

Health Care Antitrust: Are Courts Adapting to a Complex and Dynamic Industry or Are They Making Exceptions?

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Do courts inconsistently apply antitrust laws when it comes to health care? Is health care afforded a “pass” that has not been afforded to other industries? These are questions to which Professor Spencer Waller answered with a strong “yes” in his article, How Much of Health Care Antitrust Is Really Antitrust?, and has offered several examples from case law on group boycotts, price-fixing schemes, and hospital industry consolidation to support his conclusion.

This Article offers a comment to Professor Waller’s observations: antitrust law has had, and should continue to have, an important role in protecting competition in health care markets. To explain lower court decisions that are seemingly inconsistent with case law in other industries, Professor Waller suggests that courts give health care providers a de facto exemption. But this Article offers a simpler explanation: antitrust cases often rest on facts specific to the allegation, the competitors involved, and the market at issue, and this is perhaps truer in health care than it is in other industries. It is not that courts have given health care providers a pass; it is simply that the complexities of the health care industry, coupled with the legal and economic analyses in these cases, often expose specific facts that can make a great difference to a given outcome. This Article revisits the examples offered by Professor Waller and offers an optimistic outlook for health care antitrust. Courts are armed with the ability to consider the many case-

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and time-specific facts that the health care industry presents, and antitrust enforcement in health care can continue to be effective in the future.

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INTRODUCTION

Antitrust theory and law is founded on a simple principle: competition ensures that goods and services are provided at low prices and high quality. This is true for the United States health care system, just as it is for any other industry. Yet some question whether courts effectively exempt health care providers from antitrust laws, which has subsequently restricted competition, the very thing antitrust laws are meant to protect. Though courts have varied their antitrust decisions in health care over time, there is no trend toward exceptionalism merely because the cases “touch” health care. Rather, health care antitrust cases rest on fact-specific analyses, and courts inevitably must consider the unique and varied characteristics of the health care industry.

In his symposium article, however, Professor Waller argues that courts give health care providers an antitrust “pass” and treat the health care differently than any other industry. Professor Waller states:

[K]ey 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

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.¹

This Article presents an alternative view of antitrust in health care. If it appears that courts lack uniformity, it is not due to logical or legal inconsistency. Instead, it is much more likely that the nature of the health care industry creates specific circumstances and economic issues that vary considerably from one case to the next. Differences in judicial decisions reflect this complicated reality and likely demonstrate careful evaluation of specific facts on a case-by-case basis.

This Article is not an effort to enumerate each and every way in which the health care industry varies or is potentially different from other industries. Nor is it an effort to rationalize each and every decision in the case law. And further, it is not an appeal to regulators, courts, and legislators to carve out new or increased exceptions for the industry. Rather, this Article seeks to point out an important tension in the health care industry: there has been (and continues to be) ambiguity in how patients and health care payors define the price, quality, and “output” of health care services.² As technology and medical practices change, and as health care providers and payors move their organizations toward providing value-based care, case-specific facts concerning price, quality, and output become even more important. Regulators and courts tasked with assessing a proposed transaction or a given contractual arrangement have faced complex issues in their attempt to define the price, quality, and output of health care services in the relevant markets. Being aware of the ongoing complexity and dynamism in the health care industry is critical to understanding much of the seemingly inconsistent variation in the application of antitrust law to health care described in Professor Waller’s article.

Part I of this Article begins by describing why there is so much ambiguity in the health care industry and, at times, conflicting definitions. For example, varying definitions of price, quality, and output necessarily make an antitrust analysis in the health care industry turn on very case-specific facts. Part II of this Article walks through some of Professor Waller’s illustrations and suggests how they highlight the complexities of the industry, as well as efforts by regulators and courts to grapple diligently with the details and nuances of specific cases. Part III of this Article concludes with a discussion of the future—acknowledging that

1. Spencer Weber Waller, *How Much of Health Care Antitrust Is Really Antitrust?*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).

2. As is explained, “output” is often a large basket of outcomes, such as both prolonged health and quality of life. These outcomes can be conflicting, and different parties may not agree on the priority of these outcomes.

medical science and health care economics continue to evolve quickly. It is clear there is a need for regulation to keep up with this evolution and for it be tailored to the realities of the health care industry, but one can nonetheless be optimistic about the continued place for existing antitrust laws in the industry.

I. IS HEALTH CARE DIFFERENT?

Health care *is* different from other industries. The literature cites a bevy of reasons for this conclusion, including the role of third-party and government payors, institutional complexity, uncertainty and risk, asymmetric information, and vertical relationships at various levels of the delivery system.³ Compared to any given industry, some of these may be features that distinguish health care from other industries and, in combination, these features are generally sufficient to set health care apart entirely. This Article is, nevertheless, a bit more agnostic about the specific question: Is health care any different? Virtually every industry or market is “unique” in some way, and determining whether health care is wholly different from other industries is not a particularly productive undertaking. It is more useful to simply acknowledge and parse through the complexities inherent in the health care industry.

This is to say, health care is *certainly* complex, and it is often difficult to discern what it means to provide “good” health care. In health care, yes, it is socially optimal (i.e., procompetitive, proconsumer) for a firm to produce more output at a lower price, but frequently, this must be balanced with a large basket of other desired outcomes.⁴ These many

3. See, e.g., Ernst R. Berndt et al., *Medical Care Prices and Output*, in HANDBOOK OF HEALTH ECONOMICS 119, 122 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (“A number of conceptual difficulties and institutional characteristics of medical care markets, however, make reliable price measurement of medical goods and services particularly difficult and challenging.”); David Dranove & Mark A. Satterthwaite, *The Industrial Organization of Health Care Markets*, in HANDBOOK OF HEALTH ECONOMICS, *supra*, at 1093, 1096 (“No other market of substantial importance violates these three requirements of perfect competition so radically. This justifies the often-made claim that the health care market is ‘different.’”); LISA POTETZ ET AL., MEDICARE SPENDING AND FINANCING: A PRIMER (2011) (noting that Medicare covers 55 million people and is 14 percent of the federal budget); Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 948 (1963) (“This section will list selectively some characteristics of medical care market . . . taken together, they do establish a special place for medical care in economic analysis.”).

4. In general, lower prices, higher quality, and more output are associated with increases in consumer welfare and, therefore, these metrics are often used to assess whether a proposed transaction or contractual relationship has led to either an anticompetitive outcome or a procompetitive, proconsumer outcome. The question is more nuanced in health care antitrust cases. For example, a commonly cited health care policy goal is cost containment. The premise is that “too much” money is being spent on the provision of health care services or that the dollars spent

outcomes are woven together, possibly at competing angles, creating complexities that might affect the issues common to antitrust analysis. Some examples of how complexity and ambiguity arise and grate against some basic economic issues—many of which have direct implications for antitrust analysis, enforcement, and regulation—include:

- In many contexts, very little is known about the human body and the way it works, which leads to uncertainty over whether more medical treatment is better than less medical treatment.⁵ Hence, it is not always the case that more “output” is better in health care.
- Technology continues to improve access to care by enabling medical treatment to be provided in many types of facilities, but the industry still lacks consensus on what types of patients are best treated in certain ways and in what types of facilities is care optimized.⁶ Not every patient needs to receive medical care at a hospital, yet many are treated at hospitals; and not every hospitalized patient needs to be treated at an academic medical center, yet many choose to do so. Such considerations complicate the nature of competition among providers.
- There are differing views about the importance of long- and short-run outcomes from medical treatment, such as the use of more aggressive treatment versus less aggressive treatment and the repercussions for quality of life.⁷ Depending on the issue at

on health care services could be spent more efficiently. This premise, however, runs counter to the general premise in antitrust law that more output (i.e., the provision of more health care services at the same price and quality) is better than less output.

5. For example, in some situations achieving the optimal medical, societal, and proconsumer outcomes may actually necessitate reducing the amount of care provided (i.e., restrict output), something generally considered bad under traditional antitrust theory. See Deborah Grady & Rita F. Redberg, *Less Is More: How Less Health Care Can Result in Better Health*, 170 ARCHIVES INTERNAL MED. 749, 749 (2010) (“In fact, the opposite is true—some measures of health are worse in areas where people receive more health services.”); Tammy C. Hoffmann & Chris Del Mar, *Patients’ Expectations of the Benefits and Harms of Treatments, Screening, and Tests: A Systematic Review*, 175 JAMA INTERNAL MED. 274, 274 (2015) (“The majority of participants overestimated intervention benefit and underestimated harm.”).

6. For example, the literature is mixed as to whether academic medical centers provide higher quality care. See John Z. Ayanian & Joel S. Weissman, *Teaching Hospitals and Quality of Care: A Review of the Literature*, 80 MILBANK Q. 569, 588 (2002) (“[M]ajor teaching hospitals generally offer better care than do nonteaching hospitals.”); Ashish K. Jha et al., *Care in U.S. Hospitals—the Hospital Quality Alliance Program*, 353 NEW ENG. J. MED. 265, 271 (2005) (“[A]cademic hospitals had higher performance scores for acute myocardial infarction . . . but lower scores for pneumonia.”).

7. For example, society may disagree about the appropriate balance between aggressive cancer treatment and quality of life. It may be optimal from the standpoint of an insurer or medical provider to aggressively treat a patient, thereby minimizing the risk of more costly treatments in the future or prolonging the patient’s life. But from the perspective of the individual patient, the

hand, the fact that different treatment protocols could lead to different quality of life outcomes (each with its own benefits) may act as a factor when comparing health care prices and quality across providers. The introduction of a technology that produces higher quality—such as less pain, a fuller restoration of health, or quicker recoveries—may lead a provider to charge higher prices.

- Various aspects of medical care delivery may interact in unknown or unpredictable ways that could affect health outcomes or the overall coordination of care that is required to provide effective treatment.⁸ But this recognition, in turn, has implications for the way health care providers are organized.

The abovementioned examples, combined with the many institutional and economic features of health care (i.e., the presence of government payors, uncertainty and risk, asymmetric information, etc.) breeds immense complexity and variation in contracting relationships (between providers, between providers and payors, and between patients and providers), firm structures, and incentives facing the many actors in health care markets. Trade regulation of the health care industry, whether through enforcement of antitrust law or by other legislation, must as fully as possible account for this complexity and variation.

To be clear, however, this Article does not argue that the complexity somehow leaves health care exempt from the “background rules” that antitrust law is meant to provide.⁹ As Professor Waller rightly observes, an industry is not exempt from normal antitrust law simply on account of complexity, technology, or importance. Rather, complexity merely makes it difficult to assess from a macro perspective whether courts are uniformly applying antitrust law without knowing many more details

medically optimal treatment may degrade quality of life so as to be undesirable from his or her perspective. See Jane C. Weeks et al., *Relationship Between Cancer Patients' Predictions of Prognosis and Their Treatment Preferences*, 279 JAMA 1709, 1709 (1998) (“Patients with metastatic colon and lung cancer overestimate their survival probabilities and these estimates may influence their preferences about medical therapies.”); Julia J. van Tol-Geerdink et al., *Do Patients with Localized Prostate Cancer Treatment Really Want More Aggressive Treatment?*, 24 J. CLINICAL ONCOLOGY 4581, 4581 (2006) (“Our findings indicate that many patients attach more weight to specific quality-of-life aspects ([e.g.,] GI toxicity) than to improving survival.”).

8. For example, behavioral health is often an issue for people with chronic physical conditions. See Steven L. Gortmaker et al., *Chronic Conditions, Socioeconomic Risks, and Behavioral Problems in Children and Adolescents*, 85 PEDIATRICS 267, 267 (1990) (“Analyses confirmed that chronic physical conditions were a significant risk factor for behavior problems”); Danson R. Jones et al., *Prevalence, Severity, and Co-occurrence of Chronic Physical Health Problems of Persons with Serious Mental Illness*, 55 PSYCHIATRIC SERVS. 1250, 1250 (2004) (studying “co-occurrence of physical illness within a representative sample of persons with serious mental illness”).

9. Waller, *supra* note 1, at 3–4.

about each case. In health care, circumstances and facts vary greatly, and applying the same background rules in different cases can lead to different and seemingly contradictory outcomes. One should not be so quick to ascribe the apparent variation to misapplication of the law, when it may be simply a result of very different case-specific facts.

This same line of thinking also applies to the use of the per se and rule of reason standards that designate violations under the Sherman Act. A practice “with no purpose other than to limit competition” is a per se violation of the Sherman Act.¹⁰ The rule of reason analysis, on the other hand, weighs the harm of a practice against its benefits and is applied in cases in which the harm to competition is not blatantly obvious. Identifying per se practices—those that are expected to be unambiguously bad, from which no good can come—requires at least tepid agreement on the socially optimal outcomes and the ways the practices in question have prevented these outcomes. In health care, however, the legal, medical and economic communities do not agree on what is unambiguously bad (or good), which, in many cases, has led to an emphasis on the rule of reason analysis. Thus, a lack of per se determinations in health care antitrust cases may simply reflect acknowledgement of the many cost-benefit tradeoffs that arise due to the complexity of the organizations and institutions that shape the way patients receive medical care. Part II discusses group boycotts and price fixing, which are two examples of these cost-benefit tradeoffs and illustrate the courts’ reluctance to find per se violations.¹¹ Part II also discusses the fact-specific nature of the antitrust analyses performed in hospital merger litigations.

II. EXAMPLES OF HEALTH CARE ANTITRUST AT WORK

Variation in lower courts’ rulings and their reliance on rule of reason are merely byproducts of evolution and complexities in the health care industry—these are not symptoms of health care exceptionalism. This Part makes this case by revisiting three of the examples cited by Professor Waller: (1) group boycotts; (2) price-fixing schemes; and (3) hospital industry consolidation. In the first two examples, the rarity of per se rulings and a mix of decisions (both for and against the alleged

10. *United States v. Am. Express Co.*, 838 F.3d 179, 193–94 (2d Cir. 2016).

11. To preview the arguments below, Professor Waller argues that group boycotts (two or more parties agreeing to jointly boycott another party) and price fixing (two or more parties agreeing to a price outside of a competitive setting) are blatant forms of collusion; hence, they are per se violations. Waller, *supra* note 1. In the next section, it is argued that it is difficult to determine if behavior in the health care industry matches these practices; hence, courts are reluctant to rely on the per se rule.

conspirators) likely reflect careful consideration of the facts and appropriate use of the rule of reason by the courts. In some instances, the courts are following the evolution of medical and economic thought and are responding accordingly; in other instances, the courts are without consensus over what is optimal for the market or for patients and are responding accordingly. In the third example—hospital industry consolidation—the history of hospital merger litigation is not one of inconsistency and “lawless” behavior by the courts, but rather reflects developments in medicine and economic knowledge.

A. Group Boycotts

In Professor Waller’s view, any decision by a group of “competing” physicians to exclude another physician (from a hospital, group practice, or other organization) would be a group boycott.¹² Early on, the courts treated these as per se violations, but later, the courts turned to the rule of reason as their preferred standard for evaluating these claims.¹³ The courts’ maneuvers more or less disregarded established case law, creating a tide of opinions that eventually compelled the United States Supreme Court to agree that these cases should be judged by rule of reason.¹⁴

Rather than lawlessness, this history is illustrative of careful enforcement of antitrust law in health care. Health care antitrust is not an area of the law where a minority set of opinions have overturned well-accepted antitrust rules, thereby allowing the occurrence of obvious violations of the law. Rather, the law in this area reflects how economic thought and the practice of medicine have evolved and become more complex, and how the courts have adapted to consider and account for these changes. For a specific example, a hospital might restrict its radiology department to a single radiology group, which prohibits independent radiologists from working there. The hospital’s decision is not necessarily an anticompetitive conspiracy—it could simply reflect the hospital’s desire to guarantee coverage and the efficient use of its imaging equipment by holding a single group accountable. Moreover, the hospital may be reacting to a shift toward value-based care or rigorous competition from a nearby independent imaging facility, which are both socially desirable outcomes of a dynamic, competitive process. The move toward rule of reason is an affirmation of this sort of complexity

12. *Id.*

13. *Id.*

14. *Id.* (citing *Jefferson Parish Hosp. Dist. v. Hyde*, 466 U.S. 2 (1984)). Professor Waller points out that this ruling still specifies a per se decision, albeit a peculiar one. Still, as he also observes, this per se rule requires additional inquiry that amounts to essentially a rule of reason treatment.

that is commonplace in the health care industry. There is no reason to view this as an abandonment of antitrust law or its respective principles.¹⁵

As the health care industry evolves, the way physicians and other health care providers practice medicine, and the methods that measure their performance are changing rapidly and significantly. Some important changes that already occurred include:

- The practice of medicine becomes more complicated as society's understanding of the body progresses.¹⁶
- Physicians are increasingly specialized now that new techniques exist.¹⁷
- It is now understood that there are pitfalls to evaluating performance by rigid numeric measures, such as simply counting deaths during surgery or rates of readmission at hospitals.¹⁸
- There is a continued movement to emphasize more subjective measures of performance, such as patient satisfaction.¹⁹
- Health plans and hospital systems are focusing on ways to

15. Again, acknowledging and weighing the complexity of the facts within a given case is not the same as making exceptions *because* of the presence of complexity. This Article agrees with Professor Waller on the latter: industries should not be exempt from the antitrust laws simply because of complexity. But in the area of health care, a determination of antitrust liability is likely to depend greatly on the specific facts of the case.

16. For example, "precision medicine" now allows physicians to target treatments at the genetic level, going beyond what was possible even ten years ago. Francis S. Collins & Harold Varmus, *A New Initiative on Precision Medicine*, 372 NEW ENG. J. MED. 793, 794 (2015); J. Larry Jameson & Dan L. Longo, *Precision Medicine—Personalized, Problematic, and Promising*, 372 NEW ENG. J. MED. 2229, 2230 (2015).

17. See Rosemary Stevens, *Trends in Medical Specialization in the United States*, 8 INQUIRY 9, 9 (1971) ("Technological excellence presses toward increasing specialization . . ."); see also GEORGE WEISZ, *DIVIDE AND CONQUER: A COMPARATIVE HISTORY OF MEDICAL SPECIALIZATION* 3 (2006) (chronicling the history of physician specialization over the last three centuries); ASSOC. OF AM. MED. COLLS., *THE ROAD TO BECOMING A DOCTOR*, <https://www.aamc.org/download/68806/data/road-doctor.pdf> (last visited Apr. 19, 2017) (noting that residency and fellowship training can exceed seven years after graduation, indicating the depth of specialization some areas require).

18. See, e.g., Ryan P. Merkow et al., *Underlying Reasons Associated with Hospital Readmission Following Surgery in the United States*, 313 JAMA 483, 483 (2015) (noting that readmission rates are associated with post-discharge complications); J. William Thomas & Timothy P. Hofer, *Accuracy of Risk-Adjusted Mortality Rate as a Measure of Hospital Quality of Care*, 37 MED. CARE 83, 83 (1999) ("Reports that measure quality using risk-adjusted mortality rates misinform the public about hospital performance.").

19. See, e.g., Paul Dolan, *The Measurement of Health-Related Quality of Life for Use in Resource Allocation Decisions in Health Care*, in *HANDBOOK OF HEALTH ECONOMICS*, *supra* note 3, at 1723, 1727 ("[T]he role that individual preferences should play in determining priorities in health and elsewhere is a matter of intense debate . . ."); Paul G. Ramsey et al., *Use of Peer Ratings to Evaluate Physician Performance*, 269 JAMA 1655, 1659 (1993) ("[P]eer ratings provide a practical method to assess clinical performance in areas such as humanistic qualities and communication skills that are difficult to assess with other measures.").

provide value-based health care, which will require providers to bear more risk and collaborate more frequently.

These changes shifted the way physician markets operate and the way health care providers are organized. First, the importance of peer review, clinical integration, and physician coordination continues to increase. Second, and closely related, it is increasingly important to involve physicians and obtain physicians' input to run an effective health care organization (such as a hospital), making it difficult to disentangle the organization's decisions from those of the physicians.

In light of those factors, it is inappropriate to rely on a *per se* standard for many alleged group boycotts. It cannot be enough for a plaintiff to simply establish that a physician was excluded from an organization that included other physicians to call it a *per se* violation. Due to the complicated realities that surround the health care industry, gathering the facts and subsequently understanding their implications requires one to peel back the layers of the "antitrust onion." This process typically reveals a fairly extensive set of questions and issues, which is consistent with what is expected in cases subject to a rule of reason standard. For example, a seemingly innocuous question such as "are the physicians, in fact, competitors?" easily leads one down the rabbit hole of antitrust market definition, because relevant markets for physicians are often very difficult to define.²⁰ Or another question—"what was the nature of the involvement of the allegedly competing physicians?"—can spiral into a long digression about performance measurement and the structure of the organization in question.²¹ And a question such as "is the real dispute between different physicians or between physicians and a hospital (or payor)?" raises inquiries about whether the violation is horizontal or vertical in nature.²²

As the courts recognized the increasing complexity in the health care industry and the evolution of economic thought on the topic, they, in turn,

20. For example, suppose an orthopedic surgeon was excluded from a specialty hospital that was jointly owned by her and ten other independent orthopedic surgeons. As their titles suggest, they all have similar training in the musculoskeletal systems of the body, yet in practice, they may be very different, each focusing on a different subspecialty (e.g., hands, shoulders, ankles, spines, etc.). Without more extensive inquiry (or formal market definition), it may be difficult to determine if the physicians are competitors in the context of an antitrust inquiry.

21. For example, if peer reviews from competitors are one of many factors that decide performance or competitors are only a small minority of voting physicians, it may be unclear if the conspiracy is enforceable. Delving into the specifics of the case is inherently a detailed exercise.

22. *United States v. Am. Express Co.*, 838 F.3d 179, 179 (2d Cir. 2016) ("Vertical restraints 'are generally judged under the rule of reason.'") (citing *Anderson News, LLC v. Am. Media, Inc.*, 680 F.3d 162, 183 (2d Cir. 2012)).

recognized that the alleged “group boycotts” were not really attempts to fix prices or to eliminate a competitor, but rather efforts to better organize and coordinate health care delivery.²³ Analyzing the details of these many factors requires a fact-intensive rule of reason inquiry, and the move toward rule of reason treatment of alleged group boycotts was not simply on a judicial whim; it was because changes in medical technology, market conditions, organizational structure, and economic thought led courts to appreciate the complexity of the inquiry.

Perhaps further to the point, simply observing that courts evolved their standard does not imply that courts then abandoned applicable antitrust principles when analyzing physician markets (or health care more broadly), or that the courts created socially undesirable outcomes. Most physician markets are competitive and regulators are generally focused on hospital and health plan market concentration, and less so on physician market concentration.²⁴ Moreover, antitrust law is still being used successfully to prevent practices similar to those in question. For example, one needs to look no further than a recent landmark case, *North Carolina Board of Dental Examiners v. FTC*, in which the Supreme Court ruled that the State’s dental board, comprising a group of physicians, could not join together (i.e., act as a group) and hide behind state action immunity simply to foreclose and exclude competing providers (i.e., dental assistants).²⁵ In sum, the courts’ track record concerning group boycotts in health care is not one of inconsistency, nor is there evidence that health care markets are worse off as a result. Rather, the courts’ decisions continue to evolve sensibly and their history indicates diligent application of antitrust law in a complex industry.

B. Price Fixing

Professor Waller argues that separate, independent physicians’ efforts to contract together (or otherwise jointly determine prices for their

23. See, e.g., Phillip A. Proger, *Mergers, Virtual Mergers and Consolidation: Hot Business and Transactional Issues*, AHLA SEMINAR MATERIALS (1997) (citing *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438 (11th Cir. 1991)) (“The hospital contended that it denied plaintiff’s application to administer CT scans to preserve the efficient operation of the radiology department and thereby maintain the competitiveness of the hospital.”).

24. See, e.g., Martin Gaynor & William B. Vogt, *Antitrust and Competition in Health Care Markets*, in *HANDBOOK OF HEALTH ECONOMICS*, *supra* note 3, at 1405, 1407 (“Our focus is mainly on hospitals and interactions between hospitals and insurers. This is due, in part, to where there has been antitrust activity. Physician markets have been for the most part very unconcentrated, and as such have not lent themselves to the kinds of anti-competitive conduct the antitrust laws prohibit.”); Martin Gaynor et al., *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LITERATURE 235, 240 (2015) (“The market for physician services is generally unconcentrated.”).

25. *N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1117 (2015).

services) should be viewed as price-fixing schemes and are, therefore, per se unlawful.²⁶ In his view, price-fixing schemes occur far too often, and the United States Department of Justice (“DOJ”) (and perhaps the courts, too) is reluctant to treat these as criminal, rather than civil, violations.

Changes in the health care industry have necessitated greater clinical and financial integration, and these changes have raised a number of important antitrust questions. One of the more important questions is: Is joint price setting required to achieve the desired level of clinical integration? As with alleged physician group boycotts, the many complexities of the health care industry make it difficult to determine what constitutes clinical and financial integration in health care and whether joint price setting is or was necessary. For example, negotiations over physician reimbursements became more complicated as payor contracting moved from indemnity to Health Maintenance Organizations (“HMOs”) and then to Preferred Provider Organizations (“PPOs”), leading to various forms of partial risk sharing. The spectrum between fee-for-service and full-risk contracting will become even broader and more complicated as providers and payors move toward other value-based reimbursement models. Thus, it should not be a surprise that antitrust cases involving clinical and financial integration are treated under a rule of reason standard instead of being universally treated as per se violations.

Consider, as an example, the progeny of the Supreme Court’s 1982 ruling in *Arizona v. Maricopa County Medical Society*, which found that an agreement among competing physicians on maximum fee schedules—which the physicians adopted to promote fee-for-service medicine and to provide patients with an alternative to health plans—was an agreement to fix prices and was therefore per se illegal.²⁷ Since then, the health care industry has experienced the development and acceptance of capitated reimbursement models based on financial integration among groups of physicians. More recently, there is great interest in value-based contracting among large groups of employed and independent physicians. As the delivery of medical care and contracting arrangements between physicians and health plans change, the antitrust concerns change as well. And with those changes, the analyses performed to assess the competitive consequences of new clinical and contractual arrangements also transform.

The key theme of the analyses, however, remains largely the same. Antitrust inquiry continues to revolve around the following questions:

26. Waller, *supra* note 1.

27. *Arizona v. Maricopa Cty. Med. Soc’y*, 457 U.S. 332, 356–57 (1982).

What are the provider incentives under the contract and how much risk is the physician group bearing? As with the questions surrounding group boycotts, the lack of consensus on clinical standards and best practices make these difficult questions even more challenging to answer. To further complicate things, the variety of physician contracting and reimbursement methods problematizes the establishment or enforcement of bright-line tests that specify some minimally acceptable degree of financial integration.²⁸ Without a clear roadmap, it is difficult for regulators to establish catchall guidelines and for the courts to establish exemplary cases that can be used to generalize antitrust enforcement and treatment.

For health care providers, navigating the unknown is not new, but to expect providers to come up with solutions that do not hinge on the specific facts and circumstances of their market is unrealistic. Instead, the industry and the courts should expect physicians and hospitals to respond to buyers' demands for the delivery of low-cost, high-quality medical care by creating new organizational structures, developing new contracting relationships, and building on the local institutions and facilities that currently exist. Thus, any inquiry into the anticompetitive and procompetitive rationales for an agreement that involves clinical and financial integration is likely to depend greatly on local market conditions and case-specific facts. From this angle, it would appear that the regulators' and the courts' approaches, which are based on a rule of reason analysis, are appropriate.

C. Hospital Industry Consolidation

Last are Professor Waller's views on hospital industry consolidation. In his view, in the 1990s, the lower courts endorsed defenses of hospital mergers that stood in clear violation of the background rules of antitrust law.²⁹ He believes these decisions present contradictions in the case law and are a potential danger to future antitrust enforcement.³⁰ Furthermore,

28. See, e.g., Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026, 67,028 (Oct. 28, 2011) ("The Agencies emphasize that [Accountable Care Organizations ("ACOs")] outside the safety zone may be procompetitive and legal. An ACO that does not impede the functioning of a competitive market will not raise competitive concerns. The creation of a safety zone reflects the view that ACOs that fall within the safety zone are highly unlikely to raise significant competitive concerns; it does not imply that ACOs outside the safety zone necessarily present competitive concerns.").

29. For example, Professor Waller cites Carilion Health System's appeal to its nonprofit status as an example of a violation of his fourth background rule. Waller, *supra* note 1.

30. *Id.*

Professor Waller points to recent state actions as “gauzy cloak[s]” used to mask anticompetitive mergers and to carve out exceptions for the health care industry.³¹

Judicial decisions will always be the subject of legal debate and discussion, and the examples cited by Professor Waller do not show that the antitrust laws are failing when it comes to health care or that there is a systematic trend by the courts to give health care providers an antitrust “hall pass.” There is no question that the issues arising in hospital merger challenges evolved with changes in the understanding of health care markets and the tools used by economists to assess potential impacts of a proposed transaction. But legal and economic thinking has progressed because medical delivery has developed; the benefits and cost savings anticipated from many of the proposed transactions reflect underlying medical and technological transformations. Also, essentially all the mergers that United States antitrust agencies challenged in court since 2008 sought to follow a consistent (albeit, sometimes contentious) line of thought, and, since then, the regulators have won all of these challenges.

As is argued above, changes in medical practices and economic thought have been instrumental in driving the evolution of health care antitrust case law. As the courts’ understanding of this complex industry and markets evolved, the case law adapted in suit. To wit, some of the hospital merger decisions of the 1990s that Professor Waller cites raised legitimate economic and legal questions that were important and relevant at the time. But with new research and study, questions from the past are no longer asked and new questions have surfaced. For example, one of the important issues in a 1989 case, *United States v. Carilion Health System*, was the role of nonprofit ownership in tempering the incentive to raise prices to anticompetitive levels.³² In that case, the district court ruled in favor of the merging parties, and one of the factors that weighed in favor of the merging parties was their nonprofit statuses.³³ Since that case was tried, there has been substantial economic research addressing the behavior of for-profit and nonprofit hospitals.³⁴

31. *Id.*

32. *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 846, 849 (W.D. Va. 1989), *aff’d*, No. 89-2625, 1989 WL 157282 (4th Cir. Nov. 29, 1989).

33. *Id.*

34. See William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. ECON. 437, 438 (1995) (examining the differences between for-profit and nonprofit hospital statuses in relation to antitrust regulation); see also Frank A. Sloan, *Not-For-Profit Ownership and Hospital Behavior*, in HANDBOOK OF HEALTH ECONOMICS, *supra* note 3, at 1141, 1153–61; Jill R. Horwitz, *Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals*, 24 HEALTH AFF. 790, 790 (2005) (proposing that for-profit hospitals are more likely to

From 1994 to 2001, the United States antitrust agencies lost every case they brought to court. Although the specific facts of each varied, the central debate of each was over the size of the relevant geographic market. The Federal Trade Commission (“FTC”) and the DOJ’s Antitrust Division were unable to convince the courts of their relevant geographic market definitions, and the courts generally agreed to the larger geographic markets proposed by the defendants. But since 2001, economic research has resulted in the development of new methods to assess hospital demand and geographic market definition.³⁵ Against the backdrop of this body of knowledge and the government’s success in challenging many hospital mergers since 2008, it is arguably unclear whether courts treat hospital mergers differently under the law. Indeed, it is possible that the antitrust vise has more recently been squeezed too tightly.

Finally, on the issue of state action, Professor Waller points to a West Virginia hospital merger challenged by the FTC in 2016.³⁶ There, the West Virginia legislature introduced legislation that could be viewed as shielding the merging parties from antitrust scrutiny under the guise of state action immunity.³⁷ Professor Waller is right to raise the issue, but state action immunity is well established in the body of antitrust law. In some instances, active and appropriate state supervision may be lacking or insufficient, but inadequate state oversight continues to be the subject of antitrust review. And there are not enough examples to draw clear conclusions about the adequacy or inadequacy of state supervision and regulation as an alternative to antitrust enforcement in hospital merger cases. With the FTC’s continuing and appropriate interventions on Certificate of Public Authority (“COPA”) laws and Certificate of Need (“CON”) regulations, the ultimate boundaries of state action are yet to be set. As Professor Waller notes, the issue is an important one and worth watching, but these actions are not necessarily evidence of general

decide which medical services to offer based on profitability); Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121, 124 (2007).

35. *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1055 (8th Cir. 1999); *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). For later research, see Cory Capps et al., *Competition and Market Power in Option Demand Markets*, 34 RAND J. ECON. 737, 738 (2003) (developing an index of the market power of suppliers in option demand markets); Martin S. Gaynor et al., *A Structural Approach to Market Definition with an Application to the Hospital Industry*, 61 J. INDUS. ECON. 243, 244 (2013) (assessing market power in antitrust cases); Robert Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. HEALTH ECON. 733, 733–34 (2001) (framing an analysis for bargaining relationships between hospitals and Health Maintenance Organizations (“HMOs”) under selective contracting).

36. Waller, *supra* note 1.

37. *Id.*

antitrust law failings and judicial error.

III. A FORK IN THE ROAD?

This Article agrees with Professor Waller that there has been evolution in the thinking and standards applied by the courts. Although he makes the case that the lower courts practice antitrust exceptionalism, there is another explanation: antitrust cases in health care are complex matters, with outcomes dependent on case-specific facts that reflect the evolution of a dynamic health care industry. There is variation in case outcomes, but that is the nature of rule of reason analysis, even for conduct that might be (or has been) labeled as a group boycott or price fixing. As long as the outcomes reflect the application of long held antitrust principles and an appreciation of case-specific facts, one should be confident that the outcomes reflect the healthy functioning of the courts and the regulators in enforcing antitrust laws.

The health care industry can certainly continue to expect changes, variation, and complexity moving forward. Medicine continues to evolve and there will continue to be innovation in the way health care is financed and delivered. Legal scholars and economists will have their future work cut out for them because health care policy will continue to evolve as well. As changes continue, industry leaders should continue to ask: How should one think about consumer welfare in health care markets, particularly when there are difficult issues implicated when measuring prices, assessing quality of care and quality of life, and accounting for the benefits of medical innovation that allow for better treatment and improved access to care? In addition, regulatory and policy goals may fluctuate in the future, and varying regimes might make it difficult to adhere to long-term goals. Finally, consumer preferences continually change—what is now popular among patients and providers may not hold in the future.

How does the above analysis and questions affect the health care industry's ability to progress? In short, this Article asserts that the industry should appreciate the notion that situation-specific factors matter greatly in health care, which means that, appropriately, court decisions and interpretation of antitrust law will continue to vary across markets and over time. One should be skeptical that new regulation and regulatory processes can handle the complexity and case-specific nature of competition issues in health care. But the courts are well equipped to do just this, as they are armed with the ability to consider case- and time-specific facts and to apply antitrust law with those facts in mind. The health care industry is not at a fork in the road and it has not lost its way when it comes to antitrust. In fact, applying antitrust in health care is the

road that has always been traveled, and with the right antitrust principles in hand to lead the way, the industry will continue to move forward, not backward.