Hospitals Caught in the Antitrust Net: An Overview

John J. Miles

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John J. Miles*
Mary Susan Philp**

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Ms. Philp and Mr. Miles wish to express their appreciation to Mrs. Georgiann Thompson for her assistance and patience in preparing the manuscript.
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I. INTRODUCTION

Once upon a time not long ago, hospitals led a relatively comfortable economic existence in comparison with today. To a large extent, many third-party payors paid whatever it cost the hospital to treat their beneficiaries; competing hospitals worked in a cooperative environment and determined among themselves what services each would offer; hospital relations with their medical staffs were relatively idyllic; and economic integration among otherwise competing facilities, running the gamut from loose shared service arrangements to complete merger, raised no eyebrows.

Hospitals aggregated their market power and collectively negotiated reimbursement amounts with some third-party payors. The hospital organization was relatively simple, there being little pressure to reorganize and form the holding companies seen today, whose subsidiaries produce a plethora of services other than traditional inpatient hospital services. Finally, the last thing a hospital president had to worry about was compliance with the federal antitrust laws.

That era is now "gone with the wind."

A. The Changed Business Environment

The economic, legal and business environment in which hospitals operate has changed dramatically over recent years. In a broad sense, the greatest change is that hospitals find themselves in an increasingly competitive environment. The major factor leading to this has been increasing concern over the cost of hospital services by those purchasing or paying for them. For example, businesses (and others) have formed numerous health care coalitions across the country to study ways to restrain health care cost increases. Payors are beginning to demand that hospitals compete for their business based, at least in part, on price.


2. Indeed, the Department of Justice has issued two favorable business review letters to coalitions planning to collect and disseminate the charges of hospitals in their areas. Letter from Charles F. Rule, Acting Assistant Attorney General, Antitrust Division, to Joseph J. Feltes (Aug. 30, 1985) (business review letter to the Stark County, Ohio, Health Care Coalition); Letter from William F. Baxter, Assistant Attorney General, Antitrust Division, to Patrick N. Renaud and John P. Hanna (Feb. 19, 1982) (business review letter to the Maryland Health Care Coalition).

3. See, e.g., Hospital Corp. of America, 3 Trade Reg. Rep. (CCH) ¶ 22,301 at 23,341-43
Another result of concern about hospital costs has been the advent of prospective payment reimbursement, under the so-called diagnosis-related group methodology, by which hospitals are reimbursed a fixed sum based on the patient's diagnosis rather than being paid whatever it costs to treat the patient.\(^4\) Prospective payment provides strong incentives for hospitals to (1) compete for admissions to fill beds, (2) enter into joint ventures and other forms of economic integration to achieve economies of scale and other types of cost savings, and (3) diversify into the provision of services and products other than traditional inpatient hospital services.

At the same time, concern over the cost of health care has also led to the growth of “alternative delivery systems,” such as health maintenance organizations, preferred provider organizations, and competitive medical plans which compete against other more traditional plans, such as Blue Cross and commercial insurance, in financing or delivering health care. Participation in alternative delivery systems provides hospitals with a mechanism to compete more effectively for admissions against hospitals which are not participants. Alternative delivery systems often include providers who are drawn together in one partially integrated unit, but who otherwise continue to compete against each other.\(^5\) Hospitals may be founders or members of the system, or simply contract with it to provide services. In any event, the hospital must constrain its costs such that it can participate profitably and the system in the aggregate can compete effectively against similar entities.

A growing number of physicians are competing for positions on the medical staffs of a relatively stable (or perhaps declining) number of hospitals.\(^6\) In light of prospective payment and other reasons for concern over their costs, hospitals have increasing incentives to select for staff membership only those physicians and other practi-
tioners who practice in what the hospital believes is a cost-effective manner. "Overutilizers" may be terminated from the staff or have their applications rejected initially. Physicians and hospitals even find themselves in competition with each other as hospitals diversify into nontraditional hospital services and physicians establish free-standing facilities to provide services such as diagnostic radiology, ambulatory surgery and emergency care. Indeed, hospitals, when they diversify, find themselves competing against other providers as well. Home health agencies, nursing homes and pharmacies are common examples.

While health planning, a regulatory scheme which both limits entry and encourages agreements among competitors to restrict output, has not disappeared entirely at either the state or federal levels, it seems clear that the hospital industry is experiencing deregulation. Several states have repealed their certificate-of-need laws, and the National Health Planning and Resources Development Act of 1974 itself was amended in 1979 to inject competition into health planning as an important policy variable. Indeed, several bills were introduced in Congress proposing procompetitive, "consumer choice" solutions to the health care cost problem. In short, the hospital industry is moving from an environment of regulation and implicitly-mandated cooperation to one of competition.

As any industry moves from the cozy confines of a regulatory or cooperative setting mandated or induced by the government to a

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7. For example, under a proposed FTC consent order, a medical staff will be enjoined from boycotting a hospital which had established an urgent care center in competition with some staff members. See Medical Staff of John C. Lincoln Hosp. & Health Center, File No. 831 0147 (FTC Jul. 16, 1985) (consent decree), summarized at 3 TRADE REG. REP. (CCH) ¶ 22,271.

8. See, e.g., DRGs Spur Hospital Interest in Long Term Care, WASH. REP. ON MED. & HEALTH (PERSPECTIVES), Jan. 28, 1985; Tatge, Firms Suggest Hospitals Consider the Business of Home Healthcare, MODERN HEALTHCARE, Nov. 1, 1984, at 94.


11. 42 U.S.C. §§ 300k to 300n-6 (1982) [hereafter referred to as the Health Planning Act]. For a discussion of the Health Planning Act and its operation, see Miller, Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture, 68 Geo. L.J. 873 (1980). For a discussion of the antitrust ramifications of health planning activities, see generally infra Section V.


more aggressive, competitive environment, antitrust principles become an increasing concern because the legal and economic rules of the game change. Many hospital executives have been and are being subjected to what best can be called an “antitrust adjustment period,” during which their entire approach to many business problems facing their facilities has had to change. Antitrust, an area of law they once perceived as applying only to the IBMs and AT&Ts of the American economy, now substantially affects what they can and cannot do in the more competitive environment. Having been told in the past that cooperation was both appropriate and necessary (and thus cooperation having become institutionalized in the industry), some are now confused as to what the new rules of the game are.

B. The Changed Antitrust Environment

While the business and economic environment in which hospitals live was changing, the legal environment also was becoming more conducive to the application of antitrust principles to health care sector industries. Three developments, beginning in 1975, were particularly important. First, in Goldfarb v. Virginia State Bar,14 the Supreme Court, in reversing a decision of the Fourth Circuit,15 eliminated any doubt about whether the antitrust laws apply to the activities of professionals. The Court explained that “[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act, . . . nor is the public service aspect of professional practice controlling in determining whether § 1 includes professions.”16 In sum, there is no exemption from antitrust coverage for professionals.17

Second, and perhaps more important, the Court’s 1976 decision in Hospital Building Co. v. Trustees of Rex Hospital,18 again reversing the Fourth Circuit,19 held that a restraint on competition, even in a local hospital market, can “‘substantially and adversely affect[ ] interstate commerce,’” and thus meet the jurisdictional

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15. 497 F.2d 1 (4th Cir. 1974) (finding a “limited exemption” for “learned professions”).
16. 421 U.S. at 787.
19. 511 F.2d 678 (4th Cir. 1975).
requirement of the antitrust laws. There, the restraint allegedly affected the interstate flow of a hospital's medicines and supplies, third-party payment, management fees, and construction financing.

Third, in National Gerimedical Hospital and Gerontology Center v. Blue Cross, decided in 1981, the Court held that the Health Planning Act provides no blanket implied repeal immunity to activities arguably falling under the rubric of health planning. More generally, it is interesting that, while the Court decided only two antitrust cases focusing on the health care sector between passage of the Sherman Act in 1890 and the Goldfarb decision in 1975, it has decided eight antitrust cases relating to health care between 1976 and the present.

The last ten years have also seen government agencies, at both the federal and state levels, become increasingly interested in antitrust enforcement in the health care sector. The Federal Trade Commission established a health care "shop" within its Bureau of Competition in 1975. The Antitrust Division assigned health care matters to its Special Litigation Section, which recently was merged into a new Professions and Intellectual Property Section. Both agencies, in addition to enforcement actions, have issued a number of advisory opinions and business review letters relating to


25. E. Gee, Deputy Assistant Director, Bureau of Competition, Federal Trade Commission, Remarks before the National Health Lawyers Association's Sixth Annual Program on Antitrust in the Health Care Field (Feb. 1, 1983).

proposed activities in the health care sector. State attorneys general also have been active in filing enforcement actions under both federal and state antitrust laws; the *Maricopa County* case, an enforcement action by the Attorney General of Arizona, is a prominent example.

Although antitrust actions involving hospitals are still a relatively new phenomenon, the types of antitrust problems hospitals face or likely will encounter in the future are becoming increasingly clear. Indeed, there now is substantial interest in antitrust compliance programs for hospitals. Analyses of some of these problems by the courts, however, are inconsistent, ambiguous, and in some instances, nonexistent.

This article attempts to set forth major areas of particular antitrust concern to hospitals, explain how courts have analyzed the issues involved to the extent that there are decided cases, and discuss generally how these issues might be analyzed to reach appropriate results. The potential problem areas include medical staff and clinical privilege issues, hospital participation in various types of joint ventures, joint negotiations among hospitals with third-party payors over reimbursement, health planning issues, hospital referral arrangements with affiliated providers rendering


30. *See infra* Section II.

31. *See infra* Section III.

32. *See infra* Section IV.

33. *See infra* Section V.
nonhospital services, potential problems faced by hospitals under the Robinson-Patman Act, and hospital mergers. In less detail, it notes questions that may arise from restraints relating to attempts by hospitals to compete with their staff members and vice versa.

Specific answers to all the antitrust questions these activities raise, of course, are impossible, but the article attempts to provide appropriate and helpful frameworks for analyses, together with references for examination when specific problems arise.

II. HOSPITAL STAFF PRIVILEGE ANTITRUST PROBLEMS

A. Introduction

Although apparently no statistically valid empirical study has been undertaken, an informal survey conducted by the National Health Lawyers Association, as well as a superficial examination of reported decisions, indicates that staff privilege cases (including those challenging exclusive contracts) are by far the single most common type of health care antitrust case. A staff privilege antitrust problem can arise in a number of different factual contexts, including:

1. Denial of a physician's initial application for medical staff membership or clinical privileges;

2. Denial of privileges to allied health practitioners, such as nurse midwives, nurse anesthetists, podiatrists, and chiro-
practors;\(^43\)
3. Nonrenewal of a practitioner’s clinical privileges;\(^44\)
4. Denial of some clinical privileges while granting others;\(^46\)
5. Suspension,\(^46\) reduction,\(^47\) or termination\(^48\) of privileges; and
6. An exclusive contract between the hospital and a single physician (or single group of physicians) to provide the medical service in question at the hospital.\(^49\)

The typical staff privilege antitrust claim is brought under both sections 1 and 2 of the Sherman Act.\(^50\) While the specific positions of persons named as defendants vary, they may include individual members of the hospital’s medical staff, the medical staff as an entity, the hospital itself, the hospital’s president (or administrator), and even individual members of the hospital’s governing board.\(^51\)

Where the crux of the complaint involves an exclusive contract, the plaintiff usually claims that the agreement constitutes both a tying arrangement and an illegal exclusive dealing contract under section 1.\(^52\) In other staff privilege antitrust cases, the section 1 claim usually is that the medical staff members conspired among themselves and with the hospital to boycott the plaintiff.\(^53\) The

43. See Wilk v. American Medical Ass’n, 719 F.2d 207 (7th Cir. 1983), cert. denied, 104 S. Ct. 2398 (1984) (conspiracy to preclude chiropractors from hospitals alleged as part of a conspiracy to destroy chiropractic).
45. See, e.g., Cardio-Medical Assocs. v. Crozer-Chester Medical Center, 721 F.2d 68 (3d Cir. 1983) (relating to sufficiency of interstate commerce allegations).
46. See, e.g., Hayden v. Bracey, 744 F.2d 1338 (8th Cir. 1984) (relating to sufficiency of interstate commerce allegations).
51. In Ritter v. North Penn Hosp., No. 85-6849 (E.D. Pa. filed Nov. 27, 1985), an exclusive contract case, the plaintiff named 32 defendants, including the individual members of the governing board and the medical staff an an entity. Naming so many defendants seems unnecessary and serves only to complicate the case.

The hospital’s status as a for-profit or nonprofit entity is irrelevant for antitrust purposes. See National Collegiate Athletic Ass’n v. Board of Regents of the Univ. of Okla., 104 S. Ct. 2948, 2960 n.22 (1984); American Soc’y of Mechanical Eng’rs v. Hydrolevel, 456 U.S. 556 (1982).

The legal theories relied upon by allied health practitioners in staff privilege antitrust cases tend to be the same as those used by physicians. See, e.g., Ables v. City of Parkersburg, No. 84-A106 (S.D. W. Va. filed Sept. 19, 1984) (nurse anesthetist alleged, inter alia,
plaintiff usually adds a section 2 claim that at least some of the defendants monopolized, attempted to monopolize and conspired to monopolize the physicians services market in which the plaintiff is an actual or potential competitor. Often, however, the section 2 challenge focuses on the hospital’s market power (or the hospital’s importance to the physician’s ability to compete); the plaintiff alleges that the hospital is a so-called “essential facility” and thus must grant the plaintiff access to it.

B. Hospital Organization and Staff Credentialing

To assess how staff privilege antitrust cases have been or should be analyzed, a general knowledge of hospital organization and the process through which it grants privileges—that is, its credentialing procedure—is essential. Briefly, a hospital has a tripartite organizational structure. Overall responsibility for the hospital rests with its board of trustees or board of directors—that is, the

group boycott, exclusive dealing, tying, monopolization and attempted monopolization). Applications for staff privileges from allieds may present hospitals with some practical problems which applications from physicians do not. See generally J. Miles, “Allied Practitioner Staff Privileges and Exclusives Between Physicians and Hospitals,” Outline of Remarks before the National Health Lawyers Association’s Medical Staff Legal Issues Seminar (Mar. 4, 1985); see also C. Stromberg, “Antitrust Law and Limitations on Allied Health Professionals,” Outline of Remarks before the American Bar Association’s Section of Antitrust Law and Forum Committee on Health Law’s Joint Program on Competition, Economic Change, and Antitrust Issues in the Health Care Industries (Feb. 2, 1984).


This article does not discuss application of section 2 to staff privilege cases. In general, courts have rejected § 2 claims, holding that (1) the requisite intent to monopolize was lacking, Weiss v. York Hosp., 745 F.2d at 827-28; (2) the essential facilities doctrine is inapplicable, Pontius v. Children’s Hosp., 552 F. Supp. at 1370; (3) many other hospitals in the market offer the same services, Seidenstein v. National Medical Enters., 769 F.2d 1100, 1106 (5th Cir. 1985); or (4) a hospital cannot monopolize a market (the physicians services market) in which it is not a participant, Smith v. Northern Mich. Hosps., 703 F.2d 942, 955 (6th Cir. 1983).

55. Credentialing procedures, although following a similar pattern, vary from hospital to hospital depending on state laws and regulations, the hospital’s corporate bylaws, and the medical staff bylaws. For other and more detailed discussions, see generally Cray, Due Process Considerations in Hospital Staff Privileges Cases, 7 HASTINGS CONST. L.Q. 217 (1980); Dolan & Ralston, Hospital Admitting Privileges and the Sherman Act, 18 Hous. L. Rev. 707, 709-21 (1981); Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 DUKE L.J. 1071, 1084-92; Kissam, Webber, Bigus & Holzgraefe, Antitrust and Hospital Privileges: Testing the Conventional Wisdom, 70 CALIF. L. REV. 595, 606-07 (1980); McCall, A Hospital’s Liability for Denying, Suspending and Granting Staff Privileges, 32 BAYLOR L. REV. 175 (1980); Comment, Medical Staff Membership Decisions: Judicial Intervention, 1985 U. ILL. L. REV. 473, 476-79; see also CALIFORNIA HOSP. ASS’N, MODEL MEDICAL STAFF BYLAWS (1984). The articles by Havighurst and Kissam contain the fullest discussions to date about the antitrust ramifications of staff privilege exclusions.
"governing board." Often, the board is composed primarily of business persons and community leaders in the area who serve without remuneration for public service motives. The hospital's day-to-day operations are the responsibility of the hospital administration, headed by the hospital president, an employee who reports and is responsible to the governing board.

Finally, there is an organized medical staff which is responsible, and accounts to the governing board for the quality of professional services rendered in the hospital. The medical staff is composed of individual medical practitioners who are permitted to use the hospital's facilities in the care of patients. For the most part, medical staff members are independent contractors, who practice outside as well as inside the hospital, rather than hospital employees. The governing board delegates to the medical staff the responsibility, among others, of evaluating the qualifications of applicants to the staff and then recommending to the board (which makes the final decision) whether the applicant should be given medical staff membership and clinical privileges. The medical staff also is delegated the responsibility of monitoring the actions of staff members, and, in the case of an errant staff member with privileges, recommending whether the board should take "corrective ac-

57. JCAH Manual, supra note 56, at 83-85.
58. For conflicting views about the legal status of medical staffs, compare Hortsy & Mulholland, The Legal Status of the Hospital Medical Staff, 22 St. Louis U.L.J. 485 (1978) (staff part of hospital), with Willett, The Legal Status of the Medical Staff (1984) (report to the California Medical Association opining that staff is separate legal entity).
60. Prior to January 1, 1985, standards of the Joint Commission on Accreditation of Hospitals prevented hospitals accredited by JCAH from admitting practitioners other than those practicing medicine or dentistry to the medical staff. In light of antitrust and other concerns, this was changed, and JCAH now permits hospitals to admit any licensed practitioner who is permitted by law to provide patient care services independent of supervision. See generally American Hosp. Ass'n, An Analysis of the Revised Medical Staff Standards of the Joint Commission on Accreditation of Hospitals 4, 11-12 (1984).
61. Usually, there are several categories of medical staff membership such as active, courtesy, and honorary. Some hospitals also have a separate "allied" staff which consists of allied health practitioners such as podiatrists, nurse midwives, nurse anesthetists, and clinical psychologists.
62. "Clinical privileges" is the permission, granted by the governing board, to render certain delineated services within the hospital. The JCAH does not require that a practitioner be a member of the medical staff to obtain clinical privileges.
against that person and what, if any, sanction should be imposed. Usually, corrective action sanctions can run the gamut from a reprimand to the revocation of staff membership and clinical privileges.

The medical staff, although independent from the hospital in many respects, is connected to the hospital formally through the medical staff bylaws. The bylaws, which typically are drafted by the staff and approved by the board, establish the medical staff's organization, its committees, its relationship to the hospital, and the procedures by which staff privileges are granted and corrective action taken. In some states, the medical staff bylaws are deemed to be a contract between the staff and the hospital, and the hospital breaches that contract if the bylaws are not followed in credentialing and taking corrective action against practitioners. The board, however, has final decision-making responsibility for determining who can practice in the hospital.

The procedure for granting or otherwise affecting a practitioner's staff privileges must follow that set forth in the medical staff bylaws. In general, in the case of an initial application, the practitioner submits a formal application, including his or her credentials. This is examined by the credentials committee of the medical staff which checks the applicant's credentials and recommends to the medical staff's executive committee what clinical privileges, if any, should be granted. The credentials committee or the chairperson of the clinical department to which the applicant would be assigned may conduct a personal interview of the applicant.

The medical staff executive committee examines the recommendation and determines whether to endorse it. If its recommendation is favorable to the applicant, it forwards the recommendation to the board which usually approves it, or in some cases, the entire medical staff votes on the recommendation before it is sent to the board. If the recommendation is unfavorable, typically a special committee of medical staff members is appointed to conduct an evidentiary hearing to review the recommendation. Its recom-

63. JCAH Manual, supra note 56, at 114.
64. Id. at 103.
66. JCAH Manual, supra note 56, at 43.
mendation is transmitted through the medical staff executive committee to the board for a final decision. If the recommendation remains adverse to the applicant, the bylaws provide for formal or informal appellate review by the board itself.

Proceedings to adversely affect a staff member’s privileges, or “corrective action proceedings,” usually follow a similar path. “Charges” are brought against the practitioner by someone with authority under the bylaws to do so (for example, the hospital or medical staff president, or the chairperson of the practitioner’s clinical department). Often the charges first are heard informally by the medical staff executive committee to determine preliminarily whether the matter should be pursued. If that decision is affirmative, a committee of medical staff members is appointed to hear evidence, and the remaining procedures are substantially identical to those used in the case of an applicant for privileges. Once again, the governing board makes the final decision.

Several factors relevant to an antitrust analysis are obvious. First, a hospital and its medical staff have many attributes of a joint venture. Independent entities—the hospital and its staff physicians—partially integrate their businesses to produce services that none could produce efficiently, if at all, by themselves. \[^6\][^9] This joint venture often competes against similarly organized joint ventures (that is, other hospitals), and its competitive success will depend to a large extent on the quality of its medical staff. This suggests that both the hospital and members of its medical staff have a substantial and legitimate competitive interest in ensuring that staff members are as highly qualified as possible. Indeed, the exclusion of less qualified individuals is procompetitive in the market for the joint venture’s services.

Second, while the exclusion of a practitioner can affect the hospital services market, its effect on a physicians services market must also be examined. Typically, the hospital and physicians bill separately and the physicians compete among themselves for patients within the confines of the joint venture. Moreover, the exclusion can affect the provision of physicians services provided outside the confines of the joint venture as well, because a physician who needs access to a hospital to sustain a practice, if denied hospital privileges, is not likely to locate in an area and open an office practice if that access is unavailable.

Third, the procedure used to grant or deny privileges to a practi-

[^6]: See infra Section III(B)(1) for a discussion of the characteristics of a joint venture.
[^9]: See infra Section III(B)(1) for a discussion of the characteristics of a joint venture.
tioner has substantial potential for competitive abuse. To some extent, it puts the "fox in the chicken coop." In many instances, direct competitors will have substantial input (and in some cases, may have de facto decision-making authority) with regard to the practitioner's application. Indeed, even when the medical staff committees reviewing the application are not comprised of the affected practitioner's competitors, there are incentives for their members to defer, at least to some extent, to the views of staff members who do compete with the applicant. They may wish to keep peace in the medical staff family; they may recognize that a practitioner in the affected practitioner's specialty can best assess the applicant's credentials, a particularly important consideration; they know that they may find themselves in the same situation when a competitor of theirs applies; they may depend on referrals from the staff member who objects; or they may recognize that the hospital's resources they use are limited and wish to limit use to themselves.

Whether the potential for competitive abuse is realized depends substantially on the ability and willingness of the hospital's governing board to counteract it if it does occur. Whether this will happen is a function of two variables: The board's willingness to review carefully the medical staff's recommendation and its willingness to render a decision with which its staff may not agree and which may result in political repercussions within the hospital. Importantly, however, whether members of the medical staff are able to abuse the credentialing and corrective action procedures says little about the important ultimate issue in an antitrust case—the actual effect of any exclusion on competition.

C. The Legal Analysis

Many courts apparently dislike antitrust staff privilege cases. They are expensive and time consuming; the plaintiff wins infrequently; and the courts appear quite reluctant to second-guess

70. See, e.g., Lloyd v. Jefferson Davis Hosp., 345 So. 2d 1046 (Miss. 1977).

71. If the governing board is unwilling to render independent, well-informed decisions that maximize the hospital's interests as opposed to those of its staff members, the hospital is little more than a physicians' cartel. See generally Pauly & Redisch, The Not-for-Profit Hospital as a Physicians' Cooperative, 63 Am. Econ. Rev. 87 (1973).


the decisions of hospitals and medical staffs with regard to staffing decisions. Perhaps because of these factors, a number of courts have appeared to grasp at ways to dismiss such cases on a preliminary, summary basis, obviating the need to conduct an indepth examination of the exclusion's actual effect on competition. This approach has not necessarily led to incorrect ultimate results, but it has led to inconsistent and ambiguous analyses, which make counseling both hospital and practitioner clients difficult. Ways must be sought to weed out meritless cases early on, but without doing injustice to appropriate principles of antitrust jurisprudence. Otherwise, confusion will reign supreme. Moreover, overly speedy dismissals can result in injustices to both the plaintiff and the competitive policies that the antitrust laws are designed to protect.

1. Preliminary Issues

The plaintiff in any antitrust case brought under sections 1 and 2 of the Sherman Act must allege and prove a substantial effect on interstate commerce. There is a split in the circuits regarding whether the plaintiff must show that the alleged restraint affects commerce, or whether a showing that the general business activities of the defendant affect interstate commerce is sufficient. Where only the latter need be shown, the plaintiff almost always should be able to allege the requisite effect because of the defendant hospital's third-party reimbursement, purchases of equipment


77. See, e.g., Seglin v. Esau, 769 F.2d 1274 (7th Cir. 1985); Crane v. Intermountain Health Care, Inc., 637 F.2d 715 (10th Cir. 1980) (en banc); see also Furlong v. Long Island Hosp., 710 F.2d 922 (2d Cir. 1983) (activities "infected" by the restraint must affect commerce); Stone v. William Beaumont Hosp., 1986-1 Trade Cas. (CCH) ¶ 66,932 (6th Cir. 1986) (same, relying on Furlong).


Shahawy, where the plaintiff had been denied privileges to conduct cardiac catheterizations, is particularly interesting. In its initial decision, 755 F.2d 1432 (11th Cir. 1985), the panel found that the requisite effect on commerce had not been alleged sufficiently. In reversing itself, the panel recognized that the dispute among the circuits "is whether defendant's general business activity or its specific anticompetitive conduct is to be measured for substantial effect on interstate commerce." 778 F.2d at 639-40. It opted for the former: "in this circuit Sherman Act jurisdiction requires a focus on the interstate markets involved in the defendant's business activities." Id. at 640.
and supplies, treatment of out-of-state patients, and other interstate contacts.

On the other hand, a single practitioner may have more difficulty alleging and proving that the restraint itself resulted (or would result) in a substantial effect on his or her interstate transactions. As a practical matter, however, a motion to dismiss for failure to allege the requisite effect on commerce is successful only in unusual circumstances and counsel for the defendants should assess carefully whether pursuing the defense aggressively by early motion is worth the expense to the client.

At least in Indiana and perhaps elsewhere in the Seventh Circuit, the state action exemption may provide a defense in antitrust challenges to staff privilege decisions. In Marrese v. Interqual, Inc., the court upheld the revocation of the plaintiff's privileges because, according to the court, the challenged conduct was "clearly articulated and affirmatively expressed as state policy" and "actively supervised by the state." Accordingly, the hospital's actions met the requirements for state action exemption protection set forth by the Supreme Court in California Liquor Dealers Association v. Midcal Aluminum, Inc. and Hoover v. Ronwin.

The correctness of the Marrese analysis, as a matter of both antitrust law and antitrust policy, is open to serious question. According to the court, the "clearly articulated state policy" prong of the state action test was met because Indiana law authorized hospitals to establish peer review committees composed of medical staff members to evaluate the qualifications of providers. Reasonable persons can quibble over whether this constitutes a clearly articulated state policy relating to the restraint in question. More surprising is what the court held met the "active state supervision" prong of the test. Succinctly stated, the requisite supervision was

80. See, e.g., Stone v. William Beaumont Hosp., 1986-1 Trade Cas. (CCH) ¶ 66,932 (6th Cir. 1986) (insufficient effect because excluded physician plaintiff would have used defendant hospital only twice a month); Hayden v. Bracey, 744 F.2d 1338 (8th Cir. 1984) (same because physician not expelled from the hospital but told to upgrade his education).
81. 748 F.2d 373 (7th Cir. 1984), cert. denied, 105 S. Ct. 3501 (1985).
82. Id. at 384.
83. 445 U.S. 97, 105 (1980) ("First, the challenged restraint must be one clearly articulated and affirmatively expressed as state policy; second, the policy must be 'actively supervised' by the State itself.").
85. Marrese, 748 F.2d at 388-90.
present because, with respect to physicians, the Indiana Medical Licensing Board "clearly supervises" Indiana physicians by requiring them to register and qualify for a license and because confidential communications of medical staff peer review committees may be disclosed to it. 86 With regard to hospitals, state supervision was sufficient because (1) hospitals are licensed by the State Board of Health, (2) their operations are reviewed by the state's Hospital Licensing Council to determine whether their licenses should be renewed, and (3) state inspectors are entitled to review the meeting minutes of hospital boards, their medical staffs, and their peer review committees. 87

Frankly, it is impossible to discern how these functions possibly can satisfy the requirement that the allegedly anticompetitive conduct be actively supervised by the state. Indeed, it seems highly unlikely that the state would ever learn of the hospital's credentialing proceedings, much less that it could correct an abuse even if it were discovered. More generally, the Indiana regulatory system probably is little different than those in many other states, and it will be interesting to see how other courts analyze the same defense. One court already has rejected the Marrese analysis, 88 although two subsequent Indiana cases follow it, 89 perhaps because it is binding precedent there. 90

86. Id.
87. Id.
88. Quinn v. Kent General Hosp., 617 F. Supp. 1226 (D. Del. 1985); see also Jiricko v. Coffeyville Memorial Hosp. Medical Center, 1986-1 Trade Cas. (CCH) ¶ 66,935 (D. Kan. Oct. 10, 1985) (holding that the Marrese analysis is not applicable where a physician was not granted due process before his status was reduced).
90. Municipal and other special district hospitals also may be able to invoke the "state action" exemption or the protection of the Local Government Antitrust Act of 1984, 15 U.S.C. §§ 34-36 (1984). Under the former, the municipality's action need only be pursuant to a clearly articulated state policy; it need not be actively supervised by the state. Town of Hallie v. City of Eau Claire, 105 S. Ct. 1713 (1985).

Town of Hallie was applied in Coastal Neuro-Psychiatric Assoc's. v. Onslow County Hosp. Auth., No. 84-51-Civ-4 (E.D.N.C. Jul. 10, 1985), where a complaint challenging the hospital's exclusive contract in radiology was dismissed on state action grounds. The defendant hospital was a local governmental unit. Based on a North Carolina statute permitting hospitals to base staff privilege decisions on the reasonable regulations of the hospital, (including appropriate utilization of its facilities), as well as the fact that evidence showed that the hospital had justifications for using an exclusive contract, the court held that the hospital's action was "taken pursuant to a clearly articulated state policy to replace competition . . . with regulation." Id., slip op. at 5 (quoting Town of Hallie, 105 S. Ct. at 1721).

The Local Government Antitrust Act prevents antitrust damages, costs and attorneys fees
2. Staff Privilege Cases Not Arising from Exclusive Contracts

In examining approaches taken by courts to staff privilege exclusions not resulting from a hospital-physician exclusive contract, as well as how an appropriate analysis might proceed, it is helpful to discuss separately the general legal issues that commonly arise. These include: (1) Whether, as a matter of law, the alleged co-conspirators are capable of conspiring among themselves; (2) if they are, whether, as a matter of fact, they did conspire; (3) the appropriate standard of antitrust analysis—the per se rule, the rule of reason, or some intermediate standard; (4) the relevance of the purpose or intent behind the credentialing decision; and (5) the decision's effect on competition.

a. Capacity to Conspire as a Matter of Law

Because staff privilege antitrust cases uniformly allege a conspiracy between the medical staff or certain of its members and the hospital, a major issue is whether the medical staff is capable, as a matter of law, of conspiring with the hospital, or whether the two are a single entity for antitrust purposes. On one hand, the argument can be made that, at least with regard to credentialing, the hospital and its medical staff are a single entity since the hospital delegates to the staff the responsibility for assessing credentials while retaining ultimate responsibility for making the final decision itself. If the hospital and staff are one entity for antitrust

from being assessed against units of local governments, employees of local governments acting in their official capacity, and other persons directed to act by the local governmental unit or its employees. The fullest discussion of the Act's applicability in the antitrust staff privileges context is in Palm Springs Medical Clinic v. Desert Hosp., No. CV 85-6163 PAR (C.D. Cal. Jan. 17, 1986), a suit brought by a medical clinic against a hospital owned by a governmental hospital district and against a physician who was chairman of the hospital's medical executive committee and its chief of staff. After reviewing the Act's legislative history, the court granted the hospital's motion to dismiss, holding that the Act provided it with absolute immunity against damages regardless of whether its actions were "official conduct." The court denied the individual defendant's motion for a more definite statement, holding that discovery was a better avenue to ascertain whether the Act would apply to his actions.

The Act has been applied in other cases as well. In Everts v. South Lincoln Hosp. Dist., No. C84-0210-B (D. Wyo. Mar. 31, 1985), the court exercised what it believed was its discretion under the Act to award the plaintiff physician actual rather than treble damages. In Northern Valley Indian Health Clinic v. Indian Valley Hosp., No. S-83-1421 (E.D. Cal. June 13, 1985), the Act was applied with no explanation to protect hospital district defendants from damages, costs, and attorney fees in a staff privilege suit brought by a nurse practitioner.

91. See supra text accompanying notes 61-63 & 68.
purposes, then no "conspiracy" for section 1 purposes is possible because the requisite plurality of actors is missing.\textsuperscript{92}

On the other hand, it can be argued that since staff members have businesses independent of the hospital’s, their recommendations may be colored by what is in their own best interests which may diverge from the hospital’s best interests. In this case, the hospital and staff may be pursuing different goals, not acting as a single entity, and a conspiracy between them should be possible.\textsuperscript{93}

The analysis of when a corporation is capable of conspiring with its subsidiaries, divisions, employees, and agents—that is, the "intraenterprise conspiracy doctrine"—was chaotic\textsuperscript{94} prior to the Supreme Court’s 1984 decision in \textit{Copperweld Corp. v. Independence Tube Corp.}.\textsuperscript{95} In that case, however, the Court explicitly held that a corporation and its wholly-owned subsidiaries are incapable of conspiring among themselves as a matter of law. While that holding itself is of little value in a staff privileges case (unless the staff is viewed as a wholly-owned subsidiary of the hospital—a perception that might upset some physicians), the Court’s rationale for its decision provides guidance in assessing whether a hospital and its medical staff, or members of the medical staff inter se, should be capable of conspiring:

The officers of a single firm are not separate economic actors pursuing separate economic interests, so agreements among them do not suddenly bring together economic power that was previously pursuing divergent goals.

. . . A division within a corporate structure pursues the common interests of the whole rather than interests separate from those of the corporation itself[.]. . . Because coordination between a corporation and its division does not represent a sudden joining of two independent sources of economic power previously pursuing separate interests, it is not an activity that warrants § 1 scrutiny.

. . . A parent and its wholly owned subsidiary have a complete unity of interest. Their objectives are common, not disparate; their general corporate actions are guided or determined not by two separate corporate conscious-

\textsuperscript{92} \textit{See generally Note, "Conspiring Entities" Under Section 1 of the Sherman Act, 95 Harv. L. Rev. 661 (1982).}

\textsuperscript{93} \textit{See, e.g., Los Angeles Memorial Coliseum Comm’n v. National Football League, 726 F.2d 1381, 1387-90 (9th Cir.), cert. denied, 105 S. Ct. 397 (1984) (joint venture was a combination among its members); see also Fisher v. City of Berkeley, 54 U.S.L.W. 4222, 4223 (U.S. Feb. 26, 1986) ("Even where a single firm’s restraints directly affect prices and have the same economic effect as concerted action might have, there can be no liability under § 1 in the absence of agreement.").}

\textsuperscript{94} \textit{See generally AMERICAN Bar Ass’n SECTION OF Antitrust Law, Antitrust Law Developments (Second) 11-14 (1984).}

\textsuperscript{95} 104 S. Ct. 2731 (1984).
nesses, but one. . . . With or without a formal “agreement,” the subsidiary acts for the benefit of the parent, its sole shareholder.

. . . [A] parent and a wholly-owned subsidiary always have a “unity of purpose or a common design.” . . . [T]he parent may assert full control at any moment if the subsidiary fails to act in the parent’s best interests.96

Thus, the crux of the Court’s decision is the complete unity of interests among a corporation and those controlled by it, the related fact that such an amalgamation does not bring together entities which previously had been pursuing divergent goals, and the fact that the corporation “may assert full control” when necessary. Interestingly, however, the Court assumed, in dicta, that the activities of participants in joint ventures would meet the section 1 requirement for a “combination.”97

The Court recognized, but neither approved nor disapproved, the so-called “independent stake exception”98—a doctrine holding that a firm and its agents (which otherwise are incapable of conspiring) are capable of conspiring if the agent has an independent stake separate from its principal in the success of the alleged conspiracy among them.99 The parameters of the exception, however, are not clear. For example, is the theoretical possibility of an independent stake sufficient, or must it be shown that the independent stake actually was being pursued? Must the independent stake be the sole purpose for the defendant’s action? Dominant purpose? Or only some part of the reason for its action? What evidence adequately shows either the theoretical possibility or the actual pursuit of an independent stake? For example, is the fact that the plaintiff and a defendant are competitors sufficient? Is the test met when the alleged co-conspirators desire the same ultimate result but for different reasons?100 These are important questions to which clear answers are necessary.

The intraenterprise conspiracy doctrine issue has arisen (or at least been mentioned) in several antitrust staff privilege cases de-

96. Id. at 2741-42 (emphasis in original) (footnote omitted).
97. Id. at 2740-41.
98. Id. at 2741 n.15.
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cided both before and after Copperweld. Early on, in Sokol v. University Hospital,\textsuperscript{101} the court held that there could be no conspiracy, noting that where the action complained of was that of the hospital, the fact that the concurrence of other hospital personnel (a competitor of the plaintiff in that case) was necessary did not present the requisite plurality of actors. In Moles v. Morton F. Plant Hospital,\textsuperscript{102} where the defendants included the hospital and individual members of the medical staff’s executive and ad hoc committees, the conspiracy claim was dismissed preliminarily because the complaint failed to allege that the individuals were not acting as officials of the hospital.

In both Robinson v. Magovern\textsuperscript{103} and Williams v. Kleaveland,\textsuperscript{104} the courts held that medical staff members could conspire with the hospital because they were competitors of the plaintiff physician and thus might have an independent stake in excluding him from the staff. In Yurko v. Carteret County General Hospital,\textsuperscript{105} the Fourth Circuit went so far as to say that the hospital’s president, a layperson, might have been acting “individually” in revoking the privileges of physical therapists.

On the other hand, where one of the hospital’s alleged co-conspirators was a full-time physician-employee of the hospital, the court in McMorris v. Williamsport Hospital\textsuperscript{106} had no trouble in holding that the hospital and physician were incapable of conspiring because they were one entity.\textsuperscript{107} In also holding that the hospital and its medical staff were incapable of a conspiracy, the court recognized the independent personal stake exception but explained that the staff was acting as an “arm” of the hospital and, in addition, did not compete with the plaintiff.\textsuperscript{108}

The leading case at present focusing on the intraenterprise conspiracy question in the staff privilege context is the Third Circuit’s decision in Weiss v. York Hospital.\textsuperscript{109} There, where a hospital and its medical staff were found to have applied more stringent stan-

\textsuperscript{102} 1980-81 Trade Cas. (CCH) ¶ 63,600 (M.D. Fla. 1978), aff’d mem., 617 F.2d 293 (5th Cir.), cert. denied, 449 U.S. 919 (1980).
\textsuperscript{105} No. 82-2068 (4th Cir. Sept. 23, 1983).
\textsuperscript{107} See also Seglin v. Esau, 1984-2 Trade Cas. (CCH) ¶ 65,835 (N.D. Ill. 1984) (holding the same), aff’d on other grounds, 769 F.2d 1274 (7th Cir. 1985).
\textsuperscript{108} McMorris, 597 F. Supp. at 914.
\textsuperscript{109} 745 F.2d 786 (3d Cir. 1984), cert. denied, 105 S. Ct. 1777 (1985).
ards to the applications of osteopathic physicians than to those of allopathic physicians, the court held that the medical staff entity was incapable of conspiring with the hospital, but that "the medical staff itself is a combination as a matter of law."\textsuperscript{110}

The court's holding that medical staffs are "walking conspiracies" rather than single entities resulted from the fact that "[e]ach staff member . . . has an economic interest separate from and in many cases in competition with the interests of other medical staff members."\textsuperscript{111} On the other hand, the staff as an entity, according to the court, was actually empowered to make privilege decisions on behalf of the hospital and had no interest in competing with it. Accordingly, it was incapable of conspiring with the hospital.

The \textit{Weiss} decision seems to leave open the possibility of conspiracy between the hospital and staff where the hospital, rather than the staff, is the real decision maker, as well as the question of whether \textit{individual} staff members are capable of conspiring with the hospital as often is alleged. Where the hospital is the actual decision maker, the argument that it and the staff are one entity would appear to be even stronger because the hospital then is exercising the requisite \textit{Copperweld}-type control, and the relationship between it and its staff bears a stronger resemblance to a parent-subsidiary relationship. Whether an individual staff member can conspire with the hospital probably will depend on what the individual allegedly did. If he simply was a participant in the credentialing process, and his actions were merely part of that process, the \textit{Weiss} holding probably protects him from a claim that he conspired with the hospital. Otherwise, it may not.

It will be interesting to see if other courts of appeals follow the holdings in \textit{Weiss} that the medical staff itself is inherently a conspiracy but that, as an entity, it is incapable of conspiring with the hospital. The former holding appears correct for the reasons given by the court and clearly is supported by strong precedent.\textsuperscript{112} The court's holding that the hospital and medical staff cannot conspire seems more questionable.\textsuperscript{113} Clearly, for example, joint venturers

\textsuperscript{110} Id. at 814.

\textsuperscript{111} Id. at 815.

\textsuperscript{112} See, e.g., United States v. Topco Assocs., 405 U.S. 596 (1972); United States v. Sealy, Inc., 388 U.S. 350 (1967) (associations of competitors are combinations). The \textit{Weiss} holding was followed in Quinn v. Kent General Hosp., 617 F. Supp. 1226 (D. Del. 1985), where the court explained that staff members competed among themselves for "operating room facilities and the limited number of beds."

\textsuperscript{113} The court in Quinn v. Kent General Hosp., 617 F. Supp. 1226 (D. Del. 1985), also followed the \textit{Weiss} precedent on this issue but expressed doubt about its validity:
are able to conspire. Moreover, it is highly likely that the staff members' independent interests—the basis for the holding that the staff itself is a combination—may spill over into the staff's activities purportedly on behalf of the hospital. In general, there does not seem to be that "complete unity of interest" between the hospital and its medical staff that *Copperweld* appears to demand. Many hospital administrators wish that there were.

While application of the "independent stake exception" raises many subtle difficulties, it potentially provides a way to dismiss some staff privilege cases early in the litigation. For example, the court could require, as a prerequisite to the plaintiff's escaping summary judgment, that he produce evidence that a competitor, or the medical staff, acted in "bad faith" in the credentialing process. This showing would be required so that an independent stake in the success of the alleged conspiracy could be inferred, which in turn would substantiate the possibility of a conspiracy itself. The necessary proof might be similar to that used to prove the "sham" exception in cases involving the *Noerr-Pennington* doctrine. The problems with this approach are twofold: First, furtherance of an "independent interest" often can be achieved without engaging in sham activity; and second, sham activity is not necessarily indicative that an independent interest was being pursued. While somewhat ironic, the better approach toward early dismissal of staff privilege cases is to examine whether a conspiracy occurred as a matter of fact.\footnote{114. See infra Section V(C)(2).}

Perhaps in holding that a hospital and its staff cannot conspire,

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The reasons for the Third Circuit's holding are not entirely clear. The court stated that the medical staff was empowered to make staff privilege decisions on behalf of the hospital and, with respect to these decisions, operated as an officer of a corporation would in relation to the corporation, but the court also recognized that the members of the medical staff had independent economic interests of their own. The court appeared to place weight on the fact that the medical staff had no interest in competition with the hospital, but this is puzzling, since economic actors may combine for purposes of section 1 of the Sherman Act even if they are not competitors, as in the various vertical arrangements that are subject to proscription under section 1. *Id.* at 1243 n.16.

In fact, in focusing on whether the medical staff and hospital were competitors, the court focused on the wrong question. It should have focused on whether the staff and the applicant were competitors because that is what could negate the "unity of interests" between the staff and hospital. Cf. 7 P. Areeda, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 1471e at 295-96 (1985) (corporation and a separate firm run by the corporation's employee cannot conspire unless separate firm is a competitor of the plaintiff).

\footnote{115. See infra text accompanying notes 125-30.}
the court in Weiss did not want to, in effect, punish the hospital if the staff went off on its own "joyride." This seems unlikely, however, in light of the court's suggestion elsewhere in the opinion that the hospital could be vicariously liable for the conspiracy among staff members even though it was incapable of conspiring with the staff. 116 If the staff is a "walking conspiracy" and the hospital is vicariously liable for its actions, hospitals must monitor credentialing matters closely for their protection and for protection of their staffs.

b. Conspiracy as a Matter of Fact

Assuming a conspiracy among at least some of the defendants is possible as a matter of law, the question turns to whether a conspiracy occurred as a matter of fact. Thus far, courts have been hesitant to infer the requisite concerted action in staff privilege cases.

The evidence sufficient for an inference of conspiracy, especially in vertical restraints cases, is one of the most difficult issues in antitrust jurisprudence. Closely related is the question of what evidence of conspiracy a plaintiff must show to escape the defendants' motions for summary judgment on the conspiracy issue.

The Supreme Court's 1984 decision in Monsanto Co. v. Spray-Rite Service Corp. 117 sets forth some helpful guidelines applicable to the first question, although at least one court has held that a plaintiff need not meet those standards at the summary judgment stage. 118 The specific issue in Monsanto was whether sufficient evidence had been presented from which it could be inferred that the defendant supplier had terminated the plaintiff dealer as part of a vertical price-fixing agreement with other dealers; that is, alleged was a conspiracy between the supplier and some of its distributors to terminate a competitor of those distributors—a scenario quite analogous to that in the typical staff privilege suit where a plaintiff physician alleges that his competitors and the hospital conspired to terminate him.

Noting that a supplier typically "has a right to deal, or refuse to deal, with whomever it likes, as long as it does so indepen-


dently,"119 the Court felt that this important antitrust principle would be compromised "[i]f an inference of . . . agreement may be drawn from highly ambiguous evidence."120 A supplier's customers, the Court explained, are important sources of information, and thus to permit an inference of conspiracy based on complaints by some distributors against others, or even from the fact that the termination resulted from those complaints, "could deter or penalize perfectly legitimate conduct."121 Thus, there had to be more: Not only must there be evidence of a "conscious commitment to a common scheme," but "[t]here must be evidence that tends to exclude the possibility that the manufacturer and nonterminated distributors were acting independently."122

In the context of the usual staff privileges case, Monsanto suggests that a governing body's decision to accept a medical staff recommendation to deny an application or to discipline a staff member is insufficient evidence from which to infer a conspiracy. Indeed, several cases decided prior to Monsanto hold that a party's decision to accept a recommendation does not result in a conspiracy between it and the party making the recommendation. As one court explained in a slightly different context, "That a public official is persuaded by the entreaty of a lobbyist does not make him the lobbyist's co-conspirator."123 Monsanto's holding that a conspiracy between a supplier and dealer to terminate another dealer cannot be inferred from complaints and subsequent termination is analogous.

But implicit in Monsanto and similar cases is the assumption that the supplier, and not the distributors, is the actual decision maker and that, in making its decision, the supplier is determining its own independent "marketing strategy."124 Thus, it seems especially inappropriate to permit the inference of conspiracy where the medical staff's role is truly limited to examining a practitioner's credentials and behavior and then submitting a recommendation to the board, where the hospital's governing body makes a

119. 104 S. Ct. at 1469 (citing United States v. Colgate & Co., 250 U.S. 300 (1919)).
120. 104 S. Ct. at 1470.
121. Id.
122. Id. at 1471. For a helpful discussion of Monsanto, see McGibbon, Proof of a Vertical Conspiracy Under Monsanto, 30 Antitrust Bull. 11 (1985).
124. Monsanto, 104 S. Ct. at 1470.
serious and objective study of the matter, and where the rejection or exclusion promotes the hospital's economic interests (other than its interest in keeping the medical staff happy).

In fact, staff privilege antitrust litigation could be streamlined considerably if these standards were applied to motions for summary judgment by defendants. The plaintiff practitioner, to escape the defendants' motion for summary judgment on the conspiracy-in-fact issue, should be required to adduce evidence at a minimum that (1) the medical staff (or its members) went beyond merely making a recommendation; or (2) the governing body gave the recommendation no serious consideration before accepting it; or (3) the rationale for the governing body's decision was unrelated or only peripherally related to an independent economic interest of the hospital; or (4) the governing board acted with the specific intent of restraining competition in the relevant market for physicians services. Each of these factors tends to show that the hospital did not act independently and thus "tends to exclude the possibility that the [hospital] and [staff] were acting independently" as Monsanto requires.

The presence or absence of a medical staff anticompetitive intent or purpose should be neither necessary nor sufficient for a conspiracy to be inferred. Such evidence may be probative but should not be dispositive, even at the summary judgment stage. Of course, if, on summary judgment, affidavits submitted by the defendants deny a conspiracy, and the alleged co-conspirators had no motive to conspire, summary judgment is even more appropriate unless other evidence tends to show concerted action.

125. For one judge's view that courts are overly timid in granting summary judgment when purported "material" facts appear to be in "genuine" dispute and for an excellent discussion of when summary judgment should be granted, see Schwarzer, Summary Judgment under the Federal Rules: Defining Genuine Issues of Material Fact, 99 F.R.D. 465.

126. This requirement could be met, for example, by evidence that members of the staff tacitly or explicitly coerced the board to accept the staff's recommendation. Cf. Cernuto, Inc. v. United Cabinet Corp., 595 F.2d 164, 170 (3d Cir. 1979) (termination "alleged to have been predominately the result of customer pressure").


128. If an anticompetitive intent is not an essential element for a violation of § 1, see infra notes 154-55 and accompanying text, then it cannot be an essential element of a conspiracy.

129. See Kreuzer v. American Academy of Periodontology, 735 F.2d 1479, 1488 n.12 (D.C. Cir. 1984) (exclusion from a professional association; motive to restrain trade necessary before conspiracy can be inferred). The court also explained, with regard to summary judgment:

Once a plaintiff has brought forth sufficient circumstantial evidence from which a
standard suggested above mandates that governing boards play an active role in the credentialing process and that decisions be well documented. They should do this anyway, and it is a small price to pay to avoid a lengthy and complicated trial.

Case law on the conspiracy-in-fact issue in the context of antitrust staff privilege disputes is sparse, and most of the decisions predate Monsanto. In Alvares v. St. Francis Hospital,\textsuperscript{130} the court held simply that the plaintiff was unable to prove a "meeting of the minds" among the defendants to reduce his privileges. In McMorris v. Williamsport Hospital,\textsuperscript{131} the court held that a hospital's decision to close a department resulted from an independent consultant's report recommending that action rather than from a conspiracy. In McElhinney v. Medical Protective Co.,\textsuperscript{132} however, the court found a conspiracy where medical staff coercion was involved.

The most helpful pre-Monsanto decision is Robinson v. Magovern,\textsuperscript{133} where one question was whether sufficient evidence existed to infer a conspiracy between the hospital and Dr. Magovern, a department head and direct competitor of the plaintiff. In finding no conspiracy, the court emphasized that the hospital had no motive to conspire, and that even if Dr. Magovern reiterated his position against the applicant to hospital officials many times (thus, perhaps, going beyond a mere recommendation), no conspiracy could be found if he and the hospital reached their decisions independently. Seeming to anticipate Monsanto, the court explained that, "If the first entity discontinues its business relationship with a firm for its own, independent reasons, no concerted activity has occurred even though the second entity had requested that the first entity take such action."\textsuperscript{134}

In sum, courts appeared reluctant to infer the requisite conspiracy in staff privilege cases even before Monsanto, although none

\textsuperscript{130} No. CV-820-0239 (E.D.N.Y. 1985).
\textsuperscript{132} 549 F. Supp. 121 (E.D. Ky. 1982), rev'd mem. on other grounds, 738 F.2d 439 (6th Cir. 1984) (unpublished opinion reported at 1984-1 Trade Cas. (CCH) ¶ 66,054).
\textsuperscript{134} 521 F. Supp. at 907.
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really established concrete guidelines that might be helpful in counseling hospital or practitioner clients. It seems fair to assume that Monsanto will increase that degree of reluctance. Moreover, the standards enunciated in Monsanto, as well as those suggested here, should go far in permitting the dismissal of nonmeritorious cases at an early stage of the litigation.

c. The Appropriate Standard of Analysis

Assuming the requisite conspiracy, the question then becomes what antitrust standard of analysis to apply—the strict per se rule, the full-blown rule of reason, or some intermediate standard. Although no reported antitrust staff privilege case has applied a strict per se rule, several courts have indicated that they would do so in appropriate circumstances.

In Vučićević v. MacNeal Memorial Hospital, for example, the court indicated that it would have applied the per se rule if the hospital had not afforded the applicant procedural due process. This dicta, however, probably was overruled by the Supreme Court.

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135. This intermediate standard of antitrust analysis has been called the "truncated rule of reason," the "quick look rule," and the "facially unreasonable rule." In general, each involves an initial, early determination of the restraint's likely effect and its justifications before the court determines what standard of analysis to apply. See generally Areeda, supra note 113, at ¶ 1508-09; Brunet, Streamlining Antitrust Litigation by "Facial Examination" of Restraints: The Burger Court and the Per Se-Rule of Reason Distinction, 60 Wash. L. Rev. 1 (1984); Clanton, The FTC and the Professions, 52 Antitrust L.J. 209 (1983); see also infra text accompanying notes 142-47, 353-62, 379.


in its recent *Northwest Stationers* decision, where the Court held that whether an entity excluded from a group is afforded due process determines neither the standard to be applied nor whether an antitrust violation occurred.\(^\text{138}\)

In *Robinson v. Magovern*, the court suggested that the per se rule would apply to a group boycott, even if vertical in form: "If group A was to conspire with administrators at Hospital X to revoke the staff privileges of the members of Groups B and C, certainly a court would find that Group A and the hospital were engaged in an illegal group boycott."\(^\text{139}\) This dicta, however, should not be read literally.

In *Quinn v. Kent General Hospital*,\(^\text{140}\) the court refused to apply the per se rule where the hospital’s decision not to increase the plaintiff’s status from the courtesy to the active staff was based on the distance he lived from the hospital. It explained that

\[\text{[t]he distinction between a per se rule and rule of reason analysis has never been entirely clear, and in recent cases the Supreme Court has emphasized the importance of engaging in what amounts to a truncated rule of reason analysis before deciding whether to apply a per se rule. Among the factors the courts should consider are the market power of the defendants, the probable effects of the alleged restraint on competition and the plausibility of any procompetitive justifications for the practice.}\(^\text{141}\)

The reported decision which comes closest to applying the per se rule is *Weiss v. York Hospital*.\(^\text{142}\) The court there analogized the medical staff’s discrimination against osteopaths to a horizontal group boycott. Rather than applying a strict per se approach (under which the conduct would have been struck down regardless of its purported justifications),\(^\text{143}\) the court held that if the action

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If the challenged concerted activity of [the group’s] members would amount to a per se violation of § 1 of the Sherman Act, no amount of procedural protection would save it. If the challenged action would not amount to a violation of § 1, no lack of procedural protections would convert it into a per se violation because the antitrust laws do not themselves impose on joint ventures a requirement of process.

\(^\text{139}\) 521 F. Supp. at 906.


\(^\text{141}\) Id. at 1244 (footnotes omitted). The defendant’s motion for summary judgment was denied because factual issues were raised under the standard.

\(^\text{142}\) 745 F.2d 786 (3d Cir. 1984), cert. denied, 105 S. Ct. 1777 (1985).

\(^\text{143}\) See, e.g., National Collegiate Athletic Ass’n v. Board of Regents of the Univ. of Okla., 104 S. Ct. 2948 (1984) (consideration of justifications necessary, so per se rule not applied).
had been based on "public service or ethical norm[s]," it would have applied the rule of reason. Indeed, the court specifically held that the defendants could exclude unqualified practitioners or those engaging in professional misconduct from the hospital. Thus, the defendants in Weiss lost not because a strict per se rule was applied, but because they denied that the conduct in question occurred rather than attempting to justify it.

Weiss applied the middle standard of analysis—a truncated rule of reason or "quick look" rule. Because relevant markets were not defined, market power was not assessed, and the actual effect on competition was not examined, the analysis lacked the characteristics of a full-blown rule of reason inquiry. On the other hand, a true per se analysis would not have permitted justifications based on "public service or ethical norm[s]" or any other reasons.

It seems highly unlikely that any staff privilege case will be judged under a strict per se rule. Where the theory is that the conduct constitutes a group boycott, the Supreme Court's Northwest Stationers decision appears to require at least a threshold determination that the boycotters have market power or control of an essential facility. Other cases suggest that the per se rule is inapplicable absent an intent to drive out competitors and that the necessity for the restraint must be examined, at least if it is not clearly a naked restraint. This is as it should be. As discussed more fully below, exclusions from a hospital's staff may have little or no anticompetitive effect; they may even be procompetitive in both the hospital services and physicians services markets. Because they are not inherently "naked restraints of trade," the rationale for invocation of a per se standard simply is not applicable.

145. Weiss, 745 F.2d at 820 n.60.
146. See supra note 135 and accompanying text.
147. "In fullest flower, a per se rule condemns conduct without proof of power, effect, or purpose and without hearing claims of legitimate objectives." AREEDA, supra note 113, at ¶ 1509, p. 409; see also L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 68 (1977) (discussing elements of rule of reason analysis).
148. Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 105 S. Ct. 2613, 2621 (1985) ("When the plaintiff challenges expulsion ... some showing must be made that the cooperative possesses market power or unique access to a business element necessary for effective competition.").
150. See infra text accompanying notes 161-68.
151. See, e.g., Broadcast Music, Inc. v. Columbia Broadcasting Sys., 441 U.S. 1, 20
d. Purpose and Effect

Concerted action violates section 1 of the Sherman Act only if undertaken for anticompetitive reasons (that is, with an anticompetitive purpose or intent) or if its effect is to restrain competition unreasonably.\textsuperscript{152} The ultimate question in every antitrust case should be the effect of the restraint on competition—that is, whether output is restricted and prices increased.\textsuperscript{153} In staff privilege cases, however, with few exceptions, the dispositive variable has been the intent or purpose for the hospital's action. In some cases, the analyses of purpose or intent and effects melt into one, and the court assumes that if the hospital's stated purpose for its decision was not anticompetitive, then neither was the effect.

Early on, the Supreme Court held that "[g]ood intentions will not save a plan otherwise objectionable,"\textsuperscript{154} and it has never varied from that view.\textsuperscript{155} Notwithstanding this, the court in Robinson v. Magovern\textsuperscript{156} held that a plaintiff must show that the defendants' actions were the product of an anticompetitive motive. In Smith v. Northern Michigan Hospitals,\textsuperscript{157} the court flatly stated that the defendants must have intended to unreasonably restrain trade before a violation would occur. In Williams v. Kleaveland,\textsuperscript{158} the court explained that the issue was whether the defendants acted

\begin{itemize}
\item \textsuperscript{152} See United States v. United States Gypsum Co., 438 U.S. 422, 436 n.13 (1978).
\item \textsuperscript{153} See generally National Collegiate Athletic Ass'n v. Board of Regents of the Univ. of Okla., 104 S. Ct. 2948 (1984).
\item \textsuperscript{154} Appalachian Coals, Inc. v. United States, 288 U.S. 344, 372 (1933); see also Kreuzer v. American Academy of Periodontology, 735 F.2d 1479, 1492-94 (D.C. Cir. 1984), holding specifically that a restraint is not legal under a rule of reason analysis simply because it did not result from an anticompetitive intent.
\item \textsuperscript{155} See Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551, 1565 nn.41 & 42 (1984); National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679 (1978) ("public benefit" rationale not a relevant justification in a rule of reason analysis); see generally Areeda, supra note 113, ¶ 1506 at 390:
\begin{quote}
[A] good intention will not save conduct that we are otherwise prepared to judge unreasonably anticompetitive. . . . [E]mphasizing purpose frequently masks a failure to analyze the conduct. The judge or jury seems more comfortable examining the defendant's soul than analyzing his conduct and why antitrust policy calls for its prohibition or toleration.
\end{quote}
\item \textsuperscript{156} 456 F. Supp. 1000, 1006 (W.D. Pa. 1978) (denial of motions for summary judgment).
\item \textsuperscript{157} 703 F.2d 942, 949 (6th Cir. 1983) ("To establish a violation of section 1 . . . plaintiff must establish that the defendants combined or conspired with an intent to unreasonably restrain trade.") (footnote omitted).
\item \textsuperscript{158} 1983-2 Trade Cas. (CCH) ¶ 65,486 (W.D. Mich. 1983).
\end{itemize}
“in good faith for valid medical and business reasons.” And in *Pontius v. Children’s Hospital*, the court held that a hospital’s failure to reappoint a staff member was reasonable as a matter of law if not resulting from an anticompetitive purpose, if supported by substantial evidence, and if the plaintiff was afforded procedural due process.

Perhaps the reason why courts have relied so heavily on purpose and have been reluctant to assess actual effect is, first, that an appropriate examination of the exclusion’s actual effect is time consuming, complex, and even subjective; and second, that the purpose for which an activity is undertaken is at least probative of what its likely effects will be. Courts, however, do violence to both antitrust legal principles and antitrust policy when they make no effort to assess the restraint’s actual effect.

The analysis of an exclusion’s effect is difficult because two relevant product and two relevant geographic markets often will have to be defined, the effects on each analyzed, and then those effects balanced to see whether procompetitive or anticompetitive effects predominate. Each of these steps is complex by itself; in the aggregate, they can present severe analytical and measurement problems. Rightly or wrongly, however, this is what the antitrust laws require and what the parties deserve.

Typically, a hospital’s decision regarding staff privileges will affect, first, *its* competitive position in the hospital services market. Its decision may result from, for example, its desire to build a par-

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159. *Id.* at 68,357.
161. See, e.g., *Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918) ("knowledge of intent may help the court to interpret facts and to predict consequences").
162. In *Quinn v. Kent General Hosp.*, 617 F. Supp. 1226 (D. Del. 1985), where a physician was denied active staff status because of the distance between his home and the hospital, the court explained:

> [T]he defendants misconstrue the meaning of a rule of reason analysis. Such analysis would not merely consider whether the 10-15 mile rule imposed by the credentials committee is “reasonable” in the sense of being rationally related to legitimate purposes, such as insuring a high quality of effective medical treatment at the Hospital and limiting the Hospital’s vicarious liability that might arise from improper staffing decisions. Rather, a rule of reason analysis would have to balance any possible benefit accruing to patients from the rule against the rule’s anti-competitive effects in the market for hospital facilities. This analysis would require factual determinations as to the Hospital’s need for the rule to maintain quality medical care, the definition of the relevant market, the market power of the Hospital and its medical staff and the actual effect of the rule on competition among physicians for hospital facilities. Such factual issues obviously make summary judgment impossible.

*Id.* at 1244.
ticular type of department\textsuperscript{163} or research and educational programs\textsuperscript{164} to compete against other hospitals; or it may result from the hospital’s desire not to admit unqualified practitioners\textsuperscript{165} action clearly affecting its competitive status. Even in a one-hospital geographic market, the decision may increase the hospital’s efficiency—clearly a procompetitive effect. Usually, a hospital will be able to assert a procompetitive justification for its action. Proving and quantifying that effect, however, may be more difficult.

The anticompetitive effect from the exclusion normally will be felt in the physicians services market of the excluded practitioner. In many cases, he or she will not become, or will cease to be, a competitor in that market, especially if access to the hospital is essential to his or her type of medical practice. Even in that product market, however, the effect of the exclusion could be procompetitive if, for example, it enabled that market to rid itself of an incompetent.

The question of the exclusion’s effect on the physicians services market requires an analysis of what other facilities are available to the excluded practitioner within the relevant market\textsuperscript{166} and if none are, what the effect of the exclusion is on competition in that market. Measuring and then assessing that effect, again, will be complex and subjective. If the exclusion decreases the number of physicians in the plaintiff’s specialty from 100 to 99, little concern should arise. The antitrust laws are impersonal in nature; they protect competitors only to the extent necessary to ensure that the market is competitive.\textsuperscript{167} On the other hand, a decrease from two to one would present a different situation.\textsuperscript{168}

How and where should the line be drawn? The only practical


\textsuperscript{166} See, e.g., Robinson v. Magovern, 521 F. Supp. at 892 (applicant physician could perform the relevant surgery at several other hospitals in the area).

\textsuperscript{167} See, e.g., Brown Shoe Co. v. United States, 370 U.S. 294, 320 (1962). On the other hand, it could be argued that any reduction in the number of actual or potential competitors has some anticompetitive effect and should not be tolerated if absolutely no procompetitive effects result from the exclusion.

\textsuperscript{168} Where the hospital terminates but replaces a staff member, however, summary judgment for the defendants may be appropriate. See, e.g., Trepel v. Pontiac Osteopathic Hosp., 599 F. Supp. 1484 (E.D. Mich. 1984), aff’d mem., 780 F.2d 1023 (6th Cir. 1985).
means would appear to involve using some type of market structure test, especially since there likely will be no actual “before” and “after” empirical evidence about competitive variables such as price. For example, a measure of concentration such as the Herfindahl-Hirschmann Index which is applied in merger analysis could be used. 169 Analogous to the use of the index in merger analysis, an exclusion would be deemed to have the requisite anticompetitive effect if the post-exclusion level of concentration (as measured by the HHI), and the change in the index resulting from the exclusion (in the case of a termination of privileges) were at certain levels. 170

The most difficult issue will be comparing procompetitive effects in the hospital services market to the anticompetitive effects resulting in the relevant physicians services market. To some extent, this is analogous to comparing effects on interbrand and intrabrand competition in a nonprice vertical restraints case, 171 or, to a lesser extent, comparing the efficiency procompetitive effect and “dead weight loss” anticompetitive effect in a merger analysis. 172 Both types of examinations are notoriously difficult.

Rather than enter this admitted quagmire, courts have assumed implicitly that, if the hospital sets forth procompetitive justifica-

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169. See generally United States Dep't of Just., Merger Guidelines § 3.1 (June 14, 1984), reprinted at 2 TRADE REG. REP. (CCH) ¶ 4493. The Herfindahl-Hirschmann Index (HHI) is a statistical measure of market concentration, calculated by squaring and then summing the market shares of each firm in the market. The Department of Justice considers a market “highly concentrated” if the HHI is above 1800 and “moderately concentrated” if between 1000 and 1800. For a fuller discussion, see infra text accompanying notes 770-72.

Because the HHI guidelines were developed for analyzing mergers under section 7 of the Clayton Act, 15 U.S.C. § 18 (1982), and it is not clear that the analytical standards for analyzing anticompetitive effects under §§ 7 and 1 are the same, see infra notes 754-56 and accompanying text, some adjustments in the analysis (perhaps in the level of concentration that should trigger a finding of anticompetitive effect) may be appropriate.

170. In merger analysis, the change in the HHI shows the increase in the level of concentration resulting from the merger. See generally infra text accompanying notes 770-72. Because a new physician, whose application for privileges is denied, will have no market share, his exclusion will not change the HHI, and thus the change in the HHI cannot be used to measure the anticompetitive effect resulting from the exclusion. In this situation the conceptual underpinnings of “potential competition” merger doctrines could be applied. See infra text accompanying notes 310-18. In general, the requisite anticompetitive effect would be presumed if the market were highly concentrated and if the physician's entry likely would be a significantly deconcentrating factor.


tions for the exclusion, (1) the exclusion actually results in the procompetitive effects (in the hospital services market) the hospital says it does, and (2) those effects outweigh any anticompetitive effects in the relevant physicians services market. Indeed, while not stated as such, these presumptions underlie the writings of commentators who urge an intent-based test in hospital privilege antitrust cases. Some cases appear to go so far as to suggest that the hospital need only believe that the procompetitive reasons for its decision are valid and only have some “factual basis underlying each of” its reasons.

A better, although far from theoretically perfect, approach might be to establish procompetitive effects in the hospital services market as an affirmative defense. The plaintiff would have the burden of proving, first, that he or she is unable to obtain privileges at another hospital in the relevant geographic market, and second, based on concentration data, that the exclusion unreasonably restrains competition in the relevant physicians services market. The defendants would have the burden of proving the affirmative defense. If both sides met their burdens, the plaintiff would lose. While not as analytically pure an analysis as might be desirable (because effects in the two markets are not quantified and then balanced), the suggested approach seems to be the most that can be done given the practical constraints of litigation and the present state of economic theory.

If the purpose for the hospital’s action is a valid predictor of effect and because the hospital usually has no incentive to restrain competition in the relevant physicians services market (other than physician pressure), the hospital’s stated reasons for its actions should be given significant weight. Because, however, the focus of any antitrust analysis should be on the restraint’s actual effect on competition, the hospital’s stated reasons or purposes should not be dispositive.

3. Hospital-Physician Exclusive Contracts
a. Introduction

An exclusive hospital-physician contract—referred to here as an

175. See, e.g., Weiss v. York Hosp., 745 F.2d at 828 (“York, like any hospital, would maximize its revenues by giving staff privileges to every qualified doctor who applied.”).
"exclusive"—is an agreement between a hospital and a physician (or group of physicians) in which the parties agree that no other physician will be granted clinical privileges to render the medical services covered by the agreement. Not discussed here (because there have been no reported challenges) is the other side of the coin—that where the physician or group agrees not to render services at any other facility.176

Exclusive contracts are a form of vertical integration. As such, they can result in the same harms and benefits to competition as various forms of vertical integration in other industries.177 On the plus side are productive efficiencies and savings in transaction costs. On the minus side are potential foreclosure, collusion, and creation of barriers to entry.178 In the hospital setting, the integration can result from the hospital's employing the physician or from its entering into an agreement with the physician as an independent contractor. As noted later, the form that the integration takes can affect what legal theories may be applicable to challenge the arrangement.179

The antitrust problem normally arises when the hospital denies a privilege application because of its exclusive arrangement, when it decides to switch from an open staff to an exclusive, or when it terminates the physician with an exclusive and brings in a replacement.180 Although not always clear from the contract or the medical staff bylaws, a physician's loss of an exclusive contract usually

176. Theoretically, this type of provision could cause a problem if it "foreclosed" other area hospitals from providing the service in question. As a practical matter, it is difficult to believe that other hospitals could not, at a low cost, obtain their "own" physicians to provide the same services. Barriers to entry seem low and the geographic market nationwide. Thus, it is unlikely that an antitrust problem would arise. The contract examined in Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551 (1984), included such a provision, id. at 1555 n.3, but it did not require discussion by the Court.


179. See infra text accompanying notes 184-86.

180. It is hard to discern how the requisite anticompetitive effect could occur in the last situation. As one commentary notes, "It has been argued, with repeated success, that the substitution of one exclusive distributor for another should be lawful [because] the antitrust laws serve to protect competition, not competitors, and . . . substitution does not reduce the number of distributors competing." American Bar Ass'n Section of Antitrust Law (Monograph No. 9), Refusals to Deal and Exclusive Distributorships 26-27 (1983); see also Trepel v. Pontiac Osteopathic Hosp., 599 F. Supp. 1484 (E.D. Mich. 1984), aff'd mem., 780 F.2d 1023 (6th Cir. 1985) (no violation where one hospital-based physician substituted for another).
results in loss of his or her clinical privileges as well.\textsuperscript{181}

Exclusives differ from the usual staff privilege denial or termination in one important respect. Usually, the impetus for use of an exclusive, and thus the decision not to grant the applicant privileges, clearly comes from the hospital itself rather than the medical staff. Sometimes the decision is based on the recommendation of an independent consultant. In short, often it is clearer that the decision is really that of the hospital. Indeed, often the medical staff recommendation regarding the applicant will be positive. This is strongly probative of both the lack of intent to restrain competition in the physicians services market and also that the hospital believes, rightly or wrongly, that use of an exclusive contract promotes efficiency in the delivery of hospital services and thus that it is procompetitive. Further, the hospital must believe that these procompetitive justifications outweigh both the increased revenues that admitting more practitioners would generate and any anticompetitive effect in the market for physicians services.\textsuperscript{182}

The use of exclusives is quite prevalent. A recent study by the Hospital Research and Educational Trust discovered that some 73.4\% of responding hospitals used at least one exclusive.\textsuperscript{183} In terms of frequency, some 62.3\% had an exclusive in pathology, 59.5\% in radiology, 48.7\% in emergency medicine, 30.2\% in anesthesiology, and 12.7\% in cardiology. A superficial examination of reported antitrust cases where exclusives have been challenged suggests that the vast majority of litigation has involved exclusives in radiology and anesthesiology.

Two antitrust legal theories predominate in challenges to exclusive arrangements: First, that the agreement \textit{between the hospital and physician} is an exclusive dealing arrangement violative of section 1 because, under a rule of reason analysis, potential competitors are foreclosed from a substantial portion of potential customers; and second, that the arrangement results in a tying agreement \textit{between the hospital and certain of its patients}, because, to ob-

\begin{itemize}
\item \textsuperscript{182}. Because physicians services and hospital services are complements (that is, used together), when the price of physicians services rises (because of an anticompetitive effect in that market, for example), demand for hospital services will fall. See \textit{generally E. Mansfield}, \textit{Microeconomics: Theory and Applications} 118-21 (3d ed. 1979). Assuming that the exclusive does have some anticompetitive effect, the hospital must believe that any reduction in the demand for its services is more than offset by the arrangement's efficiencies.
\item \textsuperscript{183}. Morrisey & Brooks, \textit{The Myth of the Closed Medical Staff}, Hosps., Jul. 1, 1985, at 75.
\end{itemize}
tain certain types of hospital services that they desire, the patients must purchase physicians services from the group chosen by the hospital if they need that service.

The form the arrangement takes can be important. For example, where the physician under the exclusive is a hospital employee and is paid only a salary, a "conspiracy" between the physician and hospital usually is impossible because they are one entity for antitrust purposes. A tying claim in such circumstances is perhaps more viable than otherwise, however, because the hospital derives a direct economic benefit from the sale of the tied product and becomes a competitor in that market. Conversely, where the agreement is between the hospital and an independent contractor, it clearly meets the concerted action requirement of section 1. But if the physician bills separately from, and does not share revenues with, the hospital, a strong argument can be made that the hospital (the seller of the tying product) receives no direct economic benefit from the sale of the tied product, and thus, that no illegal tying arrangement can exist.

Early antitrust cases dealing with hospital-physician exclusives gave the plaintiffs' claims short shrift. In Harron v. United Hospital Center, for example, the Fourth Circuit instructed the district court to dismiss a case involving a radiology exclusive, explaining that "it is frivolous to urge that the employment of a single doctor to operate the radiology department of a hospital invokes the Sherman Act." The same court, five years later, affirmed a case involving an anesthesiology exclusive in which the district court had found no claim stated under section 1. The turning point toward a fuller analysis appeared to be the district and appellate court opinions in Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, a case involving an anesthesiol-

186. For a discussion of the relevance of the hospital's economic interest in the sale of the tied product, see infra text accompanying notes 253-61.
188. Id. at 1134.
190. 1982-1 Trade Cas. (CCH) ¶ 64,498 (N.D. Ill. 1981) (preliminary injunction granted), rev'd, 684 F.2d 1346 (7th Cir. 1982).
ogy exclusive. No tying claim was made, but the district court enjoined the arrangement as an illegal exclusive dealing contract under the rule of reason. It appeared to hold that patients were purchasers of the services provided by the physicians, that the one hospital where the exclusive was in effect was the relevant geographic market, and thus that the market was foreclosed completely to other potentially competing anesthesiologists. The Seventh Circuit reversed, holding that the hospital might be the real purchaser under the contract and, if so, that the geographic market might be substantially larger than the district court thought and foreclosure, accordingly, substantially less. On remand,\textsuperscript{191} the district court took the appellate court’s advice; it found a national market (from which the hospital could choose anesthesiologists) and thus little foreclosure. It also emphasized the efficiencies resulting from the arrangement which enabled the hospital to become a stronger competitor.

In a February 24, 1983 advisory opinion,\textsuperscript{192} the FTC approved an exclusive contract between a hospital and a group of radiologists. The group was chosen by the hospital after it had reviewed proposals from other groups (that is, there was competition for the contract), and three nearby hospitals offered similar radiological services. The hospital proposing to enter the exclusive had about 26\% of the beds in what appeared to be the relevant geographic market. The FTC analyzed the question under the rule of reason, recognizing that exclusives can have both procompetitive and anticompetitive effects. It explained that relevant factors included whether the decision to enter the contract was a unilateral decision by the hospital or the result of a conspiracy with the staff, the market power of the hospital, the purpose for the contract, its duration, and whether it achieved any procompetitive benefits.\textsuperscript{193}

b. The Hyde Decision

Next came the Supreme Court’s 1984 decision in \textit{Jefferson Parish Hospital District No. 2 v. Hyde}.\textsuperscript{194} East Jefferson Hospital, the

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  \item \textsuperscript{191} No. 81 C 4296 (N.D. Ill. 1983).
  \item \textsuperscript{192} Letter from Benjamin I. Berman, Acting Secretary, Federal Trade Commission, to Robert E. Nord (Feb. 24, 1983) (Burnham Hospital advisory opinion).
  \item \textsuperscript{193} For comments submitted by the American Hospital Association to the FTC concerning the potential procompetitive benefits from exclusive arrangements, see Letter from Richard L. Epstein, Senior Vice President, to Carol Thomas (December 21, 1982) with attachments.
  \item \textsuperscript{194} 104 S. Ct. 1551 (1984).
\end{itemize}
defendant, contracted with one group of anesthesiologists to provide all physician-anesthesiology services in its operating rooms. Thus, a patient using the hospital's surgical facilities, as a practical matter, had to use the one group chosen by the hospital for physician-anesthesiological services. The plaintiff, an excluded anesthesiologist, claimed that the arrangement constituted both an illegal tying agreement and an illegal exclusive dealing contract. With regard to the tying claim, the hospital's surgical facilities allegedly were the tying product, and the physicians' anesthesiology services were the tied product.\textsuperscript{195}

The hospital employed a number of nurse anesthetists to perform services which otherwise would have been performed by anesthesiologists. The patient was billed a single fee for all anesthesia services, which included the use of the hospital's equipment and nurse anesthetists, as well as the physicians' services. The hospital and the physician group split the revenues approximately in half. There were at least twenty hospitals in the New Orleans metropolitan area where the defendant was located, and the evidence indicated, at least according to the Court, that 70\% of hospital patients living in Jefferson Parish (where East Jefferson Hospital was located) went to hospitals other than East Jefferson.

The Court upheld the arrangement unanimously, but there was a sharp, five-to-four split over how the arrangement should be analyzed. Five Justices were unwilling to jettison application of the per se rule to all tying arrangements.\textsuperscript{196} It is perfectly appropriate, they explained, for a seller with market power in the tying product market to exploit that power by raising the price for that product; it is inappropriate, however, for a seller to exploit that power "to impair competition on the merits in another market"\textsuperscript{197} by forcing the purchaser to buy a second product. Accordingly, the "essential characteristic" for application of the per se rule is the seller's "exploitation" of its control or market power over the tying product to "force" the buyer to purchase the tied product—that is, either a product that the purchaser did not want at all or one that he may

\textsuperscript{195} A "tying arrangement" is "an agreement by a party to sell one product [the tying product] but only on the condition that the buyer also purchases a different (or tied) product, or at least agrees that he will not purchase that product from any other supplier." Northern Pac. Ry. v. United States, 356 U.S. 1, 5-6 (1958).

\textsuperscript{196} Hyde, 104 S. Ct. at 1556 ("It is far too late in the history of our antitrust jurisprudence to question the proposition that certain tying arrangements pose an unacceptable risk of stifling competition and therefore are unreasonable 'per se.' "). Justice Stevens wrote the opinion.

\textsuperscript{197} Id. at 1559.
have purchased from someone else.\textsuperscript{198} The per se rule, they held, is appropriate where "the existence of forcing is probable,"\textsuperscript{199} although elsewhere the opinion suggests that actual force must be shown.\textsuperscript{200} Forcing is likely where the tying product is patented, where "the existence of market power is probable,"\textsuperscript{201} or where the seller offers a unique product.

The concurring Justices, in an opinion by Justice O'Connor,\textsuperscript{202} put forth an analysis laced to a greater degree with economic analysis. They noted generally that the purchaser should be indifferent as to whether the seller of the tying product exploits its market power by charging a monopoly price for it or by requiring the purchase of a second product. As a matter of economic theory, the seller cannot do both\textsuperscript{203} and thus should be permitted to do either. Thus, they differed fundamentally with the majority as to how a seller should be able to exploit its monopoly power.

The concurring Justices would also jettison the per se analysis of tying arrangements and apply the rule of reason. Their reasoning is that the relevant market for the tying product has to be defined and the seller's market power assessed in any case, even under the majority's analysis. Given that these often complicated tasks must be performed anyway, they felt that courts might as well take the last step, apply a full rule of reason analysis, and examine the restraint's actual effect on competition. The requisite anticompetitive effect is impossible, they concluded, unless the seller has market power in the tying product and the market for the tied product is concentrated with high entry barriers.

\begin{itemize}
\item 198. \textit{Id.} at 1558. The majority later stated that there can be no anticompetitive effect where a buyer is forced to purchase a product that he otherwise would not have purchased at all "because no portion of the market which would otherwise have been available to other sellers has been foreclosed." \textit{Id.} at 1560. Courts subsequent to \textit{Hyde} have relied on this language in holding that there is no illegal tying arrangement where the purchaser, while forced to purchase the tied product, would not have purchased it at all but for the tying arrangement. \textit{See} Friedman v. Adams Russell Cable Servs., 1986-1 Trade Cas. (CCH) ¶ 66,933 (S.D.N.Y. 1986); Patterson Dental Co. v. McGaughey, 1986-1 Trade Cas. (CCH) ¶ 66,931 (D. Ore. 1985).
\item 199. 104 S. Ct. at 1560.
\item 200. \textit{Id.} at 1561 (emphasis added) ("we must consider whether ... [defendants] have used their market power to force their patients to accept the tying arrangement").
\item 201. \textit{Id.} at 1560.
\item 202. \textit{Id.} at 1569 (O'Connor, J., concurring). Chief Justice Burger and Justices Powell and Rehnquist joined in this opinion. Justices Brennan and Marshall wrote a separate short concurring opinion in which they noted only that the per se rule should continue to apply to certain tying arrangements. \textit{Id.}
\item 203. This is true at least where the two products are used in fixed proportions. \textit{See}, \textit{e.g.}, Bowman, \textit{Tying Arrangements and the Leverage Problem}, 67 \textit{Yale L.J.} 19 (1957).
\end{itemize}
Because there must be "two products" for a tying arrangement to exist, a second significant aspect of the decision was its analysis of whether one product or two was being sold. The answer, according to the majority, turns not on whether the products are functionally linked (that is, whether they are used together), but rather on the "character" of their demands. At bottom, it hinges on whether the products are in "two distinguishable product markets,"204 and this depends on whether there is "a sufficient demand for the purchase of anesthesiological services separate from hospital services to identify a distinct product market in which it is efficient to offer anesthesiological services separately from hospital services."205 Noting that the services "could be provided separately,"206 that patients frequently request a specific anesthesiologist, and that separate bills were rendered for anesthesiological and other hospital services, the majority concluded that "consumers differentiate between anesthesiological services and the other hospital services"207 and thus that two products were being sold.

The concurring Justices disagreed with this approach and set forth their own two-step approach. For there to be separate products, the allegedly tied product should be one that has independent uses—that is, uses other than in conjunction with the tying product. If the tied product is used only with the tying product, there is only a single product. In any event, the products should be viewed as one "[w]hen the economic advantages of joint packaging are substantial."208 Based on these standards, they felt that only one product was being sold.209

The majority indicated that the reasons for using an exclusive arrangement were irrelevant and that the alleged procompetitive benefits from it probably could be achieved through some less restrictive alternative.210 The concurring Justices disagreed, noting that "the tie-in conferred significant benefits." It "improves patient care and permits more efficient hospital operation in a num-

204. Hyde, 104 S. Ct. at 1563.
205. Id.
206. Id. (emphasis added).
207. Id. at 1564.
208. Id. at 1573.
209. "Patients are interested in purchasing anesthesia only in conjunction with hospital services, so the Hospital can acquire no additional market power by selling the two services together." Id. at 1574 (emphasis in original) (footnote omitted); see also R. Posner, Antitrust Law: An Economic Perspective 171-74 (1976); Bowman, supra note 203.
210. Hyde, 104 S. Ct. at 1565 nn.41 & 42.
ber of ways.”

The majority then turned to the remaining question of whether “this arrangement involves the use of market power to force patients to buy services they would not otherwise purchase.” Because some 70% of patients residing in Jefferson Parish, where the hospital was located, used hospitals other than the defendant hospital, its “‘dominance’” over residents was “far from overwhelming.” Accordingly, the hospital’s market power in the market for the tying product was insufficient to trigger a per se analysis.

The opinion finally turned to whether the arrangement constituted an illegal exclusive dealing agreement. This analysis, according to the majority, required “an inquiry into the actual effect of the exclusive contract on competition among anesthesiologists” for (1) patients, and perhaps, for (2) exclusive contracts with hospitals.

There was too little evidence of any actual adverse effect on the demand for specific anesthesiologists, or on the price or quality of anesthesiological services, to find a violation under the rule of reason.

Significantly, the majority concluded its exclusive dealing analysis by explaining that there must be “a showing of actual adverse

211. Id. at 1575.
212. Id. at 1566 (emphasis added); but see supra note 198.
213. 104 S. Ct. at 1566. The majority thus appeared to assume that Jefferson Parish was the relevant geographic market and that East Jefferson Hospital had a 30% market share. The validity of this is far from clear. First, the evidence showed that 70% of patients residing in the East Bank of Jefferson Parish (not the Parish as a whole) went to other hospitals. See Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. 532, 539, 542 (E.D. La. 1981), rev’d on other grounds, 686 F.2d 286, 289-90 (5th Cir. 1982). Moreover, the fact that 70% of patients residing in the East Bank (or the parish) used other hospitals provides little help in defining the relevant geographic market because patients using other hospitals may have used hospitals in the East Bank, in Jefferson Parish, or in the New Orleans metropolitan area as a whole. Thus, any one of these areas might be the relevant geographic market.

The evidence also showed that 70% of East Jefferson’s patients were residents of the East Bank of Jefferson Parish. See 513 F. Supp. at 543. Thus, 30% of the hospital’s patients came from outside that area, suggesting that the area is not a relevant geographic market, but providing little help in determining what the relevant geographic market actually was.

In sum, a geographic market could not be defined from the evidence presented in the case. Without defining a geographic market, East Jefferson’s market share in the tying product market was impossible to calculate. The Court appeared to hold in general, however, that a 30% market share in the market for the tying product (regardless of what the geographic market happens to be) is insufficient to trigger application of the per se rule. The Department of Justice’s Vertical Restraints Guidelines at § 5.3 (Jan. 23, 1985), reprinted at 5 TRADE REG. REP. (CCH) ¶ 60,473, suggest the same. It is highly unlikely that East Jefferson had more than a 30% market share in whatever the relevant geographic market actually was and in fact, it probably had substantially less.

214. Hyde, 104 S. Ct. at 1567 (emphasis added).
effect on competition."216 This language, together with a statement suggesting that there must be "an empirical demonstration concerning the effect of the arrangement on price or quality"216 indicates that a plaintiff may have to prove more than simply that a certain percentage of the market was foreclosed by the arrangement, and from that, ask the factfinder to infer an unreasonably anticompetitive effect. Rather, a plaintiff may have to show that effect directly—not a simple task.217

c. Post-Hyde Decisions and Remaining Questions

The Hyde analysis is sufficiently ambiguous that exclusive hospital-physician contracts should remain a fertile ground for antitrust litigation, especially in areas where the market for hospital services (or whatever the plaintiff alleges as the tying product) is highly concentrated. The majority opinion apparently ushers in no great change in the way tying arrangements will be analyzed.218 As one court has stated, "Hyde thus makes no change in the law concerning the use of a per se standard in tying cases."219

Thus, the major issues in tying cases will continue to be (1) determining when there are two products and what the relevant markets are; (2) determining what degree of "coercion" or "forcing" is necessary for application of the per se rule and what proof suffices to show it; (3) determining what, if any, "business justifications" will provide successful affirmative defenses; and (4) an issue not discussed in Hyde, determining whether the seller of the tying product has an economic interest in the sale of the tied product.220

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215. Id. at 1568.

216. Id. at 1567 n.49.

217. The Court emphasized that "[t]he record simply tells us little if anything about the effect of this arrangement on price or quality of anesthesiological services." Id. at 1568 n.52. Thus, rather than relying on a structural analysis to show the requisite effect, the plaintiff may have to show that the market actually is performing poorly.

218. Traditional tying analysis has received severe criticism. See, e.g., R. Blair & D. Kaserman, Antitrust Economics 404 (1985); R. Bork, The Antitrust Paradox: A Policy at War with Itself 365-83 (1978); Posner, supra note 209, at 171-84; Baker, The Supreme Court and the Per Se Tying Rule: Cutting the Gordian Knot, 66 Va. L. Rev. 1235 (1980); Bowman, supra note 203. In general, the criticism is that a seller, in most circumstances, cannot increase its market power by using a tying arrangement and thus that it should be permitted to exploit that power by either charging the profit-maximizing monopoly price or by using a tying arrangement, especially in light of the fact that tying arrangements can achieve procompetitive effects.


220. See infra text accompanying notes 253-61.
In an exclusive dealing analysis, the major issues will be (1) who should be deemed to be the purchaser of the service—the patient or the hospital—a(n) important issue *Hyde* touched upon but did not answer; (2) the relevant geographic market; (3) the degree of foreclosure and what degree may trigger illegality; (4) the procompetitive effects from the arrangement; and (5) precisely what type of evidence a plaintiff must adduce to show the requisite unreasonable anticompetitive effect. Post-*Hyde* cases, thus far, present little concrete guidance on any of these issues.

(1) **Two Products**

Few health care cases after *Hyde* have analyzed in detail whether, where an exclusive contract was used, separate products were being sold. The court in *Konik v. Champlain Valley Physicians Hospital Medical Center* held, with no analysis and based solely on the result in *Hyde*, that a hospital's operating room facilities and the provision of anesthesiology services were separate services. The issue, however, is one of fact, and while the *Hyde* analytical approach may be binding precedent, the majority's conclusion is not.

*McMorris v. Williamsport Hospital* applied the *Hyde* two-product analysis to a hospital exclusive contract arrangement where the physician was a hospital employee. The hospital employed a salaried nuclear medicine physician to administer its nuclear medicine department and provide all necessary physicians services. One issue on summary judgment was whether “use of nuclear medicine facilities” and “use of [the physician’s] services” were one product. The court refused to grant the hospital summary judgment on the issue, but noted that the question was closer than in *Hyde* because the patient received only one bill for all services and the physician was a hospital employee. On the other hand, it noted that some physicians did request the services of another nuclear medicine physician, that there was no evidence that nuclear medicine physicians usually are salaried employees, and that there was evidence showing that other hospitals permitted the two services to be purchased by patients separately.

The more interesting discussions have come in nonhealth care

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221. *See infra* text accompanying notes 266-72.
224. *Id.* at 910.
sector cases. In *Digidyne Corp. v. Data General Corp.*, for example, the issue was whether a computer central processing unit (the tied product) and its copyrighted "operating system" (the tying product) were one product or two. Noting that "a demand existed for the [tied product] separate from [the tying product], and that each . . . could have been provided separately and selected separately by customers if defendant had not compelled purchasers to take both," the court held that they were distinct products.

In *Casey v. Diet Center, Inc.*, the court emphasized that, under *Hyde*, there were two products if the demand for the products were "separate." Based on this, it found that a weight-loss franchise and diet pills sold by the franchisor to franchisees were one product because, but for the franchise, there would be no market at all for the pill, the pill could be purchased only by franchisees, and the pill was used as an integral part of the franchise program. This result, while perhaps correct in economic theory, seems wrong under *Hyde*. In fact, it is more consistent with Justice O'Connor's approach.

*Mozart Co. v. Mercedes-Benz of North America, Inc.*, discussed whether Mercedes-Benz autos and Mercedes replacement parts were separate products. Paraphrasing *Hyde*, the court explained that the test is "whether there is a 'sufficient demand' for the purchase of the tied product separate from the tying product 'to identify a distinct product market in which it is efficient to offer' the two separately." Noting that Mercedes had different personnel and price lists for auto and replacement parts sales, that many parts were manufactured by outside suppliers, and that there were separate demands for the autos and replacement parts, the court held that they were separate products.

The most interesting discussion thus far of the analytical difficulties in determining whether there are two products or one after *Hyde* is in *Jack Walters & Sons Corp. v. Morton Buildings, Inc.*, where the issue was whether a manufacturer of prefabricated farm buildings tied its sale of franchises and building components:
Almost every product can be viewed as a package of component products: a pair of shoes, for example, as a package consisting of a left shoe and a right shoe; a man's three-piece suit as a package consisting of a jacket, vest, and pants; a belt as a package consisting of a buckle and a strap. As shown by the last of these examples, it is possible to describe a product as a package of components even if the components are physically integrated at the point of sale to the consumer.

The problem is that there is no obvious way of deciding whether a product is a single product or an assemblage of components. The practice has been to classify a product as a single product if there are rather obvious economies of joint provision, as in the left-shoe-right-shoe example. A different but related approach was taken recently in the Jefferson Parish case... where the Supreme Court held that products are separate for tie-in purposes if there are separate markets for each product. The link to the older view is that if there are not separate markets, this is evidence that the economies of joint provision are overwhelming.

Only time will tell how far the "separate markets" approach of Jefferson Parish will be pushed. There are separate markets for sugar and for sugarless breakfast cereals, but it would be surprising to find that a sugary cereal was a tie-in (sugar tied to cereal), assuming the seller refused to sell a sugar-free version. The belt example also becomes problematic under the separate-markets approach. Belts are rarely sold without buckles; but surgical operations are even more rarely sold without anesthesia (held in Jefferson Parish to have been tied to the hospital's operating rooms). There may be overwhelming economies of joint provision for most customers and yet enough customers with idiosyncratic demands to encourage small markets tailored to their needs to emerge, as has happened with ornamental belt buckles. The separate market for ornamental buckles resembles the separate market for anesthesia, which exists because a patient can contract separately with the surgeon and with the anesthesiologist. We doubt that, even after Jefferson Parish, belts are tie-ins of buckles to straps; yet we cannot be sure where the separate market test will lead.

No doubt the Supreme Court's standard will lead to a great deal of confusion and inconsistent analysis. Ultimately, however, the

232. Id. at 703-04 (citations omitted).
233. Indeed, the Department of Justice's Vertical Restraints Guidelines (Jan. 23, 1985), reprinted at 5 'Trade Reg. Rep. (CCH) ¶ 50,473, which were issued after Hyde was decided, appear to reject the majority's standard. The Guidelines explain, "The Department does not view tied products as separate unless the 'tied' product has a use separate from the 'tying' product. Moreover, when the economic advantages of jointly packaging and merchandising two different products are substantial, the products will not be viewed as separate." Vertical Restraints Guidelines at § 5.21 n.34.

Congress has stated that the Vertical Restraints Guidelines should be recalled and not be considered as binding or persuasive by courts. In both a House resolution and a Department of Justice appropriations bill, Congress argues that the Guidelines do not reflect current law accurately. See Reagan Signs Appropriations Bill for Justice Department, FTC Funding, 49 Antitrust & Trade Reg. Rep. (BNA) 1056 (Dec. 19, 1985); Congress Takes Affirmative Steps to Attack Vertical Restraints Guidelines, 49 Antitrust & Trade Reg. Rep. (BNA) 1019 (Dec. 12, 1985). Indeed, one group was so upset with the Department of Justice's ver-
question of whether there is one product or two is a "red-herring" and unfortunately diverts the analysis from the appropriate question—the arrangement's actual effect on competition.

(2) Coercion and Market Power

The "coercion" or "forcing" element perhaps is the most confusing. The primary issues are three: Is coercion an element of a tying claim? Must there be actual coercion or only probable coercion? And if coercion is an element, what evidence suffices to prove it? After Hyde, it is clear that there must be a showing that the seller of the tying product coerced (or that it probably would coerce) the purchaser to buy the tied product or, if the purchaser would have bought it in any event, to purchase it from a source chosen by that seller.234

Some cases, however, hold that actual coercion must be shown only where there is no express contractual tie-in. In Cia. Petrolera Caribe, Inc. v. Avis Rental Car Corp.,235 for example, because there was no express tying arrangement, the court looked for affidavits from customers stating that they had been forced to purchase the tied product. Standing alone, the fact that a large percentage of customers actually purchased the tied product was not sufficient.

Another facet of the coercion element is exemplified in Coastal Neuro-Psychiatric Associates v. Onslow Memorial Hospital,236 which involved an exclusive contract relating to CT scans. The plaintiff alleged that the hospital's "hospital services" (the tying product) and its "CT scans" (the tied product) were tied. The court explained, however, that because all hospital patients were not required to have CT scans, there was no tying product. All those purchasing the tying product were not "coerced" to buy the tied product, and thus there could be no tying arrangement.

The Hyde decision itself is somewhat internally inconsistent as to whether coercion need be actual or probable.237 Several cases indicate, however, that a plaintiff-purchaser must show that it was actually an unwilling purchaser of the tied product238 or that it did

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235. 735 F.2d 636 (1st Cir. 1984).
236. 1985-1 Trade Cas. (CCH) ¶ 66,432 (E.D.N.C. 1985).
237. See supra text accompanying notes 199-200.
not want the tied product. These cases suggest that not only must the seller possess market power in the tying product, but that it must also actually exercise it. At least one case holds that a plaintiff must prove that "patients were forced to purchase the service of defendant doctors as a result of the hospital's market power." Thus, regardless of the hospital's market power, a plaintiff physician may have to present evidence that, but for that market power, patients would have chosen someone other than the "in" group to provide the tied service. In line with this, some cases hold that leverage or market power alone is insufficient to establish coercion.

Other cases are more ambiguous. While coercion cannot be inferred from the existence of a tying arrangement alone, some courts hold that coercion can be inferred from sufficient economic power plus the fact that an appreciable number of purchasers accepted the tie-in.

The majority in Hyde appears to hold that the requisite coercion may be inferred if (1) the tying product is patented, (2) the seller's share of the tying product market is "high," or (3) the tying product is "unique." Although not clear, perhaps the hospital then can present evidence that, regardless of its market power, patients would have chosen the approved group anyway, and thus, that it was not exercising whatever power it had.

If a plaintiff attempts to rely on a high market share in the tying product market to prove coercion, this certainly suggests that a relevant market must be defined and the seller's share of that market calculated. But in Digidyne Corp. v. Data General Corp., the Ninth Circuit held that a seller need not have a dominant position throughout a relevant market, but only with respect to "an appreciable number of buyers." Sufficient economic power was found

243. See, e.g., Airweld, Inc. v. Airco, Inc., 742 F.2d 1184 (9th Cir. 1984).
244. Hyde, 104 S. Ct. at 1560-61. One post-Hyde decision suggests that, to prove market power based on product uniqueness, a plaintiff must show that the price of the package exceeded the price at which the two products could have been purchased separately. Will v. Comprehensive Accounting Corp., 776 F.2d 662 (7th Cir. 1985).
245. 734 F.2d 1336 (9th Cir. 1984), cert. denied, 105 S. Ct. 3534 (1985) (White & Blackmun, JJ., dissenting).
solely because the tying product "was sufficiently attractive to some customers to enable defendant to require those who wished to obtain it also to buy [the tied product]." 246 Under this analysis, no relevant geographic market for the tying product even need be defined. The rationale of the opinion seems totally divorced from any economic analysis. 247

Plaintiffs in post-Hyde exclusive contract tying cases have relied on the hospital's market share or market power in attempting to prove the requisite coercion. None of the cases, however, provides substantial guidance. In McMorris v. Williamsport Hospital, 248 the court was unable to decide on summary judgment whether "the hospital possesses the degree of market power in the tying product (nuclear medicine services) necessary to 'force' purchases of the purported tied product ([the physician's] services)." 249 Stating that a high market share can lead to an inference of the requisite market power, and noting that the hospital appeared to provide between 50% and 60% of the nuclear medicine procedures in the area, the court still found that there was a genuine issue of fact concerning the hospital's market power.

Other cases contain even less help. In Mays v. Hospital Authority of Henry County, 250 which involved a radiology exclusive, no violation was found because there were at least two other hospitals "nearby" and some thirty or more in the surrounding Atlanta area. Similarly, in Gonzalez v. Insignares, 251 an exclusive in anesthesiology was upheld because residents in the area served by the hospital used some 24 other hospitals as well as the hospital with the challenged exclusive, and 60% of patients in the county where the hospital was located used other hospitals. The result was the same in Ezpeleta v. Sisters of Mercy Health Corp., 252 where a plaintiff anesthesiologist was denied a preliminary injunction because the hospital using the exclusive had only about 9% of the market for surgical patients.

The cases thus far do not address that situation which presents the greatest risk — the rural hospital with a monopoly-proportion

246. Id. at 1341 (emphasis added).
247. If the relevant geographic market is not formally defined, market power cannot be assessed unless elasticity of supply and demand statistics are available. See generally Landes & Posner, Market Power in Antitrust Cases, 94 Harv. L. Rev. 937 (1981).
249. Id. at 912.
252. 1985-2 Trade Cas. (CCH) ¶ 66,746 (N.D. Ind. 1985).
share in the market for the tying service. This, in fact, is perhaps
the situation where an exclusive is most needed, simply as an in-
ducement to physicians to leave the more comfortable confines of a
metropolitan practice.

(3) Economic Interest in the Sale of the Tied Product

An important question in tying analyses that often appears to be
overlooked, but which could lead to early disposition of many cases
is whether the hospital has a direct economic interest in the sale of
the physicians service. If not, numerous cases suggest that no ille-
gal tying arrangement can exist.

In the usual tying situation, a single seller sells both products
and thus benefits directly from the sale of the tied product. The
seller of the tying product, thus, is a competitor in the tied product
market as well. In Hyde, for example, the Court spoke as if the
hospital itself sold both services. In other situations, however, the
tyling seller may not sell the tied product itself but rather require
that it be purchased from an independent third party—that is,
there may be an "approved source" requirement. The seller of the
tying product may or may not have an economic interest in sales of
the tied product. Where the seller of the tying product has no eco-
nomic interest in the sale of the tied product, cases addressing the
issue hold that no illegal tie-in can exist. The issue was not dis-
cussed in Hyde because the hospital clearly had an economic inter-
est in the sale of the tied service. The physicians group and the
hospital split the proceeds from the anesthesia services, and the
service was rendered in large part by the nurse anesthetists em-
ployed by the hospital.

This "no economic interest" principle is well established. In
Midwestern Waffles, Inc. v. Waffle House, Inc., for example, the
court explained that "[a]n approved source requirement is not,
alone, illegal. . . . Only if a franchisee is coerced into purchasing

F.2d 1403 (9th Cir. 1984); Keener v. Sizzler Family Steak Houses, 597 F.2d 453 (5th Cir.

254. For example, the circuit court of appeals had explained:
While it is true that the tying of anesthesia services to operating rooms in the in-
stant case did not lead to a higher charge for anesthesia services, it accomplished just
as dramatic an effect by increasing the hospital's profit. The hospital realizes a sub-
stantial profit from its practice of supplementing a small contract group of anesthesi-
ologists with a much larger group of lower priced anesthetists.

Hyde, 686 F.2d 286, 291 (5th Cir. 1982).

255. 734 F.2d 705 (11th Cir. 1984).
products from a company in which the franchisor has a financial interest does an illegal tie exist." As the Seventh Circuit explained more recently, "[W]hen the seller of the tying goods has no interest in the sale of the tied product, he is not using his power in the tying product market to invade a second market." What constitutes a sufficient economic interest is not clear, but it seems it must be something in the nature of a rebate, commission or profit from the sale of the tied product; that is, the economic interest must be relatively direct.

The only case discussing the principle in the context of a hospital-physician exclusive contract is Griffing v. Lucius O. Crosby Memorial Hospital, decided two months before the Supreme Court's Hyde decision. The hospital had an exclusive in radiology with an independent contractor. The patient received a single bill reflecting a total fee set by the hospital. The hospital and the physician split the proceeds 60-40. The court emphasized that there can be no tie-in unless the seller of the tying product competes in the tied product market by either (1) selling the tied product itself, or (2) receiving profits, commissions, or rebates from its sale. It held that the part of the fees received by the hospital did not include any rebate or commission from the physician. The factual

256. Id. at 712 (emphasis added).

[T]he danger is that the tying seller will acquire market power in the tied product market. Absent a financial interest, the tying seller will not be using its market power in the tying product market to invade a second market and the tied goods will be (as they are here) independently priced by separate financial entities.


260. 1984-1 Trade Cas. (CCH) ¶ 65,854 (S.D. Miss. 1984).
261. The court explained:

There is no unlawful tying unless the seller of the tying product also competes in the market for the tied product, either by selling the tied product itself or by receiving profits, commissions or rebates from the sale of the tied product. . . .

It is not enough that the tying product's seller expects to or does profit from the "tying arrangement." The profit or rebate must be coming to that seller from the sale in the market for the "tied" product or services. . . .

Plaintiff's tying claim fails because it is missing this essential ingredient. The defendant Hospital is not profiting from the sale of the claimed tied service, i.e., [the defendant radiologist's] professional radiology services. The payment which [the defendant radiologist] receives is for professional services rendered by him and for ad-
situation in *Hyde* was distinguished on the ground that there, services upon which physicians based their fees were performed by hospital employees (the nurse anesthetists), the hospital realized a profit from these services, and thus the hospital was "competing" in the tied product market.

The *Griffing* holding and the "no economic interest" principle could provide some incentive for hospitals not to employ hospital-based physicians, but rather to use independent contractors. When the physician is an employee on salary, the hospital is bound to receive the requisite direct economic benefit. That benefit is much more unlikely, however, where the physician bills and keeps his or her revenues. The holding also could discourage the hospital's employment of paraprofessional personnel (as in *Hyde*) who provide or help provide the tied service. As in most situations, however, considerations other than antitrust are important in making these types of decisions, and the antitrust "tail" should not be permitted to "wag the dog."

(4) Exclusive Dealing Analysis

Plaintiff physicians have fared no better under an exclusive dealing analysis than under a tying analysis. The seminal decision establishing the framework by which exclusive contracts are analyzed is *Tampa Electric Co. v. Nashville Coal Co.*, where the Supreme Court explained:

*First*, the line of commerce . . . must be determined. . . . *Second*, the area of effective competition . . . must be charted by careful selection of the market area in which the seller operates and to which the purchaser can practicably turn for supplies . . .

*Third*, and last, the competition foreclosed by the contract must be found to constitute a substantial share of the relevant market.

In addition, it is clear that courts should consider any efficiencies
flowing from this form of vertical integration.264

The plaintiff in *Hyde* failed on his exclusive dealing claim because the “market has not been defined,” and there was insufficient evidence that the contract, “as it actually operates in the market, has unreasonably restrained competition.”265 The Court noted that competition among anesthesiologists might be for patients or for exclusive contracts, a very important analytical distinction. If the focus of competition among anesthesiologists is for the contract with the hospital, then the hospital should be viewed as the purchaser, and “the area . . . to which the purchaser can practicably turn for supplies” is large—perhaps nationwide. Foreclosure of one physician or group, accordingly, would result in a *de minimus* effect.

The idea that the hospital, rather than the patient, should be perceived as the purchaser has been urged by commentators266 and accepted by some courts.267 In *Rockland Physician Associates v. Grodin*,268 involving an anesthesiology exclusive, the court explained that “[t]he area from which the Hospital . . . seeks applicants for its exclusive contracts helps to define the relevant market in cases where, as here, there is little or no evidence that patients or surgeons ordinarily specify an individual anesthesiologist, so that the Hospital will be treated as the ‘buyer’ of services.”269 In fact, in *Aviani v. Sisters of St. Mary*,270 another case challenging an exclusive in anesthesiology, the plaintiff alleged that physicians were “customers” of the hospital for admission to the staff. Under this view, the relevant geographic market obviously is large since both hospitals and physicians each can “practically turn” to a large geographic area in meeting their needs. Finally, the court in *Alvares v. St. Francis Hospital*271 explained that “the market rele-

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264. See, e.g., Roland Mach. Co. v. Dresser Indus., 749 F.2d 380, 395 (7th Cir. 1984) (“The calculus of competitive effect must also include some consideration of the possible competitive benefits of exclusive dealing.”).


267. See, e.g., Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, No. 81 C 4296, slip op. at 9 (N.D. Ill. Oct. 25, 1984) (“it is the Medical Center, rather than the patient, that can properly be characterized as the real purchaser of anesthesia services and the relevant market can be defined as the area in which the Medical Center can practicably turn for alternative provision of anesthesia services”).


269. *Id.* at 956-57.

270. No. 82 C 2966 (N.D. Ill. June 14, 1985).

vant to the restraint alleged herein is the market for the supply of open-heart anesthesiology services by anesthesiologists to hospitals. Thus, the hospital, rather than the patient, is the ‘buyer’ of the relevant product."\textsuperscript{272}

Should it become generally established that the hospital is the “purchaser” of physicians services under exclusive contracts, plaintiff physicians will find it all but impossible to prove an exclusive dealing violation since the relevant geographic market will be large and any foreclosure would be slight. It would then seem anomalous that the same arrangement could constitute an illegal tying arrangement. The arrangement’s effect on competition is not a function of what it is called, and its legality should not depend on what label is attached.

It remains unclear what percentage of foreclosure triggers illegality or even serious concern or, after \textit{Hyde}, whether illegality can be shown by foreclosure without evidence of actual effects on price or quality—that is, evidence of effect on market performance.\textsuperscript{273} Perhaps the most that can be done is to attempt to apply the Department of Justice’s \textit{Vertical Restraints Guidelines}.\textsuperscript{274} Under these, foreclosure of 10\% or less appears to be a safe harbor.\textsuperscript{275} Beyond that, arithmetic computations of a “vertical restraints index” and “coverage ratio” are necessary, and these require information about the relationship that each hospital in the market has with its hospital-based physicians and their respective market shares.\textsuperscript{276}

The ultimate question is whether plaintiff physicians will be more successful in winning exclusive contract cases than they have been in the past. The likelihood is that they will not but that costly litigation will continue. In the context of a tying claim, many cases can be disposed of early if the hospital has no direct economic interest in the sale of the tied service, a fact that, when true, should be easy to prove. Early disposition of exclusive dealing claims could result from the hospital’s being deemed the purchaser under the contract, together with evidence that it recruits physicians on a regional or national basis. While both issues are factual

\textsuperscript{272} Id., slip op. at 57.
\textsuperscript{273} See supra text accompanying notes 215-17.
\textsuperscript{274} Supra note 233.
\textsuperscript{275} \textit{Vertical Restraints Guidelines, supra} note 233, at § 4.1. For an attempt to apply the Guidelines to hospital-physician exclusive contracts, see Miles, \textit{Hospital Exclusive Contracts and the Department of Justice Vertical Restraints Guidelines, Health L. Vigil, Mar. 8, 1985, at 7.}
\textsuperscript{276} \textit{Vertical Restraints Guidelines, supra} note 233, at § 4.1 nn.25-26.
questions, it would appear that both could be decided on summary judgment in many circumstances.

D. Conclusion

The lack of success by plaintiff physicians in staff privilege antitrust cases suggests that the number of these cases may decrease. There are several untested scenarios, however, which may lead to litigation. With the advent of diagnosis-related group reimbursement, hospitals must concern themselves with physicians who overutilize hospital services and increase the hospital’s costs unnecessarily. The ultimate recourse is to terminate those physicians’ privileges. Handled appropriately, a termination for this reason should not result in an antitrust violation because if the staff member is indeed an overutilizer, the exclusion has a procompetitive effect, and it is likely that the termination would result from unilateral hospital action.

A more difficult question is presented if a staff member’s privileges are revoked because he or she establishes a free-standing facility which competes with the hospital. No court yet has grappled with this issue, but it is bound to arise. A similar situation was alleged in one case, but the hospital’s decision to terminate a staff member was upheld because the court believed that the decision resulted from other, more legitimate concerns. Again, however, the hospital’s action would likely be unilateral, triggering application of section 2 rather than section 1. Staff privilege cases brought by allied health professionals (or enforcement agencies on their behalf) will also likely proliferate. There have been relatively few thus far, and the plaintiffs have been unsuccessful. Blanket exclusion of a class of practitioners, however, is troublesome, especially when the result of medical staff action, and some states prohibit them by statute.

277. The converse situation, where the staff pressures the hospital not to compete with its members, has arisen. See Medical Staff of John C. Lincoln Hosp. & Health Center, File No. 831 0147 (FTC Jul. 16, 1985), summarized at 3 TRADE REG. REP. (CCH) ¶ 22,271, where a cease and desist order was entered prohibiting the medical staff from boycotting the hospital to force it to cancel its involvement with an urgent-care center.


279. See, e.g., Health Care Mgt. Corp., File No. 841 0016 (FTC Oct. 10, 1985), summarized at 3 TRADE REG. REP. (CCH) ¶ 22,302 (consent order prohibiting hospital and staff from conspiring to restrict the practices of podiatrists).

280. See cases cited supra in notes 40-43.

281. See, e.g., D.C. Code Ann. § 32-1307(c) (1984) (medical staff membership must be
After *Hyde*, it would appear that exclusive contracts cases will be extremely difficult to win, especially in metropolitan areas. The post-*Hyde* cases seem to confirm this, but it will be interesting to see how the courts will analyze exclusive contracts used by rural hospitals.

III. HOSPITAL PARTICIPATION IN JOINT VENTURES

   A. Introduction

Hospital participation in joint ventures is not a new phenomenon. Shared service organizations, group purchasing programs, and equipment joint ventures, among others, have existed for many years. What is new is the recent growth in both the number and types of joint ventures which hospitals have established or joined.

The explosive growth of hospital joint ventures is a direct result of the highly competitive environment in which hospitals now find themselves. Prospective payment demands cost-cutting, and so the goal of some ventures is to achieve efficiencies. Prospective payment also induces hospitals to increase admissions, and therefore, the goal of other ventures is to increase market penetration or, at the least, protect market share already achieved. Hospitals have incentives to offer new services outside the sphere of traditional inpatient hospital services, and these often can be produced only, or most efficiently, through a joint venture. Finally, if competition becomes a nemesis, a joint venture (or what is labeled a "joint venture") can be used to eliminate it through collusion, aggregation of market power, or destruction of potential competition. Therein lies the potential antitrust problem.

Of all antitrust issues, the analysis of joint ventures is probably the most difficult and complex. As one commentator has stated, "No area of antitrust law is more murky than the application of the Sherman Act to joint ventures." As another has explained, "joint venture" is "an expansive notion without definite meaning

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Because, however, hospital participation in joint ventures will most likely increase dramatically in the future and because joint ventures can raise serious antitrust problems, their potential antitrust ramifications must be analyzed early on—that is, before the structure of the joint venture is established and before a final decision is made as to how it will operate.

Why is the analysis difficult? First, as suggested above, it is not clear precisely what a joint venture is. When two entities agree to do anything in conjunction with each other, the activity can be called a joint venture. Indeed, the term "joint venture" appears to be overused in the health care sector, especially by hospital executives who often refer to any type of cooperative arrangement as such, even agreements among competing hospitals as to what services each will offer.

Second, joint ventures can engage in an almost infinite number of different types of activities, each requiring a somewhat different antitrust analysis. Third, the economic relationship among the venturers can be of several types. The venturers may be actual competitors (a horizontal relationship), potential competitors (to a large extent analyzed as a horizontal relationship), a seller and a buyer (a vertical relationship), or unrelated (a conglomerate relationship). Each type can raise different antitrust issues. Fourth, the degree of economic integration resulting from the joint venture can be anywhere on a wide spectrum, and this greatly affects the antitrust analysis. Fifth, although joint ventures can raise a plethora of legal issues under sections 1 and 2 of the Sherman Act and section 7 of the Clayton Act, there are relatively few cases addressing their antitrust ramifications, and those cases that do exist tend to be ambiguous.

Regardless of labels, the ultimate issue in any joint venture analysis is the same as in any other antitrust examination: The ultimate effect on competition of the activity in question. In the case of joint ventures, as in the case of a merger or a contractual arrangement, the activity will often have both procompetitive and anticompetitive effects, and the trick is to ascertain which predominates.

286. See, e.g., Ventures Show Cooperation with MDs Up, Hosps., Oct. 1, 1985, at 37 (Ernst & Whinney study showing that 98% of responding hospital executives believed number of joint ventures involving hospitals and physicians will increase).
B. A Framework for Analysis

Because of the diversity in the forms that joint ventures can take, activities engaged in, types of participants, and likely resulting effects, it is hopelessly impossible to formulate specific rules that can be applied precisely or easily to every hospital joint venture that is encountered. The best that can be done is to set forth an analytical framework or checklist of general questions to be examined before an opinion of the venture’s potential antitrust ramifications is reached. The questions overlap to some extent, and, because the framework is general in nature, there are exceptions to many of the rules of thumb used and the conclusions reached. As in so many other areas of antitrust, small differences in the facts can lead to substantial differences in the conclusions.

In general, the analysis is simplified when the major potential antitrust problems are kept in mind. Succinctly stated, these are collusion, exclusion, and overinclusion (or “CEO”). In analyzing the venture, eight questions should be addressed. Three preliminary questions are: (1) Is the combination a true joint venture or is it a cartel? (2) Does the venture obtain an input for the venturers or does it produce an output? (3) Is the venture a horizontal or nonhorizontal venture? Once these questions are answered, the real antitrust analysis begins: (4) What product and geographic markets will the venture likely affect? (5) Is the venture overinclusive in that too large a percentage of providers are participants? (6) Is the venture underinclusive in that those who need access to it to compete effectively are excluded? (7) Does the venture contain unnecessary horizontal ancillary restraints? (8) Does the venture contain unnecessary vertical ancillary restraints?

A question cutting across all the above is the purpose for the venture. A purpose to achieve productive efficiencies or enter a new product or geographic market is perfectly appropriate. A purpose, however, to aggregate market power, provide a vehicle for collusion, or stymie other actual or potential competition always raises serious antitrust concern.

Joint ventures in the health care sector are many and varied. They might include a hospital which can be viewed as a joint ven-

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289. This question is not discussed separately in the article. In general, focus must be placed on effects in the joint venture's market and the markets of the individual venturers themselves.

290. Vertical restraints, potentially of an ancillary nature, likely will arise in the context of referral practices of hospitals to nonhospital providers. The antitrust concerns that these practices can cause are discussed infra at Section VI.
ture between the hospital entity and its medical staff; a preferred provider organization or other type of alternative delivery system; a venture among a hospital and other types of providers to render hospital or medical services in a free-standing facility, or to provide another type of service such as home health services or long-term care; a venture among hospitals or others to purchase and operate an expensive piece of equipment; an arrangement among two hospitals to manage or lease a third hospital; hospital group purchasing programs; or a health care coalition. A recent study indicates that the most frequent types of ventures among hospitals and physicians were, in order, ambulatory care facilities, alternative delivery systems, and long-term care facilities.²⁹¹ Other types included medical office buildings, clinical laboratories, laundry services, and substance-abuse programs.

1. *Is the Combination Really a Joint Venture?*

The formation of a joint venture is one method businesses can use to integrate some of their economic functions, whether it be purchasing, research and development, production, or marketing. The methods they can choose constitute a continuum representing various degrees of economic integration—from loose contractual arrangements, to the formation of a new entity in which some functions are integrated, to outright merger. Of course, a firm may choose not to integrate at all and thus attempt to accomplish its objective through internal expansion.

Where a form of integration between firms is chosen, a general rule is that the greater the degree of integration, the greater the efficiencies flowing from the arrangement, and thus, the greater the venture's likely procompetitive effects. The purpose for choosing the joint venture vehicle is usually to achieve as many efficiencies as possible or to enter a new market, while permitting the participating firms to remain autonomous in their other activities. Because joint ventures are often not permanent in nature and because the venturers remain free to compete against each other in markets in which the venture itself is not a competitor, the antitrust laws tend to treat joint ventures more leniently than mergers.²⁹²

²⁹¹ *Ventures Show Cooperation with MDs Up, Hosps.*, Oct. 1, 1985, at 37.
²⁹² As one former Assistant Attorney General has stated, "Because mergers generally do not carry with them the same promise for new operating capacity as many production joint ventures, the market concentration threshold at which anticompetitive concerns gener-
There is no completely acceptable definition of joint venture for antitrust purposes. The best, perhaps, is Professor Brodley's:

A joint venture can be defined for antitrust purposes as an integration of operations between two or more separate firms, in which the following conditions are present: (1) the enterprise is under the joint control of the parent firms, which are not under related control; (2) each parent makes a substantial contribution to the joint enterprise; (3) the enterprise exists as a business entity separate from its parents; and (4) the joint venture creates significant new enterprise capability in terms of new productive capacity, new technology, a new product, or entry into a new market.

This definition is helpful here, except that there seems to be no reason, at least for analytical purposes, to require that a new entity be established to carry on the venture's operations. The ultimate question is the effect of the integration on competition, and this is not a function of whether the venturers seek to accomplish their objectives by a contractual arrangement or whether a new, independent entity is formed. Thus, for present purposes, a joint venture is the partial economic integration of two or more firms (by the creation of a new firm or otherwise) which permits the substantially more efficient production or distribution of a good or service, or entry into a new product or geographic market.

The initial task is to examine whether the arrangement is indeed a joint venture whose purpose and likely effect are to increase output, or whether it is a cartel, whose purpose or likely effect is to restrict output and increase price. Often, answering this question requires examination of the other questions listed above, but it is a

ally arise should be greater for production joint ventures than for merger between the partners." P. McGrath, Assistant Attorney General, Antitrust Division, Text of Remarks before the Eighteenth Annual New England Antitrust Conference, at 14 (Nov. 2, 1984).

293. Brodley, Joint Ventures and Antitrust Policy, 95 HARV. L. REV. 1521, 1526 (1982); see also Brodley, Analyzing Joint Ventures with Foreign Partners, 53 ANTITRUST L.J. 73, 75 (1984) ("convenient legal test is whether . . . the undertaking involves the creation of a new product or entry into a new market or . . . a new competitive dimension").

294. As former Assistant Attorney General William F. Baxter has explained:

Functional integration can occur as genuinely through agreement as through ownership. What is important, rather is whether the scope of the coordination integrates non-trivial activities of the several firms or serves only to suppress rivalry between the firms.

. . . .

If antitrust significance is sensibly to be accorded to any distinction between integration through ownership and integration through contracting, that significance must be attributed to differences in practical consequences, as yet unidentified, that bear on the likelihood that choice of institutional form will contribute to the acquisition or exercise of market power.

good conceptual starting point.

The Supreme Court's decisions in *Broadcast Music* and *Maricopa County Medical Society* present interesting contrasts. In the former, numerous musical composers literally fixed the price paid for using their compositions by permitting Broadcast Music, Inc. (BMI), and the American Society of Composers, Authors and Publishers (ASCAP), their agents, to sell "blanket" licenses—that is, licenses by which users obtained the right to perform all compositions in the libraries of BMI and ASCAP for a single fee. The arrangement destroyed price competition among the composers. The two organizations facilitated dealings between composers and persons wishing to use their music and protected the music against unauthorized use.

Although recognizing that the arrangement "fixed prices" in a literal sense, the Court refused to apply the per se rule because of the substantial efficiencies that the arrangement achieved. The question, according to the Court, is "whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output, . . . or instead one designed to 'increase economic efficiency and render markets more . . . competitive.'" The arrangement resulted in substantial integration and, most important, led to a new product which none of the individual composers could produce. The Court concluded by noting that "[j]oint ventures and other cooperative arrangements are . . . not usually unlawful, at least not as price-fixing schemes, where the agreement on price is necessary to market the product at all."

In *Maricopa County Medical Society*, a number of otherwise independent, competing physicians formed a foundation for medical care through which they contracted their services as a group to insurers. As part of that arrangement, they agreed on the maximum prices that they would charge the insurers' beneficiaries.

The Court rejected the Society's argument that the foundation and its activities were analogous to those in *Broadcast Music*, and

298. The Court explained that "[t]he blanket license is composed of the individual compositions plus the aggregating service. Here, the whole is truly greater than the sum of its parts; it is, to some extent, a different product. . . . ASCAP . . . made a market in which individual composers are inherently unable to compete fully effectively." *Id.* at 22-23 (footnote omitted).
299. *Id.* at 23.
it therefore applied the per se rule to the maximum price-fixing agreement. The primary difference between the two factual settings, according to the Court, was that the foundation resulted in the sale of no new product. Rather, it simply provided a different vehicle through which physicians sold the same services that they had been selling before.\(^\text{300}\) The Court also emphasized that the arrangement was different from a partnership or other joint arrangement in which the venturers pooled their capital and shared risk in the venture’s success. Although recognizing that it might be more efficient for the physicians rather than the insurers to fix maximum reimbursement, the Court felt that this allegedly procompetitive effect would likely be small and was offset by the arrangement’s anticompetitive potential.

These two decisions provide significant guidance as to the variables a court will examine in determining whether the purported joint venture is indeed a joint venture. Are the venturers producing a new product? Do efficiencies from the arrangement appear to outweigh any anticompetitive effects from the venture? Do the venturers share the risk of the venture’s success? Are important business functions substantially integrated through the venture?

If the arrangement constitutes a joint venture, some facets of its operations which might otherwise might trigger the per se rule may be analyzed under some form of the rule of reason. As will become more clear below, however, often heard categorical statements such as “because it’s a joint venture, the rule of reason applies” are overbroad, ambiguous, and thus dangerous.\(^\text{301}\)

2. What is the Venture’s Function?

The next requisite determination focuses on what the venture produces. Very generally, a joint venture that produces (or otherwise obtains) an input which the venturers then use in their own individual production processes carries less antitrust risk than a venture which itself produces an output. Examples of “input joint ventures” include group purchasing programs and some types of shared services ventures such as a laundry. An example of an “output joint venture” is the joint operation by hospitals of a magnetic resonance imager.

The antitrust risks from input joint ventures are discussed be-

\(^{300}\) Maricopa County, 457 U.S. at 356-57.

\(^{301}\) See infra text accompanying notes 369-70, 391, 395, 398.
low.\textsuperscript{302} Suffice it to say here that exclusion of the venturers’ competitors can be troublesome if it adversely affects their ability to compete effectively, and a problem can arise if the venturers have substantial market power as buyers of the inputs which they obtain through the venture.

Especially in the context of a vertical joint venture, for example, one between a hospital and its staff physicians, it is not always easy to determine whether the arrangement should be analyzed as an input or output venture. To illustrate, the acquisition of a lithotripter by a hospital and its urologists would be viewed as an output venture by the hospital, but as an input venture by the physicians using it to the extent that it increased the competitive status of their individual practices. In this situation, the venture must be analyzed as both an output and an input venture.

In the case of an output venture, it is sometimes helpful to ascertain whether its function is research and development, production, or marketing. Production and marketing are often combined, but as a general rule, marketing joint ventures pose the greatest antitrust risks, with production ventures second, and research and development ventures third.

3. \textit{Is the Venture Horizontal or Nonhorizontal?}

As is perhaps obvious, joint ventures among competitors or potential competitors are more suspicious than those between non-competitors because of the antitrust law’s overriding concern with horizontal arrangements that may restrict output and increase price.\textsuperscript{303} As one court, in discussing a joint venture, explained:

When a group of competitors . . . join together to cooperate in the conduct of their business, there naturally arise antitrust suspicions. As Adam Smith, the archangel of the free enterprise system observed, “People of the same trade seldom meet, even for merriment or diversion, but the conversation ends in a conspiracy against the public or in some contrivance to raise price.”\textsuperscript{304}

The suspicion is much less where the arrangement is among non-competitors. In what perhaps is an overstatement, a former Assistant Attorney General in charge of the Antitrust Division noted:

\begin{itemize}
  \item \textsuperscript{302} See \textit{infra} text accompanying notes 335-46, 354-63.
  \item \textsuperscript{303} See, \textit{e.g.}, Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 52 n.19 (1977).
  \item \textsuperscript{304} United States v. Realty Multi-List, Inc., 629 F.2d 1351, 1370 (5th Cir. 1980) (footnote omitted).
\end{itemize}
I wish to emphasize that the following discussion focuses on joint ventures among firms that are or potentially may become direct competitors. Joint ventures among firms at the same level of production that have no such competitive links raise no competitive concerns. Thus, I would advise you not to lose any sleep worrying about the antitrust ramifications of such ventures—from an antitrust standpoint, they are legal.305

Three caveats are appropriate. First, nonhorizontal joint ventures may include restraints that can present serious antitrust concerns. In the context of joint ventures in which hospitals participate, the most likely problem will involve exclusive referral arrangements between the hospital and, for example, a home health agency joint venture in which the hospital has an interest.306 Second, the venture may be both horizontal and nonhorizontal. A hospital-medical staff preferred provider organization provides a classic example. In this situation, both potential horizontal and vertical issues must be examined. Third, with regard to an input venture, problems can arise where the venturers, while not competitors in the output market, are competitors in the input market. Group purchasing is a prime example.

4. Is the Venture Overinclusive?

The primary issue in most joint venture analyses will be whether the venture is overinclusive in the sense that too large a percentage of competitors or potential competitors in the market are participants. As one former Assistant Attorney General has stated, "The real problem with joint ventures, if there is a problem . . . , is that they are too inclusive."307 Legal principles under both section 7 of the Clayton Act and section 1 of the Sherman Act must be applied.

a. Section 7 of the Clayton Act

Section 7 of the Clayton Act prohibits acquisitions whose effects may be to substantially lessen competition. The section applies to the establishment of joint ventures.308

If the joint venture is among actual competitors to establish or operate another competitor (where, for example, two competing hospitals form a joint venture to operate a competing hospital),

306. See infra Section VI.
horizontal merger analysis under section 7 of the Clayton Act is appropriate, and the Department of Justice’s Merger Guidelines\textsuperscript{309} should be applied. If the venturers are potential competitors in either the product or geographic market in which the venture will operate, then section 7’s “potential competition” merger doctrines are appropriate.\textsuperscript{310}

The potential competition merger doctrines apply most often when the firm to be acquired is already in the market and the acquiring firm is not, but (1) the acquiring firm probably would have entered the market independently but for the acquisition (the “actual potential entrant” doctrine), or (2) the acquiring firm was perceived by firms in the market as a potential entrant and therefore constrained their competitive behavior with a resulting procompetitive effect (the “perceived potential entrant” doctrine).\textsuperscript{311} Although the elements of the doctrines are not crystal clear, four general conditions must be shown to prove a violation: (1) The relevant market must be highly concentrated; (2) the acquiring firm’s independent entry into that market, if it would have occurred, must result in a substantial likelihood of deconcentrating the market; (3) the acquiring firm must be one of only a few potential entrants; and, (4) under the actual potential entrant variant, the acquiring firm would have entered the relevant market independently but for the merger.\textsuperscript{312}

A potential competition analysis was applied in Yamaha Motor Co. v. FTC,\textsuperscript{313} where Yamaha and Brunswick established a joint venture to produce an outboard motor which was to be marketed in the United States. Brunswick already was the second largest

\textsuperscript{309} United States Dep’t of Justice, Merger Guidelines (June 14, 1984), reprinted at 2 TRADE REG. REP. (CCH) ¶ 4490. The Merger Guidelines as they apply to horizontal acquisitions are discussed in more detail infra at Section VIII(B).

\textsuperscript{310} See generally \textit{American Bar Ass’n Section of Antitrust Law, Antitrust Law Developments} (Second) 178-84 (1984); \textit{United States Dep’t of Justice, Antitrust Guide Concerning Research Joint Ventures} (1980).


\textsuperscript{312} The fullest recent discussion of the potential competition doctrines and their elements is in B.A.T. Indus., 3 TRADE REG. REP. (CCH) ¶ 22,218 (FTC Dec. 17, 1984).

\textsuperscript{313} 657 F.2d 971 (8th Cir. 1981), \textit{cert. denied}, 456 U.S. 971 (1982).
United States producer and the market was highly concentrated. In striking down the joint venture, the court asked whether “Yamaha, absent the joint venture, probably [would] have entered the U.S. outboard-motor market independently, and would this new entry probably have increased competition more than the joint venture did.”\(^3\) Answering the questions affirmatively, the court explained that Yamaha had both the ability and incentive to enter and that its independent entry would likely have deconcentrated a highly concentrated market.

The above analysis is not strictly applicable to most joint ventures because typically neither venturer is in the joint venture market initially. The purpose of the venture is to enter that market. Section 7, however, applies to the establishment of joint ventures even when neither of the venturers is in the market initially. In *United States v. Penn-Olin Chemical Co.*,\(^3\) two companies established a venture to compete in a new geographic market. The Supreme Court held that, under section 7, the issue was not whether both firms would have entered the market independently but rather whether only one would have entered by itself and the other would have remained “at the edge of the market, continually threatening to enter.”\(^3\) The case was remanded for this determination. Thus, a violation could occur if one of the venturers were an “actual potential” entrant while the other was a “perceived potential” entrant.

Neither of the firms participating in the proposed venture was already in the venture’s market in *United States v. FCC.*\(^3\) There, the question was whether the FCC should have approved a joint venture among Comsat, IBM and Aetna to provide a domestic satellite communications system. Opponents of the venture argued that it would destroy potential competition. Although the market was concentrated (there were four competitors at the time and another ready to enter), the court approved the venture. None of the venturers, in light of particularly high entry barriers, was likely to enter independently, and little procompetitive effect would result from one of the venturers remaining “on the edge” of the market threatening to enter.

How then might hospital joint ventures which enter a new market be analyzed? It probably is both safe and appropriate to apply
the *Merger Guidelines*. The first question is whether the joint venture market is already highly concentrated. If the HHI is less than 1800, the analysis can be ended and the joint venture passes section 7 muster. If the venture would be the first or only participant in the market, the market should be treated as highly concentrated. If the market is highly concentrated, the next task is to assess the number of potential entrants. Generally speaking, this involves examination of barriers to entry (CON requirements, for example) and a search for other firms with the ability and incentive to enter the joint venture market. If there are three or more potential entrants other than the venturers, the analysis probably can be ended and the venture likely is legal under section 7.

If there are few potential entrants, the analysis turns to what the individual venturers would likely have done had the venture not been established. If there are two potential venturers and it is likely both would have entered the market independently, the venture is probably illegal. It may also be illegal if only one would have entered, but the other would have remained on the “edge of the market” and constrained the competitive conduct of those in the market.

Several generalizations can be made. The first is that the discussion above is general. Potential competition cases today are extremely difficult to prove, and each element of a violation has a surrounding body of complex legal and evidentiary principles. In particular, determining which firms are potential entrants and establishing that one or more of the firms would have entered independently, but for the venture, present numerous questions and problems.

Second, entry barriers are crucially important in two, somewhat opposite, respects. As noted above, they may result in there being few potential entrants. On the other hand, however, they may be such that the relevant service can only be provided through a joint venture. In some circumstances, for example, a condition for obtaining a required CON may be that the service be offered through a joint venture, and it might be clear that no other CONs would be

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318. See *supra* notes 309, 312.

issued. Likewise, the service involved may have natural monopoly characteristics in the sense that demand and fixed costs are such that it would be grossly inefficient for there to be more than one supplier in the market.\textsuperscript{320} Still further, the cost (or risk) of the project may be such that no individual firm can (or is willing) to undertake it. In these situations, the venture is appropriate and legal. In particular, if, but for the venture, the service would not be provided at all (or no other firms would have entered the market), the venture should be legal under section 7.

\textbf{b. Section 1 of the Sherman Act\textsuperscript{321}}

Because the venturers typically will have other facets of their businesses independent from the venture, the venture will likely be treated as a "contract, combination, or conspiracy" within the meaning of section 1,\textsuperscript{322} rather than as a single entity to which only section 2 of the Sherman Act would apply.\textsuperscript{323} Once the concerted action requirement of section 1 is satisfied, the remaining questions are whether there is an anticompetitive purpose for the venture or whether it has an unreasonably anticompetitive effect. If so, the venture is illegal.\textsuperscript{324}

There are two potential "overinclusiveness" problems under section 1. First, the percentage of potential joint venturers in the market participating in the venture may be so large that the venture will have an unreasonable degree of market power. Second, and related to the first, the percentage may be so large that too few potential venturers are left in the market to establish competing ventures. This, in effect, is the potential competition problem that section 7 addresses. Both problems are lessened substantially to the extent that (1) there are numerous other competitors in the


\textsuperscript{321} Because the broad objectives of § 7 of the Clayton Act and § 1 of the Sherman Act are the same—to prevent anticompetitive conduct or actions likely to result in anticompetitive conduct — the antitrust analyses under the two statutes overlap to a substantial degree.


\textsuperscript{323} Section 2 also might apply to the venture's activities, but, because a joint venture is a "combination," it is hard to imagine conduct by it that would violate § 2 and not § 1.

venture's market, and (2) the venturers remain free (and have an incentive) to compete with the venture through participation in similar ventures. Indeed, the Department of Justice has stated that a production joint venture should create few problems if entry into the venture's market is easy and there are a significant number of potential entrants.325

As is the case under section 7, it is unlikely that a venture will violate section 1, regardless of its inclusiveness, if for technical or practical reasons, that degree of inclusiveness is necessary for the venture's service to be provided at all. Short of that, the percentage of potential venturers in the market actually participating in the venture—the "percentage of participation" is the term used here—should be limited to that number necessary for the venture to operate efficiently: "[T]he groups, in general, should be no larger than is necessary to exhaust scale economies," but "[a]s the inclusiveness of the group increases, as there comes to be room only for four or three or two more [ventures] of equal size, we should pay even closer attention to whether the scale economies really demand a group that inclusive."326

Not surprisingly, there are no clear rules regarding the percentage of participation in a joint venture that should trigger antitrust concern. Indeed, the figure will vary depending on many circumstances. The most important is whether the venturers are willing and able to participate in competing ventures. This will vary depending on the type of venture under consideration. In the case of a PPO, for example, the participants likely can and will participate in other competing "joint venture" health plans. The same would likely not be true in the case of a joint venture to purchase and operate a magnetic resonance imager. If the venturers can and would participate in competing ventures, then there should be little concern about the venture's market power or there being sufficient potential venturers to establish or participate in competing ventures. Thus, the percentage of participation, by itself, is not necessarily a reliable indicator of either the venture's market power or whether the venture will substantially reduce potential competition.

Cases provide little guidance as to how inclusive the venture can be. Rather, commentary is more helpful, although it is usually directed at specific types of ventures rather than joint ventures in

325. McGrath, supra note 305.
general—indicating again that joint venture analysis is fact-specific and that generalizations are both difficult and dangerous.

Particularly helpful with respect to analysis of provider-controlled health plans is the FTC Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans.\textsuperscript{327} So-called “partially integrated plans”—that is, plans where physicians establish, control, and participate in a plan but otherwise retain their independent practices—are analyzed as joint ventures. According to the Commission, sufficient potential competition should remain if the plan does not include more than two-thirds of the providers in the relevant market.\textsuperscript{328} The Commission, however, warns plans against requiring providers to agree not to participate in other plans, at least if the percentage of participation is likely to be such that other plans have difficulty finding providers to participate.\textsuperscript{329}

The Department of Justice has indicated that provider-controlled preferred provider organizations (PPOs) should be analyzed as joint ventures if their degree of integration is such that efficiencies would likely result.\textsuperscript{330} Efficiency-enhancing integrational characteristics, according to the Department, would include risk sharing features, discounts, utilization review, joint administration and marketing, and a limited-size panel which competes against other plans. The PPO should pass antitrust muster if any horizontal restraints are reasonably ancillary to the venture, the aggregate market share of the participants is not so large that it forecloses competition, and the venture has no anticompetitive purpose.

The Department suggests that a percentage of participation of 20% or less is a “safe harbor” and that, at this level of participation, the providers may even be able to agree on the prices they will charge through the PPO.\textsuperscript{331} Where the percentage is greater,

\begin{itemize}
\item \textsuperscript{327} 46 Fed. Reg. 48,982 (1981).
\item \textsuperscript{328} Id. at 48,991.
\item \textsuperscript{329} Id.
\item \textsuperscript{330} P. McGrath, Assistant Attorney General, Antitrust Division, Text of Remarks before the Thirty-Third Annual American Bar Association Antitrust Spring Meeting, at 7 (Mar. 22, 1985).
\item \textsuperscript{331} Id. Importantly, Mr. McGrath explained as follows:
\end{itemize}

To avoid the rule set forth in \textit{Maricopa}, the provider-controlled PPO must show that the horizontal aspects of its operations (e.g., an agreement between physicians setting price and utilization standards) are reasonably related and ancillary to a new competitive venture. Where a PPO can make the showing that it offers economic integration and efficiency advantages and that those advantages outweigh harms from lessening competition among participating providers, it should pass antitrust muster.

\textit{Id.} at 7-8.
the Department will attempt to assess the plan's probable competitive effect by examining whether providers are likely to participate in other plans, whether the plan's percentage of participation is necessary for it to compete effectively, the degree of actual and potential competition in the market for such plans, and the efficiencies that the plan achieves.

In one instance, the Department threatened to challenge a PPO under section 1.\textsuperscript{332} The plan was provider controlled and, depending on how the geographic market was defined, either 50\% or 90\% of physicians in the market were participants. In addition, however, the plan prohibited participants from contracting with other plans, and, according to the Department, the plan was formed with a purpose to inhibit the development of other PPOs and to suppress price competition.\textsuperscript{333}

Overinclusiveness analysis is also important in the examination of group purchasing program joint ventures. Although these programs can raise a plethora of antitrust issues,\textsuperscript{334} the three most important revolve around whether the program constitutes illegal price fixing by the participating purchasers, whether the plan will likely have monopsony power, and whether exclusion of those wishing to participate constitutes an illegal concerted refusal to deal. All depend to a large extent on the program's market power as a purchaser, and the percentage of participation bears directly on that issue.

Although the Supreme Court has held that naked price-fixing agreements among buyers share the same fate as those among sellers—per se illegality\textsuperscript{335} —the Court also has recognized that group purchasing programs may achieve significant efficiencies and should be analyzed as joint ventures rather than as naked restraints:


\textsuperscript{333} For advice relating to nonprovider-controlled health plan joint ventures, see, e.g., Letters from William F. Baxter, Assistant Attorney General, Antitrust Division, to Dr. Irwin S. Smith and Donald W. Fish (Sept. 21, 1983) (Department of Justice business review letters to Health Care Management Associates and Hospital Corporation of America).


\textsuperscript{335} \textit{See Mandeville Island Farms v. American Crystal Sugar Co.}, 334 U.S. 219 (1948).
Wholesale purchasing cooperatives . . . are not a form of concerted activity characteristically likely to result in predominantly anticompetitive effects. Rather, such cooperative arrangements would seem to be "designed to increase economic efficiency and render markets more, rather than less, competitive." . . . The arrangement permits the participating retailers to achieve economies of scale in both the purchase and warehousing of wholesale supplies, and also ensures ready access to a stock of goods that might otherwise be unavailable on short notice. The cost savings and order-filling guarantees enable smaller retailers to reduce prices and maintain their retail stock so as to compete more effectively with larger retailers.336

Given these potentially procompetitive effects, the analysis turns to identifying those situations in which they might be offset by anticompetitive effects. There are three: (1) where the purchasers in the aggregate have monopsony power over the inputs being purchased; (2) where the participants are competitors in the output market, the price of what is purchased is a significant fraction of the cost of the output, and thus explicit or tacit collusion over the output's price is likely; and (3) where a competitor of the participants is excluded and needs access to the program to compete effectively.

Although the courts have held that the purchasers' degree of market power as buyers is the most important variable,337 cases provide little specific guidance as to what degree of power should cause concern. More guidance can be obtained by extrapolating from some of the principles above and by examining Department of Justice views. Assuming, for example, that participants are not required to deal exclusively with the program but remain free to seek the best deal possible and that a participation percentage of 20% or less creates no problems for a PPO,338 it seems logical that a participation percentage of 20% in a group purchasing program would clearly create no problem unless those participants accounted for a disproportionately large market share of purchases.339

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338. See supra text accompanying notes 330-33; see also Letter from Arthur N. Lerner, Assistant Director, Bureau of Competition, Federal Trade Commission, to Michael L. Denger (Sept. 24, 1985) (favorable FTC staff advisory opinion to a PPO formed by purchasers of health care services; group stated that its market share as purchasers would not exceed 20%).

339. The Department of Justice has issued a number of recent business review letters
Antitrust Division officials have stated that the Division will begin to become concerned where the purchasers' aggregate market share constitutes 35% or more of the sellers' aggregate capacity.\textsuperscript{340} Thirty-five percent was chosen because that is the point, according to the Department's \textit{Merger Guidelines}, at which a single firm could begin to exercise market power.\textsuperscript{341}

It is important that the focus of the analysis be on the group as \textit{buyers} and not as sellers, and thus the relevant geographic market is the area from which the group does or could purchase. With regard to hospital group purchasing programs, which often deal with regional or national vendors, the relevant geographic market is relatively large, which means that the group's power is probably small.

The second potential problem focuses on the output market of the participants rather than on the input market. The fear is that if the participants are competitors, if all pay the same price for inputs purchased through the program, and if the cost of those inputs is a significant fraction of the price of the output (more than 20% according to the Department of Justice),\textsuperscript{342} then collusion over the price of the output becomes easy. For the collusion to have any effect, however, a substantial percentage of competitors in the output market would have to participate both in the purchasing program and the subsequent collusion. The theory seems somewhat far-fetched as a practical matter.

The final potential problem is exclusion—that is, whether a

\textsuperscript{340} See e.g., Letter from Douglas H. Ginsburg, Assistant Attorney General, Antitrust Division, to Alan F. Wohlstetter (Sept. 19, 1985) (business review letter relating to group purchasing program of Household Goods Forwarders Association; market share of less than .5%); Letters from Charles F. Rule, Acting Assistant Attorney General, Antitrust Division, to Arthur H. Harding and James A. Calderwood (Aug. 30, 1985) (business review letters to Mid-America National Cable Television Cooperative and the Wine and Spirits Shippers Association; market shares of less than one percent, and .6% or 4.9%, respectively, depending upon how market is defined).

\textsuperscript{341} \textit{Merger Guidelines}, supra note 309, at § 3.12.

\textsuperscript{342} Rule, supra note 340.
member's expulsion, or the refusal to admit someone who wishes to join, constitutes an illegal group boycott. This exclusion or under-inclusiveness issue is discussed later. Suffice it to say here that it usually raises an antitrust issue only if the venture is an input joint venture (such as a group purchasing program). For the problem to be serious, those participating in the venture must have substantial market power, participation must be necessary for the excluded party to compete effectively, or there must be little or no pro-competitive justification for the exclusion.

The government enforcement agencies have taken lenient attitudes toward group purchasing programs. The Department of Justice explains, in general, that such ventures should cause few problems if they do not result in monopsony power in the input market or collusion in the output market. In addition, the Department suggests that participants should remain free to deal with other sellers, negotiations with sellers should be conducted by someone other than an employee of an individual participant, and communications between the venture and individual members should be kept confidential. The last two of these requirements add some degree of safety, but their marginal contributions seem minimal.

The Federal Trade Commission has issued two letters and the Department of Justice one which provide advice to health care sector group purchasing programs. One of the Commission's letters, to the Louisiana Health Care Association, merely mentioned what could cause problems: significant market power, unreasonable exclusion from participation, and the creation of a forum for possible collusion. Somewhat more helpful, but still lacking in analysis was the Department of Justice's business review letter to the Ohio Hospital Association. That purchasing group represented some 160 of the 204 nonprofit hospitals in Ohio. It recommended to hospitals from whom they should purchase, but hospitals could purchase from whomever they wished. The group would permit nonmember hospitals to participate upon payment of their "fair share" of the program's cost. The letter does not disclose the

343. See infra Section III(B)(5).
344. Rule, supra note 340.
346. Letter from William F. Baxter, Assistant Attorney General, Antitrust Division, to B. William Dunlap (June 9, 1982).
group's likely market share as purchasers. Rather, the Department simply stated that the program probably would result in "further cost containment by hospitals" and indicated that no challenge would be forthcoming.

The letter is particularly interesting because, at first glance, the percentage of participation seems high—78% of the nonprofit hospitals in Ohio. Because, however, the relevant geographic market probably was national and because participating hospitals were not bound to deal with sellers chosen by the group, the group's market power was likely small.

5. Is the Venture Underinclusive?

Many joint ventures do not include all firms that wish to participate. Moreover, it may become necessary, once the venture is formed, to expel a member. In either case, the question becomes whether the exclusion constitutes an illegal group boycott, a denial of access to an essential facility, or an illegal predatory refusal to deal.

At first glance, the antitrust laws appear to place the venture in a "Catch-22" situation. On one hand, the venture encounters serious trouble if it is overinclusive. On the other, the venturers may engage in what often is said to be a per se violation—a group boycott—if they agree to exclude those who wish to participate. This dilemma, however, is more theoretical than real. Language in cases suggesting that all group boycotts are per se illegal are clearly overstatements, especially after the Supreme Court's decision in Northwest Wholesale Stationers.

347. Former Assistant Attorney General William F. Baxter has explained the problem and set forth a guideline:

"If scale economies really require an assemblage as large as 20 in order to do the [research and development], what about the ten that have been left out. They are now at a permanent disadvantage. This is the circumstance under which questions about underinclusiveness arise.

Questions about underinclusiveness should arise only when more than half of the industry get together in the joint venture. It would be a rare industry where, it seems to me, any such fraction would be necessary.

Baxter, supra note 307 (emphasis added).

348. See, e.g., FMC v. Aktiebolaget Svenska Amerika Linien, 390 U.S. 238, 250 (1968) ("Under the Sherman Act, any agreement by a group of competitors to boycott . . . is illegal per se.").


A first step in examining an exclusion from a joint venture is to determine the exact type of venture involved. In the case of an output joint venture, it is hard to discern how exclusion can result in an adverse effect on competition. Antitrust policy would encourage exclusion to the extent that inclusion is unnecessary for the venture's efficient operation. Indeed, it would encourage those excluded to establish competing joint ventures. The exclusion problem should thus arise primarily when the venture has characteristics of an input joint venture—that is, it provides the individual venturers with a competitive advantage which permits them to compete more effectively as individual entities.

The Department of Justice's concern about the percentage of participation in PPOs indicates that it views them primarily as output joint ventures. Unless undertaken for an anticompetitive purpose, a PPO's exclusion of providers wishing to participate usually should not raise an antitrust problem. Indeed, the exclusion is procompetitive to the extent that those excluded likely will join or establish competing programs.

Group purchasing programs present the opposite case. Exclusion theoretically could result in the excluded party's being placed at a serious competitive disadvantage vis-a-vis participants as a result of significantly higher input costs. Outside the health care sector, multiple listing services present a similar situation. These, typically, are joint ventures whose purpose is not to compete with

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351. See supra text accompanying notes 330-31.

352. See McGrath, supra note 330, at 10:

[F]rom an antitrust perspective, at least, PPOs need not be overly concerned about excluding physicians or hospitals as participants. The essential feature of a PPO is its selectivity, and the primary competitive risks associated with PPO formation—as with most joint ventures—are of over-inclusiveness rather than exclusion. Thus, the exclusion of some interested physicians and hospitals will likely promote competition among panels, and is a necessary part of the process.

But see Letters from Arthur N. Lerner, Assistant Director, Bureau of Competition, Federal Trade Commission, to William Kopit (March 26 & May 22, 1984) (informal advice relating to Kitsap Physicians Service). The service was a physician-sponsored plan with between 25% and 33% of the health plan market and 95% of area physicians as participants. It asked the FTC whether it could "deny membership . . . to all [new] physicians in a specific category in which the physician to enrollee ratio is currently higher than certain specified generally accepted standards."

Mr. Lerner replied that such a policy could result in "substantial anticompetitive effects" because it would "discourage or prevent entry by many [new physicians] into the market." The letter appears to stand for the proposition that if the plan already has a large market share and percentage of participation, then everyone must be permitted to join. The plan apparently is viewed as as an input rather than an output joint venture.
other joint ventures (although this certainly is possible), but rather whose purpose is to provide members with an input that results in their having an important competitive advantage over nonmembers. Antitrust scrutiny of exclusions, therefore, is important.

Even where exclusion has the potential to create an anticompetitive effect, however, several conditions are necessary before that effect can come to fruition. First, the output market in which the members of the venture participate must be concentrated. If the structure of that market is atomistic, the exclusion results in no anticompetitive effect even if exclusion from the joint venture prevents the excluded party from competing in the market at all. Second, the inability to participate must raise the excluded party's costs to the extent that it cannot be an effective competitor. Third, participation in or formation of a similar group affording comparable benefits must be impossible—that is, there must be entry barriers. And fourth, any anticompetitive effects must outweigh any procompetitive effects or efficiencies resulting from the exclusion.

Especially in recent years, courts have become more willing to take at least a "quick look" at group boycotts or exclusions rather than immediately applying a strict per se rule. Indeed, there is developing a middle ground of antitrust analysis between a strict per se rule and the full-blown rule of reason inquiry which requires detailed delineation of markets and a complex assessment of actual effects. The two most important variables in this preliminary, "quick look" analysis are the purported justification for the exclusion and the joint venture's market power.

United States v. Realty Multi-List, Inc., a government challenge to a multiple listing service's criteria for membership, presents an interesting example of this approach. The court analogized the membership restrictions to a group boycott, noting that "[t]he presence of purposely exclusionary or coercive conduct," would indicate that the per se rule should apply. It also noted, however, that "‘there is more confusion about the scope and operation of the per se rule against group boycotts than in reference to any other aspect of the per se doctrine.’” Determining that it should "inquire further to determine whether the practice is at least potentially reasonably ancillary to joint, efficiency-creating

354. 629 F.2d 1351 (5th Cir. 1980).
355. Id. at 1366.
356. Id. (quoting L. SULLIVAN, HANDBOOK ON THE LAW OF ANTITRUST 229-30 (1977)).
economic activities,” the court refused to apply the per se rule because reasonable ancillary restraints were necessary to permit the venture to accomplish its procompetitive purposes, and there were legitimate reasons to have membership restrictions.

The court explained that exclusion would be per se unreasonable if the venture had significant market power and the restraint lacked competitive justification or was broader than necessary to meet the venture’s legitimate needs. Based on that analysis, it found the membership restrictions in question illegal. The standard, referred to by the court as “facial unreasonableness,” is neither a strict per se rule nor the traditional rule of reason.

More recently, the Supreme Court put to rest the notion that all group boycotts are per se illegal in *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.* The plaintiff there claimed that its expulsion from a purchasing cooperative controlled by its competitors was per se illegal. The Court, while noting that “[g]roup boycotts’ are often listed among the classes of economic activity that merit per se invalidation under § 1,” explained that per se condemnation is generally inappropriate unless the restraint is “likely to result in predominantly anticompetitive effects.” An exclusion, according to the Court, is not likely to have the requisite anticompetitive effect “[u]nless the cooperative possesses market power or exclusive access to an element essential to effective competition.” A “threshold showing” of one of these factors must thus be made before per se analysis is appropriate. Lower courts were warned not to apply a strict per se rule to group boycotts without determining preliminarily that the action, on the specific facts presented, would likely have an anticompetitive effect.

Exclusion can also raise antitrust issues under section 2 of the Sherman Act where the venture is charged with monopolization or

358. *Id.* at 1369.
360. *Id.* at 2619.
361. *Id.* at 2620.
362. *Id.* at 2621. It is hard to discern why the cooperative’s having market power or access to an essential facility logically leads to the conclusion that the exclusion likely will be “predominantly” anticompetitive. If the market in which the venturers compete is atomistic, the exclusion will have little, if any, effect. Moreover, regardless of the group’s market power, there may be reasonable, procompetitive justifications for its action. See generally Baxter, *Preface to A Review of Antitrust Division Briefs*, 15 J. Reprints for Antitrust L. & Econ. i, xix-x (1985) (discussing circumstances under which exclusion can have anticompetitive effects).
attempted monopolization by denying a competitor access to an essential facility or by engaging in a predatory refusal to deal. Indeed, when a plurality of actors is involved, the essential facilities scenario is simply a type of group boycott. The elements of the claim, whether brought under section 1 or section 2 mirror the analysis in *Northwest Stationers*:

The case law sets forth four elements necessary to establish liability under the essential facilities doctrine: (1) control of the essential facility by a monopolist; (2) a competitor's inability practically or reasonably to duplicate the essential facility; (3) the denial of the use of the facility to a competitor; and (4) the feasibility of providing the facility.\(^3\)

Under this standard, a plaintiff must prove what it would have to prove to show a per se violation under *Northwest* (assuming the requisite agreement) and more. Thus, if a plaintiff could not succeed on a section 1 group boycott claim, it would likely have no more success under section 2.

A final argument the excluded party might make is that the venture's refusal to deal with it was "predatory." In *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*,\(^3\) the Court discussed when a firm with monopoly power in an output market must deal with a competitor which needs that firm's cooperation to compete effectively. Although noting that a single firm, even one with monopoly power, can usually deal with whomever it chooses or not deal at all, the Court recognized an exception to this general rule when the refusal is "predatory." A predatory refusal to deal or cooperate evidences an intent to monopolize that, when combined with monopoly power, results in illegal monopolization under section 2.\(^3\) A refusal to deal is predatory, according to the Court, when its sole rationale is to harm a competitor, when no efficiency considerations justify it, and where the defendant elects to forego the short-term benefits associated with dealing by destroying the competitor so that it can charge monopoly prices in the long run.

The common thread running throughout these theories and

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365. *See*, e.g., United States v. Grinnell Corp., 384 U.S. 563, 570-71 (1966) (elements of monopolization are "possess of monopoly power," and the "willful acquisition or maintenance of that power").
cases is that exclusion from joint ventures should cause few antitrust concerns unless participation is necessary for the excluded party to compete with the venturers. Moreover, because the antitrust laws protect competitors only to the extent that their exclusion unreasonably restrains competition,\textsuperscript{366} it would seem that exclusion from a joint venture should create antitrust difficulty in few instances. The greater risk remains that the venture will be overinclusive.

6. \textit{Does the Venture Contain Unnecessary Ancillary Horizontal Restraints?}

Assuming the formation of the venture presents no problems itself, actions taken by the venturers to implement the venture's operations may still raise antitrust questions. For example, the venture can result in implicit or explicit price-fixing or market allocation agreements among the venturers which, in some contexts would be per se illegal. In general, the primary question is whether these "ancillary restraints" are reasonably necessary for the venture to exist as an efficiently operating organization and to achieve its legitimate, procompetitive goals.

The doctrine of ancillary restraints as it relates to the federal antitrust laws is almost as old as the Sherman Act itself. An early case, \textit{United States v. Addyston Pipe & Steel Co.},\textsuperscript{367} explained the nature of an ancillary restraint and how it should be analyzed:

\begin{quote}
[N]o conventional restraint of trade can be enforced unless the covenant embodying it is merely ancillary to the main purpose of a lawful contract... [To be lawful,] the contract must be one in which there is a main purpose, to which the covenant in restraint of trade is merely ancillary. ... The main purpose of the contract suggests the measure of protection needed, and furnishes a sufficiently uniform standard by which the validity of such restraints may be judicially determined. In such a case, \textit{if the restraint exceeds the necessity presented by the main purpose of the contract, it is void}.\textsuperscript{368}
\end{quote}

In analyzing ancillary restraints, the following framework can be used:

1. Would the conduct violate section 1 if it did not arise in the context of a joint venture? That is, is there an agreement of the

\textsuperscript{367} 85 F. 271 (6th Cir. 1898), \textit{aff'd}, 175 U.S. 211 (1899).
\textsuperscript{368} \textit{Id.} at 282 (emphasis added). For a recent application of the doctrine, see National Bancard Corp. v. Visa U.S.A., Inc., 1986-1 Trade Cas. (CCH) ¶ 66,912 (11th Cir. 1986).
type that is usually per se illegal or is likely to have an unreasonably anticompetitive effect? If not, the analysis need go no further because the conduct is legal.

2. Assuming the conduct would violate section 1, is the joint venture itself otherwise procompetitive? If not, the analysis need go no further because the conduct is illegal.

3. Assuming that the conduct would violate section 1 but that the venture is otherwise procompetitive, is the conduct reasonably necessary for the venture to operate at all or to operate at maximum efficiency? If not, the analysis need go no further because the conduct is illegal.

4. Is there another way to accomplish the conduct’s objective in an equally efficient manner which has significantly less anticompetitive effect? If so, it should be chosen.

5. If the conduct is necessary and the least restrictive alternative, are the procompetitive effects of the venture itself greater than the anticompetitive effects of the conduct? If so, the conduct is legal.

An obvious point from the above is that an ancillary restraint is not legal simply because it appears in the context of a joint venture. As the Supreme Court explained in *Timken Roller Bearing Co. v. United States*:

Nor do we find any support in reason or authority for the proposition that agreements between legally separate persons and companies to suppress competition among themselves and others can be justified by labeling the project a “joint venture.” Perhaps every agreement and combination to restrain trade could be so labeled.369

Rather, there must be a close nexus between the restraint and the efficient operation of the venture.

While it often is loosely stated that “the rule of reason applies to joint ventures,” courts will not hesitate to apply a per se standard to ancillary restraints in appropriate circumstances. As one court has explained, “[T]he nomenclature ‘joint venture’ does not automatically exempt a combination from the per se rule which is found to have elements inherently offensive to the antitrust laws.”370

The extremes are clear. For example, an agreement among hospitals participating in a magnetic resonance imager joint venture


370. Engine Specialties, Inc. v. Bombardier, Ltd., 605 F.2d 1, 8 (1st Cir. 1979), cert. denied, 446 U.S. 983 (1980).
as to the price the venture will charge would be a reasonable ancillary restraint. On the other hand, if the venture resulted in the hospitals’ agreeing on the room price each will charge, a per se violation would be found because this restraint is in no way ancillary or reasonably necessary for the venture to exist or operate efficiently. Indeed, joint ventures of competitors must always be careful that this genre of “spillover collusion” does not occur.

Usually, however, the antitrust standard of analysis will be the middle ground discussed above. A court will not hold the restraint illegal on its face but will consider whether it is reasonably necessary for the venture to achieve its procompetitive goals. If it is not, the court might then declare the restraint illegal without a full-fledged rule of reason analysis of its actual effect on competition.

Beyond these broad principles, generalizations about ancillary restraints are difficult because of the fact-specific nature of the requisite analysis. The ancillary restraints most likely to create problems in joint ventures are those involving potential price-fixing and market allocation agreements, as well as group boycotts.

Again, a comparison of Broadcast Music and Maricopa County Medical Society provides a good starting point. In the former, musical composers literally fixed the price paid for their compositions by authorizing the use of blanket licenses under which users paid a flat fee to use all compositions. But while perhaps constituting a price-fixing agreement among the composers, that “price fix” was ancillary and necessary to an efficiency-enhancing joint venture. As the Court explained:

A middleman with a blanket license [the venture] was an obvious necessity if the thousands of individual negotiations, a virtual impossibility, were to be avoided. Also, individual fees for the use of individual compositions would presuppose an intricate schedule of fees and uses, as well as a difficult and expensive reporting problem for the user and policing task for the copyright owner.

. . . . [The venture] reduces costs absolutely by creating a blanket license that is sold only a few, instead of thousands, of times. . . . Moreover, a bulk license of some type is a necessary consequence of the integration necessary to achieve these efficiencies, and a necessary consequence of an aggregate license is that its price must be established.

371. See supra text accompanying notes 135, 141, 146-147.
372. Indeed, the “underinclusiveness” problem discussed supra at Section III(B)(5) usually arises from an ancillary restraint.
373. These cases are discussed supra text accompanying notes 295-301.
Conversely, the Supreme Court, in *Maricopa County* would probably have invalidated the physicians’ maximum price-fixing agreement even had it believed that the physician-controlled foundation for medical care was a joint venture. This is suggested by the majority’s statements that any efficiencies from the restraint would likely be offset by its anticompetitive effects and that “[e]ven if a fee schedule is . . . desirable, it is not necessary that the doctors do the price fixing” because it could be done by insurance companies with which the foundation contracted. Thus, the restraint was not reasonably necessary to the foundation’s operations.375

The Court’s most recent and most interesting discussion of ancillary restraints is that in *National Collegiate Athletic Association v. Board of Regents of the University of Oklahoma*,376 which focused on NCAA rules limiting telecasts of its members’ football games. In general, the rules limited the members’ ability to negotiate their own contracts for telecasts, prohibited member schools from competing among themselves to have their games telecast, limited the number of games that member institutions could televise, and set a minimum aggregate price that networks would pay the NCAA (and thus its members) for the right to televise packages of games. In short, according to the Court, the rules resulted in price-fixing and horizontal market allocation agreements—naked restraints of trade traditionally held per se illegal.

The Court, however, refused to apply the per se rule because the NCAA is a joint venture “in which horizontal restraints on competition are essential if the product is to be available at all.”377 Justifications for the restraint, therefore, had to be considered under a rule of reason analysis. That analysis, however, need not be full-blown. In particular, the plaintiff did not need to prove that the venture had market power; rather, the defendant had to prove a procompetitive justification:

As a matter of law, the absence of proof of market power does not justify a naked restriction on price or output. . . . We have never required proof of market power in such a case. This naked restraint on price and output requires some competitive justification even in the absence of a detailed mar-

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375. *Maricopa County*, 457 U.S. at 352. As Professor Areeda has explained in analyzing the case, “[A] ‘quick look’ at the defense found it insufficient to displace per se treatment.” 7 P. Areeda, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION § 1510c at 426 (1985).
377. Id. at 2961.
Under the Rule of Reason, these hallmarks of anticompetitive behavior place upon petitioner a heavy burden of establishing an affirmative defense which competitively justifies this apparent deviation from the operations of a free market.\footnote{378}

Upon examining the purported justifications for the restraint, the Court could find no efficiencies or any reason that the restraints were necessary for the NCAA to put together and sell an attractive package of games—that is, for the joint venture to exist and operate efficiently. Most telling, according to the Court, was that the arrangement actually reduced output and increased price—exactly the opposite of what would be expected if the defendant’s purported procompetitive justifications were valid. Accordingly, the Court was able to condemn the restraints under a truncated rule of reason analysis, exemplifying Professor Areeda’s statement, important in the analysis of ancillary restraints, that “the rule of reason can sometimes be applied in the twinkling of an eye.”\footnote{379}

At issue in \textit{Los Angeles Memorial Coliseum v. National Football League}\footnote{380} was the NFL’s rule which prohibited a professional football franchise from moving without approval from three-fourths of league members. Although explaining that the rule constituted a horizontal market allocation, normally per se illegal, the court refused to apply the per se standard because the NFL is a joint venture and the rule arguably was ancillary to the league’s “main purpose of producing NFL football.”\footnote{381} The critical question, according to the court, was whether the rule “reasonably served the NFL’s interest in producing and promoting its product . . . or whether [the rule] harmed competition among the 28 teams to such an extent that any benefits to the League as a whole were outweighed.”\footnote{382}

The anticompetitive effects of the rule were clear: “Exclusive territories insulate each team from competition within the NFL market, in essence allowing them to set monopoly prices. . . .”\footnote{383} On the other hand, the court agreed with the league that some ter-

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\begin{tabular}{ll}
378. & \textit{Id.} at 2965. \\
379. & \textit{AREEDA, supra} note 353, at 30. \\
381. & 726 F.2d at 1395. \\
382. & \textit{Id.} at 1394. \\
383. & \textit{Id.} at 1395. \\
\end{tabular}
Territorial restrictions were necessary "to encourage participation in the venture and to secure each venturer the legitimate fruits of that participation." But, according to the court, the legitimate goals could be achieved in ways less harmful to competition. The rule was unreasonable because it contained no standards for members to consider when determining how to vote on a proposed move which, if applied, would result in a decision beneficial to the league as a whole. In effect, the restraint was not the least restrictive means by which to achieve the league's legitimate goals, and therefore, it was illegal.

Ancillary market allocation agreements or agreements not to compete, however, have been upheld. In Polk Bros. v. Forest City Enterprises, the plaintiff and defendant, both of whom were retailers, entered into an arrangement that one would construct a building large enough for both to use as stores, and the second would lease space from the first. As part of the arrangement they agreed not to compete in the sale of certain products. The court had to determine whether this agreement not to compete was "naked"—that is, a restraint "unaccompanied by new production or products;"—or "ancillary"—that is, "part of a larger endeavor whose success [it] promote[s]."

The venture itself increased output because it resulted in a building and stores that otherwise would not have existed. The restraint was reasonably ancillary because the evidence showed that the party who built the building would not have done so had the restraint not been part of the arrangement: "[T]he restrictive covenant made the cooperation possible." The court emphasized that, although the restraint would result in a market allocation arrangement during the time it was in effect, the relevant time period for analysis is that when the restraint is agreed upon:

The evaluation of ancillary restraints under the Rule of Reason does not imply that ancillary agreements are not real horizontal restraints. They are. A covenant not to compete following employment does not operate any differently from a horizontal market division among competitors—not at the time the covenant has its bite, anyway. The difference comes at the time people enter beneficial arrangements. A legal rule that enforces covenants not to compete, even after an employee has launched his own firm, makes it easier for people to cooperate productively in the first place. Knowing that

384. Id. at 1396.
385. 776 F.2d 185 (7th Cir. 1985) (decided under the Illinois Antitrust Act but applying federal antitrust principles).
386. Id. at 188-89.
387. Id. at 190.
he is not cutting his own throat by doing so, the employer will train the
employee, giving him skills, knowledge, and trade secrets that make the firm
more productive. Once that employment ends, there is nothing left but the
restraint—but the aftermath is the wrong focus.

A court must ask whether an agreement promoted enterprise and produc-
tivity at the time it was adopted.\textsuperscript{388}

Upon determining that the restraint should not be judged under
the per se standard, the court then had no trouble upholding the
restraint under the rule of reason because there was no evidence
that the plaintiff and defendant had significant market power.\textsuperscript{389}

Courts, however, have not hesitated to apply per se analysis to
purported ancillary restraints appearing in the context of joint
ventures. In \textit{United States v. Columbia Pictures Industries,}\textsuperscript{390} Co-
lumbia, Universal, Paramount, Fox and Getty Oil established a
joint venture called “Premiere” which planned to exhibit feature
films on pay television in competition with firms such as Home
Box Office.

The government challenged three restraints within the venture.
First, Premiere would have exclusive access to films distributed by
the venturers for a nine-month period before they would be dis-
tributed to its competitors. The government alleged that this con-
stituted a group boycott. Second, although complicated, the ven-
turers agreed on the value of the films they contributed to the
venture. After the value was recouped, the venturers split the prof-
its. Third, the venturers agreed on the price that the venture
would charge cable systems for the Premiere service. The govern-

\textsuperscript{388} Id. at 189 (emphasis added).

\textsuperscript{389} Id. at 191 (“The first step in any Rule of Reason case is an assessment of market
power.”).

The facts in \textit{Polk} may be analogous to agreements among hospitals and their staff mem-
bers not to compete, and perhaps a similar analysis would apply. For example, as a condi-
tion to staff privileges or an exclusive contract, a hospital may obtain an agreement from a
radiology group that it will not establish a free-standing facility in competition with the
hospital. Usually, “agreements not to compete among potential competitors are also illegal
per se.” Transource Int’l v. Trinity Indus., 725 F.2d 274, 280 (5th Cir. 1984).

As always, the ultimate issue is whether the agreement, on balance, restricts output and
increases price. The likely effect, however, of a “noncompete” agreement between a hospital
and hospital-based physicians is too ambiguous and the appropriate analysis too compli-
cated to permit application of the per se rule, at least at present. What the parties would
have done “but for” the agreement and the effect this would have had on radiology services
output is unclear and likely would vary from case to case. Ultimately, however, such ar-
rangements, which are quite common now, may be declared illegal, and they should be ex-
amined carefully before implementation.

\textsuperscript{390} 507 F. Supp. 412 (S.D.N.Y. 1980) (preliminary injunction granted), aff’d without
opinion, No. 81-6003 (2d Cir. Apr. 7, 1981).
ment claimed that these agreements constituted illegal price fixing. The defendants argued that Premiere was a joint venture; that the restraints were ancillary, reasonable, and necessary to allow it to enter the market and compete effectively against HBO, the well-established industry leader; and finally, that the restraints should be tested under the rule of reason and found legal.

In analyzing the restraints and then preliminarily enjoining the venture, the court emphasized that "[t]he fact that defendants have chosen a joint venture as the vehicle for their combination . . . does not necessarily change the applicable analysis [from the per se rule to the rule of reason]." In fact, the challenged restraints, according to the court, were "hardly ancillary," but rather were "the heart of the joint venture." It perceived the venture not as offering a new product but simply as a very anticompetitive way to distribute what the defendants had been distributing before—films.

In **COMPACT v. Metropolitan Government of Nashville**, several minority architectural firms formed what they called a joint venture, COMPACT, to combat alleged racial discrimination. Through COMPACT, the firms would bid for jobs as a group rather than individually. The court had no difficulty striking down what in effect was a horizontal market allocation scheme under a per se-type standard. Its discussion of relevant considerations is helpful:

> Joint ventures present a difficult concept for antitrust analysis, defying neat classification and precise definition and, by extension, well established rules for evaluating their competitive impact. . . . On one hand, the joint venture provides a method of organization which enables competitors to join together to produce that which is beyond the productive capacity or inclination of its individuals members. Conversely, the joint venture threatens to reduce actual or potential competition between rivals by providing a method of operations which engenders collusion detrimental to competition. In the instant case, the issue turns on whether COMPACT's operations create significant new productive capacity in the architectural product market.

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391. 507 F. Supp. at 429.
392. Id. at 430.
393. **Columbia Pictures** should be studied carefully when establishing provider-controlled PPOs because they can present similar types of price-fixing and group boycott questions. Moreover, as in **Maricopa County**, and **Columbia Pictures**, it could be held that PPOs do not sell any new product. Finally, it is worth noting that the venturers in **Columbia Pictures** had a 50% market share of movies licensed to pay television firms. Thus, as in **Maricopa County**, see infra text accompanying note 405, the venturers probably had market power.

already served by the coalition's members in their individual capacities, or, stated another way, whether the whole is greater than the sum of its parts. . . . This Court thinks not.

A court must be guided by facts, rather than the legal characterizations the parties attach to the facts. Individuals who normally compete directly against one another may not hide the collusive nature of mutual concessions by labeling their agreements "joint ventures."

While joint ventures traditionally have been subject to the rule of reason . . . federal courts will not hesitate to apply the per se rule to impose Section 1 liability upon finding of some intrinsic or ancillary aspect of the joint venture which falls within the well-defined parameters of the per se rule.395

The decision illustrates once again that not every arrangement called a joint venture actually is one and that not every purported ancillary restraint will be tested under the rule of reason.

The latter point was also emphasized in General Leaseways, Inc. v. National Truck Leasing Association.396 There a number of geographically dispersed local businesses which leased trucks to users in different areas set up an association through which members would service the trucks of other members when the trucks were not in the lessor's own area. As part of the arrangement, however, members agreed among themselves to do business only from one particular location, and association franchises were spaced ten to twenty miles apart to prevent competition among members.

The question was whether the restraint—in effect, a horizontal market allocation agreement—should be judged under the per se or rule of reason standard. This hinged, as usual, on whether the restraint was "naked" or ancillary to the joint venture. The court had no difficulty holding that the restraint was not ancillary:

[I]n this case the organic connection between the restraint and the cooperative needs of the enterprise that would allow us to call the restraint a merely ancillary one is missing. Although some degree of cooperation among members of [the] Association in providing reciprocal services may well promote competition in the truck-leasing industry, no reason has been suggested why that cooperation requires that members be forbidden to compete with each other in leasing trucks.397

Because a "quick look" at the restraint showed that its "elimination of competition is apparent,"398 a per se-type rule was applied.

Each of the ancillary restraints cases suggests that if a defendant

395. Id. at 1574 (emphasis added).
396. 744 F.2d 588 (7th Cir. 1984).
397. Id. at 595.
398. Id.
claims that the restraint is ancillary to a joint venture, the court will not apply a strict per se analysis—that is, it will not strike the restraint without considering the context in which it arises or whether it is reasonably necessary for the venture to exist or operate efficiently. On the other hand, if the restraint is one that otherwise would trigger per se analysis and it is not reasonably necessary, the court will not engage in a full rule-of-reason inquiry before condemning it.

If the restraint is not one which normally is per se illegal or if it is ancillary to the venture's main purpose, a full rule of reason analysis is appropriate. The questions then become whether the restraint's legitimate objectives could have been accomplished by a significantly less restrictive means and, if not, whether the procompetitive effects from the venture as a whole outweigh the restraint's anticompetitive effects. The latter question in particular is difficult to answer because it may require comparing effects on competition in different markets. No court has undertaken a detailed analysis of this type.

The types of ancillary restraints that can arise in health care sector joint ventures are far too numerous to permit discussion of each. Provider-controlled PPOs, however, present a convenient vehicle to briefly illustrate the analytical framework discussed above in a practical context. Three questions which arise and which present possible ancillary restraints are (1) whether the providers can agree on the fees they will be charged through the PPO arrangement, (2) whether they can agree among themselves, with the PPO, and with a payor not to give other payors lower prices, and (3) whether they can agree not to participate in other PPOs. To simplify the analysis, it is assumed that the providers have integrated their practices through the PPO to the extent necessary for it to be analyzed as a joint venture.399

The first question is by far the most interesting and important and has led to many creative ways of taking the fee-setting function out of the hands of the providers.400 The question is whether this is necessary. Maricopa County401 suggests that it is. The Department of Justice suggests that the agreement relating to fees is

399. For the Department of Justice's views about what the requirements are, see generally supra text accompanying notes 330-31.
401. See supra text accompanying note 375.
reasonably ancillary and legal if the PPO contains 20% or less of the providers in the market.\textsuperscript{402}

The initial question is whether the restraint is reasonably necessary for the venture to function efficiently. (Clearly, it is not necessary for the venture to exist at all.) Because delegating this function to nonproviders would seem inherently inefficient, the answer would seem to be affirmative. Indeed, the \textit{Maricopa} court suggested this, noting, however, that the "validity of that assumption is far from obvious."\textsuperscript{403}

If this "quick look" suggests significant efficiencies from the restraint, then some type of rule of reason analysis is appropriate, and as \textit{Forest City Enterprises} suggests, focus should primarily be on the participants' market power.\textsuperscript{404} Therein lies the rationale for the Department of Justice's 20% participation percentage guideline which serves as a surrogate for the providers' market power. More interesting, it appears that the majority in \textit{Maricopa}, where some 70% of physicians in the area were participants in the foundation, had the same concern.\textsuperscript{405} Immediately upon noting that the physicians might be able to set prices more efficiently than others, the Court explained that it was "entirely possible that the potential or actual power of the foundations to dictate the terms of such insurance plans may more than offset the theoretical efficiencies upon which the respondents' defense ultimately rests."\textsuperscript{406} It made clear that "the fees are set by a group with substantial power in the market for medical services."\textsuperscript{407}

This suggests that while the positions of the Department of Justice and the majority in \textit{Maricopa} appear inconsistent superficially, any inconsistency may be more a matter of form than substance. Despite all its discussion about the per se rule, the Court did not apply a strict per se standard. Rather, without explaining what it was doing, it applied a "quick look" approach and was able to determine, without a full market analysis, that the restraint, on balance, would likely have anticompetitive effects.

Can clients be counseled safely based on the Department of Jus-

\begin{footnotesize}
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\item \textsuperscript{402} See supra notes 330-31 and accompanying text; see also Vogel v. American Soc'y of Appraisers, 744 F.2d 598, 603 (7th Cir. 1984) ("before we leap to the conclusion that an agreement among competitors is price fixing we should take a quick look to see whether it has clear anticompetitive consequences and lacks any redeeming competitive virtues").
\item \textsuperscript{403} \textit{Maricopa County}, 457 U.S. at 353 (footnote omitted).
\item \textsuperscript{404} See supra note 389 and accompanying text.
\item \textsuperscript{405} \textit{Maricopa County}, 457 U.S. at 339.
\item \textsuperscript{406} Id. at 354 (footnote omitted).
\item \textsuperscript{407} Id. at 354 n. 29.
\end{itemize}
\end{footnotesize}
tice's advice that agreements relating to price among providers in provider-controlled PPOs are lawful ancillary restraints where other conditions are met? Probably so, but it will remain problematic until the courts either accept or reject that position. Clients, obviously, should be warned of the risk.  

If a potential government prosecution concerns the PPO or its participating providers, then a business review letter from the Antitrust Division or an advisory opinion from the Federal Trade Commission can be sought. If the fear is a private treble-damage action, then counsel should examine who the potential plaintiffs are and whether the agreement in question, even if found to be illegal, would likely result in anyone being damaged.

A second potential ancillary restraint is a "most favored nations"-type clause in the contract between a provider-controlled PPO and a payor, under which the providers agree not to give other payors a lower price. Superficially, it would seem that if an agreement among the providers as to specific fees would pass muster under section 1 as a reasonable ancillary restraint, a most favored nations clause would likewise be valid. That, however, may not be the case.

The clause, together with the prices agreed upon with the payor, may establish a price floor below which the providers will not contract with others. If the providers can offer lower prices to others only if they lower the price to the payor using the clause, there is a disincentive to discount. If the providers, in effect, agree among themselves and with a payor not to offer other payors a "better deal," there may be a horizontal agreement not to discount — a practice which constitutes price fixing and has been held per se

408. Also interesting is an FTC staff advisory opinion relating to whether the physician members of an IPA-type HMO could set their own fees by agreement. The HMO had about 12% of the market, and some 60% of physicians in the area participated. The physicians were "at risk," in that the HMO paid the IPA on a capitated basis, the HMO and IPA shared any loss, and the IPA owned an interest in the HMO. The IPA members wanted to know if they could (1) negotiate collectively the capitation rate with the HMO, and (2) agree on what the IPA would pay its providers. Especially in light of the degree of risk sharing, the FTC had little problem with either. See Letter from Arthur N. Lerner, Assistant Director, Bureau of Competition, Federal Trade Commission, to Gilbert Frimet (Mar. 22, 1984).

409. See A. Lerner, Outline of Remarks before the National Health Lawyers Association's seminar on Legal and Operational Issues in HMOs, PPOs, and CMPs (Dec, 11, 1985) (labeling such clauses in PPO arrangements a "forthcoming antitrust issue"); see also Letter from Arthur N. Lerner, Assistant Director, Bureau of Competition, Federal Trade Commission, to William Kopit (Mar. 26, 1984) (refusing to issue advisory opinion relating to a most favored nations clause because "substantially the same course of action" by another party was under investigation).
illegal.\textsuperscript{410}

Because the restraint arises in the context of a joint venture, a court is unlikely to apply a strict per se rule even were it to believe that the provision literally fixed prices. On the other hand, it is not clear that the court would apply a full-blown rule of reason analysis, either. Rather, it likely would examine the provision as an ancillary restraint and take a "quick look" at its likely effect and at whether it is reasonably necessary for the venture to function efficiently.

Although the degree of the restraint's effect would depend upon the providers' market power, it is reasonable to believe that it would have some anticompetitive effect. In its decision in Ethyl Corp.,\textsuperscript{411} the Federal Trade Commission (in a different context)\textsuperscript{412} explained that "conventional economic theory support[s] the principle that selective discounting is procompetitive rather than anticompetitive,"\textsuperscript{413} and one expert testified that "[t]he absence of a most favored nations clause in [the sellers'] business helps them compete because they don't feel at all constrained in terms of giving special deals and discounts."\textsuperscript{414}

Assuming that the provision would have at least some adverse impact, the analysis should then turn to whether a nexus exists between it and the existence or efficient operation of the venture. If there is one, it is difficult to discern. Indeed, this is the analytical distinction between the PPO providers' agreeing on their prices and their agreeing to a most favored nations clause: Efficiencies appear to result from the former but not from the latter. Arguments that it would be "unfair" to offer other payors a lower price or that it is "reasonable" for a payor to want the "best price" will likely not be sustained:

To the extent [the sellers] attempt[ ] to justify the [most favored nations clause] on the grounds of "fairness" or "ethical" business behavior . . . , we reject that notion.

\dots

[T]he procompetitive justifications for these practices proffered by [the sellers] are not persuasive. They essentially amount to a claim that individual customers prefer them because no single customer wants to be at a price disadvantage. . . . [T]his is an understandable perspective from the
point of view of an individual customer that is not necessarily consistent with the long run interests of all customers in price competition.415

Thus, although it is not clear how a court will react to a most favored nations-type provision in a provider-controlled PPO contract, there is some risk that it will constitute a violation of section 1 of the Sherman Act. In light of this and because it is difficult to see why the providers would want to agree to such a provision in the first place, its use seems unwise.

The final potential restraint, agreement among participating providers not to participate in other plans, is the least difficult to assess. This type of restraint clearly should cause substantial concern if the percentage of providers in an area participating in the plan is high, and one court has held such a provision illegal.416 When that percentage is significant, there likely will be some anticompetitive effect as the participating providers are no longer participants or potential participants in competing plans. Moreover, it again is difficult to think of any significant efficiency-enhancing justification for the restraint. Its most obvious purpose is to stymie the development of other plans, and thus it should be avoided regardless of the percentage of participation.417

Although care is necessary in examining ancillary restraints that accompany joint ventures, a reasonable conclusion sometimes can be reached with relatively little analysis. Common sense often shows whether the restraint in question is reasonably necessary, what its purpose is, whether there is a less restrictive way of doing the same thing, and what the general effect is likely to be. For those restraints not susceptible to an “eye-ball” analysis, the analytical framework discussed above should provide some help.

C. Conclusion

It seems clear that hospital participation in joint ventures will continue to increase as long as the economic incentives remain as they are today. Moreover, joint ventures are procompetitive in the vast majority of cases. When, however, a joint venture is used as a vehicle to (1) stifle competition by gobbling up potential competi-

415. Id. at 632, 642.
416. Blue Cross of Washington & Alaska v. Kitsap Physicians Serv., 1982-1 Trade Cas. (CCH) ¶ 64,588 (W.D. Wash. 1981); see also Letter from Arthur N. Lerner to Gilbert M. Frimet, supra note 408 (warning an IPA with a 65% participation percentage against implementing such a provision).
417. The Department of Justice also found the provision troublesome in the Stanislaus Preferred Provider Organization matter. See supra text accompanying notes 332-33.
tors, (2) exclude those who must participate to be effective competitors, or (3) reach unnecessary "side agreements" to fix prices, allocate markets, or not to compete, serious antitrust problems can follow.

With regard to the first problem, ask whether it is necessary for all who wish to participate to actually participate in order for the venture to operate efficiently. As to the second, ask whether there is an efficiency justification for the exclusion, whether inclusion itself would raise an antitrust problem, and whether the exclusion will substantially affect the excluded firm's ability to compete. As to the third problem, seek out less restrictive alternatives that achieve the same legitimate goal and work to insure that there is no "spillover collusion"—that is, collusion affecting the venturers' businesses outside the context of the joint venture itself.

IV. CONCERTED NEGOTIATIONS OVER REIMBURSEMENT

A. Introduction

This section discusses briefly the antitrust exposure incurred by hospitals when they negotiate as a group with third-party payors over reimbursement—a not uncommon happening. The degree of exposure depends, to a large extent, on what types of conduct the term "negotiate" encompasses and what actions the hospitals take in conjunction with those "negotiations." The antitrust questions involved are first, whether group negotiations constitute a horizontal price-fixing agreement among the participants, and second, whether the negotiations result in a group boycott to enforce that price-fixing agreement.418

For analytical purposes, it is helpful to divide "group negotia-

418. The usual rationale for group negotiations is that the payor exercises monopsony power as a purchaser of hospital services and thus that it is only "fair" that the hospitals aggregate their market power as sellers to offset this monopsony power. As Milton Friedman has explained, however, "Businessmen who sing the glories of free enterprise and then demand 'fair' competition are enemies, not friends, of free markets. To them 'fair' competition is a euphemism for a price-fixing agreement." Friedman, Fair Versus Free, Newsweek, July 4, 1977, at 70.

It seems clear that if the payor obtained its monopsony power in a legitimate manner, the antitrust laws permit it to exercise that power by obtaining the best deal it can. See, e.g., Kartell v. Blue Shield of Massachusetts, 749 F.2d 922 (1st Cir. 1984), cert. denied, 105 S. Ct. 2040 (1985). Moreover, as a matter of economic theory it is not clear that permitting the sellers to aggregate their market power would improve consumer welfare. The welfare effects of "bilateral monopoly" (where the buyer and seller have monopsony and monopoly power respectively) is indeterminate. See F. Scherer, Industrial Market Structure and Economic Performance 299 (2d ed. 1980).
tions” into four broad types of conduct on a continuum from the most innocuous to the most dangerous. These are (1) a group recommendation or a “sharing of information and views” by the hospitals with the payor; (2) active give-and-take negotiations; (3) the establishment of a joint selling agency by the hospitals; and (4) a group boycott (or threatened boycott) of the payor by the hospitals if the payor rejects their recommendation. It is difficult to successfully argue that any of these activities (except perhaps the first) should be analyzed as the activities of a legitimate joint venture.  

B. Concerted Recommendations

Where the group does no more than collectively formulate and recommend terms and conditions of sale, with no explicit or implicit threat of coercion, and where the group is not the de facto decision maker, it is hard to see how a violation of section 1 could follow. In fact, this action probably is procompetitive in the sense that it provides the decision maker (or “purchaser”) with useful information on which to base its decision.

Two cases appear to agree. In Virginia Academy of Clinical Psychologists, the court held that a collective recommendation (albeit one not relating to price) by an association of psychiatrists to Blue Shield did not constitute a violation of section 1. Although the specific issue for decision was whether the association conspired illegally with Blue Shield (rather than whether its members conspired illegally among themselves), the court explained that “it was not illegal for the [group], as ‘seller’ of such services, to make recommendations aimed at persuading Blue Shield to adopt its proposal and use its services, absent some form of coercion.”

Similarly, in American Society of Anesthesiologists, the Soci-

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419. See United States v. Southern Motor Carriers Rate Conf., 672 F.2d 469, 479 (5th Cir. 1982) (rejecting argument that collective recommendation of rates to state agency was joint venture activity), aff’d en banc, 702 F.2d 532 (5th Cir. 1983), rev’d on other grounds, 105 S. Ct. 1721 (1985).


422. Id. at 483. Similarly, in Pennsylvania Dental Ass’n v. Medical Serv. Ass’n of Pennsylvania, 746 F.2d 248, 259 (3d Cir. 1984), cert. denied, 105 S. Ct. 2021 (1985), the court explained that “[t]o give advice when asked by the decisionmaker is not equivalent to being the decisionmaker itself.”

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ety's concerted recommendation to third-party payors as to how anesthesiologists should be reimbursed was not a violation.\footnote{Moreover, the FTC's order in Michigan State Medical Soc'y, 101 F.T.C. 191 (1983) (discussed infra at text accompanying notes 443-58), did not prohibit the group from "[p]roviding information . . . to third party payors concerning any issue, including reimbursement." 101 F.T.C. at 314.} The court noted that payors actively sought the anesthesiologists' input, but the latter never attempted to coerce payors into accepting their recommendation. In sum, "there was [no] agreement that the [relative value guide] would be used in pricing anesthesia services so as to curtail competition or interfere with the setting of prices by free market forces."\footnote{American Soc'y of Anesthesiologists, 473 F. Supp. at 158.}

Two cases, however, suggest that the per se rule could apply to similar conduct. In \textit{Georgia v. Pennsylvania Railroad Co.},\footnote{324 U.S. 439 (1945).} the Supreme Court held that allegations of rate fixing by railroads, even though the rates had to be approved by the ICC, stated a claim for illegal price fixing. Similarly in the more recent \textit{Southern Motor Carriers Rate Conference} case\footnote{672 F.2d 469 (5th Cir. 1982), aff'd en banc, 702 F.2d 532 (5th Cir. 1983), rev'd on other grounds, 105 S. Ct. 1721 (1985).} (which relied on \textit{Pennsylvania Railroad}), the court held that a rate schedule for intrastate trucking, formulated collectively by truckers but which had to be approved by the state, "'easily fits the classic description of a 'naked price restraint.'"\footnote{672 F.2d at 478 (quoting United States v. Southern Motor Carriers Rate Conf., 467 F. Supp. 471, 486 (N.D. Ga. 1979)).}

The dichotomy of treatment is somewhat difficult to understand. Perhaps there is a difference between a firm agreement on specific prices to be recommended to the decision maker and more general recommendations involving prices. Or perhaps the court in \textit{Southern Motor Carriers Rate Conference} viewed the agreed upon rate schedule not as a recommendation, but rather as a decision which the state simply would rubber-stamp. In any event, agreed upon recommendations which include specific levels of reimbursement result in some level of antitrust risk.

While no cases address the issue specifically, give-and-take negotiations ("hard bargaining"), absent actual or threatened coercion of the payor by the hospitals, should receive the same type of analysis. They are more inherently suspect, however, because, as a practical matter, implicit coercion (and perhaps outright threats not to participate in the payor's program) is more likely. Such ac-
tivity should be closely monitored.

C. Joint Selling Agencies

Although unlikely, the hospitals could go so far as to create an independent joint sales agency to sell their services and then argue that an agreement among them as to price is a reasonable ancillary restraint in a legitimate joint venture. The differences between this and a provider-controlled PPO, for example, are that the PPO arguably creates a new product and results in significant functional integration, while the joint selling agency arrangement typically does not.

In Appalachian Coals, Inc. v. United States,\textsuperscript{429} the Supreme Court accepted the argument that an agreement among competing sellers on price was a justifiable ancillary restraint. There, 74\% of the bituminous coal producers in the Appalachian area had established a joint selling agency to market their coal at a fixed price. The Court explained that the purpose for the arrangement was to "make competition fairer" and "to produce fairer price levels."\textsuperscript{430} Because of the terribly distressed condition of the coal industry, however, the Court upheld this conduct in a decision "widely recognized as an anomaly in antitrust law with no status as a precedent."\textsuperscript{431} The case was wrong even when decided,\textsuperscript{432} and clearly the result would not be the same today.

Other courts have not been so charitable. In Virginia Excelsior Mills v. FTC,\textsuperscript{433} for example, where 25\% of excelsior producers in the eastern seaboard market established a joint selling agency whose board of directors fixed the price of excelsior, the Fourth Circuit applied the per se rule, explaining that "[t]he primary purpose of the arrangement was to eliminate competition amongst the producers which had been characterized by price cutting. The intention of the new arrangement was to stabilize prices."\textsuperscript{434} Similarly, in another case where one firm appointed its competitor as

\textsuperscript{429} 288 U.S. 344 (1933).
\textsuperscript{430} \textit{Id.} at 372, 373; \textit{see} Friedman, \textit{supra} note 418.
\textsuperscript{432} \textit{See, e.g.}, United States v. Trenton Potteries Co., 273 U.S. 392, 396 (1927), where the Court explained that "[t]he reasonable price fixed today may... become the unreasonable price of tomorrow... Agreements which create such potential power may well be held to be in themselves unreasonable or unlawful restraints, without the necessity of minute inquiry whether a particular price is reasonable or unreasonable."
\textsuperscript{433} 256 F.2d 538 (4th Cir. 1968).
\textsuperscript{434} \textit{Id.} at 541.
its exclusive sales agent, the court found that the arrangement constituted both a per se illegal price fixing agreement and a market allocation between them. 435 Finally it is worth noting that in Broadcast Music, 436 when the Court refused to apply the per se rule to the “price fixing” agreement there, 437 it specifically stated that ASCAP was “not really a joint sales agency offering the individual goods of many sellers, but is a separate seller offering its blanket license, of which the individual compositions are raw material.” 438

In short, joint selling agencies in which the members have not otherwise substantially integrated their businesses are probably illegal. This is especially true if the members, in the aggregate, have significant market power.

D. Group Boycotts to Enforce Price-Fixing Agreements

Lastly, the hospitals may agree not to participate in the payor’s plan, or may agree to withdraw, if the group believes that the reimbursement offered is insufficient. This type of conduct is fatal. In fact, precedent is so well established and the conduct may be so egregious that, in the future, provider boycotts to increase reimbursement may result in criminal rather than civil prosecution as in the past.

In DeGregorio v. Segal, 439 for example, the plaintiff alleged that four nursing homes and their trade association had agreed, first, not to accept new Medicaid patients and then to terminate participation in the program unless Medicaid reimbursement were increased. In overruling the defendants’ motion to dismiss for failure to state a claim, the court indicated that a per se violation of section 1 was alleged and in addition, that, for purposes of section 2, the boycott activities were sufficient to show the requisite intent to monopolize.

The Department of Justice has brought three similar cases. Two, against nursing home trade associations in Montana 440 and South

440. United States v. Montana Nursing Home Ass’n, 1982-2 Trade Cas. (CCH) ¶ 64,852 (D. Mont. 1982) (consent decree).
Carolina,\textsuperscript{441} resulted in consent decrees. In both, the associations and their members had agreed to boycott, or threaten to boycott, the states' Medicaid programs if reimbursement were not increased. The third, filed against the North Dakota Hospital Association for its members' allegedly agreeing not to participate in an Indian Health Services program unless reimbursement were increased,\textsuperscript{442} is presently before the court on summary judgment motions.

Most interesting and illuminating, however, is the Federal Trade Commission decision in \textit{Michigan State Medical Society}.\textsuperscript{443} There, in actions directed at both the Medicaid and Blue Shield programs, the Society and its members agreed to attempt to negotiate collective agreements with the payors and to engage in group boycotts to increase reimbursement. Indeed, coercive threats were actually made.\textsuperscript{444}

The most important issue was whether the per se rule applied to the boycott activity or whether it should be analyzed under the rule of reason. Following an approach that perhaps was overly charitable, the Commission explained that "since this conduct does not involve direct fee setting, we are not prepared to declare it \textit{per se} illegal at this juncture and close the door on all asserted procompetitive justifications."\textsuperscript{445} The proffered justifications were that the conduct resulted in no effect on fees, that the Society was trying to insure that physicians would be treated "fairly" in light of Blue Shield's monopsony power,\textsuperscript{446} and that the Society was attempting to correct abuses in the Medicaid system.

Not surprisingly, these arguments were rejected almost out of hand. With regard to the first, the Commission stated that no actual effect on fees need be shown\textsuperscript{447} and that the conduct would

\begin{itemize}
\item \textsuperscript{441} United States v. South Carolina Health Care Ass'n, 1980-2 Trade Cas. (CCH) \textsuperscript{\textsuperscript{\textsuperscript{1}}} \textsuperscript{63,316} (D.S.C. 1980) (consent decree).
\item \textsuperscript{443} 101 F.T.C. 191 (1983).
\item \textsuperscript{444} In a related type of case, the FTC sued a loosely-knit organization of attorneys whose members represent indigent criminal defendants in Washington, D.C. Allegedly, the members agreed to "strike" unless the local government increased their reimbursement. In a highly unusual decision based on highly unusual facts (for example, the local government agreed that the attorneys deserved more money and encouraged the strike), the administrative law judge invoked the "no harm, no foul" rule and found no violation. Superior Court Trial Lawyers Ass'n, No. 9171 (FTC Initial Dec. Oct. 18, 1984).
\item \textsuperscript{445} 101 F.T.C. at 291.
\item \textsuperscript{446} See Friedman,\textit{ supra} note 418.
\item \textsuperscript{447} In United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 224 n.59 (1940), for
\end{itemize}
likely affect competition both among physicians "on the terms of insurance coverage offered by" Blue Cross and Medicaid, as well as among payors for physician participation.

With regard to the purported "fairness" justification, the Commission refused to enter the quagmire of determining the relative market power of the parties and deciding what was "fair." For it to do so, it explained, would require it to become similar to a public utilities regulatory agency. The Society's concerns about Medicaid abuses, the Commission said, should be addressed through political channels: The Society "could have expressed its views in ways that fell well short of organized boycott threats."

Finally, the Commission searched for procompetitive effects from the boycott activity but could find none.

Although finding a violation, the Commission was particularly careful to attempt to "strike a proper balance between the need for insurers to have efficient access to the views of large groups of providers and the need to prevent competitors from banding together in ways that involve the unreasonable exercise of collective market power."

Accordingly, the Society was permitted to provide information to insurers, "even as to fee-related activities," as long as it made no attempt to coerce the payors to accept its views.

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448. 101 F.T.C. at 292. Although this language is ambiguous, presumably it represents the view that physicians compete among each other to participate in third-party plans.

449. Id. at 295.

450. The Society argued that its threatened boycott of the Medicaid program was protected by the Noerr-Pennington doctrine. 101 F.T.C. at 296-301. The Commission rejected the argument for two reasons. First, threats and coercion are not protected forms of expression, at least when prohibiting them likely would not chill first amendment rights. See, e.g., Sacramento Coca-Cola Bottling Co. v. Chauffeurs, Teamsters & Helpers Local 150, 440 F.2d 1096 (9th Cir.), cert. denied, 404 U.S. 826 (1971). Second, in "purchasing" the services of physicians, the state, through its Medicaid program, was acting in a commercial or proprietary capacity, in which case the Noerr doctrine, according to the FTC, is inapplicable. See, e.g., George R. Whitten, Jr., Inc. v. Paddock Pool Builders, Inc., 424 F.2d 25 (1st Cir.), cert. denied, 400 U.S. 850 (1970); but see Airport Car Rental Litigation, 693 F.2d 84 (9th Cir. 1982), cert. denied sub nom. Budget-Rent-A-Car, Inc. v. Hertz Corp., 462 U.S. 1133 (1983) (Noerr doctrine applicable, even where government acting in commercial capacity).

451. 101 F.T.C. at 296.

452. Id.

453. The Commission's order could present some extremely difficult problems of interpretation. Although the Society can present its views, even about reimbursement, to third-party payors notwithstanding the other provisions of the order, agreements with third-party payors concerning reimbursement amount and agreements among members "to affect or to
Michigan State Medical Society provides yet another example of a middle standard of antitrust analysis — neither a strict per se rule nor a full-blown rule of reason. The propriety of that approach given the facts of the case is questionable, and two Commissioners would have applied the strict per se rule. In any event, it is not unusual for conduct tested initially under the rule of reason to subsequently become a per se violation, and that may be what will happen to price-related group boycotts of third-party payors. Ultimately, perhaps it makes no difference which standard is applied because purported justifications can be brushed aside so easily and the rule of reason applied “in the twinkle of an eye.”

E. Conclusion

Two clear principles emerge from the cases. First, any type of concerted negotiations relating to reimbursement by a plurality of hospitals with a payor raises a significant degree of antitrust risk because of the types of anticompetitive conduct that it can lead to. What begin as meetings to formulate a recommendation can easily result in discussions of price, which themselves lead to im-
plicit or explicit price-fixing agreements or perhaps to an illegal exchange of pricing information. Furthermore, emotions may run high and the discussions may turn into an irrational call for a group boycott. Still further, although no boycott is actually recommended, it may become so clear to each member that others plan not to participate in the payor’s plan that an agreement to boycott can be inferred. The risk is sufficiently significant that hospitals should seek advice before participating in discussions among themselves relating to reimbursement.

Second, it can and should be assumed that an agreement among hospitals not to participate in a payor’s program unless reimbursement is increased—whether explicit or in the form of veiled threats to this effect—is illegal regardless of the group’s market power or its justifications for the conduct. Indeed, seemingly innocuous comments to the payor such as “our members won’t go for that,” and written statements from the association recommending what

460. The requisite agreement can be inferred as a factual matter from the parties’ actions. In a classic statement, the Ninth Circuit explained:

A knowing wink can mean more than words. Let us suppose five competitors meet on several occasions, discuss their problems, and one finally states—“I won’t fix prices with any of you, but here is what I am going to do—put the price of my gidget at X dollars; now you all do what you want.” He then leaves the meeting. Competitor number two says—“I don’t care whether number one does what he says he’s going to do or not; nor do I care what the rest of you do, but I am going to price my gidget at X dollars.” Number three makes a similar statement—“My price is X dollars.” Number four says not one word. All leave and fix “their” prices at ‘X’ dollars.

We do not say the foregoing illustration compels an inference in this case that the competitors’ conduct constituted a price-fixing conspiracy, including an agreement to so conspire, but neither can we say, as a matter of law, that an inference of no agreement is compelled. As in so many other instances, it remains a question for the trier of fact to consider and determine what inference appeals to it (the jury) as most logical and persuasive, after it has heard all the evidence as to what these competitors had done before such meeting, and what actions they took thereafter, or what actions they did not take.

Esco Corp. v. United States, 340 F.2d 1000, 1007 (9th Cir. 1965) (emphasis in original); see also United States v. Foley, 598 F.2d 1323 (4th Cir. 1979), cert denied, 444 U.S. 1043 (1980), where a seemingly innocuous dinner meeting among several realtors ultimately resulted in their criminal conviction for price fixing.


462. See, e.g., Interstate Circuit, Inc. v. United States, 306 U.S. 208, 226 (1938) (“It was enough that, knowing that concerted action was contemplated and invited, the [group members] gave their adherence to the scheme and participated in it.”).

463. As one court has explained, “[B]oycotts are illegal per se only if used to enforce agreements that are themselves illegal per se — for example, price-fixing agreements.” Marrese v. American Academy of Orthopaedic Surgeons, 706 F.2d 1488, 1495 (7th Cir. 1983), rev’d on other grounds, 105 S. Ct. 1327 (1985).
action members should take can cause serious problems later and should be avoided. Suffice it to say here that in a hospital antitrust audit, group negotiations are an area that demand serious and careful examination.

V. HEALTH PLANNING ACTIVITIES

A. Introduction

With the enactment of the National Health Planning and Resources Development Act of 1974, Congress launched a new era of regulation of the health care industry. The Health Planning Act established an elaborate scheme for federal funding of state and local health planning activities and state certificate-of-need (CON) programs. Although several states had adopted CON laws prior to enactment of the Health Planning Act, the Act, by providing strong financial incentives for states to enact CON programs consistent with the federal model, made health planning a national policy. Within a few years of its passage, most states had adopted CON laws conforming with the Act’s requirements.

The potential for conflict between the health planning laws and the federal antitrust laws was apparent early on to many observers. Health planning and CON laws are premised on the concepts of output restriction and resource allocation by private fiat rather than by market forces. Certificate-of-need laws seek to avoid duplicative or unnecessary services by requiring that hospitals and other health care facilities obtain prior approval from the

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464. 42 U.S.C. §§ 300k—300n-5 (1982) [hereinafter referred to as the Health Planning Act or the Act]. Comprehensive federal involvement in health planning actually began with the Section 1122 program. See 42 U.S.C. § 1320a-1 (1982). In 1972, Congress amended Section 1122 of the Social Security Act to authorize the Secretary of the Department of Health, Education and Welfare to enter into contracts with states whereby the states would review and make recommendations to the Secretary on the need for capital expenditures proposed by or on behalf of health care facilities. A negative recommendation by the state usually meant that the Secretary would withhold Medicare and Medicaid payments for capital costs for the project. Many states entered into Section 1122 agreements. See generally SIMPSON, FULL CIRCLE: THE RETURN OF CERTIFICATE OF NEED REGULATION OF HEALTH FACILITIES TO STATE CONTROL 18-21 (Western Center for Health Planning 1985).


466. C. HAVIGHURST, Deregulating the Health Care Industry 53 (1982).

state before undertaking certain capital expenditures or providing new institutional health services. Furthermore, local, nongovernmental health planning agencies, known as health systems agencies (HSAs), develop and implement local health plans, known as health system plans and annual implementation plans, that identify the desirable types and levels of services in a specific health service area. The HSAs then attempt to persuade providers in that area to implement them.

These regulatory principles seemed inherently at odds with the antitrust law's basic precepts of competition, unrestricted market entry, and free enterprise. Indeed, while the antitrust laws themselves can be viewed as a regulatory scheme, they are based on a premise or philosophy of freely operating markets. Conversely, the health planning laws are based on the premise that those free markets have failed and cannot allocate resources in an efficient manner.

Not surprisingly, antitrust enforcement agencies, the courts, and commentators have grappled with how to reconcile these seemingly conflicting federal statutes. Although health planning has not generated the volume of antitrust litigation that some other health care issues have, it represents one of the most controversial and complex areas in health-antitrust. This section first identifies those

469. One of the stated purposes of the Health Planning Act was to compensate for the perceived market failure and lack of competition in the health care services industry. This rationale was set forth in a statement of national health priorities incorporated in the Act:

(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.

(2) For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services.

470. For example, there has been a substantially greater number of cases involving the application of the antitrust laws to hospital staff privilege decisions and exclusive contracts. See supra Section II.
health planning activities that are likely to raise antitrust concerns. It then examines how the antitrust laws have been applied to health planning activities and how the courts have attempted to reconcile these two different regulatory systems.

B. Health Planning Activities that May Raise Antitrust Concerns

Although various health planning activities may prompt antitrust concerns, two areas have received the greatest attention. The first is the extent to which competing providers may agree to abide by goals established by local health planners. The second is the extent to which providers may participate in the CON application proceedings of their competitors. Although these two issues have sparked the most controversy (and the most litigation), health planning antitrust issues have arisen in other areas as well, such as third-party payment policies and mergers and acquisitions. Each of these areas is described briefly below.

1. Agreements to Abide by Health Planning Goals

As noted above, HSAs develop local health systems plans which often include recommendations regarding the appropriate level and type of health care services in their health service areas. An HSA might recommend, for example, that certain services be consolidated among providers or that some providers should not offer particular services. Of course, a "recommendation" can mean anything from a general statement that the health service area is overbedded to an institutional-specific recommendation as to what should be done about it.

With regard to these recommendations, health systems agencies have often sought voluntary compliance from providers. For example, the HSA might recommend that two hospitals with ob-gyn services meet and agree that one will terminate those services. Agreements among competitors not to compete or to allocate markets, however, raise serious antitrust concerns. Indeed, horizontal market allocation agreements are illegal per se, and antitrust enforcement agencies have indicated that hospital market allocation

471. See, e.g., United States v. Topco Assocs., 405 U.S. 610 (1972); General Leaseways, Inc. v. National Truck Leasing Ass'n, 744 F.2d 588 (7th Cir. 1984); Transource Int'l. v. Trinity Indus., 725 F.2d 274 (5th Cir. 1984). Indeed, horizontal market allocation agreements often lead to criminal prosecution. See, e.g., United States v. Cadillac Overall Supply Co., 568 F.2d 1078 (5th Cir.), cert. denied, 437 U.S. 903 (1978).
agreements should be treated no differently. Because of these legal constraints, the extent to which providers could agree to comply with health planning recommendations was uncertain.

This issue came to the forefront in 1978 when the Central Virginia Health Systems Agency (CVHSA) requested a business review letter from the Antitrust Division of the United States Department of Justice regarding its antitrust enforcement intentions with respect to various CVHSA activities. These activities included (1) review of CON applications and the making of recommendations to the appropriate state agency regarding whether a CON should be granted; (2) review of federal grant applications; (3) review of the appropriateness of existing health services; and (4) implementation of its Health Systems Plan and Annual Implementation Plan "with the assistance of individuals and public and private entities." The final activity involved the CVHSA's efforts to obtain voluntary compliance with its recommendations regarding the placement of new or existing health services and facilities and created the potential for providers to agree to abide by the recommendations.

While the CVHSA business review letter request was pending, Congress was considering amendments to the Health Planning Act. The question of provider agreements to abide by HSA recommendations was brought to the attention of certain congressional staff members. Although the health planning legislation which was eventually adopted, the Health Planning and Resources Development Amendments of 1979, did not expressly address the antitrust issue raised by the CVHSA request, its legislative history is instructive. While the House committee report which accompanied

472. See, e.g., Op. Att’y. Gen. (Utah) No. 85-002 (Oct. 21, 1985), reprinted at 1985-2 Trade Cas. (CCH) ¶ 66,882 (agreement between two hospitals under which one hospital would terminate its general pediatric and newborn intensive care units and the other would refrain from offering adult clinical inpatient and outpatient services would constitute a per se illegal allocation of markets); Op. Att’y. Gen. (Iowa) (Jan. 9, 1984), reprinted at 1984-1 Trade Cas. (CCH) ¶ 65,813 (participation by competing hospitals in a private coalition seeking to formulate plan for reallocation of services and equipment among hospitals and implementation of plan by hospitals would constitute a per se unlawful market allocation agreement); see also Letter from Sanford M. Litvack, Assistant Attorney General, Antitrust Division, to Paul A. Schraff (Aug. 27, 1980) (Antitrust Division business review letter to Westlake Health Campus Association refusing to approve proposed settlement agreement whereby defendant agreed not to provide specific hospital services; letter noted that agreement had not been authorized by any regulatory agency or addressed in health systems plan).

473. See Havighurst, Deregulating the Health Care Industry, supra note 466, at 131.

the 1979 amendments indicated that the application of the antitrust laws to promote competition "is and should be the general rule," it expressed the view that "a practical and realistic analysis of the health care industry argues for exceptions to the rule."475 The report continued that, in light of the statutory requirement that health planning agencies perform certain functions, Congress had not intended the antitrust laws to apply to those agency actions which were necessary to carry out their statutory functions.

The report also noted, however, that agency actions which were not necessary to carry out their statutory functions or which were outside the scope of the health planning laws, "are not authorized and therefore not immune from the application of the antitrust laws."476 In listing the specific health planning agency functions that the antitrust laws should not inhibit, the committee report did not mention the fostering of agreements among providers regarding agency recommendations. Moreover, the committee report's discussion focused solely on the question of application of the antitrust laws to the actions of planning agencies,477 and it did not address the issue of whether the actions of private parties, even when taken in response to planning agency recommendations, should be immune from the antitrust laws.478

In May 1980, the Antitrust Division finally responded to the CVHSA request.479 The letter indicated that the Division had no

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476. Id. at 54-55. For a discussion of the 1979 health planning amendments, see Havighurst, DEREGULATING THE HEALTH CARE INDUSTRY, supra note 466, at 142-48.
477. To ensure that HSAs would not be subject to money damages for actions taken within their authority, the committee amended the health planning statute to provide immunity from liability for HSAs when the member of the HSA board or HSA employee who acted on behalf of the agency acted within the scope of his duty, exercised due care, and acted without malice. See H.R. Rep. No. 96-190, 96th Cong. 2d Sess. 56 (1979). See infra text accompanying notes 606-11 for a discussion of the statutory immunity provision.
478. The Senate report which accompanied the 1979 health planning amendments encouraged health planning agencies to promote competition where appropriate in carrying out their functions, stating:

Despite the fact that the health care industry has not to date responded to classic marketplace forces, the committee believes that the planning process — at the Federal, State and Local level — should encourage competitive forces in the health services industry wherever competition and consumer choice can constructively serve to advance the purpose of quality assurance and cost effectiveness.

479. Letter from Sanford M. Litvack, Assistant Attorney General, Antitrust Division, to William G. Kopit (May 6, 1980) (Central Virginia Health Systems Agency business review
present intention of bringing antitrust enforcement actions with respect to three of CVHSA's proposed activities—CON review, federal grant review, and appropriateness review—because these activities appeared to be clearly contemplated by the federal health planning laws. The Division indicated, however, that it was unable to state its enforcement intentions with respect to CVHSA's proposed health plan implementation activities. It noted that these activities, unlike the others, covered a broad spectrum of conduct not authorized or even contemplated by the federal health planning laws and stated that it could not imply antitrust immunity for such activity. The letter expressly stated that the Division believed

agreements among competing hospitals limiting the number of patients they could serve or the kinds of services they could offer in the absence of conscious and explicit authorization and supervision by the State are probably not contemplated by the [federal health planning] Act nor exempt from the application of federal antitrust laws.

Thus, the Antitrust Division refused to give a green light to HSA-sponsored agreements among competing providers, even where the agreements were undertaken to implement the objectives of a local health plan.480

The antitrust risk involved in provider agreements to abide by health planning objectives is still uncertain today, and there has been surprisingly little litigation involving the issue. Whether this means that hospitals have avoided such agreements because of the antitrust risk involved, or that such activity has occurred but has not been discovered by a willing plaintiff, is unclear. In any event, thus far, this question has received little attention from the courts,481 and therefore, it is uncertain how the substantive issue would be analyzed or what result would be reached. The possible application of certain antitrust exemptions to such agreements, however, is discussed below.482

letter).

480. See also Letter from Sanford M. Litvack to Paul A. Schraff, supra note 472.

481. A market allocation agreement among competing providers was alleged in Hospital Bldg. Co. v. Trustees of Rex Hosp., 691 F.2d 678 (4th Cir. 1982), cert. denied, 104 S. Ct. 231 (1983), discussed infra text accompanying notes 507-14. Although the legality of such an agreement was not specifically addressed by the Rex Hospital court, the opinion suggests that the Fourth Circuit would find the agreement lawful if undertaken in "good faith" in order to avoid the "'needless' duplication of health care resources." 691 F.2d at 686.

482. See infra text accompanying notes 522-25 and 602-03 for discussion of the possible application of the implied repeal and state action doctrines, respectively, to provider agreements to abide by health planning goals.
2. Provider Participation in Certificate-of-Need Proceedings

The heart of health planning is the CON program. Under CON laws, hospitals and other health care facilities must submit a CON application before undertaking certain capital expenditures or other projects. The local HSA, comprised of both consumer and provider representatives, reviews the application to determine whether need exists in the community for the proposed project. The HSA then makes a recommendation to approve or deny the proposal to a state agency, the state health planning and development agency. The state agency conducts an administrative hearing on the application and issues a formal decision as to the need for the project. Administrative and judicial appeals may follow. Unless the applicant is ultimately successful in obtaining a CON, the project may not be undertaken.483

The CON process has often turned into a fiercely contested battle to determine who will (or who will not) obtain permission to build a new facility, expand an existing one, or introduce new services. It is not surprising, given the economic significance of CON determinations, that this has been the most litigated aspect of health planning activity. Furthermore (and also not surprising given what is at stake), it is also, by far, the area of health planning that has generated the most attention under the antitrust laws.484 Indeed, the vast majority of cases that have addressed the application of the antitrust laws in the health planning context have stemmed from CON proceedings. Antitrust plaintiffs may allege, for example, that other hospitals have sought to thwart their market entry by impeding the processing of their CON applications through procedural obstacles, submitting competing CON applications, and placing representatives who were opposed to plaintiffs' projects on planning agencies. The substantive antitrust theories asserted encompass violations of both sections 1 and 2 of the Sherman Act, including group boycott, "garden-variety" conspiracy in restraint of trade, unlawful monopolization, and attempt and conspiracy to monopolize.

The health planning laws contemplate that providers will be involved in the CON review process.485 How far providers may go,


485. The Health Planning Act requires that at least 40%, but no more than 49%, of
however, in seeking to oppose or block the CON application of a competitor has been the focus of considerable litigation. As discussed in greater detail below, the cases involving CON opposition activity have addressed various antitrust issues, including the application of the Noerr-Pennington, state action, and implied repeal doctrines. In fact, issues and questions regarding whether one of the antitrust law exemption doctrines applies to the conduct in question have greatly overshadowed the question of whether the conduct actually violated the antitrust laws.

3. Other Health Planning Issues

Although agreements to abide by health planning goals and CON oppositions are probably the most significant examples of the antitrust implications of health planning activities, health planning issues have arisen in other types of antitrust cases as well. Thus, for example, the health planning laws have been injected into antitrust actions challenging third-party payor reimbursement policies and hospital mergers and acquisitions.486

C. Application of Antitrust Principles to Health Planning Activities

The decisions involving antitrust challenges to health planning activities have focused primarily on the application of three traditional antitrust defenses: the implied repeal, Noerr-Pennington, and state action doctrines. In addition, some cases have considered the applicability of the express statutory exemption from liability provided by the Health Planning Act itself.488 Finally, in at least one health planning case, antitrust defendants have sought to in-

the membership of each HSA governing body must be composed of provider representatives. 42 U.S.C. § 300l-1(b)(3)(C)(ii). In addition, "any person directly affected" by a CON application may participate in a CON hearing, and any person "adversely affected" by a CON decision may seek judicial review of that decision. 42 U.S.C. § 300n-1(b)(12)(A) and (E). See also Hospital Bldg. Co. v. Trustees of Rex Hosp., 691 F.2d at 685 ("while [the health planning laws] do not mandate participation by local hospitals or their administrators, participation by private health-care providers is certainly anticipated and we think desirable").


voke the Local Government Antitrust Act of 1984.489 Each of these defenses, or "immunities," is discussed below.

1. The Implied Repeal Doctrine

The doctrine of "implied repeal" immunizes from antitrust attack conduct that is undertaken to implement a federal regulatory scheme that is inconsistent with the antitrust laws.490 The Supreme Court has frequently emphasized, however, that exemptions from the antitrust laws are to be "strictly construed,"491 and that implied repeal should be found only in cases where there is a "plain repugnancy between the antitrust and regulatory provisions."492 Furthermore, repeal of the antitrust laws may be implied "only if necessary to make the [regulatory scheme] work, and even then only to the minimum extent necessary."493

The inherent inconsistencies between the federal health planning laws and the antitrust laws made it almost inevitable that the implied repeal doctrine would be asserted by defendants against antitrust challenges to health planning activities, and, indeed, the implied repeal issue quickly surfaced in the early antitrust health planning cases. The implied repeal doctrine was also the central issue in the only antitrust health planning case considered thus far by the Supreme Court — National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City.494

In National Gerimedical, the defendant Blue Cross plan had refused to grant the plaintiff, a hospital, status as a participating provider under the Blue Cross plan. The refusal was based on Blue Cross' policy that conditioned the granting of participating provider status on approval of the hospital's construction by the local HSA. The plaintiff had not sought such approval because of the HSA's announced policy that it would not approve any additional acute-care beds in light of its determination that there already was a surplus of beds in the area. Missouri, however, had not adopted a CON law at that time.495

490. This doctrine was first applied in the antitrust field in Keogh v. Chicago & N.W. Ry., 260 U.S. 156 (1922).
495. Missouri also did not conduct capital expenditure review under § 1122 of the Social Security Act, 42 U.S.C. § 1320a-1. See 452 U.S. at 383-84 n.7. For a brief description
When the plaintiff was denied participating status, it brought suit under sections 1 and 2 of the Sherman Act, alleging an illegal concerted refusal to deal by Blue Cross and the HSA. The district court dismissed the hospital's claims, holding that Blue Cross' actions were not subject to the antitrust laws because the Health Planning Act impliedly repealed the antitrust laws for actions clearly within its scope. The Eighth Circuit affirmed.

The Supreme Court reversed, holding that the Health Planning Act did not create a pervasive repeal of the antitrust laws or immunize the challenged conduct from antitrust liability, even though it had been undertaken in response to health planning objectives. The Court emphasized that the challenged action had been "neither compelled nor approved by any governmental regulatory body."

Rather, the Court characterized the action as a "spontaneous response" to the findings of the HSA, which under the Act had no regulatory authority over providers. Further, the Court commented that application of the antitrust laws to Blue Cross' conduct would not frustrate operation of any particular provision of the Act or create a conflict with the orders of any regulatory body. It noted that there was no reason to believe that Congress had contemplated enforcement of HSA advisory decisions by private insurers, let alone relied on such actions to put "teeth" into the voluntary health planning process.

Finally, it concluded that the Health Planning Act was not so inconsistent with the antitrust laws as to create a blanket immunity for every action taken in response to the health planning process.

The Court, however, left open the possibility that the implied repeal doctrine might provide a defense to antitrust challenges to other health planning activities. In its now-famous footnote 18, the Court stated that its holding "did not foreclose future claims of antitrust immunity in other factual contexts."

After acknowledging Congress' findings that competition does not operate effectively in some parts of the health care sector, the Court suggested that implied repeal might be found where "for example, an HSA has expressly advocated a form of cost-saving cooperation among

\[\text{of the } \S 1122 \text{ program, see supra note 464.}\]

497. 628 F.2d 1050 (8th Cir. 1980).
499. Id. at 390-92.
500. Id. at 393 n.18.
501. See supra note 469.
Several lower court decisions have also addressed the application of the implied repeal doctrine to antitrust challenges to health planning activities. In an en banc opinion, State of North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc., the Fourth Circuit reversed the decision of a panel and ruled that a hospital acquisition was not immune from antitrust challenge even though the acquisition had received a CON. Noting that the North Carolina CON statute was more stringent than required under federal health planning laws (it required CON review of acquisitions that did not involve a change in bed capacity), the court reasoned that if Congress had not contemplated CON review of all acquisitions, it could not have intended for CON review to supplant antitrust review. The Fourth Circuit also concluded that public policy considerations militated against a finding of implied immunity because the CON review in question would not necessarily further one of the Health Planning Act's goals — ensuring that more people had access to health care services. Finally, the court concluded that the regulation of acquisitions under health planning was not so "pervasive" as to indicate a congressional intent to repeal the antitrust laws, nor were the antitrust laws so irreconcilable with the Act as to satisfy the "clear repugnancy" standard of the implied repeal doctrine.

502. 452 U.S. 393 n.18 (emphasis added).
504. The FTC rejected a similar argument by American Medical International, Inc. (AMI), when AMI attempted to defend an FTC challenge to its acquisition of a hospital in San Luis Obispo, California, on the ground that the acquisition was immune from antitrust challenge under the implied repeal doctrine. The acquisition, according to AMI, was intended to advance the goal set by the local health systems agency of reducing excess capacity by hospital mergers. The FTC indicated that, even though there might be some type of voluntary cooperation by providers contemplated by the Health Planning Act which would be impliedly immune, AMI's conduct was not of this type because the acquisition was not in response to a specific request from the HSA. See American Medical Int'l, Inc., 3 TRADE REG. REP. (CCH) ¶ 22,170 (FTC July 2, 1984).
505. In concluding that the "pervasiveness" test was not met, the Fourth Circuit relied upon the following: (1) the Health Planning Act's legislative history evidenced a concern for allowing competition to operate as fully as possible; (2) the CON program had no provision for remedial relief commensurate with that provided by the antitrust laws; and (3) the program did not impose a duty on anyone to enforce an antitrust standard of administrative regulation. 740 F.2d at 283.
506. But see Save Our Samaritan v. Bay Medical Center, No. 79-10297 (E.D. Mich. Jan. 13, 1981), where the court held that the antitrust laws were impliedly repealed with respect to a hospital acquisition that was subject to the Michigan CON law. This decision, however, preceded the Supreme Court's ruling in National Gerimedical, and the Save Our Samaritan court relied upon the lower court decisions in National Gerimedical and Huron...
Another Fourth Circuit decision that appears to address the implied repeal issue indirectly is Hospital Building Co. v. Trustees of Rex Hospital.\textsuperscript{507} The facts in Rex Hospital are relatively complex. Essentially, the case involved allegations by the plaintiff hospital that the defendant hospital and assorted co-conspirators had hindered its efforts to expand its hospital facilities in the Raleigh, North Carolina area. Among other things, the plaintiff claimed that the defendants had manipulated the local health planning and state regulatory processes (including the CON process) to exclude it from the market.

The trial court instructed the jury that the alleged practices, if proven, would constitute per se violations of the antitrust laws as a horizontal market allocation agreement and a concerted refusal to deal. In light of the trial court's position, the defendants were not permitted to defend their participation in voluntary health planning activities, and the jury returned a verdict for the plaintiff in the amount of $7.3 million.

The Fourth Circuit reversed and remanded the case for a new trial, finding that the trial court should have allowed assertion of the defense that the defendants engaged in health planning in good faith and not for anticompetitive purposes. The court reasoned that because Congress had expressed an intent to encourage voluntary health planning in order to remedy the problems with competition in the hospital industry, cases involving health planning required a slightly different inquiry than most other cases. Specifically, it stated:

We think a very narrow "rule of reason" is required in order to permit defendants to show, if they can, that participation in certain planning activities that would otherwise violate § 1 might not under the circumstances have been an unreasonable restraint on trade. The appropriate rule, we find, is simply that planning activities of private health services providers are not "unreasonable" restraints under § 1 if undertaken in good faith and if their actual and intended effects lay within those envisioned by specific federal legislation in place at the time of the challenged activities as desirable consequences of such planning activities.\textsuperscript{508}

\textsuperscript{507} Valley Hosp. v. City of Pontiac, discussed infra text accompanying notes 515-17, both of which subsequently were reversed. Therefore, the continued validity of the Save Our Samaritan decision is questionable.

\textsuperscript{508} 691 F.2d 678 (4th Cir. 1982), cert. denied, 104 U.S. 231 (1983). The Rex Hospital case has had an interesting procedural history. Prior to the Fourth Circuit's 1982 decision, the Supreme Court had reversed dismissal of the plaintiff's complaint, ruling that it sufficiently alleged the requisite effect on interstate commerce. 425 U.S. 738 (1976), rev'd, 511 F.2d 678 (4th Cir. 1975).
The court noted, however, that planning activities would not be “reasonable” if their purpose or effect were “only to protect existing health care providers from the competitive threat of potential entrants into or expanders within the same ‘market.’” The opinion further indicated that the “critical question in application of this rule is likely always to be whether the ‘duplication of resources’ sought to be avoided by planning . . . is in fact ‘needless’ duplication.”

Although the Rex Hospital court framed the issue as whether the per se rule or rule of reason standard should apply to the challenged conduct, its analysis appears to be grounded in the implied repeal doctrine. Essentially, the effect of the decision is to apply a standard similar to that of the implied repeal cases to determine what standard of antitrust analysis should be used. The decision confuses immunity analysis and substantive analysis and does little to clarify either the proper role of the implied repeal doctrine in the health planning context or how the substantive issues should be analyzed.

Moreover, the standard devised by the court is probably unworkable. Its distinction between the “needless” duplication of resources (which providers, by agreement, may act to avoid) and the “needful” duplication (which they may not) is not only difficult to understand, but perhaps impossible to apply. Although the court indicated that the “needless” versus “needful” issue should be resolved by an objective assessment of the “health care needs of the consumer public in the market area at the time in question,” such assessments are not easy to make. Furthermore, a provider may not be in a position, at the time of CON proceedings, to deter-

509. Id. at 686.
510. Id.
511. This conclusion is supported by the Fourth Circuit’s reliance upon Silver v. New York Stock Exch., 373 U.S. 341 (1963), an implied repeal doctrine case.
512. One commentator has characterized the Rex Hospital decision as fashioning an “implied amendment” to the antitrust laws. Havighurst, Health Planning and Antitrust Law: The Implied Amendment Doctrine of the Rex Hospital Case, 14 N.C. CENT. L.J. 45 (1983). Havighurst also argues that the Fourth Circuit’s “doctrinal innovation” was not necessary and that the alleged actions of the defendants may not have constituted an antitrust violation at all, even absent the application of the court’s “special rule of reason.” Id. at 51-54.
513. The Rex Hospital court’s creation of a “special rule of reason” for health planning cases is arguably inconsistent with Supreme Court precedent rejecting the application of “special” antitrust rules for cases involving the health care field. See Arizona v. Maricopa County Medical Soc’y, 457 U.S. 332, 349-50 (1982).
514. 691 F.2d at 686.
mine whether, in fact, any proposed project will result in "needless" or "needful" duplication. In short, the Rex Hospital opinion is not only doctrinally confusing, but impractical as well.

A somewhat similar factual situation was the focus in Huron Valley Hospital v. City of Pontiac. There, the plaintiff hospital claimed that its efforts to obtain a CON from the state health planning agency had been blocked by a competing hospital. Specifically, it alleged that the competing hospital had "captured" the CON process and that one of its board members had used his position as chairman of an HSA planning committee to manipulate the administrative process to deny the plaintiff's application.

The district court dismissed the plaintiff's antitrust claim on a variety of grounds, including a finding that the Health Planning Act provided the defendants with a broad exemption from antitrust liability under the implied repeal doctrine. The Sixth Circuit reversed. Relying upon National Gerimedical, the court simply stated, with no real analysis, that "consideration of Huron Valley's antitrust allegations is not precluded by the health [planning] statutes."

Thus, defendants who have attempted to invoke the implied repeal doctrine in defending against antitrust challenges to health planning activities have met with little success. Although some lower courts have sustained an implied repeal defense, the de-

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515. 666 F.2d 1029 (6th Cir. 1981).
517. 666 F.2d at 1034. The court ruled, however, that adjudication of the plaintiff's antitrust claims should be deferred until resolution of the state administrative proceedings. Id. See infra text accompanying notes 559-61, 588-89, and 619-20 for discussions of subsequent proceedings in the Huron Valley case.
518. An implied repeal defense was upheld by the court in Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina, 1983-2 Trade Cas. (CCH) ¶ 65,674 (D.S.C. 1982). The Trident court's holding that certain HSA action was immune from antitrust challenge is more clearly grounded, however, in the express statutory immunity of the Health Planning Act itself and the state action doctrine, see infra text accompanying notes 609-11, and 597-600, respectively, than in the implied repeal doctrine. See also Denver v. Santa Barbara Community Dialysis Center, 1981-1 Trade Cas. (CCH) ¶ 63,946 (C.D. Cal. 1981), where the antitrust claims of nephrologists that a hospital, a dialysis center and other nephrologists had conspired to monopolize and restrain trade were stayed pending the allocation of remaining unallocated dialysis stations by health planning agencies. Although the court granted the stay under the doctrine of primary jurisdiction, it noted that the implied repeal issue was substantial and that disposition of the parties' competing CON applications would aid in resolving the immunity issue, as well as affect the possible need for judicial action. The court stated that "the elaborate regulatory process and the criteria used in evaluating CON applications create the distinct possibility that the antitrust laws have no place in the question of which applicant should receive the right to operate a dialysis facility." 1981-1 Trade Cas. (CCH) at 75,875.
fendants’ victories usually have been short-lived, with the exemp-
tion ultimately being rejected.\textsuperscript{519} With the possible exception of
the Fourth Circuit’s decision in \textit{Rex Hospital} (if that is viewed as
an implied repeal case), the implied repeal doctrine has found little
favor in the health planning context.

This does not mean, however, that the exemption should be con-
sidered a dead issue in health planning cases. Certainly, it may be
available in cases involving planning activities that are expressly
authorized or contemplated by the Health Planning Act, for exam-
ple, HSA appropriateness review or review of CON applications.\textsuperscript{520}
Moreover, the Supreme Court’s footnote 18 in \textit{National Gerimedi-
cal}\textsuperscript{521} may be read as suggesting that the implied repeal doctrine
has broader implications in the health planning context than the
lower courts have found thus far. The parameters of any protection
offered by footnote 18 are undefined, however, and no case has ad-
dressed specifically what provider activities might fall within its
scope.

Footnote 18 suggests that the implied repeal doctrine may be
applicable to joint action by providers to implement HSA-advo-
cated cost containment measures, including, arguably, agreements
to allocate markets in accordance with an HSA recommendation.
Although some authorities imply that this interpretation is cor-
rect,\textsuperscript{522} it is not clear that the Supreme Court would so hold,\textsuperscript{523}
and, indeed, language in the \textit{National Gerimedical} opinion itself

\textsuperscript{519} See also Rehab Hosp. Servs. v. Health Sys. Agency of Southwestern Pennsyl-
ania, No. 84-1639 (W.D. Pa. Feb. 27, 1985). There, the district court stated that it had given
“careful consideration” to “implied immunity,” as well as the \textit{Noerr-Pennington} and state
action doctrines, in denying the defendants’ motion to dismiss an antitrust action challeng-
ing their opposition to plaintiff’s CON application. Without any analysis, the court simply
stated that these possible defenses could not be resolved in the context of a motion to dis-
miss. \textit{Id.}, slip op. at 4 n.1.

\textsuperscript{520} See Department of Justice business review letter to Central Virginia Health Sys-
tems Agency, discussed supra text accompanying notes 479-80. Other defenses, such as the
Health Planning Act statutory immunity, discussed \textit{infra} text accompanying notes 606-11,
may be applicable with respect to such activities as well.

\textsuperscript{521} 452 U.S. 393 n.18; see supra text accompanying notes 500-02.

\textsuperscript{522} See \textit{American Medical Int’l, Inc.}, supra note 504, wherein the FTC suggested
that the implied repeal doctrine \textit{might} have been applicable if the acquisition in question
had been in response to a specific HSA recommendation. 3 \textit{TRADE REG. REP.} (CCH) at
(CCH) ¶ 65,813 (suggesting that allocation of services and equipment by competing hospi-
tals pursuant to HSA formulated health systems plan would be exempt from antitrust scrup-
tiny under implied repeal and state action doctrines).

\textsuperscript{523} At least one commentator has suggested that it is doubtful that the Supreme
Court would accept the argument that the antitrust laws do not apply to HSA-sponsored
casts doubt on that conclusion. As a result, advice to this effect is dangerous. Furthermore, the legislative history of the 1979 health planning amendments, which endorsed the injection of competition into the health care sector and which gave no indication that the health planning activities of private parties should be immune from antitrust challenge, argues against a finding of implied repeal in such a case.

In short, more than a decade after passage of the Health Planning Act, the applicability of the implied repeal doctrine to health planning activities remains as unsettled as ever. One thing that does seem clear, however, is that the Act offers no blanket immunity for all health planning-related activities under the implied repeal theory, and antitrust defendants will bear a heavy burden if they attempt to rely solely on this defense. Furthermore, if the health care sector continues to move toward deregulation and increased reliance on market forces to control health care costs, the argument becomes stronger that the antitrust laws should not be compromised to accommodate anticompetitive health planning activities. Therefore, the courts should apply a very narrow interpretation of the implied repeal doctrine to health planning cases, and the doctrine should be invoked only where the challenged activity appears to be “specifically contemplated” by the federal health planning laws and necessary for their effective implementation.

2. The Noerr-Pennington Doctrine

Perhaps the broadest antitrust immunity doctrine is the Noerr-Pennington exemption, which protects individual and collective efforts to influence government action. The doctrine, premised on the first amendment right to petition the government, shields from successful antitrust challenge joint action to induce legislative, ju-

524. For example, the Court noted that HSAs had no regulatory authority over health care providers and that application of the antitrust laws to the conduct in question would not frustrate a particular provision of the Health Planning Act or conflict with the orders of any regulatory body. National Gerimedical, 452 U.S. at 390-92. These same comments might be made with respect to provider agreements in response to HSA recommendations.

525. See supra text accompanying notes 473-78.

526. National Gerimedical, 452 U.S. at 391. Obviously, if the federal health planning laws are repealed, as has been proposed, an implied repeal defense would not be available, even if some states choose to continue state health planning programs. See infra text accompanying notes 623-24.

dicial or administrative action, even though the conduct may be motivated by an anticompetitive purpose or has an anticompetitive effect.\(^{528}\)

The doctrine is inapplicable, however, to any petitioning of government which constitutes “a mere sham to cover what is actually nothing more than an attempt to interfere directly with the business relationships of a competitor.”\(^{529}\) The so-called “sham exception” to Noerr-Pennington immunity was first applied by the Supreme Court in California Motor Transport Co. v. Trucking Unlimited.\(^{530}\) There, the Court held that “a pattern of baseless, repetitive claims . . . effectively barring respondents from access to the agencies and courts” would not qualify for Noerr-Pennington immunity.\(^{531}\) It noted, in a rather prophetic understatement, that the difference between sham and legitimate conduct may be “a difficult line to discern and draw.”\(^{532}\)

Defining the parameters of the Noerr-Pennington “sham exception” has indeed proven to be a difficult task for the courts, and this issue can be characterized as one of the most confusing in antitrust jurisprudence.\(^{533}\) As a result, the courts have reached varying results on such issues as whether (1) a single lawsuit provides sufficient evidence of sham;\(^{534}\) (2) the defendant’s success in inducing governmental action defeats application of the sham exception;\(^{535}\) and (3) the knowing submission of false information constitutes a sham.\(^{536}\) In general, however, it appears that the sham

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528. Pennington, 381 U.S. at 670.
529. Noerr, 365 U.S. at 144.
531. Id. at 513.
532. Id.
533. See generally American Bar Ass’n Section on Antitrust Law, Antitrust Law Developments (Second) 613-619 (1984).
534. Compare MCI Communications Corp. v. AT&T, 708 F.2d 1081, 1155 (7th Cir.), cert. denied, 104 S. Ct. 234 (1983), and Clipper Exxpress v. Rocky Mountain Motor Tariff Bureau, 674 F.2d 1252, 1265 (9th Cir. 1982), cert. denied, 459 U.S. 1227 (1983) (finding that a single claim is sufficient) with Mountain Grove Cemetery Ass’n v. Norwalk Vault Co., 428 F. Supp. 951, 955 (D. Conn. 1977) (must be multiple baseless claims to invoke sham exception).
536. Compare Woods Exploration & Producing Co. v. Aluminum Co. of America, 438 F.2d 1286, 1298 (5th Cir. 1971), cert. denied, 423 U.S. 833 (1975) (submission of false evidence not protected under Noerr) with St. Joseph’s Hosp. v. Hospital Corp. of America, 1985-2 Trade Cas. (CCH) ¶66,784 (S.D. Ga. 1985), appeal docketed, No. 85-8660 (11th Cir. Aug. 16, 1985) (defendant’s alleged misrepresentations to state health planning agency were
exception will apply where the alleged activity was undertaken to
bar others from access to government processes537 or where the de-
fendant has initiated baseless proceedings for the purpose of injur-
ing its competitor directly through the proceedings themselves,
rather than through whatever action the government takes.538

The Noerr-Pennington doctrine has been raised as a defense in
several of the health planning antitrust cases, particularly those in-
volving challenges to CON oppositions. It has met with varying de-
grees of success and, not surprisingly, the critical issue has been
whether the defendants' actions fell within the sham exception to
the doctrine.

One of the first appellate court cases to consider the applicabil-
ity of the Noerr-Pennington doctrine to health planning activity
was the Ninth Circuit's decision in Phoenix Baptist Hospital and
Medical Center v. Samaritan Health Services.539 There, the plain-
tiff hospital had sought a CON to expand its bed capacity. Prior to
its request, two other hospitals had each created subsidiary corpo-
rations which, in turn, formed a joint venture to build a new hospi-
tal. The joint venture applied for and was awarded a CON, beating
out, among others, the plaintiff.

Although the plaintiff's CON application was approved initially,
the defendants, who included the various corporate entities in-
volved in the joint venture, appealed that approval, arguing that it
did not take into consideration the effect of their own project. The
defendants' appeal was successful, and the plaintiff's CON applica-
tion was denied.

The plaintiff then filed an antitrust action. The two subsidiary
corporations and the joint venture moved to dismiss the action on
the grounds that their actions in opposing plaintiff's CON and ob-
taining a CON for their own project were protected under both the

537. See Trucking Unlimited, 404 U.S. at 513, 516; Federal Prescription Serv., Inc. v.
American Pharmaceutical Ass'n, 663 F.2d 253, 262-63 (D.C. Cir. 1981), cert. denied, 455

538. See P. Areeda, Antitrust Law: An Analysis of Antitrust Principles and Their
Application ¶ 203.1b (Supp. 1982). An example of the latter type of activity might be where
a hospital opposes a competitor's CON application, even though a need for the project
clearly exists, simply to delay the project in hopes that the competitor's financing might fail
or that the delay will increase the costs of the project. This situation illustrates the kind of
"non-price predation" that FTC officials recently have indicated warrants application of the
antitrust laws. See infra note 571.

539. No. 81-5848 (9th Cir. Aug. 25, 1982).
Noerr-Pennington and state action exemption doctrines. Their motion was granted by the district court, and the Ninth Circuit affirmed.

With respect to the defendants' Noerr-Pennington claims, the court simply stated that:

The facts surrounding the . . . defendants' participation in the 1980 administrative proceedings, resulting in denial of [plaintiff's] request to expand, do not indicate a bad faith campaign, a groundless or "frivolous" attempt to influence the administrative process sufficient to bring the case within the "sham exception" to the Noerr-Pennington rule.

The court further noted that its conclusion that the sham exception was inapplicable was reinforced by the fact that the defendants had been successful in their effort to influence the CON process. Other than that, the Ninth Circuit did not elaborate upon the basis for its conclusion, nor did it address the plaintiff's argument that the defendants' CON-related activities were merely part of a larger conspiracy to exclude it from the market.

A Noerr-Pennington defense was also upheld in Garst v. Stoco, Inc., where the plaintiffs had applied for a CON to build a four-bed "birthing center." The defendants, a hospital and various individuals who were either staff members or part owners of the hospital, had actively opposed the plaintiffs' CON application before the local HSA. The HSA recommended to the state planning agency that the application be denied, and that recommendation was adopted. The plaintiffs filed an antitrust action, and the defendants moved for summary judgment on the ground that their...

540. See infra text accompanying notes 572-605 for a discussion of the application of the "state action" doctrine in health planning cases.

541. See infra text accompanying notes 592-96 regarding the Ninth Circuit's treatment of the state action issue.

542. Phoenix Baptist, slip op. at 4.

543. Although the Ninth Circuit's opinion mentions that the plaintiff had made the "larger conspiracy" argument, the court did not discuss what facts, if any, it had relied upon to support that theory. The court did note, however, that it expressed "no opinion on whether the parent corporations of the [subsidiaries and joint venture] may be liable under the broader conspiracy alleged by [the plaintiff]." Slip op. at 6. This suggests that perhaps the facts offered by the plaintiff regarding the broader conspiracy related only to the parent corporations, not the other defendants, although the court's opinion is ambiguous on this point.

The courts have often held that the Noerr-Pennington doctrine does not apply where the allegedly protected activity is part of a larger illegal scheme of which there is independent evidence. See, e.g., MCI Communications Corp. v. AT&T, 708 F.2d 1081, 1158-59 (7th Cir.), cert. denied, 104 S.Ct. 234 (1983); Webb v. Utah Tour Brokers Ass'n, 568 F.2d 670, 674 (10th Cir. 1977).

CON-related activities were protected under the *Noerr-Pennington* doctrine.\(^{545}\)

A threshold question addressed by the court was whether the HSA, a private corporation, should be viewed as a government body for purposes of invoking *Noerr-Pennington* protection. Although the court noted that the Supreme Court in *National Gerimedical* had characterized HSAs as private planning bodies, rather than as governmental entities, it concluded that the Supreme Court’s characterization was not applicable because of the different factual context of the two cases.\(^{546}\) It found that, at least with respect to CON recommendations, an HSA should be considered a government body, and therefore, efforts to influence it would be protected under *Noerr-Pennington*, absent the defendants’ opposition constituting a “sham.”\(^{547}\) The court then easily disposed of plaintiffs’ claims, stating:

Once it is determined that *Noerr-Pennington* protection does apply, it is clear that plaintiffs could not prevail on their claim concerning defendants’ activities before the [HSA]. Plaintiffs’ claim is simply that defendants opposed plaintiffs’ application before the [HSA] and that their opposition was motivated solely by anticompetitive intent. *Noerr-Pennington* protects such opposition from antitrust liability. Plaintiffs have made no allegations which could support an exception to *Noerr-Pennington*; defendants have not been accused of fraudulent conduct or of conspiracy with HSA members. Thus, with respect to plaintiffs’ claim concerning defendants’ activities before the [HSA], defendants’ motion for partial summary judgment will be granted.\(^{548}\)

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545. The plaintiffs also alleged that the defendants had conspired to influence the plaintiffs’ patients to file complaints against them with the Arkansas State Medical Board. The court found that this alleged conduct was also protected by the *Noerr-Pennington* doctrine. 604 F. Supp. at 332-333.

546. 604 F. Supp. at 330. The court relied upon *National Gerimedical’s* footnote 18 as indicating that the Supreme Court’s ruling should not automatically apply in other factual situations. It also noted that the Fourth Circuit, in *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, see supra text accompanying notes 507-14, had implicitly recognized that an HSA was acting as a government body as to CON recommendations.

547. 604 F. Supp. at 331-32. The court discussed at some length the so-called “co-conspirator” exception to *Noerr-Pennington*. Under this exception, where a party conspires with a member of a governmental agency, the party is not protected by the *Noerr-Pennington* doctrine. The *Garst* court noted that: “In reality a finding of co-conspiracy indicates that a party was denied meaningful access to the government body, and would support the application of the sham exception. Accordingly, some courts prefer to treat co-conspiracy as part of the sham exception rather than as a separate exception.” Id. at 332 (citing Hospital Bldg. Co. v. Trustees of Rex Hosp., 691 F.2d 678 (4th Cir. 1982)). It then expressed the view that the CON process “may present a situation particularly appropriate for application of the co-conspirator exception.” 604 F. Supp. at 332. See infra note 564 regarding the co-conspirator exception.

548. 604 F. Supp. at 332.
The Garst court’s apparent assumption that Noerr-Pennington immunity could be defeated only by allegations of either fraudulent conduct or a conspiracy with HSA members seems misplaced. Certainly, other kinds of conduct (for example, the assertion of a frivolous opposition simply to delay the CON process) might support application of the sham exception. The court’s ultimate conclusion, however, appears correct. Based on the facts stated in the opinion, there was no indication either that the defendants had done anything that was intended to or had the effect of denying the plaintiffs’ access to the CON process, or that their opposition had been baseless and undertaken simply to injure the plaintiffs.

Another recent decision which upheld the defendants’ claims of Noerr-Pennington immunity is St. Joseph’s Hospital v. Hospital Corporation of America.549 There, the plaintiff filed a CON application for a cardiac surgery facility. While its application was pending, the state health planning agency adopted a “new cardiac surgery rule,” which, in effect, imposed a two-year moratorium on new cardiac surgery programs in the state. The defendants, who operated a competing hospital with a cardiac surgery program, also submitted a letter to the state planning agency which, plaintiffs alleged, misrepresented the defendant’s capacity to provide cardiac surgical services. The state agency denied the plaintiff’s application based on the new cardiac surgery rule and the information submitted by the defendants.

The plaintiff pursued its state administrative remedies550 and, in addition, brought an antitrust action alleging that the defendants had engaged in bad faith opposition to its CON. The defendants filed a motion to dismiss claiming that their activities were immune from antitrust challenge under Noerr-Pennington.

The court granted the motion to dismiss, holding that the plaintiff’s allegation that the defendants had made an intentional misrepresentation to the state agency was insufficient to invoke the “sham exception.” Although the court acknowledged that there might be instances where a single misrepresentation could form the basis for invoking the sham exception, it indicated that a plaintiff must allege that the misrepresentation “subverted the in-

550. At the time of the district court’s decision, the plaintiff had succeeded in obtaining an order from a state court directing the state agency to issue the CON. An appeal of that order was pending before the Georgia Court of Appeals. See 1985-2 Trade Cas. (CCH) at 63,851.
tegrity of the governmental process."551 The court then concluded that the plaintiff had not alleged that it had been denied a meaningful opportunity to dispute the information submitted by the defendants, or that the state agency itself was so underequipped that the defendants would have known that their misrepresentations would be accepted without question. Finally, the court noted that the state agency had an independent basis for denying the plaintiff’s application—that is, the new cardiac surgery rule—which provided “an insurmountable causation”552 problem for the plaintiff. In other words, the state agency would have denied the application anyway, regardless of the defendants’ misrepresentation.

If St. Joseph’s means that the submission of intentionally false information to the government decision maker is insufficient to trigger the sham exception, its view is overly narrow. The opinion relied heavily upon the Ninth Circuit’s decision in Omni Resource Development Corp. v. Conoco, Inc.,553 which held that the submission of false and fraudulent affidavits in a state court proceeding did not result in the loss of Noerr-Pennington protection.554 Both decisions, however, appear inconsistent with the Supreme Court’s suggestion in California Motor Transport v. Trucking Unlimited,555 that a defendant’s use of perjury or fraud constitutes a sham. There, the Court expressly stated that “[m]isrepresentations, condoned in the political arena, are not immunized when used in the adjudicatory process.”556

Thus, if a defendant has knowingly and intentionally submitted false information to a judicial or regulatory body (as was allegedly the case in St. Joseph’s), the Noerr-Pennington defense should not be available.557 Where intentional misrepresentations are

552. 1985-2 Trade Cas. (CCH) at 63,860.
553. 739 F.2d 1412 (9th Cir. 1984).
554. The Omni Resource court distinguished between false and fraudulent affidavits and a “pattern of fraudulent activity.” 739 F.2d at 1414-15. The Ninth Circuit may be suggesting an analogy to the issue of whether a single baseless claim is sufficient to sustain the sham exception or whether a “multiplicity” of such claims is required. See supra note 534. The two issues, however, are unrelated, and the making of even one intentionally false misrepresentation before a judicial or regulatory body should warrant application of the sham exception.
556. Id. at 513.
557. The making of statements that are not intentionally false, however, should be protected activity. Indeed, it would have a chilling effect on first amendment activities (and would be detrimental to governmental processes) if parties were held strictly liable for the
made, such conduct is tantamount to fraud and effectively bars the other party from meaningful access to governmental processes. The sham exception should thus be invoked.\footnote{558} The St. Joseph's court's ruling to the contrary is misplaced, and it misconstrues the scope of the protection offered by the Noerr-Pennington doctrine. Furthermore, the St. Joseph's holding appears particularly inappropriate in light of the procedural stance of the case: The issues were resolved on a motion to dismiss, before the plaintiff even had an opportunity to conduct any discovery regarding the defendants' actions.

Other courts, however, have been more reluctant to sustain the Noerr-Pennington doctrine in health planning cases. For example, the district court's most recent decision in the Huron Valley Hospital v. City of Pontiac saga\footnote{559} refused to dismiss the plaintiff's complaint, holding that, assuming its allegations were true, the defendants' actions in opposing plaintiff's CON were not protected by the doctrine. The court stated that the plaintiff alleged more than the mere filing of a single lawsuit by the defendants to block the CON; rather, plaintiff's allegations that the defendants had conspired with state officials to deny plaintiff's CON were "more analogous to the sort of abuse of process in barring access to agencies or courts" that would fall within the sham exception.\footnote{560} It noted that the allegations amounted to a claim of "agency capture," a sham exception situation where the regulatees control the regulatory process.\footnote{561} Thus, Noerr-Pennington did not provide a

\begin{footnotes}
\item[558] See \textit{Rex Hospital}, 691 F.2d at 687, where the court suggested that in order to fall within the sham exception, the misrepresentation must be made with the intent to abuse the administrative process so as to deny access to the regulatory body in question.
\item[559] 612 F. Supp. 654 (E.D. Mich. 1985). This decision followed the Sixth Circuit's decision reversing the district court's dismissal of the case and remanding for further proceedings. \textit{See supra} text accompanying notes 515-17.
\item[560] 612 F. Supp. at 663.
\item[561] \textit{Id.} The Huron Valley court relied upon Litton Sys. v. AT&T, 700 F.2d 785, 809 n.36 (2d Cir. 1983). In \textit{Litton}, the Second Circuit rejected the argument that it was necessary to establish that a competitor had been barred access to administrative agencies to invoke the sham exception. The court indicated, however, that the sham exception would apply in the case of "regulatory capture," a situation it seemed to distinguish from "access barring." Logically, however, "regulatory capture" is simply a means of barring access to government, and the Second Circuit's observation appears misplaced. \textit{See generally} Miller, \textit{Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act and Regula-
basis for dismissal.

Similarly, in Rehab Hospital Services Corp. v. Health Systems Agency of Southwestern Pennsylvania,\textsuperscript{562} the court simply stated that the Noerr-Pennington issue could not be resolved in the context of a motion to dismiss.\textsuperscript{563} There, as in Huron Valley, the plaintiff alleged that the defendants had "captured the regulatory process" in thwarting its efforts to obtain a CON for its facility. The plaintiff also claimed that state health planning officials were biased because of their affiliations with its competitors.

Although it is difficult to make generalizations regarding what specific conduct will be sufficient to invoke the sham exception, at least three situations should warrant its application in the health planning context. First, as discussed above, Noerr-Pennington protection should not be available where the defendant has made one or more intentionally false representations to planning authorities or in court proceedings involving a CON application. Second, Noerr-Pennington should also be inapplicable where it is shown that a competing provider has conspired with planning officials,\textsuperscript{564} or has otherwise "captured" the regulatory process by controlling CON decision making. Control of CON proceedings by other providers would seem to be a clear example of effectively denying a competitor access to the regulatory process, thus falling within the scope of the sham exception.

Finally, the sham exception should apply where it appears that the defendant has opposed a competitor's CON application simply for the purpose of delaying the project in question, with no reason-

\textsuperscript{562} No. 84-1639 (W.D. Pa. Feb. 27, 1985).

\textsuperscript{563} See also General Hosps. of Humana, Inc. v. Baptist Medical Sys., No. LR-C-84-455 (E.D. Ark. Oct. 10, 1984). In Humana, the court held that the application of the Noerr-Pennington defense to CON opposition could not be decided on a motion to dismiss. Rather, it stated that allegations should be evaluated as part of a "broad factual inquiry into whether fair and meaningful access was denied." The Humana court subsequently ruled on a motion for summary judgment that the defendants' CON-related activities were protected under the Noerr-Pennington and state action doctrines. See infra notes 564 & 587.

564. A conspiracy with planning officials is not established, however, simply because a competing hospital may have met with them or urged them to adopt a particular position. It must be shown that the public officials actually collaborated with a provider in a conspiracy to restrain competition. See, e.g., Duke & Co. v. Foerster, 521 F.2d 1277, 1281-82 (3d Cir. 1975); see generally Miller, supra note 561, at 908-17. For example, one court has held that the membership of individuals who have worked for, or are closely affiliated with, competing hospitals on a planning agency is insufficient, as a matter of fact, to establish a conspiracy with planning officials and thus does not satisfy the co-conspirator exception. General Hosps. of Humana, Inc. v. Baptist Medical Sys., No. LR-C-84-455 (E.D. Ark. Feb. 12, 1986).
able expectation that the opposition will be successful. This standard would be met if the opposition were "baseless" and undertaken simply to injure the competitor directly through the CON process, that is, if the primary motivation for the action was not to harm the applicant's business through an adverse decision by the government, but rather to harm it through the costs of litigation or the costs resulting from delay. This standard may be the most difficult to apply because it will often be hard to discern what the defendant's intent was at the time of the opposition. Moreover, an improper intent should not be inferred simply because the defendant's opposition was unsuccessful. There must be reasonably objective evidence both that the defendant's intent was improper and that its claims were baseless in order to invoke the sham exception.

Although the Noerr-Pennington doctrine offers perhaps the most promising defense to antitrust challenges to health planning activities, particularly those based on CON oppositions, its umbrella of protection may not extend as far as some hospitals (and their counsel) may believe. The doctrine's murky legal status, especially regarding what conduct triggers the sham exception, means that it will be unclear in many cases whether Noerr-Pennington protection will be available. Furthermore, many courts may not be willing to decide the applicability of Noerr-Pennington at an early stage of the proceedings, but will postpone that decision until the facts have been more fully developed. This means

565. For a discussion of how existing hospitals may use the CON process to delay or increase the costs of a proposed project, see the FTC decision in Hospital Corp. of America, 3 Trade Reg. Rep. (CCH) ¶ 22,301, at 23,348-49 (FTC Oct. 25, 1985).
567. Id. at ¶ 203.1e ("mere fact that the antitrust defendant was unsuccessful ... does not mean that it was unreasonable of him to pursue his interest"). On the other hand, if the defendant's claim was successful, there is a strong presumption that its assertion was not a sham. Id. at ¶ 203.1d.
568. Evidence that the defendant knew its claims were baseless may support an inference of improper intent, that is, that the claims were pursued simply for the purpose of injuring the competitor in question, rather than to obtain the requested governmental action.
569. See Note, Antitrust and Health Planning Under the 1974 NHPRD Act, 1982 J. Corp. L. 311, 336 (suggesting that because the CON process itself is anticompetitive, activity which attempts to influence the outcome of the CON process should be subject to stricter Noerr-Pennington standards than activities to influence other governmental tribunals).
that even though a *Noerr-Pennington* defense may be upheld ultimately, a hospital defendant may nevertheless find itself involved in time-consuming and expensive litigation. In short, hospitals which oppose a competitor's CON application should do so cautiously in order to avoid crossing the fine (and often gray) line between *Noerr-Pennington* protected activity and activity falling within the sham exception.\(^{571}\)

3. **The State Action Immunity Doctrine**

In the seminal decision of *Parker v. Brown*,\(^ {572}\) the Supreme Court articulated what has become known as the "state action" doctrine. There, the Court upheld as an "act of government which the Sherman Act did not undertake to prohibit," a California program which regulated the production and marketing of raisins. The program was created by a state statute and implemented by a public advisory commission. The statute authorized the adoption of programs designed to restrict competition among growers and maintain commodity prices. Although the raisin producers proposed and approved each program, the Court concluded that "it is the state acting through the Commission, which adopts the program and which enforces it with penal sanctions, in the execution of a governmental policy."\(^ {574}\) The Court then held that, based on principles of federalism, such state action was immune from antitrust challenge.

Beginning in the mid-1970s, the Supreme Court examined the state action doctrine in a series of decisions. In *Goldfarb v. Virginia State Bar*,\(^ {575}\) the Court held that the state action doctrine

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571. In a recent presentation, the Acting Chairman of the Federal Trade Commission warned against the use of tactics amounting to "non-price predation," that is, behavior designed to raise competitors' costs. To illustrate this concept, he pointed to the example of hospitals opposing a CON application and exhausting all administrative and judicial appeals, regardless of the merits of their position. He posited the view that the sham exception may apply to such "non-price predation" and indicated that the federal antitrust enforcement agencies may investigate these practices. T. Calvani & R. Tritell, *Invocation of United States Import Relief Laws as an Antitrust Violation*, Text of Remarks before the Fordham Corporate Law Institute Program on Antitrust and Trade Policy in the United States and the European Community (Oct. 3, 1985); see also Calvani, *Non-Price Predation: A New Antitrust Horizon*, 54 ANTITRUST L.J. 409 (1985). For an example of the FTC's investigation of "non-price predation," see the complaint filed by it in Amerco, No. 9193 (FTC filed June 24, 1985), summarized at 3 TRADE REG. REP. (CCH) ¶ 22,264.


573. *Id.* at 352.

574. *Id.*

did not apply to a local bar association's adoption of minimum fee schedules, even though the state supreme court had statutory authority to regulate the practice of law and the state bar, which enforced the fee schedule, was an administrative agency of the court. The Court declared: "[I]t is not enough that . . . anticompetitive conduct is 'prompted' by state action; rather, anticompetitive activities must be compelled by direction of the State acting as sovereign."576 In contrast, two years later in Bates v. State Bar of Arizona,577 the Court sustained the state action exemption in a challenge to an Arizona disciplinary rule restricting lawyer advertising. The rule was both adopted and enforced by the state supreme court, which was authorized under the state constitution to regulate the practice of law.

The Court's most explicit articulation of the state action doctrine, at least as it applies to the activities of private parties, came in California Retail Liquor Dealers Association v. Midcal Aluminum,578 where it considered the legality of a state-mandated vertical price-fixing scheme that applied to wine. In Midcal, the Court held that to sustain the immunity, a defendant must meet a two-pronged standard: first, the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy"; and second, the conduct must be "actively supervised" by the state itself.579 The Court struck down the wine pricing program at issue in Midcal, finding that while it was clearly articulated by the state, it did not meet the active supervision requirement because the state did not review the reasonableness of the privately-established price schedules or monitor the market conditions existing under the program.

Despite the Midcal decision, confusion persisted regarding the applicability of the state action doctrine. First, it was unclear whether the Midcal two-part test applied where the challenged action was that of the state itself, as opposed to that of private parties. Second, and perhaps more importantly, at least some courts interpreted Goldfarb and Bates to mean that state action immunity was available to a private party only if the state had actually compelled580 it to engage in the challenged conduct.581

576. Id. at 791.
579. Id. at 105.
The Supreme Court addressed the first issue in *Hoover v. Ronwin*,\(^{582}\) which involved an antitrust challenge to the grading of bar examinations by a committee that was appointed by, and pursuant to, the rules of the Arizona Supreme Court. The Court held that the *Midcal* two-prong standard only applied where the challenged activity was carried out by individuals pursuant to state authorization, rather than by the state itself. Where, however, the conduct was that of the state legislature or the state supreme court, the issues of "clear articulation" and "active supervision" did not need to be addressed. It concluded that the actions of the committee regarding the grading of bar examinations were, in reality, those of the Arizona Supreme Court, and therefore were exempt from Sherman Act liability under *Parker v. Brown*.

The second issue was resolved by the Supreme Court in *Southern Motor Carriers Rate Conference v. United States*.\(^{583}\) In *Southern Motor Carriers*, two common carrier "rate bureaus" developed joint rate proposals which were submitted to the public service commissions in the states in which they operated. None of the four states involved required collective ratemaking, but three states explicitly sanctioned it by statute and the regulatory agency in the fourth actively encouraged it. The Fifth Circuit held that this activity was not protected from antitrust challenge under the state action doctrine. It reasoned that (1) the *Midcal* two-prong test was inapplicable to suits against private parties in that *Midcal* involved a challenge to a state program rather than the conduct of private parties, and (2) even if *Midcal* were applicable, *private conduct* must be *compelled* by the state in order to be pursuant to a "clearly articulated state policy" within the meaning of *Midcal*'s first prong.\(^{584}\)

The Supreme Court reversed, holding that the collective ratemaking was immune under the state action doctrine. The Court held, first, that the *Midcal* test was applicable to the activities of private parties. Second, it rejected the Fifth Circuit's conclusion that state *compulsion* is a prerequisite, stating that "[t]he

\(^{581}\) Confusion also existed regarding a third issue: the proper legal standard to apply when the restraint in question was imposed by a political subdivision of a state (for example, a county or municipality) as opposed to the state itself. This issue was addressed subsequently by both the Supreme Court and Congress. See *infra* notes 612-18 and accompanying text.


\(^{583}\) 105 S. Ct. 1721 (1985).

\(^{584}\) 702 F.2d at 538-40.
federal antitrust laws do not forbid the states to adopt policies that permit, but do not compel, anticompetitive conduct by regulated private parties. As long as the state clearly articulates its intent to adopt a permissive policy, the first prong of the Midcal test is satisfied."

With regard to antitrust challenges to health planning activities, the state action doctrine has been asserted as a defense by private parties as well as by HSAs and officials involved in the planning process. As with the Noerr-Pennington doctrine, it has been analyzed by the courts with mixed results.

The Fourth Circuit addressed the state action doctrine in its en banc decision in State of North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc., concluding that the doctrine did not immunize a hospital acquisition, even though the acquiring firm had obtained a CON. The court applied the two-prong Midcal test in considering whether the hospital was shielded from antitrust liability. Although it concluded that the CON review process represented a "clearly articulated state policy" by North Carolina to regulate hospital acquisitions, thus satisfying the first prong of the Midcal test, it found that the second prong—active state supervision—was not met because there was no continuing state scrutiny. The state was not required to determine whether the hospital's post-acquisition conduct was in harmony with the expressed goals of the Health Planning Act or the legislative intent of the state CON law. In fact, the court noted that the hospital had raised its prices immediately following the acquisition.

A state action exemption argument was also rejected in Huron Valley Hospital v. City of Pontiac. There, four defendants who

585. 105 S. Ct. at 1728 (emphasis in original).
587. 740 F.2d at 278-79. The court in General Hosps. of Humana, Inc. v. Baptist Medical Sys., No. LR-C-84-455 (E.D. Ark. Feb. 12, 1986), however, reached the opposite conclusion on this issue. There, the court ruled that the state action doctrine applied to the defendants' expansions of their own facilities because the expansions had received CON approval. After finding that the CON process constituted a "clearly articulated state policy," the court then considered whether the requisite "active state supervision" was present. It rejected the reasoning of P.I.A. Asheville, stating that the Fourth Circuit "had incorrectly interpret[ed] active supervision to require in effect wholesale regulation of an entire industry." Slip op. at 9. The court found that the CON process was subject to the necessary state supervision because cost overruns for a project had to be approved, significant future expansions required an additional CON, and the state considered the existing situation in an area in determining whether to permit new entry.
were current and former officials of the state’s department of health claimed immunity under the state action theory. The district court easily found the doctrine inapplicable to the alleged actions of the state defendants, explaining:

Here, plaintiff has challenged the good faith of the state defendants, and a state court held that [the department of health] exceeded and abused its statutory authority and denied plaintiff due process and equal protection. Therefore, it cannot be said that the actions of these defendants were taken pursuant to a clearly articulated state policy.

The court indicated that it was “precisely such allegations of actions taken ultra vires and in bad faith” that distinguished the case from *Southern Motor Carriers Rate Conference*, noting that in the latter case, there were no allegations of bad faith or that the rate bureaus’ conduct had exceeded that authorized by the state.

The *Huron* court also found the Supreme Court’s decision in *Hoover v. Ronwin* to be inapplicable to the state defendants because they acted neither as a legislature nor a state supreme court. Rather, they were merely the officials of a state administrative agency, a body which the court concluded was not the “state itself” under *Hoover*.

In other cases, however, the state action doctrine has been held to immunize certain health planning activities from antitrust attack. The Ninth Circuit upheld a state action defense in *Phoenix Baptist Hospital and Medical Center v. Samaritan Health Services*. After concluding that the actions of certain defendants in opposing plaintiff’s CON application were protected under *Noerr-Pennington*, the court then analyzed whether the defendants’ action in applying for their own CON was protected under the state action doctrine. Characterizing the state CON process as a “statutory division of markets,” adopted pursuant to the congressional mandate of the Health Planning Act, the Ninth Circuit concluded that the CON scheme clearly satisfied the *Midcal* two-
prong state action standard. First, the policy behind the CON process was plainly articulated as both state and federal policy. Second, the "active supervision" requirement was met because the state continually evaluated health care supply and demand in each geographic area, awarding a CON for new facilities only as the need arose. Therefore, the defendants' action in applying for a CON was immune from challenge.

Finally, the district court in *Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina*, found that a health system agency's recommendations that (1) CAT scanners be located only in general acute care hospitals and (2) third-party payors deny reimbursement for services performed by a CAT scanner for which no CON had been obtained were immune from successful antitrust challenge pursuant to, among other theories, the state action doctrine. The court noted both that the HSA acted pursuant to the clearly articulated state policy established by the South Carolina health planning statute and that the state actively supervised the HSA, requiring it to submit health plans for state review.

The *Trident* court's sweeping conclusions regarding applicability of the state action doctrine are somewhat questionable. First, there

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596. The court's conclusion regarding the "active supervision" requirement would appear, at first glance, to be at odds with the Fourth Circuit's holding in *State of North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, discussed supra notes 586-87 and accompanying text. The two cases, however, may be reconciled. In *P.I.A. Asheville*, the issue was whether a hospital acquisition, since it had received CON approval, was immune from antitrust challenge under the state action doctrine. The Fourth Circuit found the doctrine inapplicable since there was no active supervision of the hospital's post-acquisition activities. In *Phoenix Baptist*, the challenged conduct was simply the act of applying for a CON, conduct that was required by the state if the defendants were to undertake construction of a new hospital facility. Certainly, that action would be pursuant to a "clearly articulated state policy," and the CON application process itself (although not the defendants' post-CON activities) would be actively supervised by a state agency.

597. 1982-3 Trade Cas. (CCH) ¶ 65,674 (D.S.C. 1983).

598. In another decision in the same case, however, the court concluded that there was sufficient evidence for the plaintiffs to defeat a motion for summary judgment on their claim that Blue Cross, which had denied reimbursement for CAT scans performed in physician offices, had conspired to prevent the acquisition of CAT scanners by private physicians. Among other things, Blue Cross had commissioned a study discouraging the acquisition of CAT scanners by physicians; that study was relied upon by the HSA in recommending that insurers not reimburse for scans done on physician-owned scanners; and Blue Cross had sought to impose a ceiling on Medicare reimbursement for scans done on physician-owned equipment. See *Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina*, 1983-2 Trade Cas. (CCH) ¶ 65,559 (D.S.C. 1983).

599. The court also concluded that the HSA's action was immunized under the implied repeal doctrine, see supra note 518, and the express statutory immunity provided by the Health Planning Act, see infra text accompanying notes 609-11.
was no suggestion in the Health Planning Act or state statutes that the HSA's functions included making recommendations regarding third-party payment policies. Second, although the health systems plans and annual implementation plans prepared by the HSA were submitted to a state agency, there is no indication in the court's opinion that the particular recommendations in question were either incorporated in those plans or had otherwise been reviewed and approved by a state agency so as to satisfy the active supervision requirement.

The role of the state action doctrine in health planning cases remains unclear. Although state health planning statutes apparently supply the "clearly articulated state policy" requirement for most legitimate health planning-related activities, private party defendants may have difficulty in establishing that their actions were actively supervised by the state. The issue of provider agreements to abide by HSA recommendations regarding the allocation of services illustrates this point. While arguably a state health planning statute might amount to the articulation of a state policy that contemplates or permits such conduct, it is unlikely that there would be active supervision by the state or a state agency of any agreement among providers. Therefore, it is doubtful that the state action doctrine would insulate such agreements from antitrust challenge.

Furthermore, the state action doctrine may, in many cases, be largely duplicative of other possible defenses, such as the Noerr-Pennington doctrine or the Health Planning Act statutory exemp-

600. Cf. National Gerimedical, 452 U.S. at 390-92 (no indication in Health Planning Act that Congress had contemplated enforcement of HSA advisory decisions by private insurers).

601. This assumes, of course, that the challenged actions appear to have been contemplated by and are in accordance with the planning statutes. See Huron Valley Hosp. v. City of Pontiac, 612 F. Supp. 654 (E.D. Mich. 1985) (allegations that state officials exceeded statutory authority precluded application of state action doctrine).

602. See Southern Motor Carriers Rate Conf. v. United States, 105 S. Ct. 1721, 1728 (1985) ("[a]s long as the State clearly articulates its intent to adopt a permissive policy," the first prong of the state action test is met). The clear articulation of policy, however, must come from the state itself in the form of a policy approved by the state legislature or the state supreme court. Id. at 1730. Apparently, under Southern Motor Carriers, a state agency could not articulate the requisite state policy for state action purposes.

603. It is doubtful that supervision of private conduct by an HSA could satisfy the active supervision requirement, since HSAs are private bodies, not state agencies. See National Gerimedical Hosp. and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378, 390 (1981) (HSAs are only private advisory boards, with no regulatory authority); but see Garst v. Stoco, Inc., 604 F. Supp. 326, 330-32 (E.D. Ark. 1985) (holding that HSA is a government body for purposes of Noerr-Pennington doctrine).
tion. For example, a hospital's action in opposing a competitor's CON application is more logically analyzed under Noerr-Pennington principles, and it seems improbable that the state action immunity would be available if a Noerr-Pennington defense were rejected. Similarly, the first line of defense in an antitrust suit challenging the actions of an HSA and its members or employees would probably be the Health Planning Act statutory exemption, although state action might provide an alternative ground for immunity.

In short, although the state action doctrine may be a viable defense in some health planning cases, the scope of its protection is relatively limited. In particular, hospital defendants may find it difficult to satisfy the active state supervision requirement with respect to challenged health planning activities.

4. The Health Planning Act Statutory Exemption

The Health Planning Act itself exempts from liability HSAs, members of their governing bodies, and their employees for actions taken within the scope of their functions. Specifically, the statutory immunity provision states:

(i) a health systems agency shall not, by reason of the performance of any duty, function, or activity, required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if the member of the governing body of the agency or employee of the agency who acted on behalf of the agency... acted within the scope of his duty, function, or activity..., exercised due care, and acted without malice toward any person affected by it; and

(ii) no individual member of the governing body of a health systems agency or employee of a health systems agency shall, by reason of his performance on behalf of the agency of any duty, function, or activity required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision of a State) if he believed he was acting within the scope of his duty, function or activity... and, with respect to such performance, acted without gross negligence or malice toward any person affected by it.

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604. See discussion of the Health Planning Act statutory exemption infra text accompanying notes 606-11.

605. Conduct that fell within the sham exception to Noerr-Pennington could probably not be characterized as being taken pursuant to a clearly articulated state policy, nor would it be supervised by the state.

606. 42 U.S.C. § 300l-1(b)(4)(A) (1982). The exemption does not apply to actions for personal injury or property damage. 42 U.S.C. § 300l-1(b)(4)(B). Furthermore, it only precludes liability for damages and apparently does not affect the availability of injunctive
Because of its relatively limited applicability, this exemption has been asserted by defendants in only a few antitrust health planning cases.

In *DeSoto Medical Center v. Methodist Hospitals of Memphis*, the plaintiff alleged that the defendants, including the local HSA, had conspired to prevent plaintiff from constructing a new hospital so that certain defendants might build one instead. The HSA filed a motion to dismiss the action based on the Health Planning Act statutory exemption. The court, however, found the exemption inapplicable because the plaintiff alleged that HSA officials had acted in bad faith and in violation of the HSA's own regulations and guidelines, stating:

> The reason that no further inquiry is necessary for this Court at this preliminary stage is that the statute by its own terms even as it relates to the imposition of liability on individuals associated with the health systems agencies is couched in such terms which exclude any exemption for liability where the individuals or officials of the agency acted beyond the scope of their duties as officials or employees of the agency or in bad faith as to the individuals affected by their actions. The allegations of the Plaintiffs in this lawsuit include alleged misconduct by officials outside the scope of their duties as officials and employees of the agencies and with bad faith toward the Plaintiffs. This takes the Defendant [HSA] outside of the exemption expressly provided by Congress in the statutory scheme and requires them to defend this lawsuit as they have failed to show that there is no genuine issue of material fact relative to the allegation of bad faith and actions outside the scope of their duties as officials of [the HSA].

The statutory exemption was, however, successfully invoked by the HSA defendant in the *Trident Neuro-Imaging* case. There, as discussed above, the HSA had recommended that CT scanners be located only in general acute care hospitals and that all third-party payors deny reimbursement for CT scan services performed by a scanner for which no CON had been obtained. The court rejected the plaintiffs' contention that these recommendations went beyond the scope of the Health Planning Act and that they were outside the protection of the statutory immunity. It found that the HSA had acted in accordance with the South Carolina health planning statute, the Health Planning Act and the federal guidelines

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607. 1985-1 Trade Cas. (CCH) ¶ 66,384 (S.D. Miss. 1985).
608. *Id.* at 64,883 (emphasis added). The *DeSoto* court also rejected the argument of another defendant, the Mississippi Health Care Commission, that the claims against it were barred by the eleventh amendment.
It, therefore, concluded that the HSA's activities were shielded from liability pursuant to the statutory immunity. 611

As illustrated by the few cases considering it, the statutory exemption from liability provided by the Health Planning Act will probably be of little significance in most health planning antitrust cases. First, most antitrust actions are brought against private parties, such as competing hospitals, rather than against an HSA or its agents. Second, if an HSA or its agent is named as a defendant, it is likely that there will be allegations that the challenged actions were taken with malice, in bad faith, or were outside the scope of the HSA's functions, any of which render the exemption inapplicable. While the exemption may provide some degree of protection for HSAs and their agents, its limited availability means that it should not be a major factor in resolving most antitrust challenges to health planning activities.

5. The Local Government Antitrust Act of 1984

Two years ago, Congress enacted the Local Government Antitrust Act of 1984. 612 This legislation was adopted in response to the concerns of municipalities and other local governmental bodies that certain Supreme Court decisions had limited the extent to which the state action doctrine was applicable to local governments, thus spawning an increasing number of antitrust suits against them. The Act was intended to protect local governments against antitrust damages so long as they acted within their authority, and thereby dispense with the test articulated by the Supreme Court in Community Communications Co. v. City of Boulder. 613 In City of Boulder, it was held that local government action must be pursuant to a "clearly articulated and affirmatively ex-

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610. Actually, the guidelines established a minimum number of scans that should be performed by each CAT scanner, and indicated that no additional scanners should be approved unless each existing scanner in an area was performing more than that amount. The regulations discussed neither where CAT scanners should be located, however, nor reimbursement policies. 1982-3 Trade Cas. (CCH) at 69,451.

611. As discussed supra text accompanying note 600, it is debatable whether the specific HSA recommendations at issue in Trident, particularly its recommendation regarding third-party reimbursement policies, were within the intended functions of an HSA. The Trident court also found that the HSA's actions were immune from antitrust challenge under the state action and implied repeal doctrines, as well. See supra text accompanying notes 597-600 and note 518.


613. 455 U.S. 40 (1982).
pressed" state policy before immunity attached.

Specifically, the Act provides that an antitrust plaintiff may not recover damages, costs or attorneys' fees (1) from "any local government or official or employee thereof acting in an official capacity," or (2) "in any claim against a person based on any official action directed by a local government, or official or employee thereof acting in an official capacity." Thus, only injunctive relief is available in antitrust actions brought against "local governments," their officials and employees, or private parties performing "official action" pursuant to their directive. The term "local government" includes cities, counties and other general function governmental units, as well as special function governmental units such as school and sanitary districts.

The Act also includes a "retroactivity" provision which, under certain circumstances extends its prohibition against local government damage liability to antitrust actions filed prior to the Act's effective date. Specifically, section 3(b) of the Act states that the statute's protection is not applicable to cases that were pending unless the defendant established and the court determines, in light of all the circumstances, including the stage of litigation and the availability of alternative relief under the Clayton Act, that it would be inequitable not to apply this subsection to a pending case. In consideration of this section, existence of a jury verdict, district court judgment, or any stage of litigation subsequent thereto, shall be deemed to be prima facie evidence that Subsection (a) shall not apply.

Thus far, the new Act has been addressed in only one antitrust health planning case, the recent district court decision in *Huron Valley Hospital v. City of Pontiac*. There, two of the defendants, a city and its hospital building authority, sought to invoke the Act retroactively pursuant to section 3(b). These government defendants argued that, despite the fact that the case had been filed in 1978, it was still in an early stage of litigation because it

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614. *Id.* at 52. See H.R. Rep. No. 98-965, 98th Cong., 2d Sess. 2, *reprinted in* 1984 U.S. Code Cong. & Ad. News 4602, 4603. Subsequent to the adoption of the Act, the Supreme Court addressed the issue of local government liability in *Town of Hallie v. City of Eau Claire*, 105 S.Ct. 1713 (1985). It held that the state action exemption protects the activities of local governments undertaken "pursuant to a clearly expressed state policy." 105 S. Ct. at 1717. The state need not actively supervise the local government's action, however, as it must that of private parties, before the exemption applies.

had been stayed and appeals had been taken.\textsuperscript{620}

The court rejected that argument. It concluded that the government defendants had not met the statutory burden of establishing that it would be inequitable if the Act were not applied. To the contrary, the court found that the equities clearly favored no application of the retroactivity provision. Among other things, it noted that the plaintiffs had not been dilatory in pursuing the litigation and that injunctive relief against the government defendants would not be a sufficient remedy for allegations of conspiracy dating back to 1978. Barring damages would be especially inappropriate in light of allegations that the government defendants had been instrumental in conspiring with others to deprive the plaintiffs of due process and to stifle competition.

As with many of the other "defenses," the potential applicability of the Local Government Antitrust Act to antitrust challenges of health planning activities is relatively narrow. The Act might, for example, be invoked by a hospital district or hospital authority that is an antitrust defendant.\textsuperscript{621} It may also be asserted by a city- or county-operated hospital, its officials or employees. It is unlikely, however, that its provisions would apply to HSAs, which are typically private organizations, or to the other governmental agencies usually involved in health planning, because these entities are generally state agencies, not local governmental units. Furthermore, actions of private parties pursuant to an HSA or other planning agency directive would probably not fall within the scope of its protection. In short, although the Act may be raised occasionally in the health planning context, like the Health Planning Act statutory exemption, it will probably not be a significant obstacle in the path of most antitrust plaintiffs.

D. Conclusion

Thus far, antitrust analysis of health planning activities has fo-

\textsuperscript{620} See supra note 517.

\textsuperscript{621} At least three courts have ruled that a hospital district is a "local government" within the meaning of the Act. See Palm Springs Medical Clinic, Inc. v. Desert Hosp., No. CV 85-6163 PAR (C.D. Cal. Jan. 17, 1986) (court granted hospital district's motion to dismiss claims for damages, holding that the Act provided it with absolute immunity against damages under the antitrust laws, regardless of whether its actions were "official conduct"); Northern Valley Indian Health Clinic v. Indian Valley Hosp., No. S-83-1421 (E.D. Cal. June 13, 1985) (order granting motion to strike claims for damages, attorneys' fees and costs as to hospital district defendants); Everts v. South Lincoln Hosp. Dist., No. C84-0210-B (D. Wyo. Mar. 31, 1985) (court viewed Act as giving it discretion to award plaintiff actual, rather than treble, damages against hospital district defendant).
cused on the application of certain defenses, in particular, the implied repeal, *Noerr-Pennington*, and state action doctrines. The predominant (although perhaps not universal) view of the courts has been that there are no "special" antitrust rules for health planning cases. Rather, the courts have applied established antitrust doctrines (as confusing as they might be), such as *Noerr-Pennington* or state action, to determine whether the challenged action may be immune from antitrust attack. No case (with the exception of the Fourth Circuit's decision in *Rex Hospital*) has actually addressed the merits of an antitrust challenge to health planning activities. Assuming, however, that no traditional or statutory defense is available, standard antitrust principles should be employed to determine the legality of the activity. The *Rex Hospital* court's articulation of a "special rule of reason" for health planning cases is inappropriate and unnecessary.

At the present time, the future of federal health planning remains uncertain. The Reagan Administration has consistently opposed health planning and Congress has not reauthorized the federal health planning program since 1981, although funding for it has continued through appropriations resolutions. Several legislative proposals are now pending before Congress that would reauthorize the health planning program, but with significant modifications to the law. The duration of the proposed reauthorization differs under the various measures. Finally, some states have already allowed their CON laws to expire.

Obviously, if the extent of health planning activities diminishes in the future, there should be a corresponding diminishment in antitrust challenges to such activities and the antitrust-health planning issue may simply become a matter of historical interest.

622. The recent infusion of competition in the health care sector argues against any relaxation of antitrust principles simply because health planning activities are involved. Indeed, the increased competition in health care may justify the termination of health planning programs entirely since one of the basic premises of the Health Planning Act was the perceived need to compensate for the lack of competition in health care delivery. See supra note 469.


624. These states include Utah, Arizona, Texas, Kansas, Idaho, New Mexico and Minnesota. Some of these states, however, participate in the federal section 1122 program. Telephone interview with James O'Donnell, American Health Planning Association (Jan. 2, 1986).

625. Of course, some of the same types of activities, for example, market allocation agreements among competing hospitals, may continue to occur outside of the context of
Moreover, even if health planning programs continue, changes in the legal structure in which they operate may affect the availability of possible defenses.\textsuperscript{626} In short, the future of antitrust-health planning cases may largely depend on the future of health planning itself.

VI. \textbf{HOSPITAL REFERRALS TO DOWNSTREAM PROVIDERS}

A. \textit{Introduction}

Hospitals no longer provide merely traditional inpatient and outpatient hospital services. Clearly, in light of prospective payment and its effect on the utilization of inpatient services, the current trend in the hospital industry is toward diversification and "vertical integration" as hospitals venture into new product and service markets. Thus, for example, hospitals are becoming involved in such areas as ambulatory care, home health, durable medical equipment, nursing homes—even the insurance business.\textsuperscript{627}

The home health field is a prime example of this phenomenon. Home health is one of the most rapidly growing health care industries,\textsuperscript{628} and hospitals are entering that market in growing numbers. During 1984, the number of Medicare-certified, hospital-based home health agencies increased by approximately 60 percent, and, according to a recent survey by the American Hospital Association, more than 75 percent of responding hospital chief executive officers indicated that they were planning to add to or ex-
expand their home health services.\textsuperscript{629}

Hospital participation in these new “downstream” (and in some cases, “upstream”) markets may take a variety of forms. The hospital may be the sole owner of the downstream provider or it may joint venture the new service with another party. Alternatively, it may simply establish a contractual arrangement with an existing provider of the downstream service.

Regardless of the precise nature of the relationship between the hospital and the downstream provider, the hospital may have an economic interest in attempting to ensure that its patients needing the downstream services use the provider which the hospital owns or with which it is affiliated.\textsuperscript{630} Accordingly, using various tactics involving different degrees of persuasion, a hospital may attempt to “steer” or force its inpatients to select an affiliated downstream provider. With home health services, for example, hospital discharge planners, who typically wield considerable influence over patient selection of a home health agency, may recommend that patients use the hospital-affiliated agency or they may disparage the services of other agencies. Another tactic may be the hospital’s refusal or failure to inform its patients that the services of competing home health agencies are available. Similarly, the hospital may permit representatives of the affiliated home health agency to participate in the hospital’s discharge planning activities, but preclude competing agencies from doing so. In short, there are various ways—some more subtle than others—that a hospital may afford an affiliated home health agency or other downstream provider with competitive advantages over its competitors.

Efforts to “steer” hospital inpatients to a particular downstream provider may raise antitrust concerns because other downstream providers in the area may be foreclosed from obtaining—or perhaps even competing for—the business of the hospital’s inpatients.

\textsuperscript{629} Home Care Agencies Up 25 Percent Since ’84, Hosp., May 16, 1985, at 64; see also Anders, More Hospitals Will Use Joint Ventures To Enter Home Care Market Experts, Modern Healthcare, Nov. 8, 1985, at 51.

\textsuperscript{630} A hospital referral arrangement with a home health agency or other downstream provider may also raise possible concerns under federal or state laws prohibiting the payment or receipt of rebates or “kickbacks” in return for the referral of patients. See, e.g., 42 U.S.C. § 1395nn(b) (1982) (Medicare statute); 42 U.S.C. § 1396h(b) (1982) (Medicaid statute); Cal. Bus. & Prof. Code § 650 (West 1985 Supp.) (state law). For discussions of the potential fraud and abuse implications of such arrangements, see generally American Hosp. Ass’n, Medicare-Medicaid Antifraud and Abuse Amendments: Application to Hospital Activities Under the Medicare Prospective Payment System (1985); Sax, HHS Begins to Monitor Recent Joint Ventures, Hosp., Nov. 1, 1985, at 87.
If the hospital represents a substantial source of referrals for the downstream service market, the degree of foreclosure may be large. Competing downstream providers may have a strong incentive to challenge the arrangement through antitrust litigation.

Although there are no helpful opinions at present which address the antitrust implications of hospital arrangements with downstream providers, a number of antitrust theories may be applicable. If the hospital does not own or control the affiliated downstream provider, a competing provider may challenge the arrangement under section 1 of the Sherman Act as an unlawful exclusive dealing agreement or an exclusive dealing agreement that results in a tying arrangement between the hospital and its patients. A section 2 conspiracy to monopolize claim might also be alleged. Where the hospital owns or in some way participates financially in the profits of the downstream provider, efforts to steer hospital patients to that provider may prompt claims of an illegal tying arrangement or violation of the section 2 prohibitions against monopolization and attempted monopolization.

This section outlines the arguments that might be made and also how the courts may analyze the antitrust issues raised by hospital referral arrangements with downstream providers. It will be seen that, regardless of the theory employed, the key variable is the hospital's importance (or power) as a source of referrals for the downstream service.


At least one case has considered the implications of hospital "steering" tactics under another federal statute. In Home Health Servs. v. Currier, 706 F.2d 497 (4th Cir. 1983), a home health agency alleged that a physician and a state medical university refused to allow their patients to deal with the plaintiff and generally "steered" patients away from it, thus violating the federal Medicare "freedom of choice" requirement. See 42 U.S.C. § 1395a (1982). The Fourth Circuit held, however, that the plaintiff had neither an implied right of action under that statute nor a cause of action against the state university under 42 U.S.C. §§ 1983 or 1985. Accordingly, it did not reach the merits of the plaintiff's claims.

A conspiracy between a hospital and a respiratory therapy provider was alleged in Barker Medical Co. v. East Alabama Health Care Auth., No. 84-H-1075-E (M.D. Ala. June 27, 1985). The action was dismissed on summary judgment, but the opinion provides little guidance. An "upstream" referral problem is possible also. The plaintiff hospital in Ohio Valley Medical Center v. Wheeling Hosp., No. 85-0060-W (N.D.W. Va. filed May 24, 1985), challenged an arrangement where an HMO allegedly referred all its members to another hospital.
B. Antitrust Analysis of Hospital Referrals to Downstream Providers

1. As an Exclusive Dealing Arrangement

If the hospital does not own or control the downstream provider, hospital efforts to steer hospital patients to that provider may be challenged as an exclusive dealing arrangement. An exclusive dealing arrangement is an agreement by one party that it will deal solely, or "exclusively," with a second party and not with any other parties. Thus, a downstream provider not affiliated with the hospital may claim that the hospital and an affiliated downstream provider have agreed that all hospital patients needing the downstream services will be referred to that provider for those services.

A threshold issue in considering the applicability of an exclusive dealing theory is whether, as a matter of fact, an agreement to refer hospital patients exclusively to the downstream provider exists. In most cases, there will be no express agreement to that effect between the hospital and downstream provider. An exclusive dealing agreement, however, may be inferred from circumstantial evidence. With home health services, for example, facts showing that (1) hospital personnel did not inform hospital patients of the services offered by other home health agencies, and (2) all or a substantial portion of hospital patients needing home health services used the hospital-affiliated home health agency, will probably raise a factual question as to whether an exclusive dealing agreement

632. If the downstream provider is a wholly-owned subsidiary of the hospital, the exclusive dealing theory would not apply since, as a matter of law, no agreement could exist between the two entities. Copperweld Corp. v. Independence Tube Corp., 104 S. Ct. 2731 (1984). Similarly, the exclusive dealing theory would be inapplicable if the hospital and downstream provider were both subsidiaries of a common parent. See Hood v. Tenneco Life Ins. Co., 739 F.2d 1012 (5th Cir. 1984). As discussed infra in this section passim, however, other antitrust theories may be applicable in this situation.

633. Exclusive dealing arrangements involving goods, supplies or commodities may be challenged under section 3 of the Clayton Act, 15 U.S.C. § 14 (1982), while exclusive dealing arrangements for services must be challenged under § 1 of the Sherman Act. With some exceptions (for example, durable medical equipment), it is likely that services would be involved in most cases of hospital referrals to downstream providers and thus that § 3 would be inapplicable.

634. See, e.g., White and White, Inc. v. American Hosp. Supply Corp., 540 F. Supp. 951, 1027-28 (W.D. Mich. 1982), rev'd on other grounds, 723 F.2d 495 (6th Cir. 1983). There, the court focused on two issues in analyzing whether an exclusive dealing agreement could be implied: first, whether the parties intended an exclusive dealing arrangement, and second, whether the arrangement had the effect of an exclusive dealing arrangement, that is, whether the parties in fact dealt exclusively with each other. The court refused to imply an exclusive dealing arrangement because the hospitals in question had purchased a significant percentage of supplies from vendors other than the defendant. 540 F. Supp. at 1032.
existed, thus precluding summary judgment for the defendants.

The plaintiff in Beacon Med Care, Inc. v. Sound Home Health Services, Inc., a federal antitrust action filed in the State of Washington, alleged the above scenario. Although the defendant home health agency and the area's only hospital had enjoyed a close relationship for many years, there was no formal agreement requiring that hospital inpatients be discharged to that agency. Thus, there was no express exclusive dealing arrangement. The plaintiff, a competing home health agency, claimed that an overwhelming majority of the hospital's inpatients used the defendant agency because the hospital's discharge planners recommended it and because the hospital permitted the defendant agency's personnel to participate in discharge planning. Further, it was alleged that the hospital did not distribute the plaintiff's promotional brochure and did not inform patients of the availability of the plaintiff's services. This, according to the plaintiff, amounted to an illegal exclusive dealing agreement.

The Beacon case was settled before trial. Prior to settlement, the defendants filed motions for summary judgment, arguing that there was no evidence that would support a finding of an exclusive dealing agreement. The court denied the motions stating only that disputed factual issues were present. Thus, although Beacon offers no analytical guidance, it shows the willingness of downstream providers to engage in antitrust litigation when they believe that important sources of referrals are foreclosed.

Assuming that an exclusive dealing agreement exists as a factual matter, the arrangement does not necessarily violate the antitrust laws. Its legality is analyzed under the rule of reason, and the ultimate question is whether the arrangement "unreasonably" restrains competition in the downstream services market. This analysis will focus primarily upon the share of the downstream services market in the relevant geographic area that has been foreclosed to other downstream providers by the hospital's action. The extent of foreclosure will be determined by identifying the percentage of all patients needing the downstream services in the area that come

from the hospital in question.

In determining what degree of foreclosure may result in an "unreasonable" restraint of trade, the Department of Justice's \textit{Vertical Restraints Guidelines},\cite{footnote638} which discuss exclusive dealing arrangements, provide perhaps the most objective criteria. There, the Department indicated that it would not challenge an exclusive dealing arrangement if the degree of market foreclosure were less than 10\% (a "safe harbor").\cite{footnote639} Where the degree of market foreclosure exceeds 10\%, the risk that a hospital-downstream provider exclusive referral arrangement may violate the antitrust laws increases, and such an arrangement should be carefully analyzed. In this regard, the \textit{Guidelines} set forth relatively complicated arithmetic formulae that can be applied to assess the risk.\cite{footnote640}

Analysis of the legality of an exclusive referral arrangement should also consider the reasons or purposes for the arrangement and whether it may result in any procompetitive benefits. For example, a hospital may argue that an exclusive home health referral policy is beneficial because it helps facilitate a patient's transition from hospital to home health care. A hospital may also claim that it steers patients to an affiliated provider because the patient's state of health impairs a rational decision and the hospital is confident of the high quality services provided by that provider, while competing providers are unreliable or have a reputation for offering poor quality services. In short, any asserted procompetitivejustifications or benefits of the arrangement should also be examined in assessing the arrangement's reasonableness and some effort made to balance these against any anticompetitive effect.

In sum, assuming that the tactics utilized by the hospital are found to result in an agreement to deal "exclusively," the legality of the arrangement should depend primarily upon the importance of the hospital as a referral source for the downstream services. If

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  \item \cite{footnote638} United States Dep't of Justice, \textit{Vertical Restraints Guidelines} (Jan. 23, 1985), reprinted at 5 \textit{TRADE REG. REP.} (CCH) ¶ 50,473.
  \item \cite{footnote639} \textit{Vertical Restraints Guidelines}, supra note 638, at ¶ 4.1.
  \item \cite{footnote640} Id. at ¶¶ 4.1-4.2. For a discussion of the \textit{Vertical Restraints Guidelines} and their application to arrangements in the health care industry, see Miles, \textit{Hospital Exclusive Contracts and the Department of Justice Vertical Restraints Guidelines}, \textit{HEALTH L. VIGIL}, Mar. 8, 1985, at 7.

Unfortunately, decided cases are of little help in determining what percentage of foreclosure is likely to trigger a problem. See generally \textbf{AMERICAN BAR ASS'N SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS (SECOND) 95-99} (1984); \textbf{AMERICAN BAR ASS'N SECTION OF ANTITRUST LAW (MONOGRAPH No. 8), VERTICAL RESTRICTIONS UPON BUYERS LIMITING PURCHASES OF GOODS FROM OTHERS 84-87} (1982).
the hospital represents a substantial percentage of downstream referrals and insubstantial countervailing procompetitive justifications are established, the arrangement may then be subject to a successful antitrust challenge.

2. As a Tying Arrangement

Competing downstream providers may claim that hospital efforts to steer patients to an affiliated provider amount to an illegal tying arrangement—that is, "an agreement by a party to sell one product but only on the condition that the buyer also purchase a different (or tied) product, or at least agree that he will not purchase that product from any other supplier." Thus, an argument might be made that, by engaging in steering tactics, a hospital is attempting to tie the sale of hospital services or some component of hospital services (the "tying product") to the sale of the downstream services (the "tied product") by "forcing" hospital patients who need the downstream services to use the hospital-affiliated provider rather than other downstream service providers.

As an initial matter, how the "tying product" is defined may be crucial in determining whether a tying arrangement would result if a hospital tried to steer patients to an affiliated provider. At least one court has ruled that no tying arrangement can exist unless all purchasers of the tying product are required to purchase the tied product. In Coastal Neuro-Psychiatric Associates v. Onslow Memorial Hospital, the issue was whether a tying arrangement resulted where a hospital’s patients who needed CAT scans were required to use the hospital’s own CAT scan equipment. The plaintiff alleged that "hospital services" was the tying product and use of the hospital’s CAT scan equipment was the tied product. In rejecting the plaintiff's argument, the court stated:

All patients who use the hospital’s services are not required to use its CAT Scan equipment. Only those who need a CAT Scan are required to use that equipment. Thus, there is no tying product.... [This] situation would con-

641. Northern Pac. Ry. v. United States, 356 U.S. 1, 5-6 (1958). Because tying arrangements are per se illegal if the seller of the tying product has market power in the tying product, see generally supra Section II(C)(3), a tying claim is particularly dangerous.

642. The tying arrangement theory could apply only if the hospital owns the affiliated downstream provider or otherwise has some economic interest in the sale of the downstream service. See Carl Sandburg Village Condo. Ass’n v. First Condo. Dev. Co., 758 F.2d 203 (7th Cir. 1985) (seller of tying product must have economic interest in the sale of the tied product in order for tying arrangement to exist); see generally supra text accompanying notes 253-61.

643. 1985-1 Trade Cas. (CCH) ¶ 66,432 (E.D.N.C. 1985).
stitute a tying arrangement only if all patients who sought the hospital's services were required to undergo a CAT Scan.\textsuperscript{644}

Under the reasoning of the \textit{Coastal Neuro-Psychiatric} opinion, if, "hospital services" are alleged as the tying product, no tying arrangement could be established unless all hospital patients were required to purchase the downstream services. This, obviously, is an unlikely occurrence in the typical downstream referral situation.\textsuperscript{645} It is not clear, however, that other courts would adopt the rationale of the \textit{Coastal Neuro-Psychiatric} court.\textsuperscript{646} Even were they to do so, however, it may be possible to avoid its result by more careful and narrow definition of the tying product. For example, a plaintiff may attempt to delineate a submarket of hospital services provided to patients needing the downstream services.

A critical issue in determining whether the use of downstream referral tactics results in a tying arrangement is whether it can be shown that the hospital has "conditioned" the sale of hospital services on the sale of the downstream services—that is, does the hospital "require" that patients purchase those services from the hospital-affiliated downstream provider. Tying cases indicate that such "conditioning" may be established by showing either the existence of a formal agreement that imposes the condition or that the purchase of the tied product was "coerced." Thus, one court has stated:

Obviously, with respect to the [requirement that the sale of one product be conditioned on the sale of a second], a formal agreement is not necessary, although it is sufficient. But, in the absence of a formal agreement, a plaintiff must establish in some other way that a tie-in was involved and not merely the sale of two products by a single seller. This can be done by proof that purchase of one product, the tied product, was not voluntary, i.e., by proof of coercion.\textsuperscript{647}

\textsuperscript{644} Id. at 65,165 (emphasis in original).

\textsuperscript{645} For example, all hospital patients do not use home health or nursing home services, two of the service areas where downstream referral arrangements are most likely to arise.

\textsuperscript{646} The Supreme Court has implied that a tying arrangement may exist even though the requirement of purchasing the tied product applies only to some purchasers of the tying product. See \textit{Fortner Enters. v. United States Steel Corp.}, 394 U.S. 495, 502 (1969) ("Our tie-in cases have made unmistakably clear that the economic power over the tying product can be sufficient . . . even though the power exists only with respect to some of the buyers in the market."); \textit{see also Digidyne Corp. v. Data General Corp.}, 734 F.2d 1336 (9th Cir. 1984), \textit{cert. denied}, 105 S. Ct. 3534 (1985) (White & Blackmun, JJ., dissenting), discussed supra text accompanying notes 245-47.

\textsuperscript{647} \textit{Ungar v. Dunkin' Donuts of America}, 531 F.2d 1211, 1224 (3d Cir.), \textit{cert. denied}, 429 U.S. 823 (1976); \textit{see also Photovest Corp. v. Fotomat Corp.}, 606 F.2d 704 (7th Cir. 1979), \textit{cert. denied}, 445 U.S. 917 (1980); \textit{Bogus v. American Speech and Hearing Ass'n}, 582
It is improbable that a hospital would impose an express requirement that hospital patients who need the downstream services must purchase them from an affiliated downstream provider. Therefore, the analysis is likely to focus on whether the "steering" tactics employed by the hospital (for example, not informing patients of the services offered by others) amount to coercion.

Several cases suggest that a seller's use of mere "salesmanship" or persuasion in trying to sell a second product to a customer does not supply the requisite coercion for a tying arrangement. For example, the Third Circuit has stated:

The purpose of the antitrust laws is to stimulate economic competition, the essence of which is the presence of many competing sellers; salesmanship—the art of persuasion and influence—is inherent in competition among sellers. It is only when the buyer's freedom to choose a given product is restricted that the tying doctrine comes into play: so long as "the buyer is free to take either product by itself there is no tying problem."

Similarly, in Unijax, Inc. v. Champion International, the Second Circuit held that, absent actual conditioning, a seller's efforts to induce a purchaser to buy a second product did not constitute coercion. The court stated that:

Actual coercion by the seller that in fact forces the buyer to purchase the tied product is an indispensable element of a tying violation. . . . A manufacturer's use of "strong persuasion, encouragement or cajolery to the point of obnoxiousness to induce [its] retailer to buy its full line of products" does not, however, amount to actual coercion. . . . Actual coercion supporting a finding of a tying violation is present only if the manufacturer goes beyond persuasion and conditions its retailer's purchase of one product on the purchase of another product.

These decisions strongly suggest that a tying arrangement may not be established if a hospital simply recommends or tries to persuade hospital patients to use an affiliated downstream provider.

Other cases support the conclusion that a seller's failure to ad-
vise customers that the allegedly tied product might be purchased elsewhere is insufficient to establish the coercion required for a tying arrangement. For example, in *Cia. Petrolera Caribe, Inc. v. Avis Rental Car Corp.*, the plaintiff claimed that the requirement of certain rental car companies that customers pay a refueling charge if the rental car's gas tank was not full when returned amounted to an unlawful tying arrangement. According to plaintiff, by requiring a refueling charge for any gas needed to refill the tank, the rental companies "forced" their customers to purchase gas from them. The First Circuit rejected this argument, stating:

Put in the most favorable possible light, [plaintiff's] claim comes down to an offer to show that the rental car companies "coerce" customers to purchase gasoline from them by lulling them into returning the cars with partially empty tanks. This is accomplished by their alleged failure to give sufficient advance warning that the refueling charge will be higher than at a retail station.

There is nothing in the record however, to suggest, nor does [plaintiff] allege, that any customers who asked about the nature of the refueling charges were not told of them. . . . Ignorance, however, is not a substitute for coercion under the antitrust laws, [plaintiff's] bald and repeated assertions of "force" notwithstanding. 651

Similarly, in *E.B.E., Inc. v. Dunkin' Donuts of America*, the court refused to find that a franchise agreement involving a packaged sale of the franchise which included all necessary operating equipment and a property lease, amounted to a tying arrangement. The court noted that the plaintiff had not claimed that she was forced to accept the equipment and lease in order to obtain the franchise. Rather, she merely asserted that it had never been "affirmatively impressed upon [her that she] could buy [those products] from other sources." The court held that this was insufficient to establish the requisite coercion for a tying arrangement.

Thus, these decisions indicate that the seller of the tying product must actually require the customer to take the second product by refusing (or threatening to refuse) to sell the first product unless the second is purchased as well. Mere efforts to persuade a customer to purchase the second product or failure to inform the customer that it may be purchased elsewhere are insufficient to establish coercion. Under this reasoning, no coercion could be found.

650. 735 F.2d 636 (1st Cir. 1984).
651. Id. at 638 (emphasis added).
653. Id. at 737-38.
in the downstream referral situation unless a hospital created an impression (either expressly or implicitly) among hospital patients that it would not provide hospital services (or some submarket of hospital services) unless they agreed to purchase the downstream services from an affiliated provider.

It is improbable that a hospital would go to this extreme. Rather, the hospital is more likely to encourage the patient to use an affiliated provider or simply not advise its patients that other downstream providers are available. This conduct should not amount to coercion, particularly because the hospital’s action probably would be taken after the provision of hospital services. Quite simply, no “conditioning” can occur if the seller has already sold the alleged “tying product” to the customer before engaging in the allegedly coercive conduct. Thus, while competing downstream providers may claim that a hospital’s efforts to steer hospital patients to an affiliated provider amount to a tying arrangement, absent actual “conditioning,” such claims are unlikely to succeed.  

3. As Monopolization

Hospital downstream referral practices may also be challenged as unlawful monopolization under section 2 of the Sherman Act. The monopolization theory may come into play if the hospital owns or participates financially in a downstream provider and thus would be considered an actual competitor in the downstream service market. In order to prove a monopolization claim, a competing downstream provider must establish that the defendant (1) possesses monopoly power in the relevant market, and (2) has engaged in conduct amounting to the “willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen or historic accident.”

In determining whether the first element—the existence of monopoly power—is present, two separate markets should be considered. First, if the hospital represents a substantial source of refer-

654. In addition, the Supreme Court has made clear that “coercion” is not probable unless the seller of the tying product has market power in that market or the product is unique. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551, 1560-61 (1984). The per se rule likely would not apply unless the hospital had at least 30% of that market. Id. at 1566; see also Vertical Restraints Guidelines, supra note 638, at § 5.3.

rals for patients in need of the downstream services, it may be found to have monopoly power in the market for "downstream service referrals." In this respect, the hospital may be analogous to a so-called "essential facility" in its relationship with nonaffiliated, downstream providers. Second, the downstream services market itself should also be examined to determine whether the hospital-affiliated downstream provider possesses monopoly power in that market. Although the competitive effects of the "steering" practices will be felt in the downstream services market, the possession of monopoly power either by the hospital (in the "referral" market) or by the affiliated downstream provider (in the downstream services market) could satisfy the first element of the monopolization offense.


657. Another § 2 theory that may be applied to the downstream referral situation is that the hospital's steering tactics involve the use of unlawful "leveraging," that is, the use of monopoly power in one market to gain an advantage in another market. See, e.g., White and White v. American Hosp. Supply Corp., 723 F.2d 495 (6th Cir. 1983); Berkey Photo, Inc. v. Eastman Kodak Co., 603 F.2d 263, 284 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980). This theory may apply where a firm attempts to vertically integrate into a new market, such as a hospital's entry into the home health market.

Leveraging is similar to tying in that the seller's market power in one product market is used to induce (rather than coerce as in the case of tying) the buyer to purchase a second product. In SmithKline Corp. v. Eli Lilly & Co., 575 F.2d 1056, 1061-62 (3d Cir.), cert. denied, 439 U.S. 838 (1978), the court held illegal an arrangement by which the seller offered substantial discounts on purchases of its patented products if buyers would purchase its unpatented products which faced stiff competition. The leveraging theory may also apply where a monopolist refuses to deal with a competitor in the second market. As stated by the Second Circuit in Berkey Photo, "[W]e accept the proposition that it is improper, in the absence of a valid business policy, for a firm with monopoly power in one market to gain a competitive advantage in another by refusing to sell a rival the monopolized goods or services he needs to compete effectively in the second market." 603 F.2d at 284.

658. The § 2 analysis becomes more complicated if the hospital is a defendant and is deemed not to be a competitor in the downstream market itself. There is substantial authority for the principle that a firm cannot monopolize or attempt to monopolize a market in which it is not a participant—a so-called "adjacent market"—and that it can arbitrarily "refuse to deal" with those in that market, even if the latter need access to compete effectively. See, e.g., Smith v. Northern Mich. Hosps., 703 F.2d 942, 955 (6th Cir. 1983); Official Airline Guides, Inc. v. FTC, 630 F.2d 920, 927 (2d Cir. 1980), cert. denied, 450 U.S. 917 (1981); see generally 3 P. AREEDA & D. TURNER, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION 736 (1978).

This principle is not applicable if the firm refusing to deal is controlled by competitors of the excluded party or if the firm competes with that party. Then, the "essential facilities" doctrine comes into play under either § 1 (if there is a plurality of actors), see, e.g., Associated Press v. United States, 326 U.S. 1 (1945), or § 2, see, e.g., MCI Communications Corp. v. American Tel. & Tel. Co., 708 F.2d 1081 (7th Cir.), cert. denied, 104 S. Ct. 234 (1983). For there to be a violation under that doctrine, (1) access must be controlled by a firm with monopoly power; (2) the plaintiff must be excluded and be unable to duplicate the competi-
Assuming that the existence of monopoly power in either market is established,\textsuperscript{5} the question then becomes whether the hospital's attempt to "steer" patients to an affiliated downstream provider constitutes the type of action that satisfies the "willful" conduct requirement for a monopolization violation. Obviously, the exact nature of the hospital's actions may vary from case to case. As noted in the home health agency example, the most common "steering" tactics include not informing patients of competing home health agencies, allowing representatives of the affiliated agency to participate in discharge planning but not permitting representatives of competing agencies to do the same, and recommending that patients use the affiliated agency. These actions could be characterized as a "refusal to deal" with nonaffiliated downstream providers or dealing with them on discriminatory terms vis à vis the hospital-affiliated provider. The critical question then is whether such conduct is permissible by a firm with monopoly power or whether it satisfies the second requirement for monopolization—that the firm maintain (or increase) its power by inappropriate means.

The Supreme Court's recent decision in \textit{Aspen Skiing Co. v. Aspen Highland Skiing Corp.}\textsuperscript{6} offers some guidance on this issue. The plaintiff and defendant in \textit{Aspen} were competing ski resorts. The plaintiff owned one mountain and the defendant owned three nearby mountains. For a number of years, the parties had jointly sold an "all-Aspen ticket," which permitted skiers to ski on the four mountains. Subsequently, however, the defendant refused to market the all-Aspen ticket with the plaintiff. There was evidence that the purpose for its refusal was to increase its market share by excluding the plaintiff, and, in fact, the plaintiff's market share

tive benefits that access achieves; and (3) it must be feasible to grant the plaintiff access. 708 F.2d at 1132-33.

If the hospital owns or controls the downstream provider, or if it shares in its profits, it likely will be deemed to be a competitor in the downstream provider service market. Cf. \textit{Carl Sandburg Village Condo. Ass'n No. 1. v. First Condo. Dev. Co.}, 758 F.2d 203 (7th Cir. 1985) (seller of tying product invades the market for the tied product if it receives commissions or rebates from its sale, even if it does not sell the product itself). In that case, the "essential facilities" doctrine is applicable to a refusal to deal. The Federal Trade Commission, however, would apply the doctrine even where the "essential facility" is not controlled by the excluded party's competitors. \textit{See} \textit{General Motors Corp.}, 99 F.T.C. 464, 580 n.45 (1982).

\textsuperscript{5} In general, a market share of 60% or more may be sufficient to establish monopoly power. \textit{See}, e.g., \textit{Holleb & Co. v. Produce Terminal Cold Storage Co.}, 532 F.2d 29, 33 (7th Cir. 1976); \textit{United States v. Aluminum Co. of America}, 148 F.2d 416 (2d Cir. 1945).

\textsuperscript{6} 105 S. Ct. 2847 (1985).
steadily decreased thereafter from approximately 21% to 11%.

The plaintiff claimed the defendant had engaged in unlawful monopolization and obtained a $7.5 million jury verdict. The Tenth Circuit affirmed, holding that the multi-area ticket was an "essential facility," that the defendant had a duty to market it jointly with the plaintiff, and that the defendant intended to create or maintain a monopoly. 661

The Supreme Court framed the issue presented as whether "a firm with monopoly power has a duty to cooperate with its smaller rivals in a marketing arrangement in order to avoid violating § 2." 662 Although the Court stated that a monopolist has no general duty to cooperate with its competitors, it held that a section 2 violation occurs if the monopolist's refusal is unreasonably "exclusionary" or "predatory." 663

The Court then considered what refusals to deal could be characterized as exclusionary or predatory, and thus illegal, when implemented by a firm with monopoly power. Although the opinion is somewhat ambiguous, it indicates that a firm with monopoly power has an affirmative duty to deal with competitors (assuming cooperation is essential to the competitor's ability to compete effectively), unless it has some efficiency or other legitimate justification for not doing so. 664 As the Court stated, "[I]f a firm has been 'attempting to exclude rivals on some basis other than efficiency,' it is fair to characterize its behavior as predatory." 665 Thus, if the basic purpose or intent of a firm with monopoly power is to exclude competitors from the market by not dealing with them, a violation of section 2 occurs.

The Aspen holding strongly suggests that where a hospital has monopoly power over downstream referrals or where the hospital-affiliated downstream provider has monopoly power in the downstream market, the hospital may have a duty to cooperate with competing downstream providers, at least if a refusal to deal is likely to injure those competitors and no efficiency or other legiti-

661. 738 F.2d 1509 (10th Cir. 1984).
663. Id. at 2857.
664. The Aspen analysis closely resembles that employed in "essential facilities" cases. See supra note 658. The Aspen Court, however, expressly disclaimed reliance on that doctrine, stating that it was "unnecessary to consider the possible relevance of the 'essential facilities' doctrine." 105 S. Ct. at 2862 n.44.
mate justification exists for the refusal to cooperate. Thus, in these circumstances, the hospital may be required to deal with competing downstream providers on a nondiscriminatory basis. For example, it may be necessary to inform patients of competing services by distributing information about them or allowing them to participate in discharge planning activities (at least if the hospital-affiliated provider is accorded such treatment). Indeed, one interesting question is how far courts will require firms with monopoly power to go in cooperating with their rivals. Much may depend on why the firm refused to cooperate because this can be dispositive of whether the requisite intent to monopolize was present.

Significantly, Aspen, as well as earlier decisions, indicates that a monopolist may refuse to deal with its competitors if efficiency or other legitimate justifications exist for the refusal. As noted, one possible legitimate justification for the use of "steering" tactics might be that competing downstream providers offer poor quality services or are unreliable, and the patient's condition is such that he or she cannot make a rational decision. If this were established, even a hospital which possessed monopoly power may be able to defend against charges that its practices of discriminating against nonaffiliated providers amounted to unlawful monopolization. In the home health or nursing home situations, another possible justification for these tactics might be that an exclusive referral policy is more efficient and facilitates a patient's transition from hospital to home health or nursing home care. This justification, however,

666. In Aspen, the firm with monopoly power and the excluded party were competitors. It is not clear whether the result would have been the same if they had not been. See generally supra note 658.

667. There may be situations where a hospital, for example, informs patients of the services of all competing home health agencies, but only allows the hospital-affiliated agency to participate in discharge planning. This essentially amounts to a partial refusal to deal; the hospital has not completely denied competing agencies access to patients, but it has afforded the affiliated agency a favored status and an advantage in obtaining referrals. Whether this type of practice would raise concerns under Aspen should depend on why it was undertaken, its impact on competing downstream providers, and whether whatever access competitors have been given to patients is meaningful in light of the advantages afforded the affiliated provider.

668. For an interesting discussion and criticism of the Aspen decision, see Malina, Supreme Court Update — 1985, 54 Antitrust L.J. 289, 289-295 (1985). The author concludes that Aspen "is a troublesome case, in that it seems to impose on a lawful monopolist some degree of a paternalistic obligation to watch out for its competitors' interests." Id. at 295.

669. See, e.g., Becker v. Egypt News Co., 713 F.2d 363 (8th Cir. 1983) (monopolist may refuse to deal to vertically integrate if there are legitimate reasons for the refusal).
Antitrust Scrutiny may be difficult to substantiate, and a hospital which seeks to rely on it should try to develop objective evidence that the policy enhances efficiency. Moreover, it may be that the procompetitive effects from the action are overwhelmed by its anticompetitive effects.

In sum, where a hospital has monopoly power over downstream referrals or where a hospital-affiliated provider has monopoly power in the downstream market, section 2 may require that the hospital cooperate or deal with competing downstream providers, at least to some presently undefined extent. In these circumstances, a hospital that attempts to steer hospital patients to an affiliated provider may run a risk of antitrust liability, at least in the absence of efficiency or other procompetitive justifications for its action.

4. As an Attempt to Monopolize

Where a hospital's or an affiliated downstream provider's market share does not reach monopoly power proportions, a competing downstream provider may allege that the hospital's discriminatory practices nevertheless constitute attempted monopolization under section 2. This violation requires that a plaintiff establish that (1) the defendant had a "specific intent" to monopolize and (2) there was a "dangerous probability" of success in achieving a monopoly in the relevant market.670

The requisite specific intent to monopolize may be inferred from anticompetitive conduct.671 Although the courts have indicated that conduct which fails to satisfy the "willful acquisition or maintenance of monopoly power" requirement for the offense of monopolization cannot form the basis for the specific intent element of an attempted monopolization claim,672 it is unclear whether there is any difference between the types of conduct required for the two offenses. The Aspen decision suggests that, at least where the conduct amounts to a predatory refusal to deal, the standards are essentially the same.673 Thus, the analysis outlined above re-

672. See, e.g., Transamerica Computer Co. v. International Business Mach. Corp., 698 F.2d 1377, 1382 (9th Cir. 1983) (citing California Computer Prods., Inc. v. International Business Mach. Corp., 613 F.2d 727, 738 (9th Cir. 1979)).
673. The distinction between "general intent," traditionally necessary in monopolization cases, and the "specific intent" required in attempted monopolization cases has become
regarding whether hospital steering tactics would supply the requisite "predatory" or "exclusionary" conduct for unlawful monopolization likely is applicable with respect to the offense of attempted monopolization as well. In general, absent efficiency or other procompetitive justifications, hospital actions aimed at favoring affiliated downstream providers by discriminating against nonaffiliated providers may be sufficient to infer the requisite specific intent for purposes of an attempt to monopolize claim. 674

The second element of attempted monopolization—a dangerous probability of success—requires proof of the defendant's market power. 675 Again, two markets should be considered in analyzing the downstream referral issue: the hospital's share of the market for downstream referral sources and the affiliated provider's share of the downstream product or service market. If either market share is sufficient to establish a dangerous probability that the affiliated

blurred in recent years. For example, in Aspen, a monopolization case, the Supreme Court relied upon Lorain Journal v. United States, 342 U.S. 143 (1951), which involved attempted monopolization, in analyzing what kind of conduct would supply the requisite general intent for unlawful monopolization. 105 S. Ct. at 2857. Both often are shown by exclusionary conduct from which the requisite intent can be inferred. See generally Areeda & Turner, supra note 658, at ¶¶ 626a, 626b, 821 (1978).

674. The Eighth Circuit, in an attempted monopolization case explained that:
Anti-competitive conduct is conduct without legitimate business purpose. . . . Such conduct makes sense only because it eliminates competition. . . . Acts which are ordinary business practices typical of those used in a competitive market do not constitute anti-competitive conduct violative of Section 2. . . . The exercise of business judgment cannot be found to be anti-competitive. To be labeled anti-competitive, the conduct involved must be such that its "anticipated benefits were dependent upon its tendency to discipline or eliminate competition and thereby enhance the firm's long term ability to reap the benefits of monopoly power."
Trace X Chem., Inc. v. Canadian Indus., 738 F.2d 261, 266 (8th Cir. 1984) (quoting William Inglis & Sons Baking Co. v. ITT Continental Baking Co., 668 F.2d 1014, 1030 (9th Cir.), cert. denied, 459 U.S. 825 (1982)).

675. Some Ninth Circuit decisions appear to suggest that proof of market power is not necessary for an attempt to monopolize claim. In Janich Bros. v. American Distilling Co., 570 F.2d 848, 853 (9th Cir. 1977), the court stated that evidence of anticompetitive or predatory conduct can support an inference of specific intent, which in turn can support a further inference of dangerous probability of success. The Ninth Circuit's position, however, is the minority view. See generally American Bar Ass'n Section on Antitrust Law, Antitrust Law Developments (Second) 140-144 (1984).

Where proof of market power is required, a plaintiff must necessarily define the relevant market and identify the defendant's market share in order to establish an attempt to monopolize claim. See, e.g., Quality Foods v. Latin American Agribusiness Dev. Corp., 711 F.2d 989, 996 (11th Cir. 1983).

676. The hospital's market power in the referral market may serve as a predictor of the likelihood that an affiliated provider will achieve monopoly power in the downstream market if the hospital's steering tactics are successful.
provider will achieve a monopoly in the downstream market, then an attempted monopolization claim may be viable provided the requisite specific intent can also be shown.

In sum, even if the hospital or affiliated downstream provider does not possess monopoly power in the relevant market, hospital efforts to exclude nonaffiliated providers may support a claim of an unlawful attempt to monopolize. Again, the critical issues are likely to be the hospital's importance as a referral source, the affiliated provider's market share in the downstream market, and whether the hospital is able to establish that its actions are prompted by purposes other than solely to harm competing downstream providers.

5. As a Conspiracy to Monopolize

Finally, in situations where the hospital does not control the downstream provider, a disadvantaged competing provider may also allege that discriminatory practices against it resulted from a conspiracy to monopolize. Elements of this violation are (1) the existence of a combination or conspiracy; (2) an overt act in furtherance of the conspiracy; and (3) a specific intent to monopolize.

The first and third elements—agreement and specific intent to monopolize have been discussed earlier. If there is a "meeting of the minds" to adopt and implement the policy, the first requirement is met; if no efficiency or other legitimate justification is offered for a hospital's steering tactics, then specific intent might be inferred. In addition, the steering practices themselves, if resulting from the agreement, would probably supply the requisite overt act to satisfy the second element of a conspiracy to monopolize claim. Significantly, it is not necessary to prove that there is a danger-

677. Although there are no bright lines for determining what market share is required to establish a dangerous probability of success, a market share of approximately 40-50% should be sufficient, particularly if there is evidence that the share is increasing. See, e.g., Structure Probe, Inc. v. Franklin Inst., 450 F. Supp. 1272 (E.D. Pa. 1978), aff'd mem., 595 F.2d 1214 (3d Cir. 1979).


679. See supra text accompanying notes 117-34.

680. See supra text accompanying notes 671-74.

681. The overt act required to establish a conspiracy to monopolize need not be unlawful by itself and may be found in almost any type of activity or practice. See American Tobacco Co. v. United States, 328 U.S. 781, 809 (1946).
ous probability that the conspiracy to monopolize will succeed.\textsuperscript{682} Thus, unlike the other section 2 offenses discussed above, the hospital’s or affiliated provider’s market share is not critical.\textsuperscript{683} Indeed, relevant product and geographic markets need not even be defined. Furthermore, unlike a section 1 conspiracy, it is not necessary that a conspiracy to monopolize result in an unreasonably anticompetitive effect. Rather, once a conspiracy is shown, it is only necessary to establish the specific intent to monopolize and an overt act in furtherance of that conspiracy.\textsuperscript{684}

\section*{C. Conclusion}

Efforts to steer hospital patients to affiliated downstream providers can raise numerous potential antitrust issues. Such actions may be challenged under several different antitrust theories, including exclusive dealing, tying, monopolization, and attempt and conspiracy to monopolize. The key factors in analyzing the antitrust implications of such practices are (1) the hospital’s importance as a source of referrals for patients needing the downstream services; (2) the affiliated downstream provider’s market power in the downstream market; and (3) whether any procompetitive justifications, such as efficiencies, can be shown.

At the present time, there are no court decisions which specifically address either how far a hospital may go in attempting to steer patients to an affiliated provider or the extent to which a hospital must “cooperate” with nonaffiliated, downstream providers if it has monopoly power. At one extreme, a hospital’s actual forcing of its patients to use an affiliated downstream provider would certainly raise serious concern; at the other, a hospital surely has no duty to “tout” the services of competing downstream providers, regardless of the effect of not doing so.

\begin{itemize}
\item \textsuperscript{683} Some courts, however, have indicated that market power is relevant in determining whether the defendant possessed the requisite specific intent to monopolize. See, e.g., Hunt-Wesson Foods v. Ragu Foods, Inc., 627 F.2d at 926-27; Perrington Wholesale, Inc. v. Burger King Corp., 631 F.2d 1369, 1377 (10th Cir. 1979).
\item \textsuperscript{684} As Areeda and Turner have noted, the conspiracy to monopolize theory appears superfluous in light of § 1’s prohibition of agreements undertaken with an anticompetitive intent. Indeed, the theory “appears to be no more than an afterthought appended to § 1 claims, and it seldom gets the court’s primary attention.” \textit{Areeda & Turner, supra} note 658, at ¶ 839.
\end{itemize}
These issues, however, are recurring ones which already have been the subject of numerous opinion letters to clients and which will probably be the subject of considerable litigation in the future. In addition to the Beacon case discussed above, at least one other antitrust action has been filed challenging hospital practices aimed at favoring a downstream provider. It is likely that antitrust risk in this area will intensify, and hospital steering policies should be examined carefully before they are implemented.

VII. HOSPITAL RESALES OF COMMODITIES PURCHASED AT DISCRIMINATORY PRICES

A. Introduction

Hospitals, through participation in group purchasing programs or otherwise, often purchase commodities from suppliers at prices that are lower than those offered to other purchasers. Pharmaceuticals are a common example. For various reasons, a pharmaceutical manufacturer may be willing to "price discriminate" by selling pharmacy products to a hospital at a price that is significantly lower than that at which it sells to other customers, such as retail pharmacies. In some instances, hospitals may transfer or "resell" pharmaceuticals or other commodities that have been purchased at a discount to other entities. For example, a hospital may resell these products to patients or to an affiliated or nonaffiliated provider, such as a home health agency or skilled nursing facility. The hospital may also be approached by a third party "entrepreneur" who wishes to buy supplies purchased by the hospital and resell them to others in a type of arbitrage scheme.

Hospital transfers or resales of commodities purchased at dis-

685. See supra text accompanying notes 635-36.
686. Key Enter. of Florida v. Venice Hosp., No. 85-1074-CIV-T-15 (M.D. Fla. filed July 3, 1985). The plaintiff, a durable medical equipment (DME) leasing company, alleged that the defendant hospital, which is also in the DME business, conspired with a group of home health agencies to boycott the plaintiff. The case is premised on the theory that the hospital, since it is a major referral source for patients needing home health services, has been able to pressure the home health agencies into using only its DME company for supplies by refusing to refer hospital patients to any home health agency that did not use its DME company. The plaintiff alleged an unlawful tying arrangement, concerted refusal to deal, monopolization, and conspiracy and attempt to monopolize, as well as state law violations.

criminatory prices may raise concerns under the Robinson-Patman Act, a federal antitrust statute that prohibits sellers from giving, and buyers from receiving, discriminatorily low prices where competition may be affected adversely. Purchases by nonprofit hospitals are exempt from the Act when used by the hospital itself. The exemption may be lost, however, if the hospital resells commodities to others. The following discussion provides an overview of the Robinson-Patman Act as well as the exemption which often applies to purchases by nonprofit hospitals. It then examines the issues that should be analyzed in determining whether transfers or resales destroy that exemption.

B. The Federal Antitrust Price Discrimination Laws

1. The Robinson-Patman Act

Section 2(a) of the Robinson-Patman Act prohibits a vendor from selling "commodities of like grade and quality" to different purchasers at different prices "where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly, . . . or to injure, destroy, or prevent competition with any person who . . . receives the benefit of such discrimination." This provision prohibits price discrimination that injures competition, not only at the market level of the seller, but also at the market levels of the purchaser and customers of the purchaser.

Section 2(a) focuses on the potential liability of sellers for price discrimination. Section 2(f), on the other hand, addresses the potential liability of buyers, providing that "it shall be unlawful for any person . . . knowingly to induce or receive a discrimination in price which is prohibited by this section." In order to establish a violation of section 2(f), a plaintiff must show both that a violation of section 2(a) occurred (that is, there was unlawful price discrimination by the seller) and that the buyer knew that the price dis-

688. Resales may also prompt concerns under state price discrimination statutes. While the Robinson-Patman Act is only applicable to the sale of goods or commodities, some state price discrimination statutes apply to services as well. See, e.g., Va. Code § 59.1-9.7(a) (Repl. Vol. 1982).
689. For extended discussions of the Robinson-Patman Act, see F. Rowe, Price Discrimination under the Robinson-Patman Act (1962); 1 & 2 American Bar Ass'n Section of Antitrust Law (Monograph No. 4), The Robinson-Patman Act: Policy and Law (1980 & 1983).
A "price discrimination" is nothing more than a seller's charging different prices to different customers for the same commodity. Not all price discrimination, however, violates the Robinson-Patman Act. As an initial matter, a plaintiff must show that there is a reasonable probability that the price discrimination will result in an injury to competition at some market level. Injury occurs at the seller's level (so-called "primary-line injury") where a seller's low price disadvantages its competitors. For example, a seller may charge a high price in an area where it faces no competition, but price predatorily in an area where it faces stiff competition to drive its competitors out of business. Increasingly, courts are requiring plaintiffs to prove that the lower price was below some measure of the seller's cost before the requisite injury can be inferred.

Injury at the buyer's level (so-called "secondary-line injury") occurs where the vendor sells at different prices to customers who compete with one another, thus giving those who receive the favorable price a competitive advantage over others. The evidentiary standard for showing the requisite competitive injury appears to be more lenient here than in primary line cases. It may be inferred from long-standing differences in prices where competition in the buyers' market is intense and profit margins are low.

Several defenses are available to charges of price discrimination. Section 2(a) itself provides for a "cost justification" defense, permitting a seller to discriminate where the differences in price "make only due allowance for differences in the costs of manufacture, sale, or delivery resulting from the differing methods or quantities" in which the commodities are "sold or delivered." Section 2(b) establishes a "meeting competition" defense, allowing a seller to price discriminate where it is done "in good faith to meet an

equally low price of a competitor."  

Finally, and most significantly for hospitals, the Nonprofit Institutions Act exempts certain purchases of supplies by nonprofit institutions from the general prohibitions of the Robinson-Patman Act.

2. The Nonprofit Institutions Act

As a general rule, a nonprofit hospital's purchase of goods at discriminatorily low prices poses no problem because the Nonprofit Institutions Act provides that the Robinson-Patman Act is inapplicable "to purchases of their supplies for their own use by schools, colleges, . . . hospitals, and charitable institutions not operated for profit." Therefore, many purchases by nonprofit hospitals are exempt from the Robinson-Patman Act and may not provide the basis for a claim of unlawful price discrimination. The exemption, however, is limited to purchases of supplies by nonprofit institutions that are "for their own use." Where the hospital resells the supplies, the critical issue is whether those resales, to an affiliated organization or otherwise, will destroy the exemption because the goods will be deemed not for the hospital's "own use."

In *Abbott Laboratories v. Portland Retail Druggists Association*, the Supreme Court examined the "for their own use" constraint. There, an association of retail pharmacies claimed that drug manufacturers had violated the Robinson-Patman Act by selling drugs to hospitals, which operated pharmacies, at prices lower than those charged the retail pharmacies. After concluding that the Nonprofit Institutions Act did not provide a blanket exemption for all hospital purchases, the Court's analysis focused on what resales by the hospitals would be considered "for their own use." It then formulated the following general standard: "'their own use' is what reasonably may be regarded as use by the hospital in the sense that such use is a part of and promotes the hosp-

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703. Id. (emphasis added).
704. The literal language of the Nonprofit Institutions Act suggests that the exemption may apply to both nonprofit and proprietary hospitals, since the word "hospitals" is not qualified and the phrase "not operated for profit" arguably only modifies "charitable institutions." This interpretation of the exemption, however, would be at odds with the statute's name and its legislative history which indicate that it was intended only to apply to nonprofit institutions. See S. Rep. No. 1769, 75th Cong. 3rd Sess. 1 (1938); H. R. Rep. No. 2161, 75th Cong., 3rd Sess. 1 (1938).
tial's intended institutional operation in the care of persons who are its patients.\textsuperscript{706} The Court held that the following resales of drugs were for the hospital's "own use:" to inpatients, to patients admitted to the emergency room, to inpatients who used the drugs after discharge, to outpatients for use at the hospital, to outpatients for use away from the hospital, to hospital employees and their dependents, and to staff members and their dependents.\textsuperscript{707} On the other hand, neither a hospital's renewal of a prescription given to a former patient nor its sale of drugs to a walk-in customer was for the hospital's "own use."\textsuperscript{708}

In a 1978 advisory opinion, the FTC considered whether a hospital's resale of drugs to a nonaffiliated nursing home would result in loss of the exemption.\textsuperscript{709} In concluding that it did not, the FTC reasoned that the exemption was intended to apply to resales of supplies, at cost, by one charitable institution to another that are limited, in turn, to the latter charitable institution's own use. A resale of this nature would constitute a not-for-profit transfer of supplies from one institution, eligible under the exemption, to another such institution, also eligible under the exemption. In the Commission's view, the exemption was intended to insulate from Robinson-Patman application all purchases of supplies (for their own use) by the designated classes of institutions not operated for profit. . . . The Commission, accordingly, would regard the resale of pharmaceuticals by your client to the nursing home at the same reduced price that it paid its supplier as not altering its exempt status under the Non-Profit Institutions Act. Such pharmaceuticals must be acquired for the nursing home's "own use," as that language was interpreted in Abbott Laboratories, for the exemption to apply.

Thus, it was the FTC's conclusion that a hospital's resale, at cost, to another nonprofit institution did not destroy the exemption.\textsuperscript{710}

In a recent decision, DeModena v. Kaiser Foundation Health Plan,\textsuperscript{711} the Ninth Circuit considered whether the purchase and resale of drugs by a nonprofit health maintenance organization, Kaiser Foundation Health Plan, was protected by the exemption. The court described its inquiry as to "determine the basic institutional

\textsuperscript{706} Id. at 14 (emphasis in original).
\textsuperscript{707} Id. at 9, 15.
\textsuperscript{708} Id. at 15-17.
\textsuperscript{709} St. Peter's Hospital, FTC Advisory Opinion (Sept. 27, 1978), reprinted at 3 TRADE REG. REP. (CCH) ¶ 22,021.
\textsuperscript{710} One commentator has suggested that the FTC's view of the "own use" limitation may be "more liberal" than that of the Supreme Court majority in Abbott Laboratories. See Enders, The Legal Risks When Hospitals Resell Supplies or Equipment, HEALTH SPAN, May 1985, at 3, 5.
\textsuperscript{711} 743 F.2d 1388 (9th Cir. 1984), cert. denied, 105 S. Ct. 1230 (1985).
function of the Kaiser-Permanente Medical Care Program and then decide which sales are in keeping with this function.\textsuperscript{7} Finding that Kaiser had the broad institutional function of providing "a complete panopoly of health care to [its] members," the court held that Kaiser's distribution of drugs to its members was "for its own use." Therefore, the nonprofit institutions exemption applied to the purchase of drugs by Kaiser for resale to its members. Sales by Kaiser to nonmembers, however, were not considered to be for Kaiser's own use, and thus, purchases for resale to nonmembers were subject to the Robinson-Patman Act.

Finally, the California Attorney General recently issued an opinion regarding whether the sales of pharmaceuticals to Medicaid beneficiaries by state-funded, nonprofit clinics were for the clinics' "own use."\textsuperscript{723} In concluding that they were, the Attorney General reasoned that dispensing of the drugs was clearly a part of and promoted the clinics' intended institutional operation and was the primary means for carrying out their charitable endeavors. The opinion also indicated that it was irrelevant, for purposes of the exemption, whether the clinics' patients were receiving public assistance or Medicaid benefits or were private pay patients.

**C. Analysis of Hospital Resales of Commodities**

The movement of nonprofit hospitals in recent years to reorganize and offer a variety of services other than traditional hospital services through separate entities greatly complicates the task of determining whether the hospital is using a commodity itself. For example, hospitals now operate or have some type of affiliation with pharmacies, home health agencies, nursing homes, wellness centers, and even catering services, often in competition with nonhospital firms not given the luxury of discriminatory low prices. When a hospital transfers supplies to these ventures or others, is the "own use" test met? If so, is this what Congress intended when the Nonprofit Institutions Act was passed in 1938?

Nothing in the Act limits the exemption to supplies purchased for use by the hospital in rendering traditional hospital services. Thus, as long as the hospital uses the supplies itself, the exact way in which they are used is likely irrelevant. Transfers, therefore, of the supplies to any entity owned or controlled by the hospital

\textsuperscript{712} 743 F.2d at 1393.

should not, by themselves, destroy the exemption.

Where the entity to which the supplies are transferred or sold is owned or controlled by the hospital, the question is not whether the transfer is a "sale" for purposes of the Robinson-Patman Act, but rather what the transferee does with the supplies. If it uses them itself, the exemption remains intact; if it resells them, the standards set forth in *Abbott Laboratories* and *DeModena* become applicable. For example, if the hospital's catering service sells drugs to attendees at the parties it caters, it is difficult to argue successfully that the exemption applies. The same is true if the hospital's separately incorporated but controlled pharmacy dispenses pharmaceuticals to the walk-in trade. On the other hand, the exemption should not be destroyed where the hospital's home health agency sells commodities to home health patients in the course of providing home care.

Moreover, it should not matter that the controlled transferee is a for-profit corporation. A for-profit corporation and its nonprofit parent are one entity for antitrust purposes, with profits from operations accruing to the nonprofit entity. Thus, "use" of the supplies is by the nonprofit entity. In sum, in the case of a controlled transferee, a hospital's transfer or resale to it will not destroy the exemption. A subsequent transfer, however, may.

If the hospital (or its controlled transferee) does not control the entity to which it resells the commodities, whether the exemption

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714. See supra text accompanying notes 705-708. The *Abbott Laboratories* standard arguably might be read as requiring that the hospital (or an affiliated entity) must use the supplies solely to promote the hospital's "intended institutional operation in the care of" hospital patients. 425 U.S. at 14. Such an interpretation, however, seems wooden and mechanical. There is nothing in the Act which limits the exemption to purchased supplies that are used by the hospital in rendering hospital services; rather, the exemption applies if the purchases are for the hospital's "own use." As long as the hospital (or affiliated entity) is using the supplies itself, and is not transferring or reselling them to others, the exemption should apply.

715. See *supra* text accompanying notes 711-12.

716. See *Copperweld Corp.* v. *Independence Tube Co.*, 104 S. Ct. 2731 (1984). There, the Supreme Court held that a corporation and its wholly-owned subsidiary are a single entity for antitrust purposes, and therefore, that they are incapable of conspiring. See generally *supra* text accompanying notes 95-97. The *Copperweld* rationale has been extended to affiliated companies controlled by a common parent. See, e.g., *Greenwood Util. Comm’n v. Mississippi Power Co.*, 1985-1 Trade Cas. (CCH) ¶ 66,404 (5th Cir. 1985); *Hood v. Tenneco Life Ins. Co.*, 739 F.2d 1012 (5th Cir. 1984).

is destroyed may depend on three other factors. First, would the exemption have applied if the other entity had purchased the commodities directly from the vendor? For example, as in the FTC's 1978 advisory opinion, if the commodities are resold to a nonprofit home health agency or nursing home "for their own use," then the exemption may not be affected because direct purchases by these organizations probably would have been protected by the exemption.\(^\text{717}\) On the other hand, "entrepreneurs" who purchase from the hospital and intend to profit by reselling the commodities are not eligible for the exemption to begin with, and thus, resales to them (or other for-profit entities) would jeopardize the hospital's exemption.

Second, will the commodities, after their transfer or resale, be used in a manner that is "part of and promotes the hospital's intended institutional operation," as required under Abbott Laboratories?\(^\text{718}\) For example, it may be argued that the services of for-profit home health agencies or nursing homes are within the hospital's intended institutional operation of caring for patients until they are able to care for themselves. If that argument is accepted, a transfer to those organizations would not destroy the nonprofit institutions exemption.\(^\text{719}\) In general, however, a transfer or resale to any noncontrolled entity should be closely examined.

Finally, a third factor which may be relevant to the analysis is whether the hospital is reselling the commodity at a profit. As noted, this appeared to be an important variable in the FTC's 1978 advisory opinion,\(^\text{720}\) although the Nonprofit Institutions Act itself does not mention it. If the hospital is profiting by the resale, commercial vendors (for example, retail pharmacies) with which the hospital is competing may be able to argue that the hospital is not

\(^{717}\) See supra text accompanying notes 709-10. This form of transaction, however, appears to fall outside of what the Act literally requires for the exemption to remain in tact — that is, for the hospital to use the supplies itself.

\(^{718}\) 425 U.S. at 14. Indeed, one court denied the purchaser's motion for summary judgment on the exemption issue where it was not clear that the purchaser had taken steps to limit the transferee's use of the supplies to those promoting the purchaser's intended institutional operations. Computronics, Inc. v. Apple Computer, Inc., 600 F. Supp. 809 (W.D. Wis. 1985).


\(^{720}\) See FTC Advisory Opinion, supra note 709.
entitled in such circumstances to more favorable treatment under the antitrust laws.\textsuperscript{721} It seems most likely that the hospital would be reselling the commodities "at a profit" where the resale is to an independent entrepreneur, not an affiliated provider,\textsuperscript{722} and thus the exemption would probably be lost.

In sum, a hospital's transfer or resale of commodities to another entity which it controls should not jeopardize the applicability of the Nonprofit Institutions Act exemption. Even if the hospital does not control the purchasing entity, the exemption may not be affected if the purchasing entity is itself a nonprofit organization or it will use the commodities in a manner that falls within the hospital's "intended institutional operation." Where, however, a hospital attempts to profit by reselling commodities purchased at discriminatory prices to an unrelated party that intends to resell them, the exemption may be destroyed.

One last potential problem merits mention. Thus far, discussion has centered on the hospital as purchaser of the supplies and thus as subject to section 2(f) of the Robinson-Patman Act. However, if the hospital or its controlled entity resells the supplies, it is also subject to the price discrimination constraints placed on sellers by section 2(a), and the Nonprofit Institutions Act provides no protection unless purchasers from the hospital qualify for the exemption. Thus, resales by the hospital may, in certain circumstances, destroy the hospital's exemption and subject it to potential liability under both section 2(a) and (f).

\textbf{D. Conclusion}

Although the above discussion has focused on the Robinson-Patman Act issue, hospital resales of commodities purchased at discriminatory prices may raise a myriad of other legal problems.\textsuperscript{723} For example, if the hospital has agreed with its vendor that the commodities are being purchased for its "own use," but then re-

\textsuperscript{721} Jefferson County Pharmaceutical Ass’n v. Abbott Laboratories, 460 U.S. 150 (1983) (although not decided under Nonprofit Institutions Act, drug manufacturer's sales to state not exempt from Robinson-Patman Act where state competed with private enterprise).

\textsuperscript{722} If, for example, the hospital is transferring the commodities to an affiliated home health agency or skilled nursing facility, under the Medicare program's "related organization" principles, the affiliated provider would only be able to claim the hospital's cost for the commodities as an allowable cost. See 42 C.F.R. § 405.427 (1985). This means that there is no incentive for a hospital to "mark-up" goods sold to affiliated providers, and thus it is unlikely that a hospital would be reselling commodities to such entities at a profit.

\textsuperscript{723} For a discussion of some of the other legal issues raised by hospital resales, see Enders, supra note 710.
sells them, it may have breached its contract with the vendor. Furthermore, even if there were no express written agreement that the goods would not be resold, if the hospital made representations to that effect and the vendor relied upon them in granting the hospital a discount, the hospital may be faced with charges of common law fraud, criminal fraud under state law, or federal mail or wire fraud.\footnote{See, e.g., United States v. Randell, 1985-2 Trade Cas. (CCH) ¶ 66,831 (S.D.N.Y. 1985), aff'd, No. 85-1150 (2d Cir. Aug. 22, 1985), petition for cert. filed, 54 U.S.L.W. 3330 (U.S. Nov. 12, 1985) (No. 85-710), (upholding convictions of various individuals under federal mail fraud, wire fraud, tax fraud and racketeering statutes on charges that they had misrepresented to pharmaceutical manufacturers that certain health facilities and clinics owned by them were entitled to purchase drugs at discounted prices under Nonprofit Institutions Act).}

In addition, this discussion has addressed only whether the nonprofit institutions exemption may be lost if resales are made by a hospital. It has not discussed whether, if the exemption is inapplicable, other defenses still may be available to a claim of price discrimination or whether the discriminatory sales are likely to result in the requisite injury to competition.\footnote{For an excellent synopsis of issues arising under the Robinson-Patman Act and relevant cases, see K. McDermott, “Robinson-Patman Act: Issues and Compliance,” Outline of Remarks at the National Health Lawyers Association’s Antitrust in the Health Care Field Seminar (Jan. 23, 1985).} In other words, simply because the exemption is inapplicable, a violation of the Robinson-Patman Act does not automatically occur when a hospital obtains a discriminatorily low price.

Moreover, if the exemption is lost, it is lost only with respect to those supplies whose use does not comport with the Nonprofit In-
VIII. HOSPITAL Mergers\textsuperscript{726}

A. Introduction

The Federal Trade Commission’s October 25, 1985 decision in Hospital Corporation of America\textsuperscript{727} marked both the third hospital merger case brought to decision by a government agency and the government’s third win.\textsuperscript{728} It is, by far, the most important and enlightening of the cases because, for the first time, the acquisitions invalidated by the Commission were ones that had not resulted in a firm with a market share of monopoly power proportions. Perhaps most important, the Commission issued a clear signal that hospital mergers will be analyzed no differently than those in other industries.\textsuperscript{729}

\textsuperscript{726} For more detailed discussions and outlines of hospital merger antitrust analysis, see Miles, Hospital Mergers and the Antitrust Laws: An Overview, 29 Antitrust Bull. 253 (1984) (from which some of this section is adapted); Schramm & Renn, Hospital Mergers, Market Concentration and the Herfindahl-Hirschmann Index, 33 Emory L.J. 869 (1984); T. Singer, Attorney, Federal Trade Commission, “Application of Federal Antitrust Law to Mergers of Competing Hospitals,” Outline of Remarks before the Nineteenth Annual New England Antitrust Conference (Nov. 8, 1985).

\textsuperscript{727} 3 Trade Reg. Rep. (CCH) ¶ 22,301 (FTC Oct. 25, 1985), appeal docketed No. 85-3185 (7th Cir. Dec. 20, 1985).

\textsuperscript{728} See American Medical Int’l, 3 Trade Reg. Rep. (CCH) ¶ 22,170 (FTC Jul. 2, 1984); United States v. Hospital Affiliates Int’l, 1980-81 Trade Cas. (CCH) ¶ 63,721 (E.D. La. 1980) (preliminary injunction); 1982-1 Trade Cas. (CCH) ¶ 64,696 (E.D. La. 1982) (consent decree).

\textsuperscript{729} See infra text accompanying note 830.
While the pace of acquisitions by investor-owned hospital companies may slacken to some extent, it seems reasonable to assume that hospital acquisitions in the aggregate will not. The Health Planning Act itself encourages consolidations, reductions in duplication of services, and other purportedly cost-saving forms of partial or complete integration among hospitals. In fact, defendants in hospital merger cases have argued unsuccessfully that the Act provides antitrust immunity under the implied repeal doctrine.

Prospective payment demands efficiency-enhancing strategies, one of which is the merger of competing facilities. Indeed, some hospitals may have to merge to survive. Integration, whether partial or complete, is also important in offensive and defensive strategies to increase market penetration or defend present market share from others attempting to encroach. Therefore, it is reasonable to assume that merger activity in the hospital industry will not abate in the near future and that enforcement actions will increase. An understanding of the fundamentals of merger analysis, therefore, is important.

The focal point in analyzing mergers is section 7 of the Clayton Act, which prohibits "acquisition[s]" whose "effect . . . may be substantially to lessen competition or to tend to create a monopoly." Five preliminary facets of section 7 analysis merit brief mention. First, as in the case of sections 1 and 2 of the Sherman Act, section 7 contains an interstate commerce requirement. Even where two local hospitals merge, however, the plaintiff should have little difficulty meeting that jurisdictional prerequisite because, under section 7, the merging firms need only be "engaged in commerce or in any activity affecting commerce." Accordingly, the acquisition itself need not affect commerce.

Second, the types of transactions to which section 7 applies are extremely broad. Not only does it apply to complete integration through merger, but it also applies to the establishment of joint ventures and the acquisition of leases and management con-

730. See generally Hospital Chain Expansion Over?, Modern Healthcare, Nov. 22, 1985, at 5.
731. See supra note 11 and Section V.
732. See infra note 792.
734. See supra text accompanying notes 18-19, 76-80.
tracts as well. An "asset," for example, subject to acquisition and thus subject to section 7, includes "property or property rights, real or personal, tangible or intangible, which is subject to transfer and which has been used by the buyer competitively." In effect, section 7 applies to the transfer of anything of value.

Third, the Supreme Court will provide guidance this Term as to whom has standing to challenge a merger under section 7. Most important is whether a competitor of the merging firms has standing to challenge the merger. The argument against a competitor's standing is that it suffers no "antitrust injury" because it actually benefits from the greater likelihood of collusion in its market that higher concentration achieves. In Montfort of Colorado, Inc. v. Cargill, Inc., however, the Tenth Circuit held that a firm did have standing to challenge the merger of two of its competitors, at least when it alleged that the consolidated firm would have sufficient market power to engage in predatory pricing and drive the plaintiff out of business. The Supreme Court has agreed to review the case.

Fourth, those contemplating an acquisition should determine early on whether the transaction must be reported to the Federal Trade Commission and Department of Justice pursuant to the premerger notification provisions of section 7A of the Clayton Act.

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738. See infra text accompanying notes 810-12.
741. 1985-1 Trade Cas. (CCH) ¶ 66,576 (10th Cir. 1985), cert. granted, 106 S. Ct. 784 (1986).
742. Where the alleged anticompetitive effects were employee dislocation, disruption in the community, customer uncertainty, and impairment of employee morale, a court recently held that a takeover target lacks standing to challenge its acquisition by its competitor. The court also noted that the plaintiff would not suffer injury because it would be a stronger competitor. H.H. Robertson v. Guardian Indus., 1986-1 Trade Cas. (CCH) ¶ 66,911 (3d Cir. 1986).

For a discussion of challenges under § 7 by private parties, see generally AMERICAN BAR ASS'N SECTION ON ANTITRUST LAW (MONOGRAPH No. 1), MERGERS AND THE PRIVATE ANTITRUST SUIT: THE PRIVATE ENFORCEMENT OF SECTION VII OF THE CLAYTON ACT, POLICY AND LAW (1977). For a helpful discussion and criticism of cases permitting plaintiffs to challenge mergers between their competitors, see Werden, Challenge to Horizontal Mergers by Competitors Under Section 7 of the Clayton Act (U.S. DEP'T JUSTICE ECON. POLICY OFFICE, DISCUSSION PAPER No. 85-16 1985).

In general, the proposed acquisition must be reported if one of the parties has annual sales or assets of $100 million or more and the other has sales or assets of $10 million or more, and the acquiring firm obtains 15% or $15 million of the acquired firm's stock or assets. The acquisition cannot be consummated until thirty days after the notification is filed, and the period can be extended an additional twenty days if the FTC or Department of Justice issue a "second request letter" asking for more information.

Finally, because of a seemingly technical shortcoming in section 7, there is a question whether it applies to the acquisition of assets by a nonprofit hospital. The section prohibits any person from acquiring the stock of another person where the effect may be substantially to lessen competition or tend to create a monopoly. With respect to asset acquisitions, however, the acquiring party must be "subject to the jurisdiction of the Federal Trade Commission." Section 5 of the Federal Trade Commission Act gives the Commission jurisdiction over "corporations," but section 4 of the same act defines "corporations" to include only a business entity "organized to carry on business for its own profit or that of its members." If, therefore, the "subject to the jurisdiction" clause is a substantive part of section 7, then the section does not apply to asset acquisitions by nonprofit hospitals. On the other hand, if the clause relates only to the Commission's jurisdiction under section 7, then a challenge could be forthcoming by the Department of Justice, a state attorney general, or a private party. Because all the cases thus far have involved challenges to acquisitions by for-profit hospital companies, the issue remains open, but the first interpretation seems the more appropriate.

745. Id. at § 18a(a)(3).
746. Id. at § 18a(b)(1).
747. Id. at § 18a(e).
751. For an interpretation of this language, see American Medical Ass'n v. FTC, 638 F.2d 443 (2d Cir. 1980) (nonprofit status not determinative; AMA served both business and nonbusiness interests of its members), aff'd by an equally divided court, 452 U.S. 960 (1982).
752. For a discussion of this issue, see Singer, supra note 726. The Supreme Court's decision in United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963), suggests that, for § 7 not to apply, the transaction must be a pure acquisition of assets and not a merger or other type of consolidation. 374 U.S. at 345-46.
Regardless of section 7's applicability, the acquisition could be challenged under section 1 of the Sherman Act\textsuperscript{753} or, in appropriate circumstances, section 2. Presently, it is not clear whether merger standards under sections 1 and 7 are identical. Because section 7 is a prophylactic statute designed to reach potential restraints in their incipiency\textsuperscript{754} while section 1 theoretically prohibits only actual restraints of trade, an argument can be made that a merger violating section 7 does not necessarily violate section 1.\textsuperscript{755} Leading commentators, however, suggest that there is little difference, if any.\textsuperscript{756} Prudent counseling suggests an assumption that the standards are identical.

B. Merger Analysis and the Department of Justice Merger Guidelines

Although merger analysis tends to be fact-specific, the requisite analytical framework is straightforward. The ultimate question is whether there is a \textit{reasonable probability}\textsuperscript{757} that an anticompetitive effect will result—that the acquisition will result in a firm able to exercise substantial market power unilaterally, or in a market structure in which tacit or explicit collusion among firms to engage

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\textsuperscript{754} See, e.g., American Medical Int'l, 3 TRADE REG. REP. (CCH) ¶ 22,170, at 23,038 (FTC July 2, 1984) (Section 7 "applies to 'incipient' violations and . . . there is no need to prove that the merger would have any actual or definite anticompetitive effects.").

\textsuperscript{755} See, e.g., White Consol. Indus. v. Whirlpool Corp., 1986-1 Trade Cas. (CCH) ¶ 66,930 at 61,792 (6th Cir. 1986) (§ 1 merger standard "more vigorous" than § 7 standard); see generally Brown Shoe Co. v. United States, 370 U.S. 294, 328-29 (1962) ("the legislative history of § 7 indicates clearly that the tests for measuring the legality of any particular economic arrangement under the Clayton Act are to be less stringent than those used in applying the Sherman Act").

\textsuperscript{756} See, e.g., 2 P. AREEDA & D. TURNER, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 304 (1978); L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 200 at 595 ("the Court in the Lexington Bank case brought the Sherman Act standards into closer accord with Clayton than they had previously seemed to be"); W. Baxter, Assistant Attorney General, Antitrust Division, Text of Remarks before the Senate Judiciary Committee (Oct. 27, 1981) ("in referring to Section 7, I do not mean to suggest that Section 1 of the Sherman Act, as it is and should be interpreted in light of Section 7's passage, imports any greater, lesser or different standards").

\textsuperscript{757} In Brown Shoe Co. v. United States, 370 U.S. 294 (1962), the Court explained: Congress used the words "\textit{may be substantially to lessen competition}\textsuperscript{\textsuperscript{1}} . . . to indicate that its concern was with probabilities, not certainties. Statutes existed for dealing with clear-cut menaces to competition; no statute was sought for dealing with ephemeral possibilities. Mergers with a probable anticompetitive effect were to be proscribed by this Act.

\textit{Id.} at 323 (emphasis in original) (footnote omitted); see also \textit{id.} at 323 n.39; United States v. Marine Bancorporation, 418 U.S. 602, 622-23 (1974).
in anticompetitive conduct is likely. To assess this, the relevant product and geographic markets must be defined, pre- and post-merger concentration in the market examined and compared, and other factors bearing on the likelihood of market power and collusion (and whether they can be sustained) analyzed. Because mergers typically achieve significant productive efficiencies (that is, the saving of resources that otherwise would be consumed), these must be examined to assess whether they may offset any likely anticompetitive effects.

The Department of Justice’s 1984 *Merger Guidelines* are the single most helpful aid in assessing horizontal mergers. While the *Merger Guidelines* tend to emphasize economic theory in merger analysis to a greater extent than most courts are willing to do at

758. In its recent decision in Weyerhaeuser Co., 3 TRADE REG. REP. (CCH) ¶ 22,315 (FTC Sept. 26, 1985), the Commission explained the concept of the relevant market as follows:

For antitrust purposes, market definition properly involves an assessment of the responsiveness of buyers and sellers in the hypothetical market to price changes. In economists’ parlance, measures of supply and demand elasticity and cross-elasticity would, ideally, provide the information necessary to accurately define these markets. However, “[i]n most instances, adjudicators and policymakers do not have very precise estimates of [these] figures.” The typical case, in this world of less than perfect information, involves a search for reasonable bases from which to infer the price-responsiveness of supply and demand in the proposed product and geographic markets.

*Id.* at 23,375 (footnotes omitted) (quoting Grand Union Co., 102 F.T.C. 812, 1040 (1983)).

759. In United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963), the Court explained:

[W]e think that a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.

*Id.* at 363.

760. See, e.g., United States v. General Dynamics Corp., 415 U.S. 486, 498 (1974) (“other pertinent factors . . . mandated a conclusion that no substantial lessening of competition occurred or was threatened by the acquisition”).

761. United States Dep't of Justice, *Merger Guidelines* (June 14, 1984), reprinted at 2 TRADE REG. REP. (CCH) ¶ 4490. The 1984 *Merger Guidelines* are the Department's third set of merger guidelines. The 1982 *Merger Guidelines* (June 14, 1982), reprinted at 2 TRADE REG. REP. (CCH) ¶ 4500, were substantially similar to those issued in 1984. Both however, are radically different from the Department’s 1968 *Merger Guidelines, reprinted at 2 TRADE REG. REP. (CCH) ¶ 4510. All references here are to the 1984 version unless otherwise noted.

Also important in merger analysis is the Federal Trade Commission’s *Statement Concerning Horizontal Mergers*, reprinted at 2 TRADE REG. REP. (CCH) ¶ 4516, which was issued at the same time as the 1982 *Guidelines*. In general, the *Merger Guidelines* take a more quantitative approach than the *Statement*, which tends to be more qualitative. Both should be consulted.

762. *See generally Fox, The New Merger Guidelines — A Blueprint for
present, the courts appear to be relying on the *Guidelines* more frequently.\textsuperscript{763} Moreover, they provide substantial insight as to when a challenge might be brought by the Department of Justice or Federal Trade Commission, the two most likely plaintiffs.

The relevant product market consists of all services that purchasers view as substitutes at prevailing prices and, in addition, those services to which a significant number of purchasers would turn if sellers raised the price of their product significantly.\textsuperscript{764} Because there usually is no empirical evidence how purchasers would respond to a change in price, the Department explains that it will draw inferences from (1) the perceptions of sellers and purchasers as to whether certain services are substitutes, (2) differences in price movements of the services, and (3) similarities or differences among the services in customary usage and technical characteristics. In determining what firms are in the product market, those firms not presently producing the product but which could easily “shift” to producing it and would do so if price increased should be included.\textsuperscript{765}

The guidelines for delineating the relevant geographic market\textsuperscript{766} are ambiguous and difficult to apply as a practical matter. The Department pretends that the merging firm is a monopolist and asks what purchasers would do (or from whom they would purchase) if that firm imposed a “small but significant” price increase. If purchasers would “shift” to other sellers, the geographic market is expanded to include those firms. This process is continued (assuming that firms in the market collusively increase price) until an area (or number of firms) is found such that the firms therein could sustain a collusive price increase because purchasers would pay the higher amount rather than seeking yet more distant sellers. Recognizing, again, that the empirical information necessary to apply this test may not be available, the Department explains that it will draw inferences based on (1) shipment patterns of the merging firm and its competitors,\textsuperscript{767} (2) evidence that purchasers actu-
ally considered shifting purchases among sellers at different locations, (3) transportation costs and costs of distribution, and (4) whether nearby firms have excess capacity.\textsuperscript{768}

After defining the product and geographic markets, the market share of each firm in the market is calculated. The Department's preferred measure is capacity, but market share in terms of sales, shipments, and production should also be examined.\textsuperscript{769} In the context of a hospital merger, market shares should be calculated using licensed beds, revenues, admissions and inpatient days.

The next step is to assess the degree of concentration in the market after the merger and to examine the extent to which the merger increased the level of concentration. To do this, the Department uses the \textit{Herfindahl-Hirschmann Index} (HHI), a statistical index of concentration which is calculated by squaring the market share of each firm in the market and then adding the squares.\textsuperscript{770} For example, suppose Firm A with 10\% of the market and Firm B with 12\% merge. Suppose also that Firms C, D, E, F, and G are in the market with shares of 25\%, 15\%, 10\%, 8\%, and 20\%. Then the post-merger \textit{HHI} = (10 + 12)^2 + (25)^2 + (15)^2 + (10)^2 + (8)^2 + (20)^2 = 1898. As noted below, it also is important to ascertain by how much the merger increases the HHI. This can be calculated simply by multiplying the shares of the merging firms and then multiplying that product by 2. In the example above, the change in HHI = (10)(12)(2) = 240.

The \textit{Guidelines} then distinguish between highly concentrated, moderately concentrated, and unconcentrated markets.\textsuperscript{771} A market is highly concentrated if the HHI is above 1800, moderately concentrated if it is between 1000 and 1800, and unconcentrated if it is below 1000. When the post-merger HHI is less than 1000, a challenge to the merger is unlikely except in "extraordinary circumstances." Where it is between 1000 and 1800, a challenge is unlikely if the merger increases the HHI by less than 100; a chal-

\begin{itemize}
\item[\textsuperscript{768}] Merger Guidelines, supra note 761, at § 2.32.
\item[\textsuperscript{769}] Id. at § 2.4.
\item[\textsuperscript{770}] Id. at § 3.1 \& n.14. For short discussions of the HHI and some of its ramifications, see Dale, Justice Eyes New Criteria for Merger Enforcement, Legal Times of Wash., Dec. 21, 1981, at 24; Pelster & Stangle, New Antitrust Chief and Herfindahl Index, N.Y.L.J., Mar. 17, 1981, at 1. For more extended discussions, see Miller, The \textit{Herfindahl-Hirschmann Index} as a Market Structure Variable: An Exposition for Antitrust Practitioners, 27 \textit{Antitrust Bull.} 593 (1982); Schramm & Renn, supra note 726.
\item[\textsuperscript{771}] Merger Guidelines, supra note 761, at § 3.11.
\end{itemize}
lenge is likely if the increase is greater. If the HHI is greater than 1800, a challenge is unlikely if the change is less than 50 but likely if it is more. If the HHI "substantially exceeds" 1800 and its increase as a result of the merger exceeds 100, a challenge will be forthcoming except in "extraordinary cases." Finally, the Department is likely to challenge a "leading firm" merger—that is, a merger between any firm with a market share of at least 1% and the "leading firm" in the market if that firm has a share of at least 35%.

The merger in the hypothetical which resulted in a post-merger HHI of 1898 and a change of 240 likely would be challenged.

In close cases, the Department will examine (1) factors indicating that a firm's market share and the degree of concentration in the market are not good indicators of a firm's competitive significance (for example, the acquired firm's financial condition), (2) ease of entry into the relevant market (clearly the most important factor other than post-merger concentration), (3) miscellaneous factors suggesting the likelihood of collusion vel non or indicating how the market is performing (profitability, for example), and (4) efficiencies flowing from the merger. Efficiencies might include "achieving economies of scale, better integration of production facilities, plant specialization, lower transportation costs, . . . [and] reductions in general selling, administrative, and overhead expenses." For efficiencies to be considered, however, there must be clear and convincing evidence that the merger will achieve them

772. Id. at § 3.12. The Department's concern in this situation is not that the merger likely will lead to concentration levels which make collusion reasonably probable. Rather, the Department fears that this "single dominant firm" may be able to exercise market power unilaterally. Id.

773. Id. at § 3.4.

774. Id. at § 3.5. Importantly, the efficiencies must be "real," not "pecuniary":

[E]fficiencies must be "real" rather than what economists call "pecuniary." Efficiencies are real if a merger could result in greater output using fewer inputs. . . . First, there may be economies of scale. . . . A second example is a transfer of technology that would be facilitated by the merger. A third example is an improvement in management, particularly if a well-managed firm is acquiring a badly managed firm, rather than the other way around.

Pecuniary efficiencies result in lower costs but not real resource savings. One example is tax gains. As a second example, suppose that the merger would result in a firm with enough buying power to give it an incentive to reduce its purchases of inputs in order to drive down input prices; i.e., create monopsony power. Such a merger may result in cost reductions, but this represents a decrease rather than an increase in efficiency.

and that they could not have been achieved by other, less anticompetitive means.

The Guidelines adopt the general tenets of the judicially-created "failing company" defense.775 The Department will not challenge a merger if one of the firms is in so precarious a financial position that it (1) likely will not be able to meet its short-term financial obligations, (2) would not succeed after a reorganization, and (3) has searched for ways to remain viable and sought purchasers whose acquisition of it would have less adverse effect on competition than its acquisition by the present suitor.776

C. The Relevant Cases

1. American Medicorp and Hospital Affiliates International

Two hospital merger cases were decided prior to issuance of the Department's second set of guidelines in 1982. American Medicorp, Inc. v. Humana, Inc.,777 involved a challenge by Medicorp to the takeover of it by Humana. That case, however, focused on product market definition—specifically, whether the acquisition, development and management of hospitals constituted a relevant product market for antitrust purposes and whether these same activities by major proprietary chains (that is, investor-owned companies controlling three or more hospitals) constituted a submarket. Medicorp claimed that firms such as Humana "compete" to serve communities by developing hospitals for them, and that the acquisition would result in Humana's having a 29.5% share of that market.

Medicorp's definition of the product market was rejected because, according to the court, a "market" requires a buyer, a seller, and a transfer of money—all of which were absent. With regard to the alleged submarket of major proprietary chains, the court noted that each service provided by for-profit hospital chains was available from other firms. Further, there was no evidence that the former had a significant cost advantage over the latter which might justify splitting them into submarkets. Focus, rather, should be on what hospitals sell, and thus the court defined the relevant product market as the "delivery of short term, acute care community hos-

776. Merger Guidelines, supra note 761, at § 5.1. The elements of the defense will be construed "strictly" by the Department.
hospital services to doctors and patients."

Using this product market definition, the court found one small market, Bluefield, West Virginia, where Humana would control 100% of the beds after the merger. It felt, however, that the effect from this was too minimal to justify a preliminary injunction halting the acquisition.

The first hospital merger challenge by the federal antitrust enforcement authorities was United States v. Hospital Affiliates International, Inc., which was filed by the Department of Justice in 1980 under both section 7 of the Clayton Act and section 2 of the Sherman Act. In that case, the Antitrust Division obtained a preliminary injunction, based only on pleadings and affidavits, preventing the owner of a private psychiatric hospital in New Orleans from acquiring a second private psychiatric hospital there, when it owned 50% of and managed the third private psychiatric hospital in the area as well.

In the eleven-county health service area including New Orleans—the alleged relevant geographic market—inpatient psychiatric hospital services were provided by the three private psychiatric hospitals and a state psychiatric hospital, as well as by the psychiatric units of seven general acute care hospitals, two federal hospitals, and two state hospitals. According to the government, the relevant product market consisted of inpatient psychiatric services provided by psychiatric hospitals and the psychiatric departments of general acute care hospitals. Services provided by government hospitals should not be included, the government argued, because of those hospitals’ different requirements for admission and staffing. The government alleged a submarket consisting only of services rendered by private psychiatric hospitals.

The court found it unnecessary to reach the government’s section 2 claim or its theory that private psychiatric hospitals constituted a submarket. Noting that the merger would increase HAI’s market share in the alleged relevant market from 32.5% to 72.9% and that this “approached monopoly proportions,” the court had no trouble determining to enjoin the acquisition.

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778. Id. at 605.
779. Id. at 605-06.
780. 1980-1 Trade Cas. (CCH) ¶ 63,721 (E.D. La. 1980) (preliminary injunction granted).
782. 1980-81 Trade Cas. (CCH) at 77,853-54.
2. American Medical International

More detailed and sophisticated analyses of hospital mergers began with the Federal Trade Commission’s decision on July 2, 1984 (about a month after issuance of the 1984 Merger Guidelines) in American Medical International. There, the Commission had challenged, under both sections 7 and 2, American Medical International’s acquisition of French Hospital, a 138-bed facility in San Luis Obispo, California.

There were three hospitals in the city itself: French, the acquired facility; Sierra Vista Hospital, a 172-bed facility also owned by American Medical International (AMI); and the county-owned San Luis Obispo General Hospital with seventy-eight beds. Outside the city, in San Luis Obispo County, there were two other hospitals: the seventy-nine bed Arroyo Grande Hospital, some fifteen miles south of the city, which AMI also owned; and Twin Cities Community Hospital, an eighty-four bed facility approximately twenty-two miles north of the city, owned by National Medical Enterprises. Further distant, some thirty miles south in Santa Barbara County, were two hospitals with forty-eight and 125 beds. In Monterey County, eighty-one miles north of San Luis Obispo, was a forty-two bed facility.

The administrative law judge, in holding that the acquisition was illegal both under section 7 and as an attempt to monopolize violative of section 2, found that the relevant product market was the “cluster of services” comprising general acute care hospital services. On appeal, the Commission affirmed, rejecting AMI’s argument that the product market should include nonhospital providers who rendered individual services also rendered by hospitals. It explained that, “[a]lthough each individual service that comprises the cluster . . . may well have outpatient substitutes, the benefit that accrues to patient and physician is derived from their complementarity. There is no readily available substitute supplier of the benefit that this complementarity confers on patient and physician.” In effect, the Commission held that patients purchase not just the particular procedure or service they need but, in addition, the availability of all the ancillary services offered

783. 3 Trade Reg. Rep. (CCH) ¶ 22,170 (FTC July 2, 1984) [hereafter referred to as AMI].
785. AMI, supra note 783, at 23,040.
by hospitals but not by free-standing facilities and other nonhospital providers.786

In determining the relevant geographic market, the Commission relied primarily on patient origin data showing "in flow" and "out migration" of patients.787 With regard to the alleged San Luis Obispo County relevant geographic market, the data showed that less than 10% of persons admitted to hospitals in the county resided outside the county. In addition, it appeared that only 5% to 15% of county residents needing hospital services went to facilities outside the county.788 Because so few county residents left the county for hospital services and so few nonresidents came into the county for services, the county was a relevant geographic market.

Evidence relating to whether the city itself was a relevant geographic market was more problematic. For example, only between

786. "Cluster" product markets are encountered most often in defining the relevant product markets for commercial banks, the prototypical example of a multiproduct firm. See, e.g., United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963). The concept is relatively straightforward:

[A] cluster market can be defined as a relevant product market that includes only those firms that produce a specified cluster of products. A cluster market excludes firms that produce some but not all products in the cluster.

A relevant product market is justifiably defined to include a cluster of products when consumers perceive that cluster of products to be a commodity bundle. A commodity bundle, as the term is used here, refers to a group of items, products, or services that are purchased jointly. A good example of a simple commodity bundle would be shoes. Consumers shop for shoes with laces instead of shopping separately for the best deal on laces and shoes without laces. . . .

A critical attribute of a commodity bundle is that consumers react to a price increase for one or more items in the bundle as a price increase for the entire bundle. Hypothetically, if a shoe store increased the price charged for laces in shoes, consumers would consider alternative suppliers for shoes with laces rather than just an alternative supplier for laces. . . .

As these examples suggest, when consumers perceive a cluster of products or services to be a commodity bundle, firms that do not provide all of the items in the product cluster do not constrain the pricing discretion of firms that supply the commodity bundle. As such, it is appropriate to define a market to include only those firms that do supply or could supply the relevant commodity bundle.

Bronsteen, Product Market Definition in Commercial Bank Merger Cases, 30 Antitrust Bull. 677, 681-82 (1985); see also Note, Rationalizing Antitrust Cluster Markets, 95 Yale L.J. 109 (1985) (arguing that products should be "clustered" into a single market if buying them from a single firm significantly reduces transaction costs).

An interesting question is whether, if several services are "clustered" for purposes of § 7 product market definition, they must be considered as a single product for purposes of tying analysis. See supra text accompanying notes 204-09.

787. For a more detailed discussion of this test for delineating relevant geographic markets, see infra text accompanying notes 802-03.

788. See AMI Initial Dec., supra note 784, slip op. at 20-33, 132-140; AMI, supra note 783, at 23,040-42.
45% and 51% of city hospital admissions were city residents. On
the other hand, it appeared that few city residents left the city and
used hospitals outside. Less than one percent of Twin Cities' ad-
missions, for example, came from San Luis Obispo City, and at
least 90% of Arroyo Grande's admissions came from the "north
county," an area outside the city. Based on this, together with the
superiority of the hospitals in the city, the fact that 98% of admis-
sions to hospitals in the city came from physicians whose offices
were in the city, and the fact that the hospitals themselves per-
ceived the city as a separate geographic market, the Commission
held that it also was a relevant geographic market. 789

Within these geographic markets, the acquisition increased
AMI's market share, based on inpatient days, from 55.6% to
75.5% in the county and from 57.8% to 87% in the city. The
changes in the HHI were from 3818 to 6025 in the county and from
4370 to 7775 in the city. 790 The Commission also pointed to the
high barriers to entry resulting from CON laws and excess capacity
in the markets as factors indicating that new entry was highly
unlikely.

The defenses put forth by AMI focused on (1) implied repeal as
a result of the Health Planning Act, (2) an argument that the
merger likely would have no anticompetitive effect because there
was no worthwhile competition anyway, 791 and (3) supposed effi-
ciencies resulting from the merger. The implied repeal argument
was rejected because the acquisition was completely "voluntary" in
the sense that it was not prompted, recommended or even contem-
plated by any health planning agency, health plan, or state
agency. 792

The Commission recognized that price competition among hospi-
tals might be "'attenuate[d],' 'diminished,' or 'significantly re-
duced,'" 793 because of third-party payment and the cost-based re-
imbursed methodology then in effect. It held, however, that the
evidence showed that some price competition existed and that,

789. AMI, supra note 783, at 23,042.
790. Id. at 23,044.
791. Others have made the same type of argument. In general, it is that concentration
figures are an inadequate predictor of competitive effects resulting from hospital mergers
because nonprice competition is wasteful, there is little price competition, and thus effi-
ciency effects are likely to outweigh anticompetitive effects. See Schramm & Renn, supra
note 726, at 883-86; Miles, In Health Care Field, Usual Merger Analysis May Fall Short,
792. See generally supra Section V(C)(1).
793. AMI, supra note 783, at 23,034 (footnote omitted).
even were this not true, antitrust merger principles were applicable unless and until Congress supplied an exemption for hospitals. Indeed, the Commission relied on the attenuated degree of price competition as a reason that it should be even more wary of mergers that might destroy what price competition did exist: "[E]ven assuming that the limited price competition that does exist in these markets may produce only marginal benefits in terms of overall consumer welfare, the antitrust laws will endeavor to protect . . . [it], if for nothing else, the hope that price competition will be enhanced."794

The Commission also found that there was important nonprice competition among hospitals in the forms of competition for physicians and their patronage, and competition for patients based on the types and quality of services offered. These forms of competition, concluded the Commission, deserved even more protection than otherwise might be the case in light of the attenuated nature of price competition.

Although the Commission indicated a willingness to weigh any procompetitive efficiencies from the merger against its anticompetitive effects, it held that, as a matter of proof, AMI had "failed to establish with substantial evidence the existence of . . . cost savings from the acquisition."795 Moreover, AMI failed to show that the same efficiencies could not be achieved by a less anticompetitive merger (for example, a merger of San Luis Obispo General Hospital with either French or Sierra Vista), that any efficiencies would offset the acquisition’s anticompetitive effects, or that any cost savings resulting from the efficiencies would be passed on to patients.

3. Hospital Corporation of America

The acquiring firms’ post-merger market shares in Hospital Affiliates and AMI were so overwhelming that the outcome of those cases was a foregone conclusion. As a result, neither decision provided much guidance as to where the enforcement agencies would draw the line and how strictly they would attempt to apply the Merger Guidelines to hospital mergers, given the admitted eco-

794. Id. at 23,046; cf. United States v. Philadelphia Nat’l Bank, 374 U.S. 321, 362 (1963) (analysis of a merger requires a “prediction of its impact upon competitive conditions in the future”).

795. AMI, supra note 783, at 23,055 (footnote omitted).
nomic peculiarities of the hospital industry.\textsuperscript{796} In the most recent
decision, \textit{Hospital Corporation of America},\textsuperscript{797} the Commission in-
validated a pair of mergers which, while still resulting in post-
merger levels of concentration above the \textit{Merger Guidelines} trigger
figures, involved the smallest degree of post-merger concentration
in a hospital merger case to date. In addition, the Commission in-
dicated that nothing peculiar to the hospital industry should result
in hospital mergers being treated differently than other mergers
under the \textit{Guidelines}.

The genesis of the decision were two 1981 acquisitions made by
Hospital Corporation of America (HCA) in the Chattanooga, Ten-
nessee area, where it already owned one hospital. In August, it ac-
quired Hospital Affiliates International, Inc. (HAI), which owned
or managed five hospitals in the Chattanooga Metropolitan Statis-
tical Area (the MSA), a six-county area comprised of three coun-
ties in Tennessee and three in Georgia surrounding Chattanooga.
In this area, HCA became owner or manager of six of the fourteen
area hospitals. In the area subsequently determined to be the rele-
vant geographic market,\textsuperscript{798} the "Chattanooga urban area" (the ur-
ban area), which included the county in which Chattanooga was
located and three Georgia counties, HCA owned or managed four
of eleven hospitals after its acquisition of HAI.

In December 1981, HCA acquired Health Care Corporation
(HCC), which owned one hospital in Chattanooga. HCA thus
owned or managed, as a result both acquisitions, seven of fourteen
hospitals in the MSA and five of eleven in the urban area. The
Commission challenged each acquisition individually and both in
the aggregate.

As in \textit{AMI}, there was a dispute over definition of the relevant
product market. While there was little doubt that the market con-
sisted of some cluster of services, complaint counsel excluded hos-
pital outpatient business, while HCA included it and thus would
have included nonhospital providers providing outpatient services.
The administrative law judge agreed that both inpatient and out-
patient hospital services should be included. He refused, however,
to include nonhospital providers rendering outpatient services,
even if the services were identical to those provided by hospitals,

\textsuperscript{796} See, e.g., id. at 23,032-35; see also \textit{AMI Initial Dec.}, supra note 784, slip op. at
36-55.

\textsuperscript{797} 3 \textit{TRADE REG. REP. (CCH)} ¶ 22,301 (FTC Oct. 25, 1985) [hereafter referred to as
\textit{HCA}].

\textsuperscript{798} See infra text accompanying notes 802-09.
because nonhospital providers "are not an alternative to the kind of care which only acute care hospitals can provide: The unique combination of services which the acute care patient needs." 799

Although HCA did not appeal the product market determination, the full Commission suggested that because "free-standing outpatient facilities compete with hospitals for many outpatients and . . . hospitals offer and inpatients consume a cluster of services that bears little relation to outpatient care," 800 outpatient and inpatient services probably constitute separate markets. Theoretically, the analysis should focus separately on competition for outpatients and competition for inpatients. In the former, free-standing, nonhospital providers (perhaps including physicians' offices) as well as hospitals would have to be considered. In the latter, only hospitals would be market participants. As a practical matter, it probably makes little difference in a hospital merger case because the primary focus will be on inpatient services which likely will be the more concentrated of the two markets.

The parties also disagreed about what area constituted the relevant geographic market. Complaint counsel's expert, relying on patient origin data, testified that the market was the MSA or the MSA plus another county. On the other hand, HCA's expert, based on patient origin data and physician admitting patterns, opined that the relevant geographic market was the smaller, four-county urban area. 801

Geographic market delineation based on "shipment patterns" (or in hospital merger analysis, patient origin data), commonly referred to as the Elzinga-Hogarty test, 802 is the same analysis conceptually as that used in AMI. It requires three general steps. First, based on cursory examination of what might constitute a relevant geographic market, a hypothetical market is chosen. This might be an MSA, a county, several counties, a city, a designated health service area, specific zip code zones, or some other like area. It should, however, be the smallest area that might be the geographic market. Second, based on patient origin data, the percentage of hospital patients who reside in that area but who are hosp-

799. Hospital Corp. of America, No. 9161, slip op. at 31 (FTC Initial Dec. Oct. 30, 1984) (public version) [hereafter referred to as HCA Initial Dec.]; see also id. at 77-78.
800. HCA, supra note 797, at 23,333.
801. HCA Initial Dec., supra note 799, slip op. at 33-41.
talized at hospitals outside the area is calculated. A large percentage (more than 25%, for example) suggests that "outside" hospitals are good substitutes for "inside" hospitals and therefore that the hypothetical market should be expanded. The test is repeated until the smallest area is found where the percentage does not exceed 10% (for a "strong market") or 25% (for a "weak market").

Third, based again on the hypothetical market, admissions of hospitals in the market are examined and the percentage of admissions comprised of patients residing outside the market is calculated. A large percentage suggests again that the market has been delineated too narrowly and should be expanded (unless patients "coming in" come for services not offered by the outside hospitals located closer to them). This test also is repeated until the smallest area is found where the percentage does not exceed 10% or 25%, as above. 803

Because the test is static in the sense that it does not indicate whether the geographic market would expand if firms therein raised prices (or decreased quality), 804 it does not meet the requirements of the Merger Guidelines. 805 The 1982 Merger Guidelines, however, used the Elzinga-Hogarty concept as a first step which defined a "provisional geographic market." Then a small price increase by firms in that market was assumed and if purchasers would shift to firms outside the provisional market area, the market was expanded to include those firms. As a practical matter, the 1984 Merger Guidelines require the same type of analysis, although the section dealing with geographic market definition was rewritten and appears more ambiguous than before. 806

In HCA, the relevant Elzinga-Hogarty test percentages were approximately the same for both the MSA and the urban area. Hospitals in the MSA drew 18.8% of their admissions from outside the

803. For an excellent explanation of the test in the Commission's own words, see HCA, supra note 797, at 23,334 n.7.

804. The market would expand if firms in the market were forced to rescind their anticompetitive conduct because patients residing there went to outside facilities; patients residing outside who used hospitals in the market stopped doing so; or related to this, hospitals outside but on the fringe of the market responded to anticompetitive conduct by those in the market by increasing their marketing efforts and attempting to offer services offered by hospitals in the market.

805. See supra text accompanying notes 766-68.

806. United States Dep't of Justice, Merger Guidelines § II(C) (June 14, 1982), reprinted at 2 TRADE REG. REP. (CCH) ¶ 4500.

807. Merger Guidelines, supra note 761, at § 2.3.
MSA and only 1.6% of MSA residents needing hospitalization used hospitals outside the MSA. The corresponding figures for the smaller urban area were 21.9% and 1.7%. Because the urban area was the smaller area, the administrative law judge held that it was the relevant geographic market in which to analyze the merger.\textsuperscript{808}

The full Commission affirmed this finding but criticized the analysis because of its static nature:

Looking at a "static" snapshot of a market is thus insufficient in itself, since the picture might not reflect a likelihood of future anticompetitive market behavior suspect under section 7. Rather, evidence of current market behavior must be viewed in a "dynamic" framework that considers the possible competitive responses of firms outside the current market area to anticompetitive behavior of firms within.\textsuperscript{808}

In effect, the Commission wanted evidence of what patients using urban area hospitals would do and what hospitals outside, but on the fringe, of the market would do if hospitals in the market, as a group, raised prices or decreased quality by a small given amount. Would more residents in the market then choose hospitals outside the market? Would fewer residents outside the market choose hospitals in the market? Would these shifts away from urban area hospitals be so great that the price increase or quality reduction by firms in the market would have to be rescinded? If so, the market found by the administrative law judge was too small.

While correct in theory, credible evidence of competitive responses to a hypothetical "change in price" or "change in quality" situation may be difficult to obtain. The Commission indicated that the patient origin data itself might be helpful because it could reveal firms just outside the market to which purchasers might turn if firms in the market engaged in anticompetitive conduct. While true, this fails to answer the important question: What degree of anticompetitive conduct (a concerted price increase for example) is necessary to induce a sufficient number of purchasers to leave the market such that firms in the market could not afford to maintain their anticompetitive conduct? There needs to be some indication of how sensitive patients in fact would be to changes in price or quality.

The Commission also relied on two other facts in determining that the urban area was the relevant geographic market. First, physicians admitting patients to urban area hospitals did not ad-

\textsuperscript{808} HCA Initial Dec., supra note 799, slip op. at 33-41.
\textsuperscript{809} HCA, supra note 797, at 23,334.
mit in any significant degree to hospitals outside that area. Because physicians choose hospitals for patients, this fact suggested that the urban area was a relevant geographic market. Second, the patient origin data might understate the strength of the urban area as a market because many residents residing outside but using hospitals in the market did so because closer, outside hospitals did not offer the service they needed.

Having defined the geographic market as the Chattanooga urban area, two interesting and important issues arose when the Commission attempted to calculate HCA's post-merger market share. The first was whether hospitals managed but not owned by HCA should be included. The administrative law judge answered this negatively, explaining in the case of one managed facility:

[T]he board establishes the hospital's financial and health care objectives and expects management to carry them out . . ., and would not hesitate to dismiss an administrator who ignored its policies and, instead, attempted to further the objectives of HCA. In short, complaint counsel have not established that HCA dominates or controls the board of directors of [the hospital].

Complaint counsel suggest that even though the board of directors of the managed hospitals actually control them, they might be unaware of collusive agreements by administrators of HCA-owned and HCA-managed hospitals . . ., but speculation of this sort, unsupported by record evidence, does not justify treating HCA managed hospitals the same as owned hospitals for purposes of analyzing the competitive impact of the challenged acquisitions.810

The full Commission disagreed, citing evidence it believed showed that, as manager, HCA controlled the hospitals' competitive variables; indeed, that was why the hospital hired HCA in the first place. In sum, the Commission explained, the question was "not whether HCA 'dominates' the boards . . ., but whether the management arrangements enhance the ability to coordinate behavior between HCA-owned and managed hospitals so that any collusion in the market . . . is more likely."811 Answering the question affirmatively, it held, in effect, that obtaining a management contract constituted the acquisition of an asset to which section 5 of the Federal Trade Commission Act applies, regardless of whether section 7 of the Clayton Act would.812

The second question examined by the Commission was whether

810. HCA Initial Dec., supra note 799, slip op. at 83.
811. HCA, supra note 797, at 23,339.
812. Id. at 23,341.
HCA's loss of one of the acquired management contracts after the acquisition should result in that hospital's not being counted in HCA's market share. Although the hospital had requested termination of the contract, the Commission viewed the termination as a voluntary act by HCA because HCA had no duty to agree to the request.813 Expressing concern that firms might engage in illegal mergers and then restructure the market through divestitures to suit themselves, the Commission explained that "it is up to [us] and courts to determine the proper restoration of pre-acquisition levels of competitiveness once an illegal acquisition has been made."814

The question then became the likely effects of the mergers on competition. Hospitals in Chattanooga, as elsewhere, traditionally had competed among one another in three ways: For physicians by providing the equipment, services and amenities they desired; for patients by providing amenities such as telephones, televisions, and parking; and for patients "to a limited degree on the basis of price."815 Price competition, the Commission felt, was increasing in response to pressures from price-sensitive third-party payors and, as HCA conceded, "Section 7 protects whatever price competition exists . . . however limited."816

In calculating the mergers' effect on concentration, the Commission noted that market shares could be measured by bed capacity, inpatient days, or net revenues. The results using each varied so insignificantly, however, that it was irrelevant which was used. Prior to the acquisitions, the HHI in the urban area was 1932, and thus, the market already was highly concentrated.817 Its acquisition of HAI increased HCA's market share from 13.6% to 22.9% and the HHI from 1932 to 2242 (based on approved beds), a change of 310. The subsequent HCC acquisition increased HCA's share to 26.7% and the HHI to 2416, an increase of 174. According to the Commission, "These figures support an inference of harm to competition, all other things equal" by making an already highly concentrated market more conducive to collusion.818

The opinion does not discuss individually the effect on concentration of the smaller acquisition—that of HCC. That merger re-
duced the number of competitors only from eleven to ten, increased HCA’s market share from 13.6% to 17.4%, and increased the HHI from 1932 to 2035, an increase of 103.8. The acquisition thus exceeded Merger Guidelines standards, but not by a great deal. Because the Commission struck down both mergers, it would appear that it objected to even this increase in concentration.

The structural problem created by the high degree of concentration was exacerbated by the barrier to entry resulting from Georgia and Tennessee CON laws. Specifically, the Commission emphasized the direct cost of compliance; the delays which could result, especially if the application were opposed; and the risk that the certificate would not be granted in any event.

Significantly, the Commission viewed CON laws as a barrier only because those hospitals already in the market were established before CONs were necessary and thus were not subjected to this costly procedure. As a result, they would have a long-run cost advantage over new entrants and this—not the necessity for the CON per se—was the barrier. This suggests that, as time passes, CON

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819. To compute these figures, it is necessary to use, with necessary adjustments, the administrative law judge’s market share figures found at HCA Initial Dec., supra note 799, slip op. at 65.

820. See supra text accompanying notes 771-72.

821. In its only reference to the effect of the HCC acquisition, the Commission explained that “[e]ach acquisition occurred in an already highly concentrated market, and the increases in concentration from each acquisition were substantial. Our conclusion . . . applies to the two acquisitions viewed separately as well as collectively.” HCA, supra note 797, at 23,347 n.21.

822. As it noted in Weyerhaeuser Co., 3 TRADE REG. REP. (CCH) ¶ 22,315 at 23,382 (FTC Sept. 26, 1985) (footnote omitted), “The Commission considers entry conditions to be the most important of the array of market characteristics considered in addition to market concentration figures.”

823. HCA, supra note 797, at 23,348-49.

824. Id. at 23,348. As others have explained:

The term “barrier to entry” is often used loosely as a synonym for any significant expenditure that a new entrant must incur in order to gain a foothold in the market, such as the cost of advertising or capital. From an economic, and antitrust, perspective, a more meaningful definition is that an entry barrier is a condition that imposes higher long-run costs of production on a new entrant than those borne by firms already in the market. Under the latter definition, the costs of complying with licensing laws and JCAH standards do not qualify as entry barriers to a newcomer since predecessor firms, already in the market, must incur the same, or comparable costs. Likewise, capital requirements, while perhaps onerous, should not be considered a barrier under such a definition, as long as new entrants can obtain the same interest rate for capital as existing firms.

Schramm & Renn, supra note 726, at 880 (footnotes omitted). The logic in defining barriers to entry in this way is that firms with lower long-run costs can set price at a level that
procedures will lose their status as a barrier to entry. Indeed, if health planning becomes a thing of the past, the cost advantage in this context will shift to new entrants which will not have to bear this expense, adding a further inducement to entry.

The Commission cited two pieces of evidence probative that the CON procedure was a barrier. First, one hospital had opposed a CON application of another in order to delay it, potentially destroying the other hospital's necessary financing. Second, both the only request for a new hospital since 1974 and the last three applications by hospitals to increase bed capacity had been denied.

Not content to rest its decision on the market's structure, the Commission turned to an examination of likely anticompetitive conduct. Forms that such conduct could take included concerted resistance to pressure by third party payors to contain costs; concerted resistance to utilization review programs; and collusion to inhibit advertising by hospitals, to reduce staffs or to fix their wages, or not to compete for one another's personnel. Hospitals also might agree among themselves about which facilities would submit CON applications to provide certain services and which would oppose the CON applications of others. Further, pricing formula arrangements and agreements not to grant discounts to HMOs and PPOs might also be reached.

Given this list of imaginary horribles, the question became whether such conduct was likely if the mergers were permitted. The structural features of the market alone—high concentration and entry barriers—"indicate a market in which anticompetitive behavior is reasonably probable after the acquisitions."825 Moreover, the hospital industry exhibited characteristics conducive to collusion, including price inelasticity of demand and traditions of limited price competition and "cooperative problem solving."826 Evidence showed that two hospitals in the urban area market had signed an agreement by which one would not apply for a CON to render a certain service. The same hospitals also had agreed not to oppose each other's CON applications and not to recruit the other's medical staff or personnel. Area hospitals had discussed joint oppositions to CONs, exchanged wage and salary information, and informally discussed both current and prospective prices for dissuades new firms with higher costs from entering the market. See Echlin Mfg. Co., 3 TRADE REG. REP. (CCH) ¶ 22,268 at 23,301-02 (PTC June 28, 1985); see generally G. Stigler, THE ORGANIZATION OF INDUSTRY 67 (1968).

825. HCA, supra note 797, at 23,353.
826. Id.
their services. Accordingly, there was "a tendency for collusion in this market."^827

The Commission had little difficulty rejecting HCA's implied immunity defense under the Health Planning Act. As in AMI, no health planning agency had "prompted" the acquisitions. The Commission had little difficulty rejecting HCA's implied immunity defense under the Health Planning Act. As in AMI, no health planning agency had "prompted" the acquisitions. Although arguing that the acquisitions would achieve some efficiencies, HCA apparently did not claim that efficiencies would offset the mergers' anticompetitive effects (perhaps because it claimed there were none), and the Commission found the evidence presented about efficiencies too speculative in any event.

HCA was ordered to divest the two hospitals it acquired as well as the remaining management contract it had obtained. It also was barred from acquiring any hospital (or management contract) in the Chattanooga urban area without Commission approval. Most interestingly, it was required to notify the Commission of any hospital acquisition by it in a Metropolitan Statistical Area or county where it owned, managed or leased a hospital, and the acquisition would result in its obtaining 20% or more of the licensed beds in that area.829

D. Conclusion

The Commission's decision in HCA provides a plethora of guidance about how the enforcement agencies will analyze hospital mergers in the future. Particularly telling is the Commission's statement that "merger analysis in this [industry] need be no different than in any other case; market share and concentration figures, evidence of entry barriers and other market evidence taken together appear to yield as accurate a picture of competitive conditions as they do in other settings."^830 Thus, while recognizing that the hospital industry is "different" from others in that price competition is "attenuated" or "diminished" and that hospital selection often is not made by the ultimate customer, these differences are not of a type or degree that require any different merger analysis. Nonprice competition—competition among hospitals for patients and physicians by providing more and better facilities—is not wasteful as the Health Planning Act seems to assume, but rather is beneficial. The diminished nature of price competition is

827. Id. at 23,354.
828. Id. at 23,360; see also supra text accompanying note 792.
829. See Hospital Corp. of Am., No. 9161, slip op. order (FTC Oct. 25, 1985).
830. HCA, supra note 797, at 23,353.
not a reason for applying a more lenient merger analysis; in fact, the opposite is true.

Apparently, the structural standards of the *Merger Guidelines* will be applied relatively strictly. The HCC acquisition resulted in post-merger concentration which exceeded *Guidelines* standards by a relatively small amount and resulted in a post-merger market share of only 17.6%. The Commission’s order itself suggests that an investigation may be forthcoming of any acquisition resulting in a hospital with 20% of the market or more.\(^8\)\(^3\)\(^1\)

Unlike AMI and Hospital Affiliates, HCA was not a “merger to monopoly” case; rather, it was the first hospital merger case where the fear was that hospitals in the market, none of which individually had substantial market power, would collude or act interdependently in a number of anticompetitive ways.\(^8\)\(^3\)\(^2\) Given the typically concentrated nature of hospital markets, HCA places substantial constraints on horizontal mergers between hospitals except perhaps in the largest metropolitan areas.\(^8\)\(^3\)\(^3\) Moreover, in the short run, CON laws constitute substantial entry barriers (at least if firms already in the market did not have to obtain CONs), thus magnifying the importance and likely harmful effect of high concentration. There was nothing unusual about the facts in HCA to suggest that a different type of analysis might apply in other hospital merger cases.\(^8\)\(^3\)\(^4\)

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\(^8\)\(^3\)\(^1\) A post-merger market share of 20%, by itself, obviously does not mean that an acquisition is illegal. The acquiring firm’s share in Weyerhaeuser Co., 3 TRADE REG. REP. (CCH) ¶ 22,315 (FTC Sept. 26, 1985), was 20.6% after the merger. The acquisition, however, increased the HHI only from 955 to 1166.

\(^8\)\(^3\)\(^2\) In United States v. National Medical Enters., No. F-83-481-EDP (E.D. Cal. filed Oct. 31, 1983), the government alleged that a hospital acquisition in Modesto, California, would increase the acquiring firm’s market share from 39% to 54% and the HHI from 2660 to 3847. The case was dismissed before trial was completed, 1985-2 Trade Cas. (CCH) ¶ 66,719 (E.D. Cal. 1985), and presently is on appeal.

\(^8\)\(^3\)\(^3\) In an interesting study, Professors Schramm and Renn, see Schramm & Renn, * supra* note 726, examined the level of concentration for hospital services in 131 of California’s 137 Health Facilities Planning Areas, which they assumed to be relevant geographic markets. Based on HHI levels, they found that in only 28 (21.3%) could any hospital merger be consummated that would escape government investigation. They also examined eight mergers occurring within individual Health Facilities Planning Areas between 1977 and 1981 and found that the post-merger HHI was above 1800 in each and that its increase was more than 50 in seven.

They conclude that “application of the HHI market share analysis indicates that the majority of the nation’s hospitals are in communities where any acquisition, merger, or consolidation would be suspect and potentially illegal.” *Id.* at 870 (emphasis in original).

\(^8\)\(^3\)\(^4\) The Department of Justice also has shown interest in nursing home mergers. In three instances, it threatened suit. *See* United States Dept’ of Justice Press Releases (Apr. 19, 1982; Aug. 6, 1982; and Dec. 6, 1983) (relating to, respectively, Beverly Enterprises’ pro-
The Commission’s holding that managed hospitals should be included in the acquiring hospital’s market share, although not unexpected, is significant and raises some interesting questions. For example, is this a question of fact or one of law? The Commission suggests the former, but indicated that the burden of persuasion will be easy to meet.\textsuperscript{838} If the manager controls the competitive activity of the managed facility to the extent that it and a hospital owned by the manager are effectively one entity for purposes of section 7, are they also one entity under section 1 for purposes of the Sherman Act and, in light of the \textit{Copperweld} doctrine,\textsuperscript{838} incapable of conspiring? Thus, if HCA both owns and manages hospitals in a market, can those facilities fix prices and allocate services even though not under common ownership?\textsuperscript{837} Or can the Commission have its cake and eat it too?

The decision also suggests that in examining future hospital mergers, inpatient and outpatient services are separate product markets and may need to be analyzed individually. The degrees of concentration likely will be different, as may the relevant geographic markets. Defining the relevant product market as the cluster of services offered by hospitals may be appropriate at present, but may not be in the future. Over time, as nonhospital providers offer an increasing number of services traditionally offered only by hospitals, economic reality and changing competitive relationships

\begin{center}
\begin{tabular}{|l|c|c|c|}
\hline
Market & Beverly & HHI & Change in HHI \\
\hline
Macon, Ga. & 29\% & 1,432 & 287 \\
Augusta, Ga. & 35\% & 2,307 & 619 \\
Montgomery, Ala. & 48\% & 3,382 & 1,169 \\
Mobile, Ala. & 36\% & 1,828 & 647 \\
\hline
\end{tabular}
\end{center}

A consent decree requiring divestiture was entered. 1984-1 Trade Cas. (CCH) \$ 66,052 (M.D. Ga. 1984).

\textsuperscript{835} It explained, "Even were the evidence not as compelling, we would consider HCA's management of the two hospitals to greatly enhance the likelihood of collusion in this market." \textit{HCA, supra} note 797, at 23,340.

\textsuperscript{836} \textit{Cf.} 7 P. AREEDA, \textit{ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION} \$ 1467 at 269 (1985) ("Arguably, ownership sufficient to transform two firms into one for merger purposes should also create a single entity for conspiracy purposes.").
may demand that other providers be included in the market. Other industries in which a cluster approach has been used offer interesting parallels.838

The most time-consuming and complex task, and in many cases, the most important, will be geographic market definition. Often, as in AMI, patient origin data showing inflow and outflow will be incomplete and ambiguous. Even if not, predicting changes in patient choice based on changes in price or quality (that is, estimating price or quality elasticity of demand) is somewhere between gazing into a crystal ball and throwing dice.

In sum, hospital mergers remain a difficult and complex area for antitrust analysis, and many will be extremely suspect, especially after HCA. There remain questions as to section 7's applicability to asset acquisitions by nonprofit hospitals and the applicable standard of analysis under section 1 if that provision is used.839 The HCA decision, however, provides a substantial amount of guidance as to when a challenge can be expected.

IX. Conclusion

The past ten years have witnessed an explosion in antitrust cases involving industries in the health care sector. It is safe to say that health antitrust has been one of the most rapidly growing areas of law (indeed perhaps the only growing area of antitrust law) not only in terms of sheer volume of cases, but also with respect to the proliferation of new areas of concern. To a large extent, the dramatic development of the health-antitrust field has reflected the equally dramatic changes that have occurred in the health care sector and hospital industry themselves.840

838. See generally Bronsteen, supra note 786, at 688-94 (arguing, in general, that so many other types of financial institutions now offer services traditionally offered by commercial banks that the “cluster” approach may be inappropriate, product markets should be narrower, and other financial institutions should be included in some of these markets); but see United States v. First Nat’l State Bancorporation, 499 F. Supp. 793 (D.N.J. 1980) (refusing to include thrift institutions in a commercial bank’s market).

839. See supra text accompanying notes 748-56.

840. Many of these changes are listed and discussed in P. Starr, The Social Transformation of Medicine (1982). Starr notes, for example, that “[t]he growing supply of doctors is almost certain to increase tensions between hospitals and their medical staffs” and that “doctors and hospitals may be on a ‘collision course’ as doctors invade institutional services and hospitals invade ambulatory care.” Id. at 426.

More generally, Starr lists five “dimensions” to the new “growth of corporate medicine,” the last four of which have significant antitrust implications:

1. Change in type of ownership and control: the shift from nonprofit and governmental organizations to for-profit companies in health care
The wave of health-antitrust litigation shows no signs of abating. Indeed, it is likely that precisely the opposite is true and that the amount of health-antitrust litigation will continue to grow before stabilizing. To a large extent, the present era is a “shake-out” period, during which problems likely to arise are identified and analyzed and hospitals become familiar with new constraints.

As the trend toward more health-antitrust litigation continues, some areas are likely to receive greater antitrust scrutiny. These include hospital mergers, hospital efforts to refer patients to affiliated downstream providers, the development of (and ancillary restraints in) alternative delivery systems and other types of joint ventures, and the efforts of allied health practitioners to obtain access to the hospital. Another area that probably will be the subject of considerable litigation revolves around hospital competition with medical staff members, including outright agreements not to compete, privilege termination when a staff member does compete, and pressure by the staff on the hospital when the latter enters the former’s markets.

The continued expansion of antitrust problems in the health care sector means that the need for consistent and coherent legal analyses of crucial issues will become even more important. Thus far, that analysis, to the extent it exists, appears to be lacking, perhaps because conventional antitrust and economic principles are based on implicit assumptions about the ways firms and markets operate that do not always mesh with the economic characteristics of health care sector industries.

Although the antitrust laws may help facilitate competition (and, presumably, help control health care costs), experience has shown that antitrust is not a panacea for all the ills perceived in the health care sector. Experience also has shown that the antitrust laws can be abused by the filing of totally unmeritorious liti-

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2. Horizontal integration: the decline of freestanding institutions and rise of multi-institutional systems, and the consequent shift in the locus of control from community boards to regional and national health care corporations

3. Diversification and corporate restructuring: the shift from single-unit organizations operating in one market to “polycorporate” and conglomerate enterprises, often organized under holding companies, sometimes with both nonprofit and for-profit subsidiaries involved in a variety of different health care markets

4. Vertical integration: the shift from single-level-of-care organizations, such as acute-care hospitals, to organizations that embrace the various phases and levels of care, such as HMOs

5. Industry concentration: the increasing concentration of ownership and control of health services in regional markets and the nation as a whole

Id. at 429.
gation which wastes everyone's time and money. Courts should be vigilant to dispose of these cases early on where possible.

Hospitals should take steps to protect themselves from antitrust challenges to their activities and those of their medical staffs. As a threshold matter, hospital executives must acknowledge the changes that have occurred in the health care business environment and realize that the days of cooperative, cartel-like behavior are over. They also must heighten their awareness of antitrust principles and how those standards apply to hospital activities. In this regard, antitrust audits and antitrust compliance programs are educational and also help identify past, present, and future potential antitrust problems. In sum, hospitals should act to insure that they do not become "caught in the antitrust net."