When Antitrust Fails: Public Health, Public Hospitals, and Public Values

Michael S. Jacobs
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I. INTRODUCTION: THE PROBLEMS OF PUBLIC HOSPITALS IN INCREASINGLY COMPETITIVE MARKETS

In the past few years, large operating deficits have led governmental authorities in several major cities to close, sell, or substantially reduce the services of their public hospitals. These decisions portend the arrival of what the New York Times has called a "looming crisis" in health care for the urban poor and uninsured. Should this crisis unfold, many public health programs are likely to be casualties, including those designed to treat and prevent the spread of communicable disease.

Among others, programs aimed at the so-called "new" (multidrug resistant) tuberculosis are especially vulnerable to these compelling budgetary constraints. Poor urban populations face an elevated risk of contracting tuberculosis (TB); and when they do contract it, they often seek care in public hospital emergency departments. The prospect of public hospital closures obviously threatens to eliminate or reduce these sources of care, which provide many of the most accessible sites for the treatment and control of the disease. Moreover, public hospitals


4. See Peter E. Sokolove et al., Exposure of Emergency Department Personnel to Tuberculosis: PPD Testing During an Epidemic in the Community, 24 Annals Emergency Med. 418, 419 (1994) ("There is a higher incidence of tuberculosis in patients who are foreign born, homeless, recently incarcerated, or chronically debilitated . . . .").

5. Id; see also, e.g., Fewer MDR-TB Cases Seen in Inner City Than Expected, AIDS Wkly., Oct. 30, 1995 ("The incidence of tuberculosis has increased in urban areas in the late 1980s and early 1990s and many patients are cared for in public hospitals.").
administer outreach programs intended to educate and serve populations at high risk of contracting TB. Healthcare experts predict that not only will tuberculosis spread faster in the absence of public hospitals, but that their closures will also place extraordinary demands on mental health programs and homeless shelters.6

Of course, besides their work in combating TB, public hospitals perform other valuable social services. They function as community hospitals for their neighborhoods.7 They train nurses, medical students, and new physicians in the care of patients.8 They often contain the only special-care units in their regions.9 And they conduct important clinical and basic research.10 Their survival arguably should be an important public priority.

As noted above, however, public hospitals now face a serious risk of financial failure. Several factors are to blame. Over the past twenty years, reductions in state and federal healthcare financing, along with shrinking municipal budgets, have combined to make public payers a less reliable, and less remunerative, source of income. At the same time, and perhaps more significantly, the rapid commercialization of private healthcare markets has reshaped the hospital industry,11 placing public hospitals at a severe competitive disadvantage. Mounting concern with the high cost of healthcare has encouraged the growth of managed care corporations12 and the emergence of free-standing, outpatient service providers.13 These newly aggressive buyers and less expensive alternatives have forced hospitals to find ways of lowering their costs and prices. In particular, the bargaining power exerted by large managed care organizations has forced individual hospitals, and even small hospital chains, to grant them substantial price discounts in order to attract the patient volume necessary for profitability.14 To acquire some bargaining leverage of their

7. In the early 1980s there were almost 1800 public hospitals in the United States, but the latest figures show that as of 1993 only 1390 remained. American Hosp. Ass’n, Hospital Statistics: The AHA Profile of United States Hospitals 7 (1994).
8. Kassirer, supra note 2, at 1348.
9. Id.
10. Id.
11. Id. at 1349.
own and also to achieve the kinds of savings and efficiencies necessary to compete effectively in the new environment, private hospitals have decided lately, in unprecedented numbers, to merge with one another, effectively restructuring the hospital industry.15

Though slow to react to these changes, public hospitals have hardly been immune from their effects. Aging physical plants, high operation costs, ambitious social programs, commitments to medical education and research, and largely-uninsured patient populations make public hospitals comparatively expensive to operate and thus ill-suited to the demands of an increasingly competitive market.16 Faced with diminishing governmental support, public hospitals—like their private counterparts—have become critically dependent for their survival on attracting the business of managed care groups, whose substantial memberships and capitated payments promise high utilization and steady revenue.17 Unlike private hospitals, however, which have, for the most part, spent the past few years cutting costs, eliminating unprofitable services, and merging with competitors, public hospitals have retained their old structures, organizational forms, and social programs. As a result, their prices for services provided to paying patients have remained relatively high, effectively disqualifying them from the competition for managed care contracts.

To make matters worse, the vigorous economizing of private hospitals has not simply lowered their own costs. It has indirectly raised the costs of public hospitals and undermined any attempts they might make to become more competitive. In growing numbers, private hospitals are eliminating or reducing their own small charitable and social service programs and declining to treat “unprofitable” patients, whose age or underlying illnesses make them relatively expensive to serve.18 Because

(stating that managed care companies cap provider costs “by employing professionals and acquiring hospitals and other institutions, or by contracting with independent providers on a capitation basis,” and that “[t]he largest percentage of cost savings achieved by managed care is due to reduced use of hospital services”).

15. See infra notes 25–31 and accompanying text.
18. See, e.g., Preston, supra note 2 (“With managed care driving down their revenues, many hospitals around the country say they can no longer afford to provide free medical care to the growing number of uninsured who have come through their doors seeking treatment for everything from the flu to heart disease.”); see also California Hospital Under Fire for Seeking Healthier Patients, Mod. Healthcare, Aug. 21, 1995, at 172 (describing report that University of California Irvine Medical Center, having experienced “a dramatic increase in patients . . . with recently
the programmatic and medical needs of these patients persist, however, they must turn to public hospitals, when they can, for the high-cost services that the private sector now refuses to provide. Forced in this manner to bear by themselves the financial responsibility for unprofitable services and programs, public hospitals are becoming increasingly more expensive than their private counterparts and thus losing more ground in the competition for managed care contracts.

Because they cannot simultaneously honor their social obligations and compete successfully against the private sector, public hospitals face a bleak future. In order to survive, they may be forced to resemble private hospitals, declining to offer many of the social and public health programs that they have struggled so hard to preserve. The threat to the traditional role of public hospitals is a threat to public health. If public hospitals are compelled to abandon their social programs, private hospitals are unlikely to revive them. The unrelenting pressure to reduce costs would discourage all hospitals from resuscitating programs of proven unprofitability, especially when governments are unwilling or unable to finance the shortfalls. Even if public hospitals can survive in a more “privatized” form, the loss of these programs will inflict serious harm on populations already disadvantaged.

The plight of public hospitals underscores an apparent failure in the workings of an unregulated market for healthcare. When private and public firms compete to provide hospital services, the lower costs that result are a boon for those who can afford to purchase health care. In today’s environment, however, those lower costs are achieved in substantial measure by abandoning important if unprofitable public programs. If public hospitals are to survive direct competition with their private counterparts, they must adopt the private sector’s cost-cutting strategies. But those strategies spell misfortune for people who cannot afford to buy healthcare. In this arena, unregulated competition appears incompatible with social welfare broadly conceived.

This dilemma in turn raises questions about the fit between neoclassical economics and the antitrust analysis of hospital markets. Neoclassical economists would likely regard the recent outbreak of
diagnosed serious conditions that require expensive treatments,” had informed its medical staff that it could “no longer tolerate patients with complex and expensive-to-treat conditions”.


20. This is an arguably unintentional and non-conspiratorial variant of the “raising rivals’ costs” theory. See Thomas G. Krattenmaker & Steven C. Salop, Anticompetitive Exclusion: Raising Rivals’ Costs to Achieve Power Over Price, 96 Yale L.J. 209 (1986).
competition in hospital markets as an unmitigated blessing for consumers. In important respects, it is: after years of seeming immunity to competitive forces and apparent indifference to their chronic excess capacity, private hospitals finally have begun to lower costs, merging to achieve economies of scale and eliminate duplicative equipment, services and personnel. Assuming that the quality of hospital care has remained at an acceptable level, the lower prices resulting from this activity are an obvious benefit for consumers. The problem, of course, is that not all who need care can afford to pay. A narrow focus on consumer prices ignores the needs of this impoverished group and institutions that serve them.

Because antitrust policy has largely embraced the reasoning of neoclassical economics, the transformation-by-merger of this country’s hospital and medical services industry has occurred with the tacit approval of federal antitrust enforcement agencies and the growing encouragement of federal antitrust courts. For the past two decades, these authorities have fashioned antitrust enforcement around the basic premises of the Chicago School: business arrangements conducive to lower consumer prices are presumptively lawful and concerns about the “subjective” and “nebulous” social implications of business behavior have no useful place in antitrust discourse. On this view, unless mergers can be shown likely to raise prices, either by creating a monopolist or facilitating collusion in a tighter oligopoly, they will survive antitrust challenge because they promise the merging firms economies of scale and other efficiencies apt to be reflected in lower consumer prices.

Overlooked by this view are those who need hospital services but cannot afford to purchase them. Mergers between private hospitals, and the continued consolidation of managed care companies, seem to have generated lower prices for paying customers, but in the process they have jeopardized the continued existence of social programs and charity care critical for those too poor to be considered “consumers.” Although those

21. See, e.g., McGinley, supra note 17, at A1. (“Almost every U.S. metropolitan area is ‘overbedded.’ The Denver area, for example, is glutted with more than 30 hospitals, many operating at just 40% of capacity. In Philadelphia, more than 40% of the beds aren’t needed . . . .”).


24. See, e.g., FTC v. University Health, Inc., 938 F.2d 1206, 1213 (11th Cir. 1991); Hospital Corp. of Am. v. FTC, 807 F.2d 1381, 1391 (7th Cir. 1986).
with money may now pay less for hospital care, those without face the real prospect of losing their providers of last, or only, resort.

Current antitrust thinking is ill-equipped to resolve this conflict between consumer welfare and the well-being of the poor. In most markets, this conflict is analytically irrelevant: antitrust normally regards the poor as not “entitled” to most goods or services. But healthcare is different. Because antitrust enforcement policy ignores this difference, it mistakenly assumes that lower prices inevitably enhance social welfare. The economic principles that inform antitrust analysis are blind to the concerns of public hospitals. Moreover, institutional constraints, such as rules of standing and of evidence, along with traditional notions about the limits of judicial competence, foreclose antitrust courts from undertaking the kinds of wide-ranging inquiries necessary to comprehend and remedy the competitive disadvantages of public hospitals. As a result, antitrust policy overlooks the “market” for public health, a shortcoming that marks not just a failure of antitrust policy, but a failure of unregulated competition in the market for hospital services.

This Article first describes the great wave of mergers that has occurred in the hospital and managed care industries over the past few years. It then discusses the responses of antitrust courts to this dramatic increase in concentration. Finally, concluding that antitrust doctrine does not and cannot usefully consider the social implications of this concentration, it argues that renewed regulation of the hospital industry is both inevitable and necessary, not only because it is a moral imperative but also because unbridled competition in this area does not serve society well.

II. HOSPITAL MERGERS AND HMO GROWTH

The past two years have witnessed an unprecedented number of hospital mergers. In 1994, more than 650\textsuperscript{25} of the nation’s 5100\textsuperscript{26} hospitals took part in a merger or acquisition. Although a majority of those transactions involved the purchase of individual for-profit hospitals by large, for-profit chains, 301 private nonprofit hospitals also participated in mergers during that year.\textsuperscript{27} An industry publication described the events of 1994 as a “merger frenzy” and remarked that “[n]othing in recent history seems to parallel the activity.”\textsuperscript{23}

\begin{itemize}
  \item 26. McGinley, \textit{supra} note 17, at Al.
  \item 27. Lutz, \textit{supra} note 25.
  \item 28. \textit{Id}.
\end{itemize}
In 1995, hospital merger activity surpassed the record level of the previous year. Seven hundred and thirty-five hospitals merged, including 445 nonprofits. Industry surveys show that in the last two years alone twenty percent of all nonprofit hospitals changed hands. To place these developments in perspective, one need only consider the number of hospital mergers that occurred in prior years. The American Hospital Association, which until recently had been the only organization to track hospital mergers, counted eighteen mergers in 1993, fifteen in 1992, twenty-three in 1991, and thirteen in 1990. The effect of the recent spate of mergers on market concentration has been amplified by the approximately 400 hospital closures that have occurred over the past five years.

Representatives of the private hospital industry attribute the wave of mergers to the growth of managed care. According to the Washington Post, the percentage of workers in managed care programs rose from twenty-nine percent in 1988 to seventy percent in 1995, a rise accompanied by dramatic reductions in the rate of increase in corporate health spending. The Wall Street Journal reported that in 1994 publicly traded managed care organizations (including HMOs) completed thirteen acquisitions totaling over four billion dollars. Relatively low prices have also made managed care an increasingly attractive option to Medicare enrollees. Last year, for example, the American Association of Retired Persons announced plans to license its name to managed care organizations across the country, increasing the likelihood that many of its thirty-three million members will enroll in managed care groups. Nonprofit insurance companies are also merging to reorganize as

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30. Id.
managed care companies capable of competing more effectively against ever larger HMOs.\textsuperscript{36}

It is hardly surprising that HMOs should merge and consolidate. Through merger, HMOs can realize substantial economies in administrative, transactional, and purchasing costs. They can monitor more effectively the practice patterns of their physicians, with a view to reducing unnecessary treatment and testing. Mergers also increase the size of individual HMOs, placing more members and thus more healthcare dollars under their control. In turn, increased size enables HMOs to drive hard bargains with hospitals. In communities with competing hospitals, large HMOs can successfully initiate bidding wars, forcing down the price of hospital services for HMO members, compelling the hospitals to cut costs to be competitive, and ultimately prompting the hospitals to merge to achieve the economies and increased bargaining power that consolidation can provide.

Interestingly, while hospitals claim that the growth of managed care companies has forced them to merge, managed care companies view their own mergers primarily as a necessary response to the rapid consolidation of hospitals, doctors, and medical suppliers.\textsuperscript{37} Alternatively, they see mergers as compelled by the demands of large employers for "ever-lower premiums and fewer administrative hassles in managing their health benefits programs."\textsuperscript{38} Whatever the cause, healthcare markets are rapidly becoming more concentrated through a process of merger, cost-cutting, and more merger.

\textsuperscript{36} See, e.g., Robert Tomsho, \textit{Blue Cross Plans in Texas, Illinois Intend to Merge}, Wall St. J., Jan. 31, 1996, at B3 (reporting that in response to "increasing pressure from for-profit insurers and health-maintenance organizations in the tumultuous race to land managed-care contracts," Blue Cross/Blue Shield (BC/BS) programs around country are merging with one another; since 1985, number of BC/BS plans has decreased from 86 to 66).


III. THE ANTITRUST RESPONSE TO HEALTHCARE CONSOLIDATION

A. Hospital Mergers

Section 7 of the Clayton Act prohibits mergers and acquisitions if, "in any line of commerce . . . in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." Section 7 requires the party challenging the merger (usually the government) to establish three elements. It must satisfactorily define (1) the relevant "line of commerce" (the product market or service market) and (2) the relevant "section of the country" (the geographic market) and then must show that (3) the proposed merger would result in a market with so few firms as to threaten the continuation of competitive pricing. The notion that informs these requirements is that in highly concentrated markets (those with just a few firms) price-fixing conspiracies are more likely both to occur and to go undetected.

Traditionally, parties in hospital merger cases have agreed on the relevant line of commerce, usually defined as "acute care inpatient hospital services." But they have often disagreed about the scope of the relevant geographic market, the area "in which the seller operates and to which the purchaser can practicably turn." Plaintiffs have sought to define the market as local (and therefore small and more heavily concentrated by the merger) while defendants have argued for a more expansive market (so as to dilute the concentrative effects of the merger).

Until last year, antitrust courts, with one exception, had generally sided with plaintiffs, regarding hospital competition as local in nature,

41. Id.
42. Id. at 363.
43. Hospital Corp. of Am. v. FTC, 807 F.2d 1381, 1391 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).
46. See United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va.) (finding that patients in Roanoke, Virginia would travel to Richmond, 165 miles away, for many kinds of hospital services), aff'd, 892 F.2d 1042 (4th Cir. 1989).
confined within a relatively small geographic area. Writing for the Seventh Circuit in an oft-cited opinion, Judge Posner expressed the consensus view:

But for the most part, hospital services are local. People want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges. . . . [The defendant's] proposal [as to the relevant geographic market] is ridiculous—a ten county area in which it is assumed (without any evidence and contrary to common sense) that Rockford residents, or third-party payers, will be searching out small, obscure hospitals in remote rural areas if the prices charged by the hospitals in Rockford rise above competitive levels.

The practical effect of defining hospital markets as local, instead of regional or national, is to discourage mergers. In small markets, big firms presumably have more power to harm consumers: if buyers of hospital services cannot practicably purchase care from outside the locality, a monopoly post-merger firm within the locality can profitably raise prices and a larger post-merger firm in a tighter local oligopoly can collude more easily, and thus more successfully, with its remaining competitors to achieve the same undesirable end. In smaller geographic markets, therefore, section 7's prohibition of mergers that may "tend substantially to lessen competition" is more likely to be implicated.

In 1995, in two important hospital merger cases, antitrust courts rejected the dominant view, adopting instead a much broader conception of the geographic scope of hospital competition. In United States v. Mercy Health Services, the Justice Department challenged the proposed merger of the two largest general acute care hospitals in Dubuque, Iowa. The relevant geographic market, according to the Department's economic experts, consisted of Dubuque County and a half-circle with a fifteen-mile radius extending eastward into Illinois and Wisconsin. This area included, in addition to the defendant hospitals, a twenty-five-bed hospital in Galena, Illinois. Eighty-eight percent of hospital patients within that market, the parties agreed, used the three hospitals in

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48. Id.; see also FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991); Hospital Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).
49. 902 F. Supp. 968 (N.D. Iowa 1995), appeal docketed, No. 95-4253 (8th Cir. 1995).
50. Id. at 971.
51. Id. at 976.
question; eighty-six percent used one or both of the defendant hospitals.\textsuperscript{52} If the hospital market was indeed as local as the government claimed, the merger was clearly unlawful.

The defendants, however, had a different view of the market. In their opinion, it included not only the area described by the government, but also encompassed several regional hospitals located as far away as Iowa City, Iowa and Madison, Wisconsin, communities seventy to 100 miles from Dubuque County.\textsuperscript{53} The defendants acknowledged that most people in the Dubuque area sought hospitalization in the local hospitals, but argued that if those hospitals tried, post-merger, to raise prices, the large managed care companies whose members account for twenty-five percent of hospitalizations in Dubuque would defeat price increases by sending their insureds to the distant regional hospitals.\textsuperscript{54} This strategy was plausible, defendants contended, because HMO members are highly sensitive to price, and willing to drive the extra hour or two in order to use the low-cost facilities.\textsuperscript{55}

The court agreed. Finding that “the government’s case rests too heavily on past healthcare conditions and makes invalid assumptions as to the reactions of third-party payers and patients to price changes,”\textsuperscript{56} it adopted a broad definition of the geographic market and consequently approved the merger.\textsuperscript{57} According to the court, “the arrival of managed care” over the past ten to fifteen years has not only changed the nature of hospital competition from competition “on the basis of amenities and perceptions of quality” to competition “on the basis of price,”\textsuperscript{58} but has also greatly expanded the area in which hospitals compete for patients.\textsuperscript{59}

In the court’s view, managed care enrollees are “much more aware” of the costs of hospitalization than patients covered by traditional indemnity insurance, and thus more willing to travel long distances for hospital care if they can realize significant savings.\textsuperscript{60} At the same time, the increased use of outpatient services for procedures that traditionally required

\textsuperscript{52} Id.
\textsuperscript{53} Id.
\textsuperscript{54} Id. at 978.
\textsuperscript{55} Id.
\textsuperscript{56} Id.
\textsuperscript{57} Id. at 978, 989.
\textsuperscript{58} Id. at 973 (noting, however, that competition for Medicare, Medicaid, and traditional indemnity patients still occurs on basis of amenities and patients’ perceptions about quality).
\textsuperscript{59} Id. at 974.
\textsuperscript{60} Id. at 973-74.
overnight hospitalization, coupled with a trend toward shorter hospital stays, have led hospitals ("needing to maintain their patient volume") to establish outreach clinics, link up with physician-owned clinics, even those at some remove from the hospitals themselves, and extend their marketing efforts into "catchment areas" that were once the exclusive preserves of other, distant hospitals.\textsuperscript{61}

According to the court, the underlying facts of hospital competition in Iowa had changed dramatically since the advent of managed care.\textsuperscript{62} As a consequence, the area of effective competition has expanded, transforming what were formerly local markets into regional ones.\textsuperscript{63} The Dubuque hospitals, the court found, compete in one of these "new" markets.\textsuperscript{64} Although managed care companies account for only twenty-five percent of the hospitals' income, their business is crucial to the hospitals' financial well-being.\textsuperscript{65} Should these hospitals raise prices post-merger, the companies' willingness to send members as far away as Madison or Iowa City, along with the members' inclination to make those trips, mean that Dubuque consumers have nothing to fear from the merger. The presence of regional hospitals—seventy to 100 miles away—and their competitive prices, the court ruled, would preserve competitive pricing for consumers in Dubuque.\textsuperscript{66}

The government has appealed the ruling in \textit{Mercy}, as well it might. In its view, hospital markets are still local; HMOs have been successful in wresting price reductions from competing local hospitals; and if hospital consolidation proceeds apace in local markets, HMOs will lose their bargaining leverage and consumer prices will rise.\textsuperscript{67} The dispute on appeal revolves around the weight and admissibility of the evidence regarding the willingness of HMO members to travel long distances to save on hospital expenses, evidence that the government contends is highly questionable.\textsuperscript{68}

The larger issue, however, concerns the future of hospital merger analysis and its effect on merger enforcement. If the \textit{Mercy} court's broad
view of hospital competition is correct, federal enforcement policy respecting hospital mergers, which has never been particularly aggressive, is apt to come to a complete standstill. If acute care hospitals within 100 miles of one another are truly competitors, then it would seem that, in regions where managed care companies have sufficiently large enrollments, hospital mergers will be effectively immune from antitrust challenge. Antitrust law will thus have little effect on hospital mergers, whose occurrence will then depend entirely upon business judgment. 69

A few days after deciding Mercy, the Eighth Circuit affirmed a lower court ruling that rejected another government challenge to a proposed hospital merger. In FTC v. Freeman Hospital, 70 two of the three general acute care hospitals in Joplin, Missouri sought to merge. 71 The government objected, claiming that the merger would likely result in increased prices in the geographic market defined as Joplin and areas within a twenty-seven mile radius of it. 72 Not only did the government provide the usual expert testimony in support of its definition, it also introduced testimony from Joplin employers that if post-merger hospital prices increased due to collusion "few patients currently traveling to Joplin for care would travel instead to hospitals located outside the FTC's proposed geographic market." 73 As in Mercy, if the government's market definition was correct, the merger was conceded to be unlawful. But, as in Mercy, the defendants claimed that the relevant market was much larger, a thirteen-county area that included seventeen hospitals located up to fifty-four miles from Joplin. 74 In that market, the government acknowledged, the merger would raise no antitrust concern.

The district court in Freeman had rejected the government's proposed market definition, stating that it failed to show where consumers of hospital services could practically turn for alternatives. The appeals court affirmed. The government's analysis, it said, "gives a static, rather than a dynamic, picture of the acute care market," fails to provide "insight into the future effects of the allegedly anti-competitive merger,"

69. An unwelcome view, and one apparently shared by Melvin H. Orlans, senior litigation attorney in the FTC's Office of General Counsel, is that "if enough courts keep saying that broader markets are appropriate, ... it will prevent us from challenging hospital merger cases." Jeannine Mjoseth, Hospital Mergers: FTC Needs Success in Grand Rapids Case to Bolster Ability to Challenge Mergers, 5 Health L. Rep. (BNA) 20 (May 16, 1996).
70. 69 F.3d 260 (8th Cir. 1995).
71. Id. at 262.
72. Id. at 265.
73. Id. at 269.
74. Id. at 265.
and thus falls short of the applicable legal standard. Although the testimony of the Joplin employers was admittedly relevant on this score, "the views of market participants are not always sufficient to establish a relevant market, especially when their testimony fails to address specifically the practicable choices available to consumers." 75

Freeman differs from Mercy in significant respects. In Mercy, the court used the traditional test for defining the relevant market and found, as a matter of fact, that recent developments in healthcare competition had expanded substantially the area in which the defendant hospitals actually competed. In Freeman, although the court purported to apply the traditional test, it rejected the government's proposed market definition as insufficiently "dynamic," while failing to provide any guidance as to how this dynamic standard might be satisfied. These differences, however, are less important than the shared view that hospital competition is not necessarily local anymore and that hospital mergers must be tested against a backdrop of vigorous regional competition. If broadly applicable, this expansive definition of the relevant geographic market will discourage future challenges to hospital mergers, and add fuel to the merger movement now under way.

B. HMO Growth

Hospital executives report that the private merger movement is a direct response to the emergence of large, managed care organizations. 76 As HMOs have become larger and more powerful, their bargaining leverage has forced hospitals to reduce costs in order to remain competitive and profitable. Merger is a time-honored method of reducing costs and hospitals have turned to it, they say, to cope with the growth of the HMO sector. 77

Mercy and Freeman demonstrate that courts have come to regard hospital markets as sufficiently broad to permit mergers that would have been impermissible in smaller markets. Their view of the effective scope of hospital competition bodes well for the continuation of the hospital merger boom. If, however, antitrust courts were to limit the continued growth of HMOs then perhaps the need for hospital mergers would abate and the unfortunate social consequences of consolidation could be

75. Id. at 270.
76. See Scott, supra note 32.
avoided or delayed. In another case decided last year, though, *Blue Cross & Blue Shield United v. Marshfield Clinic*,\(^7\) the Seventh Circuit Court of Appeals effectively held that the antitrust laws pose few obstacles to mergers between large HMOs.

In *Marshfield*, Blue Cross & Blue Shield (BCBS) sued Marshfield Clinic and its HMO subsidiary.\(^7\) BCBS alleged, among other things, that the clinic had violated section 2 of the Sherman Act\(^8\) by acquiring a monopoly of the HMO “market” in the fourteen counties of north central Wisconsin and unlawfully excluding the BCBS HMO from doing business in that “market.” The jury awarded BCBS a sizeable verdict that, after trebling, remittitur, and the addition of attorney’s fees, amounted to just under twenty million dollars.\(^8\) On appeal, one of the critical issues was whether HMOs constitute a distinct product market for antitrust purposes.\(^8\) If so, the clinic would be a monopolist and the verdict might stand. If not, and HMOs were instead simply one component of the much broader market for physician services, then the clinic was not a monopolist and could not have violated section 2’s prohibition against monopolization.

Writing for the Seventh Circuit, Judge Posner ruled that “HMOs are not a market.”\(^9\) Employers and medical insurers, he stated, regard them “as competitive not only with each other but also with the various types of fee-for-service provider[s].”\(^9\) He noted that preferred provider organizations (PPOs) (“under which the insurer offers more generous reimbursement if the insured patronizes physicians who have contracts with the insurer to provide service at low cost to its insureds”) are

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79.  Id. at 1408.
80. Section 2 of the Sherman Act provides that “e]very person who shall monopolize, or attempt to monopolize . . . any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony . . . .” 15 U.S.C. § 2 (1994). Section 4 of the Clayton Act creates a private right of action for “any person . . . injured in his business or property by reason of anything forbidden in the antitrust laws” and directs the award to successful private plaintiffs of treble damages costs of suit, including reasonable attorney’s fees. 15 U.S.C. § 15 (1994).
81.  Marshfield, 65 F.3d at 1408.
82. In technical terms, the relevant product market in an antitrust inquiry is defined by the cross-elasticity of demand between a given product and its substitutes. 2 Phillip E. Areeda & Donald F. Turner, *Antitrust Law* ¶ 519a (1978). The cross-elasticity of demand for substitutes measures consumers’ propensity to switch from one product to another, similar product when relative prices change. See William J. Baumol & Alan S. Blinder, *Economics: Principles and Policy* 387 (1985). Products similar enough that a small relative price change causes consumers to substitute one for another are in the same product market. Areeda & Turner, *supra*, ¶ 525a.
83. Marshfield, 65 F.3d at 1412.
84.  Id. at 1410.
"particularly close substitutes for HMOs." All that is needed for their formation is "an array of physicians who among them provide a broad range of medical services." Because PPOs and other forms of medical-services contracting constrain the price that HMOs can charge, there is no separate "HMO market." Instead HMOs are components of the much larger market in medical services.

Although *Marshfield* dealt with claims of monopolization and territorial division, not with a merger challenge, its ruling that HMOs do not constitute a separate product market is likely to offer further encouragement to the growth of HMOs and managed care companies generally. Indeed, *Marshfield* is simply the latest in a lengthening string of opinions to decide that HMOs compete with other forms of healthcare financing and medical service contracting. By including HMOs within that broad product market, these opinions create important precedent for analyzing proposed mergers. Having ruled that HMOs do not constitute a separate product market for purposes of section 2 of the Sherman Act, courts are unlikely to define them as a separate market for merger purposes.

If HMOs are regarded as competing against all other medical service providers, the merger of two large managed care companies would be unlikely to arouse antitrust suspicion. The relevant product market would simply be too large to be adversely affected by one merger. Should an HMO merger be challenged, courts would probably conclude that if the HMO's post-merger prices were to exceed competitive levels, consumers in these broad product markets could readily switch to one of the many competitive substitutes.

These recent cases strongly suggest that antitrust law is in the process of defining healthcare markets so as to effectively encourage the

85. *Id.*
86. *Id.* at 1411.
87. *See, e.g.*, U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 596–97 (1st Cir. 1993) (affirming magistrate's finding that, in relevant geographic market (New Hampshire), HMOs compete as sellers in market that includes "all health financing" and as buyers in market for "doctor services," both of which are too broad to permit easy monopolization); *see also* Ball Memorial Hosp. v. Mutual Hosp. Ins., 784 F.2d 1325, 1331 (7th Cir. 1986) (affirming lower court holding that traditional health insurance, PPOs, HMOs, and self-insuring employers all offer "methods of financing health care" that compete against one another in "health care financing" market).
88. Because market definition is highly fact-intensive one court's determinations in this regard is not strictly binding on another. Nevertheless, the courts' factual determinations respecting HMOs all have been premised on a shared understanding of how those markets function. Later opinions also have borrowed the language and reasoning of the earlier ones.
continued consolidation of HMOs and hospitals.\textsuperscript{89} By expanding the boundaries of the geographic and product markets in which hospitals and HMOs are deemed to compete, these rulings will provide important precedent for shielding most mergers in those markets from antitrust challenge. If those rulings accurately reflect the new realities of healthcare competition, then almost all hospitals and HMOs may continue to merge and grow, unconstrained by antitrust law. And if the policy concerns animating these rulings are correct, consumers should welcome continued concentration in these markets as the harbinger of increased competition and lower prices.

As suggested above, while consumer welfare may improve, improvements may come at the expense of social well-being. The continued expansion of the private hospital sector could well toll the death knell for public hospitals and the important social services that they provide. Because of antitrust’s exclusive focus on “consumer welfare,” narrowly conceived, and on lower prices for those capable of buying healthcare, conventional antitrust analysis seems powerless to arrest this movement and incapable of considering the social interests at stake.

IV. ANTITRUST FAILURE AND HEALTHCARE MARKETS

During the past decade, antitrust scholars and economists have conducted a heated debate over the nature of competition in hospital and medical service markets. One school contends that those markets respond to the same economic forces as other industries, and that active antitrust enforcement can therefore produce important benefits for consumers.\textsuperscript{90} A second claims that healthcare markets differ fundamentally from others.\textsuperscript{91} It argues that market “imperfections,” such as inadequate consumer information, tax incentives to over-consume, and government-induced over-capacity, make hospital competition “wasteful.” On its view, these

\textsuperscript{89} Antitrust law also appears to offer very little discouragement to the continued growth of physician groups offering certain specialties. See, e.g., Morgenstern v. Wilson, 29 F.3d 1291, 1296 (8th Cir. 1994) (reversing jury finding limiting relevant geographic market for Lincoln, Nebraska-based cardiac surgeon to Lincoln and 26 surrounding counties; ruling that Omaha also should have been included in market definition because it was place to which purchasers “can practicably turn”), cert. denied, 115 S. Ct. 1100 (1995).


\textsuperscript{91} See, e.g., Fredric J. Entin et al., Hospital Collaboration: The Need For An Appropriate Antitrust Policy, 29 Wake Forest L. Rev. 107, 123 (1994) (“Hospital markets do not strictly follow the competitive paradigm.”).
imperfections counsel in favor of less intrusive antitrust enforcement, fewer merger challenges, and greater consideration of the industry's peculiarities. A third school asserts that because nonprofit hospitals do not exercise market power to the same extent as for-profit firms (do not raise prices as much in markets where they have high market shares), powerful nonprofits pose less of a threat to competition and that mergers between them should therefore be treated more leniently by enforcement authorities.  

Although these contending schools disagree about the nature of healthcare markets, they share a common but flawed understanding about the goals of antitrust policy in those markets. All believe that the critical question facing healthcare antitrust policy is the factual one of how hospital markets really work. In their view, this question is important because its answer will shape the way in which antitrust policy seeks to maximize consumer welfare. Each implicitly believes that the consumer welfare model that informs antitrust analysis generally is appropriate for hospital markets and that antitrust policy in healthcare markets should focus, as it does in other markets, exclusively on the goal of maximizing consumer welfare. In my opinion, this is a mistaken belief.

Hospital markets are meant to serve society as well as consumers. Simply by virtue of their membership in society, the poor are entitled to healthcare. This characteristic is what makes healthcare markets unique and also makes the consumer welfare model of antitrust analysis ill-fitted to those markets. As currently conceived, antitrust analysis is unable or unwilling to balance the interests of consumers against those of the poor. In most markets, there is arguably no need for this kind of balancing because the interests of consumers are presumptively those of the community. Indeed, in most markets, the relevant community consists strictly and entirely of paying customers. In most cases, then, an exclusive focus on consumer welfare might not necessarily be misplaced.

In hospital markets, though, the community is broader than antitrust analysis can conceive. In these markets, the community consists of everyone, not just those with money. Healthcare is a merit good, one that we all deserve regardless of financial circumstance. In partial recognition of our commitment to this goal, tax dollars have for decades funded the construction and maintenance of public hospitals and have subsidized many social programs thought critical to community health. But our long-standing commitment to the poor should have taught us that

healthcare markets are unavoidably imperfect, intentionally so, and for good reason. The critical issue for policymakers should therefore be not to quarrel about whether and to what extent imperfections distort healthcare markets but to identify instead the imperfections of antitrust policy as applied to those markets and to resolve the conflict between the narrow doctrinal conception of consumer welfare and the public good more broadly conceived.

The exclusive focus of antitrust courts precludes their consideration of the social values that inform, or ought to inform, the debate about competition in healthcare markets. But the problem with antitrust and healthcare markets is not simply a problem of misguided judicial philosophy. A broader conception of social values, if applied partially and episodically through antitrust enforcement and judicial decision-making, would probably do more to distort the marketplace than to reform it. At bottom, antitrust adjudication is simply a poor vehicle for healthcare policy-making.

Comprehensive regulation is the only solution. Despite the current widespread skepticism about the efficacy of regulatory regimes, active administrative oversight offers the best source of protection against private competition's eventual eradication of public health programs. A wide variety of regulatory options is possible, individually or in combination. Tax monies can be redistributed from private to public hospitals. Voucher systems can provide healthcare dollars to all and the freedom to spend them as each sees fit. Government can require private hospitals to share the expenses of important social programs. Private organizations can bid to develop, administer, and staff those programs. But some form of aggressive regulation is essential in order to foster the public good.

By succeeding on its own terms, antitrust has failed. More significantly perhaps, it is destined to fail. In healthcare markets, consumer welfare is not synonymous with social well-being. Indeed, an increasingly competitive environment threatens to extinguish many of our most important public facilities and programs. But antitrust policy is incapable of either recognizing or responding to this dilemma. We are more, one would hope, than a nation of consumers. In the provision of healthcare at least, we profess to care for the weakest among us. But because antitrust cannot countenance this aspiration or promote the values necessary for its preservation, it is inadequate to protect public health.