

## How Much of Health Care Antitrust is Really Antitrust?

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This is an article about antitrust exceptionalism. The antitrust laws are intended as laws of general applicability subject to any legislative exemptions and immunities. They are intended to be transubstantive, applying to all parties in all disputes in all sectors unless Congress has spoken to the contrary. The Supreme Court has gone so far as to refer to the antitrust laws as “the magna carta of the free enterprise system.”<sup>1</sup>

It is increasingly hard to say with a straight face that these general principles apply when the antitrust laws have been applied to the health care sector. The health care sector has long maintained it is special and that application of traditional antitrust principles will produce bad results for society. Unlike most industries where variations of this argument have been quickly rejected by the courts since the earliest days of the Sherman Act, health care antitrust cases often come out differently.

While I do not argue that this is true in every case on all issues, I seek to document how this has come to pass in critical areas of antitrust law over the past four decades and distorted the law for health care providers and in some cases infected other areas of antitrust law as well. I suggest that the law in action differs greatly for this sector from the law on the books. This in turn raises important rule of law and policy questions as the health care sector continues to grow and evolve and deal with non-antitrust regulatory changes imposed by the Affordable Care Act.<sup>2</sup> In short we have reached a fork in the road, and must confront either returning to the application

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<sup>1</sup> U.S. v. Topco Associates, Inc., 405 U.S. 596, 610 (1972).

<sup>2</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.) <http://www.hhs.gov/sites/default/files/ppacacon.pdf>.

of traditional antitrust principles in the health care sector or creating a more conscious and well thought out comprehensive scheme of sectoral regulation that clearly lays out when competition rules are secondary to other policy goals.

This essay proceeds as follows. Part I briefly outlines the general antitrust law framework that is supposed to apply to all market participants and the defenses and arguments that traditionally fail to persuade courts when faced with arguments that antitrust law produces bad results for society. Part II discusses how things often work differently in key health care antitrust issues where the lower courts have often conducted a guerilla campaign against accepted Supreme Court precedent. Part II specifically examines how lower courts have carved out their own peculiar body of health care antitrust law in four key areas, both creating outlier results from generally accepted antitrust policy and occasionally having these results influence or distort accepted antitrust doctrine more generally. Part III analyzes how similar arguments about antitrust exceptionalism are currently playing out against the background of continuing health care industry consolidation and the changes encouraged by the ACA. Part IV proposes the two paths going forward that we must choose between in order to have a consistent and meaningful law of health care antitrust rather than a series of ad hoc choices that deviate from general antitrust law and policy for the economy as a whole. Part V concludes.

## I. Antitrust for the General Economy

Antitrust provides the ground rules for a market economy. Section 1 of the Sherman Act prohibits anticompetitive agreements.<sup>3</sup> Section 2 of the Sherman Act prohibits monopolization

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<sup>3</sup> 15 U.S.C. § 1.

and attempted monopolization by powerful single firms.<sup>4</sup> Finally, Section 7 of the Clayton Acts prohibits mergers and acquisitions which may produce a substantial lessening of competition or which tend to create a monopoly.<sup>5</sup>

Antitrust is intended to be transsubstantive, applying to all types of private market behavior. Building on these basic prohibitions, there has emerged a large body of case law and an equally large body of agency guidelines, consent decrees, speeches, and scholarship interpreting and applying these rules to all parts of the economy, except where Congress has created statutory immunities and exemptions.<sup>6</sup> In the same way that the Federal Rules of Civil Procedure are intended to apply to all types of cases involving all types of parties, the antitrust laws are the basic background rules for business behavior of all types in all areas of trade and commerce unless, and until, Congress has otherwise spoken.

As a result, the Supreme Court from the earliest days of the Sherman Act has rejected certain types of defenses which it views as a frontal assault on the basic premises of the antitrust laws that competitive markets work to the benefit of society as a whole. First, the Court quickly rejected the argument that price fixing agreements were permissible if the industry in question (mostly early railroad cases) was not conducive to competition and that collusion was necessary to avoid ruinous competition.<sup>7</sup> Second, the Court rejected that the assertion that a price fixing agreement was lawful if it set a reasonable price.<sup>8</sup> Third, the Court has rejected virtually all assertions of social welfare justifications which concede the harm to competition, but assert that

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<sup>4</sup> 15 U.S.C. § 2.

<sup>5</sup> 15 U.S.C. § 18.

<sup>6</sup> See generally AM. BAR ASS'N SECTION OF ANTITRUST LAW, MONOGRAPH NO. 24, FEDERAL STATUTORY EXEMPTIONS FROM ANTITRUST LAW (2007).

<sup>7</sup> *United States v. Trans-Missouri Freight Assoc.*, 166 U.S. 290 (1897).

<sup>8</sup> *United States v. Trenton Potteries Co.*, 273 U.S. 392 (1927); *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6<sup>th</sup> Cir. 1898), *modified and aff'd*, 175 U.S. 211 (1899).

the conduct was necessary to achieve some broader societal benefit.<sup>9</sup> Fourth, the Court has rejected a learned profession exemption, but may use the necessary ethical rules of a profession to apply the normal antitrust rules in a slightly less restrictive manner.<sup>10</sup> Fifth, the courts generally have rejected the notion that industries are too high-tech, too complicated, or too important for the normal rules to apply.<sup>11</sup> All of this assumes that Congress has not enacted some comprehensive statutory regulatory scheme, exemption, or immunity changing the application of the normal rules. In short, the Sherman and Clayton Act mandate market competition and it is up to Congress, and not the Courts, to deviate from that mandate.

## II. Health Care Antitrust

Health care antitrust is a peculiarly American obsession. In most countries, there is some form of single payer health insurance scheme and/or a national health system (supplemented by private insurance), which effectively relies on comprehensive regulation in place of competition law to take care of the needs of citizens.<sup>12</sup>

In the United States, the government's role is limited primarily to various state and federal benefit programs, while the main industry actors outside of the Veterans Administration are almost all private parties subject to the full antitrust laws with the presence of certain limited antitrust exemptions for relatively minor specialized matters.<sup>13</sup> The U.S. health care sector thus

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<sup>9</sup> Nat'l Soc'y Prof. Eng'rs v. United States, 435 U.S. 679 (1978).

<sup>10</sup> *Id.*; Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

<sup>11</sup> United States v. Apple Corp., 791 F.3d 290 (2d Cir. 2015), *cert. denied*, No.15-565, 2016 WL 854227 (Mar. 7, 2016); United States v. Microsoft Corp., 253 F.3d 34 (D.C. Cir.), *cert. denied*, 534 U.S. 952 (2001).

<sup>12</sup> See Wolf Sauter, *The Impact of EU Competition Law on National Health Care Systems*, 38 EUR. L. REV. 457 (2010).

<sup>13</sup> See Pension Funding Act of 2004, Pub. L. No. 108-218, 118 Stat. 596 (2004) (resident match exception); Health Care Quality Improvement Act of 1986, 42 U.S.C.A. § 11101 (peer review exception); *Cf. See* National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1974) ("...not so incompatible with antitrust concerns as to create a pervasive repeal of the antitrust laws for every action taken in response to the health care planning process"); Nat'l Gerimedical Hosp. and Gerontology Ctr. v. Blue Cross of Kansas City, 452

attracts a significant amount of government antitrust enforcement and numerous private lawsuits given its size and prominence in the U.S. economy and the inherently private nature of our health care system.

So what do we mean by health care antitrust? One easy answer is the normal application of the antitrust laws and policies to the unique facts and economics of the health care industry. This is probably the assumption of many health law antitrust courses in U.S. law schools and the various course books and treatises in the field.<sup>14</sup>

But a closer examination of how antitrust actually plays out in the health law sector reveals a more complicated and troubling pattern. While the U.S. Supreme Court is fairly consistent in its application of traditional antitrust principles in health care settings, the lower courts are not.<sup>15</sup> There are many areas where the law in action differs from the law on the books, but something more virulent is happening here. The lower courts often appear to be conducting a guerilla law against the traditional antitrust principles they would apply without hesitation if the industry involved would be semi-conductors, industrial machinery, ice cream, or transportation.

This disconnect has two important consequences. First, health care antitrust often deviates in important ways from the rest of antitrust law producing peculiar and inexplicable results. Second, the outlier results in health care antitrust often migrate and infect more general areas of antitrust producing unintended changes in general doctrines.

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U.S. 378, 101 S. Ct. 2415, 69 L. Ed. 2d 89, 1981-1 Trade Cas. (CCH) ¶ 64125 (1981) (Blue Cross' refusal to offer a provider contract to a hospital that had failed to obtain approval from the local health planning agency designated by that Act was not exempt from the antitrust laws under the doctrine of implied immunity).

<sup>14</sup> See, e.g., BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, HEALTH LAW §13 (3d ed. 2014); DAVID MARX, JR. & JAMES SNEED, ANTITRUST AND HEALTHCARE: MEETING THE CHALLENGE (2d ed. 1998).

<sup>15</sup> See generally Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly in Health Care*, 89 OR. L. REV. 847 (2011).

This section highlights four different areas of antitrust doctrine where an unauthorized health care specific set of rules has developed and one or both of these consequences has occurred. Part IIA discusses the evolution of the interstate commerce requirement for antitrust in the health care area and the near death experience for general antitrust doctrine in the 1980s in the Supreme Court. Part IIB examines how health care tempered and relaxed the per se rule against group boycotts and how these changes were embraced by general antitrust doctrine. Part IIC analyzes the overly lenient treatment of physician price fixing in contrast to the vigilant criminal prosecution in virtually all other sectors of the economy. Part IID looks at hospital mergers where the lower courts and agencies have allowed defenses and relief which would be laughable in most other contexts.

#### A. The Failed Attempt to Narrowly Define Trade and Commerce

In order to violate the federal antitrust laws, the unlawful conduct must constitute trade or commerce in, or affecting, interstate or foreign commerce.<sup>16</sup> The definition of interstate commerce in antitrust has waxed and waned in conjunction with the general interpretation of the commerce clause. The very first antitrust case decided by the Supreme Court in 1895 held that manufacturing was not interstate commerce and hence beyond the scope of the Sherman Act.<sup>17</sup> Over the first forty years of the 20<sup>th</sup> century the scope of the commerce clause expanded until in 1942 the Supreme Court held that even the crops of a single farmer consumed or sold within the state affected interstate commerce sufficiently to be covered by New Deal agricultural production restrictions.<sup>18</sup> In recent years, the Supreme Court has cut back somewhat on the

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<sup>16</sup> 15 U.S.C. §§ 1-2, 18, 45.

<sup>17</sup> U.S. v. E. C. Knight Co., 156 U.S. 1 (1895).

<sup>18</sup> Wickard v. Fliburn, 317 U.S. 111 (1942).

scope of the commerce clause, but primarily in the area of non-economic regulatory legislation where the Court felt the connection between the prohibited conduct and interstate commerce was too tenuous.<sup>19</sup>

The definition of trade or commerce in interstate commerce for health care antitrust cases has differed significantly and resulted in a near death experience for most health care cases involving employment relationships between doctors and hospitals or practice groups. The first time the Supreme Court considered these issues was in *United States v. American Medical Association*, a 1943 case challenging an alleged boycott of group health plans in the District of Columbia.<sup>20</sup> Because this case was brought under Section 3 of the Sherman Act governing trade and commerce in the District of Columbia, the government only had to show that the trade or commerce affected the District, rather than interstate or foreign commerce.<sup>21</sup> The Supreme Court held that the practice of medicine was indeed trade and commerce and upheld the violation alleged in the complaint.<sup>22</sup>

The Court next considered similar allegations involving the State Medical Society of Oregon and its attempts to bar various group plans in that state.<sup>23</sup> Although the Court held again that the practice of medicine was trade and commerce, it also held that such trade or commerce did not constitute interstate trade or commerce,<sup>24</sup> a holding seemingly foreclosed by *Wickard v. Filburn* and other New Deal precedents.<sup>25</sup>

Going forward the Court alternated between narrow and broad interpretations of interstate commerce in health care antitrust cases. In 1976 in *Rex Hospital Trustees*, the Court

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<sup>19</sup> *United States v. Morrison*, 529 U.S. 598 (2000); *United States v. Lopez, Jr.*, 514 U.S. 549 (1995).

<sup>20</sup> *American Med. Ass'n. v. United States*, 317 U.S. 519 (1943).

<sup>21</sup> *Id.* at 529.

<sup>22</sup> *Id.* at 536.

<sup>23</sup> *United States v. Or. State Med. Soc.*, 343 U.S. 326 (1952).

<sup>24</sup> *Id.* at 338.

<sup>25</sup> *Wickard v. Filburn*, 317 U.S. 111 (1942).

held that the proper test was whether the restraint, if successful, would have a substantial effect on interstate commercial activity.<sup>26</sup> A mere four years later, the Court in *McClain v. Real Estate Board* held instead that the focus should be on whether the defendants' *activities* [and not the restraint itself] which have allegedly been infected by the antitrust violation have a not insubstantial effect on the interstate commerce involved.<sup>27</sup>

This crucial distinction played out a decade later in *Summit Health, Ltd. v. Pinhas*.<sup>28</sup> In *Pinhas*, an ophthalmologist surgeon sued the hospital which revoked his staff privileges, its owner, and various medical staff for an unlawful conspiracy to eliminate competition in eye surgery in the greater Los Angeles area. The Supreme Court held in a 5-4 decision that Pinhas alleged the requisite effect on interstate commerce.<sup>29</sup> The majority held in an opinion by Justice Stevens that the proper test was the potential harm that ensues if the restraint was successful, not upon the actual consequences of the restraint.<sup>30</sup>

The dissent written by Justice Scalia characterized the majority as introducing a new test of whether the line of commerce of the defendant, from which the plaintiff had been excluded, affected interstate commerce.<sup>31</sup> The dissent urged the Court to return to the pre-*McClain* line of cases and require a factual nexus between the harm suffered by the plaintiff and interstate commerce.<sup>32</sup> Here, these four Justices found no such nexus since the market for eye surgery in Los Angeles was a competitive one, both before and after the alleged boycott.<sup>33</sup>

Had the dissent prevailed, this would have virtually eliminated all antitrust claims by health care providers against their employers or the hospitals where they enjoyed staff and

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<sup>26</sup> *Hosp. Bldg. Co. v. Rex Hosp. Tr.*, 425 U.S. 738 (1976).

<sup>27</sup> *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232 (1980).

<sup>28</sup> *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991).

<sup>29</sup> *Id.* at 333.

<sup>30</sup> *Id.* at 330-31.

<sup>31</sup> *Id.* at 335.

<sup>32</sup> *Id.* at 335-36.

<sup>33</sup> *Id.* at 340.

admitting privileges. The exclusion of a single health care professional will seldom affect interstate commerce in most relevant product and service health care markets. Cutting off such claims was, in fact, an important motivation for the four-member dissent, and the many circuit courts which had followed such an approach prior to *Pinhas*.<sup>34</sup>

But with that avenue blocked, the profession turned to two different line of attack to limit the flood of group boycott claims that began in the 1970s in connection with the termination of a doctor's employment or hospital privileges discussed in the next section. First, hospitals and doctors obtained a statutory exemption protecting most peer review decisions from antitrust scrutiny if certain procedures were followed.<sup>35</sup> And second, health care defendants vigorously challenged whether all group boycotts (if not immune) were per se illegal, a movement that was to have broader implications for all of antitrust doctrine.

#### B. The Demise of the Per Se Unlawful Group Boycott in Health Care Antitrust and Beyond

Group boycott law has always been a subject of contention in antitrust law.<sup>36</sup> The black letter law traditionally has been that concerted refusals by competitors not to deal with other competitors (group boycotts) were per se unlawful.<sup>37</sup> The problem with such holdings and dicta was not the specific cases that the Supreme Court decided, but the effect on counseling and litigation in other situations where the effect on competition was less obvious and the

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<sup>34</sup> *Id.* at 333-342 (Scalia, O'Connor, Kennedy & Souter, JJ., dissenting); *See generally*, Josephine M. Hammack, *The Antitrust Laws and the Medical Peer Review Process*, 9 J. Contemp. Health L. & Pol'y 419 n.8 (1993)(analyzing the circuit split on whether peer review does affect interstate commerce), *quoting Health Care Statute Immunizes Physicians Involved in Peer Review*, Antitrust & Trade Reg. Rep. (BNA) No. 58, at 265, 273 (Feb. 22, 1990).

<sup>35</sup> *Patrick v. Burget*, 486 U.S. 94 (1988).

<sup>36</sup> James A. Rahl, *Per Se Rules And Boycotts Under The Sherman Act: Some Reflections on the Klor's Case*, 45 VA. L. REV. 1165 (1959).

<sup>37</sup> *United States v. Gen. Motors Corp.*, 384 U.S. 127 (1966); *Klor's v. Broadway-Hale Stores*, 359 U.S. 207 (1959); *Fashion Originators' Guild of America v. FTC*, 312 U.S. 457 (1941).

motivations behind the refusal to deal were less obviously related to competitive concerns.<sup>38</sup> All joint or membership organizations need some rules to exist and not every denial or termination of membership or privileges is motivated by a purpose or effect to harm competition. For example, I would not be allowed to admit patients or perform surgery at a hospital because I am not a medical doctor.

The situation is more complicated when a licensed physician is fired from her practice group or denied staff privileges at her hospital by a group of decision makers that include competitors in her area of practice. More problematic is when the termination is the result of a negative peer review when the staff believes the terminated doctor is below par and the doctor believes more sinister motives are at work or that the review process was flawed.

The early case law that such group refusals to deal were per se unlawful led to a flood of private treble damage antitrust suits relating to staff privileges, credentialing, peer review, exclusive dealing arrangements, and other employment situations.<sup>39</sup> As long as group boycotts or at least some group boycotts, remained per se unlawful, the plaintiffs only had to allege and prove the existence of the group decision to terminate the plaintiff for competitive reasons (and the effect on interstate commerce discussed in part II A) and then the defendants were conclusively presumed to have violated the antitrust laws.

The consensus of most commentators was that the majority of these cases involved legitimate, but disputed, assessments of qualifications or performance.<sup>40</sup> Many of these cases also involve illegitimate pretenses more likely based on race, religion, age, gender, or more

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<sup>38</sup> *Molinas v. Nat'l Basketball Ass'n*, 190 F. Supp. 241 (S.D.N.Y. 1961).

<sup>39</sup> Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1078 (1984); See generally Andrew K. Dolan & Richard S. Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707, 712-13, 724-78 (1981); William R. Drexel, *The Antitrust Implications of the Denial of Hospital Staff Privileges* 36 U. MIAMI L. REV. 207 (1982).

<sup>40</sup> Thomas L. Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 CONN. L. REV. 605, 613, 665 (1989).

idiosyncratic interpersonal issues, but only rarely the desire to harm competition at the core of the antitrust laws.

Regardless of the state of the law, the lower courts simply refused to awarded treble damages, attorney fees, and costs every time a doctor was terminated from his employment or hospital privileges, especially when other bodies of law (civil rights, employment law) provided more nuanced remedies for the likely basis of the law suit. In so doing, the lower courts often found excuses to apply the rule of reason to such antitrust allegations which normally imposed an insurmountable burden on the plaintiff to define the relevant market and show that his/her exclusion unreasonably harmed competition in that market, rather than just harmed their own financial interests.<sup>41</sup> This guerilla war against accepted doctrine bled over into other areas of group boycott law and eventually resulted in a later Supreme Court decision establishing the rule of reason as the default rule for all group boycott cases unless the plaintiff can credibly show they were excluded to harm market competition.<sup>42</sup>

In the eternal yin and yang of the battle between antitrust plaintiffs and defendants, plaintiffs tried to adapt to this new reality. Cases formerly styled as group boycott claims were recast as tying or exclusive dealing cases when the plaintiff was excluded for her practice or

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<sup>41</sup>See generally *Fundamentals of Antitrust Law*, AHLA-PAPERS P02129701 (analyzing lower court decisions rejecting application of the per se rule). See, e.g., *Everhart v. Jane C. Stormont Hosp.*, 1982-1 Trade Cas. (CCH) ¶164,703 (D. Kan. 1982) (alleged boycott of physician by two hospitals held inappropriate for treatment under per se rule); *Wilk v. AMA*, 719 F.2d 207, 226 (7th Cir. 1983), cert. denied, 104 S.Ct. 2398 & 2399 (1984) (reversing a per se verdict in a boycott case brought by chiropractors); *Langston Corp. v. Standard Register Co.*, 553 F. Supp 632 (N.D. Ga. 1982) (group purchasing agreement between VHA and a single supplier of hospital forms was not a per se illegal boycott against another supplier); *Anglin v. Blue Shield of Virginia*, 693 F.2d 315 (4th Cir. 1982) (defendant which refused to offer policies permitting exclusion of an insured's wife if she has other insurance, was not guilty of an illegal boycott).

<sup>42</sup>*Nw. Wholesale Stationers v. Pac. Stationary & Printing Co.*, 472 U.S. 284 (1985). This movement also led to the enactment of a narrow exemption for the health care industry which prevented antitrust claims involving peer review if the defendants followed certain defined procedures in their decision making process. See *supra* note 13.

hospital.<sup>43</sup> This effort culminated in *Hyde v. Jefferson Parish* another Supreme Court health care antitrust opinion, which also nearly overturned settled doctrine regarding tying law.<sup>44</sup> Although unanimous in result, the two opinions exhibited a truly Jekyll and Hyde view of the applicable law.

The gist of Dr. Hyde's antitrust claim was that the hospital that formerly employed him entered into a per se unlawful arrangement with a competing anesthesiology group that tied the provision of this group's anesthesia services to the use of hospital operating rooms. The 5-4 majority opinion for the Court held that tying claims remained per se illegal as long as plaintiffs could establish that the use of one product or service was conditioned on the use of another product or service, the defendant held market power over the tying product or service, and the tying arrangement affect more than a de minimis amount of commerce.<sup>45</sup> For the majority, Dr. Hyde's claim involved two products. There was a separate demand for each service (operations and anesthesia) since a patient's doctor often preferred to use their own anesthesiologist, instead of the group with exclusive access to the hospital.<sup>46</sup> The tying claim, however, failed, because the hospital had only a 30% share of the relevant market in New Orleans, below the level necessary to coerce patients or doctors into accepting the tied product or service.<sup>47</sup>

The concurrence written by Justice O'Connor looked at the issues in almost opposite fashion while agreeing that the plaintiff's claim failed.<sup>48</sup> She initially found that only one product was involved since no patient would want an operation without anesthesia.<sup>49</sup> While

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<sup>43</sup> See Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 579–80, 649 fn.85 (2002) (In some of these cases, one gets the impression that courts make a conscious effort not to frame the claim as a boycott in order to avoid addressing a complicated and confusing area of law).

<sup>44</sup> *Jefferson Parish Hosp. Dist. v. Hyde*, 466 U.S. 2 (1984).

<sup>45</sup> *Id.* at 33-32.

<sup>46</sup> *Id.* at 22-25.

<sup>47</sup> *Id.* at 26.

<sup>48</sup> *Id.* at 33.

<sup>49</sup> *Id.* at 43.

agreeing that the defendant lacked market power, the concurrence chided the majority for two additional reasons. First, in her view, the majority was requiring virtually all the work of the rule of reason with none of its benefits and considerations of efficiencies.<sup>50</sup> Second, she found it peculiar that the same exact claim when styled as tying (from the patient's view) would be quasi per se illegal but when viewed as exclusive dealing (from the competing anesthesiologist's view) would be judged under the more demanding rule of reason standard.<sup>51</sup>

The issue is not whether the Supreme Court got these cases right or wrong, but rather how once again the felt needs of the health care industry and the hydraulics of the lower court's guerilla war resulted in an important change in doctrine, and in another case nearly so, affecting the many because of the perceived needs of the few.<sup>52</sup>

### C. What Don't Doctors Get About Price Fixing?

A large percentage of the doctors in private practice have failed to understand or comply the core message of antitrust law regarding the setting of prices. The bedrock rule of antitrust is that price fixing and related horizontal practices like bid rigging, market division, and customer allocation are per se unreasonable and hence unlawful.<sup>53</sup> Once the agreement to engage in these practices is established, the defendants' conduct is conclusively presumed unlawful.<sup>54</sup> The professional stature of the defendants is irrelevant, as are the reasons behind the conspiracy, the asserted reasonableness of the prices set, any lack of power by the defendants, any lack of effect

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<sup>50</sup> *Id.* at 34-35.

<sup>51</sup> *Id.* at 43-46.

<sup>52</sup> *Cf.*, SCIENCE FICTION QUOTATIONS: FROM THE INNER MIND TO THE OUTER LIMITS 197 (Gary Westfahl ed., 2008) (Spock: In any case, were I to invoke logic, logic clearly dictates that the needs of the many outweigh the needs of the few. Kirk: Or the one. Jack B. Sowards, *Star Trek II, The Wrath of Khan* (film, 1982)).

<sup>53</sup> *Palmer v. BRG of Georgia, Inc.*, 498 U.S. 46 (1990); *FTC v. Superior Court Trial Lawyers Assoc.*, 493 U.S. 411 (1990); *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 210 (1940).

<sup>54</sup> *Id.* at 224 n.59.

in the market, any purported efficiencies that would have resulted, or the purported societal benefits of such price fixing.<sup>55</sup> Such per se unlawful cartel type agreements have been dubbed the supreme evil of antitrust<sup>56</sup> and normally prosecuted as criminal felony violations of the law with heavy jail sentences for individuals and whopping fines for corporate defendants.<sup>57</sup>

At the same time, the case law and agency guidelines have provided a way out of the per se rule. As in other areas of the economy, competitors who cooperate with each other through the development of new products and services and/or meaningfully integrate their practices to share risk normally will not be subject to the per se rule.<sup>58</sup> Thus, doctors who form a legitimate partnership, an HMO, or pool their resources to buy an expensive piece of equipment or billing system have not automatically violated the Sherman Act, even though a common price will eventually have to set to offer these services to the public.

This general rule has been customized in several ways for the health care industry. The Supreme Court laid out the basic framework in a health care context in the 1980s in *Maricopa County*.<sup>59</sup> The Antitrust Division and the FTC provided more specialized guidance in the 1996

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<sup>55</sup> *Supra* notes 7-11 and accompanying text.

<sup>56</sup> *Verizon Commc'ns Inc. v. Law Offices of Curtis V. Trinko*, 540 U.S. 398, 408 (2004).

<sup>57</sup> See Bill Baer, Ass't Att'y Gen., Antitrust Div., Dep't of Justice, *Prosecuting Antitrust Crimes*, Remarks as Prepared for the Georgetown University Law Center Global Antitrust Enforcement Symposium 7-9 (Sept. 10, 2014), <http://www.justice.gov/atr/file/517741/download>; Brent Snyder, Deputy Ass't Att'y Gen., Antitrust Div., Dep't of Justice, *Compliance is a Culture, Not Just a Policy*, Remarks as Prepared for the International Chamber of Commerce/United States Council of International Business Joint Antitrust Compliance Workshop 4-6 (Sept. 9 2014), <http://www.justice.gov/atr/file/517796/download>; Brent Snyder, Deputy Ass't Att'y Gen., Antitrust Div., Dep't of Justice, Remarks at the Yale Global Antitrust Enforcement Conference: Individual Accountability for Antitrust Crimes (Feb. 19, 2016), <https://www.justice.gov/opa/speech/deputy-assistant-attorney-general-brent-snyder-delivers-remarks-yale-global-antitrust>.

<sup>58</sup> *Broad. Music, Inc. v. Columbia Broad. Sys., Inc.*, 441 U.S. 1 (1979).

<sup>59</sup> *Ariz. v. Maricopa Cty. Med. Soc'y*, 57 U.S. 332 (1982).

Health Care Antitrust Statements and even more detailed guidance on so-called messenger models and other ways to proceed in the absence of meaningful economic integration.<sup>60</sup>

However it is still per se unlawful pricing fixing without such economic integration or legitimate risk sharing for doctors (or anyone else) to set prices with their competitors or to collectively bargain with hospitals or insurance companies over reimbursement rates. Sadly, most of the reasons medical doctors and other providers still think it is okay to do so are actually confessions, not defenses.<sup>61</sup> Nevertheless, there remain a slew of sham independent practice associations, joint ventures, and other blatant violations that show a lack of knowledge or interest in complying with these basic rules by a substantial segment of the profession.<sup>62</sup> Dentists in Indiana unsuccessfully tried versions of this defense not once, but twice, in seeking to justify a collective refusal to provide requested x-rays to insurance companies.<sup>63</sup> They and other health care defendants have sought to invoke a quality of care defense that has been mostly unsuccessful as it has been in other industries and other contexts.<sup>64</sup> All attempts to justify such conduct or to enact an exemption for a doctors' "union" or collective negotiation with insurers have failed.<sup>65</sup> As a result the FTC has been forced to engage in a long costly mop up operation resulting in consent decrees barring hard core price fixing by various practice groups and medical societies across the country.<sup>66</sup>

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<sup>60</sup> U.S. Dep't of Justice & Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (Aug. 1996), [https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements\\_of\\_antitrust\\_enforcement\\_policy\\_in\\_health\\_care\\_august\\_1996.pdf](https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf).

<sup>61</sup> Nat'l Soc'y Prof. Eng'rs v. United States, 435 U.S. 679 (1978).

<sup>62</sup> Thomas Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217, 235 (2009)(discussing opportunities for both competition and collusion between hospitals and doctors); *See, e.g.*, *Rome Ambulatory Surgery Ctr. v. Rome Mem'l Hosp.*, 349 F. Supp. 2d 389 (N.D.N.Y. 2004); *Gordon v. Lewiston Hosp.*, 272 F. Supp. 2d 393 (M.D. Pa. 2003); *See also Mahan v. Avera St. Luke's*, 621 N.W.2d 150 (S.D. 2001).

<sup>63</sup> *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447 (1986).

<sup>64</sup> *Id.* at 464.

<sup>65</sup> *Id.* at 465; *See, also Nat'l Soc. of Prof'l Engrs v. U.S.*, 435 U.S. 679 (1978).

<sup>66</sup> Thomas L. Greaney, *Thirty Years of Solicitude: Antitrust and Physician Cartels*, 7 HOUS. J. HEALTH L. & POL. 189, 190 (2007) (since 1996, the FTC has settled by consent decrees approximately forty-one enforcement actions against

The problems with this approach are manifest. The Department of Justice and the FTC have made clear that price fixing among competitors without any meaningful economic integration or risk sharing is the type of per se unlawful behavior that is normally prosecuted criminally.<sup>67</sup> In every other context, price fixers are described as well-dressed thieves.<sup>68</sup>

Even if the conduct of the various doctors was somehow once a novel antitrust issue, that is decades in the past and the medical profession and their counsel should by this point be on fair notice that this type of conduct is per se unlawful. In other industries, there would be, at most, a civil test case establishing that the conduct is per se unlawful, and then the grand juries would start convening.<sup>69</sup>

Instead, the DOJ has played virtually no role in attacking this pattern of conduct, there have been less than a handful of criminal cases involving physician price fixing,<sup>70</sup> and the FTC is left to bring civil cases resulting in consent decrees or more resource intensive litigated cease and desist orders. To make matters worse, the FTC occasionally brings these cases as quick look

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hospital-contracting and physician-contracting networks for jointly negotiating on behalf of their members with payors in a manner that constituted unlawful horizontal price-fixing agreements); R. Dale Grimes, *Under the microscope, antitrust enforcers focus on healthcare consolidations*, BECKER'S HOSPITAL REVIEW (June 20, 2016), <http://www.beckershospitalreview.com/legal-regulatory-issues/under-the-microscope-antitrust-enforcers-focus-on-healthcare-consolidations.html> (half of the FTC's enforcement actions were in the healthcare sector from 2011 to 2015, with 24% in "Health Care-General," 26% in "Health Care-Pharmaceuticals & Medical Devices").

<sup>67</sup> FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS § 3.2 (2000), [https://www.ftc.gov/sites/default/files/documents/public\\_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf](https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf).

<sup>68</sup> Scott D. Hammond, Dir. of Criminal Enforcement, U.S. Dep't of Justice, Antitrust Div., *The Fly on the Wall has Been Bugged - Catching an International Cartel in the Act* (May 15, 2001)(address before the International Law Congress 2001 EU Competition Law), [www.usdoj.gov/atr/public/speeches/8280.htm](http://www.usdoj.gov/atr/public/speeches/8280.htm).

<sup>69</sup> See, e.g., FTC and DOJ Release Guidelines for Human Resource Professionals on How Antitrust Laws to Employee Hiring and Compensation (Oct. 20, 2016), available at <https://www.ftc.gov/news-events/press-releases/2016/10/ftc-doj-release-guidance-human-resource-professionals-how>.

<sup>70</sup> *United States v. Alston*, 1991-1 Trade Cas. (CCH) 69,366 (D. Ariz. 1990), *affd in part, vacated in part*, *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992); *United States v. Alston*, No. CR-10-042-Tuc (D.C. Ariz., Jan. 15, 1993) (plea agreement); *Cf. United States and State of Mich. v. Hillsdale Cmty. Health Ctr.*, Case 2:15-cv-12311-JEL-DRG, <https://www.justice.gov/opa/file/623436/download>; *United States v. Charleston Area Med. Ctr., Inc. and St. Mary's Med. Ctr., Inc.*, Case 2:16-cv-03664, <http://s3.amazonaws.com/cdn.orricks.com/files/West-Virginia-Complaint.pdf>.

violations<sup>71</sup> leading to the sighting of two mythological unicorn-like creatures that are not supposed to exist in the antitrust forest -- the civil per se violation and the quick look cartel case.<sup>72</sup>

Most recently, the DOJ brought a per se civil complaint alleging that two hospital systems agreed to allocate marketing territories, which was promptly settled by a consent decree.<sup>73</sup> These actions over the years belie the words of the Supreme Court in *Maricopa County* where it stated: “the Sherman Act, so far as price fixing agreements are concerned, establishes one uniform rule applicable to all industries alike.”<sup>74</sup>

Another similar form of health care antitrust exceptionalism came in the long fight over the medical resident match program.<sup>75</sup> Fourth year medical students engage in an application and preference process with teaching hospitals as to where they will spend their residency year following graduation from medical school. Rather than compete for residents on the basis of price or non-price factors, the hospitals engage in a “match” process that results in hospitals offering one and only one residency to any given medical graduate.

The match program eventually was challenged as an unlawful price fixing and market division scheme in a private class action. When the defendant medical schools and teaching hospitals lost a motion for summary judgment,<sup>76</sup> they didn’t settle or litigate. They instead ran to Congress, which eventually and quietly passed non-germane amendment to an unrelated ERISA

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<sup>71</sup> *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346 (5th Cir. 2008). More recently, at least one of these creatures a civil per se government case appears to have migrated to other industries as well.

<sup>72</sup> *United States v. Apple Corp.*, 791 F.3d 290 (2d Cir. 2015), *cert. denied*, No.15-565, 2016 WL 854227 (Mar. 7, 2016).

<sup>73</sup> U.S. Dep’t of Justice, Press Release, Justice Department Sues Two Hospital Systems for Agreeing to Allocate Marketing Territories (Apr. 14, 2016) <https://www.justice.gov/opa/pr/justice-department-sues-two-hospital-systems-agreeing-allocate-marketing-territories>.

<sup>74</sup> *Maricopa County*, 457 U.S. at 349.

<sup>75</sup> NATIONAL RESIDENT MATCHING PROGRAM (2002-2016), <http://www.nrmp.org/>.

<sup>76</sup> *Jung v. Ass’n of Med. Colls.*, 300 F.Supp. 2d 119 (D.D.C. 2004), *later proceedings*, 339 F.Supp.2d 26 (D.D.C.2004), *cert. denied*, 549 U.S. 1156 (2007).

pension bill, retroactively immunizing the match program from antitrust scrutiny.<sup>77</sup> It is hard to think of too many other defendants or industries that retroactively win their litigation in Congress rather than in the courts.

#### D. The Continuing Weirdness of Hospital Mergers

The poster child for antitrust exceptionalism in the health care industry consisted of the disastrous defeats suffered by both the Antitrust Division and the FTC in the 1990s in challenging a series of hospital mergers in different areas of the country.<sup>78</sup> This was probably the darkest era for government merger enforcement since the enactment of the modern version of Section 7 of the Clayton Act in 1950. To re-paraphrase Justice Stewart, the only consistency was that the government always lost.<sup>79</sup> Although (or because) the Supreme Court never weighed in on these cases, the lower courts were awash with virtually lawless decisions. Courts would bend market definitions to ensue no violations.<sup>80</sup> Other courts accepted variations of the good citizen defense that normally gets laughed out of court.<sup>81</sup> One court found that non-profit hospitals were like non-profit cooperatives and were therefore unlikely to harm their own members.<sup>82</sup> Another court accepted the related notion that hospital board members would not injure their own

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<sup>77</sup> See Pension Funding Equity Act of 2004, §207, Pub. L. No. 108-218, 118 Stat. 596 (2004).

<sup>78</sup> See *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 69 F.3d 260, 273 (8th Cir. 1995); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1085 (N.D. Cal. 2000), *amended by*, 130 F. Supp. 2d 1109, 1137 (N.D. Cal. 2001); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1302-03 (W.D. Mich. 1996), *aff'd*, No. 96-2440, 1997 WL 420543, at \*1 (6th Cir. July 8, 1997); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632, 637 (8th Cir. 1997); *Adventist Health Sys./West*, 117 F.T.C. 224, 285 (1994)

<sup>79</sup> *United States v. Von's Grocery Co.*, 384 U.S. 270, 301 (1966).

<sup>80</sup> See, e.g., *FTC v. Tenet Health Care Corp.*, 186 F. 3d 1045 (8<sup>th</sup> Cir. 1999).

<sup>81</sup> *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997); *FTC v. Butterworth*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 121 F. 3d 128 (6<sup>th</sup> Cir. 1997).

<sup>82</sup> *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, No. 89-2625, 1989 WL 157282, at \*4 (4th Cir. Nov. 29, 1989).

communities.<sup>83</sup> Other judges essentially accepted a promise that the merged hospitals would not raise prices in finding that the merger would not harm competition.<sup>84</sup> One would be hard pressed to find any of these results in a litigated decision or consent decree involving any other industry.<sup>85</sup>

The FTC should be commended for not giving up the fight. Research, an extended retrospective study of past hospital mergers,<sup>86</sup> and a renewed enforcement commitment brought victory in the Evanston/Highland Park hospital merger, a merger that has been cleared some years before.<sup>87</sup> But even here, a rare behavioral remedy diluted a strong and important victory where a horizontal merger found to harm competition was allowed to continue operating without any divestitures. Instead teams from the formerly competing hospitals had to establish a firewall and, in essence, compete with each other for participation in new insurance networks with a highly doubtful real world impact.<sup>88</sup> These earlier cases and the remedy provisions of the *Evanston/Highland Park* consent decree are mostly relics of the past,<sup>89</sup> but still remain as potential landmines in the legal battlefield which can cause continued mischief as both agencies have returned to challenge the continued consolidation of the hospital sector.

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<sup>83</sup> FTC v. Freeman Hosp., 911 F. Supp. 1213, 1222 (W.D. Mo. 1995). See generally Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 Health Affairs 185, 187 (2002).

<sup>84</sup> United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997); FTC v. Butterworth, 946 F. Supp. 1285 (W.D. Mich. 1996), aff'd, 121 F. 3d 128 (6<sup>th</sup> Cir. 1997).

<sup>85</sup> See generally Barak D. Richman, *Antitrust and Non-Profit Hospital Mergers*, 156 U. PA. L. REV. 121 (2007).

<sup>86</sup> See Federal Trade Commission, & Dep't of Justice, *Improving Health Care: A Dose of Competition* (July 2004), <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

<sup>87</sup> Evanston Nw. Healthcare Corp., 144 F.T.C. 1 (2007), see *In re* Evanston Nw. Healthcare Corp., File No. 011-0234, Opinion of the Comm'n (Aug. 6, 2007), <https://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf> (Commission declined to require divestiture of Highland Park, the acquired hospital, and instead imposed a conduct remedy).

<sup>88</sup> Evanston NW Healthcare Corp. and ENH Med.Group, Inc., 6 Docket No. 9315, Decision and Order (issued May 17, 2005), at 3, <http://www.ftc.gov/os/adjpro/d9315/050520do.pdf>.

<sup>89</sup> *But see* FTC v. Penn State Medical Ctr., \_\_\_ F. 3d \_\_\_, 2016 WL 5389289 (3d Cir. 2016) (reversing denial of FTC preliminary injunction).

A different front has also opened in the hospital merger wars. The FTC has engaged in a successful litigation campaign to limit the application of the state action defense in both general health care regulation and hospital mergers where state government regulators have thrown a gauzy cloak of governmental approval over largely self-interested, mostly private, anticompetitive decision making. For example, in *Phoebe Putney*, the Supreme Court upheld the FTC position that the necessary active supervision prong of the state action defense is not satisfied when broad general powers are conferred on a state agency but without specific authority to explicitly approve the anticompetitive effects of the actions taken.<sup>90</sup> To qualify for protection under the doctrine of state-action immunity, something more was required--the Hospital Authority must be able to show that it had been delegated the “authority to act or regulate anticompetitively.”<sup>91</sup> Antitrust law, according to the Court, could not be displaced by a statute granting a state or municipal general authority to act.<sup>92</sup> While this holding is helpful, it does nothing to prevent states from implementing even more intrusive state regulation of hospital mergers, which would fully satisfy both prongs of the state action defense.

For example, the West Virginia legislature responded to a pending FTC merger complaint against the consolidation of two local hospitals by introducing legislation that subjected all cooperative agreements (including mergers) to a comprehensive regulatory system involving the State Attorney General and Health Care Authority.<sup>93</sup> This presumably is designed to satisfy both the clear articulation and active prongs of the state action defense, but hardly

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<sup>90</sup> *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003 (2012).

<sup>91</sup> *Id.* at 1010-12.

<sup>92</sup> *Id.* at 1011-12; *See also* *N.C. State Bd. of Dental Examiners v. FTC*, 135 S. Ct. 1101 (2015).

<sup>93</sup> Lisa Schencker, *West Virginia bill would shield merging hospitals from antitrust laws*, MODERN HEALTHCARE (Feb. 18, 2016), <http://www.modernhealthcare.com/article/20160218/NEWS/160219892>.

seems likely to ensure a competitive market for hospital services. As a result, the FTC was forced to drop its merger challenge.<sup>94</sup>

### III. The Next Frontier of the ACA

The next frontier where these claims of health care exceptionalism are playing out are the tensions between competition and clinical integration inherent in the PPACA, more colloquially known as the Affordable Care Act (ACA).<sup>95</sup> The ACA has many different and conflicting aims. The first is to expand insurance coverage and Medicaid coverage to a wider percentage of the population. The second, and less politically controversial, involves a variety of mandates and incentives to provide lower cost and more efficient health care for both insured and uninsured patients.

To deal with these mandates and incentives, there has been additional consolidation in the health care industry, including the formation of Accountable Care Organizations (ACOs), expressly provided for in the ACA, which will provide both carrots and sticks in return for certain forms of cost control, quality assurance, as well as clinical and economic integration.<sup>96</sup> At the same the ACA contains an explicit antitrust savings clause that provides no exemptions for ACO formation or operation.<sup>97</sup> A raft of speeches, policy statements, workshops, and

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<sup>94</sup> Lisa Schenker, *FTC Drops Challenge of West Virginia Hospital Merger*, *Modern Healthcare* (July 6, 2016), <http://www.modernhealthcare.com/article/20160706/NEWS/160709960>.

<sup>95</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.) <http://www.hhs.gov/sites/default/files/ppacacon.pdf>. See generally FURROW, et al, *supra* note 14, at § 13.32.

<sup>96</sup> See e.g. Havighurst & Richman, *supra* note 15, at 871-76; Erin F. Dine, Comment, *Money Will Likely be the Carrot, but What Stick Will Keep ACOs Accountable?*, 47 *Loy. U. CHI. L.J.* 1377, 1394-98 (2016).

<sup>97</sup> Patient Protection and Affordable Care Act, Sec. 1560(a); See generally Thomas L. Greaney & Douglas Ross, *Navigating Through the Fog of Vertical Merger Law: A Guide to Counseling Hospital Physician Consolidation Under the Clayton Act*, 91 *WASH. L. REV.* 199 (2016).

publications from both enforcers and lawyers in the private sector have sought to provide guidance in this complicated overlap of antitrust and health care regulation.<sup>98</sup>

These tensions played out in the St. Luke's litigation in the District Court in Idaho and the 9<sup>th</sup> Circuit.<sup>99</sup> In *St. Luke's*, a leading hospital chain in Idaho already employing a number of primary care physicians (PCPs) purchased the largest PCP practice group in a nearby city. This horizontal acquisition was driven in part by the cost containment goals and incentives of the ACA,<sup>100</sup> but still remained subject to the full provisions of the Clayton Act, which prohibits mergers and acquisitions which may tend to substantially lessen competition. The acquisition was challenged by the FTC, the Idaho Attorney General, and a competing hospital.

The 9<sup>th</sup> Circuit affirmed the district court's decision that the acquisition violated Section 7 of the Clayton Act. The decisions relied heavily on internal documents and buyer testimony to establish the likelihood of harm in a highly localized market for primary physician care.<sup>101</sup> The Ninth Circuit also rejected the assertion that the acquisition was either required or justified by the cost-savings provisions of the ACA.<sup>102</sup>

While *St. Luke's* was the first litigated case relating to an acquisition of a physician group, it will not be the last especially because it produced an astonishing backlash of critical commentary that, even if sincere, fails to understand the continuing role of merger law in

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<sup>98</sup> U.S. Dep't of Justice & Fed. Trade Comm'n, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating In the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011); Deborah L. Feinstein, Dir., Bureau of Competition, Fed. Trade Comm'n, Address at the Fifth National Accountable Care Organization Summit: Antitrust Enforcement in Health Care: Proscription, not Prescription (June 19, 2014), [https://www.ftc.gov/system/files/documents/public\\_statements/409481/140619\\_aco\\_speech.pdf](https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf); U.S. Dep't of Justice & Fed. Trade Comm'n, Public Workshop Examining Health Care Competition (Feb. 24-25, 2015), <https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition>.

<sup>99</sup> *Saint Alphonus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775 (9<sup>th</sup> Cir. 2015).

<sup>100</sup> There were also vertical aspects to the acquisition that were not discussed in either the district court or appellate opinions.

<sup>101</sup> *St. Luke's Health Sys., Ltd.*, 778 F.3d at 785.

<sup>102</sup> *Id.* at 791.

the wake of the ACA.<sup>103</sup> While the 9<sup>th</sup> Circuit decision included some loose language limiting the role of efficiencies in highly concentrative mergers, it is hardly an extension of existing law to hold, as the district court did, that asserted efficiencies that are not merger specific will not justify a merger found to substantially lessen competition.<sup>104</sup>

#### IV. The Fork in the Road: Is Health Care Antitrust Really So Special?

It is the medical provider sector of the health care industry that suffers from the most acute special snowflake syndrome. It is only surprising that these defendants have been reasonably successful in the lower courts, with the Supreme Court usually, but not always, treating them the same as other industries or professions.<sup>105</sup> It is not surprising that the application of the law to the facts will be different than in other industries especially given the pervasive distortions caused by third party payors. But this does not explain how basic concepts and doctrines are bent or ignored by the lower courts and occasionally the agencies. It does not explain the lack of criminal cases after decades of fair warning. Nor does it explain special one off exemptions like the Medical Residency Match exemption tacked onto an unrelated pension bill in the proverbial middle of the night.

There comes a point where a persistent difference between the accepted legal norms and the facts on the ground requires deciding which approach is going to prevail. If the bedrock

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<sup>103</sup> These issues are also playing out in the ongoing DOJ antitrust challenge to the Aetna-Humana health insurance merger. See generally Roger Blair, Christine Piette Durrance & D. Daniel Sokol, *Hospital Mergers and Economic Efficiency*, 91 WASH. L. REV. 1 (2016) (urging more economically informed analysis to better shape and reflect the changing health care landscape).

<sup>104</sup> U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 2.2.1, 6.1, 10 (2010), <https://www.justice.gov/atr/horizontal-merger-guidelines-08192010>. See generally, Havighurst & Richman, *supra* note 15, at 873 (expressing skepticism of ACO efficiency claims in merger analysis); William J. Kolasky & Andrew R. Dick, *The Merger Guidelines and the Integration of Efficiencies into Antitrust Review of Horizontal Mergers*, 71 ANTITRUST L.J. 207, 235 (2003).

<sup>105</sup> See *Cal. Dental Ass'n v. FTC*, 526 U.S. 756 (1999).

goals of economic competition are deemed paramount than the antitrust laws are doing a poor job of protecting those values in the health care provider sector. If the health care provider sector truly is different and competition does not serve the needs of consumers, providers, and society, then the industry has done a poor job of making its case before the Supreme Court, the Congress, and the general public. But to continue to rely on the antitrust laws to do the job when there is frequent cognitive dissonance in key parts of the health care sector is neither productive nor consistent with the rule of law.

As Yogi Berra once said “When you come to a fork in the road, take it.”<sup>106</sup> There is a fundamental decision as to which road to take. Either we return to a basic antitrust approach with the same basic antitrust rules of the road as in other industries, subject to occasional exemptions and immunities, or we consciously work toward creating a more sector specific health care antitrust policy with a deliberate blend of regulation and competition to create the desired goals of coverage, cost, competition, and compensation to providers. If we continue the current state of affairs, we are in essence choosing the latter, but pretending to do the former,<sup>107</sup> which may produce the worst of outcomes in the real world. There is neither a comprehensive and comprehensible competition policy; nor a thoughtful and consistent regulatory policy for health policy with a deliberate subordination of competition goals in favor of other societal values.

If the traditional antitrust path is chosen, sensitivity is required in the application of per se rules to the legitimate ethical rules of the profession,<sup>108</sup> but little deference need to be shown in

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<sup>106</sup> YOGI BERRA, *THE YOGI BOOK: I REALLY DIDN'T SAY EVERYTHING I SAID!* 48 (Workman Publishing, 1998).

<sup>107</sup> Max Huffman, *Competition Policy in Health Care in an Era of Reform*, 7 *IND. HEALTH L. REV.* 224, 269-70 (2010)(comments of Professor Christopher Sagers regarding the quiet evolution of special case law for health care, especially hospitals).

<sup>108</sup> See generally Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 *J. HEALTH POL. POL'Y & LAW* 939 (2001).

cases involving mere self-interest in seeking to raise price in response to market forces, cost containment efforts by insurers, or government mandates. Similarly, sensitivity is needed in the application of the rule of reason to competition in markets defined by third party payers and/or information asymmetries. However in neither case, should the basic antitrust rules be relaxed or applied differently where the defendants' defense is some variant of the traditional refrain that competition has been harmed but the defendants are just special or serving some broader societal interest. That is for Congress to decide, and not defendants, their counsel, and courts to assert on a case-by-case basis. Only then will antitrust in health care return to the national commitment to competition as the governing economic principle through a transsubstantive body of law with exemptions as justified. Criminal enforcement will return to the naked price fixing arrangements and similar cartel-like behavior long held per se unlawful. Merger investigations, cases, results, and remedies return to a consistently recognizable application of the modern case law and the merger guidelines. Other long standing antitrust doctrines would no longer get tortured to the breaking point to accommodate the felt needs of the health care industry. The enforcement agencies would continue to use enforcement and advocacy to limit thin state action immunity claims for states and local government actions to limit competition in health care markets.

In the alternative, we could move as a society toward a more sector specific health care antitrust policy if we choose to do so in a deliberate fashion considering the costs and benefits, rather than proceeding in the current ad hoc and sub rosa fashion. This would involve legislation that does not seek to have things both ways, with both incentives for consolidation and full-throated antitrust savings clauses. The enforcement agencies would need more industry specific guidelines and policy statements. Statutory exemptions would flourish affecting the core, rather than the periphery, of health care markets. It could perhaps extend as far as doctor's

“unions” and protection for other types of “bargaining” by doctors who are not employees and insurance companies and other payers.

Overall, there would be less reliance on Supreme Court antitrust precedents in other industries and the Supreme Court golden oldie health care antitrust decisions. Government litigation would give way to more negotiations, guidelines, business review letters, consent decrees, other informal dispositions, speeches and a great deal of counseling without case law.<sup>109</sup> Health law antitrust would be more of a defined field and less of a sub-part of a general body of antitrust law.<sup>110</sup> Regulation would be more comprehensive with competition provisions more clearly embedded in the regulatory framework, rather than as a free-standing body of law. Perhaps things would go as far as the supermarket sector in the United Kingdom which operates under its own competitive code of conduct following a detailed market sector inquiry by the former U.K. Office of Fair Trading.<sup>111</sup>

## V. Conclusion

This essay has taken a broad, but not deep, look at how traditional antitrust principles play out in certain health care contexts. This essay suggests that key health care antitrust issues enjoy a de facto exemption from the traditional antitrust doctrine. Despite a fairly faithful Supreme Court, the law just does not seem to stick, particularly in the lower courts which time after time accept arguments and defenses that simply hold water in other contexts. I share the

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<sup>109</sup> Spencer Weber Waller, *Prosecution by Regulation: The Changing Nature of Antitrust Enforcement*, 77 OR. L. REV. 1383 (1998); Richard M. Steuer, *Counseling Without Case Law*, 63 ANTITRUST L. J. 823-52 (1995).

<sup>110</sup> David Orentlicher, *A Restatement of Health Care Law*, 79 BROOK. L. REV. (2014).

<sup>111</sup>Groceries Supply Code of Practice (GSCOP) (Aug. 4, 2009), <https://www.gov.uk/government/publications/groceries-supply-code-of-practice/groceries-supply-code-of-practicem>; [The Groceries \(Supply Chain Practices\) Market Investigation Order 2009](https://www.gov.uk/government/publications/the-groceries-supply-chain-practices-market-investigation-order-2009), Competition Commission under s 161 of the Enterprise Act 2002, [http://www.offt.gov.uk/shared\\_offt/monopolies/GSCOP-Order.pdf](http://www.offt.gov.uk/shared_offt/monopolies/GSCOP-Order.pdf); [Groceries Code Adjudicator Act 2013](https://www.gov.uk/government/publications/groceries-code-adjudicator-act-2013), [http://www.legislation.gov.uk/ukpga/2013/19/pdfs/ukpga\\_20130019\\_en.pdf](http://www.legislation.gov.uk/ukpga/2013/19/pdfs/ukpga_20130019_en.pdf).

concerns expressed by Professor Greaney that thirty years of solicitude is too much and simply note that he expressed these views almost ten years ago.<sup>112</sup>

When the law in action does not match the law on the books, something has to give. The antitrust laws have served us well and rejected virtually all forms of the special snowflake defense that health care providers routinely offer. If the actual or perceived needs of the health care industry are to prevail over our national commitment to market competition then so be it. But such a dramatic shift should occur only if that decision is made in a fundamentally democratic and open fashion and not on the sly in the lower courts. And even then we would need a well thought out framework that blends competition, consumer protection, and other forms of regulation to achieve a higher order national health policy, which has yet to emerge.

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<sup>112</sup> Greaney, *supra* note 66.