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INTRODUCTION

The recent Supreme Court decision in *Eastman Kodak Co. v. Image Technical Services*[1] affirms two major premises. First, a court may find a seller or combination of sellers has market power in secondary markets (aftermarkets) into which their consumers are practically "locked" by an original purchasing decision where (1) market imperfections, including lack of information, precluded fully informed consumer choice at the time of the original purchase; and (2) the cost or practical availability of "switching" to an alternative primary product eliminates price or service sensitivity.[2] Second, a seller's refusal to deal or to allow consumers to deal with competitors in a secondary market may be monopolistic as an unreasonable business practice, particularly if the refusal results in price stabilization, service limitations, or the elimination of a competitive consumer-provider market.[3] In certain respects, *Kodak* merely reaf-

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1. 504 U.S. 451 (1992).

2. *Id.* at 472–79. According to the Court, "[m]arket power is the power 'to force a purchaser to do something that he would not do in a competitive market.'" *Id.* at 464 (quoting Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 14 (1984)). Furthermore, the Court stated that market power "has been defined as 'the ability of a single seller to raise price and restrict output.'" *Id.* (quoting Fortner Enters. v. United States Steel Corp., 394 U.S. 495, 503 (1969)). The Court concluded that the plaintiffs, composed of photocopier service companies in competition with Kodak, "have presented a triable claim that service and parts are separate markets [from photocopiers], and that Kodak has the 'power to control prices or exclude competition' in service and parts," even though Kodak lacked such power with respect to photocopiers. *Id.* at 481 (quoting United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 391 (1956)). Finally, the Court held that "[t]he relevant market for antitrust purposes is determined by the choices available to Kodak equipment owners," and that a single brand of a service or product can "be a relevant market under the Sherman Act." *Id.* at 481–82.

3. *Id.* at 465, 482–84. The Court reiterated that "[t]he second element of a § 2 claim is the use of monopoly power 'to foreclose competition, to gain a competitive advantage, or to destroy a competitor.'" *Id.* at 482–83 (quoting United States v. Griffith, 334 U.S. 100, 107 (1948)). Accordingly, the Court found that "respondents have presented evidence that Kodak took exclusionary action to maintain its parts monopoly and used its control over parts to strengthen its monopoly share of the Kodak ser-

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firmed *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*[4] But more importantly *Kodak* also affirmed the comparative significance of developing a trial record versus relying upon economic theory to assess the competitive consequences of and motives for business behavior.[5]

In the *Kodak* context, several common health care provider practices, previously challenged with varying results under traditional antitrust analysis, may be reexamined to focus upon the effect of refusals to deal in a secondary market with potential competitors in that secondary market. This Article focuses on three such practices: (1) the non-immunized[6] revocation of hospital staff privileges for other than legitimate, quality-of-care motives; (2) the denial of hospital privileges to differentially credentialed, state-licensed providers; and (3) the closure of membership in comprehen-

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vice market. Liability turns, then, on whether 'valid business reasons' can explain Kodak's actions." *Id.* at 483 (citing Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 605 (1985); United States v. Aluminum Co. of Am., 148 F.2d 416, 432 (2d Cir. 1945) (*"Alcoa"*)).

4. 472 U.S. 585 (1985). The *Kodak* Court referred to a conclusion it had reached in *Aspen Skiing*, stating: "It is true that as a general matter a firm can refuse to deal with its competitors. But such a right is not absolute; it exists only if there are legitimate competitive reasons for the refusal." *Kodak*, 504 U.S. at 483 n.32. However, the Court's reliance upon *Alcoa* is perhaps more noteworthy than its reaffirmation of *Aspen Skiing*. In *Alcoa,* the Court rejected as illegitimate Alcoa's expansion of aluminum manufacturing capacity necessary to support the allied effort in World War II. *Alcoa*, 148 F.2d at 444–45. However, in *Kodak* the Court reviewed and scrutinized carefully each of Kodak's justifications for its refusal to sell Kodak parts to the plaintiffs and concluded that characterizing those justifications as legitimate or exclusionary was a question of fact for the jury. *Kodak,* 504 U.S. at 484–85.

5. *Kodak*, 504 U.S. at 467–69. It is not the purpose of this Article to add to the extensive spin-doctoring directed toward *Kodak*. *See, e.g.*, M. Laurence Popofsky & Mark S. Popofsky, *Vertical Restraints in the 1990s: Is There a "Thermidorian Reaction" to the Post-*Sylvania *Orthodoxy?*, 62 ANTITRUST L.J. 729, 741–54 (1994) (explaining implications of *Kodak* and proposition that *Kodak* destroyed role of economic theory in antitrust analysis). Rather, this Article explores whether the *Kodak* analysis is potentially relevant in evaluating the competitive significance of common health care provider conduct.

Nevertheless, worthy of quotation is the Court's rejection of Kodak's claim that, as a matter of law, if a defendant lacks market power in a primary product market, it necessarily lacks power in "derivative aftermarkets": "Legal presumptions that rest on formalistic distinctions rather than actual market realities are generally disfavored in antitrust law." *Kodak*, 504 U.S. 466–67. The Court found that "Kodak's theory does not explain the actual market behavior revealed in the record." *Id.* at 473.

6. The Health Care Quality Improvement Act of 1986 ("HCQIA") affords antitrust immunity to participants in medical peer review if they comply with specified requirements. 42 U.S.C. § 11111 (1988 & Supp. V. 1993); Bryan v. James E. Holmes Regional Medical Ctr., 33 F.3d 1318, 1321–23, 1337 (11th Cir. 1994); Smith v. Ricks, 31 F.3d 1478, 1485–87 (9th Cir. 1994).

sive health care plans, such as preferred-provider organizations, combined with a refusal to deal with nonmembers. These practices should be increasingly vulnerable to attack under section 2 of the Sherman Act[7] using a *Kodak* analysis. That is, courts more likely could find that defendant providers have monopoly power from the locked-in patient's perspective and that their refusal to deal enhanced that power.

A *Kodak*-based challenge to the third practice, in particular, focusing on the impact of excluding a competitor from a provider-patient aftermarket,[8] threatens to undermine a central tenet of managed competition policy—the appropriateness of enhanced concentration and cooperation in the market for health care plans.[9] Such a challenge also potentially conflicts with the Clinton administration's antitrust "safety zones" for joint ventures among providers.[10]

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7. Section 2 provides: "Every person who shall monopolize, or attempt to monopolize, or combine or conspire . . . 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).

8. The primary market is the comprehensive health care plan, normally sold to employee or employer groups.

9. The Clinton administration posited that if the federal government supported the integration of providers and purchasers of health care into comparatively few large networks, "competition" between those concentrated networks of buyers and sellers would be directed and controlled by appropriate public agencies, resulting in cost efficiencies and a competitive stimulus. *See* Thomas A. Piraino, Jr., *Reconciling Competition and Cooperation: A New Antitrust Standard for Joint Ventures*, 35 WM. & MARY L. REV. 871, 875–76 (1994). Such an ill-conceived conception of how competitive markets might work to reduce cost, increase innovation, and increase supply in health care markets presumably was publicly rejected in the November 1994 election. Dramatically increased demand for health care as a result of universal coverage, with fewer independent sources of supply, could only eventually lead to significantly increased health care costs, even if the cost increases were regulated. The only models likely to succeed in providing universal coverage while controlling costs are (1) a private market with enhanced supply and cost information, and dramatically increased antitrust policing, or (2) a municipal services, local government ownership model (similar to public education) with state financing. A combination of the two extremes, as currently exists in education markets, may be feasible. That is, the public system makes primary health care available to all citizens and the private market provides supplemental special care.

10. Motivated by White House health care policy and demands to immunize provider and purchaser networks from antitrust liability, on September 27, 1994, the Department of Justice and the Federal Trade Commission released health care antitrust policy statements which expanded and revised those issued in September 1993. U.S. Dep't of Justice & U.S. Fed. Trade Comm'n, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, 4 Trade Reg. Rep. (CCH) ¶ 13,152 (Sept. 30, 1994). The policy statements purport to create "safety zones" for certain practices that the government deemed not to warrant antitrust challenge. *Id.* at 20,769–70. Statement Eight, which describes policies relevant to

This Article, not intended as a scholarly survey of the literature[11] or case law or as a prediction of how the lower federal courts will adjudicate a complaint, makes particular reference to the records developed in several health care antitrust cases in which the author has participated. This Article concludes that only by eliminating the patient-provider fee-for-service market altogether, so that there is no separate contractual relationship between patient and provider,[12] will legitimate antitrust concerns be accounted for in the newly dominant health care plan or insurance markets. Such a decision implicates fundamental economic and social policy choices,[13] however, and forces a recognition that competitive market and public utility (or state economy) approaches toward the regulation of health care markets may be mutually exclusive.

I. HORIZONTAL REFUSALS TO DEAL AS PARADIGMATIC EXCLUSIONARY CONDUCT

As is true in other antitrust contexts, the characterization of and nomenclature associated with business decisions arguably implicating a horizontal refusal to deal can be misleading, whether the decisions are pursuant to concerted action or are unilateral. Many of the classic monopolization cases under section 2 have involved allegations of a "refusal to deal," but that term has incorporated different types of conduct.[14]

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physician network joint ventures, focuses upon market power in health care plans, rather than in health care provider markets, and provides no input with respect to anticompetitive practices affecting independent provider-patient markets. *See id.* at 20,787–93.

11. For such a survey, see John J. Flynn, *Antitrust Policy and Health Care Reform*, 39 ANTITRUST BULL. 59 (1994).

12. Commenting on complex and subtle relationships between health care providers and medical plans, the Ninth Circuit observed: "In a market consisting of individual service providers and individual consumers, concerted action by the suppliers even on matters not directly related to price is viewed with the greatest suspicion." United States v. Alston, 974 F.2d 1206, 1214 (9th Cir. 1992).

13. One interpretation of the November 1994 election is that a majority of the voting public has rejected institutional—public or private—depersonalized control of decisions like the selection of health care providers which traditionally involves personal choice. However, a *New York Times* study and article demonstrates a dramatic shift in health care coverage resulting from a laissez-faire political response. *See* Erik Eckholn, *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994, at 1, 34. The shift is from independent provider-patient markets to capitated, for-profit HMOs owned by private corporations seeking to increase market concentration and control. *Id.* In this new "corporatization of health care," individuals have reduced control over selection of their providers and the nature of their care, while "'[t]he H.M.O.s are taking extraordinary profits.'" *Id.* at 34 (quoting John C. McDonald, Chief Exec. of Mullikin Medical Ctrs.).

14. *See, e.g.*, *Aspen Skiing*, 472 U.S. at 595 (claiming ski resort owner's refusal

The Supreme Court, of course, has rejected the proposition that a seller has the unfettered discretion to unilaterally decide with whom to do business, and thus to refuse to deal with competitors, customers, or others for any reason.[15] The Court in *Lorain Journal Co. v. United States*[16] firmly established that the motive for or intended effect of a defendant's decision not to deal, particularly by a seller with substantial market power, was an essential component of a section 2 case.[17] More recently, in *Aspen Skiing* the Court held that ordinarily the jury should evaluate and determine the defendant's motive.[18] The question for the jury is whether the defendant's refusal to deal or to continue dealing with the alleged victim was predominately a reasonable, competitive business decision, or alternatively, was designed primarily to exclude actual or

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to deal with neighboring resort violated Sherman Act); Otter Tail Power Co. v. United States, 410 U.S. 366, 368 (1973) (involving allegations of refusals by power company to sell power at wholesale to municipal systems in towns where Otter Tail retailed power); Lorain Journal Co. v. United States, 342 U.S. 143, 148–49 (1951) (involving allegations that newspaper refused to publish advertising by advertisers also using radio station); United States v. Griffith, 334 U.S. 100, 103 (1948) (charging movie theater operators with entering into agreement with film distributors to prevent them from dealing with competitors); United States v. Standard Oil Co., 221 U.S. 1, 42–43 (1911) (involving charges of attempts to control petroleum industry by restraining competitors' trade); Data Gen. Corp. v. Grumman Sys. Support Corp., 36 F.3d 1147, 1183 (1st Cir. 1994) ("In *Aspen Skiing*, the Court criticized a monopolist's unilateral refusal to deal in a very different situation [from that in *Otter Tail*], casting serious doubt on the proposition that the Court has adopted any single rule or formula for determining when a unilateral refusal to deal is unlawful."); United States v. Aluminum Co. of Am., 148 F.2d 416, 422 (2d Cir. 1945) ("*Alcoa*") (resolving charges of entering into covenants with power companies not to sell power to other aluminum manufacturers). Some refusal-to-deal cases involve a defendant's efforts to persuade suppliers (*Griffith*) or customers (*Lorain Journal*) not to deal with a defendant's competitors, rather than refusals by a defendant itself to deal with its competitors (*Otter Tail* and *Aspen Skiing*). As a matter of juror perception and logic, a defendant may have more difficulty providing a legitimate, nonexclusionary business explanation for its efforts to persuade third parties not to deal with its competitors than to justify its own refusal to deal, which may be based upon an internal business strategy related to a distribution policy.

15. *See Aspen Skiing*, 472 U.S. at 600–03. In a recent decision, however, the Tenth Circuit appears to have transformed the concept of "legitimate" business justification in a section 1 "rule of reason" context into profit-maximizing conduct designed to eliminate price competition. SCFC ILC, Inc. v. Visa USA, 36 F.3d 958, 969–70 (10th Cir. 1994) ("[E]vidence that a Board member voted . . . to discourage price competition . . . may reveal mental state, but is not an objective basis upon which section 1 liability may be found."). The *Visa* decision could legitimize cartels. Since the goal of businessmen is to maximize profits, which can best be achieved by eliminating competition, conduct which eliminates competition to maximize profits is rational and thus legitimate.

16. 342 U.S. 143 (1951).

17. *Id.* at 152–55.

18. *Aspen Skiing*, 472 U.S. at 604–05, 608.

potential competition.[19] However, literal refusal-to-deal section 2 cases are distinguishable from section 2 cases based on other challenged practices with respect to the reviewing courts' willingness to defer to a jury determination of motive. When the challenged conduct is predatory pricing, merger, vertical integration, or alleged exclusionary design innovation, reviewing courts have been more likely to superimpose a "rule of law" which limits the jury's discretion in evaluating motive.[20]

For example, allegations of predatory pricing must satisfy "below cost" and "recoupment" requirements as a prerequisite to jury evaluation because the courts apparently wish to avoid imposing antitrust impediments on consumer-friendly competitive pricing whose legality cannot be determined in advance.[21] A similar desire to avoid condemnation of innovative-design conduct that may be exclusionary, yet output-enhancing,[22] explains the significant judicial oversight of the jury's role in section 2 design cases.[23]

When the challenged monopolistic practice consists of voluntary integration by merger or contract, courts have recognized theoretical efficiency justifications for the conduct.[24] In some cases the efficiency explanation for integrative conduct is incomplete at best,

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19. *Id.* The rule that emerges from *Aspen Skiing* appears to be that a defendant possessing monopoly power in a relevant market who refuses to deal with a competitor for exclusionary rather than reasonable business purposes has "monopolized" in violation of section 2. *Id.* at 602–05, 610–11. That rule has been confirmed by the *Kodak* Court. *Kodak*, 504 U.S. at 483 n.32.

20. *See, e.g.*, Brooke Group Ltd. v. Brown & Williamson Tobacco Corp., 113 S. Ct. 2578, 2587–89 (1993) (predatory pricing).

21. *See id.* at 2587–88, 2591–98. *See generally* Symposium, *Predatory Pricing After* Brooke Group, 62 ANTITRUST L.J. 537 (1994).

22. *See, e.g.*, Transamerica Computer Co. v. IBM, 481 F. Supp. 965, 1002–03 (N.D. Cal. 1979) (weighing several factors to determine whether design choice is unreasonably restrictive of competition), *aff'd*, 698 F.2d 1377 (9th Cir.), *cert. denied*, 464 U.S. 955 (1983).

23. *See id.* at 974. Since the primary goals of antitrust laws are to inhibit monopoly pricing and to promote innovation and productivity through maintenance of a competitive process, the judicial creation of special rules limiting juror discretion to determine the defendants' motive is logical, even if it raises constitutional and statutory interpretation questions. For example, if Congress indeed forbade "all" forms of monopolization interfering with a competitive marketplace, then business practices which foreseeably maintain monopoly power and preclude competition should violate section 2 regardless of a defendant's mixed motives, and juries should thus be charged with the obligation of making findings regarding the challenged practices. From that perspective, even a laudable motive would not exempt avoidable conduct which maintained monopoly power. *See, e.g.*, *Alcoa*, 148 F.2d at 431–32 (stating "[w]e disregard any question of 'intent'").

24. *See* Hospital Corp. of Am. v. FTC, 807 F.2d 1381, 1389–92 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987); Paschall v. Kansas City Star Co., 727 F.2d 692, 697–701 (8th Cir.), *cert. denied*, 469 U.S. 872 (1984).

whereas in other cases the efficiency-enhancing conduct so eliminates competition that efficiencies are unlikely to be maintained or passed on to consumers. At the very least, the courts' refusal to allow juries to evaluate motive in section 2 cases involving integration can be linked in theory to recognized antitrust goals. Specifically, the argument goes, courts should not allow jurors to determine whether the purpose of a challenged integration was to attain or retain monopoly power if, theoretically, section 2 was not intended to condemn efficiency-enhancing monopolies.

Horizontal refusals to deal, however, frequently cannot be linked to purposes consistent with recognized Sherman Act goals.[25] In fact, to the extent the "dealing" in question involves a transaction within the normal sphere of the commercial market, a refusal to pursue such a transaction for other than traditional business considerations is presumptively antithetical to the marketplace paradigm. Practices designed to limit output, reduce supply substitutability, and impede the process creating allocative efficiencies can be explained only in contexts not associated with free and open markets.[26]

The best one can argue in defense of a horizontal refusal to deal, whether unilateral or concerted, is that the target represents only a small part of the market and/or that the defendant controls less than a monopoly share of the market such that consumers are not demonstrably injured by the challenged practice.[27] As will be addressed below, when section 1 is invoked to challenge concerted refusals to deal in health care markets, the issue of whether that section prohibits nakedly anticompetitive combinations which do not produce "undue" restraints or effects is frequently dispositive even though the courts have not developed a consistent or predictable set

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25. In this context, a distinction between a horizontal refusal to deal with a specific competitor and a restricted distribution or exclusive dealing policy resulting in a de facto refusal to deal should be recognized. Transaction and other efficiencies can result from restricted distribution. *See* Standard Oil Co. v. United States, 337 U.S. 293, 306–08 (1949); Jayco Sys. v. Savin Business Mach. Corp., 777 F.2d 306, 316–18 (5th Cir. 1985), *cert. denied*, 479 U.S. 816 (1986); Graphic Prods. Distribs. v. Itek Corp., 717 F.2d 1560, 1571–73 (11th Cir. 1983). When a particular market retains sufficient rivalry, efficiencies resulting from restricted distribution can be passed on to consumers leading to enhanced competition.

26. Conduct which is profit-maximizing, and thus "reasonable," frequently is designed to reduce competition. Thus "reasonable" business conduct should not be regarded as legitimate merely because a defendant provides a profit-maximizing—even efficiency-promoting, if in a noncompetitive market—justification for challenged conduct.

27. In other words, although the challenged practice is exclusionary and does not promote legitimate business purposes, the effect of the *conduct* on "competition" is negligible.

of rules in those cases. In particular, the courts have not resolved the proper role of the jury or factfinder in evaluating motive or its relevance.[28]

II. A NOTE ON THE PRACTICAL DISTINCTIONS BETWEEN UNILATERAL AND CONCERTED REFUSALS TO DEAL IN LITIGATION CONTEXTS

Section 1 of the Sherman Act obviously requires proof of concerted action whereas section 2 ordinarily does not.[29] Moreover, section 2 normally requires proof of a defendant's dominant market share in a relevant market,[30] whereas section 1 occasionally does not.[31] Based primarily on the latter consideration, plaintiffs in the vast majority of refusal-to-deal cases have alleged concerted action and invoked the "boycott" label under section 1, relying on the rule of law articulated in *Klor's, Inc. v. Broadway-Hale Stores*.[32] Reliance on section 1 has been enhanced because refusals to deal, re-

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28. Alternatively, refusal-to-deal defendants may argue that the refusal to deal is only an ancillary, not a naked, restraint that is necessary to promote a pro-competitive goal. For example, this defense, raised but not yet tested in the context of health care antitrust cases, could suggest that a sellers' efficiency-promoting joint venture requires either limited participation or a closed membership to secure the alleged efficiencies. More practically, as will be discussed in more detail below, the argument is that the defendants negotiated a trade-off of a reduced price for less competition and greater sales. Not only has such a requirement not been verified factually (there has been no showing that providers will not accept reduced fees when the provider panel remains open), the public utility based argument itself is a "destructive competition" claim which is directly at odds with basic tenets of the free market. Accordingly, without federal or state authorization, the defense should be rejected out of hand. *See, e.g.*, Goldfarb v. Virginia State Bar, 421 U.S. 773, 781–88 (1975) (finding attorney fee schedule for required title examination was not merely advisory, but was instead restraint on trade); United States v. Topco Assocs., 405 U.S. 596, 605–12 (1972) (rejecting claims that horizontal territorial restrictions encourage competition, finding instead a per se violation of section 1).

29. *See* Monsanto Co. v. Spray-Rite Serv., 465 U.S. 752, 761 (1984).

30. *See* United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 380 (1956).

31. *See* Reazin v. Blue Cross & Blue Shield of Kansas, 899 F.2d 951, 966 (10th Cir.), *cert. denied*, 497 U.S. 1005 (1990). In a recent section 2 attempt case, the Eleventh Circuit held that the plaintiff must prove that the defendant possessed at least 50% of a correctly defined market. U.S. Anchor Mfg. v. Rule Indus., 7 F.3d 986, 1001 (11th Cir. 1993), *cert. denied*, 114 S. Ct. 2710 (1994). However, the elements required to prove a section 2 conspiracy case remain ambiguous. *See* American Tobacco Co. v. United States, 328 U.S. 781, 786–87, 808–10 (1946) ("Petitioners, for example, might have been convicted here of a conspiracy to monopolize without ever having acquired the power to carry out the object of the conspiracy, *i.e.*, to exclude actual and potential competitors from the cigarette field.").

32. 359 U.S. 207 (1959). The Court in *Klor's* found: "Group boycotts, or concerted refusals by traders to deal with other traders, have long been held to be in the forbidden category, [per se illegal]." *Id.* at 212.

gardless of the legal theory invoked, frequently result from concerted action, whether voluntary or coerced. Even without direct evidence of a contract or conspiracy, it usually is not difficult to find concerted action based on circumstantial evidence. For example, consciously parallel horizontal conduct contrary to a defendant's economic self-interest is sufficient to support a finding of concerted action.[33] As discussed above, a refusal to buy or sell ordinarily is contrary to the economic interest of at least one of the alleged conspirators, particularly a coerced conspirator, and may support a finding of concerted action. Alternatively, direct evidence such as a written contract, bylaw, or rule collectively negotiated may be evidence of concerted action.

Some lower court decisions, however, have complicated the issue of concerted action in health care antitrust cases, accepting a "single entity" defense and finding that alleged conspirators are legally incapable of conspiring.[34] For that reason alone, a renewed look at the unilateral refusal-to-deal theory, and a reawakening of the traditional monopolization doctrine is appropriate. In this context, *Kodak* is significant.

Perhaps the more significant use of section 2 doctrine and the greater relevance of *Kodak* lies in the historical distinction drawn between the "reasonableness" of challenged conduct in a section 1 "rule of reason" case, where possession of monopoly power is not an element, and the "reasonableness" of challenged conduct in a section 2 monopolization case. It might initially appear that conduct characterized as "monopolistic" or "exclusionary" sufficient to satisfy section 2 would be sufficiently "unreasonable" to satisfy section 1, thus making section 2 largely superfluous. However, the relationship between the interpretations of sections 1 and 2 have not historically been described in that manner, nor should they be.

The famous *United States v. United Shoe Machinery Corp.*[35] decision by Judge Wyzanski rejected the defendants' arguments that section 2 required proof of unlawful *conduct*.[36] The Supreme

33. *See In re* Coordinated Pretrial Proceedings in Petroleum Prods. Antitrust Litig., 906 F.2d 432, 439–40, 465 (9th Cir. 1990) (reversing grant of summary judgment on ground that concerted action might be inferred from record), *cert. denied*, 500 U.S. 959 (1991).

34. *Compare* Oksanen v. Page Memorial Hosp., 945 F.2d 696, 702–05 (4th Cir. 1991) (refusing to find conspiracy between hospital and its staff because they constituted single entity), *cert. denied*, 502 U.S. 1074 (1992) *with* Oltz v. St. Peter's Community Hosp., 861 F.2d 1440, 1449–51 (9th Cir. 1988) (finding jury could have reasonably concluded that conspiracy existed between anesthesiologist and hospital to exclude nurse anesthetist as competitor).

35. 110 F. Supp. 295 (D. Mass. 1953), *aff'd*, 347 U.S. 521 (1954).

36. *Id.* at 341–45. In *United Shoe*, Judge Wyzanski referred to *Alcoa*, where

Court has followed that principle as well.[37] Courts have recognized a structure (or power)/ conduct continuum for evaluating the legality of challenged business practices under section 2 at least since *Standard Oil Co. v. United States*.[38] Under that continuum, the more economic power the defendant possesses, the less overtly predatory its conduct must be to violate section 2, and vice versa. It follows from *United Shoe* and its progeny that the conduct component of a section 2 monopolization case does not need to violate section 1, and thus does not need to fail a "rule of reason" analysis which focuses upon the effects on a consumer market. As described above, after *Aspen Skiing* a court need only find the challenged section 2 conduct more likely to be exclusionary than to be a reasonable, or normal, business practice.

For practical purposes, the section 1/section 2 conduct distinction should allow juries a greater role in making findings as to the defendant's motive and preclude courts from second-guessing those findings, at least in refusal-to-deal cases. Perhaps, returning to the amorphous *Standard Oil* language, the practical distinction is that a court could determine that refusal-to-deal defendants possessed a high market share but that their conduct, targeting a single victim, was not an "undue restraint" or did not unduly create anticompetitive effects.[39] A proper section 2 analysis under *Aspen*

Judge Hand "emphasized that an enterprise had 'monopolized' if, regardless of its intent, it had achieved a monopoly by maneuvers which, though 'honestly industrial', were not economically inevitable, but were rather the result of the firm's free choice of business policies." *Id.* at 341. Furthermore, Judge Wyzanski recognized that "[b]oth the technique and the language of Judge Hand were expressly approved in *American Tobacco Co. v. United States*," and that "[c]omparable principles were applied in *United States v. Griffith*" which established that "to prove a violation of § 2 it was not always necessary to show a violation of § 1." *Id.* at 342. *Lorain Journal, Aspen Skiing,* and *Kodak* have expressly reaffirmed this interpretation of *Griffith* in the context of a refusal to deal which may not have been "unreasonable" or unlawful—if done concertedly—under section 1. Thus, the Court has drawn and maintained the line between an "unreasonable" concerted refusal to deal under section 1 and an "exclusionary" refusal to deal under section 2, although that line is difficult to discern.

37. *See* Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 600–05 (1985); Lorain Journal Co. v. United States, 342 U.S. 143, 153–54 (1951); United States v. Griffith, 334 U.S. 100, 106–09 (1948).

38. 221 U.S. 1 (1911).

39. *See Standard Oil,* 221 U.S. at 59. *Standard Oil* was confirmed in *United States v. United States Steel Corp.*, 251 U.S. 417, 451–52 (1920). The *United States Steel* Court stated: "[T]he law does not make mere size an offence or the existence of unexerted power an offence. It, we repeat, requires overt acts . . . . It does not compel competition nor require all that is possible." *Id.* at 451; *see also* Northern Secs. Co. v. United States, 193 U.S. 197, 403 (1904) (Holmes, J., dissenting) ("The court below argued as if maintaining competition were the expressed object of the act. The

Skiing would ask the jury to determine the primary purpose of the refusal to deal. A jury could find a naked restraint monopolistic under *Aspen Skiing*, which is not undue under *Standard Oil*[40] or unreasonable under *Paschall v. Kansas City Star Co.*[41] Moreover, conduct by a defendant with monopoly power targeting only a single or potential competitor logically is characterized as an effort to maintain the power to exclude competition.[42]

In light of the current makeup of the federal judiciary, the question of whether a judge decides the issue of anticompetitive effects of a concerted refusal to deal based upon his evaluation of market power, or whether a jury decides the defendant's motive for a unilateral refusal to deal, has a significant impact on private antitrust litigation, including whether to file in federal court. The broader question is: whether private antitrust policing of the market to maintain a competitive process and to eliminate abuses by sellers enjoying dominant positions is in the public interest. That question is far more difficult in the context of health care markets.

III. THE POTENTIAL IMPACT OF *Kodak* ON SECTION 2 LITIGATION

Enough has been written about the Supreme Court's six-three decision in *Kodak* that this Article will not attempt to explore the decision in depth. Perhaps, in the battles between amici or between economic theorists and trial lawyers schooled in the pragmatism of depositions and document searches, *Kodak* represents one small slap at theory.[43] At least it appears true that, after *Kodak*, an advocate should not rely exclusively on the predictions of economic theory when at least part of the developed record contradicts that theory.[44]

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act says nothing about competition.").

40. 221 U.S. at 75–77.

41. 727 F.2d 692, 697–98 (1984).

42. *See, e.g., Lorain Journal*, 342 U.S. at 154 (holding newspaper that used its monopoly to destroy threatened competition violated "attempt to monopolize" provision of section 2). Thus, the often repeated mantra that the antitrust laws are designed to protect competition rather than individual competitors has no logical application in section 2 cases when a defendant controls or seeks control of a submarket. Exclusion of a single competitor in that context necessarily harms competition and enhances market power.

43. *See* Popofsky & Popofsky, *supra* note 5, at 741–54.

44. *See* Eleanor M. Fox, Eastman Kodak Company v. Image Technical Services, Inc.—*Information Failure as Soul or Hook?*, 62 ANTITRUST L.J. 759, 760–61 (1994). *Compare* Warren S. Grimes, *Antitrust Tie-In Analysis After* Kodak*: Understanding the Role of Market Imperfections*, 62 ANTITRUST L.J. 263, 292–97 (1994) (offering revised approach to market imperfections and tie-ins) *with* Alexander C. Larson, *Antitrust Tie-In Analysis After* Kodak*: A Comment*, 63 ANTITRUST L.J. 239, 244–64 (1994) (re-

In *Kodak*, the plaintiffs charged a lower price for servicing Kodak photocopiers than did Kodak, who enjoyed a supranormal profit margin for its service. As a result, the Kodak copier owners increasingly purchased services from the plaintiffs, rather than from Kodak, until Kodak refused to supply the plaintiffs with the necessary parts for repairing and serving Kodak copiers.[45]

Although the *Kodak* Court's conclusion regarding product market definition has received the most attention, the logic utilized to reach that conclusion may be more practically important. Most critical attention, during and after the litigation, has focused upon whether a relevant product market lawfully can consist solely of a particular manufacturer's product or brand where that product is functionally interchangeable with other product brands and, at some point in the purchaser-seller relationship, the manufacturer competes against many others. The defense argument was that defining a relevant market so narrowly does not make economic sense, because all manufacturers control their own products, which are subject to interbrand competition and substitutability.[46]

Kodak argued that (1) it concededly had no market power in the photocopier market, because (2) there was no relevant market limited to "Kodak photocopiers" from the consumers' perspective, in light of product substitutability, so that logically and economically, (3) there could be no relevant market consisting of parts and servicing of Kodak copiers, and therefore (4) Kodak could have no power in such an hypothesized market.[47] The Supreme Court rejected Kodak's logical progression from argument two to three above, holding that consumers who sought to purchase repair services for their copiers constituted a significant, differentiable consumer base for whom there were no practicable substitutes for "Kodak repair services."[48] Furthermore, low cross-elasticities of demand existed, allowing the presumed single seller of Kodak repair services to raise

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jecting Grimes's tie-in analytic framework as unsupported by "sound economic theory").

45. *Kodak*, 504 U.S. at 456–58.

46. *Id.* at 465–66. In *Kodak*, the Court recognized that "[t]he dissent in the Court of Appeals . . . accepted Kodak's argument that evidence of competition in the equipment market *'necessarily* precludes power in the derivative market.'" *Id.* at 461 (quoting Image Technical Servs. v. Eastman Kodak Co., 903 F.2d 612, 622 (9th Cir. 1990) (Wallace, J., dissenting)). Furthermore, Kodak "counters that even if it concedes monopoly *share* of the relevant parts market, it cannot actually exercise the necessary market *power* for a Sherman Act violation." *Id.* at 465; *see also id.* at 466 n.11 (explaining Kodak's argument for per se rule that "equipment competition precludes any finding of monopoly power in derivative aftermarkets").

47. *See id.* at 470–71, 481–82.

48. *Id.* at 481–82.

its price significantly without losing sales.[49]

In other words, the Court concluded that the contours of the relevant market should be defined in practical terms at the time of the purchase of the aftermarket product in question. Moreover, the market should be determined from the perspective of differentially identifiable purchasers of the initial product, by employing a test of practical, rather than theoretical, product interchangeability. From that perspective it was entirely plausible that, after purchasing a product which was not itself a relevant market, consumers would become "locked in" to purchasing service or parts unique to and necessary for the continued use of that initial product, unless those consumers could readily and practically switch to another brand of the initial product in response to unforeseen price increases in the aftermarket.[50]

Earlier, the Court, in *NCAA v. Board of Regents*[51] and *FTC v. Indiana Federation of Dentists*,[52] recognized that market definition structural analysis is but a surrogate for the ultimate question of the unreasonableness of a restraint on trade challenged under section 1; market definition analysis is unnecessary in the face of evidence of a nakedly anticompetitive purpose and actual detrimental market effects.[53] Similarly, the Court in *Kodak* appears to recog-

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49. *Id.* at 469–71, 477–78. The Court noted: "Whether considered in the conceptual category of 'market definition' or 'market power,' the ultimate inquiry is the same—whether competition in the equipment market will significantly restrain power in the service and parts markets." *Id.* at 469 n.15. Furthermore, "[e]ven if Kodak could not raise the price of service and parts one cent without losing equipment sales, that fact would not disprove market power in the aftermarkets." *Id.* at 469. Finally, "[b]ecause service and parts for Kodak equipment are not interchangeable with other manufacturers' services and parts, the relevant market from the Kodak-equipment owner's perspective is composed of only those companies that service Kodak machines. . . . The proper market definition in this case can be determined only after a factual inquiry into the 'commercial realities' faced by consumers." *Id.* at 482 (citations omitted).

50. Notwithstanding this important aspect of the *Kodak* holding, the decision may be equally important for its reliance upon actual record evidence of the defendant's market power to confirm the more theoretical market definition analysis. Thus, although it has become traditional in structural antitrust cases to first determine or define the relevant market, second to compute the defendant's market share, and third, after passing a market share screen, to assess market or monopoly power, the *Kodak* holding appears in part to recognize that theoretical arguments about market definition may be deferred or even become unnecessary in the face of convincing evidence that the defendant exercised the power to "control price or exclude competition." *See* Herbert Hovenkamp, *Market Power in Aftermarket: Antitrust Policy and the* Kodak *Case*, 40 UCLA L. REV. 1447, 1452–58 (1993).

51. 468 U.S. 85 (1984).

52. 476 U.S. 447 (1986).

53. *Indiana Fed'n*, 476 U.S. at 460–61; *NCAA*, 468 U.S. at 104–10.

nize that evidence showing Kodak possessed the power to control price and exclude competition for its repair services as measured by its profit margin, its comparatively high pricing which trended upward, and its ability to withstand consumer desire to switch to alternative providers by refusing to sell parts to competitors, proved that Kodak possessed monopoly power. Moreover, the fact that Kodak believed that it would gain power over price by refusing to sell its own parts to competitors suggested that Kodak recognized the practical significance of a Kodak-brand submarket. Kodak, a presumably rational seller, would not have foregone the profit associated with the sale of its parts to independents unless it believed that such conduct would allow it to control price and increase profit through the exercise of monopoly power in the repair market.

Thus, a pragmatic review of the record persuaded the Court that it was at least possible that Kodak possessed and exercised monopoly power as it is traditionally defined. Such a plausible finding of monopoly power pretermitted, or at least informed, the more theoretical debate over market definition, just as in *NCAA* and *Indiana Federation*.

In summary, perhaps *Kodak's* more practical significance to future section 2 litigation in general, and health care antitrust litigation in particular, is the Court's recognition that the theoretical debate regarding market definition, easily manipulated by result-oriented courts,[54] need not constitute a preliminary screen for determining monopoly power in section 2 cases. Rather, as in *NCAA* and *Indiana Federation*, if the record indicates that the defendant has exercised power over price or successfully acted to exclude competition, and if an identifiable group of consumers practically are "locked in" to purchasing the defendant's product, a finding of monopoly power may precede and inform the market definition and analysis. Finally, if the defendant's presumptively rational conduct is unambiguously exclusionary in nature, the target of its conduct also may help identify a relevant market. A presumably rational businessperson would not engage in exclusionary conduct which forgoes profit sources if he did not expect to gain a profit-maximiz-

54. *See, e.g.*, U.S. Anchor Mfg. v. Rule Indus., 7 F.3d 986, 995–99 (11th Cir. 1993) (reversing a jury finding regarding relevant market and holding relevant market did not include defendant's product even though court recognized that such market definition was reasonable), *cert. denied*, 114 S. Ct. 2710 (1994). *Compare* Flegel v. Christian Hosp., Northeast-Northwest, 4 F.3d 682, 688–91 (8th Cir. 1993) (finding neurologist failed to define market to preclude summary judgment in case against hospital that denied staff privileges) *with* Oltz v. St. Peter's Community Hosp., 861 F.2d 1440, 1445–48 (9th Cir. 1988) (finding relevant markets included market for anesthesia and patient market in case brought by anesthesiologist against hospital).

ing advantage from that conduct. If the product toward which his conduct is directed is not "relevant" but rather competes against substitutes, his exclusionary conduct would appear presumptively to be without purpose.

IV. REFUSALS TO DEAL IN ECONOMIC CREDENTIALLING AND STAFF PRIVILEGES CONTEXTS

A. Background

Two common health care antitrust contexts in which the *Kodak* decision might enlighten a section 2 analysis are (1) a hospital's or clinic's suspension or revocation of medical staff privileges, and (2) a hospital's denial of privileges to a state-licensed provider who is credentialed differentially from the medical staff in which the hospital benefits.[55] The author has participated directly in the litigation of several such cases and indirectly in several others. Only one, however, was filed after *Kodak* and attempted to incorporate *Kodak* in a section 2 claim. That case remains in a comparatively early stage of what may be a lengthy litigation process. In other cases, potential plaintiffs either settled their disputes without litigation or filed a non-antitrust case in state court.

While recognizing the limits and perils of reliance upon anecdotal evidence, some record-specific discussion of the antitrust issues identified above may reveal a commonality in health care antitrust litigation. Very little public writing in this area has bridged the academic-practice divide, and much of the writing emanates from either the defense bar to protect clients' profit-maximizing capability or from policymakers concerned about promoting or defeating some version of health care reform.

Two preliminary observations must be made. First, legal analysis in health care antitrust cases predicated upon categorical principles and deductive reasoning has created an environment of pervasive unreality, both in the context of particular litigation and in general policy discussion.[56] Second, although health care providers

55. The Supreme Court held in American Medical Ass'n v. United States, 317 U.S. 519, 534–36 (1943), that a combination of doctors engage in "trade or commerce" subject to antitrust regulation when they preclude other doctors from participating in a nonprofit provider organization. *See also* American Medical Ass'n v. FTC, 638 F.2d 443, 448–50 (2d Cir. 1980) (finding AMA acted in concert and subjected itself to FTC regulations), *aff'd*, 455 U.S. 676 (1982).

For a survey of peer-review staff privileges cases, see James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, 51 LAW & CONTEMP. PROBS., Spring 1988, at 7, 37–89. For a review of health care antitrust cases generally, see Janet L. McDavid, *Antitrust Issues in Heath Care Reform*, 43 DEPAUL L. REV. 1045, 1053–72 (1994).

56. *See* Flynn, *supra* note 11, at 131. Professor Flynn observes:

may not be primarily responsible for the inflation in health care costs, anticompetitive practices are common enough that if a primary policy goal is to control or reduce health care costs, traditional antitrust and competition rules should play a greater role in health care regulation, assuming that a command economy or "municipal services" model is not politically feasible.[57]

Certainly, if the demand for health care services is increased through universal coverage, "supply" must also be increased, and no provider should be allowed to arbitrarily and artificially restrain the supply of, or control the provision of, health care services. Moreover, providers' arguments for efficiencies resulting from greater concentration or cooperation among providers should be scrutinized very carefully and critically, because one possible motive for concentration is protection from competitive forces. Similarly, courts should critically review the actual motive and basis for the denial or revocation of staff privileges when the antitrust plaintiff introduces evidence of an anticompetitive motive by the decision makers, who are his competitors.

The Supreme Court has considered three literal refusal-to-deal antitrust cases in health care markets, but none of the three directly addressed substantive Sherman Act issues. *Patrick v. Burget*[58]

> Health care is an industry that has too long been immune from rigorous review on fundamental legal and economic grounds . . . . The complexities of sorting out which road to follow in reforming health care are in large part due to the fact that the industry has evolved without being subject to serious and consistent antitrust or regulatory review.

Id.; *see also* BCB Anesthesia Care v. Passavant Memorial Area Hosp. Ass'n, 36 F.3d 664, 666–69 (7th Cir. 1994) (dismissing antitrust staff privileges case because courts generally have been ruling for hospitals in such cases). In fact, the *Passavant* court cited the district court opinion in Boczar v. Manatee Hospitals & Health System, 731 F. Supp. 1042 (M.D. Fla. 1990), *rev'd*, 993 F.2d 1514 (11th Cir. 1993), as one example of a defense victory justifying dismissal of the nurse anesthetist's claim. *Passavant*, 36 F.3d at 668. However, while the district court in *Boczar* granted the defendant hospital a judgement notwithstanding the verdict, the Eleventh Circuit reversed that decision and reinstated the jury verdict one year before *Passavant*. *Boczar*, 993 F.2d at 1516, 1519–20.

57. *See* Robert J. Enders, *An Introduction to Special Antitrust Issues in Health Care Provider Joint Ventures*, 61 ANTITRUST L.J. 805, 812–20, 827 (1993); *see also* Reazin v. Blue Cross & Blue Shield of Kansas, 899 F.2d 951, 972 (10th Cir.) (finding large health care financing organization had sufficient market power to restrain trade), *cert. denied*, 497 U.S. 1005 (1990). A "municipal services" model for health care would be more radical than most health care reform plans under consideration. It would require a greater shift of health care resources from the private to the public sector than would a so-called "single payor" plan. Such a radical shift would stabilize costs by precluding significant private sector alternatives for providers, while increasing demand, as in public primary and secondary education.

58. 486 U.S. 94 (1988).

addressed the issue of state action immunity from antitrust;[59] *Blue Shield v. McCready*[60] addressed antitrust standing;[61] and *Summit Health, Ltd. v. Pinhas*[62] addressed "affecting commerce" jurisdiction.[63] In each case, the Court found for the plaintiff.[64] Although the Court was not asked to and did not formally address the heart of the section 1 claim in any of the cases—whether the defendant's refusal to deal was unreasonable and/or per se unlawful—the Court's decision to grant certiorari in the cases and its discussion of the allegations certainly suggests the Court's desire not to accord to health care providers the kind of de facto immunity that appears prevalent in some lower court opinions.

In *Pinhas*, for example, the Court, including Justice Scalia in dissent, recognized that concerted efforts by doctors, acting on behalf of hospitals, to suspend or revoke a competing doctor's staff privileges for pretextual, rather than quality-of-care, motives constituted a concerted refusal to deal arguably subject to boycott analysis, regardless of the defendants' "professional" character.[65] The Court in *Patrick* registered the same concern when a clinic located in a comparatively rural area revoked the plaintiff's access to clinic facilities in response to a competitive dispute between the plaintiff and other doctors controlling the clinic's decision making.[66] Finally, in *McCready* the complaint alleged that a medical insurance entity controlled by M.D. providers refused to reimburse consumer-patients for mental health care provided by non-M.D. licensed psychologists, thereby causing consumers not to deal with those psychologists.[67] Although the Court in *McCready* was adjudicating an anti-

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59. *Id.* at 95 (holding state action doctrine does not protect peer-review activities of private hospital because state supervision of those activities was inadequate).

60. 457 U.S. 465 (1982).

61. *Id.* at 467 (holding insured psychotherapy patient possessed antitrust standing to challenge conspiracy among M.D. psychoanalysts to deny insurance coverage for services by psychologists).

62. 500 U.S. 322 (1991).

63. *Id.* at 324–25 (holding conspiracy among physicians and Los Angeles hospital to employ peer-review practices to eliminate single physician from hospital sufficiently affected interstate commerce to implicate Sherman Act subject matter jurisdiction).

64. *Id.* at 332–33; *Patrick*, 486 U.S. at 105–06; *McCready*, 457 U.S. at 485.

65. *Pinhas*, 500 U.S. at 332; *id.* at 337 (Scalia, J., dissenting). "[G]roup boycotts are *per se* violations (not because they necessarily affect competition in the relevant market, but because they deprive at least some consumers of a preferred supplier." *Id.* (Scalia, J., dissenting) (citing ROBERT H. BORK, THE ANTITRUST PARADOX 331–32 (1978)).

66. *Patrick*, 486 U.S. at 96–97. The court of appeals below "found that there was substantial evidence that respondents had acted in bad faith in the peer-review process." *Id.* at 98.

67. *McCready*, 457 U.S. at 468–70. Justice Brennan, writing for the Court, stat-

trust standing challenge to a consumer-plaintiff, the Court appeared to presume that the complaint's characterization of the defendants' conduct as a refusal to deal was appropriate.[68]

None of these decisions, however, answered the currently central section 1 question: whether the *Klor's* rule[69] is still valid? Or has *Northwest Wholesale Stationers, Inc. v. Pacific Stationary & Printing Co.*,[70] combined with lower court staff privileges boycott cases, reversed that rule *sub silentio* such that refusals to deal are unlawful only if the defendants possess market power,[71] or, to further incorporate the law applicable in tying cases, if the exclusion of the boycott targets constitutes a significantly large reduction in competitive alternatives?[72]

The point, however, is that at least by implication, the Court accepted the refusal-to-deal characterization and the anticompetitive consequences of the defendants' conduct by reference to specific allegations in each case. A hospital, clinic, or third-party insurer which declines to enter into or terminates a contractual relationship with a provider, under which the provider would have produced revenues for the hospital or third party, has literally

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ed that the patient's injury, resulting from a conspiracy among psychiatrists to directly harm competing psychologists, was not too remote from the harm to those direct targets. *Id.* at 478–79, 484.

68. *Id.* at 484 n.21.

69. *See supra* note 32.

70. 472 U.S. 284 (1985).

71. The Court granted certiorari in *Northwest Wholesale* to determine only whether the denial of procedural due process by a private cooperative buying agency in excluding plaintiff from membership was a Sherman Act violation. *Id.* at 285–86, 289. The Court held that due process issues do not apply to Sherman Act cases. *Id.* at 293. Nevertheless, the Court implied, but carefully did not hold, that boycotts are per se unlawful only when the "boycotting firms possessed a dominant position in the relevant market." *Id.* at 294. Instead, the Court held that a plaintiff requesting application of a per se rule must first prove that the defendant's activity is likely to have a "predominantly anticompetitive" effect. *Id.* at 298.

72. *See* Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 13–14 (1984); Ball Memorial Hosp. v. Mutual Hosp. Ins., 784 F.2d 1325, 1334–35 (7th Cir. 1986); *cf.* Times-Picayune Publishing Co. v. United States, 345 U.S. 594, 610, 615 (1953) (holding relevant market is that of excluded competitor). Although it has become conventional, as in *Jefferson Parish*, to focus upon the defendant's market share within its own market to infer the legality of a section 1 restraint, there is precedent suggesting that the market share represented by the foreclosed or excluded competitor is determinative. *Id.* at 610. *But see* Hammes v. AAMCO Transmissions, 33 F.3d 774, 782–83 (7th Cir. 1994) (upholding validity of section 1 claim by single competitor excluded by distribution cartel because competitor was injured by alleged antitrust violation); *see also* Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810, 820 (11th Cir.) ("[I]f doctors in a hospital can exclude other doctors from practicing in that hospital, then obviously the remaining doctors can charge a higher price for their services."), *cert. denied*, 495 U.S. 924 (1990).

refused to deal with the provider contrary to the reasonable, profit-maximizing motive of the institutional defendant. In such a situation, regardless of the professional status of the services involved and the hypothesized quality-of-care motives for the conduct, it is appropriate to search for an anticompetitive motive, and the effect of the refusal is presumptively output-reducing. In *Indiana Federation*, after all, the Court unanimously rejected the defendant dentists' claim that their refusal to supply dental x-rays to their consumers' insurance companies was motivated by quality-of-care concerns.[73] At the very least, therefore, the law—at least in the Supreme Court—remains that quality-of-care motives for a boycott provide no automatic "reasonableness" defense.[74]

B. Staff Privileges Cases: Two Case Studies

The two staff privileges cases in which the author was formally involved bear similarities to *McCready*, *Pinhas*, and *Patrick*. However, the records in both cases disclosed highly revealing particularized information which should support the *Kodak* Court's elevation of fact over theory. Both cases revealed a conscious commitment to a refusal to deal among providers, using the hospital's or clinic's "gateway" institutional role in effectuating the refusal to deal for specific anticompetitive motives. To further understand the competitive consequences of the refusals to deal, in which competitors play the significant role in determining the scope of their competition, a discovery-based investigation in each case is necessary. In essence, the "storytelling" involved in the description of particular cases should become a recognized check upon theory-based deductive reasoning for antitrust policy development.

In Case A,[75] a licensed nurse-midwife accused two groups of M.D. obstetricians of combining with each other and a hospital to refuse to grant the plaintiff admitting privileges at the hospital and medical backup services. Those services were necessary for the plaintiff to compete directly against the defendants in the provision of obstetric services at a far lower price.

As the complaint was first constructed, its antitrust relevance was uncertain and it did not adequately contain a viable refusal-to-deal theory. The plaintiff, who also was a nursing instructor for a medical school, knew and alleged only that the defendant doctors pressured the hospital in which she instructed to request the medi-

73. FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 462–64 (1986).

74. *See id.*

75. The citation to this case and relevant pleadings and discovery documents are on file with the author.

cal school to transfer her and its instructional program to another hospital. The doctors acknowledged their communications but pointed to an ongoing feud between them and the plaintiff regarding the appropriateness of traditional, invasive medical practices and procedures, including the rising incidence of cesarean sections. According to the doctors, the plaintiff was interfering with their practice, patients, and hospital routine by proselytizing against them and their methods inside the hospital and by using her instructional role to solicit hospital patients for her private home-birth business.[76]

However, after eighteen months of discovery and the addition of new plaintiff's attorneys, the events and motives proved to be different than they had appeared on the surface. Further review of the evidence revealed that the hospital employed its own group of nurse-midwives to work in its clinic, enjoying substantial revenue from that source. One of the two groups of defendant doctors, moreover, also employed nurse-midwives, much as law partnerships employ associates and paralegals. As a result, these doctors doubled their revenues from the activities of the nurse-midwives who were employed to meet growing consumer preference and demand for midwives and who practiced in the hospital pursuant to their employer-doctors' staff privileges.

It turned out that the plaintiff was engaged in an unprofitable home-birth practice because the hospital had denied her admitting privileges. Many consumers who preferred to purchase services from a nurse-midwife also preferred the benefits of a hospital environment for their delivery. In other words, as the defendant doctors and hospital administrators realized from their interactions with patients, a provider's access to hospital admitting privileges was the practical gateway to competition in the provision of obstetrical services from the consumers' perspective. If nurse-midwives like the plaintiff possessed that access, their services at less than half the doctors' price could challenge the doctors' market control over price. Moreover, to the extent that the plaintiff and others overcame consumer perception of the need for a hospital environment through growing competitive practices and referrals, a home-birth practice would eliminate the hospital's role in the birthing market.[77]

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76. The plaintiff implicitly corroborated the defendants' defense by including a § 1983 First Amendment claim in her complaint, thereby shifting the focus of the case from competition and antitrust to freedom of speech. The public hospital's right to contain and preclude disruptive speech in nonpublic facilities implicated quality-of-care motives and the doctors' speech rights were entitled to as much protection as was the plaintiff's. Certainly, the hospital, as an allegedly impartial referee charged with assuring the provision of quality medical care, likely would not have been faulted for removing the source of disruption.

77. In competitive terms, the defendants recognized that controlling access to

Thus, the reasonableness of the decision to deny staff privileges was crucial. The hospital eventually claimed that its decision was legitimately non-anticompetitive. According to state licensing requirements, certified nurse-midwives required reasonable medical (M.D.) backup service to support their practices in case of emergency and to provide consultation. The plaintiff's backup physician was located at a distance from the community in question and she was unable to obtain the agreement of a local physician to provide backup services. Thus, the hospital's explanation appeared facially plausible.

Almost two years after the initial events occurred, the plaintiff discovered through detective work "smoking gun" evidence which had not been provided in discovery. A nondefendant obstetrician, who had been deposed but not originally asked the precise questions, later acknowledged that the plaintiff's inability to obtain backup services was not accidental. He acknowledged that the defendant doctors, while meeting as the medical staff of both the defendant hospital and the other hospital in the community, had resolved and voted that no physician would be permitted to provide backup services to a nurse-midwife, subject to the revocation of his own staff privileges. More specific discovery requests finally yielded the corroborating minutes of the hospital staff meeting in question. In other words, the doctor-competitors, in their competitive capacities and as decision makers for the hospital, formally combined to cause the hospital to refuse to contract for admitting privileges with the plaintiff and other nurse-midwives by superimposing the essential collateral refusal to provide backup medical services, and further combined to sanction any conspirator who violated that agreement.[78]

Perhaps the central point to this story is that in hospital staff privileges cases, initial explanations of the refusal to deal should be scrutinized carefully and skeptically, not with the kind of deference frequently seen in the lower courts. This is particularly so when the decision is implemented by competitors of the target with obvious consequences to the competitive nature of the market. As the complete record ultimately revealed, the defendants' conduct was na-

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hospital-admitting privileges was the key to precluding state-licensed, lower-cost competition which would quickly undermine their control over price and open up the market. Specifically, the doctors' average high six-figure individual incomes would be jeopardized, and the growing trend toward outpatient medical treatment would be accelerated.

78. Testimony surrounding the above decision persuaded the district court to deny the doctors' motion for summary judgment and was central to a generous mediated settlement.

kedly anticompetitive and undertaken to maintain control over price, so that consumers of obstetric services were denied complete choice of providers and paid at least double what the competitive price for those services would have been absent the restraints. The mechanism for the exercise of market control was the concerted denial of backup services, which allowed both hospitals plausibly to deny privileges. As perceived by consumers, hospital privileges were essential and symbolic far beyond any theoretical market definition or computation of market share.

In Case B,[79] currently in litigation, the issue is the more controversial use of peer review to suspend hospital staff privileges for alleged quality-of-care motives. A newly board-certified internist M.D. moved from the West Coast to the East Coast to open an independent internal medicine practice in a new city. After less than two years in practice, his revenues increased from zero to over $500,000 annually, which was double the income of the average physician in that city. Much of his practice developed through his provisional staff privileges at two of the larger hospitals located relatively near his office, and particularly through his handling of substantial emergency room patient traffic and word-of-mouth referrals. According to patient testimonials, he provided far greater patient care services than the community norm and conducted medical procedures which, in that community, were done by specialists. In fact, he was in the process of hiring another physician to service the heightened demands of his practice.

Less than three months after receiving full permanent staff privileges at the hospitals and perfect peer-review ratings, the plaintiff was summarily suspended from the hospitals. He thereby lost his emergency room privileges and his right to see patients and perform medical procedures at the hospitals. His peers accused him of "greed." The suspensions were immediately referred to the relevant state licensing authority and, as the evidence showed, word disseminated throughout the community.

Three medical experts retained by the plaintiff to review the defendants' peer-review conduct, including medical charts allegedly reviewed by staff doctors, testified that the plaintiff's performance was not deficient and that the alleged peer review and suspension were fraudulent and a sham. Evidence further revealed that the hospital committee chairman advised the plaintiff that he should not be a "jack-of-all-trades," that he should make referrals to specialists because he was allegedly taking money from their pockets,

79. The citation to this case and relevant pleadings and discovery documents are on file with the author.

that he should ask for extra "consults," and that he should do fewer outpatient procedures. Finally, the chief of medical staff, an internist in direct competition with the plaintiff, initiated the summary suspension which apparently conflicted with the hospital's bylaws. Because of the lack of notice or good faith in the process, the hospital has not and could not have claimed federal immunity for the peer-review decision.

Unlike the denial of privileges in Case A, the suspension or revocation of privileges has anticompetitive effects far beyond the hospital in question. As acknowledged by the head of the defendant's credentials committee, such a suspension is "devastating" and should not have occurred in this case. The suspension, moreover, resulted in the hospital's literal refusal to continue dealing with the plaintiff with respect to emergency room facilities and referrals.[80]

Cases like this one, of course, are not isolated. *Pinhas*, in fact, involved similar facts. *Bolt v. Halifax Medical Center*[81] and *Boczar v. Manatee Hospitals & Health Systems*,[82] recent Eleventh Circuit decisions, also involved similar facts. In the context of a peer-review proceeding, potential competitors of a health care provider often act as investigators, judges, and jurors, and thus wield substantial power over the future viability of the provider as a competitor. In this situation, distinguishing proper motives from anticompetitive ones becomes essential and should require evidentiary testing when the plaintiff plausibly challenges the defendants' conduct as a form of retaliation for failure to participate in anticonsumer conduct.[83] Such anticonsumer conduct may include unnecessary referrals or use of more expensive procedures than reasonably required.

C. Hospital Staff Privileges and Market Power

An argument can be made that if challenged peer-review conduct does not qualify for Federal Health Care Act immunity, then the challenged refusal to deal violates section 1 either under a *Klor's* per se rule or a "quick look" *Indiana Federation* analysis. Because doctors and hospitals exercise professional life or death

80. The defendant has argued, like the defendants in *Indiana Federation*, 476 U.S. at 462–63, that it boycotted the plaintiff for quality-of-care motives. The defendant has also argued that it does not have power in a relevant market and that the plaintiff lacks antitrust standing to challenge the refusal to deal.

81. 891 F.2d 810 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990).

82. 993 F.2d 1514 (11th Cir. 1993).

83. Moreover, the tension between the Supreme Court's rejection of the quality-of-care defense to a boycott claim and the lower courts' deference to such a defense in peer-review cases needs to be resolved.

decision-making authority over their peers/competitors, they should be required to assure no competitive conflicts exist among themselves and to comply with federal peer-review standards. One can see that the medical care provider market, like virtually no other, contains the potential for anticompetitive abuse through peer review.[84] Thus, hospital administrators should more closely scrutinize the results of peer reviews. They must be sensitive to the possibility of anticompetitive motives and must not simply defer to pressure from their medical staff to eliminate a competitor.

In any event, if the hospital that terminates staff privileges possesses monopoly power and its conduct is challenged under section 2 rather than section 1, the conduct need not be an unreasonable restraint of trade in order to be condemned. The conduct need only be found more exclusionary than "legitimate" under *Aspen Skiing*.[85] Additionally, an unexplained failure to comply with federally mandated procedures could be dispositive to a factfinder.

As a conceptual matter, however, if the case were analyzed under section 2, a plaintiff would need to make a strategic alteration to the traditional staff privileges allegation. He could proceed under either of two alternatives. First, the plaintiff could invoke a section 2 conspiracy theory, alleging (as in a section 1 case) that the hospital conspired with its peer-review doctors, thereby raising the same "single entity" issue which occasionally arises in section 1 litigation. Alternatively, the plaintiff could allege that, in fact, the hospital and its doctors should be viewed as a single, unified health care provider with a common monopolistic goal. He could argue that this single provider is engaged in every medical care market that each of the physicians on staff provides. This argument would assure a horizontal relationship between the plaintiff and the defendant entity.

Assuming the first and less original alternative were pursued by a staff privileges plaintiff, the allegation would be that the hospital and some of its medical staff conspired to exclude competition or control price in the plaintiff provider's market. Assuming proof of concerted action, the issue would then be whether exclusion from hospital privileges tended to exclude the plaintiff from an entire market, or whether it left the co-conspirator doctors in control of

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84. Ideally, to avoid the antitrust claim, the necessary and proper peer-review function should be more formally separated from the subsequent refusal-to-deal decision. Except in emergency situations, negative peer review should be forwarded for review to the appropriate state licensing authority before the hospital revokes any staff privileges. In addition, this state review should be accompanied by increased peer monitoring while the state is reviewing the recommendation.

85. 472 U.S. 585, 608–11 (1985).

that market.

A major hurdle for the plaintiff in such a case is *Jefferson Parish Hospital District No. 2 v. Hyde.*[86] In that case the Supreme Court employed traditional market definition analysis to conclude that a particular defendant hospital had less than a thirty-percent share of the relevant hospital and operating services market throughout a relatively broad geographic area.[87] A tying arrangement imposed by the defendant hospital was therefore not per se unlawful because the hospital lacked leveraging power in the tying product market.[88] The Court found that consumers wishing to purchase other anesthesiology services for a surgical procedure could elect to use another hospital.[89] If a single hospital did not possess sufficient leveraging power in a tying product, one could similarly argue that the hospital's exclusion of competitors or control of the price in a single hospital could not be designed to maintain monopoly power.[90]

Although the applicability of *Jefferson Parish* is a significant barrier to a section 2 conspiracy challenge in a staff privileges case, the barrier is not necessarily insurmountable, particularly after *Aspen Skiing*, *Kodak*, and other recent decisions.[91] Although, as the courts have repeatedly stated, antitrust protects competition and not competitors, if the exclusion of a particular competitor is designed to protect market-wide control, then the staff privileges decision could be found to promote monopoly power. This is particularly true when alternative providers participate in or benefit from the challenged combination.

The key to determining whether the exclusion promotes monopoly power could be either (1) the alternative provider's need for hospital privileges, from the consumers' perspective, coupled with a

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86. 466 U.S. 2 (1984).

87. *Id.* at 26–28.

88. *Id.*

89. *Id.* at 26–30.

90. The Eighth Circuit, however, recently has acknowledged that *Jefferson Parish* may not be controlling: "We acknowledge that the Supreme Court's holding in *Kodak* that a single manufacturer's aftermarket products may constitute a relevant market supports the possibility that a single hospital may constitute the relevant market." Flegel v. Christian Hosp., Northeast-Northwest, 4 F.3d 682, 690 (8th Cir. 1993) (citing Virtual Maintenance, Inc. v. Prime Computer, Inc., 995 F.2d 1324, 1328–30 (6th Cir. 1993), *withdrawn on other grounds and superseded by* 11 F.3d 660 (1993), *cert. dismissed*, 114 S. Ct. 2700 (1994)); *see also* Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 329–30 (1991) (finding that exclusion of physician from single hospital in Los Angeles may affect interstate commerce); Boczar v. Manatee Hosps. & Health Sys., 993 F.2d 1514, 1519 (11th Cir. 1993) (excluding physician from single hospital creates anticompetitive effects).

91. *See* cases cited *supra* note 90.

competitor-providers' market-wide refusal to sell essential services to allow for privileges at any hospital; or (2) the revocation of privileges to facilitate price-inflating practices—such as unnecessary consults, specialists, and hospital bed care—in retaliation for any deviation from the community norm. In both situations, the defendants could control a market broader than that limited to any particular hospital by virtue of the provider groups' market-wide participation in the concerted action and the perceived significance of withdrawal of privileges at any one hospital.[92]

In other words, to the extent that *Kodak* and *Aspen Skiing* demonstrate the need for a practical investigation of the facts to determine a defendant's power to control price or to exclude competition, a finding of actual exercise of monopoly power would define the relevant market. Thus, traditional, theoretical market definition analysis in health care provider cases may be inaccurate. In certain situations, a finding of concerted conduct to exercise monopoly power may condemn conduct that would otherwise survive a section 1 analysis because it would constitute allegedly legitimate staff privileges or peer-review determinations.

Finally, of course, if the excluded doctor provides services to patients only after they have been admitted to a particular hospital, the hospital clearly could be deemed to control its own aftermarket services pursuant to a straightforward *Kodak* analysis.[93] This is because the patient has no practical knowledge or choice regarding such secondary, in-hospital services.

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92. *See, e.g.*, Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 9–18 (1984). If the goal of the refusal to deal is to maintain price-inflating anticonsumer conduct, as in *Indiana Federation*, then the challenged combination could be deemed to "control price" throughout a market, as defined by the defendants' conduct.

93. As the court in *Flegel* noted, "a plaintiff is nonetheless required to present evidence from which a reasonable jury could find the existence of the proposed market . . . . In this, the [plaintiffs] have failed, leaving us to consider which market definition finds support in the record and Christian's role within such a market." 4 F.3d at 690.

In the hospital context, therefore, a single hospital might be a relevant market in certain instances. For example, a single hospital might be a relevant market with respect to services about which patients are not or cannot become informed before selecting the hospital—particularly ancillary services provided to hospitalized patients. However, a single hospital would not be a relevant market with respect to primary services for which patients (or their insurance company surrogate) have sufficient information. *Cf.* Allen-Myland, Inc. v. IBM, 33 F.3d 194, 205–06 (3d Cir.) (applying *Kodak* analysis to computer submarkets), *cert. denied*, 115 S. Ct. 684 (1994); *Virtual Maintenance*, 995 F.2d at 1327 (same).

V. SECTION 2 AND CLOSED PROVIDER JOINT VENTURES

Much of the preceding discussion could be considered an introduction to this final section. This section addresses the narrow issue of the legality under section 2 of certain health care provider joint ventures which maintain fee-for-service relationships between provider and patient. Additionally, this section is more broadly, if implicitly, concerned with the need to immunize or provide safe harbors for increased joint-venture concentration in provider fee-for-service markets, frequently called preferred provider organizations ("PPOs").[94]

PPOs are organizations of independent hospital and medical care providers which contract with employers or insurance companies. They defend their collaboration on the ground that the providers agree to accept a negotiated fee for identified services lower than their "ordinary" fee in exchange for the "closure" of their network. This assures the PPOs' services are in greater demand by the patient-employees.

Of course, not all joint-venture provider collaborations contain the same contractual provisions. Thus, merely invoking the broad "PPO" category is not adequate for antitrust or public policy analysis. Adoption of a rule, for example, immunizing PPOs would invite many provider networks to engage in increasing forms of anticompetitive conduct.

In Case C,[95] the PPO label coupled with the limited anticompetitive aspects of some PPO ventures initially precluded focus upon all of the conduct at issue. In this case, an excluded provider has filed section 1 and 2 claims against the defendant PPO. The hospital-initiated PPO was plainly designed to incorporate by contract a number of traditional anticompetitive devices. Although the "closing" of membership in the PPO and consequent preclusion of consumer choice of nonmember providers has been defended as necessary to secure provider participation in the network, no evidence supports the need for closure. In fact, the history of the PPO indicates that from its inception numerous providers were willing to join the PPO whether or not its network was limited—as in a public utility, "public-interest" licensing analysis.

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94. Much of the legislative debate over health care reform assumes the appropriateness of providing such immunity, frequently under the mantle of "managed" competition or efficiency promotion. *See* Symposium, *Vital Issues in National Health Care Reform*, 43 DEPAUL L. REV. 1005 *passim* (1994).

95. The citation to this case and relevant pleadings and discovery documents are on file with the author.

Thus, if the PPO membership exclusion is defended in antitrust terms as an ancillary restraint which is necessary to promote the cost savings of the joint venture—costs are saved by the providers' agreement to accept a lower-than-normal fee for their services—there is no evidence that the restraint is needed to promote the alleged cost savings. There is no need to impose a limit on competition in order to promote reasonable fees—in public utility terms—and no proof that the provision of medical services has public utility or (with a few exceptions) scale economy attributes.[96]

An examination of the various contractual documents discovered in Case C reveals several interrelated elements to the combination. First, PPO bylaws and Board of Directors' resolutions adopted a "rule of necessity," pursuant to which, after a certain date, provider membership in the PPO was fixed. The PPO would consider new members only when there was a "need" for particular categories of providers in particular geographic quadrants surrounding the metropolitan area. "Need" was determined by comparing the number of patient-employees residing in each quadrant with the existing number of provider-members in that quadrant to assure that each provider had sufficient demand for his services from patient-employees to constitute fifteen to twenty percent of his practice.

In Case C, the PPO stipulated that only seven providers of the plaintiff's specialty were needed in his quadrant, and that there already were seven members in the quadrant. Three of those seven belonged to a particular practice group. In addition, PPO members were permitted to hire new physicians as part of their respective practice groups. These newly hired physicians would automatically be admitted to the PPO, regardless of need. In other words, if a PPO member learned that a "need" arose in the PPO, he could hire a physician for his practice group to fill that need and assure that the PPO remained closed.

In addition, the Physician Participation Agreement, signed by each member-provider, required each provider to refer patients only to other physicians or hospital members of the PPO.[97] A physician referring a PPO patient to a non-PPO physician without cause could be excluded from the PPO. In addition, the provider agreement required the PPO members to provide services to PPO patients if

96. As demonstrated from the record in Case C, the evidence shows that the closed network of providers does not reduce medical costs in the intermediate term. Rather, it inflates costs by eliminating price or services competition for the captured customer base and by providing enhanced multiple services among network providers with additional fees.

97. This referral requirement may create separate legal issues which will not be addressed in this Article.

and only if "reimbursement for the services and procedures . . . [is] based upon the current"[98] fee schedule established by the PPO. Thus, providers were not free to price their services below the fee schedule established by the PPO—a safe harbor provision which plainly leads to price stabilization. Moreover, increasing fee schedules each year without competition leads to the kind of price fixing condemned in *Arizona v. Maricopa County Medical Society*.[99] The PPO assured the contracting providers that it would "use its best efforts to negotiate agreements with prospective payors . . . seeking contracts with payors on terms no less favorable to Participating Physicians than as set forth in the [PPO's] Master Payor Rate Schedule."[100]

The PPO specifically advised its employee-patients that using a non-PPO provider would result in a lower reimbursement and higher copayment and thus a higher fee for the patient to pay. Moreover, the PPO required provider-members to agree that, "if any prospective Payor declines to enter into" an agreement with the PPO, the provider "shall not participate in any program offered by such Payor for a period of six (6) months" after the prospective payor (employer or insurance company) declined to contract with this particular PPO.[101] Such a provision apparently was designed to disadvantage other PPOs from competitively bidding for a managed health care contract with employees, to disadvantage providers who were members of more than one PPO, and to preclude employers from seeking competitive bids for managed health care plans.

Finally, an examination of the actual rate schedule, as amend-

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98. Central Florida Medical Affiliates, Inc., Physician Provider Application for Participation and Physician Provider Participation Agreement, ¶ 16(b)(iii) (unpublished manuscript, on file with author).

99. 457 U.S. 332 (1982). In *Maricopa County*, the Court condemned, as a per se violation of section 1, professional association agreements among otherwise competing physicians setting maximum fees for medical services provided to insurance plan policyholders. Although the challenge in *Maricopa County* focused on voluntary, consensual conduct, boycotting consumers or excluding competitors who will not comply with such a price fixing scheme is part of and condemned along with the price fixing. *Id.* at 348–55; *see, e.g.*, FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411, 434–35 (1990) (stating that "[e]very such horizonal arrangement among competitors poses some threat to the free market. . . . [A] small conspirator may be able to impede competition . . . to inflict real injury upon particular consumers or competitors"); Hammes v. AAMCO Transmissions, 33 F.3d 774, 782 (7th Cir. 1994) (finding that "conspiracy between competitors to rotate or otherwise allocate customers among conspirators" creates "effects almost identical to those of price-fixing").

100. Health Choice Inc., Physicians' Organization Agreement, ¶ 3(c) (unpublished manuscript, on file with author).

101. Central Florida Medical Affiliates, Inc., Physician Participation Agreement, ¶ XI (unpublished manuscript, on file with author).

ed during a four-year period, showed that the respective fees were stable, uniform, and trending upward, as would be found in a de jure monopoly or public utility market, not in a competitive market.

The net effects of the various contractual provisions making up the PPO combination are that (1) the PPO members can expand their own practice groups to exclude competition for the 65,000 employee-patients whose employers contracted with the PPO; (2) the nonmember providers cannot compete to provide services to those 65,000 "contracted" employee-purchasers; (3) the member-providers cannot refer PPO patients to nonmember-providers; (4) the PPO's patients cannot solicit or purchase services from non-PPO member-providers; (5) the employers are significantly disabled from seeking competitive bids from other health care plans; (6) the member-providers have difficulty retaining membership in the defendant PPO and other plans with whom employers who first negotiated with the defendant PPO eventually contracted; and (7) the medical fees are uniform, collectively negotiated, trend upward, and are practically controlled by the defendant PPO.[102]

Under the traditional rules developed in *Klor's*, *Fashion Originator's Guild of America v. FTC*,[103] and *Associated Press v. United States*,[104] the PPO combination is a private horizontal combination organized to refuse to deal with nonmembers in order to preclude price or service competition. Under an *Indiana Federation* "rule of reason" analysis, the defendant PPO's members have collectively refused to allow employee-customers and their employers to freely select among available alternative suppliers. This refusal has created an artificial restraint on competition and limitation on consumer choice, designed to restrain price and service competition.

From the perspective of *Kodak* and *Lorain Journal*, the defendant's refusal to deal with competitors, or to allow its members or customers realistically to deal with competitors, is facially anticompetitive in motive and effect. Specifically, it is designed to control price and exclude competition in the sale of health care services. The purported justification—that such market control is a

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102. Thus, the defendant PPO has not merely closed its membership, it has imposed an anticompetitive blanket over all fee-for-service transactions sought by the 65,000 employees whose employers have contracted with the PPO.

103. 312 U.S. 457, 468 (1941) (stating that "it was not error to refuse to hear the [petitioner's] evidence offered, for the reasonableness of the methods pursued by the combination to accomplish its unlawful object is no more material than would be the reasonableness of the prices fixed by unlawful combination").

104. 326 U.S. 1 (1945). A news distribution joint venture bylaw allowing for the exclusion of new members and precluding the sale of news to nonmember newspapers was held to be a per se illegal group boycott. *Id.* at 11–19.

necessary tradeoff for private price control—has never been recognized as an antitrust defense. Rather, this view has been effectively rejected by the courts for the past ninety years.[105]

Moreover, a transformation of the fee-for-service medical services market from competitive to public utility, in the face of increasing demand-supply disequilibrium, would be as disastrous as the straightforward price controls imposed in response to the 1970s oil embargo. The result would be a dramatic, if gradual, increase in price, or an equally dramatic comparative reduction in supply.

As discussed above, theoretical efforts to define the relevant market in the context of the section 2 case against the PPO should prove unnecessary after *Kodak*. The defendant's "price control" defense virtually proves that it exercises power over price for medical services to each patient. All of the 65,000 employees whose employers contracted with the defendant PPO to purchase a health care plan are practically "locked in." They can only purchase specific medical services from the defendant PPO's members and cannot practically purchase from an alternative supplier. Because no price competition or service competition from nonmember providers is allowed, the 65,000 employee-patients of the PPO have no health care substitutes. In turn, the PPO providers have no significant incentive to compete for price or service, at least in the short term. Certainly, an employee-patient who is dissatisfied with a PPO member's price or service, as determined by the PPO's "need" analysis, cannot and will not leave his job to search for an employer with a different health care plan.

In other words, a reasonable factfinder could determine that PPO members collectively, or the PPO unilaterally, have monopoly power in the provision of medical services to employees whose employers have purchased the PPO health care plan. The defendant PPO's own conduct, as described above, supports the view that the defendant consciously sought and exercised such power over price and competition. Thus, the debated issue should not be whether the defendant is guilty of a section 2 violation—it is. Instead, the issue is whether legislatures should replace the Sherman Act and the competitive process with some alternative form of regulation, private or public, to provide health care services.

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105. After all, the "price control" defense is at the heart of public utility regulatory policy. It is understood to be antithetical to the free market and the promotion of allocative efficiencies that result from a competitive process. Any such utility-type conduct must be publicly authorized by legislation designed to displace competition. According to the Supreme Court, "[such a defense] is nothing less than a frontal assault on the basic policy of the Sherman Act." National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 695 (1978).

CONCLUSION

The potential application of a *Kodak* analysis to health care provided by hospitals and managed care joint ventures obviously is controversial. But it is disingenuous to suggest there is no legitimate argument that hospitals or provider joint ventures seek to exercise market power. In Georgia, medical groups, including doctors and hospitals, introduced a proposal to amend the Georgia Constitution[106] to specifically authorize the creation of provider joint ventures, like those discussed above, and immunize them from antitrust challenge.[107] Large employer groups and insurance companies opposed the amendment, arguing that doctors and hospitals would be able to create monopolies and allow for possible price-fixing.[108] In this classic special interest battle, each side made claims against the other, which each has disavowed in other contexts, regarding the possession or exercise of market power. For example, the providers defend the amendment on the ground that they would "have more clout in negotiating fees and contracts."[109]

The solution to such a market power battle, ideally, would be a more literal and objective application of long-standing antitrust rules to both sides—not a policy endorsing increased concentration and cooperation among private competitors and consumer groups. Such an ideal, however, does not appear on the immediate political horizon and would have to result from case-by-case litigation. However, judicial repudiation of the *Kodak* analysis and denial that refusals to deal are presumptively anticompetitive, or that hospitals and joint ventures attempt to and frequently do exercise monopoly power, will not lead to competitive health services markets or a reduction in health care costs.

Of course, the above antitrust analysis of health care markets is limited to fee-for-service provider/patient relationships. If there

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106. The Georgia Constitution prohibits the legislature from endorsing monopolies. GA. CONST. art III, § 6, ¶ 5(c).

107. Andy Miller, *"Battle Royal" Likely over Amendment 3*, ATLANTA CONST., Nov. 1, 1994, at C4.

> "All we're asking for is the same [antitrust] exemptions the insurance companies have," says . . . [the] general counsel for the Medical Association of Georgia (MAG) . . . . [A]mendment foes contend that MAG is the most powerful lobbying force in the General Assembly, and that it could shape a law to its benefit if the amendment passes.

Id.

108. *Id.*

109. James Salzer, *Heated Battle Expected over Health-Care Amendment*, ATHENS DAILY NEWS/ATHENS BANNER-HERALD, Sept. 4, 1994, at 4A. Georgia voters rejected the amendment in the November 1994 election.

were no such relationship (as in most HMOs), then the market in question becomes "health care plans" and different questions emerge. Alternatively, if the "private market" model for health care were replaced, in part, by a "municipal services" model, then antitrust would be displaced. That model incorporates the basic principles underlying the provision of free public secondary education financed directly by local government and supplemented by state and federal government. Such a model, with no fee-for-services relationship, allows for a parallel private fee-for-service market for those consumers who prefer to pay for the service. Policymakers who are concerned with fairness, availability, and costs and who wish to eliminate the problems of antitrust litigation in health care, might do well to consider dispassionately this model.[110]

110. The framework for respective states to create "municipal services" models for health care exists in a number of municipalities which provide free, walk-in neighborhood clinics. *See* S.A. Reid, *Barebones Clinic Treats Poor for Free*, ATLANTA CONST., Oct. 17, 1994, at B6; *cf.* Hilary Stout & David Rogers, *'Single Payer' Concept for Health-Care Plan Is Alive and Well Despite Downgrading by Clinton*, WALL ST. J., Dec. 31, 1993, at 32 (discussing single-payor health care reform proposals and their impact on Clinton's managed competition proposal). *See generally* Catherine T. Dunlay & Peter A. Pavarini, *Managed Competition Theory as a Basis for Health Care Reform*, 27 AKRON L. REV. 141 (1993) (discussing managed care principles and features for health care reform).

Any "municipal services" model obviously begs the general policy debate regarding privatization. *Compare* Ferdinand Protzman, *Privatization in the East Is Wearing to Germans*, N.Y. TIMES, Aug. 12, 1994, at D1 (reporting cost of privatization of services in East Germany has been staggering to economy and individuals) *with* John Tierney, *The Big City, Crossing Lake Messinger*, N.Y. TIMES, Apr. 24, 1994 (Magazine), at 22, 24 (citing advocacy by Manhattan Institute and others for increased privatization of New York City services, including schools, because of inefficiency of local governmental bureaucracy). A proposed "municipal services" model also begs the political and ethical question of whether access to adequate health care, like secondary education, should be regarded as a protected component of individual liberty, essential to the exercise of all other rights.