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Rural Health Care and State Antitrust Reform

by Michael S. Jacobs*

I. INTRODUCTION

Now more than a hundred years old, the federal antitrust laws seek generally to promote and preserve business competition. Over the past twenty years, courts and regulatory agencies have applied this broad goal in a narrow economic sense, defining "competition" not as rivalry, for example, but as those forms of business activity most conducive to "consumer welfare." Consumer welfare, in this sense, is thought to be maximized when markets produce the greatest output of goods or services at the lowest prices with the widest range of consumer choice. For purposes of analysis, antitrust courts view all markets and market participants through the same economic lens: services are not distinguished from goods nor are nonprofit firms given a dispensation unavailable to the for-profit sector.

During the same two decades, vigorous application of the antitrust laws to the activities of organized health care providers has played a critical role in moving health care markets in the direction of greater competition. Starting with the United States Supreme Court's decision in Goldfarb, which declared that professionals enjoy no special exemption from the federal antitrust laws, a series of important opinions identified and prohibited significant forms of anticompetitive conduct in

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2. Id. at 230. See also Herbert Hovenkamp, Distributive Justice and the Antitrust Laws, 51 GEO. WASH. L. REV. 1, 16-26 (1982).


the health care field. At the same time, federal antitrust enforcement facilitated the emergence of new, more efficient forms of health care delivery by consistently examining the efforts of market incumbents to prevent or impede new forms of competition. The Federal Trade Commission, for example, successfully challenged the American Medical Association's ("AMA") ethical proscriptions against competitive contracting and affiliation with Health Maintenance Organizations ("HMOs").

Courts repeatedly struck down efforts by physicians and hospitals designed to destroy competition from innovative financing arrangements or from alternative care providers and prohibited attempts by physician and hospital groups to fix collectively the prices that their members would charge consumers.

Many of these cases are well known to antitrust lawyers and scholars. They have established what is now a widely accepted conceptual framework for antitrust analysis; one that views health care professionals and institutions as profit-maximizing market participants, no less inclined than other business entities to seek monopoly profits at the expense of consumer well being and whose business activities are judged by the same rules that govern the transactions of more "conventional" corporations. Using this framework, federal courts and agencies continue to try and promote competition in health care markets, primarily by proscribing arrangements that unfairly threaten to raise prices and reduce output.

I want to begin, however, not by rehearsing these famous cases, but by describing a lesser known opinion rarely cited by antitrust scholars.

5. American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd as modified, American Medical Ass'n v. FTC, 638 F.2d 443 (2d Cir. 1980), aff'd, 455 U.S. 676 (1982).
7. See, e.g., Medical Serv. Corp., 88 F.T.C. 906 (1976) (prohibiting concerted action to deny participation in Blue Cross plan to doctors employed by HMO); Wilk v. AMA, 895 F.2d 352 (7th Cir.), cert. denied, 496 U.S. 927 (1990) (prohibiting efforts by society of physicians to boycott chiropractors through the enactment of a so-called "ethical rule" banning the former from associating in any way with "unscientific" practitioners).
9. Although the Supreme Court stated in footnote 17 of Goldfarb v. Virginia Bar Ass'n, 421 U.S. 773 (1975), that "it would be unrealistic to view the practice of professions as interchangeable with other business activities" and suggested that the "public service aspect, and other features of the professions" might justify the application to them of different antitrust rules, the Court has never acted on this suggestion.
10. For a short, clear expression of the philosophy that underlies current federal antitrust enforcement efforts in the health care field, see Hearing on HR. 2925 before the House Committee on the Judiciary, 104th Cong., 2d Sess. (February 27, 1996) (statement of Robert Pitofsky, Chairman of the FTC).
and little mentioned in the current debate about the continued wisdom of vigorous antitrust enforcement in health care markets. In Nelson v. Monroe Regional Medical Center, 11 plaintiffs, a "mildly retarded" eighteen year-old woman and her mother, alleged, among other things, that a merger between the Monroe Clinic and the Monroe Medical Center—the only two health care facilities in Monroe, Wisconsin, a small, rural community—had allowed those providers to monopolize the market for medical services in Monroe and its environs, thereby injuring plaintiffs and violating sections 1 and 2 of the Sherman Act. 12 In particular, plaintiffs claimed that the merger substantially increased concentration in the health care market in Monroe; that the merged facility, which had cared for plaintiffs in the past, refused to treat them post merger, except on an emergency basis, in retaliation for their having filed a malpractice action against one of the clinic's physicians; and that this refusal of treatment forced plaintiffs to travel forty miles—to Madison, Wisconsin—to receive care. The district court granted the defendants' motion for summary judgment on this antitrust claim on the grounds that the clinic's refusal to treat plaintiffs was "not an injury cognizable under the antitrust laws." 13

On appeal, the Seventh Circuit Court of Appeals reversed and remanded the case for trial. In its view, by allegedly reducing output—denying nonemergency care to plaintiffs—defendants' merger had injured plaintiffs in a manner directly relevant to the purpose of the antitrust laws. The merged entity would no longer care for plaintiffs, and they had no other convenient source of care. "Monopolists," said the court, "are more likely to turn away prospective clients because they do not feel the same competitive pressure to serve all comers." 14

11. 925 F.2d 1555 (7th Cir. 1991).
12. Id. at 1561. Section 1 of the Sherman Act, 15 U.S.C. § 1, prohibits "(e)very contract, combination . . . , or conspiracy, in restraint of trade of commerce among the several States." Section 2 of the Act, 15 U.S.C. § 2, punishes those who "shall monopolize, or attempt to monopolize . . . any part of the trade or commerce among the several States."
13. 925 F.2d at 1562. Private actions to enforce the antitrust laws are authorized by section 4 of the Clayton Act, 15 U.S.C. § 4, which provides that "any person injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefore." See, e.g., Blue Shield v. McCready, 457 U.S. 465, 473 (1982). Antitrust standing differs from standing under Article III of the United States Constitution, in that antitrust plaintiffs must also prove that their injury is the kind that the antitrust laws seek to prevent, that is, an injury to competition. For a discussion of antitrust standing, see Associated Gen. Contractors, Inc. v. California State Council of Carpenters, 459 U.S. 519, 535 (1983). For a discussion distinguishing standing under Article III of the Constitution from standing under the antitrust laws, see Sanner v. Board of Trade, 62 F.3d 918 (7th Cir. 1995).
14. 925 F.2d at 1564.
ring, Judge Cudahy observed that plaintiffs had suffered "the very essence of antitrust injury. Although perhaps not a matter of major moment in dollars and cents, the merger and the related refusal to deal strike at the very heart of the evils addressed by the antitrust laws."\(^5\)

The federal government was not a party in *Nelson*, and no one sought to undo the merger. The opinion, as I mentioned, is not cited very often and has attracted little scholarly attention. But it demonstrates, more poignantly than academic debates about the exercise of market power, how mergers—even those that create significant potential for cost savings—can harm some health care consumers even as they benefit the majority. Thus, while the Nelsons may have been atypical in some ways—the daughter was mildly retarded, and perhaps the mother was unreasonably litigious; in others they were paradigmatic victims of health care consolidation—"high maintenance" patients, unprofitable to treat, time-consuming, and more demanding than most.

By placing the Nelsons' inability to receive treatment at the "heart" of antitrust, Judge Cudahy drew what was doubtless an unintentional distinction, but a meaningful one nonetheless. As noted earlier, courts, commentators, public agencies, and the business community have lately come to view the antitrust laws almost exclusively in terms of economic efficiency. Under these terms, if business transactions offer the promise of lower average prices for the relevant community of consumers, they are likely to pass antitrust muster, regardless of their social or political implications and despite their adverse impact on isolated groups of disadvantaged consumers. Judge Cudahy's reference to antitrust's "heart" not only implies that the laws have economic concerns at their core, but also suggests that they have "emotional," socio-political components, in addition to the more obvious rational and economic ones. For him, it was not enough that the merger in Monroe may have lowered prices for most consumers, because it also created a firm with the power to exclude "undesirables" from the market altogether. *Nelson* implicitly recognizes that even though mergers and other forms of competitor collaboration can achieve important benefits for the majority of consumers, they can also create providers that can safely ignore the needs of the uninsured and the hard-to-treat.\(^6\)

15. *Id.* at 1568 (Cudahy, J., concurring).
16. *Id.* According to a report released on December 20, 1995 by Georgia State University's Center for Risk Management and Insurance Research, Georgia is among the states with the highest percentage of residents under 65 years of age who have no health insurance. Eighteen percent of Georgians under 65 have no health insurance, compared to 20% of Floridians, 20% of Mississippians, 21% of Louisianans, 22% of Alabamians, 23% of Californians, 26% of New Mexicans, and 27% of Texans. 4 BNA HEALTH CARE POLICY REPORT (Jan. 26, 1996).
In today's health care markets, however, the sentiments expressed in Nelson seem anomalous. The related economic concerns of cost and efficiency dominate the national debate about health care. A national consensus holds that health care costs are too high and that something must be done to lower them. The private market's answer has been to compete as never before. Driven by newly-powerful managed care groups to reduce their prices, hospitals, physicians, prescription manufacturers, and other providers are merging, expanding, and collaborating in unprecedented fashion. The federal government seems on the verge of major Medicare and Medicaid reform.

Understandably, the rapid pace of these momentous changes has provoked anxiety in many quarters. Afraid of being left behind and eager to compete at full tilt, some incumbents oppose any constraints on consolidation. Others, equally fearful but more risk averse, would like to keep their more aggressive rivals from disturbing the economic status quo. These shared fears have led industry lobbyists representing the market's most powerful incumbents—organized medicine, hospital associations, and pharmaceutical groups—to unite against a common enemy, the federal antitrust laws. Convinced that antitrust doctrine is too vague to provide sufficient guidance to the business community, that federal agencies do not appreciate the "special" characteristics of health care markets, and that the decisions of federal courts and agencies are so capricious that they deter providers from embarking on socially useful collaborations, these lobbyists have complained long and loud to the antitrust enforcement agencies, Congress, and state legislatures.17

These efforts have borne fruit. Since 1992, approximately twenty states have enacted laws intended to exempt health care providers from

17. The most recent effort at federal legislative reform, is H.R. 2925, the "Antitrust Health Care Advancement Act of 1996," introduced on February 1, 1996. It provides in substance that the rule of reason shall apply to exchanges among health care providers of information regarding "costs, sales, profitability, marketing, prices, or fees," provided that the exchange is reasonably related to "establishing a health care provider network." H.R. 2925, 104th Cong. § 2(a)(1). By securing the application of the "rule of reason" to these kinds of provider arrangements, this legislation would depart from traditional antitrust analysis, by replacing the "strong" per se rule (that condemns collective price-fixing efforts without inquiry into their purpose or effect) with the weaker rule of reason (that permits that kind of inquiry). For a fuller discussion of these analytical alternatives, see National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679 (1978).

18. "The hospital industry and others in the health care sector have actively sought the enactment of state laws that would grant immunity from federal and state antitrust enforcement actions related to mergers, joint ventures, and other agreements that could fall under the antitrust statutes." GENERAL ACCOUNTING OFFICE, PUB. NO. GAO/HEHS94-220, HEALTH CARE—FEDERAL AND STATE ANTITRUST ACTIONS CONCERNING THE HEALTH CARE INDUSTRY (Aug. 5, 1994).
federal antitrust law. Some of these statutes, often called "provider cooperation laws," apply only to rural health care providers; while most apply to all providers, many have been enacted in states with large rural populations and will have a significant impact on rural markets. Each law substitutes a state regulatory regime for federal oversight and seeks to immunize from federal liability mergers, joint ventures, and other provider agreements that would otherwise violate the antitrust laws.

Two premises underlie these state reform measures. The first presumes that the federal antitrust laws prevent efficiency-enhancing collaborations and that, by displacing the federal regime, states can encourage health care firms to generate cost savings that they in turn will pass on to consumers. The second presumes that rural markets in particular will benefit from the continued presence of their "traditional" health care providers now threatened with extinction and that provider cooperation laws will resuscitate firms that would otherwise perish.

These are laudable goals, but they are ill conceived and mutually inconsistent. As I shall argue in the following pages, these new laws are unresponsive to the major problems of rural communities, unnecessary to facilitate provider cooperation, and administratively unworkable. They benefit existing, inefficient providers and work against the emergence of new forms of health care. They threaten to harm consumers, especially "marginal" ones. Moreover, the appearance of these laws coincides with two developments that seem to make antitrust reform superfluous. Since 1993, federal agencies have gone to extraordinary lengths to spell out their enforcement policies in the health care field and to assure health care providers that the large majority of their collaborative efforts will pass unchallenged. At the same time, federal courts have substantially changed their view of health care markets, effectively making it much more difficult for enforcement agencies to bring successful challenges to mergers and joint ventures.

II. THE CHANGING HEALTHCARE MARKETPLACE

In the past ten years, an outbreak of competition has dramatically altered the shape of health care markets in this country. Hospitals in general, and public hospitals in particular, have come under severe pressure to lower costs. The growing bargaining power of managed-care plans, along with the public clamor to reduce health care expenditures, have forced hospitals to compete in order to survive. Large

employers and other well-organized groups have become informed and aggressive buyers, pitting hospital against hospital and demanding and obtaining discounted rates for the full range of hospital services. Even nonprofit health insurers are merging so they can compete effectively for large managed-care contracts.\textsuperscript{21}

At the same time, doctors and allied health care providers have intensified earlier efforts to compete directly with hospitals in areas of potential profitability. They have formed health care networks, established free-standing laboratory and diagnostic facilities, opened emergency care centers, and developed outpatient surgery clinics. Because these outpatient facilities are smaller and less expensive to operate than hospitals—having fewer employees, lower fixed costs, and no community service obligations—their owners can concentrate on providing a single service efficiently, finding inexpensive locations in relatively affluent neighborhoods, and pricing their services at levels much lower than hospitals can bear.\textsuperscript{22}

Hospitals have responded to these unsettling developments in a variety of ways. Some have cut costs drastically. Others have opened their own outpatient facilities or moved into new product and geographic markets.\textsuperscript{23} Still others have formed alliances with health care net-

\textsuperscript{21} See, e.g., Robert Tomsho, Blue Cross Plans in Texas, Illinois Intend to Merge, WALL ST. J., Jan. 31, 1996, at B3. (The article reports that Blue Cross/Blue Shield plans face "increasing pressure from for-profit insurers and health-maintenance organizations in the tumultuous race to land managed-care contracts." Since last fall, Blue Cross/Blue Shield plans in Cincinnati and Indianapolis have merged, as well as a pair of plans in Tennessee; six plans in New England have formed a joint venture in anticipation of their eventual merger. Nationwide, since 1985 the number of Blue Cross/Blue Shield plans has decreased from 86 to 66.)


Outpatient settings are cheaper places to treat people because there is not the same overhead for expensive services like round-the-clock nursing, operating theaters and kitchens that figure into the cost of care in a hospital. "If you had to think of what would be the worst place to provide accessible, ambient, efficient primary care it would be a hospital," said Dr. Robert G. Newman, president and chief executive of Beth Israel Medical Center.

\textsuperscript{23} See, e.g., id. ("As hospitals have seen inpatient revenues steadily erode, they have begun sprucing up and expanding outpatient services," a trend that is the "result of fierce
works. Over the past two years, hospital mergers have proceeded at a dizzying pace,\textsuperscript{24} consolidating the industry in significant measure, while leaving unaffiliated hospitals at substantial competitive disadvantage. Those unable to adapt have been left to perform increasingly unprofitable services on a sicker and under-insured patient population.

In addition to these powerful competitive pressures, hospitals face the prospect of drastically reduced funding from Medicare and Medicaid.\textsuperscript{25} Congressional leaders continue to quibble over the exact size of what most agree will be a sizeable cut in projected Medicare spending over the next seven years, approximately one-fourth of which will come directly from lower payments to hospitals. Further cuts are anticipated for services such as home health agencies, which many hospitals own. If this first round of reductions yields insufficient savings, Congress may reduce Medicare payments to hospitals even further.

Congress has also proposed lowering Medicaid funding by approximately $182 billion. If this proposal is enacted and if states respond predictably, by refusing to allocate additional funds for their Medicaid programs or tightening eligibility rules and lowering payment levels, the ranks of the uninsured will swell and more will likely turn to hospitals as providers of last resort. In earlier, precompetitive times, many hospitals cross-subsidized the costs of uncompensated care by including those costs in the rates charged to private insurers. But in the current climate, private payers are unwilling to tolerate higher prices for their insureds in order to subsidize those unable to pay for care. Therefore, hospitals committed to serving the disadvantaged must absorb more of those costs, stretching their thin financial resources closer to the breaking point. "The question," according to a senior vice president at the American Hospital Association, "isn't whether hospitals will close but which ones."\textsuperscript{26} The answer seems painfully obvious.

These developments have aggravated problems brewing for years. For nearly a decade, hospitals have been closing at the rate of approximately fifty per year. Analysts predict that this rate could double or triple as competitive and financial pressures intensify.\textsuperscript{27} Hospital utilization is competition in the medical industry, where managed-care companies emphasizing preventive and outpatient care have waged a relentless drive to cut costs.")}
also decreasing. Admissions, average length of stay, and inpatient days per one thousand people have all dropped significantly in the past five years\textsuperscript{28} while occupancy rates are at their lowest level in decades.\textsuperscript{29}

Though these changes affect all of the nation's 5100 hospitals, rural hospitals suffer disproportionately. According to the American Hospital Association ("AHA"), the most financially fragile hospitals—some 1600 in number—are those deriving 75% or more of their patient volume from Medicare and Medicaid. Rural hospitals, especially smaller ones, comprise a large share of this number and are therefore "most at risk of closure."

A recent study of rural hospitals with 50 or fewer beds found that there are 1041 such hospitals in this country—approximately 18% of all general hospitals and a "major portion" of rural hospitals. Statistics compiled by the AHA indicate that 389 rural hospitals closed between 1980 and 1992; two-thirds closed after 1987.\textsuperscript{30} Community health status may be the most immediate casualty of those closures, but the financial plight of rural hospitals jeopardizes more than just access to health care. Because the rural hospital is one of the largest employers in its community, its continued existence is critical to local economic vitality, not only as a source of jobs, but also in the wider competition to attract new business.\textsuperscript{31}

\textsuperscript{28} See MUTUAL OF OMAHA INS. CO., CURRENT TRENDS IN HEALTH CARE COSTS & UTILIZATION (1993 & 1995 eds.).

\textsuperscript{29} See Witnesses at FTC Examine Analysis of Efficiencies in Health Care Sector, 69 Antitrust & Trade Reg. Rep. (BNA) No. 1737, at 550 (Nov. 9, 1995) (testimony of Richard L. Scott before FTC). For hospitals nationwide, the average occupancy rate is approximately 64%; in many rural areas, of course, the rate is much lower.


\textsuperscript{31} Fred Bayles, Rural Hospitals Turn to Innovation to Survive as Hundreds Close Doors to Medicine, L.A. TIMES, Sept. 18, 1994, at A28.

\textsuperscript{32} California law, for example, expressly recognizes the role played by rural hospitals in community development. See CAL. WELF. & INST. CODE § 14132.77(c) n. § 1 (1995):

The rural hospital is often one of the largest employers in the community. The closure of such a hospital means the loss of an employer and negative economic impact beyond the health sector. Further, economic development of a rural area is, in part, tied to the existence of a hospital. For example, people tend to retire to areas where there is reasonable access to physician and hospital-based services.

In a similar vein, a report commissioned by the Greater New York Hospital Association estimates that pending proposals to cut federal health care spending by $452 billion over the next seven years would curb the growth of both jobs and personal income across the entire United States economy. According to the report, implementation of the proposed budget cuts would result, over the next seven years, in the creation of 2.3 million fewer jobs and a reduction in personal income of 1.7%. Ron Winslow, Health-Care Study Looks at
The findings of the AHA study mirror conclusions reached by state-sponsored inquiries focusing on rural hospitals. Among its major findings, a 1989 study prepared for the Minnesota legislature reported that (1) between 1985 and 1987, five rural hospitals closed, 4% of all Minnesota hospitals; (2) twelve other rural hospitals were in "precarious financial condition"; and (3) many other rural hospitals were "financially vulnerable" and could be forced to close. The study also found that small rural hospitals were "especially hard hit" during the study period—admissions fell 27%, patient days fell 36%, and the average occupancy rate dropped from 32% to 21%. Moreover, it seems likely that in the decade since the study period, prospects for rural hospitals have worsened. A Florida study undertaken in 1993 reported that half of the state's statutory rural hospitals were in financial difficulty.

Hospitals are not the only health care providers to feel the effects of the changing marketplace. Physicians complain publicly about the "problematic" financial incentives that accompany the widespread growth of aggressive managed-care arrangements—the doctors' loss of independence, the disincentives to refer patients to specialists, and the risk-selection process by which large HMOs seek to attract healthy

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members and discourage the less healthy from joining. Moreover, many rural counties suffer from a serious shortage of doctors. In Missouri, for example, almost half the state's counties, many of them rural, have been designated as Health Professional Shortage Areas by the Federal Public Health Service; six counties have no primary care physician whatsoever. Rural counties in Florida have approximately half as many physicians per resident as urban counties. Indeed, the scope of the problem is hemispheric; a 1995 report by the Canadian Health Ministry stated that "physicians are leaving rural Ontario hospitals in droves."

III. THE STATE RESPONSE TO CHANGING HEALTH CARE MARKETS: ANTIMONOPOLY REFORM

Because of the threat they pose to the survival of rural communities, the problems in rural health care have naturally attracted many responses and provoked much finger pointing. To many, the troubles of rural markets mirror those of the wider marketplace and are thought to require systemic legal reform. Although most people concerned about solving these problems recognize that their causes are deep-seated and numerous, some powerful interest groups have nevertheless singled out certain supposed causal factors for particularly harsh criticism. Prominent among the alleged culprits is federal antitrust policy.

Over the past twenty years, a chorus of representatives from the hospital industry, pharmaceutical manufacturers, and organized medicine have charged that federal antitrust laws and the agencies that enforce them have prevented health care providers from adapting efficiently to the many changes affecting their industry. Industry spokespeople have claimed that federal enforcement, especially in the


37. Richard Orr, Health-Care Reform Proposals Don't Address Shortage of Rural Doctors, Chicago Tribune, June 27, 1994, at M3.

38. See Platt, supra note 35, at 497 n.122. These shortages would likely be exacerbated if a pending immigration bill becomes law. Under the measure, employers hiring foreign recruits would be required to pay a tax of $10,000 or 10% of the recruit's first-year salary, whichever is greater, a requirement that would, among other things, further handicap the efforts of rural areas—many of which rely heavily on foreign-born doctors to staff their hospitals—to attract physicians. See Almar Latour, How Curbing Immigration Could Hurt Health Care in Inner Cities, Rural Areas, Wall St. J., Mar. 5, 1996, at B1.

areas of hospital mergers and physician joint ventures, has been overzealous, erratic, and unpredictable. They have regularly urged enforcement agencies to take a more benign view of industry consolidation, petitioned Congress for statutory exemptions from the antitrust laws, and lobbied state legislatures for "antitrust reform."

In response to these efforts, since 1992 more than twenty states have enacted legislation enabling health care providers to cooperate with one another or consolidate their operations in ways that might otherwise violate the federal antitrust laws. In one form or another, these statutes seek to shield provider collaboration from federal scrutiny by taking advantage of the so-called state-action doctrine, a common law construct immunizing certain state-regulated activity from antitrust liability.

Under that doctrine, if a state legislature announces a clear...
intention to displace competition with a regulatory regime or with state-sanctioned cooperation among competitors, the state-sponsored mechanism is immune from federal antitrust challenge provided that the state actively supervises its workings.\textsuperscript{45}

The range of activities covered by the various provider cooperation laws differs substantially from state to state. Oregon's law, for example, covers only hospital joint ventures related to heart and kidney transplant services; and each joint venture must include the state teaching hospital as a participant.\textsuperscript{46} Minnesota's law, by comparison, covers a wide array of providers and collaborative activities.\textsuperscript{47} Some statutes authorize immunity only for hospital joint ventures, others confer it on joint ventures and mergers, and one—Georgia's—applies to mergers only.\textsuperscript{48} The approval and review mechanisms established by the various laws also differ significantly. In some states, the Attorney General is the approving authority for proposed consolidations, but in others, a state regulatory agency performs that function.\textsuperscript{49} Some states have elaborate lists of relevant criteria that regulators must balance in the approval process,\textsuperscript{50} and others give the approval authority only the most general kind of guidance.\textsuperscript{51}

\textsuperscript{45} For a fuller discussion of the state-action doctrine, see HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE 676 (1994). Other scholars have questioned whether particular efforts at state reform will pass muster under the state-action doctrine. See, e.g., Sarah S. Vance, Immunity for State-Sanctioned Provider Collaboration After Ticor, 62 ANTITRUST L.J. 409, 421-23 (1994); James F. Blumstein, National Health Care Reform on Trial, 79 CORNELL L. REV. 1459, 1504-05 (1994); Ilene Gotts, Health Care Joint Ventures and the Antitrust Laws; A Guardedly Optimistic Prognosis, 10 J. CON. HEALTH L. & POLY 169 (1994). While this question is both interesting and important, especially in light of the United States Supreme Court's recent elaboration of the state-action doctrine in Ticor, this paper proceeds on the assumption that the new laws can achieve the desired immunity, but asks instead whether that immunity is necessary to permit the kind of useful collaboration most conducive to consumer welfare.

\textsuperscript{46} See 1993 OR. LAWS § 14, ch. 769.


\textsuperscript{48} See 1993 Ga. Laws 1020 (codified at O.C.G.A. § 31-7-72.1 (1996)).

\textsuperscript{49} Compare Idaho, for example, with Washington.


\textsuperscript{51} See, e.g., O.C.G.A. § 31-7-72.1 (1996).
As mentioned earlier, some of the new laws apply only to rural health care providers. Florida's statute is an example. Its announced intent is to "foster the development of rural health networks" by encouraging the consolidation of hospital services and technologies and other kinds of cooperative arrangements among rural providers "when such arrangements improve the quality of health care and moderate cost increases." To this end, the law acknowledges that it is replacing "competitive market forces . . . with state regulation," establishing an agency review process for proposed consolidations and cooperative agreements, and declaring that the statutory scheme is designed to protect state-approved transactions from the federal antitrust laws.

In addition to Florida, several other states—New York, Washington, Colorado, and Kansas—have passed statutes permitting rural health care providers to collaborate and consolidate free of the constraints imposed by federal antitrust law. Though phrased differently, the statutes all express concern about the detrimental effects of unregulated competition on rural consumers. The New York legislature, for example, found that "changes in reimbursement policies, the emergence of alternate service providers, and public pressure to control health care costs" have had a "particularly severe impact on rural health care delivery" and threaten seriously to "reduce access to quality health care services by individuals in rural environs." In a similar vein, the Washington legislature declared that it is not "cost-effective, practical, or desirable to provide quality health and hospital care services in rural

52. FLA. STAT. ch. 381.04065(1) (1995). The Act defines a "rural health network" as a "non-profit legal entity, consisting of rural and urban health care providers and others, that is organized to plan and deliver health care services on a cooperative basis in a rural area." FLA. STAT. ch. 381.04065(2)(C) (1995). It defines a "rural" area as "one with a population density of less than 100 individuals per square mile or an area defined by the most recent United States Census as rural." FLA. STAT. ch. 381.04065(2)(a) (1995).


54. Id. See also Washington Health Service Act, WASH. REV. CODE § 43.72.300-.310 (1994):

The legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and cost- efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

WASH. REV. CODE § 43.72.300(1) (1994).

55. See supra note 43.

56. N.Y. PUB. HEALTH § 2950(1), (2) (Consol. 1994) ("Legislative Findings").
areas on a competitive basis because of limited patient volume and geographic isolation.\footnote{57}

Provider cooperation laws have already attracted criticism from a variety of quarters. Some scholars doubt whether, in design or practice, they will satisfy the criteria of the state-action doctrine.\footnote{58} Some also question the wisdom of reviving state regulatory regimes for health care providers, in light of the general failings of the certificate-of-need programs popular in the 1970s and early 1980s.\footnote{59} Still others see the laws as a misguided exercise in "interest group appeasement."\footnote{60}

I, too, am critical of provider cooperation laws, but for different reasons. In my view, antitrust reform has little relevance to the problems facing poor rural communities and is unnecessary to foster the kind of consolidation that the laws hope to encourage. Moreover, if a regulatory model is thought more conducive than a competitive one to the achievement of lower costs and continued service, states should regulate the prices and services of all providers, not the structures of episodic consolidations. Finally, the premise that state antitrust reform is necessary to counteract the inhibitory effect exerted by the federal antitrust laws on efficient mergers and joint ventures runs counter to the facts. A consolidation movement is sweeping the healthcare industry; more mergers and joint ventures have occurred in the past two years than ever before, seemingly undeterred by either federal enforcement policy or the supposed ambiguity of antitrust doctrine. In fact, from the perspectives of both policy and law, health care antitrust law has lately moved decidedly in the direction of permitting ever larger degrees of provider and payor consolidation.

A. Antitrust Reform Will Not Solve the Important Problems Facing Rural Markets

By all accounts, the critical health problem confronting rural communities is the loss of access to care, a problem especially acute in areas with large Medicare and Medicaid populations. Communities at greatest risk typically have one hospital, under-utilized and on the brink of financial failure, and a few elderly physicians nearing retirement.

\footnote{57} WASH. REV. CODE § 70.44.450 (1995) ("Notes; Intent").
\footnote{58} See supra note 45.
These communities are unable to attract new physicians and fear, with good cause, that when the older ones retire their hospitals will close and their residents will need to travel long distances, if they are able to do so, to receive medical treatment.

These are serious problems, but not the kind that concern antitrust enforcement agencies. Antitrust law chiefly seeks to prevent the unfair accumulation and abuse of market power and, thus, to preserve for consumers the lowest possible prices, highest possible output, and broadest range of products (or services) and quality. To these ends, the law proscribes combinations that restrain trade and mergers that might lessen competition or create a monopoly. Hospitals in rural communities facing acute health care crises are closing, not merging, and are impotent, not powerful. With high vacancy rates and aging facilities, they present an unattractive picture to potential merger partners. By the same token, physicians in those communities are retiring, not forming joint ventures. Cooperative provider activity is simply not occurring, and individual activity is on the verge of shutting down.

Moreover, rural communities are not populous enough to realize the full range of competitive benefits possible from the formation of health care networks. A study in The New England Journal of Medicine found that consumers buying service from health care networks realize the largest amount of competitive benefit—the lowest prices and the greatest range of choice—when they live in a market with three or more competing networks. The study also found, however, that only forty-two percent of the United States population lives in markets sizeable enough to support three efficient full-service provider networks. Twenty-nine percent of the population, those in less populated areas, reside in markets capable of supporting no more than one such network.

Because federal antitrust enforcement agencies have never challenged collaborative efforts to resurrect dying markets and have no intention of

61. Market power is generally defined as the ability to raise price above competitive levels without losing sales sufficient to make the price rise unprofitable. For a full discussion of the role of market power in antitrust analysis, see George A. Hay, Market Power in Antitrust, 60 ANTITRUST L.J. 807 (1992). Hay states that "[t]he concept of market power is at the core of antitrust." Id. at 807.


63. Section 7 of the Clayton Act, 15 U.S.C. § 18 (1988), prohibits any merger or acquisition the effect of which "may be substantially to lessen competition, or to tend to create a monopoly," in any line of commerce in any section of the country.

doing so now, the immunity bestowed by provider cooperation laws is irrelevant to many rural communities. And because many rural areas are too small to support competitive markets, provider cooperation laws are unlikely to increase the range of choice available to their residents. Immunizing nonexistent mergers and small-scale joint ventures from antitrust scrutiny will neither supply the funding nor create the cost savings necessary for the survival of small-town providers. Other initiatives—fostering the development of purchasing cooperatives, for example—might help rural hospitals reduce costs and achieve some scale economies, but antitrust reform is no solution to the deep-seated financial problems plaguing rural health care.

At bottom, of course, the critical issue is funding. The communities most at risk of losing their provider base lack the resources either to support existing providers or attract new ones. They cannot afford to maintain health care services at previous levels, but at the same time they cannot bear to close them down. States could subsidize these services directly on the premise that, for reasons of social policy, rural health care should continue to exist in its present form despite its unprofitability. But direct subsidies are not popular in the current political climate, and their enactment, in any event, would likely entail a difficult and painful debate about the political and mythic importance of the countryside and the economic wisdom of supporting institutions that cannot support themselves, topics too sensitive for most legislatures to tackle openly. Seen from this vantage point, the provider cooperation laws may represent a politically expedient, albeit empty, gesture to rural constituencies.

In a strong sense, moreover, rural health care problems are a subset of the larger problem of health care for indigents. They are not special, unique, or more deserving of attention than the health care needs of other indigent communities. People of means, regardless of where they live, will almost always receive tolerably good health care. Poor people, no matter where they live, will almost always lack tolerable health care. In my opinion, we have a societal obligation of the highest importance to care for the basic needs of all indigent people, regardless of their

65. See discussion infra part VI (regarding joint Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust).
66. See infra text accompanying notes 164-71 (discussing Marshfield Clinic and natural monopoly markets).
67. This debate, moreover, would embrace many aspects of rural economic life, from farm subsidies to health care to universal access to developing communications systems to mass transportation.
residence. But this obligation is no more pronounced in the case of poor rural communities than in the case of poor urban ones.

B. Legislative Efforts to Preserve Failing Rural Hospitals Are Themselves Doomed to Fail

Many of the provider cooperation laws are animated by a desire to preserve existing institutions in their current form and location. They explicitly instruct state regulators reviewing applications for cooperative agreements to consider as a benefit of a proposed collaboration the prospect that "a hospital, if any, and health care facilities that customarily serve the communities in the area [affected by the agreement] . . . will be preserved."\(^{68}\) Though doubtless well intentioned, the goal of preserving rural health care institutions will likely prove impossible to accomplish at reasonable cost and could constitute an impediment to useful changes in rural health care markets.

Compared to potential alternatives, rural hospitals are very expensive to operate. They own large buildings with expensive equipment, offer a wide range of services, staff a large number of beds, and employ a relatively large workforce. As an historical artifact, this is understandable; for several generations hospital construction was subsidized by one federal program,\(^ {69}\) while hospital services and equipment purchases were subsidized by others. The federal subsidies have largely ended, though, and many of their former beneficiaries are now drastically under-utilized and very unprofitable.

Smaller outpatient clinics and mobile diagnostic and treatment facilities could doubtless perform many services offered by these hospitals at a fraction of the cost.\(^{70}\) Free-standing emergency care centers can offer low cost substitutes to hospital emergency rooms. Indeed, larger medical clinics and hospitals from big cities have begun to open satellite offices in rural areas—partly to serve patients on site, but mainly as a referral source for their urban operations.\(^{71}\) Video teleconferencing enables entrepreneurial specialists to provide consultation and treatment to patients nearly three hundred miles from their


\(^{70}\) See Fein, supra note 22.

\(^{71}\) See infra text accompanying notes 144-54 (Mercy Health Systems discussion).
Given the current rate of technological and organizational change, additional options must lie just over the horizon.\footnote{Bill Richards, Hold the Phone: Doctors Can Diagnose Illnesses Long Distance, To the Dismay of Some, WALL. ST. J., Jan. 17, 1996, at A1.}

If the experience of other markets offers any insights about the future of health care, we can be cautiously optimistic that providers will probably find less expensive ways of serving rural populations. Preserving old, expensive, unprofitable hospitals is a nostalgic notion with a high price tag and is incompatible with a desire to lower costs. Moreover, unless the new generation of less expensive providers is not actively prevented from entering rural markets, the efforts to preserve older, high cost institutions are bound to fail. Instead of fighting the development of new health care arrangements and seeking vainly to preserve the past, states should encourage new providers to enter rural markets.\footnote{For a glimpse of the future, see G. Bruce Knecht, Click! Doctor to Post Patient Files on Net, WALL ST. J., Feb. 20, 1996, at B1 (describing the efforts of a West Virginia doctor to load his patients' records onto the Internet, and the various benefits that he believes will ensue).}

There is a potential social cost, of course, associated with the innovative economic efficiencies likely to develop in a more fully-competitive rural health care market. Older, full-service hospitals may be more expensive to operate than smaller, mobile outpatient facilities, but their public ownership and public-mindedness have led them to offer a wide range of services to the poor, the uninsured, and the unprofitable. Privately owned facilities will be much less inclined, completely disinclined, perhaps, to serve these populations without “adequate” compensation; in markets without public providers, the private sector's refusal to serve those populations would mean that they will go unserved.

This is a difficult problem, but it has received almost no attention from recent state reform legislation. Understandably, legislative lip service is sometimes paid to the notion of preserving providers with long-standing community ties. And concern is repeatedly expressed for the general goal of maintaining patient access. But no provisions are made for funding public hospitals, converting them to lower-cost, free-standing facilities, or assuring that the private sector will effectively pursue the

\footnote{This encouragement can take a variety of forms: seed money for new providers; a state-run bidding process for the right to serve small (natural monopoly) rural markets, coupled with conditions requiring service for the uninsured; state-provided transportation to tertiary care centers for patients needing advanced care who are unable to transport themselves.}
public goal of providing necessary health care to those who cannot afford to buy it.

Some older forms of state regulation have attempted more directly to address this problem. For example, Maryland's all-payer rate-setting program, in effect since 1974, has drawn praise for controlling costs and maintaining quality of care, while simultaneously expanding access to services for the uninsured.\(^5\) Pervasive regulatory efforts, like Maryland's, are not without problems, and their large bureaucracies and disregard for market dynamics would almost certainly disqualify them from serious consideration in today's political climate. But they are attentive to the social value of universal health care, an attentiveness notably absent from the recent efforts at antitrust reform.

IV. PROVIDER COOPERATION LAWS AFFORD LITTLE PROTECTION FROM ANTICOMPETITIVE COLLaborATIONS

Of course, rural markets are not all alike. Some may have more than one hospital, and others may have a relatively large number of physicians. In numerical terms, it is unclear whether these more vibrant markets constitute a significant portion of rural markets generally. It is also unclear whether the competitive and financial forces jeopardizing the survival of sole-provider markets pose an equally grave threat to multiprovider communities. It is clear, though, that some multiprovider, rural markets present possibilities for competitor collaboration that are nonexistent in smaller markets. In these multiprovider communities, health care entities may not confront the prospect of near-term extinction and may reasonably contemplate merging or collaborating with their competitors for a variety of reasons both good and bad.

The explicit premise of the provider cooperation laws is that immunity from the federal antitrust laws is necessary to encourage useful and efficient forms of provider collaboration. The unspoken premise is that all efforts at collaboration are useful and efficient. From the perspective of health care consumers, this is a dangerous presumption. The blanket approval of all efforts at competitor collaboration would threaten consumers with higher prices, reduced services, or both. The review processes created by the new laws, however, promise to approve every proposal they encounter.

Florida's law, for example, places no effective barriers in the way of provider collaboration. After receiving a proposed agreement from

would-be collaborators, the state's Agency for Health Care Administration must decide whether "the likely benefits resulting from the agreement outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement."\(^7\) The agency must approve the proposal if it "reduces or moderates costs" and satisfies any of the following criteria:

(a) consolidates services or facilities in a market area used by rural health network patients to avoid duplication;
(b) promotes cooperation between rural health network members in the market area;
(c) encourages cost-sharing among rural health network facilities;
(d) enhances the quality of rural health care; or
(e) improves utilization of rural health resources and equipment.\(^7\)

Read literally, the statutory language suggests that if a proposal promises to reduce or moderate cost in any amount, no matter how small, it will pass the first procedural hurdle. But every merger and joint venture can plausibly offer to reduce some cost by aggregating purchasing power or eliminating overlapping personnel. The prospect of realizing these simple economies is one of the motivations for all mergers, but has special significance in hospital markets, where excess capacity in the form of overbedding and duplicative technology is a common fact of industry life. Because every collaboration, regardless of its impact on consumers, can honestly promise to achieve some efficiency, the first part of the Florida test will eliminate nothing, and agreements satisfying any of the five criteria enumerated in the second part of the test will therefore receive agency approval.

The first three of those criteria effectively reformulate the requirement that the proposed agreement reduce or moderate costs. Thus, the law requires approval of agreements that, in addition to reducing or moderating costs, (1) "consolidate services or facilities . . . to avoid duplication," (2) "promote cooperation" between the signatories, or (3) "encourage cost-sharing" among cooperating facilities.\(^7\) As noted above, the first element underlies almost all collaborative undertakings. The second element is tautological and, it would seem, automatically satisfied because interfirm agreements presume and depend upon the cooperation of the participants. The third element, cost-sharing, largely recapitulates the first, the avoidance of duplication. Any agreement

\(^{76}\) FLA. STAT. ch. 381.04065(2) (1995).
\(^{77}\) Id. at 2(a)-(e).
\(^{78}\) Id. at 2(a)-(c).
incapable of satisfying one of these criteria would be very unorthodox indeed.79

The final two criteria may be harder to satisfy, but are also very difficult for the agency to apply. If, improbably, applicants cannot satisfy any of the other statutory requirements, they can, and will, obtain agency approval by showing that their proposal promises to “enhance the quality of rural health care” or “improve utilization of rural health resources and equipment.”80 The obvious ambiguities of these requirements—How is quality measured? What constitutes “enhancement” of quality? Does “improved” utilization mean more utilization or less; higher quality or lower?—make their application imprecise and uncertain, thereby raising the odds of agency approval.81

The language of Florida’s statute is more permissive than most other reform legislation. In other states, pre-approval review entails an ostensibly more stringent inquiry into the likely competitive impact of the proposed agreement. The South Carolina law, for example, is typical in requiring that applicants demonstrate that “the likely benefits resulting from the agreement outweigh the likely disadvantages.”82 To this end, it directs the reviewing agency to consider no less than nine categories of potential benefit, five categories of potential disadvantage, and to determine that “any reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result.”83

Although laws like South Carolina’s require greater administrative attention to prospective competitive harms, they present problems of their own. Without specifying the weight to be accorded particular categories of benefit and disadvantage, they command regulators to compare the pluses of promised efficiencies and provider preservation with the minuses of reduced competition. This process of comparison arguably raises some of the difficulties ascribed to proposals for judicial consideration of potential efficiencies in merger and joint venture analysis, proposals fraught with conceptual and practical difficulties and widely thought to decrease the predictability of antitrust law.84

79. Id.
80. Id. at 2(d), (e).
81. Id.
83. Id. § 44-7-560(A)(1), (2).
84. Antitrust scholars and commentators have been generally skeptical about applying efficiency considerations to the analysis of mergers and joint ventures. Judge Posner has argued that “although clearly relevant,” efficiencies are “intractable subjects for litigation.” Richard A. Posner, Antitrust Policy and the Supreme Court: An Analysis of the Restricted Distribution, Horizontal Merger and Potential Competition Decisions, 75 COLUM. L. REV.
Moreover, by attempting to mix efficiency analysis with the goal of preserving inefficient providers, the new laws burden state agencies with an impossible task. If the "need" to preserve local facilities is allowed to trump other factors—and political pressures in favor of playing this trump card will be hard to resist—proposed collaborations will likely encounter little in the way of regulatory opposition. But they are likely to sustain inefficient providers at some potential cost to consumers. Although trading off efficiency for continuity may sometimes be socially desirable, it may not be desirable in every case. And the new reform measures fail to provide any guidance for determining when continuity outweighs inefficiency or vice versa. If there is a bias in the process, it would seem to favor the preservation of existing providers because they are there, after all, and have a constituency that can lobby for them, thus jeopardizing the attainment of lower cost or more efficient care.

Under the new statutes, provider collaboration will be easier and occur more often than it would under a regime of federal antitrust enforcement, especially in markets where the federal laws deterred or prevented powerful firms from using cooperative arrangements as a cover for price-fixing agreements or market-allocation plans.85 In these markets, while the new laws will certainly make things easier for providers, they threaten to harm consumer interests by enabling powerful firms or groups to raise the prices of important services, lower the quality of all services,6 and eliminate unprofitable services essential to community well being.

In some respects, it is too early to assess the consequences of state reform efforts. According to recent reports, the pace of collaborative activity under the new laws has been relatively slow, except in Washington, New York, Florida, California, and Minnesota—states in which health reform activities occupy a prominent place on the political

282, 313 (1975). Robert Pitofsky, the current Chairman of the Federal Trade Commission, agrees, acknowledging that "[m]ost efficiencies are exceptionally difficult to measure." Robert Pitofsky, Proposals for Revised United States Merger Enforcement in a Global Economy, 81 GEO. L.J. 195, 209 (1992). See also Alan A. Fisher & Robert H. Lande, Efficiency Considerations in Merger Enforcement, Hearings Before the Federal Trade Commission on Global and Innovation-Based Competition (Nov. 7, 1995) ("a case-by-case efficiencies defense is essentially unworkable and would significantly decrease predictability and increase litigation costs").

85. Assuming, for argument's sake, that the state agencies supervised the collaborators' post-approval activities in a sufficiently active fashion to satisfy the requirements of the state-action doctrine, an issue discussed more fully at supra text accompanying notes 43-60.

86. Subject, of course, to the limits of malpractice law.
agenda. But Washington's experience may provide a harbinger of the future. Reform legislation there spawned an "unprecedented number of alliances" among health care providers, leading the legislature to question the wisdom of broad antitrust immunity only two years after creating the mechanism for granting it. In 1995, it directed the Attorney General to report on whether federal antitrust immunity was still necessary in the current environment; the report, delivered last December, concluded that "economics do not seem to support an argument for immunity," and noted that, in compiling the report, the attorney general was "not presented with a single example by those in favor of immunity to support the existence of clear and measurable benefits to consumers that would result from activities permitted only if immunity is granted."

Why would states adopt these laws? Why stack the deck so heavily in favor of provider collaboration? And why, in the current antibureaucratic, deregulatory age, would they create new tasks for bureaucrats largely inexperienced in the workings of health care markets? The statutes themselves strongly suggest that the willingness to embark on these initiatives stems from the states' having embraced the health care industry's view that federal antitrust enforcement places unnecessary obstacles in the path of provider consolidation and rural health care reform. In my opinion, this view is mistaken. As the next section of this paper will discuss, the experience of the past several years offers strong evidence that federal antitrust law has not been an impediment to useful collaboration either in the health care industry generally or in rural markets in particular.

V. THE FRENZIED PACE OF CONSOLIDATION IN THE HEALTH CARE INDUSTRY

Many in the health care industry profess to believe that federal antitrust laws and enforcement policy have discouraged many mergers and joint ventures that would have proved beneficial to health care consumers. There is, however, little factual support for this belief. The frenzied pace of merger and joint venture activity in the health care industry over the past few years suggests that very little collaborative activity has been deterred.

88. Antitrust Immunity Not Supported by Data, Attorney General Concludes, BNA HEALTH CARE DAILY, Jan. 3, 1996.
89. Id.
The last two years have witnessed what industry analysts describe as a "frenzy" of merger activity.90 In 1994, more than 650 hospitals participated in a merger or acquisition, a record number. Reflecting on these numbers, one commentator remarked that "nothing in recent history seems to parallel the activity of 1994."91 Two Hundred Nineteen investor-owned, for-profit hospitals merged into other privately-owned chains; 301 other hospitals took part in 176 separate merger transactions.92 By comparison, data compiled by the American Hospital Association show that in 1993 there were 18 community hospital mergers, 15 in 1992, 23 in 1991, and 13 in 1990.93

But that was just a start. The record-breaking pace of 1994 was eclipsed by the even more feverish activity of 1995.94 Last year, 735 hospitals were involved in 230 mergers or acquisitions. Compared to 1994, there were fewer large corporate mergers but many more individual ones: 445 community hospitals took part in 224 transactions. As part of 44 transactions, 48 nonprofit hospitals became for-profit corporations; eight for-profits became nonprofit.95 Indeed, over the past two years, one in five community hospitals has changed hands.96

Hospitals have not been the only health care firms choosing to consolidate. In 1994, publicly traded HMOs completed 13 acquisitions totaling over $4 billion.97 If approved, the MetraHealth merger will create a multibillion dollar company that will be the country's largest provider of HMO services.98 Blue Cross Blue/Shield companies are expanding and restructuring themselves through merger.99 Shares in physician practice companies trade publicly on national exchanges: The Wall Street Journal has predicted that there will soon be ten large

90. See Sandy Lutz, Let's Make a Deal, MOD. HEALTHCARE, Dec. 19, 1994, at 47.
91. Id.
92. Id.
93. Id.
94. Nineteen ninety-five was a record-breaking year for domestic mergers and acquisitions generally, not only in hospital markets. Last year, United States companies announced 3521 mergers and acquisitions with an overall value of $355.7 billion; in 1994 there were 2958 with a value of $219.9 billion. See MERGERSTAT REV., Dec. 1995, at 1.
95. Sandy Lutz, Mergers and Acquisition Report, 1995: A Record Year for Hospital Deals, MODERN HEALTHCARE, Dec. 18, 1995, at 43). The report does not include data about management contracts or affiliation agreements between hospitals and managed care networks.
96. Id.
99. See Tomsho, supra note 21.
companies competing for a potential $200 billion market.\textsuperscript{100} And by virtue of its acquisition of Surgical Care Affiliates, Healthsouth Corporation, described as "the dominant player in rehabilitative services with nearly 500 facilities nationwide,"\textsuperscript{101} has become the nation's largest operator of outpatient surgery centers as well.\textsuperscript{102} Data on mergers is available because of the premerger notification and approval process established by the Hart-Scott-Rodino Act.\textsuperscript{103} While the Hart-Scott-Rodino Act does not apply to joint ventures, it seems likely that those transactions substantially outnumber mergers because they are less integrative and thus easier to undertake.

For reasons discussed above, the consolidation movement has not affected rural markets so dramatically as it has other, more profitable regions. Providers have generally expanded into small and mid-sized cities so they can offer the growing number of managed care organizations a comprehensive nationwide or regional network of facilities.\textsuperscript{104} What is clear, though, is that the health care industry as a whole is consolidating at an unprecedented rate, a fact that seriously undermines the claim of industry groups that antitrust law has discouraged the formation of efficient combinations.

VI. THE FEDERAL RESPONSE TO HEALTHCARE CONSOLIDATION

The fevered pace of collaborative activity in the health care industry has elicited very little challenge from the federal antitrust agencies,\textsuperscript{105} and even less in the way of reported litigation.\textsuperscript{106} The agencies have

\begin{itemize}
  \item \textsuperscript{100} George Anders, \textit{Physician-Practice Stocks Excite Some Analysts}, WALL ST. J., Nov. 15, 1994, at C1.
  \item \textsuperscript{102} Blackmon, supra note 103. According to Healthsouth's CEO, Richard M. Scrushy, the company plans to continue to acquire smaller surgical-center companies: "There are 2,000 surgical centers in the country," Mr. Scrushy said, [and] I'd say 1,300 of them are targets for acquisition.
  \item \textsuperscript{103} 15 U.S.C.A. § 18a (1995).
  \item \textsuperscript{104} Healthsouth, for example, is looking to own a surgical center and "at least" one rehabilitation center in every United States city with a population of more than 100,000. Its strategy is to use its expanded surgi-center division to "feed" recovering surgical patients into its rehabilitation facilities. Blackmon, supra note 103.
  \item \textsuperscript{105} In their Joint Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, the agencies note that they have challenged "only a handful of the hundreds of hospital mergers that have occurred in recent years." \textit{Department of Justice and Federal Trade Commission Statement of Antitrust Enforcement Policy in Health Care}, 4 Trade Reg. Rep. (CCH) P18,153, at 20,801.
  \item \textsuperscript{106} From 1989 through 1995, federal courts have decided seven merger cases: United States v. Carlilion Health Sys., 707 F. Supp. 840 (W.D. Va.), aff'd, 892 F.2d 1042 (4th Cir.
responded to this activity not, for the most part, by challenging its legality, but by providing regulatory guidance designed to alleviate the industry's often articulated fears of uncertain and irrational enforcement. In September 1993, and again in September 1994, "in order to resolve, as completely as possible, the problem of antitrust uncertainty that some have said may deter mergers, joint ventures, or other activities that would lower health care costs," the Department of Justice and the Federal Trade Commission together issued their Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust.\(^7\)

The Statements address nine areas of enforcement policy: (1) mergers among hospitals; (2) hospital joint ventures involving high technology or other expensive health care equipment; (3) hospital joint ventures involving specialized clinical or other expensive health care services; (4) providers' collective provision of nonfee-related information to purchasers of health care services; (5) providers' collective provision of fee-related information to purchasers of health care services; (6) provider participation in exchanges of price and cost information; (7) joint purchasing arrangements among health care providers; (8) physician network joint ventures; and (9) analytical principles relating to multiprovider networks.\(^8\) For all but the last category, the Statement sets forth "antitrust safety zones" describing activities or transactions that the agencies will not challenge, "absent extraordinary circumstances."\(^9\)

The section on hospital mergers is instructive. It states that "[m]ost hospital mergers and acquisitions . . . do not present competitive concerns."\(^10\) It provides a safety zone for mergers in which one of the merging hospitals "(1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years."\(^11\)

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108. Id. at S-3.

109. Although the Statements do not explicitly define the term, they state that, in the agencies' view, "extraordinary circumstances" will be "rare." Id. at S-5 n.2.

110. Id. at S-5.

111. Id.
It announces that mergers falling outside the safety zone "are not necessarily anticompetitive, and may be procompetitive." And it notes that "of the hundreds of hospital mergers in the United States since 1987, the agencies have challenged only a handful and in several cases sought relief only as to part of the transaction."

The safety zone established in this section effectively shelters the mergers of small rural hospitals most at risk of financial failure. In this respect, it amends and liberalizes the prior practice of applying the same analytical criteria governing mergers generally to hospital mergers. In addition, the section expresses, both explicitly and implicitly, an institutional reluctance to challenge mergers. Although it does not, and cannot, resolve the hard cases—mergers and other complicated transactions are too factually variable to allow for easy predictability of their legality—the section arguably offers as much certainty about the specifics of merger enforcement as guidelines can reasonably contain.

The same holds true for the other sections of the Statements. Joint ventures, the other major form of cooperative activity, receive substantial attention. Firms are informed that the agencies have never challenged a joint venture between or among hospitals. Safe harbors are defined, and attempts are made to identify threshold levels of concentration likely to arouse agency concern. Again, because joint ventures can and do take many forms, occur in a wide variety of health care markets, involve different degrees of integration, and contain widely differing potential for inflicting competitive harm, their evaluation, like that of most mergers, is necessarily fact intensive and highly resistant to formulaic analysis.

The Statements have encountered their share of criticism. FTC Commissioner Deborah Owen, dissenting from their issuance, argued that uncertainty about the precise scope of the antitrust laws does not justify sweeping, industry-specific exemptions from its application.
Scholars have complained that the Statements are ambiguous and fail to address the issues most likely to arise in the emerging managed care environment. Some practitioners have contended that the Statements have paradoxically “created more uncertainty regarding the permissible scope of physician and hospital networks.” But because health care networks are the newest of the emerging forms of organizational arrangements, their competitive consequences are admittedly the least understood. And, despite their criticism, all commentators acknowledge that the Statements represent the most determined attempt yet to specify the factors driving agency enforcement policy and the first such attempt ever addressed to the concerns of a particular industry.

The Statements are not the only form of enforcement and planning guidance that the agencies have provided to the industry. During the late 1980s and early 1990s, the FTC issued opinions, consent decrees, and advisory letters that served cumulatively to define the requisite structure and permissible scope of hospital mergers and physician joint ventures. In that same period, moreover, agency officials wrote dozens of articles and gave scores of speeches outlining their enforcement intentions and concerns, forms of advice that they continue to offer.

But the agency Statements are unique. No other industry has elicited its own set of antitrust guidelines, nor has any other been offered the sanctuary of explicit safety zones. For these reasons, the existence of the Statements goes a long way toward rebutting the charge that federal antitrust enforcement policy is arbitrary and unpredictable. To be sure, the Statements do not cover every conceivable situation. Given the inherent limitations of linguistic expression, the variability of markets and business arrangements, and the need for some semantic flexibility in legal standards, questions of interpretation are bound to arise. Since the issuance of the Statements, though, the agencies have questioned or challenged an extremely small percentage of the vast amount of relaxed enforcement fostered by the Statements posed the risk of “higher prices and reduced output or lower quality of care,” and that the premises underlying some of the Statements—that sufficient guidance had been unavailable and that past enforcement efforts had been unreasonable—“are simply insupportable.” Id.

120. See Grady, supra note 116.
121. See, e.g., Greaney, supra note 60.
collaborative activity that has occurred.Absent a declaration that they intend to approve every transaction that health care firms might propose, enforcement policy could hardly have been made more transparent.

The practical guidance provided by the policy Statements, coupled with the agencies' history of cautious enforcement, undermines one of the major rationales for provider cooperation laws and substantially weakens the case for state reform. As the next section argues, recent opinions of federal antitrust courts weaken that case further by demonstrating how changes in antitrust doctrine have made courts increasingly hospitable to collaboration and consolidation in health care markets.

VII. RECENT DECISIONS OF ANTITRUST COURTS APPEAR TO FACILITATE PROVIDER CONSOLIDATION

In the past six years, federal courts have decided a handful of hospital merger cases. The hospital industry's dissatisfaction with the earliest of these decisions apparently constitutes one of the main impulses for its lobbying efforts on behalf of provider cooperation laws. However, the more recent decisions demonstrate that federal courts have modified their views of health care markets in light of competitive developments, adopting more expansive definitions of the relevant areas of product and geographic competition, and have thus become less receptive to agency challenges to mergers and joint ventures.

Although mergers and joint ventures are governed by different antitrust statutes, their legality is determined by substantially

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123. See supra note 108.

124. See Greaney, supra note 60, at 150. For a discussion of the American Hospital Association's position on these earlier cases and its criticisms of merger policy generally, see Fredric J. Entin et al., Hospital Collaboration: The Need for an Appropriate Antitrust Policy, 29 WAKE FOREST L. REV. 107, 110 (Spring 1994) (“At best, federal antitrust policy is imprecise; at worst, it is affirmatively incorrect as it relates to hospital collaboration.”).

125. Most merger challenges are brought pursuant to Section 7 of the Clayton Act, which proscribes any merger whose effect "may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18 (1988). Section 1 of the Sherman Act, which applies to joint ventures and other forms of competitor collaboration, prevents "any contract, combination, or conspiracy ... in restraint of trade." 15 U.S.C. § 1 (1988). Section 1 of the Sherman Act could provide (and has in the past provided) the statutory basis for merger challenges; however, Section 7 of the Clayton Act is used more often. In any event, courts in merger cases use the same standard of analysis regardless of the statute invoked: Will the merger tend to reduce competition or create a monopoly in the relevant market? See United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir.
similar inquiries. In each case, the critical question is whether the proposed arrangement will so reduce the number of firms in the relevant market as to enable firms to collude successfully to raise price above competitive levels.\textsuperscript{126} The answer to this question depends heavily upon the proper definition of the "relevant market," a term of art designed to describe the location and array of firms capable of producing goods or offering services practicably competitive with those of the defendant. For analytical purposes, the "relevant market" has two components, product and geography. The product market consists of the good or service offered by the defendants and all "reasonably interchangeable" substitutes;\textsuperscript{127} the geographic market consists of the territory "in which the seller operates and to which the purchaser can practicably turn for supplies."\textsuperscript{128}

In the vast majority of merger and joint venture cases, the definition of the relevant market is outcome-determinative. It is not hard to see why. If the product market is defined broadly enough to include many goods or services in addition to those sold by defendants, defendants' share of that market will be smaller, often substantially smaller, than it would be in a more narrowly drawn market. The merger of firms with relatively small market shares does not usually threaten the competitive evils associated with the creation of bigger firms; therefore, a broad market definition usually predicts victory for defendants. By the same token, the larger the geographic market, the more choices there are for consumers and the less likely it is that defendants will have the ability to impose durable price increases.

Unfortunately, markets are not self-defining. The crucial issues in market definition, (1) which products or services are "reasonably interchangeable" with defendants', and (2) which territory best describes the area to which consumers can turn for substitutes, require fact-intensive inquiries and remain, at bottom, matters of degree.\textsuperscript{129} Market definition is difficult enough in relatively stable markets, but when industries experience rapid change, as is the case now with health care, the difficulty of the task is multiplied.

\textsuperscript{1990).}

\textsuperscript{126.} See, e.g., Hovenkamp, supra note 45, at 445-48. See also Hospital Corp. v. FTC, 807 F.2d 1381, 1386 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987). (Section 7 forbids mergers likely to "hurt consumers, as by making it easier for the firms in the market to collude, expressly or tacitly, and thereby force price above or farther above the competitive level.").


In the late 1980s and early 1990s, most antitrust courts regarded health care markets as local in nature, difficult to enter, and easily monopolized. In *United States v. Rockford Memorial Corp.*, for example, the Seventh Circuit Court of Appeals affirmed an order enjoining the merger of the two largest hospitals in Rockford, Illinois. The district court had defined the relevant geographic market narrowly, limiting it to the City of Rockford and its immediate environs, and therefore determined that the merger would have created a hospital with a market share of approximately seventy percent, resulting in a highly concentrated market in which the three largest firms would have possessed a collective share of ninety percent. Antitrust theory, as the Seventh Circuit observed, normally regards such markets warily: “three firms having 90 percent of the market can raise prices with relatively little fear that the fringe of competitors will be able to defeat the attempt by expanding their own output to serve customers of the three large firms.”

The Seventh Circuit conceded that its analysis hinged on the reasonableness of the geographic market definition adopted by the district court. But while acknowledging that “[i]t is always possible to take pot shots at a market definition,” the court upheld the district court’s formulation under the deferential “clearly erroneous” standard, observing that “for the most part hospital services are local” and that “people want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges.”

In 1990, one might reasonably have thought, as the Seventh Circuit did, that the business of most hospitals was local in nature and that special characteristics of the industry facilitated successful collusion by hospitals in highly concentrated markets. Because the managed care revolution had not yet taken hold in the payor market, courts could plausibly have regarded a patient’s choice of hospital to be governed by her doctor and thus effectively restricted to local hospitals where the doctor held admitting privileges. Furthermore, a variety of factors could have persuaded courts that new entry into hospital markets was unlikely and have led them to regard hospital mergers with a heightened sense of alarm.

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130. 898 F.2d 1278 (7th Cir. 1990).
131. Id. at 1283.
132. Id.
133. Id. at 1285. In an earlier opinion involving a merger in Chattanooga, Tennessee, the Seventh Circuit had taken a similar view of the market for hospital services. See Hospital Corp. v. FTC, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).
In the late 1980s, prospective entrants into hospital markets could have encountered three separate obstacles to entry. In some states, certificate of need laws and other forms of regulation continued to govern new entry and expansion. Then, as now, new hospitals took time to construct and staff, and unsuccessful hospitals could not be readily converted into cash or easily put to other profitable uses, a prospect that suggested a cautious approach to new entry. Finally, the kinds of free-standing and mobile care centers prevalent in today's market, which are unencumbered by the entry barriers applicable to full-service hospitals, had not yet emerged as a competitive force. For these reasons, in 1990 incumbent hospitals in highly concentrated markets that were inclined to conspire to raise price would be undeterred from doing so by the prospect of outside entry.

But the hospital market of today is not the hospital market of 1990. Courts have come to recognize that today's market for acute care hospital services is no longer a local one. The growth of large, aggressive buyer organizations, hospital clinic outreach programs, increasing cost consciousness among consumers, and a greater collective willingness on their part to travel longer distances in exchange for lower-priced care, have substantially stretched the territorial bounds in which acute care hospitals compete. Moreover, the success of smaller, free-standing treatment facilities has demonstrated the growing permeability of old barriers to entry.

In the past year, merger courts have concluded that these changes warrant a new approach to market definition. In particular, they have found that the aggressive purchasing arrangements characteristic of large managed care groups have worked a substantial expansion of geographic markets for medical services. Therefore, they have rejected static measures of market size in favor of more dynamic ones.

134. See Rockford Memorial, 898 F.2d at 1285 ("Regulatory limitations on entry into the hospital industry increase the propensity to collude by preventing (or at least delaying and increasing the cost of) entry by new competitors . . . ").

135. According to the President and CEO of Columbia/HCA Healthcare Corporation, which operates 330 hospitals, 100 surgery centers, and various other health care businesses in 36 states and 2 foreign countries, "practically any hospital can be built and put into operation in two years." See supra note 29 (testimony of Richard L. Scott).

136. The "static" measure, employed regularly in past hospital merger cases, is the Elzinga-Hogarty test. See Kenneth G. Elzinga & Thomas F. Hogarty, The Problem of Geographic Market Delineation Revisited: The Case of Coal, 23 ANTITRUST BULL. 1, 2 (1978). It looks at empirical data to determine (1) the area from which the defendant hospitals draw their patients and (2) where residents in that area go for hospital care. It has been criticized as "static" because it fails to consider necessarily where patients would go for care if merging hospitals raised prices significantly.
Eighth Circuit Court of Appeals has been particularly active in this regard. In *FTC v. Freeman Hospital*, decided in November of 1995, the appellate court affirmed an order denying the FTC's request for an injunction to prevent the merger of two of the three general acute care hospitals in Joplin, Missouri. Finding that the FTC had failed to produce sufficient evidence on "the crucial aspect" of geographic market inquiry, "where consumers of acute care inpatient hospital services could practicably turn for alternative sources of that product," the district court had rejected the FTC's relatively narrow market definition in favor of the much broader one proposed by defendants.  

Similarly, in *Morgenstern v. Wilson*, plaintiff, a cardiac surgeon in Lincoln, Nebraska, alleged that defendants, other cardiac surgeons doing business as the Nebraska Heart Institute, had monopolized the market for cardiac surgery in an area described as "Lincoln and twenty-six surrounding Nebraska counties extending in certain directions over 200 miles beyond Lincoln" but excluding "the heart programs in Omaha and all other regional and national heart programs." Reversing a district court order in favor of plaintiff, the Eighth Circuit ruled that plaintiff's definition of the relevant geographic market focused improperly on where cardiac patients in Nebraska "actually went as opposed to where they could practicably go." The court held that defendants lacked monopoly power in the properly defined, larger market. Though not a merger case, *Morgenstern* provides further evidence of the shift to a more expansive judicial view of the geographic markets in which some kinds of health care competition are now thought to occur.  

Most significantly, in *United States v. Mercy Health Services*, a federal district court in Iowa rejected the government's challenge to the merger of the only two general acute care hospitals in Dubuque. Again, the case revolved around the proper definition of the relevant geographic market. The government contended that the market included Dubuque County and a half-circle with a fifteen mile radius extending from the county's eastern edge into Illinois and Wisconsin, and calculated

137. 69 F.3d 260 (8th Cir. 1995).  
138. Id. at 268. The court also discounted testimony by market participants, a majority of whom testified that they would not travel outside the FTC's proposed market in the event that the merging hospitals raised their prices post-merger. The court emphasized that what matters for this purpose is not what consumers will do but what they could do. Id. at 265.  
139. 29 F.3d 1291 (8th Cir. 1994), cert. denied, 115 S. Ct. 1100 (1995).  
140. 29 F.3d at 1296.  
141. Id.  
142. Id. at 1297.  
defendants' share of that market as between seventy-six percent and eighty-eight percent.144 Defendants claimed that the proper market included Dubuque County, the seven closest rural hospitals, and regional hospitals in Cedar Rapids, Iowa City, Davenport, and Madison, Wisconsin,145 a market in which its share was approximately ten percent.146

The court resolved this dispute by first examining the competitive changes forced upon hospitals by aggressive managed care companies. It found that, while the scope of hospital competition had historically been limited to reputation and amenities, the growth of large, managed care groups has made many consumers sensitive to hospital prices, enabling those groups to steer members to lower cost hospitals and engendering vigorous price competition among hospitals for managed care contracts.147 At the same time, the court found competition to maintain or increase patient volume has caused hospitals to enlarge their “catchment areas,” the areas from which they draw patients, by branching out into locales previously considered too remote. This movement has taken various forms—the establishment of hospital-owned satellite clinics and the purchase of physician practices are two of the most common—and has naturally led to a substantial expansion of the area of effective competition between and among hospitals.148

The court held that the government's narrow market definition ignored these trends and rested “too heavily on past health care conditions.”149 Just five years after the Seventh Circuit's declaration in Rockford that “for the most part, hospital services are local,”150 the court in Mercy found that patients from Dubuque will travel as far as one hundred miles for hospital care if price incentives are sufficiently strong, and that doctor-patient loyalty is not powerful enough to overcome this willingness.151 These dramatic changes in buyer

144. Id. at 976.
145. These regional hospitals were found to be within 70 to 100 miles of Dubuque and to offer the same or a greater range of services as the defendant hospitals. Id. at 972.
146. Id. at 976.
147. Id. at 973-74.
148. Id. at 974.
149. Id. at 978.
150. Rockford Memorial, 898 F.2d at 1285.
151. Mercy Health Services, 902 F. Supp. at 978. If the court’s findings in Mercy about the aggressive behavior of managed care providers and consumers’ price-sensitivity and travel proclivities accurately describe other markets, the search for medical care becomes a function of the combined price of the care itself and the cost of travelling to that care: if the price of the care (surgeries, for example) is high enough and the price differences between potential providers sufficiently wide, cross-country travel for lower cost care would become cost-effective.
behavior formed the express basis for the court's judgment about the market in which Dubuque hospitals compete. More importantly, however, they implicitly reconceptualized the notion of hospital competition. If other courts adopt the Mercy approach, the only mergers remaining subject to effective challenge will be those involving remote rural hospitals.

From the perspective of judicial administration, the Mercy court's approach to market definition is a mixed blessing. On the one hand, it is more sensitive than earlier methodologies to the range of buyer and seller responses likely to follow a post-merger price increase. In addition, its appreciation of recent changes in health care financing and hospital competition promises a more informed jurisprudence. On the other hand, the prediction of the market's reaction to a hypothetical post-merger price increase necessarily involves highly speculative proof, the development of which will not only further complicate an already complicated discovery and trial process, but which will also be easier, because of its speculative quality, to rebut. This new approach is likely to increase the government's burden of proof as to the relevant geographic market and lessen the prospects for successful governmental challenges to consolidation generally.

Market definition has not been the only issue of concern in hospital merger cases. Some cases have raised interesting philosophical and economic questions about the competitive ideology of nonprofit hospitals and whether consumers have as much to fear from their mergers as from those of for-profits. Legal scholars and antitrust economists continue to struggle with these questions and with the issue of whether competition in hospital markets differs qualitatively from competition in other markets.

152. In Mercy, for example, the court's finding rested in part on small-scale survey results indicating that, given certain cost savings, significant numbers of Dubuque residents would be willing to travel relatively long distances, up to one and a half hours, for complex hospital treatment. See id. at 982-83.

153. According to The Wall Street Journal, the hospitals' victory in Mercy is likely to embolden hospitals to seek some mergers they may have shied from before. See Bryan Gruley & Laurie McGinley, Rebuke in Dubuque: Antitrust Lawyers Fail to Stop Deal, With Big Implications, WALL ST. J., Jan. 4, 1996, at Al.

154. See, e.g., the discussions in Rockford, 898 F.2d at 1278, Hospital Corp. 807 F.2d at 1381, and FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991).

155. See, e.g., Dennis A. Yao, The Analysis of Hospital Mergers and Joint Ventures: What May Change?, 1995 UTAH L. REV. 381. For the most recent addition to the economics literature and a citation to other works, see William J. Lynk, Nonprofit Hospital Mergers and the Exercise of Market Power, 38 J.L. & ECON. 437 (1995).
In addition, recent decisions in the First and Seventh Circuits demonstrate that geographic market definition is not the only area of health care antitrust undergoing doctrinal expansion. Each decision involved an HMO that was alleged, among other things, to have unlawfully acquired or misused monopoly power in a product market claimed to consist exclusively of HMO services. In each, the court concluded that because HMOs compete against many other types of health care financing, plaintiffs had failed to prove that HMO services constituted a separate product market.

In U.S. Healthcare, Inc. v. Healthsource, Inc., the First Circuit noted that HMOs compete in two distinct markets, in each of which they face “familiar alternatives.” On the “financing” front, their rivals include traditional insurance companies, Blue Cross/Blue Shield plans of various types, and Medicare and Medicaid programs. At the “provider” end, the court affirmed a magistrate’s finding that their competition consists of preferred provider organizations, “ordinary group medical practices,” and doctors engaged in independent practice. The breadth of these markets makes it highly unlikely that any HMO, even a relatively large one, could attain the high level of market share necessary to arouse antitrust concern. For these reasons and others, the court upheld a ruling that the defendant lacked the power to exclude its rivals from the relevant product markets.

The Seventh Circuit reached similar conclusions in Blue Cross & Blue Shield United v. Marshfield Clinic. In reversing a jury finding that HMOs constitute a separate product market, the court ruled that HMOs face competition not only from each other but from all “forms of medical services-contracting that are free from the perceived perverse incentive effects of the HMO form.” Even seemingly powerful HMOs cannot profitably raise their prices above competitive levels, stated the court, so

156. U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589 (1st Cir. 1993); Blue Cross & Blue Shield United v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995).
157. See Healthsource, 986 F.2d at 596; Marshfield Clinic, 65 F.3d at 1409.
158. Healthsource, 986 F.2d at 598; Marshfield Clinic, 65 F.3d at 1409.
159. 986 F.2d 589, 591 (1st Cir. 1993).
160. Id. at 591.
161. Id. Especially the fact that its contracts with physicians, though exclusive in nature, were terminable on short notice, and covered no more than 25% of the primary physicians in New Hampshire. Id. at 595-96.
162. Id. at 598. For a similar approach to health care financing markets, see Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325 (7th Cir. 1986).
163. 65 F.3d 1406 (7th Cir. 1995).
164. Id. at 1410.
long as they must compete against "an array of [independent] physicians who among them provide a broad range of medical services."165

By broadly defining the product market in which HMOs compete, these cases make it unlikely that HMOs or other managed care arrangements can obtain the high market shares necessary to trigger antitrust liability. This freedom from liability is especially likely if the associated providers remain free to contract with nonmembers of the HMO—earlier decisions effectively immunize nonexclusive, legitimate HMOs and individual practice associations ("IPAs") from antitrust challenge166—but is probable even if they do not. The case of Healthsource, for example, legitimated an exclusive contracting arrangement because the contracts were of short duration and did not appear to foreclose the defendant's competitors from a substantial portion of the physician market.167

In analytical terms, the practical effect of these recent decisions is to broaden significantly the size and scope of health care markets. Smaller markets formerly regarded as appropriate objects of antitrust concern are now likely to be viewed as components of much bigger competitive organisms too large and too dispersed to be controlled by any but the largest firms. The overwhelming majority of hospitals or insurers wishing to merge or consolidate in these redefined and enlarged markets will likely be able to do so with impunity.

The Seventh Circuit's opinion in Marshfield Clinic also contains an interesting bit of dictum particularly relevant to small rural markets. The Court acknowledged that north central Wisconsin, the area served by the clinic, contains some regions—whole counties in fact—"too small to support more than a handful of physicians."168 The court stated that if one of those counties were to have just twelve physicians, all allied exclusively to the clinic, the clinic would be a monopolist but not an unlawful one. It would be a natural monopolist, "a firm that has no competitors because the market is too small to support more than a

165. Id.
166. See, e.g., Hassan v. Independent Practice Assocs., 698 F. Supp. 679, 695 (E.D. Mich. 1988) (IPA whose members comprised more than 75% of the physicians in the relevant market lacked market power, because its members were free to affiliate with other providers).
167. Healthsource, 986 F.2d at 594. The United States Supreme Court has recognized that exclusive dealing arrangements may create efficiencies that foster competition and should therefore be upheld unless they foreclose competitors from a "substantial" percentage of the relevant market. See Standard Oil Co. v. United States, 337 U.S. 293 (1949); Tampa Elec. Co. v. Nashville Coal Co., 365 U.S. 320 (1961).
168. Marshfield Clinic, 986 F.2d at 1412.
The court observed that in such circumstances one would hardly expect those physicians to compete with each other. "Only as part of a large and sophisticated medical enterprise . . . [could] they practice modern medicine in rural Wisconsin."170

The Seventh Circuit's statement should provide some encouragement to providers in small rural markets wishing to ally themselves with regional joint ventures and health care networks. Although proof that a particular market is "too small to support more than a single firm" may be difficult to mount, Marshfield suggests that some concerns about small market concentration and exclusive provider groups may not necessarily receive a receptive judicial audience.171

Would-be collaborators should also draw encouragement from the emerging judicial view that most health care markets are easy to enter. Ease of entry makes a market difficult to monopolize and makes market power difficult to acquire: if powerful incumbents cannot exclude newcomers from competing for their high profits, they will be less likely to charge noncompetitive prices in the first place and unable to sustain those prices in any event. In the last decade, antitrust courts have come increasingly to conclude that health care markets are easy to enter,172 and the continued development of relatively low-cost treatment options, such as mobile imaging facilities and outreach clinics, are likely to reinforce that view. Collectively, these factors strongly suggest that health care collaborations will not face a particularly hostile judicial response.

VIII. CONCLUSION

The administrative and judicial developments described in this paper should be good news for most health care providers. They may also be good news for consumers, if the way to increasing competition can be kept free of artificial roadblocks. The "trouble" with increased competition, however, is that one firm's gain is often another's loss. Fearful of becoming losers, incumbents in changing markets sometimes conspire to keep would-be competitors from entering their markets; if they succeed,

169. Id.
170. Id.
171. See, e.g., Ball Memorial Hosp., 784 F.2d at 1325; Marshfield Clinic, 986 F.2d at 1406.
172. Hassan, 698 F. Supp. at 679. In Mercy the court concluded that while Iowa's certificate of need laws may prevent the construction of new hospitals, existing hospitals were nevertheless able to enter new markets by establishing outreach clinics as sources of referrals and by allying themselves with physician groups whose clinics could likewise refer patients to the allied hospital. Mercy Health Services, 902 F. Supp. at 974.
consumers are harmed. In particular, powerful incumbents in health care markets have a long history of combining to prevent new competition, and the attraction of conspiracy is still strong.

In the past five years, the Federal Trade Commission, Department of Justice, and state attorneys general have successfully challenged numerous attempts by groups of physicians and others to fix prices or boycott initiatives aimed at cost-conscious purchasing. Last fall, for example, the Justice Department’s antitrust division settled two civil suits accusing hospitals and doctors in separate areas of the country of trying to prevent managed care firms from competing with them. The suits claimed that in Danbury, Connecticut and St. Joseph, Missouri, respectively, the dominant acute-care hospital and a majority of local physicians formed an alliance to exclude managed care providers from entering the markets in order to preserve the existing, noncompetitive price levels. Naturally, the defendants admitted no wrongdoing; one of the principals of the Danbury alliance noted that his organization was “similar to many others around the country.”

Neither Connecticut nor Missouri has enacted provider cooperation legislation. If either had, though, it seems likely that the incumbents’ alliance would have received statutory approval and, thus, would have been immunized from federal antitrust attack. Their consumers would have been deprived of competitive alternatives. Providers in other states would not have received the message sent by the successful conclusion of the Justice Department’s suits and might have continued to charge consumers noncompetitive prices.

This is the risk of state reform legislation. Not only will “unprofitable” consumers—like Ms. Nelson and her daughter—be placed in jeopardy, but all consumers will lose their most effective ally in the fight to maintain and continue the growing competitiveness of health care markets. As the data about recent consolidation efforts demonstrate beyond dispute, it is a risk that is unnecessary to foster consolidation in


176. Id.
the health care industry and that promises no corresponding reward. Federal antitrust laws have helped open health care markets to competition and are still critical to continue that movement. State reform laws represent an ineffectual response to the serious problems of rural poverty and an ill-conceived solution to "problems" with federal antitrust law that are more imagined than real.