
INTRODUCTION: ANTITRUST AND HEALTH CARE

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In the spirit of confession, about twelve years have passed since I have participated in a health care related antitrust symposium. At that time, as a student at the University of Utah, my professor and now co-author described the state of health care antitrust as follows:

Health care markets and related sectors of the economy like insurance provide essential services in our society. They have been undergoing rapid change for at least the past decade, yet some thirty-seven to thirty-nine million citizens lack health care insurance at one time or another each year; rapid inflation of costs has more often been the case than not; and equal access to the system for both consumers and providers is too often the exception rather than the rule. Despite the reality that Congress has not adopted major legislation reforming health care, reform continues to take place. Whether that reform will be constructive or whether it will make matters worse for both providers and consumers is by no means clear. Reform is taking place in the context of regulation through the constraints placed upon the exercise and enforcement of private contract and property rights by special state legislation and state and federal antitrust laws. The most basic and fundamental state and federal laws governing the private sector of the economy have been and will likely continue to be the antitrust laws. Whether the changes now taking place will benefit all consumers, provide competitors equal access to markets, and enhance or retard allocative, productive, and innovative efficiencies, may well depend upon whether and how the antitrust laws influence and direct the change taking place. In the absence of viable and comprehensive legislative alternatives being adopted in the near future, antitrust policy will continue to be the primary force shaping health care reform.¹

The reality, twelve years later, is that much of the discourse of the 1990s is still the discourse of today. Lack of affordable and adequate health insurance continues to plague the United States,²

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¹ John J. Flynn, *Introduction to Symposium: Antitrust Policy and Health Care Reform*, 1995 UTAH L. REV. 365.

² Timothy Stoltzfus Jost, *Our Broken Health Care System and How To Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537 (2006) ("Nearly forty-six million Americans (15.7% of the population) lacked health insurance in 2004."); see also SARA R. COLLINS ET.

skyrocketing costs in the health care sector continue to outstrip inflation,³ and Congress has been unsuccessful in implementing any major health care reform. The industry continues its trend toward consolidation, which has had profound impacts as to the price, quality, and quantity of services offered in various geographic regions throughout the country. Moreover, the industry is becoming vertically integrated to a greater degree, recently demonstrated by the acquisitions between pharmacy benefit managers and pharmacies. Vertical integrations, alongside continued horizontal combinations, raise the twin spectres of foreclosure and monopoly power while also heralding productive, allocative, and innovative efficiencies.

Against this backdrop, the role of antitrust is prominent, seeking to balance the potential procompetitive benefits of conduct or transactions against their potential anticompetitive effects. Antitrust may not be the best tool for such an endeavor, at least as currently informed by 1970s Chicago school industrial organization doctrine.⁴ While the federal antitrust enforcement agencies have expressed concern and interest in the industry,⁵ they have hardly appeared vigorous in merger enforcement.⁶

It is appropriate, therefore, to engage in an inquiry as to the current state of the health care industry. This symposium has brought together nationally-known health care and antitrust schol-

AL., GAPS IN HEALTH INSURANCE: AN ALL-AMERICAN PROBLEM, REPORT FOR THE COMMONWEALTH FUND (2006), available at http://www.cmf.org/publications/publications_show.htm?doc_id=367876 (noting that forty-one percent of “working-age Americans with incomes between \$20,000 and \$40,000 a year were uninsured for at least part of the past year—a dramatic and rapid increase from 2001 when just over one-quarter (twenty-eight percent) of those with moderate incomes were uninsured.”).

³ Michael Barton, *Reforming Health Care in America*, 22 No. 4 JOURNAL OF COMPENSATION AND BENEFITS 8 (“Health care insurance costs have doubled since 1995 and we are fast approaching a point where employers can no longer afford to cover the cost.”); Vanessa Fuhrmans, *Health-Care Premiums Climb by 7.7%, Outstripping Inflation*, WALL ST. J., Sept. 27, 2006, at A2 (noting inflation only at 3.5%).

⁴ See Thomas L. Greaney, *Chicago’s Procrustean Bed: Applying Antitrust Law in Health Care*, 71 ANTITRUST L.J. 857 (2004).

⁵ See DEPARTMENT OF JUSTICE/FEDERAL TRADE COMMISSION, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), http://www.usdoj.gov/atr/public/health_care/204694.htm.

⁶ For a short list of Justice Department achievements, see Statement of J. Bruce McDonald before the Committee of the Judiciary, United States Senate, on “Examining Competition in Group Health Care” (Sept. 2006), <http://www.usdoj.gov/atr/public/testimony218312.htm>. Comparing the years between 1997 and 2000, and 2001 through 2006, one finds a marked decrease in merger enforcement and enforcement under Section 2 of the Sherman Act by the DOJ; see Antitrust Division, Workload Statistics FY 1997-2006, <http://www.usdoj.gov/atr/public/workstats.htm>. For a list of FTC achievements, see Greaney, *infra* note 7, at n.6.

ars for that purpose. What follows is a brief summary of their respective works. It is hoped that this introduction gives the flavor of each work without spoiling the plot.

Tim Greaney takes us through a thirty-year journey concerning the illegality of physician collaborations.⁷ It is true that the one area in health care, to which the federal enforcement agencies in general (and the FTC in particular) have devoted their scarce enforcement resources, is in the realm of physician collaborations. Despite this extensive allocation, the (mostly per se) illegal physician collaborations keep coming. Of course, this has occurred against the backdrop of consolidation in virtually every other sector within health care. But the physicians continue to attempt to collaborate, according to Professor Greaney, not because they lack understanding about the law, but because there is underenforcement. Thus, the benefits of collaboration outweigh the costs. Professor Greaney explains why this is so under a compelling historical analysis of political incentives, economic incentives, and policy implications.

Peter Hammer provides a refreshing piece, taking to task the traditional neoclassical economics view of health care markets.⁸ According to Professor Hammer, neoclassical economics provides an incomplete (and probably inaccurate) view of health care markets because it assumes essentially what is not factually true. For example, markets are not exogenous structures with existential reference; they exist in the context of a social interplay between the state and its citizens. Indeed, the state may be an actor in the market as well as overseer. Hammer does not stop there, arguing such neoclassical heresies as the firm is not the proper unit of analysis and that competition does not necessarily maximize efficiency. Regardless of whether he is correct on all of these points, it is likely that he is right that neoclassical economics—particularly the 1970s static, ahistorical, afactual theory embraced by the courts—is deeply lacking and limits our understanding of markets and institutions.

Next, Kristin Madison wrestles with an issue that plagues merger analysis generally, but most importantly in the context of health care: the relationship between concentration and quality.⁹ As Professor Madison points out, the traditional economic thinking is

⁷ Thomas L. Greaney, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels*, 7 Hous. J. HEALTH L. & POL'Y 189 (2007).

⁸ Peter J. Hammer, *The Architecture of Health Care Markets: Economic Sociology and Antitrust Law*, 7 Hous. J. HEALTH L. & POL'Y 227 (2007).

⁹ Kristin Madison, *Hospital Mergers in an Era of Quality Improvement*, 7 Hous. J. HEALTH L. & POL'Y 265 (2007).

that competition in health care could decrease quality, as firms seek to cut costs to stay competitive. Of course, the reverse is also true in that mergers may have a negative effect on health care quality, a point Professor Madison is quick to make. Professor Madison also notes that few empirical studies have endeavored to examine the relationship between competition and quality, although many studies examine the link between competition and quantity/price factors. Through the lens of the Evanston Northwestern Healthcare Corporation's ("ENH") merger with Highland Park Hospital,¹⁰ Professor Madison discusses the theoretical underpinnings of antitrust analysis of consolidation's relationship to quality. Professor Madison also discusses alternative mechanisms for undertaking such an analysis.

Jeff Miles's article examines the potential that the nationwide nursing shortage is the result of collusion between hospitals.¹¹ The nationwide nursing shortage is of great importance because nurses are the hospital staff most frequently encountered by patients, and, as Mr. Miles points out, nurse-staffing levels have a direct impact on the quality of care a patient receives in the hospital. While, as Mr. Miles points out, there may be many causes for nursing shortages, his focus is on the Nursing Wages Antitrust Litigation complaints.¹² These complaints in each instance allege that certain hospitals violated Section 1 of the Sherman Act by fixing nursing wages and entering into information exchanges concerning nursing wages, resulting in lower RN wages than would take place under market conditions. In undertaking an examination of the complaints and their merits, Mr. Miles takes us on a tour of the familiar landscape of information exchanges and their potential procompetitive and anticompetitive effects, the harm associated with monopsony power, oligopsony power, and cartelistic behavior, and the difficulties for

¹⁰ Compl. ¶¶1, 5, *In re* Evanston Northwestern Healthcare Corp. Docket No. 9315 (Oct. 20, 2005), available at <http://www.ftc.gov/os/caselist/0110234/040210emhcomplaint.pdf>.

¹¹ Jeff Miles, *The Nursing Shortage, Wage-Information Sharing Among Competing Hospitals, and the Antitrust Laws: The Nurse Wages Antitrust Litigation*, 7 HOUS. J. HEALTH L. & POL'Y 305 (2007).

¹² *Unger v. Albany Med. Ctr.*, No. 06-CV-0765 (N.D.N.Y. filed June 20, 2006); *Reed v. Advocate Health Care*, No. 06-C-3337 (N.D. Ill. filed June 20, 2006); *Schultz v. Evanston Northwestern Healthcare*, No. 06-CV-3569 (N.D. Ill. filed June 30, 2006); *Clarke v. Baptist Mem'l Healthcare Corp.*, No. 2:06-cv-02377-JPM (W.D. Tenn. filed June 20, 2006); *Cason-Merendo v. Detroit Med. Ctr.*, No. 2:06-CV-15601 (E.D. Mich. filed Dec. 13, 2006); *Maderazo v. Vanguard Health Sys. San Antonio Partners, L.P.*, No. 06-CV-05 (W.D. Tex. first amended complaint filed Aug. 29, 2006) [hereinafter referred to collectively as the Nurse Wages Antitrust Litigation].

plaintiffs seeking to prove an agreement between competitors as opposed to tacit oligopolistic collusion.

Finally, Rebecca S. Yoshitani and Ellen S. Cooper examine one of the largest issues in antitrust and health care; namely, the use and misuse of intellectual property.¹³ Specifically, Yoshitani and Cooper discuss the “reformulation” of drugs by pharmaceutical companies in order to extend their patent protection. As Yoshitani and Cooper point out, this requires a careful balance, as altering the product too much would mean new FDA trials, while altering it too little would mean no additional patent protection. The authors guide us through these two worlds with ease, noting that a regulatory informational gap exists since the two agencies do not readily converse with one another. Between the Scylla of the FDA and the Charybdis of the PTO many a ship has successfully sailed, potentially to the detriment of competition.

While it would be impossible to address every antitrust issue involved in health care markets, the issues addressed in the pages that follow are certainly worth a great deal of consideration, and in many instances, legislation. It is hoped that the reader finds these articles as interesting and provoking as has the author of this introduction.

¹³ Rebecca S. Yoshitani & Ellen S. Cooper, *Pharmaceutical Reformulation: The Growth of Life Cycle Management*, 7 HOUS. J. HEALTH L. & POL'Y 379 (2007).

