ANALYZING DAMAGES IN HEALTH CARE ANTITRUST CASES

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I. INTRODUCTION

All damage cases proceed on the basis that liability will be proven at trial. Typically, the damage expert's job is to examine whether defendant's alleged wrongful acts injured plaintiff and, if so, to quantify the amount of the injury. One of the important features that distinguishes antitrust damage cases from other commercial damage cases is the nature of the injury at issue. In antitrust cases, the injury usually stems from a harm to competition. This differs from, say, a tortious interference case where the injury often arises from harm to a competitor only.

Harm to competition means that the process of competition has been injured. Such injury occurs either when prices in a relevant market have increased above competitive levels or when quality in that market has decreased below the level that would be offered under competitive conditions. In contrast, harm to a competitor means that an individual firm has lost some economic advantage—usually profits—that it otherwise would have achieved but for the alleged bad conduct of defendants. This second type of injury can occur even if competition has not been harmed.

Damages in antitrust cases generally take one of two forms. The first form represents harm to buyers of the monopolized product. If the suppliers in a market successfully collude, this will likely cause the prices in that market to increase above competitive levels. The most direct measure of damages to the buyers, therefore, equals the per unit overcharge times the number of units purchased. The second form of damages represents harm to competitors. If suppliers join together and monopolize a market, this may result in other competitors either being substantially foreclosed from the market or prevented from entering in the first place. In either case, these competitors will likely have lost customers, and thus profits. The antitrust laws generally allow

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1 Antitrust injury can also arise from a serious threat of monopolization.

2 Even if harm to competition represents a reduction in quality, an overcharge can still be estimated.
competitors to sue for damages if they can prove that the alleged anticompetitive behavior reduced competition and that they were harmed as a consequence.³

While there are distinct issues raised in calculating damages in health care antitrust cases, the basic approach is generally the same as in other antitrust cases. The first step involves examining whether the alleged anticompetitive behavior caused the injury (i.e., fact of damage).⁴ In any type of antitrust case, this requires establishing that the injury plaintiff suffered is "injury of the type the antitrust laws were intended to prevent . . ."⁵ The second step involves quantifying the damages (i.e., quantum of damage). The analysis of antitrust issues in health care markets is set apart from that in other markets by the complexity of the institutional facts and data. For example, the health care industry is generally characterized by heterogeneous services, differential pricing, and many parties to the buying decision (patients, employers, third party payors, and, to varying degrees, physicians as agents for their patients). In contrast, many other industries (e.g., agriculture and manufacturing) are characterized by much more homogeneous products, a single or narrow range of prices, and simpler buying arrangements.

In this paper, we first discuss rules that are common to analyzing damages in most antitrust cases and, thus, set the basic boundaries for analyzing damages in health care antitrust cases.⁶ These rules are divided into conceptual and empirical rules. The conceptual rules include defining the but-for world, linking the damages to the alleged anticompetitive acts, and breaking out the damages separately by type of claim; the empirical rules include calculating the damages on an incremental basis, controlling for other factors that could have caused the damages, checking the damages for double counts, and adjusting the damages for proper mitigation.

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⁴ Sometimes counsel instructs the damage expert to assume fact of damage.
⁶ These rules derive both from legal precedents affecting how antitrust damages must be analyzed and from sound economic principles.
Second, we review the status of the rules in several recent health care antitrust decisions. The review shows that the conceptual rules played a prominent role in all of these decisions. Third, we describe some of the issues that arise in analyzing damages in health care cases involving harm to buyers. These cases include class action suits as well as suits brought by individual plaintiffs. The unique aspect of these cases is that damages normally include some measure of monopoly overcharge. Fourth, we discuss some of the issues that arise in analyzing damages in health care cases involving harm to competitors. These cases include staff privileges, essential facilities, and tying cases. They are often characterized by the damages representing lost profits from lost patients, both in the past and, sometimes, in the future. Finally, we offer some concluding remarks.

Throughout this paper, it must be kept in mind that every case is fact-specific. Examples presented here are, of course, highly simplified and intended to be illustrative only. Detailed analysis is required for each case before expert opinions can be properly developed and convincingly expressed.

II. RULES COMMON TO ANALYZING DAMAGES IN MOST ANTITRUST CASES

A. Conceptual Rules

1. Defining the But-For World

The first rule that is common to analyzing damages in most antitrust cases is that an expert needs to define what the world would have looked like "but for" the alleged anticompetitive behavior. This so-called "but-for world" provides the benchmark that the expert can use to determine whether plaintiff has been injured and, if so, the extent of the injury.

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7 We selected the recent decisions by running a Lexis/Nexis search for the period 1990 to the present and then examining all of the decisions that dealt with either antitrust injury or antitrust damages and that were published in the Commerce Clearing House Trade Regulation Reports.
Without a well articulated but-for world, the expert has no consistent basis for evaluating whether plaintiff was injured or by how much.\(^8\)

In antitrust cases, it is crucial that the but-for world reflect the characteristics of the actual market and not necessarily the characteristics that would prevail under a model of perfect competition. This distinction is especially important in health care antitrust cases, given the complex and dynamic nature of the industry. Economists have developed a number of different models to explain how markets operate. These models range from the model of perfect competition, with perfect information and no barriers to entry, to the model of monopoly, where effective entry is blocked. The reason that there are so many different models is that the real world is complex and not every model is appropriate for every market. The Court, in *Berkey Photo, Inc. v. Eastman Kodak Co.*, realized this problem and determined that the true measure of damages should not necessarily be based on the price that would prevail under "competitive price theory."\(^9\) Instead, it should be based on the price "which would have been charged in the absence of anticompetitive action" even if it reflects the price of a "monopolist whose position has for the most part been attained legitimately."\(^10\)

It is also important that the but-for world reflect all essential characteristics of the actual market, including any trends or institutional changes occurring in the market--a point especially important in health care. If some essential characteristics are not included, the damage expert may wrongly conclude that plaintiff was injured. For example, if in defining the but-for world an expert failed to account for a reduction in the Medicare reimbursement levels for cataract removal and intra-ocular lens implants, the expert might incorrectly conclude that an ophthalmologist had suffered antitrust injury when in fact the decline in the ophthalmologist's income may have been

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\(^8\) A narrow exception sometimes arises in contract damage cases where the appropriate remedies are specifically defined by the contract. This exception usually does not arise in antitrust cases.

\(^9\) *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263 (2d Cir. 1979).

due solely to the change in the Medicare reimbursement levels. More importantly for counsel, if some essential characteristics of the market are not included, the courts may exclude or find insufficient the expert's evidence on damages.\textsuperscript{11} For instance, the Court in \textit{Merit Motors, Inc. v. Chrysler Corp.} ruled that a motion for summary judgment had been properly granted because plaintiff's damage expert had failed to account for "the impact of the dominant forces in the automobile industry."\textsuperscript{12}

Correctly defining the but-for world is paramount to defending a damage study. At least two different methodologies are frequently mentioned for analyzing damages.\textsuperscript{13} The "before and after" approach compares plaintiff's performance (profits earned or prices paid) \textit{during} the alleged damage period with its performance \textit{before and/or after} the period. That is, the but-for world is assumed to be best reflected by market conditions before or after the period of anticompetitive conduct. The "yardstick" approach compares plaintiff's performance with those of firms or markets that were unaffected by the alleged anticompetitive behavior. In either case, the damage expert is "required to show that the periods, firms, or markets being compared are generally comparable except for the effect of the violation."\textsuperscript{14} Of course, the key to showing that they are comparable is to have correctly defined the but-for world in the first place. That is, the choice of what periods, firms, or markets to compare is based on the expert's definition of what would have happened but for the alleged bad conduct.

\textbf{2. Linking the Damages to the Alleged Anticompetitive Acts}

A second rule is that the damages should be linked to the alleged anticompetitive acts. There are two reasons for this rule. The first reason is that linkage is required for plaintiffs to

\textsuperscript{11} For more details, see American Bar Association, \textit{ABA Antitrust Section, Antitrust Law Developments}, 3d ed. (1992), pp. 673-674.

\textsuperscript{12} \textit{Merit Motors, Inc., et al. v. Chrysler Corp.}, 569 F.2d 666, 673 (D.C. Cir. 1977).

\textsuperscript{13} \textit{Antitrust Law Developments}, p. 671.

\textsuperscript{14} \textit{Ibid.}, p. 671.
establish that they have suffered antitrust injury and thus have standing.\textsuperscript{15} The Court, in \textit{Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., et al.}, ruled that for plaintiffs to have standing "they must prove injury of the type the antitrust laws were intended to prevent . . ."\textsuperscript{16} This requires plaintiffs to show that the alleged anticompetitive acts harmed competition and they were injured as a result.

The second reason why damages should be linked to the alleged anticompetitive acts is that, even if plaintiffs can establish that they have suffered antitrust injury, it is sometimes difficult to tell how much of the damages resulted from the anticompetitive acts. The Court, in \textit{Berkey Photo, Inc. v. Eastman Kodak Co.}, recognized this difficulty.\textsuperscript{17} It ruled that plaintiffs may only recover for the "increment that `flows from' the distortion of the market caused by the monopolist's anticompetitive conduct." It also ruled that the "proper standard [to measure damages] is one that bases damages on the monopolist's actual record of misconduct."

An example should help clarify this rule. Suppose four cardiovascular surgeons are accused of monopolizing a relevant market by allegedly driving out one cardiovascular surgeon and blocking the entry of new surgeons.\textsuperscript{18} The excluded surgeon claims that if he had not been driven from the market, he would have had one-fifth of all referrals. However, this damage claim may be wrong for two reasons. First, there is no reason plaintiff should expect that, but for the alleged exclusion, he would have received an equal share of the referrals. He has to link his lost referrals to the actual mechanism of exclusion and a credible but-for world regarding referral sources. Second, if entry has actually been blocked by the monopolists, this probably means that

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\textsuperscript{15} Another requirement for plaintiff to have standing under Section 4 of the Clayton Act is that plaintiff must also be an efficient enforcer of the antitrust laws. For more details, see the paper by Christopher K. Kay titled \textit{Proving Antitrust Damages: One Step at a Time.}
\textsuperscript{16} \textit{Brunswick Corp.}, 429 U.S. 477.
\textsuperscript{17} \textit{Berkey Photo}, 603 F.2d 263.
\textsuperscript{18} Though the Court of Appeals reversed the trial court on the basis of the geographic market, this hypothetical closely reflects the antitrust damage claim in \textit{Dan A. Morgenstern, M.D. v. Charles S. Wilson, M.D., et al.}, 29 F.3d 1291 (8th Cir. 1994).
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new surgeons would find it profitable to enter in the but-for world. Hence, even if plaintiff would have gotten a proportional "share," he most likely would not have gotten one-fifth of all referrals.

3. Breaking Out the Damages Separately by Type of Claim

The third rule is that damages must often be broken out separately by type of claim. An antitrust complaint usually includes both antitrust and non-antitrust claims. These claims may not be consistent with each other. For example, often the complaint includes both a monopolization claim and a business interference claim, as in one recent case we reviewed involving an anesthesiology group in an urban area. The facts in that case suggested that if the monopolization claim had merit, the caseloads for the plaintiff and another independent physician should have both fallen by roughly the same amount (relative to the alleged monopoly group). On the other hand, if the business interference claim directed solely at plaintiff (i.e., defamation) had merit, only the caseload for the plaintiff should have decreased (after correcting for other market trends). Because plaintiff's damage expert presented a single estimate covering both claims, the damage expert was at considerable risk of having his study thrown out as being speculative, especially if either the monopolization claim or the defamation claim had been dismissed.

B. Empirical Rules

1. Calculating the Damages on an Incremental Basis

Another rule is that the damages should be calculated on an incremental basis. This means that the damages should be based on the additional profits that plaintiff would have earned but for the alleged actions of defendants. These incremental profits should include all lost revenues and all avoided costs. For example, if the plaintiff is a physician and the damage claim involves lost patients, the incremental profits should equal the incremental revenues that the physician would

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19 The case was filed in California Superior Court, County of Sacramento. It settled in 1994 during trial.

20 Plaintiff based his business interference claim on an alleged slander campaign. The facts in the case suggested that, if there was an alleged slander campaign, it was against the plaintiff only.
have earned from treating the lost patients minus the incremental costs that he or she would have incurred from treating the lost patients.

Both the incremental revenues and costs depend, of course, on the size of the increment. For instance, suppose a physician claims that he has been unfairly removed from an HMO panel and that this is alleged to be an antitrust violation. If the physician's practice included relatively few HMO patients and if the alleged action took place for only a short period of time, the physician may not have lost much profit. On the other hand, if the alleged exclusion occurred for a long period of time and covered a large share of his practice, the physician may have lost substantial profit, especially if he can demonstrate that his HMO practice would have grown under the contract (and, of course, if the contract had been a profitable one to have).

The courts, in general, have adopted this rule. They usually require damages to equal lost revenues minus avoided costs. In some cases, however, the courts have accepted lost revenues as the measure of damages. But these situations appear to have occurred only when the avoided costs were very small.

**2. Controlling for Other Factors that Could Have Caused the Damages**

A fifth rule is that the damages should be calculated controlling for other factors that could have caused them. Economists generally use two different approaches to control for other factors. The first approach is multiple regression analysis. This is a statistical technique that helps the researcher to estimate the separate effect of one factor (e.g., the alleged

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21 Even though the physician may not have lost much profit, the incremental profit rate on each lost HMO patient might be fairly high since the physician may have already incurred many of the costs required to treat these patients.

22 Under this scenario, the incremental profit rate might be low since the physician may not have already incurred many of the costs required to treat the lost HMO patients.

23 For more details, see *Antitrust Law Developments*, pp. 670-671.


25 This rule is the empirical counterpart to the "linking damages" rule.
anticompetitive acts) while controlling for the effect of other factors.\textsuperscript{26} The advantage of this approach is that it may allow the economist to test whether the alleged anticompetitive acts are statistically significant, i.e., whether the alleged anticompetitive acts appear to have caused the actual profits earned or prices paid to differ significantly from what they otherwise would have been. The disadvantages of this approach are that it can be very data intensive and it is often hard for a jury to grasp.

The second approach that economists generally use to control for other factors is the "adjustment" approach. This approach involves adjusting the damages for any major trends or structural changes occurring in the market. The goal of this approach is to mimic the multiple regression approach. Economists generally use the adjustment approach when the data required to perform the more complete statistical analysis do not exist. This approach often proves as accurate as the multiple regression approach and it is usually easier for a jury to understand.

3. Checking the Damages for Double Counts

The sixth rule is that the damage calculations should be checked for double counts. These occur when the same damages appear under two different categories. Consider the following example. Suppose a physician claims that an alleged conspiracy forced him to relocate his practice to another city. Further, suppose that the physician is asking the court to compensate him for both the value of lost future patients and the value of lost goodwill. The value of lost future patients represents the profits that the physician would have earned from treating a larger number of future patients had he not been forced to move from his old location. The value of lost goodwill represents the change in the value of his practice resulting from having to relocate his practice to another city.

At first glance, these two damage categories may seem reasonable. That is, it makes sense that if the physician lost future patients and his practice decreased in value as a result of the

\textsuperscript{26} For a more detailed discussion of this technique, see, e.g., Daniel L. Rubinfeld, "Econometrics in the Courtroom," \textit{Columbia Law Review} 85 (1985), pp. 1048-1097.
alleged bad conduct (and consequent relocation), he should be compensated for both losses. However, this is not the case. By definition, goodwill represents the difference between the market value and the book value of the practice. But, also by definition, the market value of a practice equals the discounted value of the profits from the future patients that a physician will treat. Hence, these two damage categories represent a double count--they are both estimating the value of the lost future patients.

4. Adjusting Damages for Proper Mitigation

The final rule is that damages should be adjusted for proper mitigation. This rule is often a concern in cases involving damages suffered as a result of harm to competitors. In these cases, plaintiffs are usually competitors who have lost patients as a result of the alleged bad acts. Generally, these plaintiffs have a legal obligation to properly mitigate their damages. An example should help illustrate this point.

Suppose that an ambulance company accuses its main competitor of monopolizing the market for emergency medical transport services in an urban area. Further, suppose that before the monopolization took place both ambulance companies provided emergency and non-emergency medical transport services--although plaintiff provided very little of the latter. Finally, suppose that after the monopolization took place, plaintiff had an opportunity to provide more non-emergency transports, but chose not to.

In this example, plaintiff has mitigated somewhat by continuing to provide some non-emergency medical transport services. But, arguably, that is not a full and proper mitigation. If plaintiff could have profitably provided more non-emergency medical transport services, it should have done so. As a consequence, damages in this example should be offset by the


difference between what plaintiff actually earned during the alleged damage period and what plaintiff could have earned had it properly mitigated.

III. STATUS OF THE RULES IN RECENT HEALTH CARE ANTITRUST DECISIONS

Two decisions illustrate some of the issues involved in defining the but-for world. Plaintiff in Tafford E. Oltz v. St. Peter's Community Hospital argued that he was excluded from the market as a result of an exclusive contract between the defendant hospital and a group of anesthesiologists.29 In the first trial, the jury ruled that the exclusive contract violated the antitrust laws and that Mr. Oltz, a nurse anesthetist, was entitled to damages covering the period May 1980 through at least the early 1990s.30 However, the judge in the first trial considered the jury's award "excessive" and ordered a new trial on damages.31 Prior to the start of the second trial, the judge in that trial ruled that Mr. Oltz could seek to recover damages only through June 1982 because the defendant hospital and the group of anesthesiologists had signed a new exclusive contract at that time which did not violate the antitrust laws. The Court of Appeals reversed the second trial court's decision and ruled that Mr. Oltz could seek to recover damages beyond June 1982 because the "legality of any subsequent agreements between the conspirators is irrelevant." The effect of this ruling was to redefine the but-for world--in this case, how long Mr. Oltz would have been able to work at the hospital but for the conspiratorial conduct--and, thus, substantially increase damages.

29 Tafford E. Oltz v. St. Peter's Community Hospital, 19 F.3d 1312 (9th Cir. 1994).
30 The decision does not mention specific dates. We have estimated them based on other information listed in the decision.
31 The judge thought that Mr. and Mrs. Oltz might have been a joint venture and he feared that his granting of a motion to exclude the introduction of Mrs. Oltz's income after 1980 may have "contributed to this excessive award" (Tafford E. Oltz, 19 F.3d 1312). The judge's concern is an example of the "adjusting the damages for proper mitigation" rule. If the Oltzes were a joint venture and if the exclusion had caused Mrs. Oltz to earn a larger income than she otherwise would have earned, the damages should have been adjusted to reflect this mitigation. The judge in the second trial resolved this mitigation issue. He ruled that "there was no evidence supporting a joint venture between Mr. Oltz and his wife" (Tafford E. Oltz, 19 F.3d 1312).
In *Jan Purgess v. Nigel Sharrock, et al.*, Dr. Purgess, an anesthesiologist, claimed that the termination of his staff privileges from The Hospital for Special Surgery (HSS) reduced competition among New York-area anesthesiologists. The District Court in that matter ruled that Dr. Purgess did not have standing for his antitrust claims because he failed to offer any proof that competition had been harmed. The District Court also stated that, even if Dr. Purgess did have standing, his damage claim to recover lost earnings was insufficient because he had offered "no evidence" regarding "(1) the life span of anesthesiologists, either in general or at HSS; (2) an anesthesiologist's expected earnings over his or her lifetime, as a general rule or in the New York metropolitan area; and (3) how such earnings should be adjusted to reflect inflation rates, potential changes in the law regarding health care, or other relevant factors." This discussion about "no evidence" is, in effect, a discussion about Dr. Purgess having failed to properly define the but-for world regarding what would have happened to him had he kept his staff privileges. It is clear that the District Court felt that Dr. Purgess' definition of the but-for world did not reflect all of the essential characteristics of the health care market.

A decision that discusses the conceptual rule of linking the damages to the anticompetitive acts is *James C. Hufta, M.D. v. The Children's Hospital of Philadelphia, et al.* Dr. Hufta, a pediatric cardiologist, argued that The Children's Hospital of Philadelphia had illegally curtailed his staff privileges when he moved to another hospital. He also claimed that, as a result of this curtailment, he lost referrals of fetal echocardiogram patients. The District Court ruled that Dr. Hufta did not have antitrust standing because he had failed to provide any evidence showing that the curtailment of his staff privileges caused him to lose the referrals.

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Court went on to say that, even if Dr. Hufta had established antitrust injury, he still wouldn't have had standing since he was not the "proper" enforcer of the antitrust laws.\footnote{For more details about the efficient enforcer criteria, see the article by Christopher K. Kay titled \textit{Proving Antitrust Damages: One Step at a Time}.}

A similar lesson on linking damages to the alleged anticompetitive acts can be found in \textit{Judith Nelson, et al. v. The Monroe Clinic}.\footnote{Judith Nelson, et al. v. The Monroe Clinic, 925 F.2d 1555 (7th Cir. 1991).} In that case, plaintiffs claimed that the merger between two physician clinics in Monroe, Wisconsin increased concentration for health care in that city and resulted in plaintiffs having to travel to another city to receive non-emergency medical care. The District Court granted summary judgment to The Monroe Clinic because plaintiffs had failed "to demonstrate any relationship between any anticompetitive conduct and the denial of care to plaintiffs and their resulting injuries." Specifically, the District Court stated that plaintiffs had been "unable to provide evidence to support' the antitrust violations they alleged, `such as evidence that other former patients have been denied care because of filing lawsuits against the defendant."\footnote{A few years before filing the claim, one of the plaintiffs had brought a malpractice suit against her physician at one of the clinics. She eventually withdrew the suit, but only after switching to a physician at the other clinic. After the two clinics merged, she received a letter from the merged clinic stating that it would no longer treat her or the other plaintiff on a non-emergency basis.} Plaintiffs appealed the District Court's action. The Court of Appeals reversed, stating that the denial of care and the merger were directly linked because, "but for the merger, plaintiffs might still be enjoying services [in Monroe] rather than travelling" to another city.

Plaintiffs in \textit{Dennis W. Austin, et al. v. Blue Cross and Blue Shield of Alabama}\footnote{Dennis W. Austin, et al. v. Blue Cross and Blue Shield of Alabama, 903 F.2d 1385 (11th Cir. 1990). The two named plaintiffs in this case were individuals who had allegedly paid inflated charges.} alleged that the contracts Blue Cross and Blue Shield (BC/BS) entered into with hospitals in the state of Alabama reduced competition in the health, medical and hospital insurance market and caused competing insurers and other patients to pay more for hospital services than BC/BS had to pay.
The District Court granted a motion to dismiss the action finding that plaintiffs lacked "antitrust standing." The Appeals Court affirmed this dismissal, noting that plaintiffs made no allegations that "the contracts between Blue Cross and the hospitals say anything at all as to the rates the hospitals charge to other purchasers." The Appeals Court also noted that plaintiffs made no other allegations explaining how BC/BS's entering into the contracts resulted in competing insurers and other patients paying higher rates. Hence, the Appeals Court ruled that plaintiffs "have made no real showing of a causal connection between their injury and Blue Cross' alleged antitrust violation."

Another decision involving the linking damages rule is *Walter L. Reazin, M.D., et al. v. Blue Cross and Blue Shield of Kansas, Inc.*\(^{38}\) In this case, the District Court found Blue Cross guilty of conspiring with two hospitals to terminate rival Wesley Medical Center's "contracting provider agreement" and awarded Wesley $1,542,920. On appeal, Blue Cross argued that the damages were "speculative and unsubstantiated" because Wesley had provided no evidence showing that its "declining percentage of Blue Cross subscribers resulted from the announced termination." The Appeals Court did not find this argument convincing. It said, "[w]e have carefully reviewed the damages evidence presented in this case and find that Wesley's claimed damages were supported by sufficient evidence."

Finally, in *Dr. Chester A. Wilk, et al. v. American Medical Association, et al.*, four chiropractors claimed that the American Medical Association (AMA) had engaged in various activities to monopolize the market for health care services, particularly care for the treatment of musculoskeletal problems.\(^{39}\) In this case, the District Court concluded that the AMA had unreasonably restrained trade and that plaintiffs had suffered antitrust injury. The District Court based its ruling, in part, on a comparison of "chiropractors' incomes with podiatrists' and


optometrists' incomes (comparable limited license practitioners) over the relevant period of time."
This comparison showed that the chiropractors' incomes had been lower than both. It also
showed that there had been a jump in chiropractors' income during the 1978-1980 period, which
was consistent with "the acknowledged lessening of the boycott by the AMA during this period."
On appeal, the AMA argued that plaintiffs had not provided sufficient evidence for establishing
antitrust injury. The Court of Appeals stated that it was "unpersuaded" by the AMA's argument
about the lack of evidence.

IV. HEALTH CARE ANTITRUST CASES INVOLVING HARM TO BUYERS

A. Overcharge Damages

The first form that damages can take in a health care antitrust case is harm to buyers. If
the suppliers in a health care market join together and successfully monopolize the market, such
conduct will likely cause the prices of the health care services to increase above what would
otherwise be competitive levels. This increase in prices may give rise to overcharge damages to
buyers.

There are two types of buyers that could be harmed in health care markets. The first type
is the direct purchasers of the services. In health care cases, a variety of arguments are raised.
Direct buyers might include the patients who receive the health care services, the employers
paying the insurance premiums, or the insurers paying all or part of the bills. The second type of
buyers is the indirect purchasers of the services. These buyers might include the same parties
listed as direct buyers. One of the important and peculiar complications in health care antitrust
cases is the difficulty involved in defining who the ultimate buyer is. This has consequences for
calculating damages--that is, who actually bears the overcharge.
More importantly for counsel, the difficulty involved in defining who the buyer is also has consequences for determining whether plaintiff has standing.\textsuperscript{40} For example, retail pharmacies recently claimed a horizontal and vertical conspiracy to fix prices by both manufacturers and wholesalers, largely in order to be considered the direct buyers and the bearers of the full overcharge by the court.\textsuperscript{41} Similarly, in cases involving monopolization by health care providers, third party payors may argue that they have standing because they are really direct purchasers given that they often negotiate the prices, pay balance billing settlements, and may pay supracompetitive UCR amounts to monopoly providers.\textsuperscript{42} In contrast, the alleged monopoly providers may argue that the third party insurers have no standing because the patient is the direct purchaser of the health care services. Regardless of who prevails in a given situation, the main category of damages will most likely be overcharge damages.

In what follows, we discuss two examples of health care antitrust cases involving harm to buyers. We start with a hypothetical monopolization case since it helps to identify some of the major issues that a damage expert must consider when evaluating overcharge damages. We then discuss an actual monopolization case, \textit{Blue Cross & Blue Shield United of Wisconsin, et al. v. Marshfield Clinic, et al.}, to illustrate how these issues have recently been addressed in the courts.\textsuperscript{43} Here, we focus on how plaintiffs' handled the issues since defendants put on a rebuttal case only.

\textsuperscript{40} This issue relates to a line of cases following \textit{Illinois Brick Co., et al. v. State of Illinois, et al.}, 431 U.S. 720 (1977).

\textsuperscript{41} \textit{In re: Brand Name Prescription Drug Antitrust Litigation}, MDL 997 (N.D. Ill., 1993).

\textsuperscript{42} UCR stands for usual, customary, and reasonable plans. A private insurance company will usually pay any amount up to the UCR that it has set for that service. Many companies set their UCRs to equal the 90th or 95th percentile of all charges in an area (usually lagged somewhat). If the alleged anticompetitive behavior raised the prices in an area above competitive levels, this could have also raised the UCRs in that area above competitive levels.

\textsuperscript{43} \textit{Blue Cross & Blue Shield United of Wisconsin, et al. v. Marshfield Clinic, et al.}, No. 94-C-0137-S (W.D. WI, January 6, 1995). In our review of this case, we take no position on the merits of the damage analysis since the case is currently on appeal.
B. A Hypothetical Monopolization Case

Consider the following hypothetical. Assume that a hospital has monopolized the market for inpatient acute care services in a relatively rural area. Also, assume that a private insurance company offering indemnity insurance only has filed a monopolization claim against the hospital. How might an expert proceed on damages, assuming, of course, that liability will be shown?

1. Identifying Competitive Benchmarks

After a clear articulation of the but-for world, the first step in evaluating overcharges would be to identify appropriate competitive benchmarks. These benchmarks represent comparable relevant markets that can arguably be used to determine what prices the hospital would have charged but for the alleged monopolization. They are important since they provide the damage expert with a basis for analyzing damages. Of course, the complexity of health care markets heightens the usual debate between experts as to what is truly "comparable."

One approach an expert should generally not take in developing a competitive benchmark in health care markets is to estimate the benchmark based on some measure of the short-run marginal cost of providing inpatient care, i.e., the theoretical, perfectly competitive market standard rejected by the Berkey Court (Section II.A.1. above). There are too many differences from market to market (e.g., product heterogeneity, excess capacity, and price differentiation based on meeting competition for patients) to be able to develop a generic standard that could be used in all markets. Thus, the "price equals marginal cost" test is usually not an appropriate benchmark.

To identify the competitive benchmarks, the damage expert might consider the following steps. First, the expert can conduct interviews to find out what relatively isolated geographic areas to focus on. These areas should be no more competitive than the market being assumed in

44 An alternative approach is to look at pricing before and after the merger. This approach often suffers the problem that the pre-merger world could not have continued as prices may have been too low to sustain both hospitals. Thus, the pre-merger evidence may not always be an appropriate measure of the but-for world.
the but-for world, e.g., in this hypothetical, the benchmark areas should generally include more than one acute care hospital preferably with active, informed buyers participating in the market.\textsuperscript{45} Second, the expert can use hospital patient origin data to identify or confirm the size and similarity of the relevant geographic markets. Third, as further confirmation that the benchmark areas are suitably competitive, the expert can calculate market concentration statistics in each relevant market to check whether the benchmarks are likely to represent competitive outcomes.\textsuperscript{46}

2. Comparing Prices

Once the expert has identified the appropriate competitive benchmarks, he or she is in a position to compare the prices charged in the monopolized market with the prices charged in these more competitive benchmark areas. There are a number of complex issues involved in this comparison, mainly because hospitals and other health care providers have adopted complicated pricing structures to accommodate a wide variety of payors. These issues include: What prices should be compared? Should the prices represent billed amounts or collected amounts? Should the prices represent individual services or standardized measures of output (e.g., revenue per inpatient day)? What criteria should be used to determine if the prices significantly differ? If some of the prices do not significantly differ, how should the results be interpreted?

Which prices to compare and the basis for comparison depend, in part, on the purpose of the comparison. In this section, the purpose is to analyze harm to competition, i.e., whether inpatient prices in the allegedly monopolized market are at supracompetitive levels.\textsuperscript{47} This step is

\textsuperscript{45} One of the lessons learned from \textit{Berkey Photo} is that the but-for world should be \textit{no more competitive} than the market that would have prevailed absent the antitrust violations (Section II.A.1. above). If benchmarks from areas that are agreed by all to be fully competitive are used to show that the alleged monopoly prices are the same or lower than prices in more competitive areas, this comparison strengthens defendant's case but is probably an unnecessarily high standard under the teachings of \textit{Berkey Photo}.

\textsuperscript{46} Although the concentration statistics will not prove whether a market is monopolized, they can normally be used to rule out monopolization. This is the approach that the Department of Justice and Federal Trade Commission normally use when analyzing mergers.

\textsuperscript{47} In the next section, the purpose is to analyze the alleged overcharges.
necessary since establishing harm to competition is a prerequisite for evaluating whether plaintiff was injured and, if so, the extent of the injury.

In general, the preferred procedure is to use collected or reimbursed amounts, which reflect actual transaction prices. These amounts are often compared on both a per-service basis and an aggregated, standardized measure of output basis. The goal is to derive a transaction price that reflects the relevant product that has allegedly been monopolized—in this simplified case, inpatient hospital services. When analyzing harm to competition, the appropriate prices are those that can be set by the hospital, such as fee-for-service, PPO, and HMO prices. This is because hospitals usually have no control over Medicare or Medicaid prices. Similarly, the appropriate measure of price for examining harm to competition is total reimbursements from all sources, e.g., the insurer and the patients paying for the hospital services. These data are often very difficult to measure, particularly in the competitive benchmark areas, since the balance billing policies and collections from patients are hard to identify and quantify. If these sources are not available, some proxy, such as billed charges, is sometimes adopted but this is appropriate only if it can be established that these charges are a reasonable measure of the total amounts reimbursed. This is usually difficult since differences in payor mix, managed care contracting, and hospital ownership may lead to varying degrees of cost shifting to indemnity payors.

The unit of comparison can also be a complex issue. Most health care outputs are priced on a per-service basis. For example, hospitals often set their list prices on a charges or fee-for-service basis. Likewise, physicians usually set their prices on a CPT, ICD-9 procedure

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48 Pricing should not be confused with reimbursement. Some patients and insurers do pay a hospital's billed charges. However, hospital services for patients covered by Medicare, some Medicaid programs, and even some insurance programs are reimbursed on a diagnosis related group (DRG) basis. The unit of reimbursement for these patients is a per-discharge flat fee for each DRG. Another reimbursement method for hospital services is per-diem rates, as often negotiated in managed care contracts. Overcharges are possible on these rates as well, which creates an added complication in establishing competitive benchmarks by payor type.
code, or Medicare HCPCS basis. These per-service prices are likely to be used to analyze harm to competition because they are often the only data available. However, individual services do not usually represent a true measure of the relevant product being sold by the provider. They are usually too narrowly defined. Thus, if the relevant product market is thought to be OB hospital services, measuring antitrust injury using a single service—such as a normal delivery—is only appropriate if it can be shown that this single service is a reasonable proxy for the relevant product. It is generally recommended that the expert use as many of the services that make-up the relevant product as possible.

Comparing prices on a per-service basis and then aggregating is useful because it is often the most direct way of determining whether competition has been harmed. However, prices should also be compared on an aggregated, standardized measure of output basis, especially since such a measure may more closely reflect the "true" transaction price for the relevant product at issue. Moreover, the alleged monopolization in our hypothetical may not have had a large effect on individual prices. Instead, it may have resulted in the hospital producing more services than it otherwise would have (i.e., "unnecessary services"). One possible standardized measure of output that could be used for our hypothetical to capture this effect is revenue per inpatient day.

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49 CPT and HCPCS stand for current procedural terminology and HCFA common procedure coding system, respectively. (HCFA is the acronym for Health Care Financing Administration.) ICD-9 represents the ninth version of the International Classification of Diseases' coding system.

50 There are two caveats to this recommendation. First, in order to compare prices, the expert is constrained to using only those services for which data can be provided in both the monopolized market and the competitive benchmark areas. Second, the expert should rely more heavily on those services that are commonly provided to avoid the problem that the observed prices are not representative of what a typical patient would pay.

51 This problem is usually not significant in hospital monopolization cases since hospitals have a limited ability to influence the number and types of services ordered for patients. It is more likely to be significant in monopolization of physician services cases, where physicians may treat patients for an extended period of time and can more easily influence the number and types of services rendered.

52 Another possible standardized measure is revenue per adjusted patient day. This is the output measure often used by hospitals to summarize and compare revenues from both inpatient and outpatient services. Which standardized measure is preferable depends, of course, on the definition of the relevant product market. Our hypothetical above assumes the simplified relevant product market which is often used by the antitrust agencies as their initial screening device for hospital mergers, i.e., the cluster of inpatient acute care services.
If the alleged monopolization has allowed the hospital to raise prices and produce many unnecessary services, the revenue per inpatient day in the monopolized area will likely be significantly greater than in the competitive benchmark area. Of course, to make this comparison valid, the figures would need to be adjusted for differences in case mix and, perhaps, for payor mix.

Even if the alleged monopolization has taken place, we would not expect a comparison of prices to show that every price in the monopolized market is significantly greater than in the competitive benchmarks, especially when per-service prices are used. Hospitals provide many services that represent complementary services. These are services that are required for most any type of hospital stay (e.g., hospital rooms, blood tests, injections, etc.). Economic theory suggests that, even if the hospital has monopolized the market, it might have an incentive to charge competitive (or but-for) prices for these complementary services.\(^5\) In addition, hospitals bundle many of their services and may use sophisticated strategies to price the bundles. Economic theory also suggests that, even if the hospital has monopolized the market, it might have an incentive to charge competitive (or but-for) prices for some of the unbundled services.\(^4\) For these reasons, if the alleged monopolization has taken place, we would expect a comparison of prices to show that some prices in the monopolized market are about the same as in the competitive benchmarks, whereas others are significantly greater. Aggregation over the group of services making up the relevant product minimizes this problem.

### 3. Evaluating Overcharges

When analyzing the existence and extent of *injury to the insurer*, the relevant price is the reimbursement amount actually paid by the insurer. This is the amount that can be used to examine whether the hospital overcharged the insurer for inpatient acute care services. In this

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hypothetical, there are two potential sources of overcharge damages.\textsuperscript{55} The first arises from higher reimbursement prices. That is, in the but-for (competitive) world, the hospital would have most likely charged lower prices and the insurer would have most likely paid smaller reimbursement amounts. Thus, the first source of overcharge damages represents the difference between the actual reimbursement amounts and the reimbursement amounts based on the prices from the competitive benchmarks.

The second possible source of overcharge damages to the insurer is balance billing settlements. Sometimes, when the insurer pays only part of the hospital bill, the enrollee is liable for the remainder of the bill. If the hospital tries to take legal action against the enrollee for some portion of the unpaid bill, the third party insurer may step in and settle the unpaid bill with the hospital. If the alleged monopolization had taken place, we would expect that there might be more balance billing disputes than otherwise would have been the case.

C. An Actual Monopolization Case

This recent health care antitrust case involved an alleged monopolization of several markets for physician services in central and northern Wisconsin.\textsuperscript{56} Plaintiffs, Blue Cross & Blue Shield United of Wisconsin (BC/BS) and its HMO (Compcare), claimed that through internal growth, acquisitions, affiliated provider agreements, and other means the Marshfield Clinic and its HMO (Security Health Plan) had been able to control the behavior of physicians in the areas in question and exclude Compcare's entry.\textsuperscript{57} Plaintiffs also claimed that these anticompetitive acts resulted in two types of damages: (1) overcharge damages from Blue Cross & Blue Shield

\textsuperscript{55} This discussion assumes that the alleged monopolization had a significant effect on individual prices only. If the monopolization also resulted in the hospital producing "unnecessary services," the methodology discussed in this section would have to be supplemented.

\textsuperscript{56} Blue Cross & Blue Shield United of Wisconsin, No. 94-C-0137-S. In our review of this case, we take no position on the merits of the damage analysis since the case is currently on appeal.

\textsuperscript{57} The Marshfield Clinic is one of the largest physician clinics in the U.S. It is a multi-specialty clinic and employees over 400 physicians. These physicians are located at the main campus in the City of Marshfield and at several satellite clinics located throughout central and northern Wisconsin. The affiliated provider agreements refer to agreements between Security Health Plan and non-affiliated physicians.
paying higher reimbursement amounts than it otherwise would have had to pay and (2) exclusion damages from Compcare not being able to enter the "monopolized" markets (i.e., lost profits on lost premiums).

Plaintiffs' damage expert used a three-step procedure to calculate overcharge damages. The first step involved identifying a competitive benchmark area. The area he selected was the Eau Claire area, which is located in the northeastern part of the state approximately 70 miles from the City of Marshfield. The expert chose this area because (1) it had economic and demographic characteristics similar to the Marshfield Clinic's service area, (2) it exhibited some degree of competition in the provision of physician services, and (3) it provided a wide range of physician services.\textsuperscript{58}

The second step involved computing percentage overcharges for primary care, pediatrics, and specialty care physician services--the relevant product markets being asserted. To make the calculations, the expert first identified the specialties of all of the physicians in each "monopolized" area and in the Eau Claire area. He then grouped the physicians by area and by specialty to determine which common procedures (based on CPT codes) each group had performed. Next, he computed the percentage overcharges for each group by comparing the actual BC/BS reimbursement amounts in the monopolized areas with the BC/BS reimbursement amounts in the Eau Claire area. Finally, he created a single percentage overcharge for primary care, pediatrics, and specialty care physician services by taking an average of the appropriate percentage overcharges for each of the "monopolized" areas.\textsuperscript{59}

\textsuperscript{58} One difficulty with choosing Eau Claire as the benchmark area was that plaintiffs' liability expert had claimed that the area was part of the relevant geographic market that had been monopolized. The damage expert defended the use of Eau Claire by arguing that it was a fringe area of the relevant geographic market and that competition can occur in such fringe areas even if the relevant geographic market has been monopolized.

\textsuperscript{59} Plaintiffs' liability expert identified sixteen categories of physician services that the Marshfield Clinic had allegedly monopolized. These included primary care, pediatrics, and fourteen specialty care categories. For purposes of computing a percentage overcharge for specialty care physician services, plaintiffs' damage expert took an average of an average. That is, he first took an average of the specialty care overcharges within each area and then he took an average of the resulting figures across each area.
Finally, the last step that plaintiffs' damage expert used to calculate overcharge damages involved multiplying the amount of money that BC/BS had reimbursed to the Marshfield Clinic for primary care, pediatrics, and specialty care services by the percentage overcharges. Because there were different percentage overcharges for each year, he performed the multiplication separately for each year. Based on this three step procedure, he estimated that, for the period 1990 to 1993, overcharge damages equaled $1.085 million.

Judge Shabaz, the District Court judge, bifurcated the trial into a liability phase and damage phase. The liability phase began on December 12, 1994 and ended near the end of the month with the jury finding that defendants had monopolized separate relevant markets for primary care, pediatrics, and specialty care physician services as well as for HMO health insurance. At the beginning of the damage phase, counsel for plaintiffs offered the jury an alternative overcharge methodology--in addition to the one sponsored by his damage expert. This alternative consisted of taking the total amount of money that BC/BS had paid the Marshfield Clinic over the past six years and multiplying it by the percentage difference between the Marshfield Clinic charges and the "comparable" average statewide charges. It resulted in overcharge damages of $10.5 million (before trebling). On January 6, 1995, the damage phase ended and the jury awarded plaintiffs this alternative amount.

At the end of the trial, defendants filed a motion asking the court either to overturn the jury's verdicts or to grant new trials on liability and damages. After considering the defendants' motion (and plaintiffs’ opposing motion), Judge Shabaz ruled that the basic liability verdict should stand and that equitable relief was needed.60 He also ruled, however, that a new trial on

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60 The equitable relief included: (1) restricting the types of agreements that the Marshfield Clinic and Security can enter into with other health care providers and (2) requiring that the Marshfield Clinic make its physicians available to Compcare at "competitive prices."
damages should be held unless plaintiffs agreed to accept his proposed remittitur for a lower overcharge damage amount. He stated:

A remittitur is appropriate in the case . . . [because the overcharge] damage award is clearly excessive, totally monstrous, contrary to the evidence presented at trial and based on a figure lacking adequate foundation. . . . The damage award to Blue Cross lacks testimony relating to the relevant markets and those markets in which defendants had market power. Without this information there is no casual link between essential elements of the cause of action and the damage award. Defendants are liable only for those damages directly caused by their illegal conduct. They are not liable for a percentage of all payments made to them by Blue Cross. Such an amount could reflect payments that are not the result of defendants' illegal conduct.

V. HEALTH CARE CASES INVOLVING HARM TO COMPETITORS

A. Lost Profits on Lost Patients

The second form that damages can take in a health care antitrust case is harm to competitors. If a group of suppliers monopolizes a market, such conduct may result in other competitors being partially or completely excluded from the market. This exclusion may give rise to lost profits on lost patients.

B. A Hypothetical Staff Privileges Case

To illustrate the issues involved in analyzing damages in this type of case, we will discuss a somewhat hypothetical case involving the alleged monopolization of anesthesia services in an urban area. Assume that plaintiff, an anesthesiologist, claims that the formation of a corporation and the implementation of a "pure request" system (i.e., a scheduling system requiring surgeons to choose which anesthesiologist to use) allowed his competitors to monopolize the market for anesthesia services at the hospital where he worked. Also, assume

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61 Judge Shabaz recommended that overcharge damages be lowered to $594,277, an amount derived from plaintiffs' damage experts' testimony. The Judge let stand the exclusion damage amount because he did not feel that this award was "unreasonably high."

62 This is a "somewhat" hypothetical case because the stylized facts come from an actual staff privileges case that we worked on. The actual case was filed in California Superior Court, County of Sacramento and it settled in 1994 during trial.
that as evidence of antitrust injury, plaintiff shows that his actual annual caseload dropped dramatically starting in the first year of the alleged damage period. Further assume that defendants, who include most (but not all) of the other anesthesiologists who worked at the hospital, argue that prior to forming their group, the anesthesiology department had experienced serious quality and service problems and that the hospital had threatened to close the department by signing an exclusive contract with an outside anesthesiology group.

1. Choosing the But-For World

Analysis of damages in this type of case usually proceeds by the expert choosing a but-for world and then comparing plaintiff's performance in the actual world with his performance in the but-for world. The choice of the but-for world, of course, can have a dramatic impact on the expert's conclusions. In this hypothetical, there are at least two possible but-for worlds.

The first is a world that includes the old rotation system. Before the implementation of the pure request system, a scheduling nurse assigned anesthesiologists to surgical cases based on a rotation system. The principle behind this system was that every anesthesiologist would be assigned to approximately the same number of cases. If the expert adopted this but-for world, it would allow him or her to argue that, but for the alleged monopolization, plaintiff would have worked on the same number of cases and earned the same amount of money as he actually did under the old rotation schedule.

A second but-for world is a world that includes a closed anesthesia department. The assumptions in this hypothetical indicate that, but for defendants' actions, the hospital might have closed the department and contracted exclusively with an outside anesthesiology group. If the hospital had closed the department, this would have prohibited plaintiff from practicing at the hospital unless, of course, he joined the group that won the contract (which, in the actual case, he said he would never do). Under this but-for world, even if the alleged monopolization had taken place, plaintiff would not have been injured and there would have been no damages.
2. Investigating Alternative Explanations

As evidence of antitrust injury in this hypothetical, plaintiff has produced data showing that his actual annual caseload dropped dramatically starting in the first year of the alleged damage period. Although this evidence seems consistent with plaintiff’s monopolization claim, it is insufficient to prove the claim. There could be other "competitive" explanations for the drop. In this hypothetical, there are four possible alternative explanations.

The first alternative explanation is that the annual caseload may have dropped because plaintiff had serious service and quality problems. This explanation is consistent with the drop first occurring when the pure request system was implemented, since before that time the surgeons had to work with whichever anesthesiologist the scheduling nurse assigned to them. To test this explanation, the damage expert could compare plaintiff's caseload with the caseload of the other independent anesthesiologist who also worked at the hospital. If the alleged conspiracy caused the drop in plaintiff's caseload, it should have also caused the other independent anesthesiologist's caseload to drop by a similar amount. But, if the service and quality problems caused the drop in plaintiff's caseload, the other independent anesthesiologist's caseload should have remained about the same (after correcting for other market trends).

A second alternative explanation is that plaintiff’s annual caseload may have dropped as a result of some "common" factor that was unrelated to the alleged conspiracy. For example, in an effort to cut medical costs there could have been a general trend to substitute nurse anesthetists for anesthesiologists whenever medically possible. To test this explanation, the damage expert could compare plaintiff's caseload with defendants' caseloads. If the alleged conspiracy caused the drop in plaintiff's caseload, it should not have had much of an effect on defendants' caseloads (after adjusting for other market trends). But, if some "common" factor caused the drop in the plaintiff's caseload, it should have also caused a similar drop in defendants' caseloads.
Another alternative explanation is that the annual caseload may have dropped because plaintiff started working on more complicated cases. In general, the difficulty of a case can be measured by the number of anesthesia units charged for the case.\textsuperscript{63} Difficult cases, involving complicated inductions and/or taking a long time, have more units than simple cases. If plaintiff started working on more complicated cases, his annual caseload would have dropped even though his annual number of anesthesia units (and thus his annual income) would have remained about the same. To test whether the data support this explanation, the damage expert could compare the annual number of units in the pre-damage period with the annual number in the damage period.

Finally, the last alternative explanation is that, even if plaintiff's annual caseload is linked to the alleged anticompetitive acts, his monthly caseload may not be. Plaintiff's evidence of antitrust injury is based on annual caseload data only. If daily, monthly, or quarterly caseload data exist, it should also be examined. If this other data showed that plaintiff's caseload did not drop until nine or ten months after the start of the alleged damage period, this would tend to support the conclusion that some "unique" factor unrelated to the alleged conspiracy--for example, the filing of a wrongful death suit against plaintiff--may have caused the drop in plaintiff's annual caseload.

3. Examining the Assumptions of the Damage Model

Assuming that the damage expert could establish antitrust injury in this hypothetical, the expert might calculate damages by subtracting plaintiff's actual income from his but-for income. To implement this method, the expert would have to make a number of assumptions. These include: (1) choosing the measure of but-for income, (2) selecting the length of the damage period, and (3) deciding whether plaintiff properly mitigated.

\textsuperscript{63} The fee that an anesthesiologist charges for a case generally equals a fixed amount plus a price per unit times a number of units. The price per unit usually does not change from case to case. On the other hand, the number of units can vary substantially based on the complexity of the procedure.
There are at least two possible measures that the expert could use to measure the but-for income. The first is the average income that anesthesiologists, who had the same experience and worked in roughly the same geographic area, actually earned during the alleged damage period. This type of information can be gathered from a number of public sources, including American Medical Association publications and *Medical Economics*. The problem with this type of information is that it may not be representative of what the plaintiff would have actually earned. The plaintiff's training, mix of patients, location of practice, and competitive conditions may differ substantially from the average physician on which the information is based. Further, the assumed but-for world may substantially differ from the average physician's circumstances, thereby making the comparison inappropriate.

A second measure of but-for income is the actual income that the plaintiff earned before (and perhaps after) the damage period. This measure helps to control for the actual circumstances surrounding plaintiff's own practice. But even this measure has problems. For example, which pre-damage years should be used to measure the but-for income? The magnitude of the but-for income may be very sensitive to the choice of years. Similarly, how should the actual income be adjusted to account for trends occurring in the market? If there are upward or downward trends but the data are not adjusted, this would cause a bias in the damage estimates.

The next assumption that the expert would have to make involves the length of the damage period. The length of the damage period depends, in general, on how long it will take plaintiff to fully recover. In some situations, plaintiff may never fully recover and the damage period may extend out for many years (e.g., until plaintiff retires). But in this hypothetical, the damage period would most likely end upon the conclusion of trial. The alleged anticompetitive acts in this example consist of two distinct acts: the formation of the corporation and the implementation of the pure request system. If the court found that these acts had allowed

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64 The survey's accuracy may also vary by specialty, year, location, and other factors and, thus, may be generally informative but not directly applicable without additional support.
defendants to monopolize the market, it is unlikely that the court would allow them to continue. Instead, the court would probably dissolve the corporation and reinstate the rotation system. The court's relief would likely stop any future damages.

Finally, the last assumption that the expert would have to make involves whether the plaintiff properly mitigated. In this hypothetical, the plaintiff mitigated by continuing to work at the hospital where the alleged monopolization took place. Arguably, this was not proper mitigation. There are many other hospitals in the surrounding urban area where plaintiff could have either found full employment or worked part-time as a locum tenens. The plaintiff, in both of these situations, would have earned more money than he actually earned. In addition, there is an active national job market for physician services and the plaintiff, had he chosen to, most likely could have found full employment in some other area.65

VI. CONCLUDING REMARKS

Analyzing damages in health care antitrust cases involves many of the same elements as analyzing damages in other antitrust and complex commercial cases. However, as with all generalizations, the "devil is in the details." The institutional differences and the complexities created by heterogeneous products, differential pricing, and the agency relationship among patients, physicians, and third party payors can affect how these markets function. This makes analyzing damages in health care antitrust cases a case-by-case issue requiring careful attention to the way in which competition has been harmed, if at all, and how this harm translates to injured buyers or competitors.

An additional theme, which is true for all antitrust cases, is that there must be consistency between the liability testimony and the damage testimony. Many times counsel will hire different

65 This hypothetical assumes that liability has been shown in a narrow, one hospital market. Such a small relevant geographic market is generally implausible. In this particular case, the market for anesthesiology services covered at least a large urban area and was arguably a national market given the way anesthesiologists are recruited and the way exclusive anesthesia contracts are bid for.
experts to testify on liability and damages. These experts may use different assumptions, methods, and data. If so, these differences may undercut each other's testimony. One way to minimize this problem is to be sure that both experts agree on the same but-for world. This ensures that the experts start their analyses from the same point. It also constrains the experts to consider all aspects of the case. A consistent but-for world is usually the key to convincing damage testimony.