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GOVERNMENT ANTITRUST ENFORCEMENT IN THE HEALTH CARE MARKETS: THE REGULATORS NEED AN UPDATE

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Pamela E. Hepp**

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I. INTRODUCTION

The health care industry was once viewed as outside the normal rules of the competitive process. For many years government programs paid health care providers based on the actual costs incurred by the providers, thus explicitly discouraging efficiency and subsidizing a high-cost approach to health care. Consumers not covered by governmental programs were typically covered by private insurance plans that paid on the basis of “usual and customary charges,” a payment system that did little to promote competition or encourage efficiency. Health care consumers had the least incentive to encourage efficiency or cost containment, as they were largely insulated from costs (by governmental or private insurance) and, when not insulated, had a generally strong motive to subordinate any cost concerns to (at least perceived) quality of care concerns.

Massive changes in health payment systems are dramatically changing the importance of both efficiency and cost in the selection of health care providers. Both governmental payers and the private sector have moved away from traditional payment mechanisms. Congress, for example, enacted the Social Security Amendments of 1983 establishing a “prospective payment system” that, by paying a flat rate “prospectively,” ceased to reward high spending, long-stay providers. Similarly, as employers began seeing their health care costs spiral, they encouraged the creation of alternative modes of delivery of services and alternative payment mechanisms, generally lumped under the rubric of “managed

care.” Under managed care, the provider becomes responsible, at least in part, for reducing the total cost of the service package to the buyer. The shift is dramatic. In 1988, 72.6% of the private insurance market was traditional indemnity insurance; by 1993, traditional insurance accounted for only 33.3%.²

It is generally accepted that total health care costs can be reduced only if a large part of the chain of service providers has an incentive to encourage preventative care and discourage the use of high cost treatments. This, of course, encourages the formation of entities capable of providing a much broader spectrum of health care services.

Economic forces are thus pushing providers toward integration and cooperative arrangements. Physicians are finding it necessary to join together, both with and without hospitals, to negotiate effectively over managed care contracts. Because of the presumed attractiveness of a single, broad-spectrum provider to managed care purchasers, and because of the downward pressure on payments generally, hospitals are seeking to provide a wider array of services, such as home health care, hospice care, long-term care, rehabilitation services and outpatient services.

The scope of antitrust restrictions on health care providers, as they seek to anticipate and participate in the demands of the market, is in doubt. The government’s enforcement agencies, the Federal Trade Commission (FTC) and the Department of Justice (DOJ), have made the health care field an area of special focus. The agencies have issued, and recently updated, specific statements of antitrust enforcement policy.³ Until recently the Policy Statements provided little guidance to providers beyond the clearest cases. Even the most recent revisions fail to reflect a recognition that changes in the market have dramatically altered the range and intensity of competition among providers. A similar weakness exists in the government’s enforcement position on hospital mergers.

This Article will first briefly discuss the antitrust laws in general and then examine the current state of the law as it exists in relation to the government’s enforcement position. In particular, the Article will examine the position of the courts as to hospital mergers and the possible implications of the government’s general position on collaboration and networking. There are strong indications that the government’s enforcement policies fail to recognize market realities in the


³ U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996) [hereinafter POLICY STATEMENTS] (revising and clarifying, with regard to Physician and Multi-provider Networks, two prior Statements: Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust (Sept. 27, 1994) and Statements of Antitrust Enforcement Policy in the Health Care Area (Sept., 1993)).
health care field and that the government’s static analysis will not be upheld when challenged by evidence of the actual fluidity of today’s health care market.

II. THE ANTITRUST LAWS

A. The Statutory Framework

Most antitrust challenges to activities of health care providers have been brought under either section 1 of the Sherman Act\(^4\) or section 7 of the Clayton Act,\(^5\) although section 2 of the Sherman Act has seen some limited application to collaborative efforts on the part of health care providers. The Sherman Act has been described by the United States Supreme Court as being “designed to be a competitive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade.”\(^6\) The underlying principle is that unrestrained competition will produce the best allocation of resources and will yield the lowest prices and highest quality of goods and services.\(^7\)

The Sherman Act consists of seven sections; however, the first two sections provide the primary antitrust enforcement tools and are the only sections pertinent to this Article. Both sections state their prohibitions in very broad terms. Section 1 proscribes agreements, contracts and conspiracies “in restraint of trade,” and provides, in part: “Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.”\(^8\) Section 2 applies to attempts to monopolize or conspiracies to monopolize and provides: “Every person who shall monopolize ... or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several


States, or with foreign nations, shall be deemed guilty of a felony...9

The monopolization restrictions of section 2 are supplemented by the Clayton Act. Section 7 of the Clayton Act prohibits mergers, or stock or asset acquisitions, that may "substantially... lessen competition, or tend to create a monopoly."10 The government regards the Clayton Act and the Sherman Act as setting the same standard with regard to mergers.11

The Sherman Act is enforced civilly by both the DOJ and the FTC, although criminal jurisdiction rests solely with the DOJ.12 The FTC and the DOJ share concurrent jurisdiction over civil enforcement as to Clayton Act section 7 violations, relating to mergers or stock or asset acquisitions. Civil violations under either the Sherman or Clayton Act may result in the award of treble damages and attorneys' fees against a defendant. Criminal penalties for violation of the Sherman Act may result in corporate fines of up to $10,000,000 and fines against individuals of up to $350,000, as well as imprisonment for up to three years.13

9 Id. § 2.

10 15 U.S.C. § 18. The full text provides:

No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or tend to create a monopoly.

Id.


12 Although the FTC also lacks direct authority to enforce the Sherman Act, it can do so indirectly through its power to prohibit unfair trade practices. See 15 U.S.C. §§ 41-58 (1994). A Sherman Act violation is necessarily an unfair trade practice. FTC v. Cement Inst., 333 U.S. 683 (1948). A possible gap in FTC, although not DOJ authority as to non-profit entities has generally been resolved in favor of the FTC. See discussion infra note 118.

B. Rule of Reason Versus Per Se Illegality

On its face, section 1 of the Sherman Act seems to prohibit every agreement that "restrains" trade. Under a very literal reading, section 1 could apply to essentially every contract, because, every contract to some extent "restrains" trade. For example, agreeing to sell to A precludes any sales of the same items to B. The United States Supreme Court, however, has interpreted the Act as prohibiting only "unreasonable" restraints on trade. As a result, the courts generally apply a "rule of reason" analysis, which balances the potential pro-competitive and anti-competitive effects of the arrangement. However, some activities may be so "plainly anti-competitive that no elaborate study of the industry is needed to establish their legality," and thus, they are held to *per se* illegal. *Per se* violations are so offensive to competition that no defenses may be presented and no balancing of benefits and burdens will be undertaken. The traditional list of *per se* violations includes price-fixing, market allocation or division, as well as boycotts and tying arrangements.

The majority of health care decisions have involved the application of the rule of reason. In general, the analysis involves a determination of the relevant

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14 See Standard Oil Co. of N.J. v. United States, 221 U.S. 1, 87 (1911) (Harlan, J., concurring in part, dissenting in part).


16 See Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 344 n.15 (1982) (quoting Northern Pac. Ry. v. United States, 356 U.S. 1, 5 (1958)). The list is not quite as straight-forward as it may seem. Although price fixing is the archetype of *per se* violations, some apparent price fixing violations have escaped *per se* treatment. See NCAA v. Board of Regents of the Univ. of Okla., 468 U.S. 85 (1984) (holding that price fixing agreement by collegiate sport association was illegal, but only after rule of reason analysis); Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1 (1979) (holding that price fixing agreement was lawful after rule of reason analysis; an agreement on price was necessary to the creation of the product, blanket music licenses), cert. denied, Columbia Broadcasting Sys., Inc. v. American Soc'y of Composers, Authors and Publishers, 450 U.S. 970 (1981). Boycotts and tying actions are *per se* violations only in specified circumstances. See, e.g., Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284 (1985) (finding that expulsion from group buying cooperative was not a *per se* violation and that the group boycott label must be applied sparingly); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984) (holding that tying is a *per se* violation only if the seller has sufficient market power in the "tying" product).

17 See, e.g., United States Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589 (1st Cir. 1993). The general appropriateness of the use of the rule of reason in healthcare actions is supported by the Policy Statements issued by the DOJ and FTC, and discussed in detail in Section III. See generally
market or markets, calculation of the appropriate market share or other indicia of market power, and then weighing the countervailing pro-competitive and anti-competitive interests. A rule of reason analysis is very fact intensive, and the analysis performed will vary according to the type of transaction involved. Given the fact intensive nature of the analysis, it is particularly important to determine whether there are meaningful guidelines as to the courts’ and the government’s position on the many new provider arrangements.

III. THE GOVERNMENT POSITION ON PROVIDER NETWORKS

A. Preliminary Issues as to Provider Networks

Provider networks may take many forms, ranging from independent practice associations (IPA), which involve very little integration of physician practices, to health maintenance organizations (HMO), which may provide complete integration of physician practices. An HMO, for example, may provide services exclusively through hospitals it owns and physicians it employs. Even where the HMO does not directly employ its physicians, it will nonetheless create extensive risk sharing between the providers with which it contracts; the HMO will impose part of the financial risk of high health care costs on the physicians. Preferred Provider Organizations (PPO) fall somewhere between IPAs and HMOs in the extent of integration.

To the extent that these networks involve physicians or providers joining together and setting a price to be charged for their services, antitrust implications are raised. An agreement by competitors as to the price to be charged for their products or services is, absent additional circumstances, price fixing — a per se violation of the Sherman Act. However, the more integrated the group’s practice is, the less likely antitrust concerns will be raised. A fully integrated network is a single entity and thus, cannot by its own actions commit price fixing or other

POLICY STATEMENTS.

18 See Policy Statements, supra note 3.

section 1 violations.\textsuperscript{20}

HMOs are fully integrated entities. For example, HMOs often employ their physicians. The HMO sets the fees that it will charge members for its coverage and the physicians (and other direct providers) are paid from the premiums collected from HMO participants. There is no question that an entity may set the fees that it charges and set the salary it pays its employees without creating any price fixing concerns.\textsuperscript{21} Even where the HMO does not employ physicians or other providers, its contracts with the providers do not constitute price fixing because they are buyer-seller arrangements, not agreements between competitors on a price they will charge purchasers (unless the sale was part of a larger agreement with other sellers).\textsuperscript{22} There may, however, be questions as to the share of the market foreclosed by the HMO, which could raise monopoly concerns.\textsuperscript{23}

\textsuperscript{20} See, e.g., Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984) (holding that a corporation and wholly owned subsidiary are not separate actors and, therefore, cannot “conspire,” a necessary predicate for a section 1 violation).

\textsuperscript{21} Of course, any entity can create section 2 problems if the price is set below cost in an effort to drive out competitors. See, e.g., Brooke Group Ltd. v. Brown & Williamson Tobacco Corp., 509 U.S. 209 (1993) (setting forth standard for proof of predatory pricing in Robinson-Patman Act cases, and stating that the same standard applies in Sherman Act section 2 cases).

\textsuperscript{22} Agreements on price must be between competitors to constitute price fixing. See, e.g., Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, 340 U.S. 211, 213 (1951), overruled by Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984). If a buyer imposes a uniform price on its suppliers, the competitor suppliers will receive a uniform price for their goods, but they have not agreed upon it and there is no price fixing. Thus, the courts have routinely upheld the practice of insurers or health purchaser plans setting out fixed, uniform prices for services to insureds or plan members. See, e.g., Kartell v. Blue Shield of Mass., Inc., 749 F.2d 922 (1st Cir. 1984) (holding that insurer requirement that physicians provide services at fixed rates is not price fixing), cert. denied, 493 U.S. 1095 (1990); Royal Drug Co. v. Group Life & Health Ins. Co., 737 F.2d 1433 (5th Cir. 1984) (upholding summary judgment for insurer/health plan that paid reduced rates to non-participating pharmacies), cert. denied, 469 U.S. 1160 (1985).

\textsuperscript{23} See, e.g., United States Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589 (1st Cir. 1993) (challenging the exclusive arrangement of an HMO and claiming the HMO substantially foreclosed market and that it gave rise to a monopoly); see also Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 883 F. Supp. 1247 (W.D. Wis.) (claiming that a physician-owned clinic and its HMO achieved a monopoly, as well as claiming that physicians engaged in price fixing and that clinic physicians agreed to divide markets), aff'd in part and rev'd in part, 65 F.3d 1406 (7th Cir. 1995), cert. denied, 116 S. Ct. 1288 (1996).
In contrast to HMOs, IPAs are necessarily agreements between economically separate competitors. The agreements also typically involve little integration of physician practices; the physicians may contribute some degree of capital but typically merge only a few aspects of their practices, such as administrative or billing functions. The arrangements generally involve little, if any, risk sharing on behalf of the physician members, and the physicians continue to provide their services independent from the IPA and continue to set their own fees.

Physician collaboration on prices immediately raises antitrust concerns and in fact may constitute price fixing.24 Of course, creating a greater degree of integration or risk-sharing can enable an IPA to escape per se treatment even when fees are agreed upon.25 In such cases the general antitrust rules as to joint ventures and similar arrangements apply to preclude per se treatment. It is well-accepted that agreements on price, if ancillary to a legitimate pro-competitive arrangement, are not "naked restraints" and are entitled to a rule of reason analysis.26

The shoals providers must navigate in establishing networks are not limited to price fixing and section 1 issues; the scope of the market "foreclosed" is also an issue. For example, the formation of even a fully integrated, risk-sharing network of providers would not be lawful if it resulted in "monopolization" proscribed by section 2, or if it tended to reduce competition

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24 See Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) (holding that a group's agreement to establish maximum fee schedules, as with a minimum fee schedule, is unlawful, and the integration of peer review and administrative function of the organization did not suffice to justify the agreement in price and could not overcome the application of the per se rule, where physicians did not share financial risk); see also Massachusetts Bd. of Registration in Optometry, 53 Fed. Reg. 26,990 (F.T.C. 1988) (final order) (finding that Board charged with engaging in unfair methods of competition in accordance with section 5 of the FTC Act for prohibiting advertising discounts, prohibiting optometrists from affiliating with retail optical chains, and otherwise preventing competition by retail optical chains could not avoid per se by labeling the board a joint venture).

25 See Hassan v. Independent Practice Assoc., P.C., 698 F. Supp. 679 (E.D. Mich. 1988) (holding that physicians did not violate antitrust laws where they jointly agreed to a fee schedule where, contrary to the physicians in Maricopa County Medical Society, the physicians in this IPA had integrated their practices and shared risk by providing services at capitated rates).

as proscribed by section 7 of the Clayton Act.\textsuperscript{27} Although the precise market share that is prohibited is not established, outside the health care arena the courts have generally considered a market share in the range of seventy percent as the monopoly threshold.\textsuperscript{28} The scope of concentration needed to create a Clayton Act violation is discussed in Section IV, below, on hospital mergers.

B. \textit{Government Enforcement Positions on Physician Networks}

Most of the recent antitrust enforcement activities taken against physician groups have involved loosely-integrated physician groups that have joined together to raise prices\textsuperscript{29} or that have joined forces to keep out managed care plans or to otherwise prevent competition.\textsuperscript{30} These do not represent the majority

\begin{footnotesize}
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\item \textsuperscript{27} 15 U.S.C. § 18.
\item \textsuperscript{28} See United States v. Rockford Memorial Corp., 898 F.2d 1278, 1285-86 (7th Cir.) (citing United States v. Aluminum Co. of America, 148 F.2d 416, 424 (2d Cir. 1945) and finding that two-thirds is a common threshold of monopoly power), \textit{cert. denied}, 493 U.S. 920 (1990); United States v. Grinnell Corp., 384 U.S. 563 (1966) (finding that defendant’s 87% market share left no doubt it had monopoly power); United States v. E. I. DuPont de Nemours & Co., 351 U.S. 377 (1956) (assuming defendant had monopoly with 75% of cellophane market); MCI Communications Corp. v. American Tel. & Tel. Co., 708 F.2d 1081 (7th Cir.) (inferring existence of monopoly power where defendant has 70% to 80% of market), \textit{cert. denied}, 464 U.S. 891 (1983), \textit{appeal denied}, 748 F.2d 799 (7th Cir. 1984); Ortho Diagnostic Sys., Inc. v. Abbott Labs., Inc., 822 F. Supp. 145 (S.D.N.Y. 1993) (finding monopoly power where the market share is greater than 70%); Heatransfer Corp. v. Volkswagenwerk, A. G., 553 F.2d 964 (5th Cir. 1977) (finding that 71% to 76% market share sufficient to establish monopoly power), \textit{cert. denied}, 434 U.S. 1087 (1978); Broadway Delivery Corp. v. United Parcel Serv. of Am., Inc., 651 F.2d 122 (2d Cir.) (finding a monopoly rarely with less than 50% market share, occasionally with 50% to 70% of market share, and strong evidence of monopoly power at a market share greater than 70%), \textit{cert. denied}, 454 U.S. 968 (1981); United States v. United States Steel Corp., 251 U.S. 417 (1920) (holding that 50% market share insufficient to establish monopoly power). \textit{But see} Domed Stadium Hotel, Inc. v. Holiday Inns, Inc., 732 F.2d 480 (5th Cir. 1984) (holding that a defendant must have at least 50% of market share to be guilty of monopolization); Hayden Publishing Co. v. Cox Broadcasting Corp., 730 F.2d 64 (2d Cir. 1984) (finding that monopoly power may be present with less than 50% market share).
\item \textsuperscript{29} See United States v. Alston, 974 F.2d 1206 (9th Cir. 1992) (charging Tuscon dentists who provided dental care to members of a pre-paid plan, were paid a capitated rate by the plan and a co-payment by patients, met to discuss fees and mailed letters to plan requesting higher fees because schedule had not been raised for several years, although it had in surrounding areas, with price fixing).
\item \textsuperscript{30} See, \textit{e.g.}, Medical Staff of Doctors’ Hosp. of Prince George’s County, 53 Fed. Reg. 2506 (F.T.C. 1988) (proposed consent agreement) (claiming hospital medical staff attempted to coerce and pressure health plan owned by parent of hospital from opening a facility in Prince George’s
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of contemplated ventures. Providers seeking guidance in other, more ambiguous arrangements must look to the government’s position set out in the government’s Policy Statements, which were issued in revised and expanded form in August, 1996.31

1. The Safety Zone for Physician Networks

The Policy Statements include guidelines for forming physician networks32 and set forth a safety zone which, if met by the physician network, will remove the arrangement from antitrust challenge by the DOJ and the FTC, absent extraordinary circumstances.33 The safety zones evidence concern with two issues. The first is the use of networks as a guise for simple multi-provider agreements on price. The second concerns avoiding the creation of providers with market power sufficient to harm competition, either directly or through tacit collusion on price.

The safety zones’ provisions related to market concentration are relatively

County by threatening to act to prevent clinic from opening and, if unsuccessful, to act to force hospital to close); Medical Staff of Dickinson County Memorial Hosp., 112 F.T.C. 33 (1989) (order) (alleging medical staff of hospital and two county medical societies conspired to prevent tertiary care hospital from building a physician office building in Dickinson County, when they allegedly refused or threatened to refuse to refer patients to specialists practicing at a new building, refused to enter into contracts, including employment agreements with medical office building, and solicited physicians throughout the area to refuse to refer to any physician practicing at office building); Physician’s Group, Inc., 60 Fed. Reg. 25,223 (F.T.C. 1995) (proposed consent agreement) (alleging members formed to negotiate with managed care plans, but members did not economically integrate, fixed and dictated fees, and thereby delayed entry of one managed care plan, and refused to deal with others); Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order) (claiming 23 obstetrician/gynecologists, who make up nearly the entire active staff of OB/GYNS at Jacksonville, Florida, hospital, formed an IPA to negotiate with third party payers, but did not share substantial risk or offer a new product and stating that IPA threatened to boycott an HMO which then increased its payments to IPA members); Medical Staff of Good Samaritan Regional Medical Ctr., 60 Fed. Reg. 10, 864 (F.T.C. 1995) (consent order) (stating that the medical staff threatened to boycott hospital in an attempt to stop hospital’s involvement in the development of a PHO to operate a multi-specialty clinic which would ultimately compete with individual staff members).

31 The statements were modifications of policy statements issued in 1993, and revised in 1994. See supra note 3.

32 POLICY STATEMENTS, supra note 3, at 66-88. Although the Policy Statements refer to physician networks, the analysis is applicable to networks involving other health care professionals, such as chiropractors, dentists and podiatrists. See infra note 35.

33 See POLICY STATEMENTS, supra note 3, at 64-70.
low. Absent “extraordinary circumstances,” the agencies will not investigate “exclusive” networks if the network involves less than twenty percent of the physicians in each specialty in the given market.34 “Exclusive” networks require providers to contract with managed care purchasers only through the network.35 For non-exclusive networks, the safety zone applies if less than thirty percent of the physicians in the relevant market are in the network.36 The market share limitation would not be particularly troubling, if the agencies gave detailed information on their market analysis. The Policy Statements do not; although theoretically recognizing that the market includes “good substitutes” for physicians in the relevant market at issue, the examples in the statements indicate that the agencies are thinking very locally. Moreover, there is no recognition that market assessment must go beyond what patients are presently doing, to consider what patients would do if confronted with an anti-competitive price increase. This is not consistent with the government’s Merger Guidelines, which explicitly recognize that determination of the relevant market hinges on assessing market dynamics in response to a change in prices.37 The absence of compliance with the dynamic approach proposed by the government’s own guidelines has proved troublesome for the government in some recent merger cases, as is discussed later in the Article.38

In addition to complying with the market share limitations noted above, networks seeking the safety zone must avoid triggering price fixing concerns. The safety zones are applicable only to networks that have an agreed-upon price

34 See id. at 66-67.

35 The agencies evaluate whether an exclusivity restriction exists based on practical indicia, not merely the formal provisions of the documents. See id. at 66.

36 In order to be viewed under the more lenient percentage requirements of a non-exclusive venture, the venture must be non-exclusive in practice and not just in name. In this regard, the agencies state that they will look at the following: whether there are viable competing networks in the relevant area; whether providers in the network actually participate in other networks or indicate a willingness to do so; whether the providers in the network earn substantial revenue outside of the network; the lack of any indication that there is significant departure from any other networks in the market; and the absence of any indication of coordination among the providers in the network regarding price or other competitively significant terms of participation in other networks or plans. See id. at 66-67.

37 See Notice, 57 Fed. Reg. 41,552, 41,554-55 (1992) (defining geographic market as including all suppliers able to the market in response to small, but non-transitory price increase).

38 See discussion infra part IV and notes 132-57.
as an element of the network plan. In order to avoid per se treatment arising from the agreement on price, the agencies note that there must be substantial financial risk shared by the participants, or the providers must integrate their practices at the clinical level, so as to create substantial efficiencies. The clinical integration may be achieved through such mechanisms as ongoing quality and utilization control procedures that instill a high degree of interdependence and a sense of cooperation among the providers to control costs. The network also should invest a significant amount of capital to carry out such a program.

The safety zone applies, however, only if the first form of integration exists: the physician members of the network share "substantial" financial risk. For purposes of the Policy Statements, examples of financial risk include the payment of a capitated rate (a fixed pre-determined payment per individual, regardless of the amount of the services actually provided) or other risk-based financial incentives provided to the members of the group. Examples of such incentives would include withholding a substantial amount of the compensation owed to the members, to be distributed only if the cost containment goals of the group are met, and establishing cost or utilization goals, with penalties or rewards given based upon the group's overall performance. The agencies also noted that global fees or all-inclusive case-rates (covering all treatments for certain illnesses) may also constitute financial risk-sharing for purposes of safety zone treatment.

39 The actual phrase in the agencies' statement is agreement on "prices or price-related terms." POLICY STATEMENTS, supra note 3, at 62. Absent such an agreement, the safety zones do not apply; however, in general there is much less need to look to safety zones for agreements that do not involve the risk of price fixing or other per se offenses.

40 Id. at 71-73. The Policy Statement includes an example of a network that involved clinical integration of physician practices. The network establishes quality control and utilization review systems, engages in case management, some degree of pre-authorization of services, reviews hospital stays on a concurrent and retrospective basis, and establishes treatment and utilization standards and protocols. The network also invest a substantial amount of money to purchase an information system necessary for gathering cost and quality data and for measuring group and individual physician performance against the quality and cost standards. An agent is used to develop a fee schedule, negotiate fees, and enter into payer contracts on behalf of the venture. The network in the example would include 25% of the primary care physicians in the medium-sized city involved, and 20% to 35% of relevant market of the physicians in various specialties, all on a non-exclusive basis. The agencies stated that such a network would be reviewed under a rule of reason analysis and would not be considered anti-competitive.

41 Id.

42 Id. at 68-69.
if the risk is borne by the network and not the individual participants.\textsuperscript{43} The agencies indicated that they would consider other forms of economic integration other than capitation, risk-withholds, global fees, all-inclusive case-rates, and utilization or cost control mechanisms, but gave no examples.\textsuperscript{44} In practice, most approved arrangements have involved either capitated payments or discounted fee-for-service arrangements with risk pool withholds — an arrangement under which a portion of the fee is withheld and paid contingent on meeting utilization or efficiency goals.\textsuperscript{45} The statements do not define “substantial” and thus give no specifics as to the required level of risk sharing. The only example given in the Policy Statements that qualifies the scope of “substantial” risk sharing is that of an IPA in which twenty percent of the compensation due the members was withheld and paid only upon meeting quality and cost containment goals.\textsuperscript{46} That arrangement was held to fall within the safety zone.\textsuperscript{47}

\textsuperscript{43} \textit{Id.}

\textsuperscript{44} \textit{POLICY STATEMENTS, supra} note 3, at 69.

\textsuperscript{45} \textit{See, e.g.}, Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Steven F. Banghart, Esquire, Katten, Muchen & Zavis (Dec. 8, 1994), \textit{available in} Westlaw, 1994 WL 721568 (stating that Chicagoland Radiological Network to offer pre-paid radiological services on capitated and discounted fee-for-service rates with at least 20% withhold); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Dee Hartzog, Esquire, Weintraub, Geneshia & Sproul (Oct. 27, 1994) \textit{available in} Westlaw, 1994 WL 590133 [hereinafter Letter to Hartzog] (stating that international Chiropractor’s Association of California (ICAC) would withhold 20% of each members’ billings to be paid only if savings and performance goals are met); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Linda M. Sekely, Esquire, Hagan, McClintock & Co. (July 17, 1995), \textit{available in} Westlaw, 1995 WL 437274 (stating that Pennsylvania Orthotics and Prosthetics Enterprise (POPE) would withhold no less than 20% of each members’ billings, to be distributed only if the group meets established efficiency and quality goals). Prior to the revisions to the Policy Statements, capitation was seen as the most effective form of risk-sharing, and thus, the most convincing evidence to the agencies that economic integration was present. \textit{See Capitation Is Seen as Brightest Lines in Quest for Sufficient Integration}, 68 Antitrust & Trade Reg. Rep. (BNA) No. 1702, at 295 (Mar. 2, 1995); \textit{THOMAS CAMPBELL & DANIEL D. McDEVITT, HEALTHCARE ANTITRUST: A MANUAL FOR CHANGING PROVIDER ORGANIZATIONS} ¶ 632.2 (1994).

\textsuperscript{46} \textit{See POLICY STATEMENTS, supra} note 3, at 92-95.

\textsuperscript{47} \textit{Id.}
2. General Analytical Approach of the Government in Analyzing Networks That Are Outside the Safety Zones

If a particular physician network does not meet the safety zone, the agencies will nevertheless review it under a rule of reason analysis, assuming that the network is not merely a conduit to naked price fixing (that is, it involves risk sharing or integration of practices). The rule of reason analysis outlined in the agencies' policy statements involves a four-step approach:

1. Determine the relevant market;
2. Evaluate the competitive effects of the physician joint venture;
3. Evaluate the impact of pro-competitive efficiencies, and
4. Evaluate collateral agreements.

These analytical steps are of such broad generality as to offer little in the way of guidance. Step one involves analyzing both the relevant product markets as well as the relevant geographic market. In analyzing the relevant product market, the services from each specialty represented in the venture will usually be considered a separate relevant service market and, therefore, multi-specialty ventures will most generally involve more than one product market. However, there may be some overlap between the services of different specialties and, therefore, such specialties may in fact comprise the same market.

For each relevant product market, the relevant geographic market will be analyzed. Although the agencies note that, in general, the relevant geographic market for physician services will be local, the statements indicate that the geographic market will include an area encompassing all physicians whom health plans and their subscribers deem to be good substitutes for the physicians in the joint venture.

Step two involves determining whether there are any anti-competitive effects of the joint venture or network. In this regard, there are two questions that will be asked: first, whether the venture can raise prices to health benefit.

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48 See id. at 73-74. The agencies will consider the following factors to be indicative of a network that is anti-competitive in nature, and thus merely a vehicle for price fixing: statements made illustrating an anti-competitive purpose; recent history of collusive or anti-competitive behavior, including attempts to keep managed care out of the market; obvious anti-competitive structure, such as being comprised of a very large percentage of local physicians on an exclusive basis without plausible justification therefor; the absence of mechanisms that could create efficiencies; the presence of anti-competitive collateral agreements; and the absence of mechanisms to prevent spillover effects to activities outside the network.

49 Id. at 74-82.
plans above competitive levels; and second, whether the network can prevent the formation of other ventures that will compete with the network in question? The analysis will turn on whether other networks currently exist in the market or, if none exist, upon the availability of physicians to join competing networks. In this regard, the agencies will look at the number of physicians in each relevant service market and the exclusive or non-exclusive nature of the network in question. If the network is non-exclusive, fewer antitrust concerns will be raised, because members of the network in question will be free to join competing networks.

The third step involves weighing inefficiencies that may arise from the network formation against any anti-competitive concerns raised as a result of step two. Most notable to the agencies are any cost savings arising from the financial risk-sharing on behalf of the physician members of the network. In addition, however, the agencies will look at decreased administrative costs, improved utilization review and quality assurance, improved case management, and economies of scale. If there were no anti-competitive concerns raised during the step two analysis, this step would be skipped entirely. Finally, in step four, the agencies will look to see if there are any collateral agreements involved. If so, the agencies must determine whether the collateral arrangements are reasonably necessary for the venture to achieve its purpose. For example, the agencies note that if the members of the venture set a price to charge patients who are not members of a health benefit plan with which they are attempting to contract, such an agreement is not necessary for the venture to achieve its legitimate purposes and, therefore, may constitute an antitrust violation.


Most physician networks that have sought business review letters or advisory opinions have been found to comply with the agencies’ safety zones. The DOJ calls statements on its enforcement intentions business review letters. See 28 C.F.R. § 50.6 (1995). The FTC refers to its statements as advisory opinions. See 16 C.F.R. §§ 1.1–3 (1996).

Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Jill L. Cobert (July 2, 1996), available in Westlaw, 1996 WL 383314 (relating that Primary and Specialist Medical Center (“PSMC”), an integrated group of 48 physicians from various specialties in the New Haven, Connecticut area proposed to negotiate managed care contracts on an exclusive basis, that network would have centralized management and would have in place quality assurance and utilization review programs, and that contracts on the basis of both a capitated and fee-for-service with a 20% withhold will be offered); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Barbara S. Accetta (Mar. 19, 1996), available in Westlaw, 1996 WL 285710 (stating...
Even when outside the safety zone, the overwhelming majority of the entities that have sought advice from the agencies have been found to be governed by and to satisfy the rule of reason analysis. Of the entities that failed to satisfy the safety zone requirements, most did so because they contained more than thirty percent of a given specialty in the relevant market, and almost all have nonetheless been approved.\textsuperscript{52} It is clear that, as to non-exclusive networks, the enforcement

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52 See Letter from Mark J. Horoshak, Assistant Director of the FTC, to John A. Cook, Esquire, Cook, Goetz & Rogers, P.C. (Mar. 28, 1995), available in Westlaw, 1995 WL 214367 (involving Oakland Physician Network (OPN), a non-exclusive physician joint venture which proposed two models, a joint pricing model with payments made in a capitated basis to members, and a messenger model, and stating that FTC said OPN included less than 30% of physicians in the relevant market, whether it be the Tri-County area or Oakland County, but noted in a footnote that it would include 25% of the colon/rectal surgeons in the Tri-County, but 44% of the colon/rectal surgeons in Oakland County); Letter to Hartzog, supra note 45 (noting that the International Chiropractor's Association of California included up to 50% of chiropractors in any relevant geographic market, but that the DOJ blessed it and noting nonexclusive nature of venture, nature of chiropractic in that referrals from other chiropractors not needed, and potential efficiencies to consumers, as well as financial
agencies are not generally troubled by an entity exceeding the safety zone threshold. The DOJ and the FTC have each found that the excess membership in a given specialty may be permissible if it is needed to ensure that adequate coverage is available and that enrollees are provided with a choice of providers.\footnote{See sources cited supra note 52.} This approach by the agencies is expressly recognized in the Policy Statements and may provide some comfort to physician networks in rural areas where it may be difficult to comply with the percentage requirements.

There is also some slight comfort in the Policy Statements in those cases where the number of specialists is quite small. The Policy Statements make several provisions as to specialties with fewer than five physicians. In such cases, an exclusive joint venture may include one physician from that specialty, thus exceeding the twenty percent limitation, but only if the physician is included in the group on a non-exclusive basis. With regard to a non-exclusive physician network joint venture, the inclusion of one physician from a specialty in which there are less than four physicians in that specialty, thus exceeding the thirty percent share limit, will not take the joint venture outside of the antitrust safety zone. However, from a practical standpoint, the inclusion of one physician in a particular specialty may prove difficult because of the need to provide on-call coverage. Recognizing this, the agencies have declined to attack joint venture physician networks in which this caveat likewise is exceeded.

An example of such a network is the Eastern Ohio Physicians

\begin{footnotesize}
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\item risk sharing; see also Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Richard C. Lague, Esquire, and Philip M. Stoffan, Esquire, Lague, Newman & Irish (Mar. 30, 1995), available in Westlaw, 1995 WL 147744 [hereinafter Letter to Lague] (invoking a Mid-South physician alliance also involved a non-exclusive joint venture in which physician members would be compensated by a capitated rate or a discounted fee-for-service rate with a 20% withhold and stating that although the network would only consist of up to 30% of the primary care physicians in the market, it would exceed the 30 percentile threshold for some specialties); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Eugene E. Olson (July 16, 1994), reprinted in 3 JOHN J. MILES, HEALTH CARE AND ANTITRUST LAW, app. at C44 [hereinafter Letter to Olson] (noting that Provider Organization, Inc. also involved substantial risk sharing on behalf of the physician members in that they would be paid a capitated rate or a discounted fee-for-service rate with a 20% withhold and that non-exclusive joint venture would involve more than 30% of physicians in six specialty areas but this was necessary to insure coverage and adequate choice); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to John R. Cummins, Esquire, Greenbaum, Doll & McDonald (Oct. 28, 1994), available in Westlaw, 1994 WL 634348 [hereinafter Letter to Cummins] (noting that Physician Care, Inc. involved 37% of the physicians in the service area and that this did not substantially exceed the 30% threshold, and the percentage in excess of 30% was necessary in the given specialties to insure coverage).
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Organization, Inc. (EOPO), which sought a business review letter from the FTC. The FTC's staff advisory opinion/comment letter, dated September 28, 1995, indicated that the operation of the EOPO as proposed did not appear likely to violate any law enforced by the FTC. The facts presented to the agency indicated that EOPO was a multi-specialty physician organization established to contract with third-party payers on behalf of its physician network members in the north eastern Ohio and the north western Pennsylvania area. EOPO was to be a non-exclusive arrangement, and the FTC specifically noted that there were three other networks already in the market. EOPO intended to contract initially with four hundred physicians in a three county area in Ohio. In this regard, it expected that it would contract with 31.39% of the primary care physicians in the area and with more than thirty percent for a number of specialties. For example, it proposed to contract with two of the four colon and rectal surgeons in the market, two of three endocrinologists in the area, two of six rheumatologists, six of fifteen dermatologists, and six of sixteen oncologists. EOPO was thus outside the safe harbors of the agencies' enforcement guidelines.

The FTC nevertheless approved the venture, relying in part on the risk sharing created by the planned fee structure. EOPO intended to contract primarily with third-party payers on a capitated basis, but it also planned some discounted fee-for-service contracts with a withhold of approximately 30% of the applicable fee schedule amounts. The 30% withhold was to be broken down into three different pools. Up to 5% would be withheld for administrative expenses, 10% to 15% would be put into a risk pool and 10% to 15% in a performance pool. The FTC determined that the member physicians would share substantial risk, although it noted that, in unusual circumstances, a 10% to 15% risk pool


55 Id.

56 Id.

57 See Letter to Lague, supra note 52; Letter to Olson, supra note 52 (noting that Collaborative Provider Organization, Inc. also involved substantial risk sharing on behalf of the physician members in that they would be paid a capitated rate or a discounted fee-for-service payment with a 20% withhold and that non-exclusive joint venture would involve more than 30% of physicians in six specialty areas but this was necessary to insure coverage and adequate choice); Letter to Cummins, supra note 52.
may not be sufficient.\textsuperscript{58}

Even absent financial integration, the enforcement agencies have approved relatively large networks, provided the network is non-exclusive. For example, the DOJ approved a potentially very large network organized on the "messenger model" in which the entity did nothing to coordinate prices of the members.\textsuperscript{59} Preferred Podiatric Network, Inc. (Network) was the wholly owned subsidiary of the New York State Podiatric Medical Association (Association). Membership in the Network was limited to podiatrists licensed to practice in the State of New York who are also members of the Association. The Association constituted 54% of the podiatrists that were licensed to practice in the State of New York; thus, it was conceivable that the Network might include up to 54% of the podiatrists in the state. The Network stated that it expected to gather fee information from the members but the fee information would not be available to the individual members. The Network intended to convey this information to third-party payers, and convey counter-offers, but would not negotiate contracts on behalf of its members. The individual members could either accept or reject each offer or negotiate on their own.

While the DOJ had concerns about the large percentage of podiatrists that might be involved in the Network, it nevertheless gave the Network its blessing.\textsuperscript{60} The DOJ noted that the Network was acting as a "bona fide intermediary" and not negotiating for particular podiatrists. It was merely gathering price information, conveying that information to third-party payers and conveying contract offers back to the individual members. The individual podiatrists then negotiated the terms of any contract proposals individually and directly with the third-party payers.\textsuperscript{61} In other advisory opinions, as well as in the Policy Statements, the FTC

\textsuperscript{58} This caution was echoed in a subsequent letter to Medial Surety's PPO. See Letter from Mark J. Horoshak, Assistant Director of the FTC, to Paul W. McVay, Nash & Co. (Sept. 28, 1995), available in Westlaw, 1995 WL 580454 (determining that in a PPO open to all members of a state medical society, the staff could not determine whether a 15% risk withhold from a fee schedule would sufficiently affect physician incentives).

\textsuperscript{59} See, e.g., Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Andrew Feldman (Sept. 14, 1994), reprinted in 3 JOHN MILES, HEALTH CARE AND ANTITRUST LAW, at C45 [hereinafter Letter to Feldman]. The messenger model has been criticized as of little practical use. Prior to the agencies' 1996 revision to the Policy Statements, financial integration and the messenger model were the only government-approved means of avoiding \textit{per se} treatment of the network involved agreement in price. See supra notes 39-40. Other forms of integration will now be viewed as justifying rule of reason analysis.

\textsuperscript{60} Id.

\textsuperscript{61} Id.
has acknowledged that the use of such a “messenger model” arrangement may avoid antitrust scrutiny even in the absence of substantial risk sharing,\(^\text{62}\) because the members are not joining together to agree on a price and thus price-fixing concerns are not present.

One of the few networks that have been advised that it may potentially violate the antitrust laws arose from the failure to comply with the agencies’ view of a true messenger model. The opinion was rendered to an independent physician association composed of eight competing orthopedists in Washoe County, Nevada, called the Northwestern Orthopedic Surgery Alliance (Alliance). The Alliance proposed to contract with health insurers and third-party payers for the provision of specialty orthopedic services. The Alliance would be non-exclusive. The information contained in the request for the advisory opinion indicated that the implementation of the Alliance’s operation would be in two phases. Initially, an intermediary would obtain historical fee data information from the physician members and formulate a proposed fee schedule that it would pass on to third-party payers. The intermediary would then accept proposed offers and convey them to the individual physicians. However, the intermediary also would become involved with negotiating and formulating the fee schedules with the third party payers, and thus the proposal did not fit the agencies’ view of a true “messenger model.” The second phase of the Alliance’s operation was to have involved the establishment of capitated fee structures with a withhold or global pricing. It was subsequently determined, however, that Nevada law would prohibit independent associations from engaging in risk sharing, and thus would preclude phase two of the proposed operational plan.\(^\text{63}\)

The FTC issued an unfavorable opinion, and stated that, where there is no substantial risk sharing, agreements on price may raise serious antitrust concerns and may amount to illegal price fixing.\(^\text{64}\) However, the staff noted that the use of a messenger model might avoid antitrust enforcement risk even if the physicians could not economically integrate their practices,\(^\text{65}\) and thus, if the

\(^{62}\) See Letter from Mark J. Horoshak, Assistant Director of the FTC, to Jacqueline Cox (July 11, 1995), reprinted in 4 BNA HEALTH L. REP. 1128 (concerning FTC staff advisory opinion regarding Northwestern Nevada Orthopedic Surgery Alliance).

\(^{63}\) Id.

\(^{64}\) Id.

\(^{65}\) See also Letter from Mark J. Horoshak, Assistant Director of the FTC, to Thomas Rhodes, Esquire, Smith, Grambell & Russell (Aug. 15, 1995), available in Westlaw, 1995 WL 521864 [hereinafter Letter to Rhodes] (noting that Otolaryngology Specialty Providers of Georgia (“OSPOG”) also proposed two phases of operation, initial “messenger model” phase and a second
arrangement were restructured it might be permitted to proceed without challenge.

Unlike the opinion issued to the Northwest Orthopedic Alliance, most of the few unfavorable statements by the enforcement agencies have not turned on the absence of financial integration, but on the agencies' views of the relevant market. For example, in March, 1996, the DOJ gave two unfavorable responses to business review letters, both based on the agency's assessment of the relevant market.

The first business review letter related to a proposed network of pediatricians in southern New Jersey. The network would have included fifty percent to seventy-five percent of pediatricians in several communities. The request argued that the venture's market shares were much lower, because the geographic markets were larger than the local communities and the relevant product market included family practitioners and general practitioners treating children. Relying in large part on the opinions of managed care providers, the DOJ rejected these contentions. The DOJ stated that, according to managed care providers, managed care patients were not willing to accept non-pediatricians as substitutes for pediatricians, nor to travel long distances for pediatric care.

The statements of managed care providers were also relied on in the next unfavorable response, delivered one week later, to a group of anesthesiologists. The anesthesiologists sought to form a network consisting of the five anesthesiology groups providing anesthesia services at six hospitals in a single county. Each of the five groups was the dominant or exclusive provider of services at its hospital. The anesthesiology groups contended that national anesthesiology providers, and providers at smaller, less prestigious hospitals in the area, were in the relevant market; thus, the groups, collectively, could not exercise market power. The DOJ disagreed, and stated that the size and expertise of each

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66 There are not yet any business review letters or advisory opinions on the new points as to non-financial integration taken in the August, 1996 Policy Statements.


group, and its reputation with surgeons, were pertinent to the relevant service (product) market. Based largely on statements by hospitals, the DOJ concluded that neither unaffiliated anesthesiologists nor national anesthesia providers would act as a check on the exercise of market power by the five groups. The area hospitals stated that they were unwilling to turn to a fragmented anesthesia system (that would result from giving small providers privileges) and did not believe national providers would be acceptable to their surgeons. Thus, the DOJ concluded that a very narrow market existed.

These recent positions are in contrast to some earlier decisions recognizing broader over-lap between physician specialties. For example, in an August 15, 1995 FTC staff advisory opinion letter regarding the establishment of a network of otolaryngologists in Georgia, the agency took a broad view of the market for otolaryngology services. The agency noted that otolaryngologists also compete with family practice physicians and internists, allergists and immunologists, plastic surgeons and dermatologists, for various types of services. The FTC accepted the position of the otolaryngologists that all of the foregoing are covered in the relevant market. A DOJ business review letter showed similar flexibility in regard to the merger of two pulmonology groups. There, the DOJ accepted representations as to the extensive competition between pulmonologists and other specialists, including family practitioners.

These decisions can be readily harmonized with the two March, 1996, business review letters. The otolaryngology and pulmonology decisions resulted from the presentation of specific evidence that other specialties provided a high percentage of the procedures performed by the specialties under consideration. The agencies therefore recognized that physicians in different specialties may compete for various types of services, thus decreasing the apparent market concentration of a given group. The agencies are not however, willing to accept a mere assertion that there is real substitutability across specialties. The anesthesiology and pediatric opinions were delivered in the absence of the concrete evidence of substitutability, and in reliance on contrary evidence from purchasers that the supposed substitutes were not, in fact, regarded as substitutable.

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69 Letter to Rhodes, supra note 65 (relating that Otolaryngology Specialty Providers of Georgia (OSPOG) also proposed two phases of operation, initial "messenger model" phase and a second phase involving payment on a capitated basis).

C. Multiprovider Networks Composed of Non-Physician Members

"Multiprovider network" is the phrase used by the Policy Statements for networks that are not limited to physicians. The phrase thus might include a broad array of providers of different health care services. For example, hospitals are seeking to develop integrated delivery systems providing a full spectrum of health care services including preventative, rehabilitative and sub-acute care, in addition to the standard acute care services typically offered by hospitals. Such a network not only involves the horizontal integration of direct competitors, but also involves vertical integration of upstream and/or downstream suppliers of services who do not directly compete (e.g., nursing homes, rehabilitation facilities).

Although the DOJ has been active in civil enforcement proceedings against multiprovider networks, those actions usually involve only clear cases of abuse and thus give little guidance to the government’s view of more ambiguous arrangements. The enforcement agencies have, however, issued a separate Policy Statement dealing with multiprovider networks other than those composed solely of physicians. Unlike the statement on physician networks, the Policy Statement on multiprovider networks does not contain any safety zones. The agencies stated that they were unable to establish safety zones applicable to such networks due to the vast number of possible structural and relationships among different types of providers, as well as the continual emergence and development of new arrangements. However, they set forth in the Policy Statements the analytical framework they will use to analyze multiprovider networks.

That framework does not differ in concept from that set forth in the statement on physician networks (as to ventures falling outside the safety zones) except that it specifically notes the distinction between "horizontal" and "vertical" aspects of multiprovider networks. Competitors who are in the same market have "horizontal" relationships and agreements between them are "horizontal." Horizontal agreements on price are, of course, always at risk of being treated as

71 For example, the DOJ has filed separate actions in Danbury, Connecticut and St. Joseph, Missouri, each of which alleges that a hospital, a physicians group, and the PHO they formed acted in an effort to delay the entry of managed care plans into the area. Both involved egregious actions whereby the hospital and virtually every member of its staff formed a PHO, without financial integration, to negotiate with managed care plans. Each was overinclusive in that virtually all of the staff of the hospital was involved and exclusive. Each resulted in the entry of consent orders. See In re United States v. HealthCare Partners, Inc., 60 Fed. Reg. 52,014 (Dep’t Justice 1995) (proposed final judgment); United States v. Health Choice of Northwest Mo., Inc., 60 Fed. Reg. 51,808.

72 POLICY STATEMENTS, supra note 3, at 115.
price fixing. Vertical agreements — those between producers of different products — do not generally raise price fixing concerns, and the agencies noted that such agreement need not achieve economic integration to avoid price fixing.\textsuperscript{73} As to horizontal agreements, the agencies repeated their prior position that sufficient financial integration will enable a network to avoid \textit{per se} treatment. As with physician networks, the agencies went further, and also recognized that networks may avoid price fixing charges, despite agreement on prices, if there is either financial risk sharing or practice integration leading to real efficiencies.\textsuperscript{74} The agreement on price must, however, “promote the venture’s achievement of efficiencies” to receive rule of reason treatment.\textsuperscript{75}

The agencies also specifically recognized as permissible the use of a messenger model, in which the messenger is used merely as an intermediary to convey price information from a purchaser to members of the network. As with physician networks, the messenger can neither convey information to the members about the other members’ positions or reactions to any offers, nor act in any way to coordinate responses. However, in a departure from their early Policy Statements, the agencies recognize that the messenger may accept offers on behalf of physicians or convey the percentage of physicians who will accept a different offer.

Beyond the realm of the clearly prohibited (price agreement without integration) and the approved method for avoiding price agreement (the “messenger” model), there is little concrete guidance in the statement on multiprovider networks.

Assuming an arrangement follows the messenger model or has sufficient financial or practice integration to escape \textit{per se} condemnation, the agencies state that they will assess its competitive impact in the relevant geographic and product markets, and in practice have begun to do so.\textsuperscript{76} The agencies recognize there may

\textsuperscript{73} \textit{Id.} at 107 n.45.

\textsuperscript{74} \textit{Id.} at 110-11.

\textsuperscript{75} \textit{Id.} at 111.

\textsuperscript{76} See, \textit{e.g.}, Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to James W. Teevans (Aug. 15, 1996), \textit{available in} Westlaw, 1996 WL 467589 (stating that government approved proposal to form PHO composed of an 80-bed acute care hospital, an eighteen member medical group composed of family practitioners, pediatricians, and internists, a four member group comprised of two pediatricians and two family practitioners, and an internist who is in solo practice to negotiate contracts through the use of a messenger model and that composed of the only hospital within one hundred miles of the rural community in which it is situated, and virtually all of physicians in the area); Letter from Anne K. Bingaman, Assistant Attorney General,
be various product markets included in a multiprovider network which may include inpatient hospital service, outpatient services, the specialties of each participating physician, or non-physician healthcare services provided by members, as well as health insurance or financing markets. The Statement says that the geographic market definition will be very fact intensive and will focus upon the location of reasonable alternatives. The Statement then refers to the agencies' more general statements on market definition, but offers no insight in that regard.

There is, however, a general statement of flexibility. The agencies specifically note that, in conducting their analysis of multiprovider networks, they will look to a wide variety of information including interviews with purchasers of healthcare services, employers who offer healthcare benefits, and competitors to those providers in the network. In this regard, the agencies indicate that they will give substantial weight to healthcare purchasers in defining relevant markets. This, of course, is consistent with the agencies' positions taken in the recent letters on proposed physician networks discussed above.

There is not, however, any statement that the agencies will look beyond purchasers' statements to the realities of where purchasers could turn in the event of an anti-competitive price increase. There is also no detailed development of any kind as to market analysis under the Policy Statements. Because the ultimate outcome of any antitrust challenge to a joint venture — absent a per se violation — will usually

Antitrust Division, Assistant to Richard A. Webb (Apr. 24, 1996), available in Westlaw, 1996 WL 204481 (stating that government approved Hospice Network composed of Medicare-certified hospice organizations throughout the state of New Jersey to negotiate contracts with third-party payers that members were not direct competitors, as each operated in its own distinct geographic markets, and membership was on a nonexclusive basis, that each member would provide price-information to an independent agent which would convey the information to third party payers and attempt to solicit contracts, that any offers would then be conveyed to the member who may accept it or may contract on its own with third party payers, that agent would also negotiate non-price terms, and that no financial integration existed). Additionally, the FTC has indicated that it will not challenge Mayo Medical Laboratories plan to form network of hospital labs. See also Federal Trade Commission News Release, July 19, 1996, available in Westlaw, 1996 WL 404062.

77 See POLICY STATEMENTS, supra note 3, at 114-15.


79 See POLICY STATEMENTS, supra note 3, at 124-25.

80 Id.

81 See supra text accompanying notes 68-70.
turn on the definition of the relevant geographic and product markets, it is important to consider the arena with the clearest law on health care markets: hospital merger cases, which is discussed infra part IV.

D. General Conclusions as to Enforcement

There are some general conclusions that can be drawn from the enforcement agencies actual rulings and enforcement actions. In general, the agencies have been lenient as to non-exclusive networks and have allowed them to operate with a much higher physician concentration levels that the safety zones specify, particularly for purposes of satisfying on-call coverage and providing patients with a choice of physicians. The practical market share level of concern for non-exclusive networks appears to be at least fifty percent. It is also apparent that the agencies will extend some flexibility as to the level risk withholding required to constitute "substantial financial integration," although the degree of flexibility is unclear.

There are many more areas that need further clarification. There is a lack of specific guidance as to role of capital in creating economic integration; and an almost equal poverty of guidance as to what sort of utilization or cost control mechanisms are sufficient to create the efficiencies required to avoid per se treatment. Finally, there is substantial doubt as to whether any leniency will be exercised in regard to exclusive networks. This is an important issue because a non-exclusive network may lack the market power to negotiate effectively with powerful payers.

Despite the lack of clarity as to government's position on these points, very few physician networks have been challenged, and those that have been have involved egregious violations. The types of activities that have been contested have generally involved loosely or generally non-integrated joint ventures that refuse to deal other than through the joint venture and generally only on their

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82 See Letter to Lague, supra note 52; Letter to Olson, supra note 52; Letter to Cummins, supra note 52.

83 For example, a 15% withhold was found to be unacceptable in the case of ACMG, Inc.; however, the physician membership's market share was over 50% in the relevant market. See Letter from Mark J. Horoshak, Assistant Director of the FTC, to Paul W. McVay, Nash & Co. (July 5, 1994). Moreover, this was said to be an unusual circumstance in the September 14, 1994 Business Review Letter regarding Preferred Podiatric Network. See supra note 57 and accompanying text. In contrast, the agency approved a withhold of 10-15% Letter to Nash, supra note 54.
There is, however, an additional source of guidance on at least one key issue affecting antitrust actions against health care networks. Although the courts have not had occasion to pass upon the enforcement agencies’ new guidelines as to provider networks, the courts have long been passing upon the government’s position on hospital mergers. Those decisions are significant because the market analysis used in the courts the merger context will have direct implications for the market analysis in health care cases generally. Recent developments suggest that the enforcement agencies need to broaden their views.

IV. HOSPITAL Mergers

A. The Agencies’ Policy Statement on Mergers

The agencies revised and reissued their Healthcare Enforcement Policy Statements in August, 1996, with the stated intention of providing some guidance to healthcare providers in forming innovative alliances. While the Policy Statements have been of some use in the area of physician ventures, the Policy Statements have not provided any meaningful insight as to hospital merger activities.

The specific policy statement on hospital mergers (Statement 1) provides a safety zone for a very minute set of mergers involving tiny hospitals, and purports to provide an explanation of the analysis used by the agencies in

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84 See, e.g., Preferred Physicians, Inc., 52 Fed. Reg. 45,970 (FTC 1987) (proposed consent agreement); Preferred Physicians, Inc., 53 Fed. Reg. 10,367 (FTC 1988) (consent order) (relating that network involving over two hundred members, most of whom were in the medical staff of one hospital in Tulsa, referred to by the FTC as the “leading” hospital in the Tulsa area, developed a fee schedule called the Redbook for negotiations, that doctors refused to negotiate other than through the network and other third-party payers that negotiated with the network were given the option of taking or leaving the Redbook price, and that complaint filed by the FTC resulted in a consent decree being entered); see also Trauma Assoc. of N. Broward County, 59 Fed. Reg. 42,051 (FTC 1994) (proposed consent agreement); Preferred Physicians, Inc., 53 Fed. Reg. 10,367 (FTC 1988) (consent order) (invoking a non-integrated joint venture that refused to deal other than on the terms that it set); La Asociacion Medica de Puerto Rico, 60 Fed. Reg. 16,144 (FTC 1995) (proposed consent agreement) (stating that Puerto Rico Association involved a group of physicians that joined together to persuade third-party payers to raise their rates, that when unsuccessful, group threatened boycott refusing to treat patients patients, that charged with price fixing, refusal to deal and boycott, and that each of these latter two investigations resulted in consent decrees as well); United States v. Alston, 974 F.2d 1206 (9th Cir. 1992).

85 The 1996 Policy Statements expanded versions in 1994 and 1993, but the 1996 version made no changes to the merger portion of the prior Statements.
reviewing mergers that fall outside the safety zone. The safety zone is applicable to too few situations to be of practical significance, and the statements as to methodology are more general and less concrete than the agencies' pre-existing guidance in the 1992 Horizontal Merger Guidelines. They certainly provide no acknowledgment of the changes in the health care market and the need to look beyond the traditional, rather static approach that has been used in the past.

The safety zone applies to mergers in which one of the hospitals has an average of fewer than one hundred beds and a daily patient census of fewer than forty patients over the most recent three years. Such mergers will not be challenged by the agencies absent "extraordinary circumstances." The statement specifically recognizes that the safety zone would apply to a merger regardless of whether the hospital meeting the requirements was the only general acute care hospital in the relevant market. This is hardly surprising. Where the qualifying partner to the merger is the only hospital in the relevant market, its combination with an entity outside the market will not change the number of competitors; at most a potential entrant into the market is lost. Where the qualifying small hospital is not the only competitor in the market, the agencies explain the safety zone by noting that small hospitals are "unlikely to achieve efficiencies" that the other, larger hospitals enjoy. Most observers of the health care market would readily agree that hospitals with a patient census of fewer than forty will have trouble achieving efficiencies and, indeed, trouble remaining viable. Congress, for example, has acted to encourage small rural hospitals to form alliances with larger regional centers. The agencies are thus recognizing nothing more than the obvious, and they are recognizing it, moreover, only as to a very small handful of potential mergers.


87 If the small hospital is less than five years old, the safety zone will not apply.


89 Studies generally indicate a two hundred-bed size as the minimum for achieving significant efficiencies. See Paul Feldstein, Health Care Economics 177-86 (3d ed. 1988) (summarizing studies).

90 The EACH/RPCH program gives higher, cost-based reimbursement to rural hospitals that essentially agree to close general acute care services and limit themselves to six beds and patient stays of three days or fewer. 42 U.S.C. § 1395i-4 (1994) (essential access community hospital/rural primary care hospital); see also 42 C.F.R. §§ 485.601-645 (1995). A Rural Primary Care Hospital ("RPCH") complying with the statutory conditions obtains a higher rate of reimbursement, in return for its voluntary reduction in scope of services, while the Essential Access Community Hospital ("EACH") to which the RPCH refers its patients needing more extensive care, gains patient volume.
As to the overwhelming majority of mergers not falling within the safety zone, the agencies do little more than refer to the 1992 Horizontal Merger Guidelines. The agencies do concede that some mergers that lead to apparently anti-competitive levels of concentration do not always “substantially lessen” competition. As examples of conditions precluding a finding of anti-competitive effect, the agencies provide the following:

1. the merger will not increase the likelihood that market power will be exercised either because strong competitors remain following the merger or because the merging hospitals were substantially differentiated, and thus a competitor is not being lost in the merger;
2. significant cost savings may be achieved as a result of the merger that otherwise may not be achievable; or
3. a hospital would likely fail if the merger did not occur, and that hospitals assets would be lost from the market.\(^91\)

The third point is a recognition of the well-established “failing firm” defense.\(^92\) The other two items go beyond black letter doctrine, and are somewhat subject to challenge.\(^93\) This “guidance” as to the conditions could have been helpful, but is too generalized to provide meaningful insight to a hospital contemplating a merger. There is no discussion of or framework for assessing the level of efficiencies required, for example, to offset any potential anti-competitive effects. What level of concentration will require a rebuttal by showing that “strong competitors” remain? What level of cost savings balances an increase in market concentration? Although one could not expect a mathematical formula to solve all of these questions, some more detailed level of guidance should have been possible.\(^94\)

\(^91\) See Policy Statements, supra note 3, at 10.

\(^92\) See, e.g., International Shoe Co. v. FTC, 280 U.S. 291 (1930) (stating that merger was not anti-competitive because acquired company would likely have failed and exited the market).

\(^93\) The existence of a strong competitor, for example, would prevent the merged entity from controlling the market, but would not preclude an increase in the risk of collusion among competitors in a highly concentrated market.

\(^94\) The agencies have not offered to redress the balance by providing case-by-case guidance on an expedited basis generally. The agencies are committed to providing business review letters or advisory opinions within 90 days of the receipt of all necessary information if a hospital believes that the given merger may fall within the safety zone. The general business review and advisory
The 1992 Horizontal Merger Guidelines (Merger Guidelines), issued by the FTC and DOJ, show that more detailed guidance is possible. The Merger Guidelines set forth substantially more elaborate methods for estimating whether the exercise of market power is possible. The Merger Guidelines, of course, give no specific recognition to the effect of managed care, or the power of managed care providers to force health care providers to remain competitive. This is not surprising, because the Merger Guidelines were promulgated as a general guide for all industries and were not focused on the health care industry.

The Policy Statements, however, were drafted for the health care industry, and it is disappointing that the Policy Statements contain no general recognition of the changes in the market and the need to specifically account for the effect of those changes on the competitive analysis. Moreover, the Policy Statements, like the Merger Guidelines, rely heavily on a static analysis of an existing market. Recent judicial decisions suggest, however, that a reassessment of this static approach may be forced upon the agencies.

B. The Significance of Recent Developments in Merger Cases: Market Definition and the Role of Managed Care

There are five recent judicial decisions on government challenges to hospital mergers, that were decided on the merits rather than on the basis of an exemption or procedural matters. The government prevailed in two of the five, but lost (at least preliminarily) in the other three. The decisions in which the government prevailed did not, to judge by the decisions, involve any challenge to the existing traditional notions of market definition. The government prevailed where the challenged hospitals made no effort to show that market changes have substantially affected the way in which one assesses the relevant market that the arena of competition for the provision of health care has generally expanded in recent years.96

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opinion process applies in all cases except the handful arguably within the safety zone.


96 In the three cases in which the defendant challenged the standard, static assessment of the scope of competition among health care providers, the government has lost. As discussed below, there is a strong appearance that the government's approach requires reassessment.
1. United States v. Carilion Health Systems

The first case, United States v. Carilion Health System, merely hints at risks to the government in a traditional, static view of the hospital market. The Carilion Health System case involved a merger between two of three hospitals in Roanoke, Virginia: Roanoke Memorial (hospital owned by Carilion Health System) and Community Hospital of Roanoke Valley. Roanoke Memorial was a 677 bed facility of which approximately 609 beds were staffed and operated, with an average occupancy level of less than five hundred patients. Community Hospital of Roanoke was licensed for 400 beds of which it staffed 220; its average occupancy was approximately 175 patients. Roanoke Memorial was also a teaching affiliate of the University of Virginia Medical School located in Charlottesville, Virginia. Both Roanoke Memorial and Community Hospital drew more than half their patients from Roanoke County (53% and 74%, respectively). There was a third hospital in the immediate area, Lewis-Gale Hospital in Salem, Virginia, which drew 70% of its patients from the Roanoke area. Lewis-Gale was slightly smaller – a 406 bed facility – and it too had excess capacity, operating about 335 beds with an average occupancy of 242 patients.

An advisory jury empaneled to hear the evidence found that the relevant product market to include acute inpatient hospital services as well as certain outpatient healthcare services provided by various clinics. The court did not entirely accept the advisory jury finding and found that the relevant product market was larger because:

providers of outpatient services compete with providers of inpatient services for the same patients in a significant number of cases, [thus] the court concludes that the relevant service market for this case includes not only other inpatient hospitals, but also various outpatient clinics that treat medical problems for which patients might otherwise have sought treatment in an inpatient setting.

Usually a hospital's product market has been defined as acute care services. The court explained the departure from the "standard" product market definition as follows:

Various witnesses agreed that some medical needs are

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98 Id. at 847.
treated exclusively on an outpatient basis, while others are treated only in a hospital. Most also agreed, however, that a significant number of problems could be treated either on an in or outpatient basis. Reasonable doctors differ as to when a problem must be treated in a hospital or when outpatient treatment is appropriate. Moreover, various insurance carriers, including Blue Cross and Blue Shield of Virginia, two of whose executives testified at trial, have restructured their reimbursement policies in recent years in order to encourage patients to use outpatient services, which are less expensive than inpatient care. Because patients or their doctors can choose to have problems treated either in a hospital or in an outpatient clinic or doctor’s office in a significant number of cases, the court finds that certain clinics and other providers of outpatient services compete with the defendants’ hospitals to treat various medical needs.99

Although the court did not explicitly state there were multiple relevant product markets, it implicitly found that there were at least two, and perhaps three, relevant product markets. After commenting on the role of outpatient providers, the court stated:

Based on the finding above that the Roanoke hospitals compete with hospitals in surrounding counties to provide primary and, in some cases, secondary services to residents of those counties, the court concludes that these areas are included in the relevant geographic market for this case with respect to primary and secondary services.100

Thus primary and secondary level care appear to have been treated as one product market. The existence of a separate product market for tertiary services is implied in the following:

99 Id. at 844-45; see also Santa Cruz Medical Clinic v. Dominican Santa Cruz Hosp., No. C 93 20613 RMW, 1995 WL 232410 (N.D. Cal. Apr. 17, 1995) (noting that, in denying plaintiffs’ motion for summary judgment, court refused to adopt plaintiffs’ position that relevant product market was inpatient acute care services, noting that medical field has changed dramatically from a technological standpoint, and thus, genuine issues of material fact exist regarding linkage between prices of nonsubstitutable services, and questioning whether supply side substitution significantly affects economic behavior).

100 Carillon Health Sys., 707 F. Supp. at 847 (emphasis added).
Based on the finding above that hospitals in central Virginia and northern North Carolina compete with defendants and Lewis-Gale to provide tertiary level services to the same residents of western Virginia that the three Roanoke hospitals serve, the court concludes that for tertiary level services the relevant geographic market includes hospitals in Charlottesville and Richmond, Virginia, and in Winston-Salem and Durham, North Carolina.101

In the court’s only specific market statement — that it “reject[ed] the advisory jury’s finding as to the relevant geographic market”102 — the court implicitly recognized two markets, without any specific discussion of the product market as a separate analytical issue. The absence of specific analysis of the product market is surprising, but the court may have thought the distinctions in areas of competition, together with the medical distinctions, made the existence of separate product markets obvious. The general test as to product markets, set out in the Supreme Court’s Brown Shoe Co.103 decision, is whether one product is a reasonable substitute for another (whether there is “cross-elasticity of demand”).104 The trial court may have thought it obvious that services such as open heart surgery are not substitutable for secondary care services such as appendectomies. This, of course, ignores the issue of supply side substitutability.

Based on its findings as to where the Roanoke hospitals competed, the court expanded upon the jury’s determination of the relevant geographic market, which had been limited to the immediate vicinity of Roanoke County. The court instead found that the geographic market contained all counties and cities from which Roanoke Memorial drew at least one hundred patients a year. That area included sixteen counties and three cities in Virginia, as well as three counties in West Virginia, and included twenty other hospitals in addition to the three Roanoke-area hospitals.105

101 Id. at 848.

102 Id.


104 The test is “reasonable interchangeability of use or the cross elasticity of demand between the product itself and substitutes for it.” Id. at 325.

105 The court also noted that all three of the hospitals in the Roanoke area drew substantial numbers of patients from outside the immediate Roanoke vicinity. Roanoke Memorial drew 27% of its patients from 11 Virginia counties, as well as the cities of Lynchburg and Radford, and three
The court did not provide any specific rationale for stating that the market would include areas from which Roanoke Memorial (the larger hospital) obtained at least one hundred discharges in the prior year. This position has no apparent direct relation to any generally-accepted market definition methodology, such as the Elzinga-Hogarty test.\textsuperscript{106} Presumably, the court was aware of the general rule that a geographic market is "the area of effective competition,"\textsuperscript{107} but the court's decision did not state why that level of patient origin put the additional areas within the range of effective competition affecting Roanoke Memorial.

Some explanation is found in the court's decision on the competitive effect of the merger, in which the court recognized the importance of high patient volume, and hospitals' sensitivity to relatively small volume shifts. The court specifically found that the hospitals could not afford to lose a "significant" number of patients.

In reviewing the reasonableness of a restraint, the court noted that "the relative effect of percentage command of market varies with the setting in which that factor is placed."\textsuperscript{108} That is, the scope of the effect of any given area of concentration may vary from industry to industry and setting to setting. The court found that patients before and after the merger could turn to many different providers for care, and that the range was particularly wide for those residents living in the outlying areas. Additionally, and "more importantly," the court found that Lewis-Gale planned to increase its tertiary care services and to affiliate with a major medical school. Therefore, Lewis-Gale promised to remain a major competitor. As Lewis-Gale had significant excess capacity, it could obviously draw off a significant number of patients in the event of a price increase. Although the court made no specific finding that a price increase by the merged hospitals could not be sustained in the face of a patient shift to Lewis-Gale, it implied its doubt. The court reasoned that:

\begin{quote}


\textsuperscript{107} Standard Oil Co. v. United States, 337 U.S. 293 (1949).

\textsuperscript{108} Carillon Health Sys., 707 F. Supp. at 848 (quoting United States v. Columbia Steel Co., 334 U.S. 495, 528 (1948)).
\end{quote}

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\textbf{GOVERNMENT ANTITRUST ENFORCEMENT}
Because hospitals have high fixed costs, Roanoke Memorial or Community would sustain significant financial harm if either lost a significant number of patients to any of their various competitors: local hospitals in outlying rural areas that compete to provide primary and secondary services to patients who live in those areas; large hospitals in Virginia and North Carolina that compete to provide tertiary level services to patients in western Virginia; outpatient clinics and other facilities that compete to treat medical problems that might otherwise have been treated in a hospital; and Lewis-Gale. 109

Although the court gave no explicit analysis of the power of a provider with excess capacity to discipline a market leader who prices anti-competitively, the court’s emphasis on the excess capacity at Lewis-Gale and de-emphasis of regulatory barriers to entry implicitly accepted the premise that managed care is a significant competitive factor. Managed care payers can induce changes in patient health care choices that are critical to hospital profitability. The court was explicit about the risk of patient loss. The court held that because “hospitals have high fixed costs . . . their financial health depends on high occupancy.” 110 The court also specifically said that hospitals’ acceptance of Medicare patients, despite the low reimbursement rate, arises from the need to “maintain their occupancy and cover high fixed costs.” 111 The court did not specifically note the fact, but was apparently aware of the increased importance private payers have, because of the inability of hospitals to alter governmental payment rates.

Given the court’s rejection of the government’s proposed geographic market, it is to some extent surprising that the court undertook as much analysis of competitive impact as it did. The government bears the burden of proving its case, and an indispensable element is proof of the relevant geographic market. 112 Typically, the government makes its prima facie case by establishing the relevant market and proving a high market share or level of concentration resulting from

109 Id. at 845.

110 Id.

111 Id.

the merger. In *Carilion Health Systems* there was no evidence of the market share the merged entity would have in the larger geographic market the court held was the proper market. The government apparently did not put in evidence of the size and occupancy of hospitals outside its defined market; the court noted its "inability to produce a concentration figure" because of the lack of data from "many of the hospitals in the market." Thus, the court in theory could have ended its analysis and ruled against the government without any analysis of competitive impact. In giving an analysis of the competitive effects the court not only illuminated its position on the relevant market, but signaled the potential importance of managed care trends in defining a geographic market.

The court also buttressed its decision with findings on subjective intent and pro-competitive efficiencies. These fact-specific findings are not of general significance, however. The generally significant aspects of the case are the court's willingness to look beyond traditional market definition techniques and give substantial weight to the competitive significance of alternative and "fringe" providers.

2. The Rockford Memorial and *University Health* Decisions: The Government Prevails Where Traditional Assumptions Are Not Challenged

Both the result and the reasoning of the *Carilion Health Sys.* decision contrast sharply with a nearly-contemporaneous decision by the Seventh Circuit in *United States v. Rockford Memorial Corp.* Neither that decision, however,  

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113 See, e.g., United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir.), cert. denied, 498 U.S. 920 (1990); discussion supra part IV.B.3.


115 The court also held that the defendants' non-profit status was a relevant factor in determining that the merger would not be an unreasonable restraint. First, the court found that the defendants' directors were business leaders in the community who would demand to keep hospital charges down. Second, the court accepted expert testimony that non-profit institutions generally charge lower rates than do for profit entities. The court also believed that the Virginia Health Services Cost Review Council could be expected to use persuasive power to keep the hospital rates low.

116 898 F.2d 1278 (7th Cir.), cert. denied, 498 U.S. 920 (1990). In addition to differing on the substantive antitrust analysis, the courts differed on the technical question of whether the FTC had jurisdiction under section 7 of the Clayton Act over non-profit hospitals. The *Carilion Health Systems* court had held that the Clayton Act does not provide independent antitrust jurisdiction to the FTC; because the general jurisdictional grant to the FTC under the Federal Trade Commission
nor the subsequent decision in *FTC v. University Health, Inc.* establish that it is safe to ignore changes in the market. Although the *Rockford Memorial Corp.* and the *University Health, Inc.* decisions relied on a static approach to market definition, neither did so in the face of evidence as to the significance of managed care in changing existing referral patterns.

Contrary to the court in *Carilion Health Systems*, the *Rockford Memorial Corp.* court found that the relevant product market was limited to inpatient acute care hospital services. The court recognized that, for many services, patients may have a choice between receiving those services on an inpatient or outpatient basis. However, for many hospital services, the court noted that there is not an outpatient complement. The court rejected the idea that there is a price linkage between services that are substitutable on an outpatient basis and those that are strictly inpatient by stating that:

The fact that for other services you have a choice between in patient care at such a hospital and out patient care elsewhere places no check on the prices of the services we have listed [such as transplants and major surgery], for their prices are not linked to the prices of services that are not substitutes or complements. If you need your hip replaced, you can't decide to have chemotherapy instead because it's available on an out patient basis at a lower price. Nor are the prices of hip replacements and chemotherapy linked.\(^\text{118}\)

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*Act excludes* non-profit institutions, the *Carilion Health Systems* court held that the FTC's only jurisdiction was under the Sherman Act. *Carilion Health Sys.*, 707 F. Supp. 891 at n.1. In contrast, in *Rockford Memorial Corp.* the court found a general grant of jurisdiction to enforce section 7 of the Clayton Act to be contained in the Clayton Act itself. Section 11 of the Clayton Act, which provides jurisdiction to various regulatory entities for specific industries, conveys jurisdiction to the FTC "where applicable to all other character of commerce," and the court held that this was a grant of jurisdiction for the purpose of enforcing section 7 of the Clayton Act. See *Rockford Memorial Corp.*, 898 F.2d at 1280. This appears to be the much better reasoned view, *id.* at 1280-81, and it has been followed by all other courts to consider the issue. See, *e.g.*, FTC v. Freeman Hosp., 69 F.3d 260, 266 (8th Cir. 1995) (citing cases). As the Fourth Circuit noted, however, in the unpublished appellate decision in *Carilion Health Systems*, the government's position that the substantive standards under Sherman Act section 1 and the Clayton Act section 7 are the same, make the point of little significance. See United States v. Carilion Health Systems, 1989-2 Trade Cas. (CCH) ¶ 68,859.

\(^{117}\) 938 F.2d 1206 (11th Cir. 1991).

\(^{118}\) *Rockford Memorial Corp.*, 898 F.2d at 1284.
Although the court was correct that there is no necessary linkage between hip-replacements and chemotherapy, that does not dispose of the competitive inquiry. In the first place, the statement that chemotherapy and hip replacement are not linked — and thus are separate markets — implies a rejection of the defined market: the group of services known as inpatient acute care hospital services. Second, despite the lack of medical interchangeability or "linkage," managed care purchasers need not pay providers on a traditional fee-for-service basis. It would certainly be possible for payers to purchase packages of services at blended rates. Furthermore, even if managed care purchasers make selections on the basis of discrete prices for each medical procedure, the selection of a provider will depend on the provider's overall cost. Thus, the cost of chemotherapy could be linked to the cost of hip replacement, because both costs influence the ability of the provider to be selected as a provider by managed care plans.

This possibility in no way questions the court's findings on the actual facts before it, but the possibility certainly shows that the court's statement is not an invariable rule. The proper factual development might well show a linkage between hip surgery prices and chemotherapy, despite their medical non-substitutability. If fixed costs are very high, and high patient volumes are required for services, a provider of the highly specialized services may need to be competitive even in its areas of dominance, so as to sustain the volume needed for profitability.

Although swiftly rejecting challenges to the government's inpatient product market definition, the court had a more difficult time determining the relevant geographic market. The district judge had noted that 87% of the hospitals' patients come from an area surrounding Rockford, consisting of the rest of the county in which Rockford was located, as well as pieces of several other counties. This area was selected by the trial court as the geographic market. The district court noted that the two defendant hospitals, which were the largest hospitals in Rockford and of approximately equal size, had combined market shares in the market between 64% and 72%, depending upon whether the assessment was based upon beds, admissions, or patient days. After the merger, the court found that the combined market share of the three largest hospitals in the area would be at 90%.

Judge Posner expressed concern at some inadequacies in the district court's market definition, including the failure to consider patient out-flow and to consider fully the ability of providers outside the market, especially in the outer areas, to divert patients. The opinion does not give details of all the challenges, but notes that the defendants attacked the district court's market definition with
"vigor and panache."119 The weaknesses in the market definition accepted by the trial court, however, were not fatal, especially since it is "always possible to take pot shots at a market definition . . . ."120 The district court's factual findings on the market survived the "clearly erroneous" standard of review to which they were subject.

In part the trial court's position was helped because any apparent flaws in it were, in Judge Posner's opinion, dwarfed by the problems in the ten-county geographic market proposed by the defendants. The court, faced with two imperfect definitions, chose the "less imperfect." Judge Posner found the defendant hospitals' geographic market proposal not only imperfect, but "ridiculous" and stated that it was contrary to common sense to assume that Rockford residents, or third party payers, would be "searching out small, obscure hospitals in remote rural areas" if the prices charged by the hospitals in Rockford rose above competitive levels.121

The trial court in Carillon had reached almost the opposite conclusion.122 Judge Turk found that the presence of tertiary care providers at significant distance and a variety of smaller hospitals or alternative care providers on the edge of the market precluded the market definition proposed by the government. The different results are not necessarily anything more than the result of variances in evidence introduced in the different proceedings. Judge Posner's criticism of the ten-county market, and his comment on searching out "small, obscure hospitals in remote rural areas," was made only after specifically noting the absence of evidence of that activity.123 The decision does not hold that such evidence must be rejected if presented.124 Indeed, the opinion specifically called

119 Id.

120 Id.

121 Id.

122 In further contrast to the decision in Carillon Health Systems, in Rockford Memorial Corp., Judge Posner specifically stated that excess capacity is an incentive to collude, the precise opposite of the view held by Judge Turk in the Carillon decision.

123 Rockford Memorial Corp., 898 F.2d at 1285.

124 Similarly, in Rockford Memorial Corp., Judge Posner said the court was "aware of no evidence -- and the defendant's present none, only argument -- that non-profit suppliers of goods are more likely to compete vigorously." 898 F.2d at 1285. Yet in Carillon Health Systems, the defendants put on evidence, accepted by Judge Turk, that the local business owners on the non-profit's board could be expected to ensure that efficiency savings from a merger were passed on to consumers. Carillon Health Sys., 707 F. Supp. at 846.
for more intensive and in-depth analysis of the health care markets; for example, the opinion called for “more effort [to be] put into studying the actual effect of concentration on price in the hospital industry . . .” Judge Posner nevertheless held that the “early and inconclusive” stages of the literature on the subject does not deprive the government of the right to go forward; the government “is not required to await the maturation of the relevant scholarship in order to establish a prima facie case.”

Rockford Memorial Corp. certainly permits the government to continue its enforcement actions, despite the unsettled nature of the relevant literature on the health care market. It does not, however, suggest the government may ignore the changes in the health care market, in those cases where evidence of that change is introduced.

The government’s other recent merger victory, FTC v. University Health, Inc., provides no greater comfort for the government. In University Health Inc., the Eleventh Circuit reversed a district court’s denial of the FTC’s request for a preliminary injunction. The FTC had sought to block the acquisition of the assets of St. Joseph’s Hospital in Augusta, Georgia, by University Hospital, also in Augusta. There were five existing hospitals in the three county “Augusta area” held to be the relevant market by the district court. The district court had agreed with the FTC that the acquisition would increase the level of market concentration significantly, but found that the not-for-profit nature of the parties, the small size and the financial weakness of St. Joseph’s, and the attainment of efficiencies (principally reductions in capital budgets) justified the merger. The court of appeals completely rejected the non-profit status of the entities as a relevant consideration. As to the other two “justifications,” the appeals court held that the district court had improperly weighed their significance in light of the government’s strong prima facie case. That prima facie case, as the court noted, consisted of proof of a relevant market

\[ \text{Herfindahl-Hirschmann index would increase by 630 to approximately 3200. University Health Inc., 938 F.2d at 1211 n.12.} \]
in which there was a high level of concentration.\textsuperscript{130} The Eleventh Circuit opinion did not address the definition of the relevant market, nor the role of managed care trends in defining the market. The latter issue apparently was not raised by any party, and there was no general discussion of the geographic market because the facts were “basically uncontested.”\textsuperscript{131}

3. Eighth Circuit Cases and the Rejection of a “Static Analysis”

The government’s string of post \textit{Carilion Health Systems} successes received a distinct check in two cases arising in the Eighth Circuit, in both of which the courts refused the government’s request for preliminary injunctions. In both cases the government’s reliance on traditional market definition was found to be so flawed that the courts held the government had failed to adequately define the relevant geographic market.\textsuperscript{132}

a. The \textit{Freeman Hospital} Decision: The Requirement to Assess Patient Reaction to Price Changes

In \textit{FTC v. Freeman Hospital}, the FTC brought suit against the two smallest of the three general acute care hospitals in Joplin, Missouri. The largest hospital, St. John’s Regional Medical Center, a non-profit allopathic hospital with 331 beds, was not involved in the merger. The two merging hospitals were Freeman Hospital, a 158 bed non-profit allopathic facility, and Oak Hill Hospital, a ninety-six bed osteopathic hospital. Freeman Hospital and Oak Hill Hospital proposed a merger because Oak Hill had been experiencing financial difficulties. The merging hospitals believed that a merger could not only alleviate these financial problems but could also strengthen the resulting hospital’s ability to compete in a managed care environment.

At the FTC’s request, Oak Hill’s trustees solicited offers from other hospitals to purchase Oak Hill. Although it received offers from two for-profit healthcare companies, Oak Hill nonetheless determined that Freeman made the superior proposal. The FTC then sought a temporary restraining order and preliminary injunction to enjoin the hospitals from merging. The district court

\textsuperscript{130} \textit{Id.} at 1218-19. The court’s discussion of the burden of proof and persuasion, and the requirements for proof of the prima facie case, is both clear and succinct.

\textsuperscript{131} \textit{Id.} at 1217.

denied the request, and the Eighth Circuit Court of Appeals upheld the denial. The court of appeals defined the relevant product market as consisting of acute care inpatient hospital services, a product market agreed to by the parties. However, determining the appropriate geographic market was much more controversial and the court’s holding marks a substantial step forward in the market definition analysis in hospital merger cases.

The court began its analysis by noting that “a geographic market is that geographic area ‘to which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition.” The FTC’s proposed geographic market included the City of Joplin, as well as areas spanning a twenty-seven-mile radius of Joplin. The hospitals, on the other hand, proposed a thirteen county market, including communities over fifty miles from Joplin. The court noted that the FTC’s testimony consisted mainly of an analysis of ZIP code data detailing patient flow into the three Joplin area hospitals and the hospitals located within the twenty-seven mile radius. The government undertook the Elzinga-Hogarty market analysis, which holds that a relevant geographic market exists in the smallest area from which there is little out-migration of consumers, and little migration into the area from consumers outside the market. The hospitals undertook an analysis of the same patient flow data, and argued that errors in methodology and data collection precluded any finding that the market was that asserted by the FTC. Although both the district court and the court of appeals regarded the hospital critiques of the data as persuasive, the far more important point was both courts’ rejection of an analysis relying solely on existing patient flow to establish a relevant market. The court of appeals found that “this analysis gives a static, rather than a dynamic, picture of the acute care market in Joplin and the surrounding areas.” The court then held that:

Even if we did not credit the concerns [the hospital’s expert]

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133 The district court initially denied the preliminary injunction request without first conducting an evidentiary hearing. Upon an interlocutory appeal, the circuit court sent the matter back to the district court to hold an evidentiary hearing. Following the evidentiary hearing, the district court again denied the request for a preliminary injunction. *Freeman Hosp.*, 69 F.3d at 263-64.

134 Id. at 268 (quoting Morgenstern v. Wilson, 29 F.3d 1291, 1296 (8th Cir. 1994), cert. denied, 115 S. Ct. 1100 (1995)) (focusing on the importance of determining practicable alternatives for consumers).

135 As discussed in the decision, the tests are sometimes referred to as LOFI/LIFO: “little out from in” and “little in from out.”

136 *Freeman Hosp.*, 69 F.3d at 269.
raised about the completeness and correctness of [the government expert’s] analysis, we would still be forced to conclude that the Elzinga-Hogarty [patient flow] analysis presented in this case did not, by itself, address the decisive question of where consumers could practicably go for alternative sources of acute care inpatient hospital services. Simply put, [the government expert’s] theory provided no insight into the future effects of the allegedly anti-competitive merger of the Hospitals.137

This is a strong statement. Although the appellate court could have upheld the district court’s order simply on a finding that the district court was not “clearly erroneous,” most of the decision’s language sweeps much more broadly. After acknowledging the deferential standard of review,138 the court noted the dispute between the parties as to the relevant market and said that:

We need not fully resolve this conflict at this juncture, for in a Section 13(b) preliminary injunction action it is the FTC’s burden to identify a geographic market within which a challenged transaction raises “serious, substantial, difficult and doubtful” questions of antitrust concern. See, e.g., Morgenstern, 29 F.3d at 1296. A geographic market is that geographic area “to which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition.” Id. In order to meet its burden, the FTC is required to present evidence addressing the critical question of where consumers of acute care inpatient hospital services could practicably turn for alternative sources of the product should the Hospitals’ merger be consummated and Joplin hospital prices become anti-competitive. The FTC has failed to produce such evidence.139

Failing to produce any evidence on a question is significantly different than producing insufficient evidence to show clear error. The strength of the statement may be in part due to the court’s view of the government’s burden of proof.

137 Id.

138 Id. at 267 (stating that reviewal is warranted only on a showing of clear error or abuse of discretion).

139 Id. at 268 (quoting Morgenstern v. Wilson, 29 F.3d 1291, 1296 (8th Cir. 1994), cert. denied, 115 S. Ct. 1100 (1995)).
The court held that the FTC's burden at the preliminary injunction stage was to produce evidence of the relevant market sufficient to raise "questions going to the merits so serious, substantial, difficult and doubtful" as to warrant preliminary relief.\(^1\) Although rejecting the hospital's claim that the FTC had to "prove the exact parameters of the relevant market," the court also rejected the FTC's position that the government needed only to raise "serious" and "substantial" questions about the relevant market. A substantial question is sufficient, the court said, on "the ultimate merits . . . the lessening of competition."\(^2\) To evaluate that question, however, it was "essential" that the government "identify a credible relevant market."\(^3\) This leaves in some doubt the level of proof required as to the relevant market at the preliminary injunction stage. The distinction between "identifying a credible market" and "proving" one is not readily apparent.

Regardless of the resolution of this technical question, the general tone of the decision, and its ultimate finding that the government had not "identified" a "credible" market, is a marked apparent divergence from the position taken by the Seventh Circuit in \textit{Rockford Memorial Corp.} The Seventh Circuit there accepted the government data on the existing flow of patients as sufficient to define a market. The Eighth Circuit's opinion appears to hold this evidence inadequate as a matter of law, because it was not sufficient to show potential consumer response to a price increase. Although the FTC produced evidence of existing patient flow patterns, it "failed to produce" evidence on where consumers can turn. Thus, static market data was not sufficient because "it [did] not by itself address the decisive question of where consumers could practicably go for alternate sources" of care.\(^4\)

The court did not hold that the FTC had failed to produce any evidence on where patients could turn, in the event of any anti-competitive price increase. The court held only that the patient flow data failed to do so. The court agreed that the FTC presented "relevant" testimony from market participants that few patients would travel outside Joplin in the event of a collusive price increase.\(^5\) The court characterized that testimony as limited mainly to current competitor

\(^1\) \textit{Id.} at 268 (quoting FTC v. Beatrice Foods Co., 587 F.2d 1225, 1229 (D.C. Cir. 1978)).

\(^2\) \textit{Id.}

\(^3\) \textit{Id.} at 269.

\(^4\) \textit{Id.} at 269-70.
perceptions and current customer habits and not to the crucial question of where consumers could practicably go in the event of changed circumstances.\textsuperscript{145}

Also relevant, but inadequate, was the testimony by the administrators for hospitals at the margin of and outside of the FTC’s defined market. According to the court, this testimony “most closely addressed the question of where patients could practicably travel for alternative sources of acute care” services.\textsuperscript{146} The testimony of “several” administrators was that patients travel to Joplin for “mainly services not otherwise available” at the local hospital.\textsuperscript{147}

Based on this testimony, the FTC asserted that the hospitals in Joplin provided superior quality care and that the hospitals in the thirteen outlying counties therefore were not competitors of the Joplin hospitals. The FTC also cited the Seventh Circuit’s finding in \textit{Rockford Memorial Corp.} that it would be “ridiculous” to expect patients in Rockford to seek out care from small obscure hospitals in the outlying areas. The Eighth Circuit rejected this argument.

First, the court held that the FTC failed to back up this argument by providing statistical evidence, such as DRG code information, that would indicate whether there were significant differences between the types of services offered in Joplin and those available in the outlying hospitals. Additionally, the court noted that the FTC’s argument could lead to a blurring of the product market, indicating that the appropriate product market actually was much more specialized. Relying on distinctions between quality or level of service would imply a separate product market for those higher level services, which might lead to an even bigger geographic area.

\textbf{b. Mercy Hospital and the Continued Requirement for a Dynamic Analysis}

The requirement for detailed evidence of the alternatives available to consumers was continued in \textit{United States v. Mercy Health Services}.\textsuperscript{148} There, the government sought to block the merger of the only two acute care general hospitals in Dubuque, Iowa, alleging a violation of section 7 of the Clayton Act and section 1 of the Sherman Act. The parties waived a preliminary injunction proceeding and, after an expedited discovery, proceeded directly to trial on the

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\textsuperscript{145} \textit{Id.} at 270.
\textsuperscript{146} \textit{Freeman Hosp.}, 69 F.3d at 270.
\textsuperscript{147} \textit{Id.}
\end{footnotesize}
merits. The district court denied the government’s request for a permanent injunction.

Mercy was a 320 bed acute care hospital which in 1994 had an average daily census of 127. Finley was a 124 bed acute care hospital which had an average daily census of sixty-three in 1994. Additionally, there were seven small rural hospitals within forty minutes of Dubuque. The rural hospitals largely provided primary care services and varied in the extent to which their services overlapped the merging hospitals; one provided as many as sixty-eight percent of the same DRG services that Mercy and Finley provided, another as few as 11.5% of the same DRG services. Within seventy to one hundred miles of Dubuque there were nine hospitals characterized as “regional” and ranging in size from 144 beds to 868.\(^{149}\)

Fifty percent of Mercy’s and Finley’s patients were covered by Medicare and Medicaid, twenty-five were covered by managed care plans and twenty-five by traditional third party payers. The court noted that, as a result of cost containment pressures and the development of managed care in the area, various managed care groups had opened up outreach clinics in the area. This allowed physicians in the Dubuque area to treat patients in clinics that were operated in towns up to fifty to sixty miles from the hospital.

The parties agreed that the relevant product market was acute care inpatient services. The focus of the hospitals’ argument was the relevant geographic market. The government defined the geographic market as consisting of Dubuque County, Iowa and extending a fifteen mile radius from Dubuque County’s eastern edge into Illinois and Wisconsin. That geographic area would include one extra hospital in addition to Mercy and Finley. Seventy-six percent of the two hospitals’ patients came from that area. At that time, eighty-eight percent of the patients in the market used the three hospitals; eighty-six percent of the patients went to Mercy or Finley.\(^{150}\) The government’s market was, therefore, highly concentrated.

The hospitals, on the other hand, argued that the geographic market should include Mercy, Finley, and the seven closest rural hospitals and three general hospitals located in Cedar Rapids, Waterloo, Iowa City, Davenport and Madison, Wisconsin. In this market, Mercy’s and Finley’s market share was approximately ten percent, which the government conceded would not justify any action.\(^{151}\)

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\(^{149}\) Mercy Health Servs., 902 F. Supp. at 972.

\(^{150}\) Id. at 976.

\(^{151}\) Id.
The district court undertook a detailed analysis of the evidence that was remarkably prescient in its approach. Although handed down four days before the *Freeman Hospital* decision, the district court’s analytical framework closely tracked that of the Eighth Circuit decision. Iowa is, of course, located in the Eighth Circuit.

Like the court in *Freeman Hospital*, the district court held that defining the relevant market requires a fluid analysis not only as to where patients currently go or have gone for acute care inpatient services, but also where they could practically go. The government’s proof, however, had consisted primarily of extensive evidence as to existing market shares in the fifty mile radius market it proposed. As indicated, 88% of all patients remained in the government’s defined area, and the two hospitals had 86% of the area patients; 76% of the two hospitals’ patients came from outside the defined market area. The court summarized the inadequacies of the government’s reliance on this evidence as follows:

> The court finds that the government’s case rests too heavily on past health care conditions and makes invalid assumptions as to the reactions of third-party payers and patients to price changes. The government’s case also fails to undergo [sic] a dynamic approach to antitrust analysis, choosing instead to look at the situation as it currently exists within a competitive market.

Specifically, the court noted that the government failed to take into consideration the outreach efforts of hospitals, the willingness of enrollees of managed care plans to change healthcare providers for financial reasons, and the strong efforts that regional hospitals were undertaking to expand their service areas. The district court buttressed its decision with detailed factual findings made with respect to “health care market trends.” The court found that managed care, excess capacity, and general cost pressures had forced a substantial increase in the scope of hospital marketing activities and a substantial change in

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152 Presumably, the district court’s accuracy arose from its close reading of Morgenstern v. Wilson, 29 F.3d 1291 (8th Cir. 1994), *cert. denied*, 115 S. Ct. 1100 (1995), a case heavily relied upon in *Freeman Hospital*.


154 *Id.* at 977.

155 *Id.* at 968.
patients' traditional travel patterns for hospital services.\textsuperscript{156}

The government had relied rather heavily on the patient flow statistics and the Elzinga-Hogarty market test. The court's characterization of this reliance was more charitable than that of the court in \textit{Freeman Hospital}, but nonetheless stressed the ultimate inadequacy of relying on existing patient flow patterns.

In this light, it is important to note that the government's reliance on the Elzinga-Hogarty test is merely a starting point - it states where Mercy and Finley are currently attracting patients and the area from which most patients seek services from either Mercy or Finley. This is the snapshot of the market as it exists under current conditions and does not pretend to answer the question of what would happen if there was an attempt to exercise market power by one of the market participants.\textsuperscript{157}

The district court found that the government's arguments to exclude the outlying areas failed to consider the market trends set forth in the counts hold,\textsuperscript{158} and wrongly assumed that patient loyalty would preclude significant shifts in patient volume in the event of an anti-competitive price increase. The court agreed with the government only in holding that the rural hospitals would not be able to attract significant patients from the more urban hospitals. The court

\textsuperscript{156} The court made a number of findings. Hospitals have begun competing on the basis of price, due to the advent of managed care and large price-conscious buyers. \textit{Id.} at 973. Managed care entities are capable of inducing enrollees to change hospitals (or physicians) by eliminating or reducing payment to non-approved institutions or physicians. \textit{Id.} The advent of managed care has made patients cost-sensitive because of the practice of managed care providers of creating economic incentives and disincentives (variances in coverage) depending on the provider selected. \textit{Mercy Health Servs.}, 902 F. Supp. at 973-74. Managed care entities compete among themselves based on price; as 35-40\% of health care costs are hospital inpatient charges, hospital rates significantly affect managed care providers. \textit{Id.} at 974. Hospitals give managed care plans the discounts they demand only because the hospitals believe the plans can shift significant patient volume toward or away from the hospitals. \textit{Id.} Managed care has increased the use of outpatient procedures and redirected inpatient usage and length of stay. \textit{Id.} Reductions in patient days, and other competitive changes are forcing hospitals to compete with one another, not only at the "fringes" — the edge of mutual markets — but in the main body of each other's traditional market. \textit{Id.} Hospitals are undertaking outreach efforts, including clinics established by provider physician groups. The clinics, although located away from the hospital, are able to induce patients to travel to the affiliated hospital, even if another regional provider is closer. \textit{Mercy Health Servs.}, 902 F. Supp. at 974-75.

\textsuperscript{157} \textit{Id.} at 978.

\textsuperscript{158} \textit{See supra} note 157.
specifically rejected, however, the government’s argument that the other hospitals in the market could not defeat a 5% price increase by the Dubuque hospitals. The parties agreed that an 8% patient shift would be needed to defeat a 5% price increase. The court held that the government’s position on this key issue failed, because it was premised solely on assumptions about patient loyalty. There was no effort to analyze potential shifts in referral and travel patterns.

C. Position Taken by the Agencies in the Administrative Context

Variances in position as to relevant market are not limited to the courts. The government’s enforcement agencies have appeared to take different views. One of the most recent examples involved an apparent discrepancy between enforcement decisions made by the DOJ and the FTC as to mergers involving apparently similar facts. The varying decisions can only be harmonized if the markets are more different than they appear.

On January 24, 1994, the DOJ blessed a merger between two hospitals in New Hampshire following a three-month investigation. The merger involved Catholic Medical Center, a 284 bed acute care hospital, and the 286 bed Elliot Hospital. These hospitals were the only two hospitals operating in Manchester,
New Hampshire. However, only one week later the FTC voted unanimously to challenge the merger of the only two acute care hospitals in Pueblo, Colorado. The hospitals involved were the 326 bed St. Mary-Corwin Regional Medical Center and the 229 bed Parkview Episcopal Medical Center. The other nearest hospitals were located in Cannon City, thirty-nine miles from Pueblo, and Colorado Springs, which was forty-two miles away. St. Mary-Corwin's parent corporation owned one of the two hospitals located in Colorado Springs.

These divergent moves by the agencies puzzled many in the industry, given the apparently similar factual situations involved. The agencies, however, asserted that the factual situations were different. In an unusual move, the DOJ commented publicly on the basis for its decision, and said it was convinced that the geographic market in the New Hampshire merger contained as many as seven hospitals in five towns, including Manchester. The DOJ made the market determination based upon patient origin information as well as interviews with key third party payers in the state and determined that if the merger resulted in increased prices, patients and payers could go elsewhere. In contrast, the primary argument of the Colorado hospitals appears to have been the contention that the town could not economically support two hospitals, given declining utilization. Although the hospitals apparently noted that three other hospitals were located within forty-two miles, one of those three was controlled by the parent of the Pueblo hospital.

Considerably more interesting than the variances in enforcement positions between the FTC and the DOJ, is the change of heart undergone by the FTC in regard to one of its own administrative actions, Adventist Health System/West. The Adventist Health System/West decision closed an extremely protracted administrative proceeding begun by the FTC in 1988, challenging the acquisition of Ukiah General Hospital in Ukiah, California, by Adventist Health System/West. In April, 1994, the FTC voted to dismiss the proceedings, which had been pending for six years. The basis for the dismissal of the complaint was that the FTC's Complaint counsel had failed to establish a relevant geographic market.

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163 Interestingly, the Commissioner did not dismiss the complaint based on the hospital merger safety zone established in the Policy Statements. Because both hospitals had fewer than 64 beds, it is likely the 100/40 rule would have applied.
The basis for the FTC’s rejection of the relevant market contentions was remarkably similar to critiques contained in Freeman Hospital and Mercy Health Systems. The FTC held that the Complaint Counsel had relied too heavily on patient flow data, and a market definition based on applying the Elzinga-Hogarty test to that data. The FTC characterized the record as containing little direct evidence regarding what purchasers of health care services would do in response to a small but nontransitory price increase in the proposed relevant markets.

The Commission’s decision stated that it was not holding the Elzinga-Hogarty test “has no place in geographic market definition;” it was simply pointing out that “other evidence is equally relevant.” One piece of evidence noted as particularly relevant was the testimony by a Blue Cross representative that patients probably could be diverted to providers in another town, in the event of a price increase.

Without specifically endorsing the ALJ’s finding on the point, the Commissioner also noted the possibility, relied on the district court in Carillon Health Systems, that privately insured patients are particularly sensitive to price changes and may be particularly important to a hospital’s profit margin, given the low rate of governmental payment.

If hospital profits depend on attracting insured patients, the response of insurers and their patients likely will determine whether a hypothetical monopolist can raise prices. A shift of patients that represents a small share of a hospital’s total patient load, but that accounts for a disproportionately large share of hospital profits, might well be sufficient to make a price increase unprofitable.

This appears, in theory, to be a methodology recognizing the centrality of managed care to the economic health of hospitals. In theory it would appear to ease the burdens of hospitals attempting to defeat a claim that a merger will lead to anti-competitive effects. Whether both enforcement agencies will take the admonition to heart remains to be seen. If they do not, they risk more results like...

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164 Adventist Health Sys./West, 1994 Trade Reg. Rep. (CCH) at 23,258.
165 Id. at 23,259.
166 Id. In fact, the Commissioner noted that the in and out migration numbers produced did not ever meet the standard Elzinga-Hogarty methodology.
167 Id. at 23,259.
those in *Freeman Hospital* and *Mercy Health Systems*.

V. CONCLUSION

The profound changes in health care payment systems are provoking wide ranging changes in provider practices, and the attitudes of consumers toward health care. Providers are struggling to position themselves to survive, either through networks, alliances or outright acquisitions. The government's stated enforcement policies are wary of these efforts, but that wariness has not, to date, fully come to grips with the market realities forcing the change. Although recognizing that potential efficiencies of new provider structure, and acknowledging that such efficiencies and justify rule of reason treatment, the agencies have shown substantially has flexibility as to market assessment.

The agencies' enforcement statements, and most of the enforcement activities, are premised almost entirely on the basis of static market analysis. There is not yet an express recognition of the power of managed care providers to defeat the efforts of providers to extract supra-competitive prices. There is no recognition that managed care has created a direct and immediate price sensitivity that has not existed in the past. There is no recognition that managed care providers, unlike the average health care consumer, have extensive knowledge of and acute sensitivity to health care prices; they can not only act on the basis of that knowledge, but can also cause many of their members to, as well. As recent decisions indicate, the courts are receptive to the evidence that the consumer, now lacking the insulation of traditional indemnity insurance plan, will respond to price incentives imposed by providers and insurers.

A reappraisal of their approach to the geographic market definition in health care cases would enable the agencies not only to produce greater success in the courts, but would also reduce unnecessary litigation. The reappraisal would not require any new economic theory, but merely an application of the government's own Merger Guidelines and the principles the FTC recognized in *Adventist Health System/West*. 