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Antitrust in the Early 1990's: Challenges to New Competitive Strategies

*Alan P. Sherbrooke**

The early 1990's saw the usual antitrust cases involving restrictions on medical staff privileges, claims of antitrust immunity based on state action and the Local Government Antitrust Act,¹ and exclusive contracts. It also produced a Supreme Court decision, *Summit Health, Ltd. v. Pinhas*,² holding that there is no interstate commerce defense in a staff privileges case.

The interesting antitrust cases, however, arose out of the efforts of healthcare providers and healthcare plans to compete more vigorously and aggressively. In general, the courts have been skeptical of claims that the defendants actually harmed competition in a relevant market, and have allowed firms that had legitimate business justifications for their conduct to compete aggressively.

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1. 15 U.S.C.A. §§ 34-36 (West Supp. 1992).

2. 111 S. Ct. 1842 (1991). In this case, Dr. Pinhas alleged that a hospital and its medical staff (petitioners) conspired to drive him out of business "because he refused to follow an unnecessarily costly surgical procedure." *Id.* at 1844. The Supreme Court granted certiorari "to consider petitioners' contention that the complaint fails to satisfy the jurisdictional requirements of the Sherman Act . . ." *Id.* The petitioners argued that "there is no factual nexus between the restraint on this one surgeon's practice and interstate commerce." *Id.* at 1847.

The Court concluded that proof of unlawful effects is not required to establish a Sherman Act violation. *Id.* at 1847-1848. In addition, the Court stated (without elaboration or support) that the boycott would, if successful, cause a reduction in the total provision of ophthalmological service in the Los Angeles market, and that jurisdiction could therefore be based on "a general conclusion that the defendants' agreement 'almost surely' had a market-wide impact and therefore an effect on interstate commerce . . ." *Id.* at 1847. In a sweeping conclusion, the Court stated: "The competitive significance of respondent's exclusion from the market must be measured, not just by a particularized evaluation of his own practice, but rather, by a general evaluation of the impact of the restraint on other participants and potential participants in the market from which he has been excluded." *Id.* at 1848.

I. COMPETITION BETWEEN HOSPITALS AND OUTPATIENT FACILITIES

*Tarabishi v. McAlester Regional Hospital*³ involved competition between a hospital's outpatient surgery department and the outpatient surgery center owned by Dr. Tarabishi, a physician who had staff privileges at the hospital. The hospital opposed Dr. Tarabishi's certificate of need application and initiated several investigations and reviews of his cases, culminating in the revocation of his surgical and emergency room privileges less than two months before his center opened. Because his privileges had been curtailed, Dr. Tarabishi could not treat patients at the hospital who had been transferred there from his center. There were no other hospitals in the area, and Dr. Tarabishi's center eventually closed.

Dr. Tarabishi contended that the actions of the hospital and a group of physicians (the "Clinic") constituted (a) monopolization of surgical care by the hospital, (b) attempted monopolization of non-surgical and office health care by the Clinic, and (c) a conspiracy to monopolize and to restrain trade between the hospital and the Clinic.

The Tenth Circuit Court of Appeals affirmed the district court's conclusion (after a nine week trial) that the monopolization claim against the hospital failed because the plaintiff did not prove market power. First, the plaintiff's expert testified that the relevant geographic market was the area within 30 miles of the hospital, based on the fact that 84% of the hospital's patients came from that area.⁴ The court rejected this as an inadequate basis for a geographic market definition because the expert "did not take into account whether patients who lived within the 30-mile radius went elsewhere than [the hospital] for surgical health care services."⁵ Second, the plaintiff "simply failed to present any evidence about the Hospital's power to control prices, a critical element of proof of monopoly power in this circuit."⁶

The Tenth Circuit also affirmed the trial court's adverse ruling on the attempted monopolization claim against the Clinic. Again, the court ruled that the plaintiff had failed to prove a relevant market, this time because the plaintiff's expert excluded physicians

3. 951 F.2d 1558 (10th Cir. 1991).

4. *Compare Bhan v. NME Hosps., Inc.*, 929 F.2d 1404, 1407 (9th Cir. 1991) ("It is generally accepted in the health industry and uncontested in this case that hospitals within thirty minutes traveling time of each other compete for patients.")

5. 951 F.2d at 1567.

6. *Id.* at 1568.

who lived within the 30 mile radius but did not practice in the town where the hospital was located. Furthermore, there was no evidence of the Clinic's ability to exclude competition and to control price.

The Tenth Circuit affirmed the adverse judgment on the Sherman section 1 claim on the ground that (1) there was no per se violation because denial of staff privileges through peer review "is not an activity 'likely to have predominantly anticompetitive effects' such that per se treatment is necessary"⁷ and (2) there was no rule of reason violation because the plaintiff failed to prove a relevant market within which there was injury to competition. The court concluded that the plaintiff had failed to "prove that Dr. Tarabishi's inability to use the facilities at the Hospital affected competition, as opposed to Dr. Tarabishi himself as a competitor."⁸

7. *Id.* at 1571.

8. *Id.* The Tenth Circuit rejected the hospital's claim of antitrust immunity under the Local Government Antitrust Act ("LGAA"), 15 U.S.C.A. §§ 34-36. The court distinguished the numerous cases from other jurisdictions that have held that public hospitals are protected by the LGAA. First, the court concluded that "the City of McAlester is the beneficiary of the public trust, and as such is clearly not liable for any damage award made against the trust. Thus, the LGAA's concern about imposing unfair burdens on the taxpayers is not implicated." 951 F.2d at 1566. Second, Oklahoma's Tort Claims Act (as in effect at the relevant time) differentiated between public hospitals and municipalities, school districts, and counties. Therefore, the court concluded, the hospital was not entitled to immunity under the LGAA. *Id.* at 1566-1567.

In another recent case involving the state action doctrine or the LGAA, *Todorov v. DCH Healthcare Authority*, 921 F.2d 1438 (11th Cir. 1991), the court held that a hospital that was a local governmental entity had immunity in a staff privileges action, based on *Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985). In *Miller v. Indiana Hospital*, 930 F.2d 334 (3d Cir. 1991), on the other hand, there was an insufficient showing of active state supervision to warrant immunity under *Parker v. Brown*, 371 U.S. 341 (1943).

In *Lancaster Community Hospital v. Antelope Valley Hospital District*, 940 F.2d 397 (9th Cir. 1991), the Ninth Circuit Court of Appeals reversed the district court's dismissal on state action and LGAA grounds, focusing on two points. First, "the state has given the defendants no power to regulate the hospital services market, but has merely authorized them to provide hospital services along with regular competitors." *Id.* at 402. Second, there were numerous other actions of the California legislature that indicated that the California state policy was not to displace competition with regulation — the test under *Town of Hallie*. "We now hold that when there are abundant indications that a state's policy is to support competition, a subordinate state entity must do more than merely produce an authorization to 'do business' to show that the state's policy is to displace competition." 940 F.2d at 403.

In *Cohn v. Bond*, 953 F.2d 154, 157-58 (4th Cir. 1991), the Fourth Circuit Court of Appeals held that members of the medical staff had LGAA immunity because they acted on behalf of the hospital.

Oksanen [v. Page Memorial Hospital, 945 F.2d 696 (4th Cir. 1991)] holds that when members of the medical staff recommend action on an application for

*Coffey v. Healthtrust, Inc.*⁹ presents an unusual twist on an otherwise ordinary case involving an exclusive contract for hospital-based physician services. Dr. Coffey's group of radiologists was the exclusive provider of radiology services at Edmond Memorial Hospital. In the spring of 1988, the group began expanding the services offered at its outpatient clinic to include computed tomography, mammography, and ultrasound, all of which had previously only been available as inpatient services at the hospital.

The hospital, concerned that "its" radiologists were taking patients away from the hospital's inpatient radiology services, terminated its exclusive arrangement with Dr. Coffey's group and entered into an exclusive contract with another radiologist, Dr. Killebrew. Dr. Coffey and his group retained their staff privileges at the hospital, but as a practical matter they no longer practiced there. Dr. Coffey claimed that the hospital and various members of its medical staff had engaged in a group boycott.

The court rejected the claim that there was a *per se* boycott on the ground that the hospital and the medical staff were not horizontal competitors.

We find as a matter of law that the relationship among the physicians is insufficient to establish a *per se* group boycott. Any relationship which existed between the physicians [on the medical staff] and [the hospital] and Dr. Killebrew and [the hospital] is vertical.¹⁰

privileges, as authorized by the municipal hospital, they are acting in their capacity as employees, as opposed to private parties. Physicians who make peer review decisions at the behest of, or by delegation from, the hospital's board of trustees, are acting as agents of the hospital and are, therefore, indistinguishable from the hospital. . . . Therefore, their actions in this respect are entitled to immunity from money damages under the LGAA because of their unitary status with Wilkes Hospital.

Recognizing that the LGAA determination disposed of the claim for damages, but not for injunctive relief, the *Cohn* court continued with the *Parker v. Brown* analysis and concluded that because the members of the medical staff acted as agents of the hospital, the active supervision prong of *Parker* was inapplicable. "A municipal hospital decision to deny privileges, therefore, meets the first prong of the *Parker* test. The actions of the staff are immune when, as is true here, they are acting as agents of Wilkes Hospital, a municipal hospital, in making their recommendation." *Cohn*, 953 F.2d at 158-59. In so doing, the court rejected Dr. Cohn's claim that the medical staff exercised undue influence over the hospital board's decisions, stating that "since the medical staff and Wilkes Hospital, in these circumstances, are the same entity, undue influence is irrelevant." *Id.* at 159.

9. 955 F.2d 1388 (10th Cir. 1992).

10. *Id.* at 1392; see also *Bloom v. Hennepin County*, 783 F. Supp. 418 (D. Minn. 1992) (stating that nephrologists provide physician services and hence do not compete with a kidney dialysis center that only provided the "technical component" of kidney dialysis).

The court also rejected the claim that the alleged boycott violated the rule of reason because (1) Dr. Coffey failed to define a relevant geographic market and (2) "what occurred . . . was only a reshuffling of competitors [that] had no detrimental effect on competition"¹¹ because there was a single, exclusive provider of radiology at the hospital both before and after the change; only the identity of the exclusive contractor was different.¹²

These cases raise some very interesting problems. It certainly appears that in both the hospitals were competitively threatened by the plaintiffs' outpatient facilities (notwithstanding the *Coffey* court's statement that physicians and hospitals do not compete). Does a hospital have the right to restrict the privileges of a physician just because that physician proposes to compete with it? Or, viewed from the other side, is a hospital required to allow open access to its facilities, even by those who turn around and compete with it?

Under traditional Sherman section 2 principles, a firm has no general duty to cooperate with its competitors,¹³ which is essentially what the plaintiffs were seeking in both *Coffey* and *Tarabishi*. But those same traditional Sherman section 2 principles seem to suggest that, at a minimum, a firm with market power must have a

11. 955 F.2d at 1393.

12. Several other cases involving exclusive arrangements were decided during the past year. The court in *Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.*, 924 F.2d 1484 (9th Cir. 1991), affirmed a summary judgment dismissing Sherman section 1 claims because the plaintiff failed to define a relevant market. The court in *Shafi v. St. Francis Hospital of Charleston, West Virginia*, 937 F.2d 603 (4th Cir. 1991) (reported in full at 1991-1 Trade Cas. (CCH) ¶ 69,500 (July 16, 1991)), found that an exclusive anesthesia contract was permissible because the market share of 11% was too small to establish a tying violation, but remanded the case to the district court to determine whether the plaintiff had sufficiently alleged a relevant market to permit a boycott claim to go forward. *Anesthesia Advantage, Inc. v. Metz Group*, 759 F. Supp. 638 (D. Colo. 1991), involved a contest between certified registered nurse anesthetists ("CRNAs") and physician anesthesiologists ("MDAs"). The district court granted defendants' motion for summary judgment essentially because the plaintiffs did not present sufficient evidence of a conspiracy to rebut the defendants' showing of legitimate independent bases for their actions. *Bhan v. NME Hospitals, Inc.*, 929 F.2d 1404 (9th Cir. 1991), also involved competition between MDAs and a CRNA who claimed that he had been unlawfully excluded from providing anesthesia services at a small community hospital. The Ninth Circuit Court of Appeals concluded that the exclusive arrangement was neither an illegal tying arrangement because the hospital did not have market power nor an illegal boycott (under a rule of reason analysis) because Bhan did not "delineate a relevant market and show that the defendant plays enough of a role in that market to impair competition significantly." *Id.* at 1413.

13. "[E]ven a firm with monopoly power has no duty to engage in a joint marketing program with a competitor." *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 600 (1985).

legitimate business justification for its refusal to cooperate.¹⁴

Similarly, if the hospitals had acted pursuant to a conspiracy, and if the plaintiffs could have proven an effect on competition in a relevant market, could the plaintiffs have prevailed on a rule of reason claim? In each case, the plaintiffs could have argued that the hospitals conspired to restrict access to the hospitals, and that the purpose and effect of those restrictions was to restrain competition from the plaintiffs' respective outpatient facilities. Once again, under traditional antitrust principles the rule of reason would require the hospitals to offer some procompetitive, efficiency, or other justifications for their actions.¹⁵

From an antitrust counseling perspective, the point to recognize is that the *Coffey* holding was based upon the defendant's lack of market power. Defendants will not always be able to defeat antitrust claims based on the failure to define a relevant market. A prudent provider that has market power should be prepared to offer legitimate justifications for its conduct.¹⁶

II. COMPETITION BETWEEN ALTERNATIVE DELIVERY SYSTEMS

Unlike *Tarabishi* and *Coffey*, which arguably involved competition between providers at different levels, *U.S. Healthcare, Inc. v. Healthsource, Inc.*¹⁷ involved two managed care plans that clearly were horizontal competitors. The plaintiff challenged attempts by the defendant to discourage "its" primary care physicians ("PCPs") from participating in the plaintiff's competing plan. The

14. *Id.* at 605-11 (upholding a jury instruction that a monopolist's refusal to deal with a competitor "does not violate section 2 if valid business reasons exist for that refusal"); *Olympia Equip. Leasing v. Western Union Tel.*, 797 F.2d 370, 376 (7th Cir. 1986) ("The monopoly supplier who retaliates against customers who have the temerity to compete with him . . . is severing a collateral relationship in order to discourage competition.").

15. "Absent some countervailing procompetitive virtue—such as, for example, the creation of efficiencies in the operation of a market or the provision of goods and services, . . . such an agreement limiting consumer choice by impeding the 'ordinary give and take of the market place,' . . . cannot be sustained . . . under the Rule of Reason." *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 459 (1986) (citations omitted) (quoting *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 692 (1978)).

16. *See, e.g., Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1457, (11th Cir. 1991) (a hospital's desire to "preserve the efficient operation of the hospital's radiology department" was a procompetitive explanation for its decision to deny privileges to another applicant); *Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 710, (4th Cir. 1991) (removing a disruptive physician was a legitimate business justification because, the court observed, "Page Memorial [Hospital] certainly had valid business and patient care reasons for removing Oksanen before he irretrievably poisoned the hospital environment.").

17. 1992-1 Trade Cas. (CCH) ¶ 69,697 (D.N.H. Jan. 30, 1992), *appeal pending*.

defendant's contracts with PCPs provided that the PCP would receive a higher capitation payment if that PCP agreed not to deal with any other health maintenance organization ("HMO") plan. Each PCP was free either to accept or reject this exclusive provision (and to terminate it on thirty days' notice), but if the PCP agreed to the exclusive, he or she would receive an average increase in monthly capitation of approximately 14%.

Eighty-seven percent of the plan's PCPs agreed to the exclusive arrangement. The defendant had 47,000 subscribers, about 5% of the state's population. The plaintiff argued that there was little or no business justification for the exclusive arrangement, rather it was only imposed in order to block the plaintiff's entry into the market and it had prevented the plaintiff from competing effectively because it created a Catch 22: the plaintiff did not have enough subscribers to induce the defendant's PCPs to give up their exclusive arrangements, and it could not get enough subscribers because it could not sign up enough PCPs.

The magistrate judge¹⁸ concluded that there was not a sufficient effect on competition to violate the antitrust laws. First, the exclusive arrangement was not a per se violation because each PCP could opt out on thirty days' notice and because the exclusive provision allowed the PCPs to participate in indemnity plans; it only restricted participation in other HMOs. Second, the court rejected the plaintiff's argument that the relevant market was the independent practice association ("IPA") HMO's in southern New Hampshire, reasoning that the geographic market was all of New Hampshire (because each plan had attempted to recruit providers and obtain subscribers throughout the state) and that the product market was all healthcare financing, not just IPA HMO plans (because "[t]he various health care financing plans are reasonably interchangeable in that they sell health care financing to employers or individuals.")¹⁹ Third, there was no Sherman section 1 violation because there was no injury to competition: "I find that . . . competition has not been lessened. While the exclusive clause has placed a restriction on PCP's [sic] participation with other HMOs, I find on balance that the restriction does not constitute an unreasonable restraint of trade under Section 1 of the Sherman Act."²⁰

18. The parties consented to trial by the magistrate judge pursuant to 28 U.S.C.A. § 636(c) (West Supp. 1992).

19. 1992-1 Trade Cas. (CCH) ¶ 69,697, at 67,181.

20. *Id.* (citation omitted).

Finally, there was no Sherman section 2 violation because the defendant's five percent share of the market was too small.

The plaintiff's most persuasive argument was its claim that the defendant's proffered justifications for the exclusivity arrangement were weak and appeared to have been contrived after the fact. Essentially, the plaintiff argued that the exclusive arrangement (1) harmed the plaintiff, (2) lacked a legitimate business justification and/or had less restrictive alternatives, and therefore (3) was a violation without the necessity of proving that the defendant had market power. The magistrate judge was not prepared to accept this argument (at least where the market shares were so low that it was difficult to see what effect on competition the exclusive arrangement had except to make it more difficult for the plaintiff to enter the market), but the arguments may have had more appeal in a market that is less competitive; antitrust counselors should advise their clients accordingly.²¹

III. ALLIANCES WITH OTHER PROVIDERS AS COMPETITIVE STRATEGIES

A. Price Fixing

A few providers appear to believe that the best strategy in a competitive environment is to join their competitors. Those that did not learn from the *Maricopa* decision²² or the numerous speeches by officials of the Department of Justice and Federal Trade Commission ("FTC") that this is often a per se violation should be reminded of that fact by this year's enforcement activities.

The FTC's consent decree in *Southbank IPA, Inc.*²³ is directed primarily at joint negotiations and joint refusals to deal by the physician members of an IPA. The FTC claimed that the physicians constituted nearly the entire OB/GYN medical staff of a hospital and that they used their IPA as a vehicle for agreeing whether and on what terms they would treat subscribers of various healthcare

21. See generally Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 YALE L.J. 209 (1986).

22. *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982); see also *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 116 (1975) ("The central message of the Sherman Act is that a business entity must find new customers and higher profits through internal expansion—that is, by competing successfully rather than by arranging treaties with its competitors.").

23. 56 Fed. Reg. 50,912 (Oct. 9, 1991), accepted by Federal Trade Commission, 57 Fed. Reg. 2,913 (Jan. 24, 1992).

plans and for agreeing to resist various plans' efforts to obtain reduced fees and/or cost containment measures. In *United States v. Burgstiner*,²⁴ similar in many respects, OB/GYNs allegedly met to discuss fees under the auspices of the medical society, exchanged information regarding current and prospective fees, and agreed on the fees they would quote to a group of payors.²⁵

The important point about the results of these enforcement activities is not what they prohibit (it is not news that price fixing is illegal) but what they permit. First, they permit physicians to "provid[e] information or views, individually or collectively with other physicians, to any third-party payor concerning any issue, including reimbursement."²⁶ Second, they permit providers to join together in an "integrated joint venture,"²⁷ at least

as long as the physician participants are free to deal individually with any third-party payor that declines to deal with the integrated joint venture, and the third-party payor is on notice that the physicians remain free to deal individually with the third-party payor at any time that it declines to deal with the integrated joint venture.²⁸

Thus, providers are free to "lobby" payors and to form joint ventures that are less integrated than a merger so long as the risk sharing and other requirements of *In re Preferred Physicians, Inc.*²⁹ are satisfied.

B. Hospital Mergers

*FTC v. University Health, Inc.*³⁰ is this year's hospital merger decision, and it is noteworthy primarily because it is basically just a merger case that happens to involve hospitals; the Clayton section 7 issues were not treated substantially differently just because hos-

24. 1991-1 Trade Cas. (CCH) ¶ 69,422 (S.D. Ga. April 29, 1991) (consent decree).

25. See also *United States v. Alston*, 1991-1 Trade Cases (CCH) ¶ 69,366 (D. Ariz. Dec. 17, 1990), the celebrated criminal case involving dentists in Tucson who sent a joint letter to payors regarding the minimum co-payments that they would accept. The jury convicted the defendants, the judge granted the motion for acquittal for two defendants and for a new trial for a third, and the Government's appeal is pending.

26. *Southbank IPA, Inc.*, 56 Fed. Reg. at 50,914.

27. The court in *In re Preferred Physicians, Inc.*, 110 F.T.C. 157 (1988), defined an integrated joint venture as "a joint arrangement to provide prepaid health care services in which physicians who would otherwise be competitors pool their capital to finance the venture, by themselves or together with others, and share substantial risk of adverse financial results caused by unexpectedly high utilization or costs of health care services."

28. *Southbank IPA, Inc.*, 56 Fed. Reg. at 50,916.

29. 110 F.T.C. 157.

30. 1991-1 Trade Cas. (CCH) ¶ 69,400 (S.D. Ga. April 11, 1991), *remanded*, 938 F.2d 1206 (11th Cir. 1991).

pitals were combining. The FTC sought to enjoin the acquisition of the assets of St. Joseph Hospital by one of its competitors. The district court denied the preliminary injunction, holding that (1) there was not substantial competition between the two hospitals because St. Joseph did not offer some of the services that were necessary to compete for managed care and preferred provider contracts; (2) the relevant market was acute inpatient services, but the primary competition was in the area of outpatient services; (3) there still would be three very strong hospitals in the community; (4) without the acquisition, St. Joseph would inevitably wither and die, even though it was fiscally sound at the time; and (5) a preliminary injunction would cause uncertainty and stress in the community.³¹

The Eleventh Circuit Court of Appeals remanded. First, the court agreed with the Seventh Circuit³² and disagreed with the Fourth Circuit³³ that section 7 of the Clayton Act applies to asset acquisitions by nonprofit hospitals. Then, relying on traditional Clayton section 7 principles,³⁴ the court had no trouble concluding that the combined hospitals' market share of 43% would result in "a firm controlling an undue percentage share of the relevant market."³⁵

Finally, the Eleventh Circuit Court of Appeals concluded that the hospital failed to prove some of its defenses, and that its nonprofit status was not a defense even in theory. The defendant claimed that although the acquired hospital was not a failing firm, it was a weak competitor and this undermined the government's statistical case. The court agreed that a defendant may rebut the government's *prima facie* case by showing that the government's market share statistics overstate the acquired firm's ability to compete in the future and that, discounting the acquired firm's market share to take this into account, the merger would not substantially lessen competition. The weakness of the acquired firm is only relevant if the defendant demonstrates that this weakness undermines the predictive value of the government's market share statistics.³⁶

However, the court concluded that the defendant had failed to

31. *Id.* at 65,614 to 65,615.

32. *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990).

33. *United States v. Carilion Health Sys.*, 892 F.2d 1042 (4th Cir. 1989).

34. *See, e.g., United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963).

35. *Id.* at 363. The showing of market concentration was bolstered, the court held, by Georgia's certificate of need laws, which constituted an entry barrier.

36. 938 F.2d at 1221 (citations omitted).

make this showing, based largely on the fact that the acquired hospital “is fiscally sound at the present time,” and the fact that the defendant “did not analyze St. Joseph’s ability to adjust to changing market conditions nor did they explain why [it] . . . would not remain competitive . . . in the future.”³⁷ The court also recognized the possibility of an efficiencies defense³⁸ but concluded that the defendant’s showing was insufficient. To support an efficiencies defense, the defendant “must demonstrate that the intended acquisition would result in significant economies and that these economies ultimately would benefit competition and, hence, consumers.”³⁹

In a footnote, the Eleventh Circuit also disposed of the hospital’s contention that the acquisition was immune under *Parker v. Brown*⁴⁰ and its contention that because buyers of hospital care typically are large and sophisticated insurance companies, there was little likelihood of injury to competition. As to the first, the court concluded that Georgia’s certificate of need (“CON”) requirement did not demonstrate a clearly articulated state policy to displace competition, in part because most acquisitions by existing hospitals were exempt from the CON requirement. As to the “sophisticated buyer” defense, the court agreed that having large buyers on one side of a market inhibits collusion. However, the court concluded that the insurers did not really have leverage over the hospitals because

as a practical matter [they] could not refuse to reimburse their subscribers because the prices in the relevant market were too high; rather, they would, as always, reimburse their subscribers for necessary medical services and, if the price remained high, they would pass these increased costs on to the individual consumers.⁴¹

For those contemplating hospital mergers, the *FTC v. University Health, Inc.* decision means that if an acquisition does not pass muster under the traditional market share tests of *United States v. Philadelphia National Bank*⁴² and its progeny, the defendants must be prepared to make a compelling factual showing that other factors make market shares insufficiently probative of future market power or that the acquisition will generate substantial efficiencies

37. *Id.*

38. “We conclude that in certain circumstances, a defendant may rebut the government’s *prima facie* case with evidence showing that the intended merger would create significant efficiencies in the relevant market.” *Id.* at 1222.

39. *Id.* at 1223.

40. 371 U.S. 341 (1943).

41. 938 F.2d at 1213 n.13.

42. 374 U.S. 321 (1963).

that will be passed on to consumers.⁴³ The interesting question will be how the Ninth Circuit Court of Appeals treats the issue of efficiencies, if the *Ukiah* case⁴⁴ ever reaches the court of appeals. There is significant Ninth Circuit law that efficiencies are *not* a defense in a merger case.⁴⁵ It will be interesting to see if the Ninth Circuit follows those precedents or whether it follows the Eleventh Circuit's ruling that such efficiencies could, at least theoretically, provide a defense.

C. Vertical Integration

M & M Medical Supplies & Service v. Pleasant Valley Hospital,⁴⁶ like *Advanced Health-Care Services, Inc. v. Radford Community Hospital*⁴⁷ and *Key Enterprises of Delaware, Inc. v. Venice Hospital*,⁴⁸ illustrates attempts to compete by vertically integrating into related healthcare fields. In these cases, hospitals expanded into the durable medical equipment ("DME") business and "steered" their patients to their affiliates supplying DME. In *M & M Medical Supplies*, the hospital placed orders for DME with its subsidiary as a part of the discharge process "without the patient being allowed the opportunity to choose among competitors."⁴⁹ The plaintiff claimed that this constituted monopolization and attempted monopolization. The district court granted summary judgment for the defendants on the ground that the affidavit of the plaintiff's expert was too conclusory to create a genuine issue of material fact as to the relevant market. The Fourth Circuit concluded that, based on the limited discovery that had been conducted, the affidavit was sufficient to create a factual dispute so as

43. At least the first of these is in fact part of the *Philadelphia National Bank* test, under which an acquisition is unlawful if it "produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market . . . in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Id.* at 363.

44. In re Adventist Health Sys./W. & Ukiah Adventist Hosp., No. 9234 (F.T.C. Aug. 2, 1990).

45. See *RSR Corp. v. F.T.C.*, 602 F.2d 1317, 1325 (9th Cir. 1979); *California v. American Stores Co.*, 697 F. Supp. 1125, 1133 (C.D. Cal. 1988), *aff'd in part and rev'd in part on other grounds*, 872 F.2d 837 (9th Cir. 1989), *rev'd on other grounds*, 495 U.S. 271 (1990).

46. 1991-2 Trade Cas. (CCH) ¶ 69,618 (4th Cir. Oct. 22, 1991).

47. 910 F.2d 139 (4th Cir. 1990) (a steering arrangement might violate Sherman section 2).

48. 919 F.2d 1550 (11th Cir. 1990) (a steering arrangement that was not supported by efficiency justification violated Sherman sections 1 and 2).

49. 1991-2 Trade Cas. (CCH) ¶ 69,618, at 66,761.

to preclude summary judgment.⁵⁰

Because of the procedural posture of the case at the Fourth Circuit, *M & M Medical Supplies* by itself is not a terribly important case. However, the court's suggestion that "the linking of DME to hospital services constitutes anticompetitive activity which may support an inference of intent to monopolize,"⁵¹ coupled with the Eleventh and Fourth Circuits' decisions in *Key Enterprises* and *Advanced Health-Care*, should lead antitrust advisors to counsel hospitals against steering practices that deprive patients of free choice, absent strong and legitimate business justifications for the practices.

*Ahram v. Roxborough Memorial Hospital*⁵² is primarily a typical staff privileges case.⁵³ The more interesting feature of the case is that the plaintiff also claimed that the hospital was trying to expand into and monopolize the OB/GYN market by buying up physician practices and requiring the purchased practices to use the hospital exclusively. The plaintiff did not appear to present enough specific factual evidence for the court to analyze this claim in any detail, but the court did rule that there was nothing wrong with the hospital buying physician practices and then requiring the physicians to admit to, and practice at, the hospital. "[I]t is permissible for a hospital to enter into practice contracts with practitioners and to include exclusive dealing clauses in them. . . . As a practical matter, doctors and hospitals do not compete with one another for patients. Rather, they work together to provide pa-

50. *Id.* at 66,763.

51. *Id.* at 66,764.

52. 1991-2 Trade Cas. (CCH) ¶ 69,528 (E.D. Pa. June 13, 1991), *dismissed without opinion*, 952 F.2d 1391 (3d Cir. 1991).

53. The plaintiff claimed that a hospital and its OB/GYN staff members conspired to exclude the plaintiff because the plaintiff could administer epidurals and other OB/GYNs could not. The court dismissed the Sherman section 1 claims on a Rule 12(b)(6) motion, holding that the plaintiff had failed to allege facts indicating an economic incentive for the conspiracy. In another staff privileges case, the District of Columbia Circuit Court of Appeals remanded the district court's decision dismissing a claim on the ground that the hospital had not made a final decision revoking the plaintiff's privileges. *Johnson v. Greater S.E. Community Hosp. Corp.*, 951 F.2d 1268 (D.C. Cir. 1991) (directing the district court to conduct additional fact-finding to determine if the privileges were in fact terminated). In addition, the D.C. Circuit stated that an alleged conspiracy to exclude the plaintiff from participating in a preferred provider organization that had contracted to provide care to an HMO's enrollees was at least arguably an antitrust violation. In *Oksanen v. Page Memorial Hosp.*, 945 F.2d 696 (4th Cir. 1991), the Fourth Circuit held that a hospital and its medical staff were legally incapable of conspiring, at least where the medical staff's privileges recommendation was made at the request of the hospital's administration.

tients with needed services.”⁵⁴ Moreover, the court ruled, the plaintiff could not have an essential facilities claim because the hospital had not denied the plaintiff access to the hospital. The plaintiff still had staff privileges, although they had been restricted.

IV. CONCLUSION

The cases of the early 1990's suggest that plaintiffs should not rely on per se rules; they must be prepared to define and prove a relevant market and the adverse effects on competition within that market. Conversely, defendants must remember that the “application of the rule of reason does not necessarily mean the practice is permissible under the antitrust laws”⁵⁵ and must have and prove legitimate business justifications for their conduct. Thus, this year's cases reinforce the court's willingness to engage in factual analysis when the alleged anticompetitive activity involves the healthcare industry.

54. 1991-2 Trade Cas. ¶ 69,528, at 66,332. This practice may also present interesting issues under the Medicare Fraud and Abuse laws.

55. *Reynolds v. California Dental Serv.*, 246 Cal. Rpt. 331 (1988).