

How Much of Health Care Antitrust Is Really Antitrust?

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INTRODUCTION

This Essay is 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, and in all sectors, unless Congress speaks to the contrary. The United States Supreme Court has gone so far as to refer to the antitrust laws as “the Magna Carta” of the free enterprise system.¹

It is increasingly hard to say with a straight face that these general principles apply when the antitrust laws are applied to the health care

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1. *United States v. Topco Assocs., Inc.*, 405 U.S. 596, 610 (1972).

sector. The health care sector has long maintained that it is unique, and that the application of traditional antitrust principles will produce bad results for society. Unlike most industries—where courts were quick to reject variations of this argument under the Sherman Act since the earliest days of the Sherman Act—health care antitrust cases often produce different results.

While I do not argue that this is true in every case on all issues, I seek to document how this came to pass in critical areas of antitrust law over the past four decades, how it 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, as well as how it deals with nonantitrust regulatory changes imposed by the Affordable Care Act (“ACA”) and what is to follow.² In short, we have reached a fork in the road, and therefore must confront either returning to the application 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 set forth when competition rules are secondary to other policy goals.

Part I of this Essay 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 litigation often works differently in key health care antitrust issues where the lower courts often conduct a guerilla campaign against accepted Supreme Court precedent. Part II specifically examines how lower courts 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 available paths going forward that the legal system must choose

2. 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 of the United States Code); *see also* OFFICE OF THE LEGISLATIVE COUNSEL, 111-1 COMPILATION OF PATENT PROTECTION AND AFFORDABLE CARE ACT (2010) (consolidating amendments made by the Affordable Care Act and the Health Care and Education Reconciliation Act, prepared for the United States House of Representatives by Legislative Counsel).

between to have a consistent and meaningful law of health care antitrust, rather than a series of ad hoc choices that often deviate from accepted antitrust law and economic policy.

I. ANTITRUST FOR THE GENERAL ECONOMY

Antitrust provides the ground rules for a market economy. Section 1 of the Sherman Act prohibits anticompetitive agreements.³ Section 2 of the Sherman Act prohibits monopolization and attempted monopolization by powerful single firms.⁴ Finally, section 7 of the Clayton Act prohibits mergers and acquisitions that may produce a substantial lessening of competition or that tend to create a monopoly.⁵

Antitrust is intended to be transsubstantive, applying to all types of private market behavior. Building on these basic prohibitions, what emerged is 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 created statutory immunities and exemptions.⁶ In the same way 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 dictates otherwise.

As a result, the Supreme Court, from the earliest days of the Sherman Act, rejected certain types of defenses it viewed 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.⁷ Second, the Court rejected the assertion that a price-fixing agreement was lawful if it set a reasonable price.⁸ Third, the Court rejected virtually all assertions of social welfare justifications that concede the harm to competition, but assert that the conduct was necessary to achieve some

3. 15 U.S.C. § 1 (2012).

4. *Id.* § 2.

5. *Id.* § 18.

6. See generally AM. BAR ASS'N, SECTION OF ANTITRUST LAW, FEDERAL STATUTORY EXEMPTIONS FROM ANTITRUST LAW, MONOGRAPH NO. 24 (2007) (surveying statutory immunities to federal antitrust laws).

7. *United States v. Trans-Mo. Freight Ass'n*, 166 U.S. 290, 547–48 (1897).

8. *United States v. Trenton Potteries Co.*, 273 U.S. 392, 39–98 (1927); *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 276–78 (6th Cir. 1898), *modified and aff'd*, 175 U.S. 211 (1899).

broader societal benefit.⁹ Fourth, the Court rejected a learned profession exemption, but it may use the necessary ethical rules of a profession to apply the normal antitrust rules in a slightly less restrictive manner.¹⁰ Fifth, courts generally reject the notion that industries are too high tech, too complicated, or too important for the normal rules to apply.¹¹ 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 Acts 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 payor health insurance scheme and/or a national health system (supplemented by private insurance), that effectively relies on comprehensive regulation in place of competition law to take care of the needs of citizens.¹²

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 United States Department of Veterans Affairs are almost all private parties subject to the full antitrust law with certain limited exemptions.¹³ The United States health care sector thus attracts a significant amount of government antitrust enforcement and numerous private lawsuits given its size and prominence in the United States

9. Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695–96 (1978).

10. *Id.* at 681, 696; Goldfarb v. Va. State Bar, 421 U.S. 773, 786–91 (1975).

11. United States v. Apple Inc., 791 F.3d 290, 297–98 (2d Cir. 2015), *cert. denied*, 136 S. Ct. 1376 (2016); United States v. Microsoft Corp., 253 F.3d 34, 49–50 (D.C. Cir. 2001), *cert. denied*, 534 U.S. 952 (2001).

12. See Wolf Sauter, *The Impact of EU Competition Law on National Health Care Systems*, 38 EUR. L. REV. 457, 458 (2013) (discussing, in part, EU competition laws and the policy objectives of national health care systems).

13. See Pension Funding Equity Act of 2004, Pub. L. No. 108-218, 118 Stat. 596 (noting the resident match exception); see also Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 (1986) (illustrating the peer review exception); but cf. National Health Planning and Resources Development Act of 1974 (“NHPRDA”), Pub. L. No. 93-641, 88 Stat. 2225 (1975) (creating various federal, state, and local bodies that would coordinate their activities for health planning). The Supreme Court in *National Gerimedical Hospital & Gerontology Center v. Blue Cross of Kansas City* stated that the NHPRDA was “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.” 452 U.S. 378, 392–93 (1981) (noting 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).

economy and the inherently private nature of its health care system.

So, what does “health care antitrust” mean? 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 United States law schools and the various course books and treatises in the field.¹⁴

But a closer examination of how antitrust actually plays out in the health law sector reveals a more complicated and troubling pattern. While the United States Supreme Court is fairly consistent in its application of traditional antitrust principles in health care settings, the lower courts are not.¹⁵ 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 semiconductors, industrial machinery, ice cream, or transportation.¹⁶

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, thus producing unintended changes in general doctrines.

This Part highlights four different areas of antitrust doctrine where an unauthorized health care specific set of rules developed and one or both of these consequences occurred. Part II.A 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 II.B examines how health care tempered and relaxed the per se rule against group boycotts and how general antitrust doctrine embraced these changes. Part II.C 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 II.D looks at hospital mergers where the lower courts and agencies have allowed defenses and relief that would be laughable in most other contexts.

14. See, e.g., BARRY R. FURROW ET AL., *HEALTH LAW* 43 (2d ed. 2000); see generally DAVID MARX, JR. & JAMES SNEED, *ANTITRUST AND HEALTHCARE: MEETING THE CHALLENGE* (2d ed. 1998) (discussing health law and policy in the form of a practitioner’s treatise).

15. See generally Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly in Health Care*, 89 OR. L. REV. 847 (2011) (discussing, in part, the impact on consumers of a health care monopoly particularly as it relates to antitrust issues).

16. See William L. Reynolds & Spencer Weber Waller, *Legal Process and the Past of Antitrust*, 48 SMU L. REV. 1811, 1824–27 (1995) (examining other antitrust contexts where lower courts contest validity of otherwise binding Supreme Court precedent).

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

To violate the federal antitrust laws, the unlawful conduct must constitute trade or commerce in, or affecting, interstate or foreign commerce.¹⁷ 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 thus beyond the scope of the Sherman Act.¹⁸ Over the first forty years of the twentieth century, the scope of the Commerce Clause expanded until 1942, when the Supreme Court held that even the crops of a single farmer consumed or sold within a state affected interstate commerce sufficiently to be covered by New Deal agricultural production restrictions.¹⁹ In recent years, the Supreme Court cut back somewhat on the scope of the Commerce Clause, but primarily in the area of noneconomic regulatory legislation where the Court felt the connection between the prohibited conduct and interstate commerce was too tenuous.²⁰

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 *American Medical Association v. United States*, a 1943 case challenging an alleged boycott of group health plans in the District of Columbia.²¹ Because this case was brought under section 3 of the Sherman Act, which governs trade and commerce in the District of Columbia, the government only had to show that the trade or commerce affected the District of Columbia, rather than prove it affected interstate or foreign commerce.²² The Supreme Court held that the practice of medicine was indeed trade and commerce and upheld the violation alleged in the complaint.²³

The Court next considered similar allegations involving the Oregon State Medical Society and its attempts to bar various group plans in that

17. 15 U.S.C. §§ 1–2, 18, 45 (2012).

18. *United States v. E. C. Knight Co.*, 156 U.S. 1, 16–18 (1895).

19. *Wickard v. Filburn*, 317 U.S. 111, 128 (1942).

20. *See United States v. Morrison*, 529 U.S. 598, 612–15 (2000) (holding that Congress cannot regulate noneconomic, violent criminal conduct simply because of the aggregate effect such conduct may have on interstate commerce); *United States v. Lopez*, 514 U.S. 549, 564–68 (1995) (finding that the Gun-Free School Zones Act of 1990 cannot be sustained under cases that uphold regulations on activities that affect interstate commerce in the aggregate).

21. 317 U.S. 519, 526–28 (1943).

22. *Id.* at 529.

23. *Id.* at 536.

state.²⁴ 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,²⁵ a holding seemingly foreclosed by New Deal precedents, such as the seminal *Wickard v. Filburn* case.²⁶

Going forward, the Court alternated between narrow and broad interpretations of interstate commerce in health care antitrust cases. In 1976, in *Hospital Building Co. v. Trustees of Rex Hospital Trustees*, the Court held that the proper test was whether the restraint, if successful, would have a substantial effect on interstate commercial activity.²⁷ A mere four years later, the Court in *McLain v. Real Estate Board of New Orleans, Inc.*, held instead that the focus should be on whether the defendants' activities (and not the restraint itself) allegedly infected by the antitrust violation "have a not insubstantial effect on the interstate commerce involved."²⁸

This crucial distinction played out a decade later in *Summit Health, Ltd. v. Pinhas*.²⁹ In *Pinhas*, an ophthalmologist surgeon sued the hospital that 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.³⁰ The Supreme Court held in a 5–4 decision that Pinhas alleged the requisite effect on interstate commerce.³¹ The majority held in an opinion by Justice Stevens that the proper test was a measure of the potential harm that ensues if the restraint was successful, not upon the actual consequences of the restraint.³²

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.³³ The dissent urged the Court to return to the pre-*McLain* line of cases and require a factual nexus between the harm suffered by the plaintiff and interstate commerce.³⁴ Here, the four dissenting Justices found no such nexus because the market for eye surgery in Los Angeles

24. *United States v. Or. State Med. Soc'y*, 343 U.S. 326, 328 (1952).

25. *Id.* at 338.

26. 317 U.S. 111, 128 (1942).

27. 425 U.S. 738, 745–47 (1976).

28. 444 U.S. 232, 246 (1980) (citing *Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738, 745 (1976)).

29. 500 U.S. 322 (1991).

30. *Id.* 326–28.

31. *Id.* at 333.

32. *Id.* at 330–31.

33. *Id.* at 335 (Scalia, J., dissenting).

34. *Id.* at 335–36.

was a competitive one, both before and after the alleged boycott.³⁵

Had the dissent prevailed, this would have eliminated virtually all antitrust claims by health care providers against their employers or the hospitals where they enjoyed staff and 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 that followed such an approach prior to *Pinhas*.³⁶

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

This Part discusses how the profession turned to two different lines 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. First, hospitals and doctors obtained a statutory exemption protecting most peer review decisions from antitrust scrutiny if certain procedures were followed.³⁷ 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 antitrust doctrine.

Group boycott law historically was a subject of contention in antitrust law.³⁸ The black letter law traditionally stated that concerted refusals by competitors not to deal with other competitors (group boycotts) were per se unlawful.³⁹ The problem with such holdings and dicta was not the

35. *Id.* at 340.

36. *Id.* at 334–42; see also Josephine M. Hammack, *The Antitrust Laws and the Medical Peer Review Process*, 9 J. CONTEMP. HEALTH L. & POL'Y 419, 420 n.8 (1993) (citing *Health Care Statute Immunizes Physicians Involved in Peer Review*, 58 ANTITRUST & TRADE REG. REP. (BNA) No. 58, at 265, 273 (Feb. 22, 1990)) (analyzing the circuit split on whether peer review does affect interstate commerce).

37. See *Patrick v. Burget*, 486 U.S. 94, 105 (1988) (holding that the state-action doctrine does not protect peer-review activities from federal antitrust law).

38. See, e.g., James A. Rahl, *Per Se Rules and Boycotts Under the Sherman Act: Some Reflections on the Klor's Case*, 45 VA. L. REV. 1165, 1171 (1959) (identifying the Supreme Court's "difficulty in articulating an internally consistent rationale" for interpreting antitrust law in relation to boycotts).

39. See *United States v. Gen. Motors Corp.*, 384 U.S. 127, 145–47 (1966) (holding that substantial restraint on price competition is unlawful per se when effected "by combination or conspiracy"); *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 212 (1959) ("Group boycotts, or concerted refusals by traders to deal with other traders, have long been held to be in the forbidden category."); *Fashion Originators' Guild of Am., Inc. v. FTC*, 312 U.S. 457, 467 (1941) (finding that the aim of the combination at issue "was the interested destruction of one type of manufacture and sale which competed" and thus fell within the "policy and prohibition of the

specific cases decided by the Supreme Court, but was the result on counseling and litigation where the effect on competition was less obvious and the motivations behind the refusal to deal were less obviously related to competitive concerns.⁴⁰ 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. The situation becomes more problematic when a physician is terminated because of a negative peer review rooted in staff beliefs that the terminated physician is below par, but the physician believes more sinister motives are at work or that the review process is flawed.

The early case law indicating 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.⁴¹ As long as group boycotts, or at least some group boycotts, remained per se unlawful, defendants were conclusively presumed to have violated the antitrust laws once the plaintiffs alleged and proved the existence of the group decision to terminate the plaintiff⁴².

The consensus of most commentators is that the majority of these cases involved legitimate, but disputed, assessments of qualifications or performance.⁴³ Many of these cases also involved illegitimate pretenses more likely based on race, religion, age, gender, or more idiosyncratic interpersonal issues, but only rarely the desire to harm competition at the core of the antitrust laws.

Sherman and Clayton Acts”).

40. *Molinas v. Nat'l Basketball Ass'n*, 190 F. Supp. 241, 242–44 (S.D.N.Y. 1961) (dismissing an antitrust boycott of claim of convicted gambler banned from playing in the National Basketball Association).

41. See, e.g., Andrew K. Dolan & Richard S. Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707, 712–13, 724–78 (1981) (analyzing admitting privileges before and after antitrust law applicability); William R. Drexel, *The Antitrust Implications of the Denial of Hospital Staff Privileges*, 36 U. MIAMI L. REV. 207, 208–10 (1982) (discussing the extent to which antitrust laws provide a remedy for the denial of staff privileges); Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1078–79 (discussing the expanding decision-making role of hospitals).

42. See *supra* Part II.A (discussing the additional effect on interstate commerce).

43. See, e.g., Thomas L. Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 CONN. L. REV. 605, 613, 665 (1989).

Regardless of the state of the law, the lower courts simply refused to award treble damages, attorney fees, and costs every time a doctor was terminated from employment or hospital privileges, especially when other bodies of law (e.g., civil rights or employment law) provided more nuanced remedies for the likely basis of the lawsuit. In so doing, the lower courts often found excuses to apply the rule of reason to such antitrust allegations that normally imposed an insurmountable burden on the plaintiff to define the relevant market and show that her exclusion unreasonably harmed competition in that market, rather than just harmed her own financial interests.⁴⁴ This guerrilla war against accepted doctrine bled 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.⁴⁵

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 his or her practice or hospital.⁴⁶ This effort culminated in *Jefferson Parish Hospital District No. 2 v. Hyde*—another Supreme Court health care antitrust opinion—and also nearly overturned settled doctrine regarding tying law.⁴⁷ Although

44. See generally Phillip A. Proger, *Fundamentals of Antitrust Law*, AHLA-PAPERS P02129701 (1997) (analyzing lower court decisions rejecting application of the per se rule). See, e.g., *Wilk v. Am. Med. Ass'n*, 719 F.2d 207, 226 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984) (reversing a per se verdict in a boycott case brought by chiropractors); *Anglin v. Blue Shield of Va.*, 693 F.2d 315, 321 (4th Cir. 1982) (holding that the 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); *Langston Corp. v. Standard Register Co.*, 553 F. Supp. 632, 639–40 (N.D. Ga. 1982) (holding that a group purchasing agreement between VHA and a single supplier of hospital forms was not a per se illegal boycott against another supplier); *Everhart v. Jane C. Stormont Hosp.*, No. 79-4191, 1982 WL 1833, at *2 (D. Kan. Feb. 18, 1982) (holding that an alleged boycott of physicians by two hospitals was inappropriate for treatment under per se rule for reasons related to the differences in operation of professions and other businesses, and the Court's limited knowledge of the professions).

45. E.g., *Nw. Wholesale Stationers, Inc. v. Pac. Stationary & Printing Co.*, 472 U.S. 284, 297–98 (1985) (rejecting a per se analysis in a group boycott case). 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 also *supra* note 13 (discussing the federal government's role in the health care industry and citing to relevant federal statutes).

46. See Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 579–80, 579 n.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.”).

47. 466 U.S. 2, 31 (1984), *abrogated by* *Ill. Tool Works Inc. v. Indep. Ink, Inc.*, 547 U.S. 28 (2006).

unanimous in result, the two opinions exhibited a truly “Jekyll and Hyde” view of the applicable law.

Dr. Hyde’s antitrust claim asserted that the hospital that formerly employed him entered into a per se unlawful arrangement with a competing anesthesiology group that conditioned, or tied, the provision of this group’s anesthesia services to the use of hospital operating rooms. The Court’s 5–4 majority opinion held that tying claims remained per se illegal if plaintiffs 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 affects more than a de minimis amount of commerce.⁴⁸ For the majority, Dr. Hyde’s claim involved two services—the hospital’s operating rooms and the anesthesiology services.⁴⁹ There was a separate demand for each product because a patient’s doctor often preferred to use his or her own anesthesiologist, instead of those of the group with exclusive access to the hospital.⁵⁰ The tying claim, however, failed, because the hospital had only a 30 percent share of the relevant market in New Orleans, below the level necessary to coerce patients or doctors into accepting the tied product or service.⁵¹

Justice O’Connor’s concurrence analyzed the issues in an almost opposite fashion, while simultaneously agreeing that the plaintiff’s claim failed.⁵² She initially found that only one product was involved because no reasonable patient would want an operation without anesthesia.⁵³ While 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.⁵⁴ Second, she found it peculiar that the same exact claim when styled as tying—from the patient’s point of view—would be quasi per se illegal, but when viewed as exclusive dealing—from the competing anesthesiologist’s view—it would be judged under the more demanding rule of reason standard.⁵⁵

The issue is not whether the Supreme Court got these cases right, but

48. *Id.* at 31–32.

49. *Id.* at 4–8.

50. *Id.* at 22–25.

51. *Id.* at 6–8, 26.

52. *Id.* at 33.

53. *Id.* at 43.

54. *Id.* at 34–35.

55. *Id.* at 43–46.

rather how, once again, the perceived 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.⁵⁶

C. *What Do Doctors Not Get About Price Fixing?*

A large percentage of the doctors in private practice have failed to understand, or comply with, 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.⁵⁷ Once the agreement to engage in these practices is established, the defendants' conduct is conclusively presumed unlawful.⁵⁸ 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, lack of effect on the market, any purported efficiencies that would have resulted, or the purported societal benefits of such price fixing.⁵⁹ Such per se unlawful cartel-type agreements have been dubbed the "supreme evil" of antitrust,⁶⁰ and are normally prosecuted as criminal felony violations with heavy jail sentences for individuals and whopping fines for corporate defendants.⁶¹

56. Cf. SCIENCE FICTION QUOTATIONS: FROM THE INNER MIND TO THE OUTER LIMITS 197 (Gary Westfahl ed., 2005) ("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." (quoting STAR TREK II, THE WRATH OF KHAN (Paramount Pictures, 1982))).

57. See *Palmer v. BRG of Ga., Inc.*, 498 U.S. 46, 48–49 (1990) (involving an allocation agreement between bar exam review providers that violated the Sherman Act); *FTC v. Superior Ct. Trial Lawyers Ass'n*, 493 U.S. 411, 430–32 (1990) (holding per se unlawful a boycott by court appointed lawyers with the aim to force the District of Columbia to increase hourly compensation); *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 647–49 (1980) (noting that price fixing is the "archetypal example" of an unlawful per se violation even if the fixers themselves are reasonable); *United States v. Socony-Vacuum Oil Co., Inc.*, 310 U.S. 150, 210, 218 (1940) (reaffirming the stance that price fixing is per se unlawful and that "no showing of so-called competitive abuses or evils which those agreements were designed to eliminate or alleviate may be interposed as a defense").

58. *Socony-Vacuum Oil Co.*, 310 U.S. at 224 n.59 ("It is the contract, combination or conspiracy, in restraint of trade or commerce which § 1 of the [Sherman] Act strikes down, whether the concerted activity be wholly nascent or abortive on the one hand, or successful on the other." (internal citations omitted)).

59. See *supra* notes 7–11 and accompanying text (discussing case law that illustrates the Supreme Court's rejection of defenses that undermined the basic premise of antitrust laws—that is, the benefit of competitive markets on society as a whole).

60. *Verizon Comm'ns Inc. v. Law Offices of Curtis V. Trinko, LLP.*, 540 U.S. 398, 408 (2004) ("[C]ompelling negotiation between competitors may facilitate the supreme evil of antitrust: collusion.").

61. Bill Baer, Assistant Att'y Gen., U.S. Dep't of Justice, Antitrust Div., Prosecuting Antitrust

At the same time, the case law and agency guidelines provide 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.⁶² Thus, doctors who form a legitimate partnership, a Health Maintenance Organization (“HMO”), or pool their resources to buy an expensive piece of equipment or billing system do not automatically violate the Sherman Act, even though the doctors will eventually have to set a common price 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 *Arizona v. Maricopa County Medical Society*.⁶³ The United States Department of Justice (“DOJ”) Antitrust Division and the Federal Trade Commission (“FTC”) provided more specialized guidance in the 1996 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.⁶⁴

But it is still per se unlawful price 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 permissible to do so are actually confessions—not defenses.⁶⁵ 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

Crimes, Remarks Prepared for the Georgetown University Law Center Global Antitrust Enforcement Symposium (Sept. 10, 2014); Brent Snyder, Deputy Assistant Att’y Gen., U.S. Dep’t of Justice, Antitrust Div., Compliance Is a Culture, Not Just a Policy, Remarks Prepared for the International Chamber of Commerce/United States Council of International Business Joint Antitrust Compliance Workshop (Sept. 9 2014); Brent Snyder, Deputy Assistant Att’y Gen., U.S. Dep’t of Justice, Antitrust Div., Individual Accountability for Antitrust Crimes, Remarks at the Yale Global Antitrust Enforcement Conference (Feb. 19, 2016).

62. See *Broad. Music, Inc. v. Columbia Broad. Sys., Inc.*, 441 U.S. 1, 23 (1979) (refusing to equate a blanket license fee for copyrighted musical compositions with a horizontal agreement among competitors).

63. 457 U.S. 332, 342–43, 356–57 (1982) (noting that the factfinder in antitrust cases must decide whether, under all circumstances of a case, the restrictive practice at issue imposes unreasonable restraint on competition).

64. U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996).

65. See *Nat’l Soc’y of Prof. Eng’rs v. United States*, 435 U.S. 679, 684–85, 692 (1978) (holding that petitioner’s affirmative defense that compliance with its governing ethics code was reasonable “confirms rather than refutes the anticompetitive purpose of its agreement”).

complying with these basic rules by a substantial segment of the profession.⁶⁶ 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.⁶⁷ They, and other health care defendants, invoked a quality-of-care defense that, for the most part, has been unsuccessful.⁶⁸ All similar attempts to justify such conduct or to enact an exemption for a doctor's "union" or collective negotiation with insurers have failed.⁶⁹ As a result, the FTC was forced to engage in a long, costly, mop-up operation resulting in consent decrees barring hardcore price fixing by various practice groups and medical societies across the country.⁷⁰

The problems with this approach are manifest. The DOJ and the FTC made it clear that price fixing among competitors without any meaningful economic integration or risk sharing is the type of per se unlawful behavior normally criminally prosecuted.⁷¹ In every other context, price fixers are described as well-dressed thieves.⁷²

Even if the conduct of the various doctors was somehow once a novel

66. See Thomas Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217, 233–35 (2009) (discussing opportunities for both competition and collusion between hospitals and doctors); see, e.g., *Rome Ambulatory Surgery Ctr., LLC., v. Rome Mem'l Hosp., Inc.*, 349 F. Supp. 2d 389, 424 (N.D.N.Y. 2004) (holding, in part, that entering into exclusive contracts with third parties to effectively remove certain players from the market constitutes a triable issue of fact as to whether precompetitive justifications exist for such behavior); *Gordon v. Lewiston Hosp.*, 272 F. Supp. 2d 393, 450 (M.D. Pa. 2003) (discussing the fact that a hospital revoking staff privileges from a doctor engaging in unprofessional conduct did not amount to antitrust violations); see also *Mahan v. Avera St. Luke's*, 621 N.W.2d 150, 161 (S.D. 2001) (holding, in relevant part, that a hospital's actions undertaken according to its bylaws and in good faith were permissible and not a breach of contract against a group of physicians).

67. *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 450–51 (1986).

68. *Id.* at 464.

69. *Id.* at 465; see also *Nat'l Soc'y of Prof. Eng'rs*, 435 U.S. at 695–96 (holding a canon of ethics that prohibited competitive bidding unlawful under the Sherman Act).

70. Thomas L. Greaney, *Thirty Years of Solicitude: Antitrust and Physician Cartels*, 7 HOUS. J. HEALTH L. & POL. 189, 190 (2007) (noting that since 1996, the FTC has settled by consent decrees approximately forty-one enforcement actions against 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 HOSP. REV. (June 20, 2016), <http://www.beckershospitalreview.com/legal-regulatory-issues/under-the-microscope-antitrust-enforcers-focus-on-healthcare-consolidations.html> (noting that half of the FTC's enforcement actions were in the health care sector from 2011 to 2015, with 24 percent in "Health Care-General" and 26 percent in "Health Care-Pharmaceuticals & Medical Devices").

71. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS § 3.2 (2000).

72. Scott D. Hammond, Dir. of Criminal Enf't, U.S. Dep't of Justice, Antitrust Div., *The Fly on the Wall Has Been Bugged—Catching an International Cartel in the Act*, Remarks at the Juries Ballsbridge Hotel in Dublin, Ireland, UK (May 15, 2001).

antitrust issue, that is decades in the past and the medical profession and its counsel should, at this stage, 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.⁷³

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,⁷⁴ 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 violations⁷⁵ 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.⁷⁶

Most recently, the DOJ brought a per se civil complaint alleging that two hospitals systems agreed to allocate marketing territories, which was promptly settled by a consent decree.⁷⁷ These actions over the years belie the words of the Supreme Court in *Maricopa County* where it stated: “[T]he Sherman Act, so far as price fixing agreements are concerned, establishes one uniform rule applicable to all industries alike.”⁷⁸

Another similar form of health care antitrust exceptionalism came in the long fight over the medical resident match program.⁷⁹ Fourth-year medical students engage in an application and preference process with teaching hospitals as to where they will spend their residency year

73. See, e.g., Press Release, FTC, FTC and DOJ Release Guidelines for Human Resource Professionals on How Antitrust Law Applies to Employee Hiring and Compensation (Oct. 20, 2016) (on file with author).

74. *United States v. Alston*, No. CR-90-042-TUC-ACM, 1990 WL 284741, at *2 (D. Ariz. Dec. 17, 1990), *aff'd in part, vacated in part*, *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992); *United States v. Alston*, No. CR-90-042-TUC (D. Ariz. Jan. 15, 1993) (plea agreement); cf. Competitive Impact Statement for Plaintiff at 3–4, *United States v. Hillsdale Cmty. Health Ctr.*, No. 15-cv-12311 (E.D. Mich. Oct. 21, 2015); Complaint at 2, *United States v. Charleston Area Med. Ctr., Inc.*, No. 2:16-cv-03664-JTC, 2016 WL 6828307 (S.D. W. Va. Oct. 21, 2016) (No. 2:16-cv-03664).

75. *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346, 360–61 (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.

76. *United States v. Apple Corp.*, 791 F.3d 290, 323 (2d Cir. 2015), *cert. denied*, 136 S. Ct. 13 (2016).

77. Press Release, U.S. Dep't of Justice, 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>.

78. *Arizona v. Maricopa Cty. Med. Soc'y*, 457 U.S. 332, 349 (1982).

79. NAT'L RESIDENT MATCHING PROGRAM, <http://www.nrmp.org/> (last visited Apr. 23, 2016).

following graduation from medical school. Rather than compete for residents on the basis of price or nonprice 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 in a private treble damage class action as an unlawful price fixing and market division scheme. When the defendant medical schools and teaching hospitals lost a motion to dismiss,⁸⁰ they did not settle or litigate. Instead, they ran to Congress. Congress eventually quietly passed a nongermane amendment to an unrelated Employee Retirement Income Security Act (“ERISA”) pension bill, which retroactively immunized the match program from antitrust scrutiny.⁸¹ It is difficult 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 DOJ’s Antitrust Division and the FTC in the 1990s in challenging a series of hospital mergers in different areas of the country.⁸² 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 paraphrase Justice Stewart, the only consistency was that the government always lost.⁸³ 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 ensure no violations.⁸⁴ Other courts accepted variations of the good citizen defense that normally gets laughed out of court.⁸⁵ One court found that nonprofit hospitals were like nonprofit cooperatives and were therefore unlikely to harm their own

80. *Jung v. Ass’n of Am. Med. Colls.*, 300 F. Supp. 2d 119, 174 (D.D.C. 2004), *later proceedings*, 339 F. Supp. 2d 26 (D.D.C. 2004), *cert. denied*, 549 U.S. 1156 (2007).

81. Pension Funding Equity Act of 2004, Pub. L. No. 108-218, § 207, 118 Stat. 596 (2004).

82. *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), *aff’d*, 217 F.3d 846 (9th Cir. 2000); *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).

83. *United States v. Von’s Grocery Co.*, 384 U.S. 270, 301 (1966).

84. *Tenet Health Care Corp.*, 186 F.3d at 1055.

85. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 149; *Butterworth*, 946 F. Supp. at 1293–94.

members.⁸⁶ Another court accepted the related notion that hospital board members would not injure their own communities.⁸⁷ Other judges essentially accepted a promise that the merged hospitals would not raise prices in finding that the merger would not harm competition.⁸⁸ One would be hard pressed to find any of these results in a litigated decision or consent decree involving any other industry.⁸⁹

The FTC should be commended for not giving up the fight. An extended retrospective study of past hospital mergers⁹⁰ and a renewed enforcement commitment brought victory in the Evanston-Highland Park hospital merger—a merger that the FTC had cleared some years before.⁹¹ But even here, a rare behavioral remedy diluted a strong and important victory. Although the court found that the horizontal merger harmed competition, the court allowed the newly formed entity to continue operating without any divestitures.⁹² Instead of divesting, 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.⁹³ These earlier cases and the remedy provisions of the Evanston-Highland Park consent decree are mostly relics of the past,⁹⁴ but still remain as potential landmines in the legal

86. *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 846 (W.D. Va. 1989), *aff'd*, No. 89-2625, 1989 WL 157282, at *4 (4th Cir. Nov. 29, 1989).

87. *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1222 (W.D. Mo. 1995); *see also* Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFF. 185, 187 (2002) (examining judicial and legislative attitudes toward applying antitrust law to healthcare).

88. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 145, 149; *Butterworth*, 946 F. Supp. at 1302–03.

89. *See generally* Barak D. Richman, *Antitrust and Non-Profit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007) (analyzing various courts' recent misapplications of antitrust law resulting in the protection of nonprofit hospitals from rigorous standard antitrust scrutiny).

90. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 16 n.77 (July 2004), <https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerept.pdf>.

91. *Evanston Nw. Healthcare Corp.*, Docket No. 9315, 2007 WL 2286195, at *85 (F.T.C. Aug. 6, 2007), <https://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf> (noting that the Commission declined to require divestiture of Highland Park, the acquired hospital, and instead imposed a conduct remedy).

92. *Decision and Order, Evanston Nw. Healthcare Corp. & ENH Med. Group, Inc.*, Docket No. 9315, at 3 (F.T.C. May 17, 2005), <https://www.ftc.gov/sites/default/files/documents/cases/2005/05/050520do.pdf>.

93. *Id.*

94. *But see* *FTC v. Advocated Health Care Network*, 841 F.3d 460, 476 (7th Cir. 2016) (reversing denial of preliminary injunction in a hospital merger in suburban Chicago and remanding for further proceedings); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 353 (3d Cir. 2016) (reversing denial of preliminary injunction in a hospital merger in central Pennsylvania).

battlefield that can cause continued mischief, as both agencies have returned to challenge the continued consolidation of the hospital sector.

A different front also opened in the hospital merger wars. The FTC 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 threw a gauzy cloak of governmental approval over largely self-interested, mostly private, anticompetitive decision making. For example, in *FTC v. Phoebe Putney Health System, Inc.*, the Supreme Court upheld the FTC's 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 the specific authority to explicitly approve the anticompetitive effects of the actions taken.⁹⁵ To qualify for protection under the state action doctrine of immunity, something more was required—the Hospital Authority must show that it had been delegated the “authority to act or regulate anticompetitively.”⁹⁶ The Court found that a statute granting a state or municipality general authority to act could not displace antitrust law.⁹⁷ 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.⁹⁸ This presumably is designed to satisfy both the clear articulation and active prongs of the state action defense, but hardly seems likely to ensure a competitive market for hospital services. As a result, the FTC was forced to drop its merger challenge.⁹⁹

95. *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003, 1015–16 (2012).

96. *Id.* at 1010–12.

97. *Id.*; see also *N.C. State Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101, 1116–17 (2015) (finding that where the Board did not claim that the State exercised active supervision over conduct relating to nondentists distributing teeth whitening services, no specific supervisory systems could be reviewed by the Court).

98. Lisa Schenker, *West Virginia Bill Would Shield Merging Hospitals from Antitrust Laws*, MOD. HEALTHCARE (Feb. 18, 2016), <http://www.modernhealthcare.com/article/20160218/NEWS/160219892> (examining proposed West Virginia legislation that would exempt actions of the State's health care authority, along with actions of hospitals and health care providers under the Authority's governance, from state and federal antitrust law).

99. Lisa Schenker, *FTC Drops Challenge of West Virginia Hospital Merger*, MOD. HEALTHCARE (July 6, 2016),

III. THE NEXT FRONTIER OF THE ACA

The next frontier where these claims of health care exceptionalism are playing out involve the tensions between competition and clinical integration inherent in the ACA.¹⁰⁰ 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 ACA's second, and less politically controversial, goal 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. ACOs provide both carrots and sticks in return for certain forms of cost control, quality assurance, as well as clinical and economic integration.¹⁰¹ Though it incentivizes collaboration and consolidation in the health care industry, the ACA contains an explicit antitrust savings clause that provides no exemptions for ACO formation or operation.¹⁰² A raft of speeches, policy statements, workshops, and publications from both enforcers and lawyers in the private sector sought to provide guidance in this complicated overlap of antitrust and health care regulation but provided few definitive answers.¹⁰³

These tensions played out in the St. Luke's litigation in the District Court in Idaho and the United States Court of Appeals of the Ninth

<http://www.modernhealthcare.com/article/20160706/NEWS/160709960>.

100. 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.); FURROW et al, *supra* note 14, § 13.32.

101. See, e.g., Havighurst & Richman, *supra* note 15, at 871–76 (arguing that the formation of an Accountable Care Organization (“ACO”) should be subject to close antitrust scrutiny); see also Erin E. 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) (describing the goals behind implementing ACOs).

102. Patient Protection and Affordable Care Act, 42 U.S.C § 18118 (2010); see also 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, 212–13 (2016) (discussing and analyzing antitrust merger law).

103. 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., Fed. Trade Comm'n, Bureau of Competition, 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; *Examining Health Care Competition*, FED. TRADE COMM'N, <https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition> (last visited Apr. 23, 2017).

Circuit.¹⁰⁴ In *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System, Ltd.*, a leading hospital chain in Idaho that already employed a number of primary care physicians (“PCPs”) purchased the largest PCP practice group in a nearby city.¹⁰⁵ This horizontal acquisition was driven in part by the cost containment goals and incentives of the ACA,¹⁰⁶ but still remained subject to the full provisions of the Clayton Act, which prohibits mergers and acquisitions that tend to substantially lessen competition. The FTC, the Idaho Attorney General, and a competing hospital challenged the acquisition.

The Ninth Circuit affirmed the district court’s decision that the acquisition violated section 7 of the Clayton Act.¹⁰⁷ The decision relied heavily on internal documents and buyer testimony to establish the likelihood of harm in a highly localized market for primary physician care.¹⁰⁸ The Ninth Circuit also rejected the assertion that the acquisition was either required or justified by the cost-savings provisions of the ACA.¹⁰⁹

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 the wake of the ACA.¹¹⁰ While the Ninth 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 that is found to substantially lessen competition.¹¹¹

104. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 792–93 (9th Cir. 2015).

105. *Id.* at 781–82.

106. There were also vertical aspects to the acquisition that were not discussed in the either the district court or appellate opinions.

107. *St. Luke's Health Sys.*, 778 F.3d at 791.

108. *Id.* at 785.

109. *Id.* at 791.

110. These issues are also playing out in the ongoing DOJ antitrust challenge to the Aetna-Humana health insurance merger. See generally Roger Blair et al., *Hospital Mergers and Economic Efficiency*, 91 WASH. L. REV. 1 (2016) (urging a more economically informed analysis to better shape and reflect the changing health care landscape).

111. 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) (analyzing efficiency claims in horizontal mergers).

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 surprising that these defendants have been reasonably successful in the lower courts, particularly when the Supreme Court usually—but not always—treats health care defendants and defendants from other industries or professions the same.¹¹² Though the Supreme Court usually treats antitrust defendants the same, there is an argument that the application of the law to the facts in health care cases is inevitably different given the pervasive distortions caused by third party payors. But this does not explain why lower courts, and occasionally the agencies, bend or ignore basic antitrust concepts and doctrines. 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.¹¹³

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 goals of economic competition are deemed paramount, then antitrust laws are doing a poor job protecting those values in the health care provider sector. If the health care provider sector truly is different and competition truly does not serve the needs of consumers, providers, and society, then the industry has done an equally poor job making its case before the Supreme Court, 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.”¹¹⁴ 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,

112. See generally *Cal. Dental Ass’n v. FTC*, 526 U.S. 756 (1999) (appearing to allow for consideration on factors other than competitive effect in judging restraints in advertising dental services).

113. See Robert N. Wilkey, *The Non-Negotiable Employment Contract—Diagnosing the Employment Rights of Medical Residents*, 44 CREIGHTON L. REV. 705, 731–32 (2011) (exploring judicial validation of the National Resident Matching Process with respect to the Match exemption).

114. YOGI BERRA, *THE YOGI BOOK: I REALLY DIDN’T SAY EVERYTHING I SAID!* 48 (1999).

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,¹¹⁵ which may produce the worst outcomes. 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,¹¹⁶ but little deference should be shown in 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 payors and information asymmetries. In neither case should a court relax or apply differently the basic antitrust rules when 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.

Whether competition should be diminished to serve a more important public policy is for Congress to decide, and not defendants, their counsel, and courts to consider 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 will return to its long-standing rule of being per se unlawful. Merger investigations, cases, results, and remedies would 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.

In the alternative, society could move toward a more sector-specific health care antitrust policy if it chooses 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

115. Max Huffman, *Competition Policy in Health Care in an Era of Reform*, 7 *IND. HEALTH L. REV.* 225, 269–70 (2010) (noting Professor Christopher Sagers' comments regarding the quiet evolution of special case law for health care, especially hospitals).

116. See generally Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 *J. HEALTH POL. POL'Y & LAW* 939 (2001) (exploring antitrust law's bearing on American health care as a consequence of rapid growth and commercialization once the government became involved as a major purchaser).

seek to have it both ways, with incentives for consolidation and full-throated antitrust savings clauses. Rather, there would be greater reliance on industry-specific guidelines and policy statements and statutory exemptions that would flourish affecting the core, rather than the periphery, of health care markets. This could perhaps extend as far as doctor's "unions" and provide protection for other types of "bargaining" between doctors who are not employees, insurance companies, and other payors.

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.¹¹⁷ Health law antitrust would be more of a defined field and less of a subpart of a general body of antitrust law.¹¹⁸ 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 that operates under its own competitive code of conduct following a detailed market sector inquiry by the United Kingdom's former Office of Fair Trading.¹¹⁹

CONCLUSION

This Essay took 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 do not hold water in other contexts. I share the concerns expressed by Professor

117. Richard M. Steuer, *Counseling Without Case Law*, 63 ANTITRUST L.J. 823, 823–52 (1995); see generally Spencer Weber Waller, *Prosecution by Regulation: The Changing Nature of Antitrust Enforcement*, 77 OR. L. REV. 1383 (1998) (discussing the legal shift in antitrust law and the resulting institutional changes).

118. David Orentlicher, *A Restatement of Health Care Law*, 79 BROOK. L. REV. 435, 455–56 (2014).

119. Groceries Supply Code of Practice 2009, (Eng.) <https://www.gov.uk/government/publications/groceries-supply-code-of-practice/groceries-supply-code-of-practice>; The Groceries (Supply Chain Practices) Market Investigation Order 2009, (Eng.), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461114/GSCOP-Order_v2.pdf; Groceries Code Adjudicator Act 2013, (Eng.), http://www.legislation.gov.uk/ukpga/2013/19/pdfs/ukpga_20130019_en.pdf.

Greaney that thirty years of solicitude is too much and simply note that he expressed these views almost ten years ago.¹²⁰

When the law in action does not match the law on the books, something has to give. The antitrust laws have served society 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.

120. Greaney, *supra* note 70, at 190.