERN HEALTHCARE, May 3, 1993, at 25-32 (describing various integration techniques which different health care groups are implementing in order to become more efficient and cost-effective); Solomon et al., *supra* note 236, at 38-40 (describing recent transformations in the health care industry, such as more consolidation, increased mergers, and the expansion of HMOs); Michael Waldholz, *Merck to Purchase Medco In \$6 Billion Transaction*, WALL ST. J., July 29, 1993, at A3 (describing the Merck purchase of Medco Containment Services, Inc. for \$6 billion, which enabled it to become the sole integrated producer and distributor of pharmaceuticals).

240. Solomon et al., *supra* note 236, at 39.

241. *Id.*

242. *Antitrust Issues in the Health Care Industry: Hearing Before the Subcomm. on Medicare and Long-Term Care of the Senate Comm. on Finance*, 103d. Cong., 1st Sess. 48-50 (1993) (testimony of Steve Wetzell, Executive Director, Business Health Care Action Group).