

Chapter 8

Antitrust

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HISTORY AND INTRODUCTION

The principal objective of antitrust laws is the prohibition of practices that interfere with free competition in the marketplace. Business enterprises are expected to compete on the basis of price, quality, and service. The underlying assumption of the antitrust laws is that “the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest price, the highest quality, and the [greatest consumer satisfaction.]”¹

The U.S. economy underwent far-reaching and significant change after the Civil War. Technological development and rapid industrialization led to the emergence of a complex economic system. The laissez-faire policy of government during this time led to the amassing of vast economic power by individuals and certain large firms. Often this power was used to destroy smaller rivals with the goal of achieving and maintaining market control.

The public response to this economic system was colored by the changing social conditions of urbanization and immigration. Many felt that business firms should not be permitted to accumulate such wealth and exercise such great control over economic conditions. Discontent was particularly prominent among farmers and laborers. The specific targets of their outrage were the giant combinations that came to be called trusts. Chief among these was Standard Oil, apparently the first to use the trust device as a vehicle for merging numerous enterprises into a cohesive entity.² Various other trusts followed. The trust device was largely replaced after the turn of the century by the holding company, but the name *trust* remained.³

The last two decades of the nineteenth century saw the legal authorities in some states moving to break up business trusts. By 1890, 14 states had constitutional provisions prohibiting monopolies, and 13 had antitrust statutes.⁴ These statutes commonly outlawed any contract, agreement, or combination to fix a common price. They also prohibited activity that tended to limit the quantity of a product sold or manufactured. Although some success was realized, the state constitutional provisions and statutes were for the most part ineffective in controlling or breaking up the large business combinations of the day.⁵ This failure was due in part to the limit of each state’s jurisdiction. The business enterprise could reincorporate in another state or

otherwise change its practices to avoid specific restrictions. This perception of business abuse of power led to public demand that Congress deal with the trusts on a national basis.⁶

The congressional response to public outrage about monopoly and predatory business practices was the Sherman Antitrust Act of 1890. Because of opposition to the trusts from both political parties, passage of the Sherman Act took several years. Senator Sherman’s proposals were strenuously attacked despite the nearly unanimous desire to enact antitrust legislation. The debates focused on the limits of the commerce power as the constitutional basis for such legislation and the definition of common law restrictions on monopolies and predatory business practices.

The Sherman Act as finally enacted has been described as being “as good an antitrust law as the Congress of 1890 could have devised.”⁷ It was a compromise that restated common law principles prohibiting restraints of trade and monopolization. However, the Sherman Act went beyond common law in several respects. Unlike common law prohibitions that were entirely civil in nature, the Sherman Act provided for criminal prosecution and penalties.⁸ The Sherman Act also expressly provided the United States the authority to bring civil actions to enjoin violations of the act. The nationwide effect of the act and access to the federal courts resolved the most serious problems of limited jurisdiction under state law.

Indifference and failure characterized early antitrust policy under the Sherman Act.⁹ The drafters of the Sherman Act had intended to curb both the power and monopolistic abuses of the great trusts. It had been assumed that the Sherman Act would be self-enforcing because the business community would follow its prohibitions. Assumptions of voluntary compliance proved incorrect. The Trans-Missouri Freight Association case was the government’s first major antitrust victory.¹⁰ The Supreme Court overturned a lower court determination that the prohibitions of the Sherman Act did not apply to price-fixing agreements between members of a railroad association. This decision was quickly followed by successful prosecutions in *United States v. Joint Traffic Association* and *United States v. Addyston Pipe & Steel Co.*^{11,12} Overall, however, results were not impressive, and

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one senator was able to compile a list of 628 trusts formed between 1898 and 1908.¹³

After the enactment of the Sherman Act, there was substantial concern about its general language. In 1911 the Supreme Court decided the Standard Oil case.¹⁴ In *Standard Oil* the court interpreted Section 1 of the Sherman Act as a prohibition on “unreasonable restraints of trade” and left to the courts the task of applying this “rule of reason.”¹⁵ Some concluded that the ambiguity of the statutory language and the new rule of reason gave excessive discretion to the courts. A movement for explicit prohibition of practices inimical to free competition gained momentum, and in 1914 Congress passed the Clayton Act.¹⁶ The Clayton Act made a number of additions to the antitrust laws, including specific authorization for suits by private parties harmed by antitrust violations.¹⁷ Remedies available to private parties include both treble damages and equitable relief.¹⁸

In 1914 Congress also passed the Federal Trade Commission (FTC) Act.¹⁹ The FTC was modeled on the Interstate Commerce Commission, and it was anticipated that the commission would notify businesses of conduct that violated the FTC Act by issuing cease-and-desist orders without initial penalty. The FTC Act was another attempt to alleviate the uncertainty caused by the general language of the Sherman Act. The language of these three basic antitrust laws has changed little since 1914.²⁰

Before 1975, it generally was believed that the antitrust laws did not apply to the health care industry. In 1975, however, the Supreme Court held in *Goldfarb v. Virginia State Bar* that “learned professions” were not exempt from the antitrust laws.²¹ Consequently the court has applied the antitrust laws to the activities of both individual and institutional health care providers, finding that the provision of medical service, as a “trade or commerce,” is within the scope of the antitrust laws.^{22,23} Especially since the 1980s, with the health care industry undergoing substantial restructuring in response to pressure to reduce costs and to governmental regulatory changes, the industry has experienced an increasing number of antitrust actions.²⁴

CONDUCT VIOLATIONS

Section 1 of the Sherman Act prohibits combinations, contracts, and conspiracies in restraint of trade among the states or with foreign nations.²⁵ To violate this section, an individual must engage in some type of concerted action that restrains trade in interstate commerce. One of the issues concerning this concerted action requirement is whether joint action by two subsidiaries of the same parent corporation can lead to antitrust liability. In *Copperweld Corp. v. Independent Tube Corp.*, the Supreme Court held that a parent corporation and its wholly owned subsidiary are legally incapable of conspiring in violation of Section 1 of the Sherman Act.²⁶ Further extending the court’s reasoning in *Copperweld* that an agreement between two subdivisions of a single corporation does not meet the requirement of concerted action in Section 1, courts have generally determined that two subsidiaries wholly owned

by the same parent corporation are legally incapable of conspiring with one another for purposes of the Sherman Act.^{27,28} Similarly, when an acute care hospital was alleged to have conspired with its corporate affiliate, the court found no concerted action under the Sherman Act.²⁹ The same reasoning has been applied in concluding that a hospital and its medical staff—a creature of the hospital—do not engage in concerted action for the purposes of the antitrust laws.³⁰

The interstate commerce requirement is a prerequisite to the jurisdiction of the federal courts over alleged antitrust violations. The conduct in question must have an appreciable impact on interstate commerce, but this has not proven to be a significant barrier to suit in the federal courts.³¹

In the health care field the Supreme Court has found that a particular hospital was not strictly a local, intrastate business because of the impact that it exerted on the purchases of drugs and supplies from out-of-state sources, as well as the revenues derived from out-of-state insurance companies.³² A denial of hospital staff privileges allegation may satisfy the interstate commerce requirement by showing that commerce in the form of medical insurance from out-of-state sources, supplies from out-of-state sources, and interstate patients using a hospital were affected.³³ Almost all business can be found to have some connection with interstate commerce. This connection, no matter how tenuous, may serve to bring the conduct of a health care provider within the scope of the relevant antitrust statutes.

Rule of Reason

Section 1 of the Sherman Act prohibits restraints of trade but contains no explicit limiting language. In interpreting this language, the courts initially struggled with the question of whether Congress intended to prohibit all restraints of trade. In 1911 the Supreme Court decided *Standard Oil Co. of New Jersey v. United States*, which held that Section 1 of the Sherman Act was intended to prohibit only unreasonable restraints of trade.³⁴ Since *Standard Oil*, the general approach to allegations of illegal restraints of trade has been to evaluate the alleged restraints under the rule of reason. The rule of reason requires a court applying Section 1 of the Sherman Act to evaluate whether a restraint of trade is an unreasonable restraint on competition. If it is found to be unreasonable, it is in violation of the statute. The rule of reason was described by Justice Brandeis in *Chicago Board of Trade v. United States* as follows:

Every agreement concerning trade, every regulation of trade, restrains. To bind, to restrain, is of their very essence. The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the restraint as applied; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for

*adopting the particular remedy, the purpose or end sought to be attained are all relevant facts.*³⁵

Substantial debate has revolved around what courts may consider in evaluating the reasonableness of a restraint. The current view is that courts are limited to considering impacts on competition and may not consider social policy or some worthy purpose allegedly furthered by the restraint. In the application of antitrust principles to the conduct of health care providers, this issue is confronted when a restraint is defended on the grounds that it advances quality of care, access to care, or some other laudable public purpose.

A good example of the Supreme Court's approach to this issue is found in the discussion of the ban on competitive bidding by professional engineers considered by the court in *National Society of Professional Engineers v. United States*.³⁶ The society defended the ban as a means of minimizing the risk that competition would produce inferior engineering work, thereby endangering public safety. Noting that the Sherman Act does not require competitive bidding but prohibits unreasonable restraints on competition, the court pointed out that:

*Petitioner's ban on competitive bidding prevents all customers from making the price comparisons in the initial selection of an engineer, and imposes the Society's view of the costs and benefits of competition on the entire marketplace. It is this restraint that must be justified under the Rule of Reason, and petitioner's attempt to do so on the basis of the potential threat that competition poses to the public safety and the ethics of its profession is nothing less than a frontal assault on the basic policy of the Sherman Act.*³⁷

Despite this rather strong statement about the scope of the rule of reason, some lower courts have been willing to consider issues other than the impact on competition in applying the rule of reason in cases involving the health care industry. In *Wilk v. American Medical Association, Inc.* the Court of Appeals for the Seventh Circuit indicated that it would allow a jury to consider issues of patient care in evaluating a prohibition on dealing with chiropractors as a restraint on trade under the rule of reason.³⁸ The court held that once the plaintiffs had established that the defendants' conduct had restricted competition, the burden shifted to the defendants to show that they had a genuine and objectively reasonable concern for patient care, that this concern had motivated the conduct in question, and that the concern would not have been satisfied with a less restrictive alternative.³⁹ The court was careful to distinguish this approach from a general consideration of the public interest served by the restraint, which would have put its approach in direct conflict with the Supreme Court decisions noted above.⁴⁰

In *Hospital Building Co. v. Trustees of Rex Hospital* the Court of Appeals for the Fourth Circuit used a narrow rule of reason to permit a nonprofit hospital to defend against charges of market allocation and a concerted refusal to deal on the grounds that the planning activities

in which the hospital participated were undertaken in good faith and their actual and intended effects were contemplated by federal health planning legislation.⁴¹ This special rule of reason was described by the court as follows:

*Because on this view the relevant federal health care legislation is in limited derogation of the normal operation of the antitrust laws, we further think that the burden of proof to show reasonableness of challenged planning and activities under this special rule of reason should be allocated as an affirmative defense to defendants seeking on this ground to avoid antitrust liability. On this basis a claimant, such as plaintiff here, makes out a prima facie case by showing acts that, but for the health care planning legislation, would constitute a per se violation of § 1 under traditional antitrust principles. This establishes liability for appropriate damages unless the defendants then persuade the trier of fact by a preponderance of the evidence that their planning activities had the purpose (and effect if plaintiff proves anticompetitive effects) only of avoiding a needless duplication of health care resources under the objective standard of need above defined.*⁴²

It remains to be seen whether the Supreme Court will be willing to accept considerations of patient care in rule-of-reason analysis in the health care industry.⁴³ In *FTC v. Indiana Federation of Dentists* the court rejected the patient care argument when the restraint did not produce any procompetitive benefits.⁴⁴ The court, however, left open the possibility that if concerns for the quality of patient care lead to the adoption of restraints that have procompetitive effects, the patient care concerns may be considered to balance against the anticompetitive effects of the restraints.⁴⁵

Rule-of-reason analysis, even if limited to issues of competition, can be extremely complex, and the burden of litigating a rule of reason case is substantial. This factor was recognized by the courts, and a presumption of unreasonableness was established quite early for certain specific categories of anticompetitive conduct.⁴⁶ This presumption is known as the per se rule.⁴⁷

Per se Rule

In contrast to the rule of reason, the courts will apply a per se rule of illegality to practices that generally have been shown to have anticompetitive effects on competition. These practices are presumed to be illegal without inquiry into specific anticompetitive effects:

*...[T]here are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused.... Among the practices which courts have heretofore deemed to be unlawful...are price-fixing...; division of markets...; group boycotts...; and tying arrangements. (citations omitted)*⁴⁸

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Because application of the per se rule forecloses an in-depth analysis of the alleged restraint and its market effect, the Supreme Court has cautioned that “[i]t is only after considerable experience with certain business relationships that courts classify them as per se violations of the Sherman Act.”⁴⁹ When a case involves a professional association or an industry in which certain restraints on competition may be essential to its product, the Supreme Court has declined to invoke the per se rule, even though it is apparent on their face that the restraints in question will increase price or constitute a refusal to deal.^{50,51} Instead the court may undertake a “quick-look” analysis under the rule of reason to ascertain the likelihood of anticompetitive effects. If an observer with even a rudimentary understanding of economics could conclude that the restraints would have an anticompetitive effect on customers and markets, the restraint will be found to be unreasonable.⁵²

In *California Dental Association v. FTC*, the Supreme Court stated that where the anticompetitive effects of given restraints are not reasonably obvious, the rule of reason demands a more thorough inquiry into the consequences of those restraints than the quick-look analysis, suggesting the appropriateness of a “sliding scale” of reasonableness.⁵³ In this case, California Dental Association (CDA), a voluntary nonprofit association of local dental societies, required its dentist members under its Code of Ethics to refrain from advertising falsely or misleadingly.⁵⁴ To help members comply with the code, CDA issued a number of advisory opinions and disclosure rules, which cautioned that price advertising must be based on verifiable data substantiating any comparison or statement of relativity and suggested that quality advertising is likely to be false or misleading because it cannot be measured or verified. The FTC brought action against CDA for unreasonably restricting truthful, nondeceptive discount or quality advertising in violation of Section 5 of the FTC Act.⁵⁵ The Court of Appeals for the Ninth Circuit found the restrictions on across-the-board discount advertising to be a naked restraint on price competition and the non-price advertising restrictions to be a form of output limitation. Accordingly the court held that these restrictions were sufficiently anticompetitive on their face to constitute unreasonable restraints of trade under a quick-look analysis.⁵⁶ The Supreme Court, however, found that the obvious anticompetitive effect that triggers the quick-look analysis had not been proved with respect to both the restraints on discount advertising and the restraints on nonprice advertising. According to the court, even assuming that the CDA disclosure rules effectively bar advertisement of across-the-board discounts, it does not follow that such a ban would have anticompetitive effects. As a matter of economics, it is possible that “any costs to competition associated with the elimination of across-the-board advertising will be outweighed by gains to consumer information (and hence competition) created by discount advertising that is exact, accurate, and easily verifiable (at least by regulators).”⁵⁷

In a similar vein the court found that restricting quality or patient comfort advertising may have a procompetitive

effect by preventing false or misleading claims that distort the market. Based on the foregoing analysis, the court held that an extended examination of the possible factual underpinnings should be conducted to determine whether the advertising restraints were predominantly anticompetitive in effect. Although the court did not elaborate on the scope of such an extended examination, its aversion to the quick-look analysis in *California Dental Association* may signal the court’s inclination to adopt a more elaborate rule-of-reason analysis when the restraints in question arise in a professional context.⁵⁸

Specific Violations

Price-Fixing

The courts have found certain types of conduct to have so pernicious an effect on competition and to be so lacking in any redeeming virtue that they are accorded per se illegal status.⁵⁹ One such type of conduct is price-fixing. As the Supreme Court noted in *United States v. Trenton Potteries Co.*, “the aim and result of every price-fixing agreement, if effective, is the elimination of one form of competition.”⁶⁰ The economic power to fix a price reflects control of a market. It does not matter whether the fixing of prices is exercised in a reasonable or unreasonable manner. An agreement that creates such power “may well be held to be... unreasonable... without the necessity of minute inquiry whether a particular price is reasonable or unreasonable... and without placing on the government... the burden of ascertaining... whether it has become unreasonable through the mere variation of economic conditions.”⁶¹

The agreement to fix prices need not be formal. The agreement itself can be demonstrated by circumstantial evidence.⁶² An agreement that tampers with price (whether it raises, lowers, or stabilizes prices) may be a per se violation.⁶³ Even agreements that affect price indirectly often are prohibited.⁶⁴ Once a practice is characterized as price-fixing, it is per se illegal. Making that characterization, however, can be difficult.

The leading price-fixing decision in the health care field is *Arizona v. Maricopa County Medical Society*.⁶⁵ There the Supreme Court applied the per se rule to an agreement among physicians to set maximum fees pursuant to a foundation program established by the county society. Approximately 70% of the physicians in Maricopa County were involved in the Maricopa plan. These physicians agreed not to charge more than the maximum agreed price for specified services and agreed with insurance companies to provide care to insured patients on that basis. The society defended the foundation plan on the grounds that it fixed only maximum prices, that it was an agreement among members of a profession, that it had procompetitive justifications, and that the courts should further investigate the health care industry before applying a per se rule to the conduct of health care providers. The majority in *Maricopa* rejected each of these arguments and held that the setting of maximum prices constituted per se illegal price-fixing.⁶⁶ The majority was unwilling to assign any weight to the

unique characteristics of the market for physician services or to the plan's purported cost-containment purposes.⁶⁷

As providers of health care services have sought to obtain some leverage in their negotiations with large HMOs and insurance company purchasers of those services, networks of providers have become increasingly popular. One risk of such networks is that the otherwise independent providers participating in a network will explicitly or implicitly engage in price-fixing. The Statements of Antitrust Enforcement Policy issued by the Department of Justice (DOJ) and the FTC include statements on physician network joint ventures (Statement 8) and multiprovider networks (Statement 9).⁶⁸ They also include statements on provider provision of fee-related information to purchasers (Statement 5) and on provider participation in exchanges of price and cost information (Statement 6).⁶⁹ Some of these statements include defined "safety zones" and they should be examined carefully by providers considering participating in a network that will touch upon the question of pricing provider services. In the last several years, the FTC has alleged price-fixing violations and challenged provider conduct in the context of networks in a significant number of cases.⁷⁰ Most of these cases have been resolved by agreement with the FTC, but in at least one, an FTC administrative law judge has expressly concluded that illegal price-fixing occurred.⁷¹

Reimbursement policies of health insurance companies have been challenged as illegal price-fixing agreements.⁷² Courts have shown interest in such claims when evidence of provider control over reimbursement rates may exist.⁷³ When the evidence shows unilateral action by purchasers with an effect on prices, courts have not been receptive to claims of price-fixing.⁷⁴

Agreements or approaches resulting in the stabilization of prices generally are considered *per se* violations. Relative value scales have been challenged as price-fixing mechanisms because they allegedly tend to standardize charges for professional services. The FTC entered into multiple consent orders barring the use of relative value scales in the late 1970s.⁷⁵

The critical issue of rising health care costs has led purchasers of health care services to take various actions in an effort to reduce their costs. Collective action, including the joint buying of services through preferred provider organizations (PPOs), may trigger antitrust price-fixing concerns.⁷⁶ An agreement among buyers not to compete on price in the purchase of goods or services is just as much unlawful price-fixing as is a similar agreement among sellers not to compete on price.⁷⁷

Joint purchasing of health care can be procompetitive by allowing individual purchasers to share information and develop skills in negotiating and contracting collectively with health care providers.⁷⁸ Absent significant market power, joint purchasing programs should be able to pass muster under the Sherman Act. When joint purchasers possess some market power, the purpose of the joint purchase will be scrutinized more closely and the probable procompetitive effects of the arrangement will be weighed against possible anticompetitive harm.⁷⁹

By the same token, hospitals can typically purchase supplies and services jointly without antitrust concerns. The Supreme Court has implicitly sanctioned wholesale purchasing cooperatives as arrangements seemingly designed to increase economic efficiency and render markets more rather than less competitive.⁸⁰ The DOJ and the FTC, in the 1996 Statements of Antitrust Enforcement Policy in Health Care (Health Care Statements), also emphasize that most joint purchasing arrangements among hospitals or other health care providers increase efficiencies and do not raise antitrust concerns.⁸¹ The Statements provide a safety zone for any joint purchasing arrangement among hospitals and other health care providers if (1) the purchases account for less than 35% of the total sales of the purchased product or service in the relevant market and (2) the cost of the products and services purchased jointly accounts for less than 20% of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement. Beyond the safety zone, the law is not clear. Some suggest that the procompetitive effect inherent in joint purchasing arrangements dictates that a flexible *per se* standard should be applied.⁸² Under this standard, horizontal pricing agreements among joint purchasers would be *per se* unlawful unless the purchasers could make an argument that the joint purchasing resulted in productive efficiencies and these efficiencies could be achieved only through an agreement designed to force prices below competitive levels.⁸³ Whether the courts will accept such a standard is difficult to predict.

Some large purchasers of health care services have sought to lower costs by insisting that health care providers include a so-called most favored nation clause in the agreement for the purchase of services. The purpose of such clauses is to ensure that the purchaser receives the lowest price given to any other purchaser. Although, in the usual case, the antitrust law would support efforts to lower prices, when the purchaser has market power, a most favored nation clause could bring the price-cutting process to a halt because any additional price cut would have to be shared with the large purchaser.⁸⁴

The development of new vehicles for the delivery of health care services has led to creative approaches to limiting prices paid for those services. This, in turn, has sometimes resulted in allegations of price-fixing being put forward by private parties. In one such instance the Eleventh Circuit upheld a conclusion that there was no price-fixing involved in the negotiation of a reimbursement schedule by a PPO, in which the payers decided the maximum amount they were willing to pay providers for medical services and the providers decided whether they were willing to accept the limitation on reimbursement.⁸⁵

Physicians seeking to avoid price-fixing problems should not agree with competing physicians on any term of price, quantity, or quality. Agreement on fee schedules and relative value scales is prohibited.⁸⁶ Although there may be exceptions to this relatively simple statement, the purported exceptions should be carefully examined with the assistance of competent and experienced antitrust counsel.

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Tying and Exclusive Dealing

Tying may be defined as the sale or lease of a product or service conditioned on the buyer taking a second product or service. Tying arrangements may be attacked as unreasonable restraints of trade under Section 1 of the Sherman Act.⁸⁷ Anticompetitive tying arrangements are specifically prohibited by Section 3 of the Clayton Act and are deemed illegal under Section 5 of the FTC Act.^{88,89} The Clayton Act is rarely encountered in suits against physicians and other health care providers because it applies only to the sales of commodities.⁹⁰

The legal standard employed in evaluating tying arrangements may be viewed as a modified per se rule. This standard was discussed by the Supreme Court in the health care context in *Jefferson Parish Hospital District No. 2 v. Hyde*.⁹¹ In *Jefferson Parish* the East Jefferson Hospital had entered into an exclusive agreement with Roux and Associates for the provision of anesthesiology services at the hospital. Hyde, a board-certified anesthesiologist, had applied for admission to the hospital's medical staff, and because of the exclusive contract the hospital's board had denied his application. Hyde sued the hospital and others, alleging that East Jefferson Hospital had engaged in tying by mandating that any person using services of the hospital requiring anesthesia also use the services of anesthesiologists employed by Roux and Associates. In *Jefferson Parish* the Supreme Court described an illegal tying agreement as follows: "[T]he essential characteristic of an invalid tying arrangement lies in the seller's exploitation of its control over the tying product to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms."⁹² The court concluded that tying should be subject to per se condemnation when the probability of anticompetitive forcing is high.⁹³

In general, to invoke the per se rule against a tying arrangement, the plaintiff must establish the existence of two separate products. In addition, the plaintiff must show that the party accused of tying has sufficient market power in the tying product to force acceptance of an unwanted tied product and that it has used that power to tie the products.⁹⁴

In applying this analysis to the facts of *Jefferson Parish* the court concluded that East Jefferson Hospital had no significant power in the market for hospital services—the alleged tying product.⁹⁵ Absent this condition, the court was unwilling to apply the per se rule against the arrangement. In evaluating the arrangement under the rule of reason, the court concluded that there was insufficient evidence in the record to support a finding that the arrangement unreasonably restrained competition.⁹⁶

Before the court's decision in *Jefferson Parish* there was substantial debate about whether inpatient hospital care could be divided into a number of different products for purposes of a tying analysis. In *Jefferson Parish* the majority had no difficulty determining that the evidence amply supported the treatment of anesthesiology services as a separate product for purposes of the tying analysis.⁹⁷ The mere fact that services, such as anesthesia and surgery, are

functionally linked does not foreclose treating the services as separate products.⁹⁸ This determination depends on a realistic appraisal of whether the products are distinct in the view of the purchasers and whether there is a distinct demand for each product.⁹⁹

The utility of *Jefferson Parish* in evaluating the antitrust risks in other factual contexts is limited. The result in the case turned entirely on an analysis of the market power of East Jefferson Hospital with regard to inpatient services. The court has, however, once again made it clear that no special consideration will be given to the fact that an alleged antitrust violation occurs in a health care context.¹⁰⁰

An exclusive dealing arrangement involves an agreement by one party to buy particular products exclusively from another party. This arrangement has the effect of foreclosing to competitors of the seller the opportunity to compete for the purchases of buyers who are parties to exclusive dealing agreements. Exclusive dealing arrangements have been challenged under Section 1 of the Sherman Act, Section 3 of the Clayton Act, and Section 5 of the FTC Act.^{101–103} Generally, exclusive dealing is regarded as a vertical restraint, which is evaluated under the rule of reason.¹⁰⁴

In evaluating exclusive dealing arrangements under Section 3 of the Clayton Act, the Supreme Court has found a violation where the arrangement foreclosed competition in a substantial share of the line of commerce affected.¹⁰⁵ In a more recent case the court used the same test but conducted a rigorous structural analysis and considered a number of unique characteristics of the market in concluding that a substantial share of the market was not foreclosed by the arrangement.¹⁰⁶

Exclusive dealing agreements are common in the health care industry. A typical example is a contract between a physician or a group of physicians and a hospital to provide exclusive services to that hospital in a particular medical specialty, such as pathology, radiology, anesthesiology, or emergency medicine. In *Jefferson Parish* the arrangement between Roux and Associates and East Jefferson Hospital is properly characterized as an exclusive dealing arrangement. The court did not find sufficient evidence of anticompetitive impact on competition among anesthesiologists as a result of the arrangement to find it unreasonable and noted that Hyde did not undertake to prove unreasonable foreclosure of the market for anesthesiological services.¹⁰⁷ Nevertheless, Justice O'Connor, representing the view of four justices, noted:

Exclusive dealing is an unreasonable restraint on trade only when a significant fraction of buyers or sellers are frozen out of a market by the exclusive deal.... When the sellers of services are numerous and mobile, and the number of buyers is large, exclusive dealing arrangements of narrow scope pose no threat of adverse economic consequences. To the contrary, they may be substantially pro-competitive by ensuring stable markets and encouraging long-term, mutually advantageous business relationships.¹⁰⁸

In evaluating the facts of *Jefferson Parish* as exclusive dealing, Justice O'Connor readily concluded that there was no potential for an unreasonable impact on competition as a result of the arrangement between Roux and Associates and the hospital.¹⁰⁹

Allegations of exclusive dealing have been brought against a variety of exclusive contracting arrangements in the managed care context. In *U.S. Healthcare, Inc. v. Healthsource, Inc.*, Healthsource, a New Hampshire HMO, offered its panel physicians greater compensation if they agreed to a clause that precluded them from serving as participating physicians for any other HMO plan.¹¹⁰ The First Circuit Court of Appeals held that the exclusive clause in question did not constitute an illegal restraint on competition. Absent a compelling showing of foreclosure of substantial dimension, the court saw no need to pursue any further inquiry into Healthsource's motive, the balance between harms and benefits, or the possible existence and relevance of any less restrictive means of achieving the benefits. It emphasized that proof of substantial foreclosure and "of probable immediate and future effects" in the market are the essential basis for an attack on an exclusivity clause.¹¹¹

An exclusive dealing allegation is unlikely to prevail absent a convincing showing that a substantial portion of a rigorously defined relevant market is foreclosed by the arrangement. It also may be assumed that a court will consider seriously and weigh in the balance of a rule-of-reason analysis any legitimate procompetitive aspects of the arrangement.¹¹²

Concerted Refusals to Deal (Boycotts)

A concerted refusal to deal occurs when a group of competitors or a competitor and others through collective action exclude or otherwise interfere with the legitimate business activities of one or more other competitors. Courts use the terms *boycott* and *concerted refusal to deal* interchangeably when referring to the exclusion of a competitor by collective action. Boycotts involve concerted action and are challenged under Section 1 of the Sherman Act.¹¹³ Traditionally, boycotts have been regarded as per se violations of the antitrust laws.¹¹⁴ More recently, however, the Supreme Court has taken a more flexible approach, insisting that the potential for anticompetitive impact be established before the per se rule will be applied.¹¹⁵

In *Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co.* the Supreme Court concluded that the exclusion of a retail office supply store from a nonprofit cooperative buying association was not a per se violation of the antitrust laws. The court noted that the per se rule generally has been applied in those cases where "the boycott... cut off access to a supply, facility, or market necessary to enable the boycotted firm to compete,... and frequently the boycotting firms possessed a dominant position in the relevant market."¹¹⁶ The court held that:

A plaintiff seeking application of the per se rule must present a threshold case that the challenged activity falls into a category likely to have predominantly anticompetitive

*effects.... When the plaintiff challenges expulsion from a joint buying cooperative, some showing must be made that the cooperative possesses market power or unique access to a business element necessary for effective competition.*¹¹⁷

Although myriad opportunities exist within the health care arena for boycott activity, the issue has arisen most commonly in cases involving the refusal of medical staff privileges at a hospital. Existing members of a medical staff, who would be in direct competition with an applicant for staff privileges, often have significant influence, if not control, over the determination of whether or not to grant privileges. In some circumstances a denial of privileges may constitute an effective bar to competition (e.g., denial of privileges to a new physician at the only hospital in a community). The privileges issue is complicated by the fact that the training, professional competence, and need for a new physician may be relevant and legitimate issues for the hospital considering an application for privileges, and physicians currently active in the applicant's specialty (and potential competitors of the applicant) will have substantial expertise and information to contribute regarding these questions.

The lower courts that have examined boycott allegations in the context of disputes over privileges have adopted a variety of approaches. In *Weiss v. York Hospital* the Court of Appeals for the Third Circuit concluded that the conduct of members of a hospital medical staff in opposing the granting of hospital privileges to a class of osteopathic physicians was the equivalent of a concerted refusal to deal.¹¹⁸ Ultimately the court determined that the per se rule should be applied to this conduct.¹¹⁹ It suggested, however, that rule-of-reason analysis would be appropriate if questions of professional competence or unprofessional conduct were at issue or the exclusion was otherwise based on public service or ethical norms.¹²⁰

In *Wilk v. American Medical Association, Inc.* the plaintiff chiropractor sued a number of medical organizations under the Sherman Act for an alleged conspiracy to induce individual medical physicians and hospitals to refuse to deal with the plaintiff and other chiropractors.¹²¹ Although the trial court instructed the jury on the per se rule, the Court of Appeals for the Seventh Circuit concluded that in the context of these facts "the nature and extent of [the] anticompetitive effect are too uncertain to be amenable to per se treatment."¹²² Moreover, the court determined that the existence of substantial evidence of a patient care motive for the conduct of the organizations made application of the per se rule inappropriate.¹²³ Other courts have adopted a similar approach.¹²⁴

In *Patrick v. Burget* the U.S. Supreme Court reinstated a treble damages verdict in excess of \$2 million against three Oregon physicians because of their participation in a peer review process that recommended that the plaintiff surgeon's hospital privileges be revoked.¹²⁵ Although the reason given for revocation was substandard care, the evidence strongly supported the conclusion that the true motivation was anticompetitive bias. Although there is some protection

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for peer review activities under the state action exemption and the Health Care Quality Improvement Act of 1986, peer review activity stemming from anticompetitive motivation that results in the denial or revocation of hospital privileges may be held to be illegal group boycott activity.^{126,127}

In addition, the issue of concerted refusal to deal has been raised when a PPO denied a physician's application for provider membership. In *Levine v. Central Florida Medical Affiliates, Inc.* the plaintiff internist sought physician provider membership with Healthchoice, a PPO in which physicians agreed to accept no more than a maximum allowable fee for services rendered to plan enrollees in exchange for a potentially higher volume of patients. Healthchoice denied Levine's request on the ground that it did not need any more internists in his geographic area.¹²⁸ The Court of Appeals for the Eleventh Circuit determined that the per se rule was not warranted in analyzing the alleged boycott because the plaintiff failed to prove that Healthchoice had market power and because selective contracting may be a method through which Healthchoice could achieve quality and cost-containment goals, thereby enhancing its ability to compete against other networks.¹²⁹ Applying a rule-of-reason analysis, the court found that Levine's illegal boycott claim could not succeed because he failed to define the relevant product and geographic markets and failed to prove that Healthchoice had sufficient market power to affect competition.¹³⁰ The *Levine* court's decision and in particular its unwillingness to adopt a per se analysis indicate that, absent necessary market power, a multiprovider network should have some leeway in selecting its preferred providers without incurring antitrust liability.¹³¹ The DOJ and the FTC have now issued a specific statement on enforcement policy on multiprovider networks, detailing the analytical approach that will be used to evaluate such arrangements.¹³²

Market Allocation

Another type of conduct that raises serious questions of restraint of trade is market allocation. Competitors, by agreeing to divide geographic markets or customers, can achieve the benefits of monopoly in their exclusive share of the market. In general the Supreme Court has regarded market allocation agreements among competitors as per se illegal under Section 1 of the Sherman Act.¹³³ There are, however, substantial questions of characterization that qualify that statement. For example, territorial or customer restraints that are insisted on by a party operating at a different level of production, such as restraints imposed by a manufacturer on wholesalers, will be evaluated under the rule of reason.¹³⁴ There may be a substantial question whether the market allocation scheme is the primary objective of an agreement among competitors or merely ancillary to an otherwise legitimate joint venture. If the latter is the case, the court may well evaluate the entire venture under the rule of reason.¹³⁵

Market allocation agreements among hospitals or physicians could take the form of agreements on geographic placement of institutions or offices. This type of arrangement

could be characterized as a geographic market division. Agreements allocating the provision of certain services exclusively to particular hospitals or physicians would be another approach to market division. Evaluation of such agreements is likely to raise complex questions of motivation and anticompetitive effect. For example, some such arrangements may be dictated or at least approved by a state agency under applicable health planning statutes. The significance of such approval by a state agency is discussed in the section on defenses. Joint ventures among hospitals generally have not been challenged by federal antitrust enforcement agencies.¹³⁶

Market allocation issues also arise in the context of managed care. In *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, the Court of Appeals for the Seventh Circuit affirmed a jury verdict upholding the plaintiff's market allocation claim under Section 1 of the Sherman Act.¹³⁷ The evidence in this case showed that Marshfield Clinic and North Central Health Protection Plan (North Central), an HMO, established "free flow" arrangements that allowed the physicians of North Central, a subsidiary of Marshfield Clinic, to refer patients to each other without getting each HMO's approval. The plan of the physician who rendered the service would bill the other plan for its cost. As part of the arrangements, the parties involved purposely chose not to place in writing clear descriptions of their respective service areas so as to minimize any risks of antitrust violations, but their understanding was to discourage the physician providers of one plan from establishing practices in the service area of the other plan. Based on these findings, the Court of Appeals for the Seventh Circuit upheld the jury's determination that the defendants had engaged in a market allocation.¹³⁸

Monopolization

Section 2 of the Sherman Act prohibits monopolization, attempts to monopolize, and conspiracies to monopolize.¹³⁹ Section 2, by its terms, does not prohibit monopoly. The antitrust laws promote competition. As a result of competition a successful competitor may achieve a monopoly in a particular market. To declare such a result illegal seems unfair and illogical.¹⁴⁰

The Supreme Court has suggested that a monopolization offense has two elements: "(1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident."¹⁴¹

Determination of the existence of the first element may be complicated. Monopoly power has been defined by the courts as the "power to control prices or exclude competition."¹⁴² Although the Supreme Court has suggested that monopoly power may be inferred from a predominant share of the relevant market, substantial question remains as to what constitutes a "predominant share" and how the "relevant market" should be defined.^{143,144} Over time, the calculation of market share and the definition of the relevant market have become much more sophisticated.¹⁴⁵

The second element of monopolization—the willful acquisition or maintenance of monopoly power—may be similarly elusive. In *United States v. Aluminum Co. of America* the court suggested that by embracing new opportunities and anticipating the need for new capacity Alcoa had monopolized the market for aluminum ingot.¹⁴⁶ More recently the courts appear to require something more than behavior motivated by legitimate business purposes to support a charge of monopolization.¹⁴⁷

The offense of attempt to monopolize generally requires the proof of three elements: (1) specific intent to control prices or to exclude competitors, (2) predatory conduct directed to accomplishing this purpose, and (3) a dangerous probability of success.¹⁴⁸ Precise definition of conduct that satisfies these elements has proven to be controversial and complex.¹⁴⁹

In *Delaware Health Care, Inc. v. MCD Holding Co.*, Delaware Health Care (DHC), a provider of home care, brought an antitrust action against MCD Foundation and its subsidiaries, asserting that before the formation of Infusion Services of Delaware (ISD), a subsidiary of MCD Foundation, discharge planners of MCD's subsidiary hospitals recommended home care providers to patients on an informal rotating basis.¹⁵⁰ When ISD was formed, however, this informal rotation process was dismantled, and the defendant hospitals issued a directive to channel patients only to ISD. In addition, ISD was given exclusive access to patients in defendant hospitals' rooms to solicit business. As a result, ISD quickly gained a substantial share of the home infusion therapy market in the county where DHC and 13 other home care providers operated. DHC alleged two specific methods by which defendants had attempted monopolization. First, MCD Foundation "leveraged" its monopoly in the hospital market to extend its monopoly into the home health care market. Second, defendant hospitals denied DHC access to an "essential facility," the home care patients already discharged or about to be discharged from the defendant hospitals, and those patients' records. In response, MCD Foundation and the other defendants moved for summary judgment.¹⁵¹

With respect to the "leveraging" claim, the District Court for the District of Delaware started by analyzing the defendants' monopoly power in the "upstream" hospital market. Without monopoly power in the hospital market, there could be no illegal leveraging of the downstream home care market. Because the parties agreed that the relevant upstream product market was inpatient hospital services, the court turned its attention to the determination of the proper geographic market, noting that "[t]he geographic market must be broad enough that consumers would be unable to switch to alternative sellers in sufficient numbers to defeat an exercise of market power."¹⁵² Rejecting the defendants' argument that DHC failed to define the relevant market according to the "standard methodology" of the DOJ Merger Guidelines by considering the crucial forward-looking component that asks what patients would do in the event of a price increase, the court found that the Elzinga-Hogarty (E-H) test analyzing the flow of consumers in and out of the proposed market may be proper because

a reasonable juror could conclude that consumers of health care would not choose to leave their local hospital market as a result of a price increase.¹⁵³ Moreover, the court held that MCD Foundation and its subsidiary hospitals' 62% share of the market, together with other evidence, could prove that the defendants possessed monopoly power in the particular geographic market. However, to succeed on the leveraging claim, DHC also had to prove that the use of the defendants' monopoly power in inpatient hospital services had resulted in "actual or threatened" monopoly power in the home infusion therapy market. It was this element that the court held DHC had failed to establish. According to the court, the information that 75.9% of ISD's patients are residents of the county does not by itself define the county as the geographic market. To define that market, DHC must consider all home infusion therapy services produced in the county. Moreover, the court opined that the home therapy market could not be properly analyzed using the E-H test. The prong of the E-H test that measures the percentage of the goods or services produced outside the market that were purchased by consumers within the market does not aid the analysis of the geographic market because the home care services are always produced in the consumer's residence. Consequently the court granted the defendants' motion for summary judgment on the illegal leveraging claim.¹⁵⁴

With respect to the "essential facility" claim, the court found that, even accepting DHC's alleged inability to gain referrals for the defendant hospitals' patients as true, other sources of business for DHC existed in a sufficient amount that the patient discharge and referral process at defendant hospitals could not be considered an "essential facility." Given the availability of these other sources of business within DHC's service area, the access to the defendant hospitals' patient discharge process could not be deemed vital to DHC's competitive viability, and the denial of such access would not necessarily inflict a severe handicap that threatened to eliminate competition in the market. Accordingly the court held that DHC's evidence was insufficient to survive summary judgment on its essential facility claim.¹⁵⁵

In the context of health care the most common instance of alleged monopolization is the situation in which a hospital with monopoly power is acting to maintain that power and to avoid competition.¹⁵⁶ Similarly an association of all or most physicians of a given specialty in a relevant market could support a finding of monopoly power in support of an allegation of monopolization.¹⁵⁷ In particular contexts an HMO, PPO, or other provider organization could face monopolization allegations.

Mergers

Mergers between business entities are generally evaluated under Section 7 of the Clayton Act.¹⁵⁸ Section 7 prohibits mergers in which the effect may be "substantially to lessen competition, or to tend to create a monopoly" in an activity "affecting commerce in any section of the country."¹⁵⁹ The purpose of Section 7 is to reach incipient problems of

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monopoly, and hence the rather broad language of the statute.

Section 7 applies to the acquisition of stock or assets of any person by any other person. It is clear that the term *person* includes corporations and unincorporated business enterprises and that the section applies to partial acquisitions of assets.^{160,161} Section 7 may apply to joint ventures, as well as to more complete integration of business resources.¹⁶² The determination of whether an acquisition or merger substantially lessens competition or tends to create a monopoly has generated enormous controversy. In applying Section 7, the Supreme Court has engaged in increasingly rigorous structural analyses of the effect of the transaction on competition.¹⁶³ This trend also has been true of merger analysis undertaken by the FTC.¹⁶⁴

The merger guidelines issued by the DOJ in 1968 and substantially revised in 1982 and 1984, and subsequently revised and issued jointly with the FTC in 1992, have been exceptionally useful and influential in advancing the analysis of the competitive effect of mergers. The merger guidelines provide a structured approach to defining relevant product and geographic markets.^{165,166} The merger guidelines use the Herfindahl-Hirschman index to measure market concentration and provide an outline of enforcement policy for different levels of and increases in market concentration.¹⁶⁷

The earliest merger cases brought in the health care context involved for-profit hospitals.¹⁶⁸ More recently, the enforcement agencies have ceased to distinguish between nonprofit and for-profit hospitals in challenging mergers.¹⁶⁹ Hospitals represent one of the largest economic entities engaged in the provision of health care services, and the consolidation of hospitals has elicited the interest of antitrust enforcement authorities. Whether the developing merger activities of other types of health care providers will elicit the same interest remains to be seen.

The Statements of Antitrust Enforcement Policy in Health Care, revised and reissued by the DOJ and the FTC in 1996, address the issue of mergers among hospitals.¹⁷⁰ Statement 1 provides a safety zone for mergers “between two general acute care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years,” and the hospital has been in operation for longer than 5 years.¹⁷¹ The DOJ and FTC recognize that a hospital qualified for safety zone protection is often the only hospital in a relevant market and is unlikely to achieve the efficiencies that larger hospitals enjoy. A merger involving such a hospital is unlikely to have a substantial anti-competitive effect.¹⁷²

Outside of the safety zone, hospital mergers are evaluated under the 1992 Merger Guidelines. The Statements recognize that “[m]ost hospital mergers and acquisitions do not present competitive concerns.”¹⁷³ This statement suggests that the government enforcement agencies might take a less strict approach in analyzing hospital mergers than mergers in other industries. For example, approximately 229 hospital mergers occurred between 1987 and

1991, and the federal antitrust enforcement authorities investigated only 27 and challenged only 5.¹⁷⁴ In 2004 the enforcement agencies reported that “the Agencies and state enforcers have lost all seven hospital merger cases they have litigated since 1994.”¹⁷⁵

ENFORCEMENT

The federal antitrust laws are enforced by the DOJ, the FTC, and private persons. In addition, state attorneys general have authority under Section 4C of the Clayton Act to bring federal antitrust actions as *parens patriae* on behalf of the citizens of a state.¹⁷⁶ The attorneys general also represent their states as private parties to an antitrust action and enforce antitrust laws enacted by their state legislatures.

On the federal level, the Antitrust Division of the DOJ is responsible for enforcing the Sherman Act and the Clayton Act through either civil or criminal prosecutions. The FTC is mainly charged with the enforcement of the FTC Act and has concurrent jurisdiction with the Antitrust Division over some sections of the Clayton Act.

Any person or entity that has been injured by conduct in violation of the antitrust laws may bring a lawsuit under Section 4 of the Clayton Act for treble damages, costs of suit, and attorney’s fees. To maintain such a private antitrust cause of action, a plaintiff must demonstrate (1) that it has suffered an injury (2) to business or property by (3) the violation of an antitrust law.¹⁷⁷ Over the years, the Supreme Court has required that the injury suffered by a private party be an “antitrust injury.” That is, the injury suffered by a private person must be a type of injury that “the antitrust laws were intended to prevent and that flows from that which makes the defendants’ acts unlawful.”¹⁷⁸ Only after establishing an “antitrust injury” may a plaintiff proceed to the liability and damage issues in a private lawsuit.

DEFENSES

State Action Exemption

There are a number of defenses or exemptions from liability under the antitrust laws. Although some of these exemptions are the result of action by Congress creating a specific statutory exception to the application of the antitrust laws, perhaps the most important—the state action exemption—was created by judicial decision.

The state action exemption is grounded on the principle of federalism. A state may choose to displace competition in the provision of certain goods or services within its borders and to replace market control with state regulation. As long as this action by the state qualifies under the state action exemption, private parties are protected from liability under the federal antitrust laws for acting in compliance with this state mandate.

The state action exemption was initially articulated by the Supreme Court in *Parker v. Brown*.¹⁷⁹ At issue in *Parker* was whether a raisin marketing program that had the effect

of restricting production and maintaining prices but was created by state legislation was in violation of federal antitrust laws. In refusing to rule against the state program, the Supreme Court noted:

*We find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature. In a dual system of government in which under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress.*¹⁸⁰

In a number of cases decided since *Parker v. Brown*, the Supreme Court has elaborated on the state action exemption.¹⁸¹ In *California Liquor Dealers v. Midcal Aluminum Inc.* the Supreme Court suggested a two-pronged test for determining whether a state regulatory scheme is exempted from the federal antitrust laws.¹⁸² First, the restraint must be clearly articulated and affirmatively expressed as state policy.¹⁸³ Second, the anticompetitive conduct must be actively supervised by the state.¹⁸⁴

Most recently the Supreme Court has reaffirmed the two-prong *Midcal* test as the appropriate analytical approach for evaluating anticompetitive conduct by private parties acting pursuant to state statute.¹⁸⁵ The court also has made clear that the second prong of the *Midcal* test is not applicable to municipalities.¹⁸⁶ Liability of municipalities and other political subdivisions for damages under the antitrust laws has now been clarified by statute.¹⁸⁷

The Supreme Court has also clarified the active supervision prong of the state action exemption. The clarification was made in the 1992 case *FTC v. Ticor Insurance Co.*¹⁸⁸ In the *Ticor* decision the court described state action immunity as “disfavored” and explained that active supervision means more than endowing a state agency with the duty to regulate.¹⁸⁹

The state action exemption has been raised by defendants in a variety of health-care-related antitrust suits. A number of state statutes have been suggested as a basis for the state action exemption, including state certificate of need statutes, state statutes mandating physician peer review, and state authorization of municipal- and county-owned hospitals to grant or deny physician privileges.¹⁹⁰⁻¹⁹² The lower courts have engaged in substantial debate as to whether a state statute constitutes a clearly articulated and affirmatively expressed state policy to displace competition and whether there is adequate state supervision to satisfy the *Midcal* test.

Explicit and Implied Exemption

The antitrust statutes are subject to any limits and exemptions that Congress chooses to place upon them. Over the years, Congress has enacted a number of specific exemptions to the antitrust laws.¹⁹³

In 1986, in response to the decision in *Patrick v. Burget*, Congress enacted the Health Care Quality Improvement Act.^{194,195} This statute provides a general immunity from damages under the antitrust laws for physicians engaging in professional peer review.¹⁹⁶ In addition, any person providing information to a professional review body regarding the competence or professional conduct of a physician is given immunity from damages under state or federal law.^{197,198} In the event that a suit is brought against a person engaging in professional peer review and is unsuccessful, the statute imposes liability on the person bringing the suit for the costs of suit, including a reasonable attorney's fee, if the claim of the person bringing suit was frivolous, unreasonable, without foundation, or in bad faith.¹⁹⁹

In 2004, Congress passed legislation explicitly exempting from the coverage of the antitrust laws sponsoring, conducting, or participating in the medical school graduate residency matching program.²⁰⁰ The statute specifically notes that it is not intended to exempt an agreement fixing the amount of stipends or other benefits provided to medical students.²⁰¹

In addition to the specific exemptions noted, there are express exemptions to aspects of the antitrust laws in the statutes establishing federal regulatory schemes for particular industries. These exemptions are generally specific and limited in scope.²⁰²

A more difficult question is generated when Congress has not enacted a specific statutory exemption to the antitrust laws but has entrusted authority over certain matters in an industry to a regulatory agency. The question becomes whether Congress has by implication created an exemption from the antitrust laws. In general, implied exemptions from the antitrust laws are disfavored by the courts and are found only when there is a clear conflict between the antitrust laws and other federal statutes.²⁰³

In the context of health care the Supreme Court has refused to find an implied exemption from the antitrust laws in federal health planning legislation.²⁰⁴ In *National Gerimedical Hospital*, Blue Cross defended against a charge of anticompetitive conspiracy as a result of denying a hospital participating status by arguing that it was acting pursuant to the local Health System Agency (HSA) plan and furthering the purposes of the National Health Planning and Resources Development Act (NHPDA) of 1974.²⁰⁵ The Supreme Court concluded that in light of the strict approach taken in evaluating the claims of implied exemption to the antitrust laws, Blue Cross would remain subject to the antitrust laws in this case. The court was not persuaded that there was a clear repugnancy between the NHPDA and the antitrust laws, at least not on the facts of this case.²⁰⁶ The court left open the possibility that an implied exemption from the antitrust laws might be found in other factual contexts in the health care industry, specifically for activities necessary to make the federal health planning legislation work.²⁰⁷

Noerr-Pennington Doctrine

The courts have created an exemption from the antitrust laws for conduct by private parties intended to influence

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governmental action by the legislative, judicial, or executive branches. This exemption is known as the *Noerr-Pennington doctrine*, drawing its name from two U.S. Supreme Court cases wherein the court discussed the defense.²⁰⁸ The underlying purpose of the Noerr-Pennington doctrine is to protect the right of citizens to petition government and to ensure that government's access to information about the desires of citizens remains unimpaired by the threat of liability under the antitrust laws.²⁰⁹ Although the Noerr-Pennington doctrine is available to protect persons genuinely undertaking to influence governmental action, it is not available where the conduct is "a mere sham to cover what is actually nothing more than an attempt to interfere directly with the business relationships of a competitor."²¹⁰

Appeals to certificate of need agencies and to physician licensing boards are types of conduct that may be subject to Noerr-Pennington protection unless subject to the sham exception just noted.²¹¹ Hospital peer review committees have not been recognized as governmental agencies for purposes of the Noerr-Pennington doctrine.²¹² Unilateral or joint action that does not take the form of an appeal to a governmental decision-maker is not accorded protection under Noerr-Pennington.²¹³

ROBINSON-PATMAN ACT

The Robinson-Patman Act prohibits vendors from selling at discriminatorily low prices (i.e., prices not generally available to other customers).²¹⁴ The act has been sharply criticized by most commentators and is not generally enforced by federal enforcement agencies.²¹⁵ The statute forbids price discrimination by vendors among their purchasers so as to lessen competition. However, an amendment to the Non-Profit Institutions Act exempts a variety of institutions, including non-profit hospitals, but only on supplies purchased for the institution's "own use."²¹⁶ Customarily, nonprofit hospitals have paid less for drugs than the corner pharmacy, with the buyer and seller being protected by the statutory exemption.

In *Abbott Laboratories v. Portland Retail Druggists Association*, "for their own use" was interpreted as applying to hospital purchases of drugs dispensed for admitted patients, emergency department clientele, patients about to be discharged, some patients receiving outpatient treatment, and for personal use of employees, students, and physicians but not for walk-in customers.²¹⁷ This exemption has also been applied to purchases of drugs by a nonprofit HMO for resale to its members.²¹⁸ Although the potential liability in damages for defendants in antitrust actions should not be taken lightly, in the health care field it appears that these suits are more likely to be pursued as a threat to alter the defendants' conduct than with the expectation of recovering a judgment. Thus far, recoveries have been uncommon among reported cases.

RECENT DEVELOPMENTS IN ANTITRUST AND HEALTH CARE REFORM

In recognition of the substantial structural change occurring in the health care industry, the DOJ and the FTC issued Statements of Antitrust Enforcement Policy in Health Policy (initially in 1993 and revised and reissued in 1996), regarding mergers and joint activities in the health care sector.²¹⁹ The statements of antitrust enforcement policy are an extraordinary and unprecedented effort by antitrust enforcement agencies to provide guidance to participants in the health care industry. The statements provide guidance in the following nine areas:

1. Hospital mergers.
2. Hospital joint ventures involving expensive medical equipment.
3. Hospital joint ventures involving specialized clinical or other expensive health care services.
4. Providers' collaboration to provide non-fee-related information to purchasers of health care services.
5. Providers' collaboration to provide fee-related information to purchasers of health care services.
6. Provider exchanges of price and cost information.
7. Joint purchasing arrangements among health care providers.
8. Physician network joint ventures.
9. Multiprovider networks.

The statements issued by the federal antitrust enforcement agencies include antitrust safety zones in seven of the nine areas. Conduct will not be challenged absent extraordinary circumstances when it falls within one of these zones.

Several of the statements rely on a four-step rule-of-reason analysis for health care joint ventures that fall outside the safety zones defined by the agencies. The first step in this process is to define the relevant market. Typically, doing so involves the identification of the service being produced by the joint venture. The second step is to evaluate the competitive effects of the venture. This step begins with an examination of the structure of the relevant market and continues with an analysis of whether the joint venture restricts competitive activity among health care providers participating in the venture. In the event that it is determined that the venture has anticompetitive effects, it will be necessary to undertake the third step in the process and evaluate the impact of procompetitive efficiencies likely to be generated by the venture. This step includes the balancing of procompetitive efficiencies against the anticompetitive effects of the venture. Any venture in which the anticompetitive effects predominate will not survive this step of the analysis. The fourth step is the evaluation of collateral agreements that are likely to restrict competition to ensure that these collateral agreements are reasonably necessary to achieve the procompetitive efficiencies to be generated by the venture. This description of the rule-of-reason analytical approach reflects a refinement of judicial approaches and

is likely to be drawn on by judges and attorneys faced with making such an analysis.

In July 2004, the FTC and DOJ jointly issued a 361-page report entitled *Improving Healthcare: A Dose of Competition*.²²⁰ This report is the culmination of a two-year project which included 27 days of joint hearings in 2003 and a workshop sponsored by the FTC in 2002. The report is characterized as a response to skeptics who believe that health care is not subject to the normal rules of competition that apply in other sectors of the economy.²²¹ In the words of the Report, it “identifies concrete steps to improve competition in the health care marketplace, and improve the application of competition law to health care.”²²²

The report makes a number of important recommendations. States are encouraged to decrease barriers to entry to health care markets, including reconsidering certificate of need legislation, which in the opinion of the enforcement agencies is likely to have significant anticompetitive risks and uncertain economic benefits. Both state and federal governments are urged not to enact legislation allowing independent physicians to bargain collectively. Despite the perception of disparities in bargaining power between payors and providers, the report concludes that “the available evidence does not indicate that there is a monopsony power problem in most health care markets” and recommends against allowing providers to exert countervailing power.²²³ The report urges purchasers and providers to continue to experiment with providing incentives to providers to lower costs and improve quality and to encourage consumers to seek lower prices and higher quality.²²⁴ Governments are encouraged to consider carefully the impact of mandates on competition and the cost of health insurance and to examine the role of subsidies in health care markets.²²⁵

While the report makes some useful recommendations, it sets forth no strategy to put these recommendations into place. All available evidence suggests that consolidations, mergers, and restructuring driven primarily by market forces will continue in the health care industry for the foreseeable future. These changes will generate significant antitrust questions in this field for many years to come.

Endnotes

1. *Northern Pacific Railway v. United States*, 356 U.S. 1, 4–5 (1958).
2. Standard Oil adopted the trust format in 1879, and this action was followed by the rapid development of trusts in other industries. The trust as a vehicle for combining economic power commonly involved a trust agreement among the shareholders of the corporations involved. This agreement gave control over the stock in the corporations to the trustees, in return for which the shareholders received trust certificates evidencing their interest in the property controlled by the trust.
3. See generally E. Kinter, *Federal Antitrust Law* (1980).
4. *Id.* at 130.
5. *Id.* at 128, 130.
6. See generally E. Letwin, *Law and Economic Policy in America*, 53–99 (1965); Kinter, *supra* at 125–129.
7. Letwin, *supra* at 95.
8. Initially a violation of the act was a misdemeanor punishable by a fine of up to \$5000 and by imprisonment of up to 1 year. The maximum fine was increased in 1955. In 1974 a violation of the act was made a felony, and penalties were substantially increased. Penalties were further enhanced in the Antitrust Criminal Penalty and Reform Act signed by the President in June 2004. The maximum fine that may be imposed on a corporation has been increased to \$100 million and the maximum fine for an individual is now \$1 million. The maximum jail term has been increased to ten years. The Sherman Act is codified at 15 U.S.C. §§1–7.
9. See generally Letwin, *supra* at 106–142.
10. *United States v. Trans-Missouri Freight Association*, 166 U.S. 290 (1897).
11. *United States v. Joint Traffic Association*, 171 U.S. 505 (1898).
12. *United States v. Addyston Pipe & Steel Co.*, 175 U.S. 211 (1899).
13. 51 Cong. Rec. 14218 21 (1914).
14. *Standard Oil Co. of New Jersey v. United States*, 221 U.S. 1 (1911).
15. *Id.* at 62.
16. Act of October 15, 1914, ch. 322, 38 Stat. 730, 15 U.S.C. §§12–27. The Clayton Act deals specifically with tying, exclusive dealing, price discrimination, and mergers.
17. 15 U.S.C.A. §§ 15, 26.
18. *Id.*
19. Act of September 26, 1914, ch. 11, 38 Stat. 717, 15 U.S.C. §§41–51.
20. The most significant change was the amendment of the law of price discrimination by the Robinson-Patman Act in 1936. Act of June 19, 1936, ch. 592, 49 Stat. 1526.
21. *Goldfarb v. Virginia State Bar*, 421 U.S. 73 (1975).
22. *E.g., Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).
23. *E.g., Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738 (1976).
24. See Phillip A. Proger, *Application of the Sherman Act to Health Care: New Developments and New Directions*, 59 Antitrust L.J. 173 (1990).
25. 15 U.S.C. §1.
26. *Copperweld Corp. v. Independent Tube Corp.*, 467 U.S. 752 (1984).
27. *Id.* at 772.
28. See, e.g., *Directory Sales Management Corp. v. Ohio Bell Tel. Co.*, 883 F.2d 606, 611 (6th Cir. 1987); *Hood v. Tenneco Texas Life Ins. Co.*, 739 F.2d 1012, 1015 (5th Cir. 1984). But see *In re Ray Dobbins Lincoln-Mercury v. Ford Motor Co.*, 604 F. Supp. 203, 205 (W.D. Va. 1984) (*Copperweld* does not apply to an allegation of conspiracy between two subsidiaries of the same parent corporation), *aff'd on other issues in an unpublished opinion*, 813 F.2d 402 (4th Cir. 1985).
29. *Advanced Health-Care Serv. v. Radford Community Hosp.* 910 F.2d 139, 143, 146 (4th Cir. 1990).
30. See *Weiss*, 745 F.2d at 814–817, *cert. denied*, 470 U.S. 1060 (1985); *Feldman v. Jackson Memorial Hospital*, 571 F. Supp. 1000 (S.D. Fla. 1983), *aff'd*, 752 F.2d 647 (11th Cir. 1985); *Cooper v. Forsyth County Hospital Authority*, 604 F. Supp. 685 (M.D. N.C. 1985). But see *Nurse Midwifery Associates v. Hibbett*, 918 F.2d 605 (1990), *cert. denied*, 112 S.Ct. 406 (1991). It is, of course, clear that a medical staff is composed of individual physicians, and the conduct of physicians within a medical staff or as individual competitors in the market for physician services is not protected by the *Copperweld* doctrine. See discussion of this point in *Weiss*, 745 F.2d at 815–816; see also *Nurse Midwifery Associates*, 918 F.2d 605 (1990), *cert. denied*, 112 S.Ct. 406 (1991).

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31. See *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991); *McLain v. Real Estate Board of New Orleans*, 444 U.S. 232 (1980).
32. *Hospital Building Co.*, 425 U.S. 738, 744 (1976).
33. *Summit Health*, 500 U.S. 322 (1991); *Everhart v. Jane C. Stormont Hospital and Training School for Nurses*, 1982-1 Trade Cas. (CCH) 164, 703 (D. Kan. 1982).
34. *Standard Oil*, 221 U.S. 1 (1911).
35. *Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918).
36. *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978).
37. *Id.* at 695. See also *Fashion Originator's Guild of America v. Federal Trade Commission*, 312 U.S. 457 (1941).
38. *Wilk v. American Medical Ass'n, Inc.*, 719 F.2d 207, 227 (7th Cir. 1983), cert. denied, 467 U.S. 1210 (1984).
39. *Id.* at 227.
40. *Id.* at 226.
41. *Hospital Building Co.*, 691 F.2d 678, 685 (4th Cir. 1982), cert. denied, 464 U.S. 890 (1983).
42. *Id.* at 686.
43. See *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982) (health care industry entitled to no special treatment).
44. *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 459 (1986).
45. See *id.* at 464.
46. The development of this presumption in the area of price-fixing began with *United States v. Joint Traffic Ass'n*, 171 U.S. 505, 568 (1897), continued in *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397 (1927), and reached its high point in *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221-223, 224 n. 59 (1940).
47. The term *per se* was first used in *Socony-Vacuum*, 310 U.S. at 223.
48. *Northern Pacific Railway*, 356 U.S. at 5.
49. *United States v. Topco*, 405 U.S. 596, 607 (1972).
50. See *National Society of Professional Engineers*, 435 U.S. 679 (1978); *Indiana Federation of Dentists*, 476 U.S. at 458.
51. See *NCAA v. Board of Regents*, 468 U.S. 85, 100 (1984).
52. *California Dental Association v. FTC*, 526 U.S. 756, 770 (1999).
53. See *id.* at 770-778.
54. *Id.* at 760.
55. 15 U.S.C.S. 45.
56. *California Dental Association*, 526 U.S. at 763.
57. *Id.* at 775.
58. The court in *California Dental Association* seemed to suggest that a detailed market analysis might not be necessary in that case. It was, however, not entirely clear how extensive the examination needed to be to satisfy the rule-of-reason analysis. As the court stated, "[T]here is generally no categorical line to be drawn between restraints that give rise to an intuitively obvious inference of anticompetitive effect and those that call for more detailed treatment. What is required, rather, is an enquiry meet for the case, looking to the circumstances, details, and logic of a restraint." *Id.* at 780-781.
59. *Northern Pacific Railway*, 356 U.S. 1 (1958).
60. *Trenton Potteries Co.*, 273 U.S. at 397.
61. *Id.* at 397-398.
62. *Eastern States Lumber Association v. United States*, 234 U.S. 600, 612 (1914).
63. *Socony-Vacuum*, 310 U.S. at 221.
64. But see *Broadcast Music Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 23 (1979).
65. *Maricopa County Medical Society*, 457 U.S. 332 (1982).
66. *Id.* at 357.
67. *Id.* at 351. *Maricopa* was decided by a vote of four to three, two justices not participating. The dissent criticized the failure of the majority to recognize the uniqueness of the market for medical services. *Id.* at 366 n. 13.
68. Statements of Antitrust Enforcement Policy in Health Care, August, 1996, 1996-4 Trade Reg. Rep. (CCH), §13,153.
69. *Id.*
70. See, e.g., *North Texas Specialty Physicians*, FTC Docket No. 9312; *Carlsbad Physician Association, Inc.*, FTC Docket No. C-4081; *California Pacific Medical Group, Inc. d/b/a Brown and Toland Medical Group*, FTC Docket No. 9306; *Washington University Physician Network*, FTC Docket No. C-4093; *Maine Health Alliance*, FTC File No. 0210017; *Physician Network Consulting, LLC*, FTC Docket No. C-4094; *SPA Helath Organization*, FTC File No. 0110197; *South Georgia Health Partners, LLC*, FTC Docket No. C-4100; *Surgical Associates of Yakima, et al.*, FTC Docket No. C-4101; *Memorial Herman Health Network*, FTC Docket No. C-4104.
71. *North Texas Specialty Physicians*, FTC Docket No. 9312.
72. See, e.g., *Glen Eden Hospital v. Blue Cross & Blue Shield of Michigan*, 740 F.2d 423 (6th Cir. 1984).
73. *Id.* at 430.
74. See, e.g., *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984).
75. See, e.g., *The American College of Radiology*, 3 Trade Reg. Rep. (CCH) 121, 236; *Minnesota State Medical Association*, 3 Trade Reg. Rep. (CCH) 121, 293; *the American College of Obstetricians and Gynecologists*, 3 Trade Reg. Rep. (CCH) 121, 171; *the American Academy of Orthopedic Surgeons*, 3 Trade Reg. Rep. (CCH) 121, 171.
76. See Clark C. Havighurst, *Antitrust Issues in the Joint Purchasing of Health Care*, Utah L. Rev. 409, 417 (1995).
77. *Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219, 235 (1948).
78. Havighurst, *supra*, at 422.
79. *Id.* at 428.
80. *Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co.*, 472 U.S. 284, 295 (1985) (quoting from *Broadcast Music*, 441 U.S. at 20).
81. *Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care*, 1996-4 Trade Reg. Rep. (CCH), s. 13,153.
82. See Roger D. Blair & Jeffrey L. Harrison, *Cooperative Buying, Monopsony, Power, and Antitrust Policy*, 86 Nw. U. L. Rev. 331, 366 (1992).
83. *Id.* at 366-367.
84. Cf. *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1415 (7th Cir. 1995), cert. denied, 516 U.S. 1184 (1996).
85. *Levine v. Central Florida Medical Affiliates, Inc.*, 72 F.3d 1538, 1548 (11th Cir. 1996).
86. See "Remarks of Charles F. Rule Before the Interim Meeting of the American Medical Association House of Delegates," Dallas, Texas, December 6, 1988.
87. 15 U.S.C. §1.
88. 15 U.S.C. §14.
89. 15 U.S.C. §45.
90. 15 U.S.C. §14.
91. *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984).
92. *Id.* at 12.
93. *Id.* at 15-16.
94. *Id.* at 17. Justice O'Connor, in an opinion concurring with the judgment in *Jefferson Parish*, which three other justices joined,

- suggests three prerequisites to an illegal tie: (1) The seller must have power in the tying product market; (2) there must be a substantial threat that the seller will acquire market power in the tied product; and (3) there must be a coherent economic basis for treating the tied products as distinct products. *Id.* at 37–39. She also rejected per se treatment of tying arrangements even if these conditions are met. *Id.* at 37–40.
95. *Id.* at 26–27.
 96. *Id.* at 29.
 97. *Id.* at 21.
 98. *Id.* at 22–24.
 99. *Id.* at 23.
 100. *Id.* at 25–26, n. 42 (citing *Maricopa County Medical Society*, 457 U.S. 332 [1982]); *National Gerimedical Hospital v. Blue Cross*, 452 U.S. 378 (1981); *American Medical Ass’n v. United States*, 317 U.S. 519 (1943).
 101. 5 U.S.C. §1.
 102. 15 U.S.C. §14.
 103. 15 U.S.C. §45.
 104. *Continental T.V., Inc., v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977). See also *Jefferson Parish Hospital*, 466 U.S. at 45 (J. O’Connor, concurring).
 105. *Standard Oil Co. v. United States*, 337 U.S. 293, 314 (1949).
 106. *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961).
 107. *Jefferson Parish Hospital*, 466 U.S. at 30 n. 51 (1984).
 108. *Id.* at 45 (J. O’Connor, concurring).
 109. *Id.*
 110. *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F. 2d 589, 592 (1st Cir. 1993).
 111. *Id.* at 596–597.
 112. See, e.g., *Jefferson Parish Hospital*, 466 U.S. at 45 (J. O’Connor, concurring); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F. 2d 589 (1st Cir. 1993).
 113. 15 U.S.C. §1. Section 1, by its terms, requires some contract, combination, or conspiracy for a violation of the section to occur. Unilateral action by a businessman has long been recognized as legitimate conduct unrestrained by the antitrust laws. *United States v. Colgate Co.*, 250 U.S. 300 (1919). One significant exception to this proposition would be unilateral action, which could be characterized as monopolization or as an attempt to monopolize in violation of §2 of the Sherman Act. 15 U.S.C. §2.
 114. See *Klor’s, Inc. v. Broadway-Hale Stores, Inc.* 359 U.S. 207 (1959); *United States v. General Motors Corp.*, 384 U.S. 127 (1966).
 115. *Northwest Wholesale Stationers*, 472 U.S. 284 (1985).
 116. *Id.* at 294 (citations omitted).
 117. *Id.* at 298.
 118. *Weiss v. York Hospital*, 745 F. 2d 786, 818 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985).
 119. *Id.* at 820.
 120. *Id.* at 820. The court drew on language from *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 348–349 (1982), recognizing some limited vitality for a learned profession’s exemption from the operation of the antitrust laws.
 121. *Wilk*, 719 F. 2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984).
 122. *Id.* at 221.
 123. *Id.* at 221. See discussion of the rule-of-reason approach in *Wilk* at 182.
 124. See, e.g., *Pontious v. Children’s Hospital*, 552 F. Supp. 1352 (W.D. Pa. 1982); *Chiropractic Cooperative Association of Michigan v. American Medical Ass’n*, 617 F. Supp. 264 (E.D. Mich. 1985).
 125. *Patrick*, 486 U.S. 94 (1988).
 126. See discussion at 105–106.
 127. 42 U.S.C. §§11101–11152. This statute was, in part, in response to the verdict in the trial court in *Patrick v. Burget*.
 128. *Levine v. Central Florida Medical Affiliates, Inc.*, 72 F. 3d 1538, 1542–1543 (11th Cir. 1996).
 129. *Id.* at 1550.
 130. *Id.* at 1552.
 131. See, e.g., *Doctor’s Hospital v. Southeast Medical Alliance*, 123 F. 3d 301 (5th Cir. 1997). In this case a PPO controlled by local hospitals terminated the defendant hospital’s membership, and accepted a rival hospital in the area as a new member instead. The court applied the rule of reason and found insufficient evidence of injury, noting that the plaintiff was affiliated with several other PPOs in the area and that the plaintiff failed to show that its exclusion from the defendant PPO would lead to increased prices under managed care plans, diminished consumer choice, or had an impact on its long-term ability to compete.
 132. *Supra* note 68, Statement 9.
 133. *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1972).
 134. *Continental T.V. v. G.T.E. Sylvania*, 433 U.S. 36 (1977).
 135. *Cf. Broadcast Music*, 441 U.S. 1 (1979).
 136. See, e.g., DOJ and FTC Statements of Antitrust Enforcement Policy in Health Care, 1996-4 Trade Reg. Rep. (CCH), §13,153.
 137. *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F. 3d 1406, 1416 (7th Cir. 1995).
 138. *Id.*
 139. 15 U.S.C.A. §2.
 140. *United States v. Aluminum Co. of America*, 148 F. 2d 416, 430 (2d Cir. 1945) (“The successful competitor, having been urged to compete, must not be turned upon when he wins.”)
 141. *United States v. Grinnell Corp.*, 384 U.S. 563, 571 (1966).
 142. *United States v. duPont & Co.*, 351 U.S. 377, 391 (1956); *accord Grinnell Corp.*, 384 U.S. at 571.
 143. *Grinnell Corp.*, 384 U.S. at 571.
 144. In *Aluminum Co. of America*, 148 F. 2d at 424, Judge Learned Hand noted that “The percentage we have already mentioned—over 90—results only if we both include all ‘Alcoa’s’ production and exclude ‘secondary.’ That percentage is enough to constitute a monopoly; it is doubtful whether 60% or 64% would be enough; and certainly 33% is not.”
 145. See in this regard the revised merger guidelines issued by the United States Department of Justice and the Federal Trade Commission in 1992, 4 Trade Reg. Rep. (CCH) §13,104, §1.1 Product Market Definition; §1.2 Geographic Market Definition; §1.4 Calculating Market Shares.
 146. *Aluminum Co. of America*, 148 F. 2d at 431.
 147. *Aspen Skiing Co. v. Aspen Highlands Skiing Co.*, 472 U.S. 585, 603–605 (1985); *Berkey Photo Inc. v. Eastman Kodak Co.*, 603 F. 2d 263, 274 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980).
 148. See *Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447, 456 (1993).
 149. See, e.g., Cartensen, *Reflections on Hay, Clark and the Relationship of Economic Analysis to Rules of Antitrust Law*, 83 Wis. L. Rev. 953 (1983); Cooper, *Attempts and Monopolization: A Mildly Expansionary Answer to the Prophylactic Riddle of Section Two*, 72 Mich. L. Rev. 373 (1974).
 150. *Delaware Health Care, Inc. v. MCD Holding Co.*, 957 F. Supp. 535 (D. Del. 1997), *aff’d*, 141 F. 3d 1153 (3d Cir. 1998).
 151. See *id.* at 538–539.
 152. *Id.* at 541 (citation omitted).

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153. *Id.* at 541–543.
154. *Id.* at 544–546.
155. *Id.* at 547–548. It should be noted that the Supreme Court has recently questioned the viability of the “essential facility” theory. See *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 411 (2004) (“We have never recognized such a doctrine, [citations omitted], and we find no need either to recognize it or to repudiate it here.”)
156. See, e.g., *Weiss*, 745 F.2d at 825, *cert. denied*, 470 U.S. 1060 (1985) (§2 violation reversed because no showing of willful conduct on part of hospital); *Robinson v. Magovern*, 621 F.Supp. at 887 (30% market share does not constitute monopoly power).
157. Allegations of monopolization, *inter alia*, by the attorney general of the State of Maine against an association of anesthesiologists in Portland, Maine, resulted in a consent decree restricting the practices of that association. *State of Maine v. Anesthesia Professional Ass’n*, Maine Superior Court, Consent Decree, June 12, 1984. In *Bhan v. NME Hospitals, Inc.*, 772 F.2d 1467 (9th Cir. 1985) a nurse anesthetist alleged violations of §§1 and 2 of the Sherman Act by anesthesiologists and a hospital acting in combination to deny access to the hospital to nurse anesthetists.
158. 15 U.S.C. §18. The FTC may review a merger pursuant to 15 U.S.C. §45, which incorporates the provisions of Section 7. *Stanley Works v. FTC*, 469 F.2d 498, 499 n. 2 (2d Cir. 1972), *cert. denied*, 412 U.S. 28 (1973).
159. 15 U.S.C. §18.
160. 15 U.S.C. §12. In regard to asset acquisitions, the acquiring party must be subject to the jurisdiction of the FTC. For discussion of this point, see Miles and Philip, *Hospitals Caught in the Antitrust Net: An Overview*, 24 *Duquesne L. Rev.* 489, 664 (1985), and see *FTC v. University Health Inc.*, 938 F.2d 1206 (11th Cir. 1991) and *U.S. v. Rockford Memorial Hospital*, 898 F.2d 1278 (7th Cir. 1990).
161. 5 U.S.C. §18.
162. *United States v. Penn-Olin Chemical Co.*, 378 U.S. 158 (1964).
163. Compare *United States v. Von’s Grocery Co.*, 384 U.S. 270 (1966), with *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974) and *United States v. Marine Bancorporation*, 418 U.S. 602 (1974).
164. See, e.g., *Hospital Corporation of America*, 3 Trade Reg. Rep. (CCH) 122, 301 (FTC Oct. 25, 1985); *American Medical International*, 3 Trade Reg. Rep. (CCH) 122, 170 (FTC July 2, 1984).
165. 1992 Horizontal Merger Guidelines, 57 Fed. Reg. 41552 (Sept. 10, 1992), 4 Trade Reg. Rep. (CCH) §13,104.
166. *Id.* at §§ 1.1, 1.2.
167. The Herfindahl-Hirschman index (HHI) is the sum of the squares of the individual market shares of all the firms judged to be appropriately included in the market. An HHI of below 1000 in a postmerger market generally is considered unconcentrated, whereas an HHI above 1800 generally is considered highly concentrated. An HHI between 1000 and 1800 will be reviewed with emphasis on the increase in the HHI caused by the merger and other factors. This statement is a summary explanation of the process followed under the Merger Guidelines and reference to the Merger Guidelines is strongly recommended.
168. See *Hospital Corporation of America v. FTC*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987); *American Medical International*, 3 Trade Reg. Rep. (CCH) 122, 170 (FTC July 2, 1984); *United States v. Hospital Affiliates International, Inc.*, 1980–1981 Trade Cases (CCH) 163, 721 (E.D. La. 1980); *American Medicorp, Inc. v. Humana, Inc.*, 445 F.Supp. 589 (E.D. Pa. 1977).
169. See *Improving Health Care: A Dose of Competition*, Joint Report of the Department of Justice and the Federal Trade Commission, July 2004, Executive Summary at 25. (“The nonprofit status of a hospital should not be considered in determining whether a proposed hospital merger violates the antitrust laws.”)
170. 4 Trade Reg. Rep. (CCH) §13,153, Statement 1.
171. *Id.*
172. *Id.*
173. *Id.*
174. See Statement of Charles A. James, Acting Assistant Attorney General, Antitrust Division, to the Joint Economic Committee of the House-Senate Subcommittee on Investment, Jobs and Prices, June 24, 1992.
175. *Id.* at 13.
176. 15 U.S.C. §15c.
177. See *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977).
178. *Id.* at 489.
179. *Parker v. Brown*, 317 U.S. 341 (1943).
180. *Id.* at 350.
181. See, e.g., *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976); *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977).
182. *California Retail Liquor Dealers Ass’n v. Midcal Aluminum Inc.*, 445 U.S. 97 (1980).
183. *Id.* at 105.
184. *Id.*
185. See *Patrick v. Burget*, 486 U.S. 94 (1988); see also *Southern Motor Carriers Rate Conference v. United States*, 471 U.S. 48 (1985). In *Southern Motor Carriers* the court rejected the contention that to gain the benefit of the state action exemption the anticompetitive conduct of the private party must be compelled by the state statute.
186. *Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985).
187. Local Government Antitrust Act of 1984, Pub. L. 98-544, October 24, 1984, 15 U.S.C. §§34–36.
188. 504 U.S. 621 (1992).
189. *Id.* at 636.
190. See, e.g., *State of North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, 740 F.2d 274 (4th Cir. 1984), *cert. denied*, 469 U.S. 1070 (1985).
191. See, e.g., *Marrese v. Interequal, Inc.*, 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985); *Quinn v. Kent General Hospital, Inc.*, 617 F.Supp. 1226 (D.C. Del. 1985).
192. See, e.g., *Coastal Neuro-Psychiatric Associates v. Onslow County Hospital Authority*, 607 F.Supp. 49 (D.C.N.C. 1985).
193. 15 U.S.C. §17 (labor organizations); 15 U.S.C. §§1011–1015 (business of insurance: McCarran-Ferguson Act). See *Union Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978); 15 U.S.C. §17; 7 U.S.C. §§291–292 (agricultural cooperatives: Capper-Volstead Act); 15 U.S.C. §521 (fishery associations: the Fisheries Cooperative Marketing Act); 15 U.S.C. §§1801–1804 (joint newspaper operating agreements: the Newspaper Preservation Act); 15 U.S.C. §§3501–3503 (intra-brand territorial restrictions on soft drink franchisees: the Soft Drink Interbrand Competition Act of 1980); 15 U.S.C. §638(d)(1), (2) (small business programs for research and development); 15 U.S.C. §§640, 2158 (national defense-related agreements); and 15 U.S.C. §§62, 4001–4021 (Webb-Pomerene Act, Export Trading Company Act of 1982) (joint exporting agreements).
194. *Patrick*, 486 U.S. 94 (1988).
195. 42 U.S.C. §§11101–11152.

196. The professional review action must meet the standards set forth in 42 U.S.C. §11112(a). This immunity may be lost if a health care entity fails to report information as required by the statute. 42 U.S.C. §11111(b).
197. Professional review body is defined at 42 U.S.C. §11151(11). It includes a health care entity conducting professional review and any committee of a health care entity or of a medical staff of such an entity conducting such review when assisting the governing body of the institution.
198. Immunity is not provided if the information is false and the person providing it knew it was false. 42 U.S.C. §11111(a)(2).
199. 42 U.S.C. §11113.
200. See Pension Funding Equity Act of 2004, §207, Pub. L. No. 108-218, Sec. 1, 118 Stat. 596 (2004).
201. *Id.* at §207(b)(2).
202. See, e.g., The Reed-Bullwinkle Act, 49 U.S.C. §10706 (joint rate filings with ICC by carriers); the Shipping Act of 1916, 46 U.S.C. §§813a, 814 (rate agreements between maritime carriers).
203. See, e.g., *United States v. National Association of Securities Dealers*, 422 U.S. 694 (1975); *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963); *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963).
204. See *National Gerimedical Hospital v. Blue Cross*, 452 U.S. 378 (1981).
205. 42 U.S.C. §3001 (National Health Planning and Development Act of 1974).
206. 452 U.S. at 391.
207. *Id.* at 393 n. 18.
208. *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965).
209. *Noerr Motor Freight*, 365 U.S. at 137.
210. *Id.* at 144; see also *Professional Real Estate Investors Inc. v. Columbia Pictures Industries, Inc.*, 508 U.S. 49 (1993); *City of Columbia v. Omni Outdoor Advertising, Inc.*, 499 U.S. 365 (1991); *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 513 (1972).
211. See, e.g., *Hospital Building Co.*, 691 F. 2d at 687-688; *Feminist Women's Health Center v. Mohammad*, 586 F. 2d 530, 542-547 (5th Cir. 1978).
212. *Feminist Women's Health Center*, 586 F. 2d at 544.
213. *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F. 2d 476, 482 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).
214. Robinson-Patman Antidiscrimination Act, ch. 592, §1-4, 49 Stat. 1526, 15 U.S.C. 13, 13a, 13b, 21a, 13c (1936).
215. See Herbert Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* §14.6 (3d ed., West Publishing Co., 2005).
216. Non-Profit Institutions Act, ch. 283, 52 Stat. 446, 15 U.S.C. 13c (1938).
217. *Abbott Laboratories v. Portland Retail Druggists Ass'n*, 425 U.S. 1 (1976).
218. *De Modena v. Kaiser Foundation Health Plan, Inc.*, 743 F. 2d 1388 (9th Cir. 1984), *cert. denied*, 469 U.S. 1229.
219. 1996-4 Trade Reg. Rep. (CCH), §13,153. In the 1996 revised statements the agencies elaborated on their discussion in two critical areas—physician and multiprovider networks.
220. *Improving Healthcare: A Dose of Competition*, July 2004 (available at www.usdoj.gov).
221. *Id.* at Executive Summary, p. 1.
222. *Id.* at Executive Summary, p. 27.
223. *Id.* at Executive Summary, p. 26.
224. *Id.* at Executive Summary, p. 19.
225. *Id.* at Executive Summary, pp. 21, 22.

