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Hospital Shared Purchasing Agreements After *White & White, Inc. v. American Hospital Supply Corp.*

**INTRODUCTION**

*White & White, Inc. v. American Hospital Supply Corp.* presented a federal district court in Michigan with the task of determining whether a purchasing agreement between a supplier of hospital goods and services and twenty-nine nonprofit hospitals violated the antitrust laws. In a lengthy opinion, the court analyzed each element of the challenged agreement and concluded that the agreement and its implementation violated sections 1 and 2 of the Sherman Act.

*White & White* marks the first time a court has applied the antitrust laws to shared purchasing agreements in the health

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3. Section 1 of the Sherman Act provides in relevant part: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1 (1976).
4. Section 2 of the Sherman Act provides:
   Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation or if any other person, one hundred thousand dollars or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.
   *Id.* § 2.
care field. It offers hospitals and other health care providers the first specific judicial guidance on the legalities of such agreements under the antitrust laws. In reaching its decision, the White & White court applied a theory commonly used to analyze anticompetitive behavior in antitrust tying cases to a nontying situation. This new application of the "leverage theory" may prove valuable for courts confronting sophisticated marketing

6. In an effort to contain rising health care costs, hospitals in the 1970's began participating in a variety of shared service programs. See Brown, Multi-Institutional Arrangements: Shared Services Gain Support, 52 HOSPITALS 131 (Apr. 1978); Ludlam & Christensen, Multihospital Arrangements and the Federal Antitrust Laws, in MULTIHOSPITAL SYSTEMS: POLICY ISSUES FOR THE FUTURE 23, 25 (G. Bisbee, Jr. ed. 1981) [hereinafter cited as Ludlam]; Taylor, Participation in Shared Programs Up Sharply, Survey Discloses, 51 HOSPITALS 192 (July 1977). Under a shared service program, a shared service organization performs one or more services for two or more hospitals. See Proger, Antitrust and Shared Services, in ANTITRUST IN THE HEALTH CARE FIELD 169 (P. Proger ed. 1977) [hereinafter cited as Proger]. Shared services range from purchasing, accounting and financial management to laboratory testing and ambulance and emergency transportation. Id. See also Domanico & Leverette, Shared Project Studies, Revises Hospital Record Retention Policies, 52 HOSPITALS 133 (May 1978); Parker & Wardell, Multihospital Systems Form a Cooperative for Sharing Services, 54 HOSPITALS 79 (June 1980); Thueson, Hospitals' Programs and Progress in Cost Containment Reported, 51 HOSPITALS 131 (Sept. 1977); and Toomey & Bruun, Multihospital Systems Minimizes Management Costs Through Centralized Financial Operations, 52 HOSPITALS 109 (June 1978).

Shared service organizations receive some statutory exemption under the Internal Revenue Code. Specifically, Cooperative Hospital Service Organizations are tax exempt under § 501(e) of the Code if all recipient hospitals are tax exempt under § 501(c)(3). See Goodrich, Recent Developments in the Hospital Shared-Service Organization Controversy, 60 NEB. L. REV. 35 (1981); Proger, supra, at 171-73. For the most part, however, shared services are competitive entities subject to antitrust regulation because of their effect on interstate commerce. See Hospital Building Co. v. Trustees of Rex Hosp., 452 U.S. 378 (1981); Proger, supra, at 170. Thus, joint purchasing programs, the most popular shared service, are especially vulnerable to antitrust challenges because of their substantial impact on interstate commerce. See infra note 17. See also Richards, From Lightbulbs to CT Scanners, Group Purchasing Is Filling the Bill at a Lower Price, 56 HOSPITALS 81 (Jan. 1982).

Shared purchasing agreements can present a variety of antitrust problems because a large volume of business, generated by a number of independent entities, is combined and is then controlled by a small number of vendors. See Dolan, What Are the Antitrust Implications of Shared Purchasing for Hospitals, 53 HOSPITALS 76 (Oct. 1979); Proger, supra, at 170-75; Wallace, Shared Services Hold Antitrust Risk, 12 MODERN HEALTHCARE 136 (July 1982). Possible antitrust violations include: (1) exclusive dealing in violation of § 1 of the Sherman Act and § 3 of the Clayton Act, (2) group boycotts in violation of § 1 of the Sherman Act, (3) tying arrangements in violation of § 1 of the Sherman Act and § 3 of the Clayton Act, (4) a combination in restraint of trade in violation of § 1 of the Sherman Act, (5) an attempt to monopolize, conspiracy to monopolize, or monopolization in violation of § 2 of the Sherman Act, and (6) price discrimination in violation of § 2(a) of the Robinson-Patman Act. White & White, 540 F. Supp. at 960.

7. See infra notes 96-100 and accompanying text.

8. See infra text accompanying notes 66-68, 101-03.
agreements which have been cleverly written to evade the antitrust laws.

This note will first explore the recent application of the antitrust laws to the health care field. It will then focus on the White & White decision and examine the court's reasoning in the case. Next, the way in which the White & White court and other federal courts have employed the leverage theory in nontying cases will be analyzed. Finally, this note will present the guidelines proposed in White & White which the health care industry should follow when executing shared purchasing agreements.

BACKGROUND

Section 1 of the Sherman Act prohibits every contract, combination, or conspiracy that restrains trade.9 Section 2, which applies to individual conduct as well as joint action not covered by section 1, makes it a crime to monopolize, attempt to monopolize, or combine or conspire to monopolize.10 The Clayton Act11 supplements the Sherman Act by prohibiting specific conduct. Section 3 of the Clayton Act12 reaches three restrictive methods of distribution: (1) exclusive dealing arrangements, (2) tying agreements, and (3) requirements contracts. Until the late 1970's, these statutes were rarely applied to the health care industry.13

The health care field's first significant encounter with the antitrust laws occurred in 1943 when the Supreme Court decided in American Medical Association v. United States14 that the business of operating prepaid health care plans constitutes "trade" and is consequently subject to antitrust scrutiny.15 It

9. See supra note 3.
10. See supra note 4.
12. Section 3 of the Clayton Act provides in relevant part:

   It shall be unlawful for any person engaged in commerce, in the course of such commerce, to lease or make a sale or contract . . . on the condition, agreement, . . . that the lessee or purchaser thereof shall not use or deal in the goods, . . . of a competitor or competitors of the lessor or seller, where the effect of such lease, sale, or contract for sale or such condition, agreement, or understanding may be to substantially lessen competition or tend to create a monopoly in any line of commerce.

Id. § 14.
13. Ludlam, supra note 6, at 26.
15. Id. at 528. See also Leibenluft & Pollard, Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints, 34 Vand. L. Rev. 927,
was not until 1976, however, that the antitrust laws were held to apply to the operation of hospitals. In *Hospital Building Co. v. Trustees of Rex Hospital*,\(^\text{16}\) the Supreme Court unanimously decided that hospital activities, such as out-of-state purchases of medicines and supplies, can have a "substantial effect" on interstate commerce.\(^\text{17}\) Prior to *Rex Hospital*, hospitals had claimed immunity from antitrust regulation because their operations were local in nature and did not affect interstate commerce.\(^\text{18}\)


16. 425 U.S. 738 (1976). In *Rex Hospital*, a corporation which operated a proprietary hospital in Raleigh, N.C. sued Rex Hospital, a private tax exempt hospital also located in Raleigh, two of Rex's officers, and a local health planning officer under §§ 1 and 2 of the Sherman Act. The complaint alleged that the defendants had conspired to block the relocation and expansion of plaintiff's hospital in order to enable Rex to monopolize the business of providing health care services in the Raleigh area.

17. *Id.* at 744. The Supreme Court found that if the defendants had succeeded in blocking the planned expansion, plaintiff's purchases of out-of-state medicines and supplies, as well as its revenues from out-of-state insurance companies, would be substantially reduced. The Court also noted that management fees to the plaintiff's out-of-state parent corporation would be less if the expansion were blocked, and out-of-state financing would not occur. This combination of factors was found to be sufficient to establish a "substantial effect" on interstate commerce under the Sherman Act. See also Borsody, *The Antitrust Laws and the Health Care Industry*, 12 AKRON L. REV. 417, 424 (1979); Halper, *Private Litigation*, in *ANTITRUST IN THE HEALTH CARE FIELD* 148, 151-52 (P. Proger ed. 1977); Ludlam, *supra* note 6, at 26; Rosoff, *supra* note 2, at 474; Wal bolt & Pankau, *Antitrust, Public Health-Care Institutions, and the Developing Law*, 1980 ARIZ. ST. L.J. 385, 388 [hereinafter cited as Wal bolt]; Note, *Antitrust and Health Planning Under the 1974 NHPRD Act*, 7 J. CORP. L. 311, 324-26 (1982).

Other courts have granted jurisdiction under the Sherman Act's "substantial effect" text in cases involving health care services. See, e.g., Feminist Women's Health Center v. Mohammad, 586 F.2d 530, 539-41 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) (payments from out-of-state patients and insurance companies as well as out-of-state purchases of supplies have substantial impact on interstate commerce); City of Fairfax v. Fairfax Hosp. Ass'n, 562 F.2d 280, 283 (4th Cir. 1977) (Virginia hospitals furnished with substantial supplies and revenues from sources outside Virginia); Ballard v. Blue Shield, 543 F.2d 1075, 1078 (4th Cir. 1976) (alleged reduction of chiropractors' business throughout state of Virginia may adversely affect interstate commerce); Contra Cardio-Medical Assoc. v. Crozer-Chester Med. Ctr., 536 F. Supp. 1065, 1074-84 (E.D. Pa. 1982) (denial of hospital staff privileges not found to have substantial effect on interstate commerce); Hahn v. Oregon Physicians Serv., 508 F. Supp. 970, 977 (D. Ore. 1981) (insubstantial effect on interstate commerce where fewer than two percent of podiatrists' patients travel across state lines); Grigg v. Blue Cross & Blue Shield, 1980-2 Trade Cas. (CCH) ¶93,500 (E.D. Mich. 1980) (complaint contained conclusionary allegation that defendant's activities substantially and adversely affected interstate commerce without specifically alleging reduced purchases of out-of-state purchaser of supplies and equipment).

18. *See*, e.g., United States v. Oregon State Med. Soc'y, 343 U.S. 326, 338 (1952) (sale of
Although *Rex Hospital* held that hospital activities are not immune from antitrust regulation, certain hospitals have been granted limited immunity under the antitrust laws. In *Abbott Laboratories v. Portland Retail Druggists Association, Inc.*, the Supreme Court considered whether drug manufacturers, who charged commercial pharmacies higher prices than they charged nonprofit hospitals for identical drugs, were guilty of price discrimination under the Robinson-Patman Anti-Discrimination Act. The defendants relied on the Nonprofit Institutions Act, which exempts purchases by nonprofit hospitals of supplies “for their own use” from application of the Robinson-Patman Act. The Court acknowledged the exemption, but narrowly inter-
interpreted the phrase “for their own use.” Thus, nonprofit hospitals have been granted limited immunity from the antitrust laws.

Notwithstanding the limited immunity recognized in Abbott, blanket immunity for the health care field has so far been denied. In National Gerimedical Hospital & Gerontology Center v. Blue Cross, the defendant argued that the National Health Planning and Resources Development Act of 1974 (NHPRDA) impliedly repealed the antitrust laws in the health care field and that its conduct was therefore exempt from antitrust scrutiny. The Supreme Court carefully examined the structure and goals of NHPRDA to determine if any conflict with the antitrust laws existed. Applying well established principles of antitrust immunity, the Court found no such conflict under the facts of

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22. 425 U.S. 1, 10-18. The Court defined “for their own use” to mean “what reasonably may be regarded as use by the hospital in the sense that such use is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients.” Id. at 14.


24. 42 U.S.C. §§ 300k - 300t (1976). The purpose of this Act is “to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.” Id. § 300k(b).


25. 452 U.S. at 382. National Gerimedical Hospital sued Blue Cross of Kansas City and the national Blue Cross Association, challenging Blue Cross's refusal to accept the hospital as a participating member in a Blue Cross health care reimbursement plan. Blue Cross had refused to accept National Gerimedical because the hospital had failed to meet a requirement of the Mid-America Health Systems Agency, a private, nonprofit corporation federally funded under the National Health Planning and Resources Development Act of 1974 (NHPRDA). Id. at 381. Acknowledging that the NHPRDA made no reference to the antitrust laws, Blue Cross argued that NHPRDA's planning structure created an implied repeal of the antitrust laws in the health care field. Id. at 382.

26. The Court relied on United States v. National Ass'n of Securities Dealers, 422 U.S. 694, 719-20 (1975) ("Implied antitrust immunity is not favored, and can be justified only by a convincing showing of clear repugnancy between the antitrust laws and the regulatory system."); United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 348 (1963) ("Immunity from the antitrust laws is not lightly implied."); Silver v. New York Stock Exch., 373 U.S. 341, 357 (1963) ("Repeal is to be regarded as implied only if necessary to
National Gerimedical.\textsuperscript{27} The Court emphasized, however, that its holding did not foreclose future claims of antitrust immunity by other parts of the health care industry in other factual settings.\textsuperscript{28}

Since Rex Hospital was decided, antitrust suits in the health care industry have proliferated.\textsuperscript{29} Even hospital staff members have invoked the antitrust laws against their hospitals.\textsuperscript{30} In a recent Seventh Circuit case, for example, an anesthesiologist sued under sections 1 and 2 of the Sherman Act challenging an exclusive dealing contract for the provision of anesthesia services at a hospital because the contract precluded the plaintiff from practicing at the hospital.\textsuperscript{31} The Seventh Circuit struck the district court's injunction enjoining enforcement of the contract,\textsuperscript{32} and remanded the case with instructions to determine whether the exclusive contract promoted competition among the hospitals and among anesthesiologists to obtain such contracts.\textsuperscript{33}

In White & White the antitrust laws were applied to yet

\textsuperscript{27} 452 U.S. at 391.
\textsuperscript{28} Id. at 393 n.18. In fact, the defendant in White & White, Inc. v. American Hosp. Supply Corp., 540 F. Supp. 951 (W.D. Mich. 1982), argued that a Medicare regulation had created an implied antitrust exemption for hospital purchasing groups and their vendors. Id. at 978. The court found that the Medicare regulation at issue does not conflict with the antitrust laws, nor does it exempt hospital purchasing groups or their vendors from complying with the antitrust laws. Id. at 979.


\textsuperscript{30} See M. THOMPSON, supra note 2, at 149; Bernstein, Staff Privileges and Antitrust Laws, 56 HOSPITALS 76 (Sept. 1982); Foster, Exclusive Arrangements Between Hospitals and Physicians: Antitrust’s Next Frontier in Health?, 26 ST. LOUIS U.L.J. 535 (1982); Stoll, Concerted Refusals to Deal: The Hospital Staffing Committee’s Liability, 1979 ANTITRUST L.J. 563; Walbolt, supra note 17, at 399; Note, Denial of Open Staff Privileges: An Antitrust Scrutiny, 26 ST. LOUIS U.L.J. 751 (1982); Note, Hospital Medical Staff: When are Privilege Denials Judicially Reviewable?, 11 U. MICH. J.L. REF. 95 (1977).

\textsuperscript{31} Dos Santos v. Columbia-Cuneo-Cabrini Med. Ctr., 684 F.2d 1346 (7th Cir. 1982).
\textsuperscript{32} Id. at 1350.
\textsuperscript{33} Id. at 1354-55.
another factual context, namely, the anticompetitive aspects of a shared purchasing agreement among hospitals.

**WHITE & WHITE, INC. v. AMERICAN HOSPITAL SUPPLY CORP.**

**The Facts**

In 1979, American Hospital Supply Corporation (AHSC), the largest manufacturer and distributor of hospital supplies in America, and a group of hospitals, shareholders of Voluntary Hospitals of America (VHA), entered into a purchasing agreement whereby AHSC would sell a high volume and wide range of products to VHA hospitals. In return, VHA hospitals would be eligible for volume discounts, price protection, and certain other vendor services.

Unlike traditional group purchasing contracts, the AHSC-VHA agreement provided that the VHA hospitals were not required to purchase any AHSC product or service, nor was AHSC required to sell to the hospitals at any stated group price. Instead, the product and terms of each sale were to be negotiated between the individual VHA hospitals and AHSC. The hospitals would become eligible for price caps and volume discounts if, as a group, they reached certain fixed purchase levels. Hospitals purchased at a floating price until price caps

34. AHSC is located in Evanston, Illinois. It is the world’s largest supplier of health care products, manufacturing and distributing over 120,000 products and services. AHSC services over 7,000 hospital customers from a national network of warehouses. In 1978, the year before White & White was filed, AHSC reported net sales of $1,741,709,000. 540 F. Supp. 951, 963 (W.D. Mich. 1982).

AHSC’s 1981 Annual Report lists net sales as $2,870,100,000, a 17% increase over 1980. For more insight into AHSC’s financial strength, see Pillsbury, The Hard-Selling Supplier to the Sick, 106 FORTUNE 56 (July 1982).

35. VHA is an Illinois corporation, headquartered in Troy, Michigan. VHA, a for-profit corporation, was founded in 1977 to provide its shareholders, 29 nonprofit hospitals located in 22 states, with management services, research and development, cost containment systems, and economies of scale. The AHSC-VHA purchasing agreement listed the smallest VHA shareholder as a 225-bed hospital, while the largest was a 1,821-bed hospital. 540 F. Supp. at 963-64.

36. Id. at 960.

37. Id.

38. Id. at 972.

39. Id.

40. Id. Volume discounts were earned if, during the year, the hospitals collectively purchased $2,000 per bed. Once the $2,000 mark was reached, discounts increased as the hospital group’s average per-bed purchases increased.
and volume discounts were earned and calculated. The ultimate price each hospital paid for a product depended upon the volume purchased by all the hospitals. Since the agreement neither required VHA hospitals to buy any AHSC product nor obligated AHSC to sell the hospitals any specific product at a specified price, the agreement was implemented through a course of dealing between VHA hospitals and AHSC.

VHA and AHSC personnel together presented the agreement to the VHA hospitals. In addition, the VHA and AHSC cooperated to inhibit competitive bidding on hospital supplies at individual VHA hospitals. The VHA attempted to persuade member hospitals to disclose competitors' prices so that AHSC would have a chance to match those prices. AHSC established a matching policy limited by a "walk away privilege" that allowed AHSC to decline "unprofitable" business. Once having offered to match a competitor's price, AHSC attempted to preclude such sellers from rebidding on the business.

The plaintiffs, White & White Surgical Supply and Pharmacies, Inc., Bluefield Supply Co., Crocker-Fels Co., and Ransdell Surgical, Inc., regional distributors of medical, surgical and other supplies, competed with AHSC for distributor business in eight VHA hospitals. The plaintiffs claimed that by executing and implementing the purchasing agreement, AHSC, the VHA, and individual VHA hospitals had conspired to violate the antitrust laws. The plaintiffs' suit alleged that AHSC had violated

41. Id. at 972-74.
42. Id. at 972-73.
43. Id. at 974.
44. Id. at 974-75.
45. Id. at 975. VHA's Robert Kitzman took notes during a planning meeting which contained statements that AHSC should be viewed as a "vendor of choice and that competitor bids should not be accepted." Id.
46. Id. As a result, many VHA hospitals accepted AHSC's matched price without giving the competitor an opportunity to rebid.
47. Through the "walk-away privilege" AHSC could turn down business it considered unprofitable, "which the VHA could obtain at an extremely low price from its usual vendor." Id. at 976.
48. Id. at 1008.
49. White & White Surgical Supply and Pharmacies, Inc. is located in Grand Rapids, Michigan. White & White distributes from two Michigan warehouses to a maximum sales area which includes the lower peninsula of Michigan, northwest Ohio, and northeast Indiana. 1980 corporate sales were $18 million. Id. at 962.
50. Id. at 960.
51. Id.
sections 1 and 2 of the Sherman Act and section 3 of the Clayton Act, and specifically charged AHSC with attempting to monopolize, price fixing, tying, exclusive dealing and group boycott, and price discrimination under the Robinson-Patman Act. The price fixing, tying, and price discrimination charges were later dropped, but the plaintiffs were allowed to amend their complaint to add a count of conspiracy between AHSC, the VHA, and the individual VHA hospitals to restrain trade. The plaintiffs sought treble damages and injunctive relief.

The White & White court found that the AHSC-VHA agreement and its implementation violated section 1 of the Sherman Act, in that AHSC had entered into a conspiracy in restraint of trade, as well as section 2 of the Act, because AHSC had attempted to monopolize the sale of medical-surgical supplies in certain standard metropolitan statistical areas. The court concluded, however, that AHSC had not violated section 3 of the Clayton Act since it had not established an exclusive dealing relationship at any VHA hospital, nor was there sufficient evidence to hold AHSC guilty of conspiring to induce a group boycott of its competitors.

The Attempt to Monopolize in Violation of Section 2 of the Sherman Act

In analyzing the section 2 allegation, the court focused on the two elements underlying an attempt to monopolize claim: proof

52. Id.
53. Id. at 961.
54. Id. at 960.
55. Id. at 1026.
56. Id. at 1013.
57. Id. at 1030. Since the terms of the AHSC-VHA agreement did not expressly require the VHA hospitals to purchase exclusively from AHSC or prohibit the hospitals from dealing with other suppliers, the plaintiffs had claimed that the terms and implementation of the agreement amounted to an implied exclusive dealing arrangement. The court found that, although the evidence established that both AHSC and the VHA had intended to build an exclusive dealing relationship between AHSC and each of the member hospitals, the evidence did not support a finding that such an agreement had in fact been established at any VHA hospital.
58. Id. at 1036. As the AHSC-VHA agreement did not expressly require the VHA hospitals to refuse to deal with vendors other than AHSC, the court looked to the implementation of the agreement to infer an agreement to boycott AHSC's competitors. The court found that, since significant medical-surgical business was still awarded to the plaintiffs and other vendors, the VHA hospitals had not entered into an agreement with AHSC to boycott the plaintiffs. Id. at 1035.
of specific intent to monopolize, and proof that there was a dangerous probability of success. Specific intent could be inferred "from circumstantial evidence such as defendant's past anticompetitive conduct, statements or business policies," but could not be inferred from activities which were conducted for legitimate business reasons. Proof of the dangerous probability element did not require that the defendant possess the market power necessary for an actual monopoly. Instead, it was necessary only to show the "dangerous probability" that the defendant could establish a monopoly, measured by the defendant's market power in a defined market. The court defined the relevant product market as a three dimensional submarket involving (1) the sale of medical-surgical supplies (2) to hospitals (3) by distributors. The relevant geographic market was also defined in terms of submarkets, namely, the Standard Metropolitan Statistical Areas (SMSA) of eight cities.

**Intent**

The *White & White* court found the terms and the implementation of the purchasing agreement to be anticompetitive acts which were "collectively sufficient" to establish AHSC's specific intent to monopolize. The terms of the agreement were anticompetitive in three respects. First, the product and geographic markets covered were too broad. Because AHSC's competitors were smaller and specialized in narrower product and geographic submarkets, they could not provide such a wide range of products or distribute to as many geographic markets. Thus, AHSC's competitors would be foreclosed from competing.

Second, under the price cap and volume discount terms of the agreement, VHA hospitals could purchase "medical/surgical, laboratory, dietary, laundry, housekeeping, parenteral therapy, surgical instruments and supplies, equipment and furnishings"

59. *Id.* at 1000.
60. *Id.* at 1001.
61. *Id.*
62. *Id.* at 982.
63. *Id.* at 993. The eight cities were Grand Rapids, Detroit, Charleston (W.Va.), Cincinnati, Columbus, Dayton, Indianapolis, and Louisville.
64. *Id.* at 1002.
65. *Id.* The court noted that a purchasing agreement with such a "broad product and geographic coverage [was] unprecedented in the hospital supply industry." *Id.* at 1002-03.
from AHSC.\textsuperscript{66} The court found that linking such a wide range of products under these provisions created a leverage effect among independent product submarkets,\textsuperscript{67} since VHA hospitals purchased not only preferred but also unpreferred AHSC products in order to qualify for the price caps and volume discounts.\textsuperscript{68} Competitors of AHSC were unable to offer the VHA hospitals a similar interproduct price cap or volume discount. In order to compete at the VHA hospitals, therefore, these distributors would have to offer not only price concessions on their particular product, but additional price concessions to compensate the hospital for foregoing "blanket incentives available on other AHSC products."\textsuperscript{69}

Finally, under the price cap and volume discount provisions, VHA hospitals purchased AHSC products without knowing their net prices.\textsuperscript{70} Because the price cap and volume discount depended upon the purchases of all VHA hospitals, no individual VHA hospital could determine the ultimate price of any AHSC product at the time of sale. The hospital could not compare AHSC's net price with that of a competitor's and as a result, the court found, price competition was injured.\textsuperscript{71}

Implementation of the agreement likewise stifled price competition.\textsuperscript{72} The court found that AHSC and the VHA had created a unique buyer-seller relationship akin to a partnership.\textsuperscript{73} AHSC and VHA personnel worked together to induce VHA member hospitals to support the agreement.\textsuperscript{74} Moreover, AHSC expected individual hospitals to pressure each other into increasing their purchases so that the group would qualify for price reduc-

\textsuperscript{66} Id. at 1003.
\textsuperscript{67} Id.
\textsuperscript{68} Id. at 1004.
\textsuperscript{69} Id. at 1006.
\textsuperscript{70} Id.
\textsuperscript{71} Id.
\textsuperscript{72} Id. at 1007.
\textsuperscript{73} Id. at 1018. The court stated that: "Prior to the AHSC/VHA Agreement equal opportunity for distributors to compete for sales opportunities has been the norm in the medical-surgical supply distribution industry . . . [B]y agreement, AHSC, the VHA and individual VHA hospitals seek to create a unique seller-buyer partnership which destroys traditional competition at VHA hospitals." Id.
\textsuperscript{74} Id. at 975. The court noted that this "partnership theory of business" was present in other VHA contracts with other suppliers. General Electric and Standard Register Company were cited as examples. Id.

Based on the White & White decision, one of VHA's former suppliers sued VHA and Standard Register Co. for restraint of trade, group dealing, and exclusive dealing in vio-
The court considered AHSC's "match-it" program, "walk-away" privilege, and peer pressure techniques to be strategies aimed at destroying price competition at VHA hospitals. Their combined result was to keep AHSC's competitors from obtaining business from individual VHA hospitals.

Dangerous Probability of Success

As noted above, dangerous probability of success requires a showing that the party charged with attempting to monopolize has market power sufficient to effect a monopoly. The White & White court assessed the dangerous probability of success in each of the eight SMSA geographic markets already established by examining AHSC's market share in each submarket. The court noted that AHSC's market share exceeded twenty-seven percent in five SMSAs but cautioned that this figure standing alone was meaningless. Such a percentage needed to be evaluated against the market structure and the trend of AHSC's market shares. Lacking data on the trend of AHSC's market shares, the court simply stated that the evidence showed a substantial increase in AHSC's sales in all eight SMSAs from 1979 to 1980. The character and objectives of AHSC's anticompetitive conduct were then measured in relation to the structure of the medical-surgical supply distribution market. The court considered "the serious anticompetitive character and objectives of [AHSC's] conduct, the fragility of [AHSC's] competitors, and [AHSC's] ever increasing dominance in the relevant metropolitan submarkets" and found that where AHSC's metropolitan market share exceeded twenty-five percent, a dangerous probability of success of monopoly existed. The court concluded that AHSC's anticompetitive conduct, with the specific intent to monopolize, posed a dangerous probability of success in five
metropolitan areas, and that AHSC had therefore attempted to monopolize these five submarkets in violation of section 2 of the Sherman Act.83

The Conspiracy to Restrain Trade in Violation of Section 1 of the Sherman Act

The White & White court presented a two-step analysis for determining whether a contract or conspiracy unreasonably restrains trade. First, the court determines whether a conspiracy exists which restrains trade in a relevant, defined market;84 next, it determines whether the restraint is reasonable.85 Restraint is considered reasonable if it promotes, rather than suppresses, competition.86

The White & White court inferred an antitrust conspiracy from three factors. The first, joint participation in an unlawful scheme, was evinced by the agreement itself to which AHSC, the VHA, and the individual VHA hospitals, as third party beneficiaries, were parties.87 All the parties worked together to introduce the agreement to the hospitals and to carry out its goals. In fact, a close-knit relationship developed between AHSC, the VHA, and

82. Id. at 1013.
83. Id.
84. Id. at 1014.
85. Id. Section 1 of the Sherman Act prohibits every contract, combination, or conspiracy that restrains trade. 15 U.S.C. § 1 (1976). Originally, this language was read literally. See United States v. Trans-Missouri Freight Ass'n, 166 U.S. 290 (1897). Since every contract restrains trade to some degree, courts have interpreted § 1 under a rule of reason analysis. The rule of reason began to emerge in United States v. Addyston Pipe & Steel Co., 85 F. 271 (6th Cir. 1898), where Judge Taft read “unreasonable” into the language of the Sherman Act. The Supreme Court adopted the rule of reason in Standard Oil Co. v. United States, 221 U.S. 1, 60 (1911), where the Court applied a “standard of reason” to the Sherman Act. The “standard” was reaffirmed in United States v. American Tobacco Co., 221 U.S. 106, 180 (1911). Justice Brandeis provided the classic definition of the rule of reason in Chicago Bd. of Trade v. United States, 246 U.S. 231 (1918): “The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.” Id. at 238.

86. 540 F. Supp. at 1014.
87. Id. at 1015.
its member hospitals. The second factor, knowledge by each party of the others’ involvement, was readily apparent. The final element, joint action to further an unlawful common design, was found in the execution and implementation of the agreement which caused the VHA hospitals to abandon competitive bidding. Having found the three essential elements of a conspiracy, the court concluded that AHSC, along with the VHA and individual VHA hospitals, had entered into a conspiracy to restrain trade.

The court next considered whether the restraint was reasonable. AHSC offered two reasons for its trade practices with the VHA and the VHA hospitals. First, AHSC claimed that the purchase agreement had forced its competitors to be more competitive and, second, AHSC urged that the agreement was reasonable as a new approach to hospital cost containment. The court found AHSC’s first argument totally without merit and rejected its second argument on the ground that the VHA hospitals were apparently paying more for their supplies from AHSC than from their former vendors. Thus, the court concluded that AHSC, the VHA, and the individual VHA hospitals had formed a conspiracy to restrain trade unreasonably in seven of the eight relevant submarkets.

The Leverage Theory

The White & White plaintiffs had originally alleged that the purchasing agreement, as implemented, was a tying arrange-
ment which violated section 1 of the Sherman Act and section 3 of the Clayton Act.\textsuperscript{95} A tying or tie-in arrangement forces a buyer to take a product he does not want, the “tied” product, in order to obtain the product he does want, the “tying” product.\textsuperscript{96} Tying arrangements are strictly construed by the courts and are usually held to be per se violations\textsuperscript{97} under both the Clayton Act and the Sherman Act.\textsuperscript{98} This is because the recognized purpose

\textsuperscript{95} Id. at 1004.

\textsuperscript{96} In Northern Pac. Ry. v. United States, 356 U.S. 1 (1958), the Court stated “a tying arrangement may be defined as an agreement by a party to sell one product but only on the condition that the buyer also purchases a different (or tied) product, or at least agrees that he will not purchase that product from any other supplier.” Id. at 5-6.


\textsuperscript{97} Some activities are considered so “inherently unlawful” that they are judged by a per se rule. Tying arrangements, group boycotts, and price fixing are activities which are considered per se violations of the antitrust laws. The per se rule was first announced in a price fixing case, United States v. Trenton Potteries Co., 273 U.S. 392 (1927). There the court stated: “Agreements which create such potential [monopoly] power may well be held to be in themselves unreasonable or unlawful restraints, without the necessity of minute inquiry whether a particular price is reasonable or unreasonable . . . .” Id. at 397. The rule was reaffirmed in another price fixing case, United States v. Socony-Vacuum Oil Co., 310 U.S. 150, reh’g denied, 310 U.S. 658 (1940), where the Court stated: “Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal per se.” Id. at 223. The rule has since been applied to tying arrangements, International Salt Co. v. United States, 332 U.S. 392, appeal dismissed, 332 U.S. 747 (1947), to group boycotts, Klor’s, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959), and to division of markets agreements, United States v. Topco Assoc., Inc., 405 U.S. 596 (1972). In a recent decision, Arizona v. Maricopa County Med. Soc’y, 102 S. Ct. 2466 (1982), the Court applied the per se rule to find an agreement among competing physicians setting the maximum fees paid by participants of certain insurance plans to be illegal per se under § 1 of the Sherman Act. See also Halper, Arizona v. Maricopa County, A Stern Warning to Healthcare Providers, HEALTHCARE FIN. MANAGEMENT, Oct. 1982, at 38.

For more information on the per se rule, see 16A J. VON KALINOWSKI, supra note 85, § 6.02[1], at 6-57; Bohling, supra note 85, at 490; Bork, supra note 85, at 820; Brace & Nissen, Antitrust: Recent Developments in the Per Se Doctrine, 61 CHI. B. REV. 49 (1979); Conant, The Antitrust Per Se Rules: Judicial Decisionmaking Under ‘Bounded Rationali-

\textsuperscript{98} 16B J. VON KALINOWSKI, supra note 85, § 11.03, at 11-18 to 11-19. See, e.g., International Salt Co. v. United States, 332 U.S. 392, 394-96 (1947) (leases for two patented salt processing machines contained tying clauses requiring purchase of unpatented salt and salt tablets consumed by the leased machines violated § 1 of the Sherman Act and § 3 of the Clayton Act).
of a tying arrangement is the suppression of competition. Buyers are denied a free choice between competing products, and competitors are denied free access to the market for the tied product. Power or leverage in the tying product market is exerted to restrain trade in the tied product market.

Although the tying claim in White & White was dismissed, the AHSC-VHA purchasing agreement, as implemented, was ultimately found to violate section 2 of the Sherman Act under the same type of leverage theory that courts employ in tying cases. The White & White leverage theory, however, does not require that products be "tied" together. Instead, the leverage exists between separate product categories that are linked together, but not tied together. By linking unrelated product categories together under the price cap and volume discount provisions of the agreement, AHSC levered the purchase of unpreferred AHSC products against the purchase of preferred AHSC products. Without deeming this interproduct linkage a tying arrangement, the court nonetheless found the linkage anticompetitive.

Other courts have held similar linkage schemes to be anticompetitive. In SmithKline Corp. v. Eli Lilly & Co., a district court in Pennsylvania found Lilly guilty of violating section 2 of the Sherman Act by creating and implementing a unique marketing scheme which linked two products on which Lilly faced no competition with a competitive product. The result of the scheme was that all three products were sold on a noncompetitive basis in what otherwise would have been a competitive market.

The standards of proof of a tying arrangement under § 1 and § 3 are not identical, but they involve the same general elements: (1) proof of a tying relationship between a defined tying product and a tied product, (2) proof that the defendant exerts "economic power" over the tying product, and (3) proof that a "not insubstantial amount of interstate commerce" is foreclosed from competition. 16B J. Von Kalinowski, supra note 85, at 11-18 to 11-9; 16A J. Von Kalinowski, supra note 85, § 6G.05[2], at 6G-81 to 6G-100.

100. Id. at 498-99 (quoting Northern Pac. Ry. v. United States, 356 U.S. 1, 6 (1958)).
101. Id.
102. 540 F. Supp. at 1004.
103. See generally Bowman, Tying Arrangements and the Leverage Problem, 67 YALE L.J. 19 (1957); Markovits, Tie-Ins, Reciprocity, and the Leverage Theory, 76 YALE L.J. 1397 (1967).
104. 540 F. Supp. at 1004.
105. Id. at 1005.
107. Id. at 1121.
108. Id.
The SmithKline plaintiffs, like the White & White plaintiffs, had originally alleged that the defendant’s marketing plan was a tying arrangement.\textsuperscript{109} While the district court in SmithKline rejected this allegation, it did state that Lilly’s plan was likely to have the same effect as a tying arrangement.\textsuperscript{110} By using the monopoly power it held in the noncompetitive drug market as a lever in its packaging scheme, Lilly would be able to extend its monopoly power into the previously competitive drug market.\textsuperscript{111}

Although the defendants in White & White and SmithKline avoided the per se liability associated with an illegal tie-in, both defendants were found guilty of attempted monopolization under section 2 of the Sherman Act because their linkage schemes created an anticompetitive leverage effect. Both courts relied on United States v. Griffith\textsuperscript{112} as authority for their leverage theories.

In Griffith, suit was brought under sections 1 and 2 of the Sherman Act against four affiliated corporations which operated movie theaters in a three state area.\textsuperscript{113} The exhibitors had entered into agreements with distributors whereby towns in which the exhibitors faced no competition were grouped with towns in which there were competing theaters.\textsuperscript{114} The exhibitors had thus been able to use the buying power of the entire area to gain exclusive privileges over competing theaters.\textsuperscript{115} The Supreme Court found that by linking the buying power of the noncompetitive towns with that of the competitive towns, the exhibitors had used their market power as leverage to obtain privileges which their competitors were denied.\textsuperscript{116}

The similarities of the defendants’ anticompetitive acts in SmithKline, Griffith, and White & White are evident. In each case, the defendants attempted to use the monopoly power they possessed in one market to create a monopoly in a second market, and in each case the court clearly held that such activity was illegal. In addition, White & White and SmithKline demonstrate that plaintiffs who fail to prove the elements of a tie-in can still recover under a leverage analysis.

\textsuperscript{109} Id. at 1110.
\textsuperscript{110} Id. at 1121.
\textsuperscript{111} Id. at 1128.
\textsuperscript{112} 334 U.S. 100 (1948).
\textsuperscript{113} Id. at 101-02.
\textsuperscript{114} Id. at 102-03.
\textsuperscript{115} Id. at 103-04.
\textsuperscript{116} Id. at 109.
AHSC has appealed the White & White decision seeking a redefinition of the relevant markets. AHSC hopes the Sixth Circuit will broaden the district court's relevant market definitions so as to diminish AHSC's market shares. Assuming the relevant markets were correctly defined and AHSC does indeed hold monopoly power, the Sixth Circuit should have little difficulty accepting the White & White leverage theory. In fact, the Sixth Circuit has already demonstrated that it would apply a rule of reason analysis in situations where a tie-in per se could not be proven.

In Ware v. Trailer Mart, Inc., for example, a mobile home owner sued a mobile home park claiming that the park was engaged in anticompetitive behavior by tying the purchase of mobile homes to leases for rental spaces at the park. The district court dismissed the complaint because the plaintiff had failed to allege an essential element of a tying offense, that the defendant possessed "appreciable economic power" in the market for the tying product, the rental space. The Sixth Circuit found that the allegation had been made, but more importantly, the court stated that proof of "appreciable economic power" was unnecessary if the plaintiff did not intend to prove a per se violation of section 1 of the Sherman Act. Since Ware did not intend to prove a per se violation, the court agreed to proceed under a rule of reason analysis. Precedent thus exists for the Sixth Circuit to apply the rule of reason to the anticompetitive leveraging found in White & White.

117. Thomas Dumit, deputy general counsel for AHSC, has stated that AHSC will ask the Sixth Circuit to redefine the relevant product market to include all hospital supplies, rather than just medical-surgical supplies. See Kuntz, AHSC Antitrust Decision May Curb Group Buying, 12 MODERN HEALTHCARE 18 (June 1982).


118. 623 F.2d 1150 (6th Cir. 1980).
119. Id. at 1152.
120. Id. at 1153.
121. Id. In coming to this conclusion, the Sixth Circuit relied on Fortner Enters. v. United States Steel Corp., 394 U.S. 495 (1969). In that case, the Supreme Court confronted a traditional tying arrangement whereby credit was sold only on the condition that the plaintiff also purchased prefabricated houses. Id. at 498. The trial court relied on the standards set forth in Northern Pac. Ry. v. United States, 356 U.S. 1 (1958), and held that the defendants lacked "sufficient economic power" over the tying product, credit. 394 U.S.
Guidelines

Although White & White is pending appeal in the Sixth Circuit, the district court opinion does highlight certain pitfalls which hospitals should avoid when entering into shared purchasing agreements. For example, contracts covering broad product and geographic categories should be avoided. There should be no linking of unrelated hospital supply products through single price cap and volume discount terms. Rather, price caps and volume discounts should be limited to a single, broad product category, such as medical-surgical supplies or parenteral products. Each hospital subscribing to the agreement should be able to calculate at the time of purchase the net price of each product covered under the agreement. Price caps and volume discounts should be based on each hospital's purchases rather than on aggregate hospital purchases. Most importantly, the agreement should avoid any hint of leveraging or tying and should stimulate competition, rather than suppress it.

Shared purchasing agreements are a useful cost containment method and can be written and implemented without violating the antitrust laws. To illustrate, on June 10, 1982, the Justice Department issued a business review letter informing the Ohio Hospital Purchasing Consortium (OHPC)\textsuperscript{123} that OHPC's proposed group purchasing program would not be challenged under the antitrust laws.\textsuperscript{124} Under the OHPC plan, OHPC would select a number of products, excluding services, for statewide group purchasing. Once estimates of needed supplies were received from the local purchasing groups, OHPC would tabulate the orders and solicit bids from a number of suppliers. OHPC would then recommend successful vendors and contracts would be sent to local purchasing group members or individual hospitals. No

\textsuperscript{122} 623 F.2d at 1154.
\textsuperscript{123} OHPC is comprised of eight local groups which represent 160 of Ohio's 204 not-for-profit hospitals.
\textsuperscript{124} U.S. Dept of Justice Business Review Letter from William F. Baxter to B. William Dunlop (June 9, 1982).
party would be committed to purchasing any product(s) offered through OHPC until the contract was executed.

The Justice Department found it significant that no purchasing group or participating hospital would be required to purchase any of its requirements for any product through OHPC, nor was any member or hospital precluded from dealing with any particular supplier. The Justice Department believed the proposal would result in further cost containment for hospitals and saw no likelihood that OHPC's joint purchasing program would restrain trade in any particular product market.

The differences between the OHPC plan and the AHSC-VHA program are striking. OHPC would solicit bids from many suppliers, individual contracts would be written, and no group member would be required to participate in the purchasing plan. Unlike the AHSC-VHA program, OHPC's plan would encourage competition, not restrain it.

CONCLUSION

Shared purchasing agreements are a useful cost containment method for hospitals and other health care providers. In order to avoid any conflict with the antitrust laws, shared purchasing agreements should be written with the White & White guidelines in mind. Anticompetitive leveraging through product linking or product tying should be avoided at all costs. The group purchasing plan proposed by OHPC illustrates that shared purchasing agreements can be drafted so as to contain rising health care costs without provoking antitrust challenges.

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125. Id. at 2.
126. Id.