

# Journal of Health Law

Spring 2002 Volume 35, No. 2

## Price Competition in Hospital Markets: The Significance of Managed Care

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HEALTH LAWYERS  
ASSOCIATION



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# Price Competition in Hospital Markets: The Significance of Managed Care

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**ABSTRACT:** Anticompetitive conduct in the healthcare industry is often hard to detect, and has been ignored by some courts that appear to lack an understanding of managed care and its significance in maintaining price competition. These courts have adopted an approach that is far too historical and mechanistic, and is characterized by outdated factors analyzed in isolation from each other. In order to preserve effective price competition, the courts should embrace a realistic analysis that accurately reflects the workings of health services markets. This article describes the many facets of market power and anticompetitive conduct, and how they affect healthcare prices. The author then turns to an analysis of two recent hospital antitrust decisions, and critiques them for their failure to properly analyze the dynamics of local hospital markets.

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It is not an exaggeration to say that the history of price competition in hospital and other health services markets is little more than the history of managed care.<sup>1</sup> The largest source of hospital revenue, Medicare, pays hospitals on a take-it-or-leave-it basis; because of the magnitude of the payments involved, hospitals cannot afford to “leave it.”<sup>2</sup> On the other hand, people with traditional indemnity coverage, and individuals unfortunate enough to be without any form of public or private health insurance, have no leverage with which to bargain. They pay the list prices charged by the hospital, although patients with indemnity coverage are reimbursed by their insurers for covered services.

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At least for complicated services, including most inpatient hospital services, individuals are faced with a maze of charges for various items, services, and procedures. There is simply no way for an individual patient to “comparison shop.” They will never know—and, if they are reimbursed in full, probably do not care—whether they could have obtained the same services at another hospital for less.<sup>3</sup>

The thesis of this article is that recent judicial decisions reveal a lack of understanding of managed care, as well as its significance in maintaining price competition in hospital and other health services markets. In order to safeguard price competition in these markets, the courts must come to appreciate the potential of certain arrangements involving dominant hospitals to reduce price competition by limiting the choices available to managed care organizations (MCOs).

In geographic areas with multiple hospitals, managed care has changed the fundamental dynamic of those markets by negotiating “bulk rate” discounted payment arrangements with selected hospitals. Not too long ago, it was relatively easy for MCOs to negotiate discounts with hospitals. Managed care enrollment was low, and hospitals viewed the discounted arrangements as relatively harmless, at worst; particularly because cost-based Medicare reimbursement provided assurance that Medicare related costs would be paid, even if the hospital was relatively inefficient.

At the same time, MCOs found more than enough hospitals to negotiate with, largely as a result of federal government policies that encouraged hospital overbuilding. At least conceptually, hospitals that failed to agree to discount arrangements deemed to be satisfactory to managed care plans were at risk of exclusion from hospital networks.

By 1983, things had begun to change. In that year, the Medicare program switched from cost-based hospital reimbursement to Diagnostic Related Group (DRG) fixed payments for inpatient hospital services, which provided a significant impetus for the hospitals to become more efficient by reducing costs. Managed care began to grow rapidly, at least in part because it offered lower premiums than traditional health insurance. As more people began to participate in managed care, however, both provider and consumer objections to the restrictive policies of MCOs, and particularly health maintenance organizations (HMOs), also increased significantly. A “managed care backlash” began to emerge, while hospitals also began to consolidate in increasing

numbers. The economic consequences of these actions are not yet fully determinable.

But this is a law journal article, so what of the courts? At least as seen through the eyes of this observer, the early antitrust decisions dealing with managed care issues, with only a few exceptions, were impressive, assimilating complicated facts and difficult legal concepts with precision and accuracy. Thus, the courts have long understood that “HMOs often can provide health care at lower costs by . . . driving hard bargains with doctors or hospitals (who thereby obtain more patients in exchange for a reduced charge).”<sup>4</sup> “One of the essential features of an HMO is that it selects preferred physicians and excludes others thereby creating competition among the providers of health care services.”<sup>5</sup> “Unlike a patient with ordinary health insurance, the HMO patient is limited to the panel of doctors who have contracted with the HMO.”<sup>6</sup>

Courts also have recognized that less-restrictive forms of managed care, often called preferred provider organizations (PPOs), are procompetitive for similar reasons. “[I]t is generally recognized that PPOs can, in the proper circumstances, lower the cost of medical care to consumers by allowing negotiation of lower prices through consumers’ representatives, such as employers or insurance companies.”<sup>7</sup>

Nevertheless, virtually everyone knows that there has been a “backlash” against managed care, particularly against the most restrictive forms of managed care. Since the arrival of this “managed care backlash,” several cases, including the two discussed in detail in this article, badly miss the mark in the author’s view, treating anticompetitive conduct as legally permissible under the antitrust laws. Whether this trend is attributable to the “managed care backlash” itself, to the increasing intricacy of managed care arrangements, or to some other cause cannot be known. It is certain, however, that the trend places the future of price competition in hospital and other health services markets in serious jeopardy.

## I. Background

There is little dispute that the antitrust laws prohibit both 1) concerted conduct that has the effect of restricting competition, and 2) unilateral conduct by dominant firms that creates or maintains monopoly power, or at least the dangerous probability of monopoly power, by precluding competition.<sup>8</sup> Except for agreements like price fixing, market division, and boycotts, which are considered “per se” illegal because their anticompetitive

potential is so obvious that it is presumed as a matter of law, all other conduct is examined on a case-by-case basis to determine whether the defendants have used, or are likely to use, their “market” or “monopoly” power to injure competition.<sup>9</sup>

“Market power is the power ‘to force a purchaser to do something that he would not do in a competitive market.’ . . . It has been defined as the ‘ability of a single seller to raise price and restrict output.’”<sup>10</sup> Monopoly power, which has been described as something greater than market power, is the power to control prices, or exclude competition.<sup>11</sup>

Liability in antitrust law almost always requires proof of market power. This is because market power is an essential ingredient of injury to consumers. Market power means the ability to injure consumers by curtailing output and raising price; no possible injury, no market power; no market power, no violation; injury to consumers is therefore an essential ingredient of liability.<sup>12</sup>

On the other hand, if dominant firms exercise their economic power to harm consumers by excluding competition or increasing prices, then the antitrust laws are clearly implicated.

Unfortunately, these generally-recognized antitrust principles are far easier to state than to apply correctly to health services markets. Health services markets are different from other markets, offering individual consumers fewer opportunities to take advantage of competitive alternatives, even where they exist. Individual consumers lack information to make informed choices, and third parties, rather than the consumers themselves, often pay all, or at least a large part, of the bill. For these reasons, the normal pressures of the marketplace simply did not operate to constrain the behavior of sellers of medical and hospital services prior to the introduction of managed care.

This was precisely the situation that Congress recognized in passing the Federal HMO Act in 1973. The Senate report noted that “[f]irst, and most important, the development of HMOs throughout the country will provide consumers with the opportunity to choose the manner in which they will pay for and receive health care services.” Indeed, HMOs were seen by Congress as a way to inject an element of competition into an essentially non-competitive area.<sup>13</sup>

### ***A. Federal Policies Initially Fueled Hospital Oversupply***

Health plans such as health maintenance organization (HMOs) and preferred provider organizations (PPOs) benefit from greater hospital competition because competition makes it easier for plans to steer their enrollees towards those hospitals that offer the most attractive contract terms. Those benefits will generally be passed along to the health plans' customers: the employers and their employees. This means that health plans constitute an important class of buyers of hospital services . . . .<sup>14</sup>

During the two decades following the enactment of the federal HMO Act, HMOs and related forms of MCOs were able to negotiate discounted arrangements with hospitals, in large part because there was significant hospital oversupply as a result of federal policies. In the years immediately following the Second World War, Congress became involved with the construction of healthcare facilities through the enactment of the Hill-Burton Program. By 1978, the program had used \$4.4 billion in federal money as leverage to get state and local governments to contribute an additional \$9.1 billion.<sup>15</sup> These funds financed 500,000 beds, almost half of the hospital beds in use in 1985.<sup>16</sup>

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With the inception of the Medicare and Medicaid programs, the federal government further contributed to a proliferation of hospital facilities. "Prior to the implementation of Medicare and Medicaid in 1965, the federal government financed about 15 percent of hospital spending. Today, with federal financing of care for the elderly and disabled, total government spending accounts for more than 50 percent of the net revenue of community hospitals . . . ." <sup>17</sup> Significantly, Medicare and Medicaid subsidized a major share of increased capital expenditures by reimbursing hospitals based on their costs.

### ***B. Medicare Prospective Payment Encouraged Hospital Efficiency***

The Social Security Amendments of 1983,<sup>18</sup> which implemented the DRG prospective payment system (PPS) for inpatient hospital services, dramatically changed hospital incentives by replacing the historical cost-based reimbursement with a fixed price system. As stated in the legislative history, the statute was "intended to reform the financial incentives hospitals face and promote efficiency in the provision of services by rewarding cost-effective

hospital practices.”<sup>19</sup> Once the new system went into operation, hospitals were placed at risk if their costs exceeded the fixed payment amount.<sup>20</sup> Still, hospital consolidation did not reach epidemic proportions until the beginning of the last decade, contemporaneous with the dramatic increase in managed care enrollment.

### *C. The Ambiguous Nature of Hospital Consolidation*

The stated goal of hospital consolidation is almost always a desire to increase efficiency.<sup>21</sup> Moreover, there can be no doubt that the reduction in the number of hospital facilities and services can, and has, reduced hospital costs in a variety of different circumstances. Nevertheless, it is also true that consolidation often leads to significant market concentration and the concomitant creation of, or increase in, market power. When this power is exercised to raise price above competitive levels or to exclude less-powerful competitors, consumers and competition are injured, even if the costs of hospitals are reduced.<sup>22</sup>

Thus, in order to avoid invalidation under the antitrust laws, facilities that increase their market power in a consolidation must pass through cost savings to consumers in the form of lower prices.<sup>23</sup> If, after consolidation, hospital prices increase beyond competitive levels, the antitrust laws are available to invalidate the merger. As explained by the Seventh Circuit in one hospital merger case,

hospitals are under great pressure from the federal government and the insurance companies to cut costs. One way of resisting this pressure is by presenting a united front in negotiations with the third-party payors. . . . The fewer the independent competitors in a hospital market, the easier they will find it . . . to frustrate efforts to control hospital costs. This too is a form of collusion that the anti-trust laws seek to discourage . . . .<sup>24</sup>

### *D. Recent Hospital Consolidation Has Been Unprecedented*

It is difficult to identify the extent of hospital consolidation during the last decade with precision. One healthcare research company that tracks hospital mergers has reported approximately 1,000 such mergers and acquisitions between January 1, 1994, and January 1, 2002.<sup>25</sup> A less-conservative source estimates that more than 760 hospitals announced merger or acquisition plans in 1996 alone, an increase of over 5% from 1995.<sup>26</sup> Addi-

tionally, the latter source estimates that almost 40% of the nonfederal hospitals in the United States were involved in merger or acquisition activity in the three years ending in 1996.<sup>27</sup> Regardless of the correct number, however, there is no dispute that the explosive trend towards consolidation is unprecedented, and may have reduced the number of competing hospitals so dramatically that it is contributing to a national increase in healthcare costs.

### *E. Hospital Costs Are Increasing*

[H]ealth care's share of the nation's gross domestic product (GDP), after rising steadily at burdensome rates for many years (claiming an additional .37 of a percentage point of GDP, on average, each year from 1980 to 1993), stopped rising altogether in 1993 and remained essentially level at around 13.6 percent for six years, through 1998.<sup>28</sup>

But that has changed. "Record consolidation took place among hospitals during the mid- to late 1990s. As a result, fewer hospital systems dominate many major metropolitan areas. In the past few years, mergers . . . have shifted negotiating leverage to major hospital systems, which in some markets has resulted in higher hospital rates."<sup>29</sup> According to a recent federal report, "[a]fter nearly a decade of stability, health care spending grew to \$1.3 trillion in 2000, up nearly 7 percent from 1999, and the fastest acceleration in twelve years."<sup>30</sup> "In contrast to recent years, hospitals drove spending growth in 2000. Hospital spending rose to \$412 billion in 2000, a 5.1 percent increase from 1999 and the first such rise since 1993."<sup>31</sup> According to another study, "[o]verall, health care costs increased 7.2 percent in 2000—the largest jump in a decade—with inpatient and outpatient hospital care accounting for nearly half, or 43 percent, of the overall increase."<sup>32</sup> "Consumer demand for broad networks of hospitals and physicians and health plans' easing of care restrictions, coupled with hospital consolidation and reduction in excess capacity, have increased some hospitals' bargaining clout with health plans."<sup>33</sup> It has been estimated that, by 2007, the elimination of managed care would increase the cost of private health insurance by \$66 billion.<sup>34</sup>

### *F. The Managed Care Backlash Has Encouraged the Creation of Less-Restrictive Managed Care Options*

Managed care enrollment, and particularly enrollment in the most restrictive form of managed care—HMOs—grew dramatically beginning in 1985. The number of Americans in HMOs rose

rapidly from fifteen million in 1984 to more than fifty million in 1996.<sup>35</sup>

In 1983, about four percent of private-sector employees belonged to an HMO. By 1993, 52 percent of those working for a company with ten or more employees were in some sort of “managed care” plan. With the failure of national health reform, private-sector migration to managed care turned into a stampede. By 2000, 92 percent of workers at companies with ten or more employees were in managed care.<sup>36</sup>

Still, there can be no doubt that managed care has encountered a serious backlash in public opinion.<sup>37</sup> Indeed, one healthcare law periodical published a special issue on the subject as early as 1999.<sup>38</sup> Because of marketplace forces, managed care plans have moved toward offering “less restrictive managed care products and product features that respond to consumers’ and purchasers’ demands for more choice and flexibility.”<sup>39</sup> As a consequence, the “share of workers covered by more restrictive HMOs has remained stable since 1998, while the share of those covered by preferred provider organizations has risen from 35 percent in 1998 to 41 percent in 2000.”<sup>40</sup>

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Precisely the same factors fueled the national enrollment increase in Blue Cross. National Blue Cross Blue Shield enrollment was 82.6 million last year, a huge rebound from a low of 65.2 million in 1994.<sup>41</sup> “The turnaround was caused partly by consumers’ negative reaction to tightly managed health maintenance organizations; customers returned to Blue Cross Blue Shield plans that offered a wider array of choices among doctors and hospitals.”<sup>42</sup>

Ironically, this trend toward more inclusive managed care provider networks further increased the market power of dominant hospitals seeking to increase prices or exclude smaller competitors. Put simply, it became more difficult, if not impossible, to exclude dominant hospitals from managed care products utilizing broad hospital networks.

### ***G. The Backlash Has Become a Part of Popular Culture***

The backlash against managed care has done more than alter plan design and consumer preference. It has become a part of popular culture; “[b]eginning with an increasing flood of media anecdotes and editorial criticism, it seemed to culminate when movie audiences throughout the country applauded an anti-HMO exple-

tive by the actress Helen Hunt in the 1997 film, *As Good As It Gets*.<sup>43</sup> Not surprisingly, there have been judicial analogues, the most famous of which was a statement made in an opinion written by Judge Richard Posner, one of the most highly-regarded antitrust jurists in the country.

Judge Posner, writing for the Seventh Circuit in *Blue Cross & Blue Shield United v. Marshfield Clinic*,<sup>44</sup> professed no desire to align himself with the critics of HMOs. He did suggest, however, that from a short-term financial standpoint, “the HMO’s incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible.”<sup>45</sup> Of course, Judge Posner did not imply that HMOs actually behaved in this way. In fact, there is empirical evidence that “[HMOs]” provide the same levels of hospital, surgical and emergency room care as do other types of health plans.<sup>46</sup>

Nor did Judge Posner argue that letting sick patients die was consistent with an HMO’s long-term market incentives. Employers and their employees easily can switch between competing health plans.

The purchasers of the [managed care] services are not necessarily the patients. Employers often supply healthcare coverage for employees, and they are intensely interested in reducing the price of any given level of care. These employers may shop around different plans assembled by different HMOs and hospitals. They also consider traditional insurance packages.<sup>47</sup>

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The events of the past few years demonstrate that employers and their employees do precisely that when they are unhappy with managed care arrangements that they view as overly restrictive. Given the existence of available alternatives, it is highly unlikely that any HMO, or any other managed care plan, that routinely permitted its sick members to die would succeed in the marketplace. It is even less likely that HMOs and/or other managed care plans in a particular market would tacitly agree to let all their sick members die quickly so that they could increase profits.

In any event, medical decisions regarding treatment provided to members of MCOs, including HMOs, are most often made by physicians—and not by the organizations themselves. In a 1998-1999 household survey involving 32,000 families and 59,000 individuals, only 44% of the adults with public or private insurance who had visited a doctor in the previous 12 months, or had a

doctor as a usual source of care, believed that their doctor was strongly influenced by health insurance company rules when making patient care decisions.<sup>48</sup> Only 7% believed that doctors fail to put their patient's needs first.<sup>49</sup>

Nonetheless, Judge Posner's statement has achieved significant notoriety, even finding its way into one of the two opinions analyzed in this article.<sup>50</sup> Both of the opinions discussed as follows seem wrongly decided, but there is a much greater cause for concern. One need not be a managed care apologist in order to recognize its critical role in maintaining price competition.

An important determinant of . . . negotiations between hospitals and third-party payors is the ability of third-party payors to turn to alternative providers. The presence of alternative hospitals helps to give these payors leverage because it is the willingness of the individuals they insure to actually use these alternatives that ultimately discipline pricing by the merged entity. That is because when hospitals negotiate reimbursement rates with payors, they balance the increase in profits that would result from raising prices further (i.e., the additional profit that would be made from those who would continue to use the hospital and pay the higher price) against the lost profits that would result from those who decide to use alternative hospitals.<sup>51</sup>

Where there are no good alternatives, a dominant hospital can use its market power to increase price or exclude competitors. When increased market power has been exercised as a result of consolidation, or is used to exclude competition, the antitrust laws should be available to interdict the conduct. In several recent cases, however, the courts appear to have lost sight of the fundamental premise of the antitrust laws, as well as the techniques available to make sound antitrust judgments.

The two cases discussed in the remainder of this article exemplify the ways in which courts can lose their way, and ultimately miss the point. The first case involves an effort by a dominant hospital in Hammond, Louisiana, to limit competition for outpatient surgery services. The second case addresses a proposed merger of the only two hospitals in Poplar Bluff, Missouri. In both cases (*Hammond* and *Poplar Bluff*), the courts misdefined the geographic market by pointing to potential hospital alternatives that were not good substitutes. In the *Hammond* case, there was no

evidence that MCOs could sell their products without a contract with the defendant, North Oaks Hospital, the only hospital in Hammond. Similarly, in the *Poplar Bluff* case, there was no evidence that MCOs could sell managed care products without a contract with one of the two merging hospitals. By failing to acknowledge this critical evidentiary deficiency, the courts failed to accurately assess the anticompetitive potential of the arrangements at issue in both cases.

## II. The Hammond Case: A Dominant Hospital's Exclusionary Conduct

In an antitrust complaint filed in 1997, the plaintiff, St. Luke's (a freestanding surgery center), alleged that the defendant, North Oaks (a full-service hospital), enjoyed a monopoly in the local market for acute care hospital services. The plaintiff claimed that North Oaks was attempting to extend its monopoly into the market for outpatient surgical care by "pressuring five of the seven largest managed care plans in the market into contracts calculated to exclude St. Luke's from the market for outpatient surgical care."<sup>52</sup> The District Court dismissed the case.

On August 27, 1998, the Fifth Circuit affirmed the District Court's dismissal, holding, as had the District Court, that the allegedly anticompetitive conduct of the defendant North Oaks was immune from antitrust scrutiny as a result of the "state action immunity" first enunciated by the Supreme Court in 1943 in *Parker v. Brown*.<sup>53</sup> However, in 1999, the Fifth Circuit, again sitting *en banc*, unanimously reversed and remanded the case to the District Court for further proceedings.<sup>54</sup> A bench trial was held in October of 2000, and on January 3, 2001, the District Court issued its Order and Reasons, once again absolving defendant North Oaks from antitrust liability.<sup>55</sup>

In concluding that St. Luke's had not established a violation of section two of the Sherman Act under the theories of monopoly leveraging or attempted monopolization, the District Court focused primarily on the definition of geographic market for inpatient hospital services, and an estimate of defendant's shares in the markets for inpatient hospital services and outpatient surgical services. The District Court's ultimate conclusion was that, as a result of the estimated market shares, the defendant, North Oaks, did not have sufficient market power to violate section two of the Sherman Act, either in the market for acute care hospital services, or the market for outpatient surgical services.<sup>56</sup>

### A. *The Undisputed Facts*

Certain essential facts appear undisputed from the District Court's opinion. In late 1992, defendant North Oaks purchased the only other acute care hospital (West Park) in the Hammond-Ponchatoula area of Louisiana.<sup>57</sup> From that time until plaintiff St. Luke's opened its doors in 1996, "there was no effective competition to North Oaks for outpatient surgery in [the] Hammond-Ponchatoula area."<sup>58</sup> Plaintiff St. Luke's was, literally, the closest competitor to defendant North Oaks with respect to outpatient surgery. As the only freestanding ambulatory surgery center in the immediate Hammond-Ponchatoula area, however, St. Luke's did not compete with defendant North Oaks, a full-service acute care hospital, for inpatient services or nonsurgical outpatient services.<sup>59</sup>

Prior to the entrance of St. Luke's into the market for outpatient surgery, North Oaks had more than a 70% market share.<sup>60</sup> By 1999, however, North Oaks' market share in the outpatient surgery market had been reduced to between 42.3% and 44.3% of the market, while St. Luke's had gained between a 22.1% and 23.3% share of the relevant market.<sup>61</sup> Faced with a diminishing market share, North Oaks offered managed care plans up to an additional 25% discount on all services across the board if the managed care plans agreed to deal exclusively with North Oaks, and did not deal with St. Luke's.<sup>62</sup> Five of the seven major managed care plans signed agreements to exclude St. Luke's.

Rejecting both the market analysis proposed by the plaintiff's expert and much of the analysis proposed by the defendant's expert, the District Court effectively constructed its own geographic market for inpatient hospital services.<sup>63</sup> The court stated that the appropriate first step in the hospital inpatient services market analysis should be the creation of a 90% service area, meaning the geographic area from which North Oaks obtained 90% of its patient days.<sup>64</sup> Noting that, within this service area, North Oaks accounted for only 50.90% of the total inpatient days, the District Court concluded that "with out-migration 'leakage' of roughly fifty percent, the service area *alone* [was] too porous to constitute a relevant 'monopoly' market."<sup>65</sup> The District Court then concluded that the geographic market must extend at least as far as Covington, a community approximately twenty-five miles away.<sup>66</sup>

Using Covington as the outer boundary of the geographic market, the District Court estimated the defendant's market share in the inpatient hospital services market at 49.2%.<sup>67</sup> The District

Court then dismissed plaintiff's monopoly-leveraging claim, explaining that, as a matter of law, defendant's market share was less than the 50% required as the threshold for monopolization.<sup>68</sup>

Turning to the plaintiff's attempted-monopolization claim, the District Court failed to define a geographic market for outpatient surgical procedures. Instead, the court accepted the testimony of the plaintiff's expert that defendant's market share was between 42.3% and 44.3% of the market for outpatient surgery.<sup>69</sup> The District Court then concluded that this share was insufficient to establish attempted monopolization in the market for outpatient surgical procedures.<sup>70</sup> The District Court relied further on plaintiff's expert to conclude that, even if St. Luke's discontinued operations, defendant's market share percentage would be no higher than the "low 60s," still too low in the District Court's view to support an attempt to monopolize the market for outpatient surgical procedures.<sup>71</sup>

The District Court also assessed the defendant's contracts with managed care plans, finding that contracting for combined inpatient and outpatient hospital services was not uncommon.<sup>72</sup> Based on that finding, and certain statements of plaintiff's expert, the court concluded that the defendant's contracting policy was "reasonable and procompetitive."<sup>73</sup>

### ***B. Health Services Markets Are Local***

Most people recognize, at least intuitively, that geographic markets for garden-variety hospital and medical services are local. At least some of the reasons for this phenomenon are painfully obvious. Patients have almost no information regarding the medical options available to them with respect to most medical procedures. They tend to rely on recommendations made by their physicians. "[O]ften, the physician rather than the patient makes the important choices."<sup>74</sup> Where local physicians are capable of performing the procedures, they are likely to utilize medical facilities close to home. An additional half-hour one-way drive time can substantially diminish a physician's ability to maximize the number of procedures that can be performed in a day.

Going to another city is out of the question in medical emergencies; and even when an operation or some other hospital service can be deferred, the patient's doctor will not (at least not for reasons of price) send the patient to another city where the doctor is unlikely to have hospital privileges.<sup>75</sup>

Even in cases in which the physician is required to make a referral, that referral is likely to be local. Physicians generally refer to other physicians with whom they have relationships, and relationships are far more common when physicians practice in the same geographic location.

### *C. The District Court Failed to Consider Market Realities*

Unfortunately, the District Court utilized a mechanistic analysis, devoted exclusively to the examination of limited shipments data, to define the geographic market and calculate market shares. This approach disregarded powerful evidence that the geographic market was far more limited, as well as significant direct evidence of both market power and anticompetitive effects.

Remarkably, the District Court did not mention the limited geographic dimensions of the exclusivity agreement itself, although the terms of that negotiated agreement provide perhaps the best evidence of the geographic area of competitive concern to the defendant. Presumably, the defendant was concerned that, if enrollees of the managed care plans had the choice, then some of them would use other competitors within the area, such as the plaintiff. Significantly, the defendant evidenced no similar concern with possible competitors *outside* the area of the exclusive agreement.

It is hard to conceive of anything more revealing of the defendant's perception of the geographic limits of competition. Had defendant been concerned about competition from a broader geographic area, its demands on the managed care plans would have been different. Even more fundamentally, in reaching its erroneous result, the District Court missed the point of market definition—to identify the existence of market power—and avoided any consideration of the relevant evidence that the defendant both had such power, and exercised it to the detriment of consumers.

Where there is direct evidence of anticompetitive conduct or market power, it should not be dismissed or disregarded. As the Supreme Court has cautioned, “[l]egal presumptions that rest on formalistic distinctions rather than actual market realities are generally disfavored in antitrust law.”<sup>76</sup> In determining the existence of market power, and specifically the sensitivity of sales of one product to price changes of the other, the Supreme Court “has examined closely the economic reality of the market at issue.”<sup>77</sup> When there is direct evidence of excluded competition, the defendant must demonstrate that “an inference of market power is unreasonable.”<sup>78</sup>

Indeed, the Supreme Court has recognized that

[s]ince the purpose of the inquiries into market definition and market power is to determine whether an arrangement has the potential for genuine adverse effects on competition, “proof of actual detrimental effects, such as a reduction of output,” can obviate the need for an inquiry into market power, which is but a “surrogate for detrimental effects.”<sup>79</sup>

Accordingly, the Seventh Circuit recently upheld antitrust liability against Toys “R” Us (TRU), a toy retailer responsible for approximately 20% of toy sales in the United States.<sup>80</sup> As that court explained:

[the Defendant] seems to think anti-competitive effects in a market cannot be shown unless the Plaintiff, or here the [Federal Trade Commission (FTC)], first proves that [Defendant] has a large market share. This, however, has things backwards. As we have explained elsewhere, the share a firm has in a properly defined relevant market is only a way of estimating market power, which is the ultimate consideration. The Supreme Court has made it clear that there are two ways of proving market power. One is through direct evidence of anticompetitive effects.<sup>81</sup>

#### *D. The District Court’s Misuse of Shipments Data*

Market share is only one indicator of market power. “When there are better ways to estimate market power, the courts should use them.”<sup>82</sup> As a technical matter, market definition involves an analysis of cross-elasticity of demand. A relevant market is, in antitrust terms, the collection of firms that are good substitutes for each other. “[T]he concept of elasticity remains indispensable in giving meaning to the concept of market.”<sup>83</sup> Thus, in a competitive market, an attempt by a single firm to increase price or decrease quality will be unprofitable because, by definition, there are good alternatives and consumers lose little or nothing by switching to other firms within the market. The existence of good alternatives is what defeats the attempt to increase price, reduce output, or exclude competitors.

Of course, cross-elasticity of demand does not come ready-made for antitrust analysis, at least in most circumstances. Reasonably

good surrogates exist, however, and courts have used them. Unfortunately, the District Court in the *Hammond* case did not use these surrogates. Instead the court relied solely on its own calculation of shipments data to mechanistically define a market and calculate market shares that the court determined were too low, as a matter of law, to produce anticompetitive effects—even though there was direct evidence of such anticompetitive effects.

Even more importantly, the court failed to recognize the significance of MCOs as the purchasers of services. An analysis of shipments data provides “little information relevant to defining geographic markets when health plans are viewed as the direct purchaser of hospital services.”<sup>84</sup> The fact that certain individuals may use hospitals outside a particular area does not allow economists to determine whether a price increase to managed care plans operating within the area would be profitable. In a word, shipments data do not speak directly to cross-elasticity, and particularly cross-elasticity for managed care enrollees, the critical question in geographic market definition.

The use of shipments data to define a relevant geographic market involves a test first postulated by two economists, Elzinga and Hogarty, to analyze the geographic market and the potential creation of market power in the context of proposed mergers within the coal industry.<sup>85</sup> The Elzinga-Hogarty (E-H) test delineates the relevant geographic market as a geographic area in which imports by consumers who live within the area account for a small fraction of area demand, and exports by firms located within the area account for a small fraction of their combined sales.<sup>86</sup> In the context of hospital markets, the test calculates the percentage of patients residing within the area who utilize facilities within the area, and the percentage of hospital admissions to (or patient days of) hospitals located within the area attributable to patients that reside within the area.<sup>87</sup> If the “leakage” percentages from both calculations are below the selected threshold, then the area is determined to be the relevant geographic market. If either leakage percentage is above the threshold, then the geographic area of the market is expanded until both thresholds are met.<sup>88</sup> The extent of leakage, however, is not necessarily definitive proof that an area is (or is not) a market for antitrust purposes.

Surely, a total lack of leakage indicates that there are no good substitutes, but the converse may not be true. Specifically, the existence of relatively high leakage of hospital patients out of an area can be consistent, not with the existence of good substitutes,

but with a hospital's ability to exercise market power by profitably increasing price or excluding competitors. Indeed, the leakage may be evidence that the hospital has been able to do precisely that because there are no good substitutes.

"The fact of shipments from one point to another is not really as important as the reason for it."<sup>89</sup> The problem with all shipments tests, including the E-H test, is that they merely compute observed inflows and outflows of patients, without shedding light on the underlying reasons why residents of an area make the choices they do. Thus, in assessing whether the exercise of market power has been, or would be, profitable, shipments tests can produce misleading results because they are necessarily "static." The exercise of market power is, rather, a dynamic concept, referring to price and/or quality changes and the resulting customer responses or changes in behavior. A test that is a mere "snapshot" of consumption patterns at a given point in time cannot reveal whether the exercise of market power has been or will be profitable. Specifically, the test cannot reveal whether, or by how much, consumer flows are likely to change in response to the future exercise of market power, or whether a previous exercise of market power is responsible for any of the historical observed customer movements across areas. Shipments data, while useful, simply are not sufficient to define markets.<sup>90</sup> For this reason, several courts have been critical of the use of shipments data as the determinant of geographic market—the approach adopted by the District Court in the *Hammond* case—and have urged the adoption of more dynamic analysis.<sup>91</sup>

### ***E. Shipments Data Overstate the Boundaries of a Geographic Market Where Market Power Has Been Exercised***

When a court must contemplate the profitability of a future exercise of market power, as in the analysis of a proposed merger, the use of shipments data can understate the size of the geographic market. A future exercise of market power by the merging parties will cause their prices to rise or their quality to fall relative to the prices or the quality of their competitors. In turn, this could induce customers to switch to lower-priced or higher-quality alternatives. If spatially more-distant sellers may be substituted for the defendant(s) in large enough quantity, the size of the geographic market will expand. However, because historical shipments data do not portray the extent to which reasonable substitution might occur in response to future price changes by defendants, analysts cannot determine from the historical information alone which additional firms, if any, must be added to comprise an appropriate antitrust market.

In contrast, in a hospital monopolization case, or in a case retrospectively evaluating the conduct of consolidated hospitals, a distinct possibility exists that the defendants have already exercised market power by charging supra-competitive prices, providing less than competitive quality, or excluding smaller competitors. If so, some of the observed sales by nondefendants to residents who reside in plaintiff's proposed geographic market may reflect the past or current exercise of market or monopoly power by the defendant. In effect, the substitution that is observed confirms, rather than refutes, the existence of monopoly power. "Reasonable interchangeability at the current price but not at a competitive price level, far from demonstrating absence of monopoly power, might well be a symptom of that power."<sup>92</sup>

Even monopolists face downward sloping demand curves. As the Supreme Court has observed, even if a defendant cannot raise prices by one cent without losing sales, that, without more, would not disprove the existence of market power. "The sales of even a monopolist are reduced when it sells goods at a monopoly price, but the higher price more than compensates for the loss in sales."<sup>93</sup> The loss of sales to other sellers outside the market hardly negates the existence of market, or monopoly, power. It can confirm the existence of monopoly power, as the District Court failed to recognize.

Indeed, the District Court compounded its error in relying exclusively on shipments data by treating those data as if they were being used in evaluating the geographic market in a case involving a future exercise of market or monopoly power, rather than a monopolization case. By the District Court's logic, "the higher the monopoly price, and therefore the greater the substitution of other products, the less likely it is that the court will find that the defendant has monopoly power."<sup>94</sup>

In contrast to the District Court's approach, other courts have utilized direct evidence of market power. Thus, in one recent case, a district court invalidated a merger between two chains of office superstores (Staples and Office Depot), even though the superstores represented an insignificant share (5.5%) of all the stores selling office supplies in any local market.<sup>95</sup> Nevertheless, the court concluded that pricing data established the presence or absence of other superstores was a significant determinant of the prices charged by superstores in any geographic market.<sup>96</sup> In economic terms, there was a high cross-elasticity of demand between superstores, but a low cross-elasticity of demand between superstores and other sellers of office supplies. As a result, the

court in that case determined that superstores represented a separate market for antitrust purposes.<sup>97</sup>

### *F. Better Ways to Identify Geographic Markets*

Similar information could have been evaluated in *Hammond*. For example, if North Oaks historically charged higher prices or granted smaller discounts than comparable facilities located in more competitive areas, then an inference of market power would be appropriate. Similarly, evidence that North Oaks increased its discounts after St. Luke's entry would constitute direct evidence that the surrounding hospitals were not in the same geographic market. Otherwise, those hospitals would have forced higher discounts prior to the time St. Luke's opened its doors.

Other direct evidence of market power relevant to any appropriate analysis would include changes in the total number of outpatient surgical procedures in the Hammond area following St. Luke's entry into the market for outpatient surgery. If the total number of outpatient surgical procedures performed in the Hammond area (the aggregate number of North Oaks and St. Luke's outpatient surgical procedures) increased significantly after St. Luke's began its operations, the influx of patients would represent highly-significant evidence that, before St. Luke's entered the market, North Oaks was exercising market power.

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Indeed, the rapid increase in St. Luke's market share after its opening strongly suggests that, prior to that opening, North Oaks faced no real competition for outpatient surgery. Interestingly, the District Court noted that plaintiff was able to quickly obtain a significant share of the outpatient surgery market. While the District Court appeared to believe that this fact was adverse to plaintiff's case, it more obviously suggests that the defendant was not offering a product that was particularly attractive to consumers. When offered a real choice, consumers were happy to take it.

The defendant's exclusive contracts with MCOs were designed to foreclose this option, restricting consumer choice. The managed care plans presumably believed that—as the national evidence suggests—consumers prefer broader provider networks. For that reason, they wanted to include the plaintiff in their networks, but were unable to do so. The only way that the defendant would provide significant discounts to the managed care plans for inpatient services was if the managed care plans agreed to exclude the plaintiff, who provided only outpatient services, from their provider networks. The court should have viewed that restraint as impermissible.

### ***G. Restricting Choice and Output Is Anticompetitive***

Congress has designated the Sherman Act as a “consumer welfare prescription.”<sup>98</sup> “A restraint that has the effect of reducing the importance of consumer preference in setting price and output is not consistent with this fundamental goal of anti-trust law.”<sup>99</sup> In *Hammond*, the elimination of choice caused by North Oaks’ restrictive managed care contracting policy significantly reduced the quality of the product available to enrollees of the five major managed care plans. A reduction in quality is, of course, merely one type of reduction in output. As explained by one commentator, “relevant output can be measured by a number of means. The most obvious is the number of units sold. Perhaps the second most obvious is the quality of the units.”<sup>100</sup> North Oaks restricted output by prohibiting the managed care plans from including an additional outpatient competitor the plans wanted, but could not afford as a result of defendant’s restrictive policy.

In many ways, the facts of *Hammond* mirror the facts addressed in the Seventh Circuit’s recent decision against TRU.<sup>101</sup> According to the FTC, TRU entered into a series of restrictive agreements with its key suppliers to prevent those suppliers from offering comparable packages of products to “warehouse clubs.” The purpose of the agreements was to prevent those clubs from competing successfully with TRU.<sup>102</sup> The Seventh Circuit noted that TRU was “successful in causing the 10 major toy manufacturers to reduce output of toys to the warehouse clubs.”<sup>103</sup> Likewise, in *Hammond*, the defendant was successful in reducing the output of five major managed care plans.

Because TRU could not provide a plausible efficiency justification for its conduct in initiating the restrictive agreements, the court concluded that TRU had engaged in impermissible anticompetitive conduct.<sup>104</sup> Similarly, North Oaks reduced the output of services of five of the seven MCOs, and offered no plausible efficiency justification for initiating its policy.

### ***H. Defendant North Oaks Did Not Offer a Legitimate Justification for its Conduct***

That the defendant’s change in its discounting policy followed St. Luke’s entry into the market for outpatient services is itself pregnant with significance.<sup>105</sup> Indeed, if North Oaks had believed that it would be more profitable to lower prices charged to MCOs on services not provided by St. Luke’s, it would have done so long before St. Luke’s opened its doors. Plainly, harming St. Luke’s in order to reduce competition is the only plausible explanation for

North Oaks' policy of requesting an outpatient exclusive in return for its offer of larger inpatient discounts. In fact, North Oaks conceded it would not receive additional hospital admissions from MCOs in return for the exclusive. Foregoing profits from inpatient services in order to prevent competition in outpatient services is a paradigmatic example of exclusionary conduct.<sup>106</sup> If it were not exclusionary conduct, defendant would have simply offered a deeper outpatient discount in return for an exclusive arrangement on outpatient services, and the concomitant increase in outpatient volume, revenues, and profit from the MCOs.

As explained by North Oaks:

The . . . rationale for the North Oaks policy of offering higher discounts in return for exclusive contracts was to respond to those competitors of North Oaks that provide only a single service or limited range of services, thus being able to pick off certain profitable lines of business such as lab, x-ray, and home health. The result of such "cherry picking" would have left North Oaks with only unprofitable lines of business and little or no margin to carry out its public service mission. Since North Oaks operates on a 1% profit margin due to the sources of payment for most of its patients, the need to retain the more profitable business was particularly important. So, as a natural and pro-competitive response to this threat, North Oaks adopted the exclusive contracting policy as a means of retaining some of this ancillary business.

The need to do this became even more acute once St. Luke's opened. The physician-investors in St. Luke's earned a return on their investment, over and above their professional fees, when they referred a patient to St. Luke's and performed outpatient surgery there.<sup>107</sup>

In other words, North Oaks' justification for offering an additional discount on inpatient services in return for the exclusive on outpatient services was that it needed the exclusive arrangements in order to prevent competition on the merits for outpatient services. The justification certainly explains defendant's motivation, but doesn't begin to explain how the conduct promotes, rather than restricts, competition.

Justifications supporting propositions other than the proposition that competition is enhanced by the restraint at issue are irrelevant, for merely offering a rationale for a restraint will not suffice; rather, the defendant must establish that the restraint does indeed have a procompetitive effect.<sup>108</sup> Thus, it is legally insufficient for the defendant to argue that a restraint improves quality or access unless the restraint also has a positive effect on competition.<sup>109</sup> To prevail, a restraint must actually enhance, rather than restrict competition, as the Supreme Court has recognized as of 1918.<sup>110</sup>

A dominant competitor cannot undertake conduct that does not improve its own product, but simply prevents its smaller rivals from competing effectively.<sup>111</sup> Offering an added discount on inpatient services in return for an exclusive arrangement on those services may improve the value of the inpatient services offered. Offering an additional discount on inpatient services in return for an exclusive on outpatient services merely forecloses competition on the merits for outpatient services. Conduct that restricts consumer choice and inhibits consumer appeal is impermissible.<sup>112</sup>

The District Court's factual finding that "inpatient and outpatient" services are often contained in the same contract does not alter the result.

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[M]any anticompetitive actions are possible or effective only if taken by a firm that dominates its smaller rivals. A classic illustration is an insistence that those who wish to secure a firm's services cease dealing with its competitors. Such conduct is illegal when undertaken by a monopolist because it tends to destroy competition, although in the hands of a smaller market participant it might be considered harmless, or even honestly industrial.<sup>113</sup>

### ***I. Defendant North Oaks Asserted an Impermissible Barrier to Entry***

By offering exclusivity for outpatient services in return for increased discounts for inpatient service not provided by St. Luke's, the defendant reduced competition in an unnecessarily restrictive way, and created a substantial barrier to entry. Indeed, as a result of defendant's conduct, no entity can compete effectively against defendant unless that entity is able to compete in both the inpatient and outpatient service markets. Put differently, the effect of North Oaks' tactics is to limit competition to

full-service hospitals. Conduct of that kind is impermissible because it restricts competition on the merits in the outpatient service markets. As the Supreme Court has held, “one of the evils proscribed by the antitrust laws is the creation of entry barriers to potential competitors by requiring them to enter two markets simultaneously.”<sup>114</sup>

The District Court failed to recognize that principle, and disregarded significant evidence of the use of market power to eliminate price competition. Regrettably, other courts, including the Eighth Circuit in the *Poplar Bluff* case, have made similar mistakes.

### III. *Poplar Bluff*: Legal Nullification of a Merger to Monopoly

In *Federal Trade Commission v. Tenet Health Care Corp.*,<sup>115</sup> the Eighth Circuit Court of Appeals reversed a decision of a federal district court granting the FTC’s motion for a preliminary injunction prohibiting the proposed merger of the only two hospitals in Poplar Bluff, Missouri. In so doing, the Court of Appeals, like the District Court in *Hammond*, failed to grasp market realities, or apply sound antitrust analysis to the interaction between MCOs and hospitals. The Court of Appeals also greatly understated the risk that market power could be exercised to the detriment of consumers, something the lower court seemingly understood.

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#### A. *The Undisputed Facts*

The defendant, Tenet Health Care, owned Lucy Lee Hospital and wished to purchase the other local hospital, Doctors Regional Medical Center (DRMC).<sup>116</sup> Both hospitals were profitable at the time of the proposed merger.<sup>117</sup> Most of the commercial patients at the two hospitals were covered by MCOs, specifically HMOs and PPOs.<sup>118</sup> Managed care had been prevalent and popular in Poplar Bluff for approximately fifteen years, and the two hospitals were willing to discount their charges in order to “entice [a] managed care entity to send its enrollees to that hospital.”<sup>119</sup>

In contrast, the two larger hospitals in Cape Girardeau, a community more than sixty miles away, had refused to negotiate with managed care plans until, at the urging of area employers, one of the hospitals, South East Missouri Hospital, entered into a discount arrangement with Health Link, an MCO.<sup>120</sup> Historically, prices in Cape Girardeau had been significantly higher than prices in Poplar Bluff, although they have fallen with the introduction of managed care to the Cape Girardeau market.<sup>121</sup>

MCOs and employers in Poplar Bluff testified that, if the merged entity were to raise its prices by 10%, the MCOs would have no choice but to pay the increased price, because it was essential for a plan to include a Poplar Bluff hospital in order to sell the products to residents of that area.<sup>122</sup> The MCOs and employers also stated that “their employees and subscribers find it convenient to use a Poplar Bluff hospital [, and] are loyal to their physicians in Poplar Bluff.”<sup>123</sup>

The case was decided exclusively on the issue of geographic market definition. In its argument before the District Court, the FTC proposed an expansive geographic market, one with a fifty-mile radius from downtown Poplar Bluff. Within that broad market, the FTC calculated that the merged facilities would command an 84% market share.<sup>124</sup> Market shares of far less have been found sufficient to create a presumption that the proposed transaction is anticompetitive.<sup>125</sup> In fact, hospital mergers have been invalidated on a showing that the combination will produce no more than a 26% market share.<sup>126</sup>

### ***B. The Court of Appeals Opinion***

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Based on the overwhelming demonstration of increased market power, the District Court issued a preliminary injunction prohibiting the merger. The Court of Appeals reversed the District Court’s decision, rejected the FTC’s proposed geographic market, and instead adopted the defendant’s proffered geographic market, which included an area with a sixty-five-mile radius from downtown Poplar Bluff.<sup>127</sup> This area included two larger hospitals in Cape Girardeau, Missouri.

Determining that the FTC had not proven its relevant geographic market, the Court of Appeals refused to uphold the District Court’s injunction prohibiting the proposed transaction.<sup>128</sup> In so doing, the Court of Appeals appears to have disregarded the “clearly erroneous” standard of review applicable to the factual findings of the District Court.<sup>129</sup> Under this deferential standard, the appellate court is obligated to accept the lower court’s factual findings unless they are without a plausible factual basis.<sup>130</sup>

In this regard, the Court of Appeals criticized the District Court for relying on testimony of managed care payors, asserting that “[w]ithout necessarily being disingenuous or self-serving or both, the testimony [of the payors] is at least contrary to the payers’ economic interest and thus is suspect.”<sup>131</sup> The Court of Appeals added: “in making this observation, we do not question the

district court's assessment of the credibility of these witnesses. Although the witnesses may have testified truthfully as to their present intentions, market participants are not always in the best position to assess the market long term."<sup>132</sup> Perhaps not, but the Court of Appeals never explained why the District Court, in its discretion, could not find otherwise. That the Eighth Circuit would have found the facts differently is legally immaterial.<sup>133</sup>

In truth, the Court of Appeals' error was more profound than simply failing to adhere to the appropriate standard of review. There was no credible evidence to support the court's determination that the geographic market included the hospitals in Cape Girardeau. Presumably recognizing the inadequacy of defining a geographic market solely by looking at shipments data, the Court of Appeals instead endorsed the "critical loss" analysis utilized by defendant's economic expert. According to the Court of Appeals, "critical loss" analysis is the methodology employed by the *Horizontal Merger Guidelines (Guidelines)*.<sup>134</sup> This statement, however, is demonstrably inaccurate.

### ***C. Distorting the Merger Guidelines***

The Department of Justice/FTC *Guidelines* do not endorse the specific methodology employed by the defendant's expert in his "critical loss" analysis. The *Guidelines* are similar only insofar as they seek to define geographic markets by asking whether a hypothetical monopolist within the proposed geographic market could profitably raise prices a small but significant and stable amount.<sup>135</sup> If the answer is yes, the *Guidelines* suggest that the area is a relevant geographic market. In this regard, however, the *Guidelines* state that an antitrust agency should consider the likely reaction of buyers to a price increase.<sup>136</sup> That, of course, is precisely what the Eighth Circuit criticized the District Court for doing.

Specifically, the *Guidelines* explain that, in considering the likely reaction of buyers, one should consider "[e]vidence that buyers have shifted or have considered shifting purchases between different geographic locations in response to relative changes in price or other competitive variables," and evidence that "sellers base business decisions on the prospect of buyer substitution between geographic locations in response to relative changes in price."<sup>137</sup> The Court of Appeals cited no evidence at all that either buyers or sellers ever discussed a shift of patients from Poplar Bluff to Cape Girardeau hospitals. Instead, the Court of Appeals cited certain employers, whom the District Court appeared not to credit, who believed they could "steer" their employees to Sikeston,

not Cape Girardeau, in the face of a price increase by the Poplar Bluff hospitals.<sup>138</sup> There simply was no evidence of switching from Poplar Bluff to Cape Girardeau hospitals.

Significantly, the Court of Appeals did not appear to dispute that the Poplar Bluff hospitals did not constrain the pricing conduct of Cape Girardeau hospitals. This fact suggests that they are not good substitutes, and consequently do not operate in the same geographic market. Although managed care contracts had existed in Poplar Bluff for a number of years, the Court of Appeals conceded that managed care prices in Cape Girardeau began to fall only after an MCO obtained a contract in that community.<sup>139</sup>

The remaining question is whether the Cape Girardeau hospitals could constrain a price increase imposed on managed care plans by the merged facilities after the merger. To answer this question affirmatively, as the Court of Appeals did, it was required to rely entirely on the testimony of the defendant's economic expert, and, in particular, on the expert's reliance on so called "critical loss" analysis.<sup>140</sup> This analysis hardly provides a satisfying answer to the question posed by the *Guidelines*.<sup>141</sup>

#### ***D. Critical Loss: Critical Mistake***

The defendant's expert performed his analysis by identifying certain ZIP codes within the FTC's market in which at least 20% of patients were using hospitals other than the Poplar Bluff hospitals.<sup>142</sup> Defendant's expert reasoned that the FTC's fifty-mile market was too narrow because, if the merged facilities raised prices 5%, a sufficient number of patients could go to hospitals outside the market to render the price increase unprofitable. In making his assessment, the defendant's expert utilized an accounting measure of the defendant's "marginal cost" to calculate the number of patients whom defendants would have to lose to make a 5% price increase unprofitable. The expert then subjectively concluded that more than that number would travel to hospitals outside the market in the face of a 5% price increase to managed care plans.<sup>143</sup> What is missing from the analysis, of course, is any explanation as to why a price increase to the managed care plans would cause patients to switch to more distant hospitals. In short, the methodology employed by the defendant's expert, and embraced by the Court of Appeals, is little more than a form of economic alchemy.

The essence of a traditional HMO is that the plan pays in full, or pays in full subject to a small fixed co-pay and/or deductible, for

any hospital service performed in any network facility. Thus, as a result of a price increase at a network hospital, the managed care plan may pay more; however, the increase is transparent to the HMO's enrollees, who have no economic reason to switch to more-distant facilities.<sup>144</sup> In theory, traditional HMOs can exclude hospitals from their provider networks, but it is unthinkable that managed care plans could successfully market traditional HMO products in the Poplar Bluff area without including a Poplar Bluff hospital in their provider network. In such a scenario, residents of Poplar Bluff would be forced to pay 100% of their hospital bill if they wanted to use a Poplar Bluff hospital.

In contrast, less-restrictive managed care products, like PPOs, typically do pay for out of network providers. The economic incentives of those arrangements, however, hardly suggest that, if PPOs treated the Poplar Bluff hospitals as out-of-network providers, Poplar Bluff residents would abandon those hospitals as a result of a 5% price increase. Ostensibly to demonstrate why many employers and employees prefer other, less-restrictive arrangements to HMOs, even though HMOs are less expensive, the Court of Appeals cited Judge Posner's statement that it is in an HMO's short-term economic interest to let sick patients die quickly.<sup>145</sup> To be sure, there currently are other preferred forms of insurance coverage that offer greater choice, but none of them would impose more than a trivial additional out-of-pocket charge to continue to use the more convenient Poplar Bluff hospitals.<sup>146</sup>

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Assume, for example, that the cost of a hospital stay is \$5,000. If the plan is a traditional indemnity plan (without co-insurance), then the insurer, not the enrollee, picks up the full amount of the increase. On the other hand, if the health plan is a PPO imposing, for example, a 20% differential co-insurance payment on any out-of-network hospital stay, then patients preferring an out-of-network hospital must be willing to pay an additional \$1,000 out-of-pocket to indulge their preferences. Now, assume the merged facilities decide to increase price by 5%, or an additional \$250, so that the total price is \$5,250. Again assuming the same 20% co-insurance, the patient's share of that price increase is only an additional \$50. Thus, the question becomes: How likely is it that patients willing to pay \$1,000 out-of-pocket to use a hospital not in an MCO's hospital network would switch to less-convenient hospitals rather than pay an additional \$50—particularly if the patients also have to change physicians? The correct answer should be somewhere between "highly unlikely" and "forget about it."

Some courts have understood that critical point. As the court in *Hospital Corp. of America* noted,

the demand for hospital services by patients and their doctors is highly inelastic under competitive conditions. This is not only because people place a high value on their safety and comfort and because many of their treatment decisions are made for them by their doctor, who doesn't pay their hospital bills; it is also because most hospital bills are paid largely by insurance companies or the federal government, rather than by the patient.<sup>147</sup>

Additionally, patients have no way of finding out in advance how much more the 5% price increase actually will cost them out-of-pocket if the hospital is not in the plan's provider network. For complex procedures, including most inpatient procedures, prices are not posted like the signs on a gasoline pump or a vegetable shelf. There are literally thousands of different hospital charges, so consumers cannot comparison shop, even if they wanted to do so. And, given the trivial difference caused by a 5% price increase, it is not clear why they would bother.

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Moreover, patients living closer to other hospitals may be willing to switch hospitals, particularly if they can keep the same physician. Conversely, however, people living close to the facility raising prices are far less likely to switch, particularly if they have to select a new physician.

Finally, the defendant's expert only calculated the number of patients whom the hospitals would be required to lose to make a 5% price increase unprofitable. However, if the hospitals raised prices by 10%, they would have to lose twice as many patients, assuming a constant downward slope to the demand curve. In fact, given the highly inelastic demand for hospital services, the more the hospitals increase price, the less likely it is that the price increase would be unprofitable. That plainly perverse, but nevertheless realistic, economic incentive was not even discussed by the defendant's expert or the Court of Appeals.

### *E. Managed Care Cannot Disregard Patient Preferences*

Presumably because there was no evidence of overlapping medical staff membership between Poplar Bluff and Cape Girardeau physicians, the Court of Appeals criticized the District Court for relying on "the seemingly outdated assumption of doctor-patient loyalty."<sup>148</sup> In this regard, the Circuit Court noted correctly that

enrollees in managed care plans are required to use only physicians who contract with the managed care plan.<sup>149</sup> From this truism, the Circuit Court erroneously reasoned that managed care plans today have the freedom to disregard the preferences of consumers in selecting physicians for their managed care networks. In fact, the

[c]hoice of caregivers is a long-standing concern for consumers in managed care plans. Historically, plans have tried to contain costs by steering members to networks of contracted providers, leading consumers to fear their providers of choice would be excluded from plan networks. Concerns about restricted provider choice have lessened over the past few years as health plans bowed to market demand for large and inclusive provider networks.<sup>150</sup>

A recent survey lends statistical support to this conclusion. According to this survey, which tracked 32,000 families and 59,000 individuals, only 13% of the individuals changed caregivers during the previous year. Of these 13%, only 22%, or a total of less than 3% of the people surveyed, switched providers because their provider was no longer covered by their health plan or their company changed insurance plans. The remaining 97% percent of the sample either did not switch providers, or, if they did, switched for personal reasons or other reasons unrelated to health plan coverage.<sup>151</sup> Patients do not simply “choose whatever doctors or hospitals are covered by their health plan,”<sup>152</sup> as the Eighth Circuit asserted. Indeed, the converse is closer to the truth. Health plans choose the physicians and hospitals necessary to satisfy the preferences of potential enrollees in order to compete effectively with other plans.

There can be little doubt that managed care plans could not successfully sell managed care products in Poplar Bluff that limit subscribers to Cape Girardeau physicians. Nor could managed care plans force Poplar Bluff physicians to hospitalize their patients in Cape Girardeau hospitals. The assertions made by the Court of Appeals in support of the defendant’s market definition are completely without factual support.

## IV. Conclusion

The *Hammond* and *Poplar Bluff* cases exemplify the misuse of market definition principles to disregard actual, or at least potential, anticompetitive effects. Both decisions appear to be

incorrectly decided. Moreover, the danger of these decisions goes far beyond the two cases discussed. Unless courts recognize the correct legal standards for defining hospital markets and identifying anticompetitive effects in those markets, there is a substantial risk that anticompetitive conduct will continue to go undeterred, and that managed care plans and their enrollees will face increased hospital prices as a result of diminished price competition.

## Endnotes

- <sup>1</sup> See *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins.*, 784 F.2d 1325, 1332 (7<sup>th</sup> Cir. 1986).
- <sup>2</sup> Under the Medicare+Choice Program, managed care organizations (MCOs) can negotiate prices with hospitals. From January 1999, many managed care plans have dropped out of the program. "The percentage of Medicare beneficiaries enrolled in managed care plans nationally grew from 11 percent in December 1996 to 16.1 percent in December 1998, but then fell to 14.5 percent in December 2001." Joy M. Grossman, et al., *Reversal of Fortune: Medicare + Choice Collides with Market Forces*, CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF NO. 52 1-2 (2002), at [www.hschange.org/CONTENT/437/index.html](http://www.hschange.org/CONTENT/437/index.html).
- <sup>3</sup> Traditional insurance offered by many Blue Cross and Blue Shield organizations, which are often described as "service benefit plans," differ somewhat from other "indemnity" type traditional insurance because of the existence of a contract between the plan and the participating hospitals, authorizing payment for covered services. See, e.g., *Ball Mem'l Hosp., Inc.*, *supra* note 1, at 1330. Payments may also be made pursuant to a formula, in many cases approved by the Insurance Department of the state. See, e.g., *Travelers Ins. Co. v. Blue Cross*, 481 F.2d 80, 82-83 (3d Cir. 1973).
- <sup>4</sup> *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 591 (1st Cir. 1993).
- <sup>5</sup> *Capital Imaging Assoc., P.C., v. Mohawk Valley Med. Assocs., Inc.*, 725 F. Supp. 669, 673 (N.D.N.Y. 1989), *aff'd*, 996 F.2d 537 (2d Cir. 1993).
- <sup>6</sup> *U.S. Healthcare, Inc.*, *supra* note 4, at 591.
- <sup>7</sup> *Doctor's Hosp. of Jefferson, Inc. v. Southeast Med. Alliance, Inc.*, 123 F.3d 301, 308 (5<sup>th</sup> Cir. 1997).
- <sup>8</sup> See William G. Kopit & Robert Hudock, *Antitrust Remedies for Managed Care: Attacking Barriers to Free Markets*, in *THE MANAGED HEALTH CARE HANDBOOK* 1203, 1205-06 (Peter R. Kongstvedt, ed., 2001).
- <sup>9</sup> See *id.*
- <sup>10</sup> *Eastman Kodak Co. v. Image Technical Servs.*, 504 U.S. 451, 464 (1992) (quoting *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 14 n.9 (1984); *Fortner Enterprises, Inc. v. United States Steel Corp.*, 394 U.S. 495, 503 (1969)).
- <sup>11</sup> *Id.* at 481.
- <sup>12</sup> *Steuer v. National Med. Enters.*, 672 F. Supp. 1489, 1504 (D.S.C. 1987) (quoting *Fishman v. Estate of Wirtz*, 807 F.2d 520, 568 (7<sup>th</sup> Cir. 1986) (Easterbrook, J., dissenting in part)).
- <sup>13</sup> William G. Kopit & Kenneth L. Klothen, *Antitrust Implications of the Activities of Health Maintenance Organizations*, 25 ST. LOUIS U.L.J. 247, 268 (1981) (citations omitted).
- <sup>14</sup> Gregory S. Vistnes, *Defining Geographic Markets for Hospital Mergers*, ANTITRUST, Spr. 1999, at 28.
- <sup>15</sup> AMERICAN HOSP. ASS'N, STATEMENT SUBMITTED TO THE FEDERAL TRADE COMMISSION (Mar. 25, 1996), at [www.ftc.gov/opp/global/amhospas.htm](http://www.ftc.gov/opp/global/amhospas.htm).
- <sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> Pub. L. No. 98-21, 97 Stat. 65 (1983) (codified at 42 U.S.C. § 1305 (1983)).

<sup>19</sup> SOCIAL SEC. ADMIN., LEGISLATIVE HISTORY: 1983 SOCIAL SECURITY AMENDMENTS – DETAILED SUMMARY, available at [www.ssa.gov/history/1983amend2.html](http://www.ssa.gov/history/1983amend2.html) (last visited June 26, 2002).

<sup>20</sup> AMERICAN HOSP. ASS'N, HOSPITAL COLLABORATION: THE NEED FOR AN APPROPRIATE ANTITRUST POLICY A6 (1992).

<sup>21</sup> See *id.* at 1-2; AM. HOSP. ASS'N, *supra* note 15.

<sup>22</sup> Both health plans and individual consumers are injured by hospital price increases above competitive levels. Health plans pay higher costs, which, at least in part, are passed on to individual consumers in the form of higher premiums. As a general matter, higher premiums also put pressure on employers to reduce health insurance coverage. “When health care costs increase, the percentage of Americans covered by an employment-based health insurance plan is expected to decline, with employers shifting the cost of coverage onto workers, or even dropping coverage completely.” *Hearing Before the Subcomm. on Health of the House Comm. on Ways and Means*, 107th Cong. 13 (Apr. 4, 2001) (statement of Paul Fronstin, Senior Research Associate and Director, Health Security and Quality Research Program, Employee Benefit Research Institute).

If fewer people can afford health insurance, health plans are deprived of potential customers, and individuals face a greater risk of catastrophic economic loss as a result of payments for expensive medical services. It has been estimated that, as a result of increased costs and economic downturn, the number of uninsured could increase from thirty-nine million in 2000 to forty-five million by the end of 2002. JOEL E. MILLER, NATIONAL COALITION ON HEALTH CARE, *A PERFECT STORM: THE CONFLUENCE OF FORCES AFFECTING HEALTH CARE COVERAGE* (2001).

<sup>23</sup> The existence of efficiencies, or cost savings, is only a defense when the cost savings produced by the transaction are passed on to consumers in the form of lower, rather than higher prices. As stated in the *Guidelines*, the federal antitrust agencies consider whether the efficiencies “would be sufficient to reverse the merger’s potential to harm consumers in the relevant market, e.g., by preventing price increases in that market.” U.S. DEP’T OF JUSTICE AND THE FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES § 4 (Apr. 8, 1997), available at [www.usdoj.gov/atr/public/guidelines/horiz\\_book/4.html](http://www.usdoj.gov/atr/public/guidelines/horiz_book/4.html). The courts have uniformly agreed that “significant efficiencies benefiting consumers [are] useful in evaluating the ultimate issue—the . . . overall effect on competition.” *Federal Trade Comm’n v. University Health, Inc.*, 938 F.2d 1206, 1222 (11<sup>th</sup> Cir. 1991); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 147 (E.D.N.Y. 1997) (citing *University Health, Inc.*, 938 F.2d at 1223); *Federal Trade Comm’n v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1300 (W.D. Mich. 1996) (citing *University Health, Inc.*, 938 F.2d at 1222-23). “A defendant . . . must demonstrate that the intended acquisition would result in significant economies and that these economies ultimately would benefit competition and, hence, consumers.” *Federal Trade Comm’n v. H.J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001). See *University Health, Inc.*, 938 F.2d at 1223; *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 147, 149; *Butterworth Health Corp.*, 946 F. Supp. at 1300, 1301.

It may, of course, be difficult to measure precisely the extent to which efficiencies are passed on to consumers. See, e.g., *University Health, Inc.*, 938 F.2d at 1223; *Long Island Jewish Med. Ctr.*, *supra* note 23, at 147. For this reason, courts have held that, “with regard to the so-called ‘efficiencies defense,’ the defendants must clearly demonstrate that the proposed merger itself will, in fact, create a net economic benefit for the health care consumer.” *Id.* at 147. See *Butterworth Health Corp.*, 946 F. Supp. at 1301; *United*

*States v. United Tote, Inc.*, 768 F. Supp. 1064, 1084-85 (D. Del. 1991); *California v. American Stores Co.*, 697 F. Supp. 1125, 1132-33 (C.D. Cal. 1988). “[E]fficiencies are most likely to make a difference in merger analysis when the likely adverse competitive effects, absent the efficiencies, are not great. Efficiencies almost never justify a merger to monopoly or near-monopoly. *Guidelines*, *supra* note 23, at § 4.

<sup>24</sup> *Hospital Corp. of Am. v. Federal Trade Comm’n*, 807 F.2d 1381, 1389 (7<sup>th</sup> Cir. 1986) (citations omitted).

<sup>25</sup> IRVING LEVIN ASSOCIATES, INC., HEALTH CARE ACQUISITION REPORT 2002 (8th ed. 2002).

<sup>26</sup> Bruce Japsen, *Another Record Year for Dealmaking: Activity Among Medium-Size Companies Fuels Continued Drive Toward Consolidation*, MODERN HEALTHCARE, Dec. 23, 1996, at 37.

<sup>27</sup> *Id.*

<sup>28</sup> Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 396 (2001).

<sup>29</sup> PRICEWATERHOUSE COOPERS, THE FACTORS FUELING RISING HEALTHCARE COSTS 5 (Apr. 2002).

<sup>30</sup> Press Release, Health Affairs, Health Spending Reaches \$1.3 Trillion in 2000, Fastest Acceleration in 12 Years (Jan. 8, 2002), at [www.healthaffairs.org/press/janfeb0201.htm](http://www.healthaffairs.org/press/janfeb0201.htm).

<sup>31</sup> *Id.*

<sup>32</sup> Press Release, Center for Studying Health System Change, Hospital Spending Drives Largest Health Care Cost Increase in a Decade (Sept. 26, 2001), at [www.hschange.org/CONTENT/382](http://www.hschange.org/CONTENT/382). This overall increase in hospital prices is even more remarkable given the federal government’s continued restrictions in the amount paid to hospitals for their treatment of Medicare beneficiaries. On average, Medicare paid hospitals 1% less than the cost of treating Medicare patients during the year 2000. AMERICAN HOSP. ASS’N, STATE OF HOSPITALS’ FINANCIAL HEALTH 2 (2002). In fact, in 1997, 45.6% of hospitals lost money on Medicare patients, and by 2000, this percentage has increased to 58.1%. *Id.*

<sup>33</sup> Press Release, Center for Studying Health System Change, *supra* note 32.

<sup>34</sup> PRICEWATERHOUSE COOPERS, *supra* note 29, at 10-11.

<sup>35</sup> See AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, STRENGTHENING MANAGED CARE, RESEARCH IN ACTION FACT SHEET (June 1996), [www.ahrq.gov/research/managed.htm](http://www.ahrq.gov/research/managed.htm).

<sup>36</sup> MICHAEL L. MILLENSON, AMERICA’S HEALTH CARE CHALLENGE: RISING COSTS 10 (Jan. 22, 2002).

<sup>37</sup> See generally Thomas L. Greaney, *Whither Antitrust: The Uncertain Future of Competition Law In Health Care*, 21 HEALTH AFF. 186 (2002); Havighurst, *supra* note 28, at 395.

<sup>38</sup> See Special Issue, *The Managed Care Backlash*, 24 J. HEALTH POL., POL’Y & L. 873 (1999).

<sup>39</sup> Debra A. Draper et al., *The Changing Face of Managed Care*, 21 HEALTH AFF. 11 (2002).

<sup>40</sup> Press Release, Health Affairs, *supra* note 30.

<sup>41</sup> Milt Freudenheim, *Battling, Politely, for Health Care’s Biggest Prize*, N.Y. TIMES, May 26, 2002, at BU 13.

<sup>42</sup> *Id.*

<sup>43</sup> Havighurst, *supra* note 28, at 395.

<sup>44</sup> 65 F.3d 1406 (7<sup>th</sup> Cir. 1995).

<sup>45</sup> *Id.* at 1410.

<sup>46</sup> CENTER FOR STUDYING HEALTH SYS. CHANGE, WHAT’S THE DIFFERENCE BETWEEN HMO’S AND NON-HMO’S?: NATIONAL SURVEY OF CONSUMERS FINDS LIMITED DISPARITIES WITH NON-HMO PLANS (Mar. 16, 2000), at [www.hschange.org/CONTENT/251](http://www.hschange.org/CONTENT/251).

- <sup>47</sup> *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins.*, *supra* note 1, at 1330.
- <sup>48</sup> J. Lee Hargraves, *Patients Concerned About Insurer Influences*, CTR. FOR STUDYING HEALTH SYS. CHANGE, DATA BULL. NO. 17 (June 2000), at [www.hschange.org/CONTENT/262](http://www.hschange.org/CONTENT/262).
- <sup>49</sup> *Id.*
- <sup>50</sup> See *Federal Trade Comm'n v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8<sup>th</sup> Cir. 1999).
- <sup>51</sup> Lawrence Wu, *The Evidence Is In: A Review of the Market Definition Debate in Hospital Merger Cases*, ANTITRUST REP., Nov. 1998, at 26-27.
- <sup>52</sup> *Surgical Care Ctr. v. Hospital Serv. Dist. No. 1*, 171 F.3d 231, 232 (5<sup>th</sup> Cir. 1999) (en banc) (*Hammond 2*).
- <sup>53</sup> *Surgical Care Ctr. v. Hospital Serv. Dist. No. 1*, 153 F.3d 220, 221 (5<sup>th</sup> Cir. 1998) (en banc) (*Hammond 1*) (following *Parker v. Brown*, 317 U.S. 341 (1943)).
- <sup>54</sup> *Hammond 2*, *supra* note 52, at 235.
- <sup>55</sup> See *Surgical Care Ctr. v. Hospital Serv. Dist. No. 1*, No. CIV.A.97-1840, 2001 WL 8586, \*15 (E.D. La. 2001) (*Hammond 3*).
- <sup>56</sup> *Id.* at \*10. "Market power is the power 'to force a purchaser to do something that he would not do in a competitive market.'" *Eastman Kodak Co. v. Image Technical Servs., Inc.*, *supra* note 10, at 464 (1992) (quoting *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 14 n.9 (1984)). "It has been defined as the 'ability of a single seller to raise price and restrict output.'" *Id.* (quoting *Fortner Enters., Inc. v. United States Steel Corp.*, 394 U.S. 495, 503 (1969)).
- <sup>57</sup> *Hammond 3*, *supra* note 55, at \*1.
- <sup>58</sup> *Id.*
- <sup>59</sup> *Id.*
- <sup>60</sup> *Id.* at \*3.
- <sup>61</sup> *Id.* at \*4.
- <sup>62</sup> *Id.* at \*5.
- <sup>63</sup> *Id.* at \*5. Specifically, the District Court adopted step one, and a limited portion of step two, of the analysis proposed by the defendant's expert. *Id.* at \*6-\*8.
- <sup>64</sup> *Id.* at \*6.
- <sup>65</sup> *Id.* at \*7 (emphasis added).
- <sup>66</sup> *Id.* at \*9.
- <sup>67</sup> *Id.*
- <sup>68</sup> *Id.*
- <sup>69</sup> *Id.* at \*10.
- <sup>70</sup> *Id.*
- <sup>71</sup> *Id.* at \*11.
- <sup>72</sup> *Id.* at \*12.
- <sup>73</sup> *Id.*
- <sup>74</sup> *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins.*, *supra* note 1, at 1332.
- <sup>75</sup> *Hospital Corp. of Am. v. Federal Trade Comm'n*, *supra* note 24, at 1388.
- <sup>76</sup> *Eastman Kodak Co. v. Image Technical Servs.*, *supra* note 10, at 466-67.
- <sup>77</sup> *Id.* at 467.
- <sup>78</sup> *Id.* at 469.
- <sup>79</sup> *Federal Trade Comm'n v. Indiana Fed'n of Dentists*, 476 U.S. 447, 460-61 (1986) (citations omitted).
- <sup>80</sup> *Toys "R" Us v. Federal Trade Comm'n*, 221 F.3d 928, 930 (7<sup>th</sup> Cir. 2000).
- <sup>81</sup> *Id.* at 937 (citations omitted).
- <sup>82</sup> *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins.*, *supra* note 1, at 1336.
- <sup>83</sup> RICHARD A. POSNER, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 126 (Univ. Chi. 1976).
- <sup>84</sup> *Vistnes*, *supra* note 14, at 28.

- <sup>85</sup> Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation in Antimerger Suits*, 18 ANTITRUST BULL. 45 (1973); Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 ANTITRUST BULL. 1 (1978).
- <sup>86</sup> Elzinga and Hogarty proposed two different percentages for measuring the threshold of imports and exports that would define the geographic market. In their first article, they proposed threshold import and export percentages of 25%. Using this standard, an area in which imports of a relevant product exceed 25% of demand and/or exports exceed 25% of production would be too small to constitute a geographic market. In the subsequent article they opine that a leakage threshold of 10% is more reliable to avoid false positives. *The Problem of Geographic Market Delineation Revisited*, *supra* note 85, at 2. No empirical basis for either cutoff threshold is contained the articles.
- <sup>87</sup> The District Court elected to use a 90% threshold, the more recent of the two cut-off points suggested by Elzinga and Hogarty in their articles about evaluating geographic markets in the context of mergers in the coal industry. There is no empirical support, however, for any cut-off in either of the two articles authored by Elzinga and Hogarty. A determination of the “correct” cut-off is, therefore, inherently arbitrary, and any evaluation about completeness and reliability is dependent on a preconception of the most appropriate “bias” to bring to the exercise given the particular task at hand. The only statement that can be made with confidence about the “correct percentage” is that it makes far more sense to use a high cut-off point in evaluating a future exercise of market power—*i.e.*, proposed mergers—in an industry involving a homogeneous product—*i.e.*, coal—as Elzinga and Hogarty were doing in their articles, than it does in estimating geographic markets for the purpose of evaluating possible exercises of monopoly or market power involving heterogeneous services like hospital services. *See Hospital Corp. of Am. v. Federal Trade Comm’n*, *supra* note 24, at 1390. The *Hammond* District Court explained that the problem of product heterogeneity in hospital markets was eliminated because any comparisons were limited to Diagnostic Related Groups (DRGs) performed at North Oaks. *Hammond 3*, *supra* note 55, at \*6. While DRGs do provide some measure of standardization, they hardly capture all significant differences between hospital facilities. Thus, the District Court noted that the “Ochsner Foundation Hospital . . . attracts patients from all over the world.” *Id.* at \*9. Yet, nobody would suggest that North Oaks represents an alternative destination for these people, even for the same DRGs. The application of DRGs cannot convert hospital services into coal.
- <sup>88</sup> It is significant that the 50% leakage figure referred to by the court did not actually represent “leakage” out of the market, as the District Court itself recognized. In the same paragraph in which the District Court discussed “leakage,” it stated that “[t]he remaining 49.10% go to competing hospitals both inside and outside of the service area.” *Hammond 3*, *supra* note 55, at \*7. The portion of the 49.10% that goes to other hospitals inside the service area, by definition, could hardly be considered leakage out of the service area. The District Court also concluded that the geographic market must extend at least as far as Covington, because “the hospitals in Covington alone are virtually the equal of North Oaks.” *Id.* at \*9. In support of this proposition, the District Court cited comparative data regarding total admissions and total hospital days. *Id.* at \*9 n.31. Total admissions (or total hospital days) are far less relevant than comparative data regarding admissions (or hospital days) of people residing within the service area. In this regard, one of the attachments to the District Court’s opinion shows Hammond with 50,588 service area admissions, while Covington hospitals account for only 17,584 service area admissions. *Id.* at \*24. Based on this data, it is difficult to

- conclude with any confidence, as the District Court did, that the Covington hospitals are an equal competitor for Hammond patients.
- <sup>89</sup> Gregory J. Werden, *The Use and Misuse of Shipments Data in Defining Geographic Markets*, 26 ANTITRUST BULL. 734 (1981).
- <sup>90</sup> See *id.* at 734.
- <sup>91</sup> See, e.g., *Federal Trade Comm'n v. Freeman Hosp.*, 69 F.3d 260, 269 (8<sup>th</sup> Cir. 1995).
- <sup>92</sup> POSNER, *supra* note 83, at 128.
- <sup>93</sup> *Eastman Kodak Co. v. Image Technical Servs.*, *supra* note 10, at 470 (1992).
- <sup>94</sup> POSNER, *supra* note 83, at 128.
- <sup>95</sup> *Federal Trade Comm'n v. Staples Inc.*, 970 F. Supp. 1066, 1075 (D.D.C. 1997).
- <sup>96</sup> *Id.* at 1075-76.
- <sup>97</sup> *Id.* at 1075.
- <sup>98</sup> *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979).
- <sup>99</sup> *National Collegiate Athletic Ass'n v. Board of Regents*, 468 U.S. 85, 107 (1984). See *California Dental Ass'n v. Federal Trade Comm'n*, 526 U.S. 756, 777 (1999) (quoting *General Leaseways, Inc. v. National Truck Leasing Ass'n*, 744 F.2d 588, 594-95 (7<sup>th</sup> Cir. 1984) ("with exceptions not relevant here, raising price, reducing output, and dividing markets have the same anticompetitive effects")); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940).
- <sup>100</sup> 11 HERBERT HOVENKAMP, ANTITRUST LAW ¶ 1901d, at 187 (1st ed. 1998).
- <sup>101</sup> *Toys "R" Us v. Federal Trade Comm'n*, *supra* note 80.
- <sup>102</sup> *Id.* at 931-33.
- <sup>103</sup> *Id.* at 937.
- <sup>104</sup> *Id.*
- <sup>105</sup> See *Aspen Skiing Co v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 608 (1985).
- <sup>106</sup> See *id.*
- <sup>107</sup> Appellant's Brief at 42-43, *Hammond 1*, *supra* note 53.
- <sup>108</sup> *Graphic Prods. Distribs. v. Itek Corp.*, 717 F.2d 1560, 1576 (11<sup>th</sup> Cir. 1983).
- <sup>109</sup> See *National Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 694-97 (1978).
- <sup>110</sup> *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918). See Kopit & Hudock, *supra* note 8, at 1206.
- <sup>111</sup> *United States v. Microsoft Corp.*, 253 F.3d. 34, 62 (D.C. Cir. 2001).
- <sup>112</sup> See *id.* at 64.
- <sup>113</sup> *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 274-75 (2d Cir. 1979) (citations omitted).
- <sup>114</sup> *Eastman Kodak Co. v. Image Technical Servs.*, *supra* note 10, at 485.
- <sup>115</sup> *Federal Trade Commission v. Tenet Health Care Corp.*, 186 F.3d 1045 (8<sup>th</sup> Cir. 1999).
- <sup>116</sup> *Id.* at 1047-48.
- <sup>117</sup> *Id.* at 1047.
- <sup>118</sup> *Id.* at 1048-49.
- <sup>119</sup> *Id.* at 1049.
- <sup>120</sup> *Id.* at 1049.
- <sup>121</sup> *Id.*
- <sup>122</sup> *Id.*
- <sup>123</sup> *Id.*
- <sup>124</sup> *Id.* at 1052.
- <sup>125</sup> *Federal Trade Comm'n v. University Health, Inc.*, *supra* note 23, at 1219; *Federal Trade Comm'n v. Butterworth Health Corp.*, *supra* note 23, at 1294.
- <sup>126</sup> *Hospital Corp. of Am. v. Federal Trade Comm'n*, *supra* note 24, at 1384.
- <sup>127</sup> *Tenet Health Care Corp.*, *supra* note 115, at 1052.
- <sup>128</sup> *Id.* at 1053.
- <sup>129</sup> *Hospital Corp. of Am.*, *supra* note 24, at 1384-85.
- <sup>130</sup> *Id.*
- <sup>131</sup> *Tenet Health Care Corp.*, *supra* note 115, at 1054.

<sup>132</sup> *Id.* at 1054 n.14.

<sup>133</sup> *Hospital Corp. of Am.*, *supra* note 24, at 1386.

<sup>134</sup> *Tenet Health Care Corp.*, *supra* note 115, at 1053.

<sup>135</sup> *Guidelines*, *supra* note 23, at § 1.21, available at [www.usdoj.gov/atr/public/guidelines/horiz\\_book/12.html](http://www.usdoj.gov/atr/public/guidelines/horiz_book/12.html).

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Tenet Health Care Corp.*, *supra* note 115, at 1049.

<sup>139</sup> *Id.* at 1055.

<sup>140</sup> *Id.* at 1053.

<sup>141</sup> After the Court of Appeals decision, several scholarly articles have described the methodological shortcomings of the defendant's critical-loss analysis. See Kenneth Danger & H.E. Frech III, *Critical Thinking About "Critical Loss" in Antitrust*, 46 ANTITRUST BULL. 339 (2001); James Langenfeld & Wenqing Li, *Critical Loss Analysis in Evaluating Mergers*, 46 ANTITRUST BULL. 299 (2001).

<sup>142</sup> *Tenet Health Care Corp.*, *supra* note 115, at 1051.

<sup>143</sup> *Id.* at 1050.

<sup>144</sup> Of course, in *Poplar Bluff*, there is even less reason to switch. The Circuit Court conceded that, with only a single exception, MCOs didn't have hospital contracts with Cape Girardeau hospitals. *Tenet Health Care Corp.*, *supra* note 115, at 1049. That means that, from the standpoint of managed care enrollees, the Cape Girardeau hospitals would be more expensive because they are outside the network.

<sup>145</sup> *Id.* at 1054 (citing *Blue Cross and Blue Shield v. Marshfield Clinic*, 65 F.3d 1406, 1410, 1412 (7<sup>th</sup> Cir. 1995)).

<sup>146</sup> For that reason, the Court of Appeals' assertion that the Cape Girardeau hospitals are better is equally unavailing. *Id.* at 1054. Perhaps some patients do go to Cape Girardeau because they believe the hospitals are superior. The point is that it is unlikely that more will go without significant economic incentives, and there are none.

<sup>147</sup> *Hospital Corp. of Am. v. Federal Trade Comm'n*, *supra* note 24, at 1388.

<sup>148</sup> *Tenet Health Care Corp.*, *supra* note 115, at 1055.

<sup>149</sup> *Id.*

<sup>150</sup> Ashley C. Short et al., *Provider Network Instability: Implications for Choice, Costs and Continuity of Care*, CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF No. 39 (June 2001), at [www.hschange.com/CONTENT/325](http://www.hschange.com/CONTENT/325).

<sup>151</sup> Marie C. Reed, *Why People Change Their Health Care Providers*, CTR. FOR STUDYING HEALTH SYS. CHANGE, DATA BULL. No. 6 (May 2000), at [www.hschange.com/CONTENT/81](http://www.hschange.com/CONTENT/81).

<sup>152</sup> *Tenet Health Care Corp.*, *supra* note 115, at 1055.

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