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Unbridled Managed Care: When Consumers Experience Antitrust Welfare Loss From Exclusionary Contracts Between HMO Insurers and Health Care Providers

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NOTES

UNBRIDLED MANAGED CARE: WHEN CONSUMERS EXPERIENCE ANTITRUST WELFARE LOSS FROM EXCLUSIONARY CONTRACTS BETWEEN HMO INSURERS AND HEALTH CARE PROVIDERS

Andrew Ruskin*

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ALTHOUGH THE NATION has ignored rising health care costs for decades, the public has felt the effects of these increases so sharply in recent years that it has begun to clamor for change within the industry. Between 1960 and 1993, the cost of health care rose an average of 11.2 percent per year as compared to the 4.7 percent per year rate for general inflation. As a result of this dramatic increase, employers who provide health coverage have limited pay increases to continue to provide health benefits, shifted some of the financial burden for health care onto the employees, or abandoned their health benefit policies altogether. American households have been forced to pick up some of the resulting burden, and thus, many have purchased fewer other goods to maintain their health care insurance. For many people without disposable income or for whom private insurance is not possible, the only choice is to forgo insurance. Consequently, cost increases have led to increasingly harsh repercussions for much of the American public.

As employers and consumers become increasingly affected by the rising costs of health care, they are switching from traditional inefficient health plans to new health care financing schemes which potentially lower overall costs. Traditionally, the major form of private health insurance has been the fee-for-service plan (FFS), typified by Blue Cross and Blue Shield (BC/BS). These plans usually do not restrict the patient's choice of provider, and they usually pay the provider based

2. Id. at 19.
3. Id. at 81. Employees are increasingly paying greater amounts in copayments and deductibles for their health care.
4. Id. at 17.
5. Id. at 19. Although the average household spent only 4.3% of its aggregate personal income in 1965 on health care, it spent 5.1% in 1991. Id. at 18.
6. Id. at 17. The number of uninsureds has grown from 10.8% of the population in 1980 to 14.7% of the population in 1993. Id.
on his costs or charges, regardless of the expense. Thus, the physician has an incentive to perform unnecessary services, and the industry has an incentive to compete in quality of services as opposed to price. This form of payment has been one of the major contributors to inflation within the health care industry.

In response to the demand for lower prices, some insurers have established health maintenance organizations (HMO). Though there are some important differences among the forms that HMOs employ, all HMOs involve prepayment for health care services with a limited choice of participating providers. In the staff model HMO, doctors are employees of the HMO and work on a salaried basis. The HMO usually owns or controls the facilities where its doctors work. This integrated provider-insurer unit must bear the financial risk of providing services at the contracted rate. In the group model, the HMO contracts with independent physician groups who agree to a capitated payment basis for their services. Thus, the doctors are accepting much of the financial risk for their patients' care. The individual practice association (IPA) model consists of independent physicians who organize to contract with the HMO to provide services either at a capitated rate or at a discounted fee-for-service rate. Though some of these physicians might avoid financial risk through fee-for-service payment systems, many IPA HMOs withhold a certain amount from the physician payments and return this portion in the form of periodic bonuses contingent upon maintaining low patterns of service use. Hence, some financial risk is still borne by the providers. Unlike the traditional model where

8. See id. at 23 (describing the system of paying physicians based on either their usual, customary, or reasonable fees).
9. PROPAC, supra note 1, at 20.
11. Id. at 586.
12. Id. (defining capitation as the method of payment whereby the provider receives a fixed sum for his services per pay period per person, regardless of the actual costs incurred).
13. Id.
14. BERMAN & ROSE, supra note 7, at 123.
15. The forms of HMOs discussed here represent only some of the many different types of integrated delivery systems (IDS) that seem to be proliferating rapidly. For a more complete survey, see Carl H. Hitchner et al., Integrated Delivery Systems: A Survey of Organizational
the FFS insurer passes any cost increases back to the enrollees in the form of higher rates, HMO insurers and providers are assuming a large part of the financial risk, which leads them to attempt to lower the costs of care.

In an increasingly competitive health care financing market where unique forms of vertical integration and shifting of financial risk are occurring, exclusionary contracts between insurers and providers actually can deprive consumers of the benefits of the lower costs achieved through these networks. For example, when accepting a group of providers into its network, an HMO might try to forbid the providers from entering into any other network for the length of the contract. If the providers agree, the HMO corners a segment of the supply market. This artificial scarcity would lead to higher costs for rival networks and higher market prices for health care. Similarly, the lack of sufficient resources would prevent the rival networks from expanding to their full potential. The successful HMO thus could extract economic rents by raising its prices to a higher than perfectly competitive rate. This price increase would result in injury to consumers because they would experience higher-than-optimal prices and lower-than-optimal HMO enrollment options. In addition to distorting the market by raising rivals' costs, the HMO in this exclusionary relationship also might exploit its strengthened bargaining power relative to the providers by reducing price and the level of service they provide enrollees. Ultimately, this would result in injury to the consumers who would prefer more services in an ideally competitive environment. Therefore, the HMO that successfully imposes an exclusionary restraint on a group of providers can cause twofold injury to consumers by raising rivals' costs and restraining providers' output.

This Note addresses both of these types of injuries and the

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16. See John J. Flynn, Antitrust Policy and Health Care Reform, Antitrust Bull., Spring 1994, at 59, 101 (asserting that future growth in the HMO industry likely will breed an increasing number of cases where exclusive dealings will have caused antitrust injuries).

17. Economic rents are profits that a firm receives in excess of its costs, including its opportunity costs. Roger L. Miller & Roger E. Meiners, Intermediate Microeconomics 332 (1986).
mechanisms through which they can be perpetrated. It then de-
scribes the factors that courts consider in recognizing the likeli-
hood of each of these injuries occurring. Focusing on the in-
correct assumptions about the health care industry relied upon
by the first circuit court in *U.S. Healthcare, Inc. v. Healthsource, Inc.*,\(^8\) and the seventh circuit court in *Blue
Cross & Blue Shield United of Wisconsin v. Marshfield Clin-
ic*,\(^9\) this Note suggests guidelines for interpreting the antitrust
injury arising out of exclusionary relationships in a manner that
better accords with the economic realities of health care.

**II. INJURY TO CONSUMERS THROUGH THE RAISING OF RIVALS’ COSTS: ECONOMIC THEORY**

One of the primary goals of economic theory is the exami-
nation of efficiency. Efficiency within a competitive market
consists of the maximization of the sum of both consumer
welfare and producer profit. Maximum efficiency within the
health care industry requires that purchasers bid upon health
care services until the price of the services equals their perfect-
ly competitive rate.\(^2\) However, it is possible that an HMO
would insist upon an exclusionary contract preventing a health
care provider from offering its services to other HMOs. By
removing potential services from its rivals, the HMO would
make them bid up the price of the services of the remaining
providers, consequently raising their costs to an above optimal
level.\(^2\) Figure one illustrates this phenomenon as a shift of \(S\)
to \(S'\), which shifts \(p^*\) to \(p'\). Here \(S\) represents the supply of

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18. 986 F.2d 589 (1st Cir. 1993). As described infra, notes 59-74 and accompanying text, this court examined the anticompetitive effects of an exclusionary relationship between an HMO and its providers.
20. Terry Calvani, *What is the Objective of Antitrust?*, in ECONOMIC ANALYSIS AND ANTI-
TRUST LAW 7, 12 (Terry Calvani & John Siegfried eds., 2d ed. 1988) (describing the factors of
economic efficiency).
21. See MILLER & MEINERS, supra note 17, at 36-38 (describing the way buyers and sellers
adjust the market through exchange to bring it to an equilibrium price).
Rivals’ Costs to Achieve Power Over Price*, in 2 ECONOMIC ANALYSIS AND ANTI-
TRUST LAW 231, 237 (Terry Calvani & John Siegfried eds., 1988). These costs of the rival HMOs are higher than
optimal because the anticompetitive HMO has created an artificial scarcity by restraining the sale
of services that the provider has the potential to produce above the needs of the anticompetitive
HMO. Krattenmaker and Salop refer to this as “real foreclosure.” *Id.*
health care services available to rival HMOs in a state of perfect competition, and $S'$ represents the supply of these services as a result of foreclosure. In this way, the HMO would have a competitive advantage over its rivals.

An HMO will impose this sort of agreement upon providers when the incremental increase in average cost it expects to incur due to the agreement is less than it expects to make in increased prices from its premiums. As illustrated in Figure two, the impact of the exclusionary dealing on the price of premiums depends upon its effect on the supply curve of rival HMOs and on the enrollee demand curve.

23. See Steven C. Salop & David T. Scheffman, Recent Advances in the Theory of Industrial Structure, 73 AM. ECON. REV. 267, 269 (1983) (discussing the relationship between the demand curve and average cost curve in an industry burdened with an exclusionary relationship). The change in average cost ($ac$) is depicted in figure two. The HMO follows this rationale because it calculates its profits as $pq - (ac)q$ where $p$ is a product's price, $q$ is the quantity, and $ac$ is the average cost of inputs. If $ac$ rises less than $p$ at a given $q$, then the overall profit increases. The demand curve equals the premium price enrollees are willing to pay for health care services at a given supply, and thus a shift up the demand curve is equivalent to a shift up of the price of premiums. See MILLER & MEINERS, supra note 17, at 25 (defining the market demand curve).

24. The supply curve also can be thought of as the rival firms' marginal cost curve. Salop
Before it can be assured of the success of its exclusionary dealing, the anticompetitive HMO needs to understand the degree of the resulting shift of the rival HMOs' supply curve as well as the elasticity of both the rival HMOs' supply curve and the consumer demand curve. Seeking maximum profitability, an HMO will impose an exclusionary restraint when it believes that: i) it will succeed initially in raising its rivals' costs; ii) its rivals will not be able to respond to any resulting industry shortage through increased production; and, iii) consumers still will enroll in the HMO that is imposing the exclusionary restraint despite an increase in the price of premiums. When

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25. Id. at 269 (defining elasticity as the degree to which the changes in price of a good affect the quantity that is bought or sold). See also GEORGE J. STIGLER, THE THEORY OF PRICE 326-29 (1966) (defining elasticity as a frame of reference within which the prices of two disparate products can be compared).

26. Salop & Scheffman, supra note 23, at 269. The authors state that a successful
these conditions are met, there is a strong incentive to engage in exclusionary behavior.

In addition to the anticompetitive gains attained from raising rivals’ costs, both the HMO and the providers realize production cost savings through the exclusionary arrangement. The providers avoid transaction costs incurred from negotiating multiple HMO contracts and from administering multiple plans.27 The HMO also benefits because assurance of its provider base decreases costs in finding sufficient capacity for its enrollees and increases its bargaining power with employers contemplating entry into the plan.28 As a team, both parties can engage in more effective planning. Because of consistency in enrollment, the provider can better predict the needs of its patients and can develop capacity appropriately.29 Through its exclusionary relationship must fulfill three conditions: i) the rival firms’ supply curve must experience a great shift upwards; ii) the rival firms’ supply curve also must be highly inelastic; and, iii) the consumer demand curve must be inelastic at the anticompetitive firm’s price range. Id.

By way of example of the HMO’s successful implementation of its exclusionary relationship, an HMO likely would prohibit specialists and specialty facilities, such as cardiologists and cardiology clinics, from providing services to other HMOs if it could do so cheaply. Since there is usually only a limited supply of cardiologists in a given area, the cardiologists not under the restraint would have increased bargaining power. Thus they would be able to charge above optimal rates for their services to rival HMOs who would experience increased costs. Consequently, the rival HMOs would likely increase their enrollment prices to cover their costs. The anticompetitive HMO also would cause a decrease in the production of rival HMOs through its exclusionary restraint because there would be fewer cardiologists available to service HMO customers. Hence there would result a decrease in the number of consumers who could enroll in rival HMO plans and receive adequate treatment. The rival HMOs would likely not try to compensate for this scarcity of cardiologists by bringing them in from other areas because they would need to expend tremendous resources either to induce new cardiologists into the area or to build new facilities. Rather, they would need to limit the number of enrollees allowed to join to prevent exceeding present capacity, which would further cause the price to rise to accommodate the scarce supply. If enrollees believe that the value of HMO enrollment exceeds this anticompetitive price, consumers consequently would pay more for their HMO enrollment subsequent to this increase in the market price and decrease in the market output. This signifies that the anticompetitive HMO could charge more for its services without any change in its product. The HMO will decide whether to engage in this action based upon whether it can earn more from the increased prices of its enrollment fees than it pays out to get the exclusionary restraint.

27. See Julie Johnsson, Magic Carpet Ride? An Exclusive Provider Deal May Seem Enchanted—Until the Insurer Pulls the Rug Out, AM. MED. NEWS, June 13, 1994, at 23 (pointing out why Austin Regional Clinic providers originally were willing to enter into an exclusionary contract with PruCare that later turned out to be problematic).

28. Id. See also Krattenmaker & Salop, supra note 22, at 232 (pointing out that a dealer incurs lower transaction costs in acquiring its inputs by being assured of its supply).

ability to share information with providers and to coordinate programs with them, the HMO can plan more effective promotions of the providers' services. Thus, savings accrue to the parties in the agreement that might be passed on to the consumers.

Even if these savings initially benefit the consumers, it is likely that this arrangement eventually would cause them injury. Due to the long-term decline of competition in the market, the anticompetitive HMO would have the incentive eventually to raise prices above their optimal level, which would result in allocative inefficiency. An allocative distortion also arises from depriving rival HMOs and their enrollees of sufficient health care resources to handle the demand for HMO services. Not only does the scarcity of resources artificially restrain output of HMO services, it also creates production inefficiency in the form of increased costs of producing the output of HMO services. The anticompetitive HMO might create additional production inefficiency by engaging in further strategic behavior to increase its position relative to its competitors. This expense, like the expense incurred by imposing the exclusionary restraint, adds costs without benefit to the consumer. Moreover, competitors would face barriers to acquiring market share, and due to uncertain payoffs, would be deterred

30. See, e.g., Berman & Rose, supra note 7, at 60 (describing the way the group practice model fosters cooperation between the HMO and providers in setting up educational classes and support groups for enrollees).

31. See Frances H. Miller, Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?, LAW & CONTEMP. PROBS., Spring 1988, at 195, 218 (discussing the ramifications of Blue Cross and Blue Shield entering into the managed care arena).


32. See Krattenmaker & Salop, supra note 22, at 244 (suggesting that exclusionary relationships increase production inefficiency). Brodley defines production efficiency as the production of goods at the least cost in the present state of technology. Brodley, supra note 31, at 1027.

33. See Richard A. Posner, The Economic Theory of Monopoly and the Case for Antitrust, in ECONOMIC ANALYSIS AND ANTITRUST LAW 231, 232 (Terry Calvani & John Siegfried eds., 2d ed. 1988) (explaining that firms are attracted to monopoly profits and will expend resources in attaining them). For instance, it might engage in heavy advertising to counteract the effects of its new supra-competitive pricing. In general HMOs already exhibit this tendency to increase production costs through advertising. See Rebecca Kuzins, HMOs Get More Profits, More Critics, BUS J. SERVING GREATER SACRAMENTO, Jan. 9, 1995, at 1, 29 (discussing the enormous amount of HMO income spent on non-health care related items such as advertising).
from investing in technological developments in health care management. Thus, there is little likelihood of increased innovation efficiency within such a system. Due to these extensive inefficiencies, any short term gains for consumers would be more than offset by long term consumer welfare loss in situations where the HMO succeeds in imposing costs on its rivals.

III. INJURY TO CONSUMERS THROUGH THE RAISING OF RIVALS' COSTS: LEGAL DEVELOPMENT

A. Statutory and Case Law

The Sherman Act, one of the primary manifestations of congressional concern about anticompetitive behavior, renders illegal any "contract, combination . . . , or conspiracy, in restraint of trade," as well as the act of any person that "shall monopolize, or attempt to monopolize." Though the underlying objective of the Act has been the subject of much debate, economic efficiency has been the most often cited reason for its enactment. Some scholars temper this goal with a need to assure that consumers receive an appropriate share of the wealth created by efficiency. Economic models are one tool courts use to determine antitrust injury, due to the intrinsically economic nature of this cause of action. Economic models illustrate the conditions that need to be fulfilled before an antitrust injury occurs. The legal system has developed criteria that resemble the factors examined by economists in

34. Cf. United States v. Aluminum Co. of Am., 148 F.2d 416, 427 (2d Cir. 1945) (asserting that the fairness of Alcoa's profits did not justify its monopoly power because rivals, if allowed in the market, could discover innovative techniques that would enhance production, lower costs, and cut prices). See also Brodley, supra note 31, at 1044 (noting that exclusionary contracts promote inefficiency). Innovation inefficiency refers to the invention, development, and implementation of new technology. Id. at 1025-26. Brodley asserts that innovative inefficiency and production inefficiency are more injurious than allocative inefficiency because they are more likely to impede increases in long-term social wealth. Id. at 1027.


38. Id. at 12.


the context of exclusionary vertical restraints that impose costs on rivals.

The Supreme Court first set out principles for examining exclusionary vertical relationships in *Standard Oil Co. v. United States (Standard Stations).* 41 In this case, the Court considered the anticompetitive effects of a contract in which Standard Oil imposed exclusive dealing arrangements upon independent stations that forbade them from selling competing products. 42 The Court found that in foreclosing a substantial share of the market, Standard Oil had engaged in anticompetitive behavior. 43 Although it acknowledged that there had been no evidence of any decline in competitive activity within the market, the Court found that market share alone created sufficient danger to warrant Standard Oil's removal. 44 Thus, the Court indicated that it need only consider the size of the anticompetitive firm in finding an antitrust violation stemming from an exclusionary vertical restraint.

The somewhat narrow approach of *Standard Stations* was expanded in *Tampa Electric Co. v. Nashville Coal Co.* 45 Tampa Electric received a guarantee from Nashville Coal that it would supply all the coal needed by Tampa Electric's generating plants for a period of twenty years. 46 In evaluating the anticompetitive effects of an exclusive dealing arrangement, the Court followed a three-step process: first, define the product market; 47 second, delineate the geographic market in which

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41. 337 U.S. 293 (1949). The Court examines this case in the context of a Clayton § 3 violation. *Id.* Since Clayton § 3 applies only to commodities, health care services cannot be considered under this cause of action. *Cf.*, e.g., Tri-State Broadcasting Co. v. United Press Int'l, Inc., 369 F.2d 268, 270 (5th Cir. 1966) (finding that a radio broadcast is not a commodity for the purposes of a Clayton § 3 analysis). However, other courts have followed the reasoning of *Standard Stations*, even within the health care service context. *See*, e.g., U. S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 595 (1st Cir. 1993).

42. *Standard Stations*, 337 U.S. at 295-96. Though this case is one in which the manufacturer imposed an exclusionary restraint upon the dealer, it illustrates how the Court deals with these types of restraints overall.

43. *Id.* at 314. The Court based its conclusion of substantial market share on its findings expressed earlier in the opinion that the independent service stations accounted for 6.7% of the relevant market. *Id.* at 295.

44. *Id.* at 314.

45. 365 U.S. 320 (1961). Similar to *Standard Stations*, this case also appears as a Clayton § 3 violation. *Id.* at 321.

46. *Id.* at 322.

47. *Id.* at 327.
the products compete; and third, find a substantial share of this market affected by the restraint. After reiterating the need for the quantitative information upon which the Standard Stations Court relied to determine substantial foreclosure within a market, the Court listed various qualitative factors to consider before finding an anticompetitive effect. These include "the relative strength of the parties, the proportionate volume of commerce involved in relation to the total volume of commerce in the relevant market area, and the probable immediate and future effects which preemption of that share of the market might have on effective competition therein." Weighing these factors, the Court did not find any substantial foreclosure within the market. Through this balancing process, the Court established criteria that more closely determine the actual competitiveness of an industry.

The analysis of exclusionary vertical restraints was refined further in Jefferson Parish Hospital Dist. No. 2 v. Hyde. A hospital had entered into a contract with a firm of anesthesiologists agreeing to use only that firm's services for its anesthesiology needs. Although the majority analyzed this case as a tying arrangement, Justice O'Connor viewed it as an exclusive dealing relationship. Concurring with the majority that no restraint of trade had occurred in this case, she stated

48. Id. (quoting a footnote in Standard Stations that alluded to the possibility that the national market might not be the appropriate market to examine in all cases). By requiring the examination of the product and geographic market, the Court compels an analysis of the elasticity of the consumer demand curve, i.e., the range of substitutes for the product under the restraint. This step accords with the economic model's description of the circumstances which could lead to foreclosure. See supra notes 23-26 and accompanying text (giving an economic analysis of the necessary criteria involved in imposing a successful exclusionary restraint).

49. Tampa Electric, 365 U.S. at 328.
50. Id. at 328-29.
51. Id. at 329. This consideration of the power of different firms within the industry helps indicate the degree to which an anticompetitive firm successfully can raise its rivals' costs through the imposition of an exclusionary restraint on a substantial amount of input. This condition must be met before the economic model would predict the existence of an antitrust injury. See supra notes 23-26 and accompanying text (discussing several economic criteria that indicate foreclosure).

52. Tampa Electric, 365 U.S. at 335.
54. Id. at 4.
55. Id. at 4, 7-32 (discussing the resulting "tying" of certain anesthesiology services with use of the hospital's operating room).
56. Id. at 33.
57. Id. at 46.
several factors to consider before finding an exclusionary agreement unreasonable. She clarified that "the proper focus is on the structure of the market for the products or services in question — the number of sellers and buyers in the market, the volume of their business, and the ease with which buyers and sellers can redirect their purchases or sales to others." The increase in the number of factors to be considered represents a greater potential for accuracy in understanding the interplay between the economic paradigm and actual contingencies within the market.

Although there is no Supreme Court case that deals with exclusionary vertical restraints between HMOs and providers, the First Circuit addressed this scenario in *U.S. Healthcare, Inc. v. Healthsource, Inc.* The defendant HMO entered into contracts with doctors under which the physicians would receive a higher rate of capitation if they agreed not to provide services to any other HMOs. When the plaintiff HMO had great difficulty in getting doctors to participate in its plan, it filed suit based on violations of the Sherman Act sections 1 and 2. After dismissing the plaintiff's claim of a section 1 per se violation, the court examined the defendant's behavior under the rule of reason test as delineated in *Tampa Electric* to determine the degree to which it had led to foreclosure in the provider market. The court found itself severely limited in

58. *Id.* at 45. By recommending that courts examine whether rivals can compensate for the exclusionary restraint by finding new suppliers, Justice O'Connor leads the courts to consider the supply curve elasticity. Firms without access to supplies have inelastic supply curves because they cannot respond to the increases in price through increases in production. This condition is a necessary precursor for the successful imposition of an exclusionary restraint. See *supra* notes 23-26 and accompanying text (listing some important factors for finding an antitrust injury in an exclusionary relationship).

59. 986 F.2d 589 (1st Cir. 1993).

60. *Id.* at 592. The doctors would still be allowed to serve patients under traditional indemnity policies or under preferred provider organization (PPO) arrangements. *Id.*

61. *Id.* at 593.

62. *Id.* at 593-94. The plaintiff tried to characterize the arrangement as a group boycott in which the doctors would be determined to have entered into a horizontal agreement in restraint of trade. *Id.* This kind of boycott would be treated as a per se violation of the Sherman Act and would mean that the defendant was liable regardless of the actual degree of anticompetitive effects. *Id.* at 593.

63. *Id.* at 595. The rule of reason test implies that the court considers all the potential procompetitive and anticompetitive effects to determine if there has been an unreasonable restraint of trade. *Id.* In addition to an unreasonable restraint of trade, courts usually must find market power, injury, and agreement to establish a Sherman § 1 violation. See, e.g., Blue Cross &
its ability to consider the issues thoroughly because the plaintiff failed to frame its case in a traditional antitrust form.\textsuperscript{64} Thus, it did not address the relevant product market or the relevant geographic market as required under \textit{Tampa Electric}.\textsuperscript{65} Instead, it began by examining the anticompetitive tendencies of the agreement. First, it found no evidence that the doctors were restrained by the agreement because many of them easily might be persuaded to leave the HMO.\textsuperscript{66} Second, the court found that the thirty day notice requirement before terminating the exclusive agreement was de minimis and thus no hindrance to trade.\textsuperscript{67} Third, the court found no evidence that the defendant HMO had blocked off a significant part of the supply market, as new doctors are always coming into the market.\textsuperscript{68} Thus, the court found ample grounds for dismissing the section 1 claim.

Though the court did not consider the HMO agreement a violation of Sherman section 1, it investigated the relationship as a potential monopolization violation of Sherman section 2.\textsuperscript{69} The court began its investigation of monopoly power by considering the product market definition, but qualified its approach by defining the relevant market as the health care consumer market and not the supply market of doctors.\textsuperscript{70} It based this conclusion on the belief that there could never be monopsonistic buying power over doctors because they have many potential buyers of their services.\textsuperscript{71} The court decided that the appropriate question was whether the product market consisted of HMOs or of health care financing in general.\textsuperscript{72} Although

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\textsuperscript{56.} U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 595 (1st Cir. 1993).
\textsuperscript{64.} U.S. Healthcare v. Marshfield Clinic, Memorandum & Order, (94-C-137-S) (W.D. Wis. Oct. 28, 1994) (finding sufficient evidence of these elements to deny defendants summary judgment).
\textsuperscript{65.} However, it found an opportunity to consider these factors later in the opinion when dealing with the Sherman § 2 violation claim. \textit{Id.} at 598-99 (discussing how to define a product market involving HMO services).
\textsuperscript{66.} \textit{Id.} at 595-96.
\textsuperscript{67.} \textit{Id.} at 596.
\textsuperscript{68.} \textit{Id.}
\textsuperscript{69.} \textit{Id.} at 597. For Sherman § 2, the plaintiff must prove monopoly power and unlawful conduct aimed at maintaining monopoly power. \textit{See infra} note 281 and accompanying text (discussing this cause of action within the context of monopsonistic power over providers).
\textsuperscript{70.} U.S. Healthcare, 986 F.2d at 598.
\textsuperscript{71.} \textit{Id.} Monopsony is the converse of monopoly power whereby there is only one buyer within a market. \textit{See infra} part V (discussing the mechanics of a monopsonistic relationship).
\textsuperscript{72.} U.S. Healthcare, 986 F.2d at 598.
\end{flushright}
the plaintiff argued that the HMO market should be the relevant product market, the court determined that mere differences in price and quality did not constitute a lack of substitutability between HMO insurance and other insurance mechanisms. Since there were too many available insurers to allow the defendant to gain market control, the court found it unnecessary to consider whether the lower court had properly determined that the relevant geographic market should be the entire state of New Hampshire, as opposed to the plaintiff's claim that it should be only southern New Hampshire. The court concluded that no monopolization of the consumer market had taken place. Though this case was decided at the circuit court level, it stands out as one of the few cases dealing with exclusionary relationships within managed care. Thus it likely will be influential in future similar cases.

73. Id. at 598-99. In finding substitutability between these two types of health insurance, the court assumed that consumers are roughly ambivalent about signing up for HMO-type insurance with its peculiar features at its ordinary cost or for FFS insurance with its peculiar features at its ordinary cost. Thus a small increase in the price of one of these financing mechanisms would lead to a corresponding decrease in its enrollment as consumers switch to the other financing mechanism. This interaction between products is called cross-elasticity. See PHILLIP AREEDA & LOUIS KAPLOW, ANTITRUST ANALYSIS: PROBLEMS, TEXT, CASES 576 (1988) (defining cross-elasticity as "the rate at which consumers change their consumption of one product in response to a price change for another").

While the court refers to cross-elasticity only in general terms, Areeda and Kaplow point out the need to define properly what price is going to be used as the baseline when determining consumer reaction to price. Id. at 571. If the potentially anticompetitive firm already is charging prices well in excess of its costs, then it already has market power, regardless of whether a slight increase in price would cause consumers to switch to another product. Id. Thus cross-elasticity should be determined in relation to the product's competitive price, which is approximately equal to its cost, including the producer's opportunity cost. Id. See also Posner's interpretation of the du Pont case in RICHARD A. POSNER, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 127-28 (1976) ("[A]t a high enough price even poor substitutes look good to the consumer .... Reasonable interchangeability at the current price level... far from demonstrating absence of monopoly power, might well be a symptom of that power ... "). Ironically, Posner did not follow this reasoning in looking at the high rate of return demonstrated by the Marshfield Clinic in his Marshfield opinion. Infra notes 91-93 and accompanying text.

Though this court determined that HMO and FFS insurance are interchangeable, studies in the area do not point to this result. See infra part IV.A.1.a. The court did make the disclaimer that because the plaintiff had not argued this point well, it did not have sufficient evidence to determine fully the true extent of substitutability of the two products. U.S. Healthcare Inc., 986 F.2d 589, 599 (1st Cir. 1993). Since the development of the HMO submarket has only recently become salient, several other courts also have failed to recognize it. See, e.g., Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1331-32 (7th Cir. 1986) and Reazin v. Blue Cross & Blue Shield, 663 F. Supp. 1360, 1478-79 (D. Kan. 1987), aff'd in part and remanded in part, 899 F.2d 951 (10th Cir. 1990), cert. denied, 497 U.S. 1005 (1990) (refusing to find an HMO submarket).

74. U.S. Healthcare, 986 F.2d at 599.

75. Id.
Another case that courts will probably turn to in examining exclusionary relationships between HMOs and providers is *Blue Cross & Blue Shield v. Marshfield Clinic*. In this case, the defendant clinic—owned by the 400 physicians it employed—established a subsidiary HMO that was highly successful in the fourteen rural Wisconsin counties where it operated. After BC/BS's subsidiary HMO found itself excluded from this market, it filed suit alleging Sherman section 2 violations. Initially successful at the district court level, the plaintiffs lost on appeal to the Seventh Circuit.

Although the court had several grounds for its reversal, it relied primarily on its finding inadequate evidence of an HMO submarket in the trial court's record. The court described HMOs as merely a "method of pricing medical services." Looking at the array of substitutes available to buyers of health care services, the court asserted that the trial record showed ample evidence of HMO competition with both FFS and PPO type plans. The court added that many people do not like the incentives to reduce services within HMOs, and therefore they likely would change plans with an increase in HMO premiums. From the sellers' side, the court said that an increase in prices for HMO services above their competitive level would attract physicians to HMOs to capture some of the wealth.

76. 65 F.3d 1406 (7th Cir. 1995), cert. denied, 116 S. Ct. 1288 (1996).
77. Id. at 1408-09. In nine of the 14 counties in which it operated, the HMO enrolled over 90% of all HMO enrollees. Id. at 1409.
78. Id. at 1408. BC/BS alleged separate Sherman § 1 violations in its own name as well; however, the court said that since the physicians and the Clinic were part of the same entity, the single firm could not collude with itself. Id. at 1415.
79. Id. at 1416. The judgment also was affirmed in part. Id. However, that segment of the case is not relevant to this Note.
80. Id. at 1411.
81. Id. at 1409. In so finding, the court disagreed with the findings of unique characteristics of HMOs made by the lower court, such as primary care physicians with gatekeeping functions, monitored use of health care resources, and extensive preventive care programs. Blue Cross & Blue Shield v. Marshfield Clinic, 883 F. Supp. 1247, 1253 (W.D. Wis. 1995), aff'd in part, rev'd in part and remanded, 65 F.3d 1406 (7th Cir. 1995), cert. denied, 116 S. Ct. 1288 (1996).
82. Id. at 1410. The term PPO refers to preferred provider organizations, a type of financing mechanism whereby the enrollee has a limited choice of physicians in return for lower premiums, deductibles, and copayments. Freiburg, supra note 10, at 587.
83. Marshfield, 65 F.3d at 1410. But see infra part IV.A.1.a (describing distinct consumer preferences for either HMOs or FFS insurance for non-price reasons).
84. Marshfield, 65 F.3d at 1410-11. The court, however, does not explain why physicians would switch to the provision of HMO services merely because of an increase in HMO premiums. The HMOs also would have to pay physicians more before their incentives to work for HMOs...
Without any finding of distinctive characteristics separating HMOs from other financing mechanisms, the court accordingly determined that HMOs did not constitute a submarket.

After investigating the nature of the product market, the appellate court went on to look at the plaintiff's definition of the geographic market accepted by the district court. The court accepted the plaintiff's proposition that primary care is generally local. Hence in the one county where all the physicians were employees of Marshfield's HMO, the court suggested that it might accept the idea of exclusion of BC/BS. However, the magnitude of the compensation demanded showed that the plaintiff asserted a much larger geographic region in which the injury was perpetrated. The plaintiffs tried to establish that in the entire north central Wisconsin region, certain procedures as defined by their DRGs were performed almost exclusively by Marshfield physicians. Yet the court decided that most procedures could be performed by other physicians if one physician charged supracompetitive prices for them. In this way, the court found that there was a substitutability of supply that negated a finding of separate markets. Thus even if HMOs were a submarket, the degree of antitrust injury would have to reflect only the harm incurred in the few local markets where BC/BS was foreclosed from offering primary care services.

The court also examined the plaintiff's claim that direct evidence of the Clinic's monopoly power could be found in the high rate of return it achieved through its HMO product. Even if the high rate of return was not a result of mere accounting conventions, the court pointed out that superior effi-

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would increase. Yet HMOs often prefer to increase their profit margins rather than pay more for services. See infra note 251 and accompanying text (discussing the tendency among HMOs to increase profits by decreasing medical loss ratios).

85. Marshfield, 65 F.3d at 1411.
86. Id.
87. Id. The judgment awarded BC/BS at the trial court level was just under $20 million. Id. at 1408.
88. Id. at 1411.
89. Id.
90. Id. Although the court found supply elasticity, it did not discuss the potential for DRGs to act as proxies for non-interchangeable specialized services. See infra Part IV.A.1.b and Part IV.A.2.b (discussing the differences among primary, secondary, and tertiary care as well as their varying geographic markets).
91. Marshfield, 65 F.3d, at 1411.
ciency could lead to a high rate of return. Yet this efficiency would not block out other competitors who were equally efficient. Accordingly, the court did not accept evidence of a high rate of return as evidence of monopoly power.

Even if the plaintiffs had proven monopoly power, the court expressed its willingness to accept that Marshfield could be a "natural monopolist" in the sparsely populated regions of rural Wisconsin. The court believed that the market was too small to support competitors. Although in some cases facilities run by a natural monopolist are viewed as essential facilities to which competitors must be given equal access, the court here found that Marshfield Clinic's resources were not essential due to the lack of an HMO submarket. Thus BC/BS could not use the legal system to force Marshfield to yield access to its resources.

Following this denial of Marshfield Clinic's status as a monopolist, the court stated in dictum how it would treat BC/BS's claims that the Marshfield Clinic unlawfully maintained its monopolistic position. BC/BS alleged various activities on the part of Marshfield Clinic that made it difficult for rival HMOs to enter, such as: refusing to allow its physicians to cross-cover with physicians outside the network, discouraging hospitals controlled by Marshfield doctors from joining other HMOs, and restricting staff privileges for non-

92. Id. at 1412.
93. Id. But see supra note 73 & infra part IV.A.1.a (stating that a firm's rate of return must be taken into consideration when judging if the present interchangeability between two products actually might be a result of supracompetitive pricing).
94. Marshfield, 65 F.3d at 1412.
95. Id. In its discussion of the need for a natural monopoly, the court inexplicably refers to the harm imposed upon a community by making its limited number of doctors compete with each other when they should be helping each other to bear the burden of the costs of expensive medical equipment. Id. This case is not about trying to instill competition among the doctors; rather, BC/BS tried to make the health care financing market more competitive by introducing its HMO product. The court does not address competition at this tier of the health care industry. The court again confuses these two tiers of the market when it says that HMO competition will not deprive physicians of their monopolistic fees. Id. at 1413. Yet it does not consider whether HMO supracompetitive profits would decrease as a result of competition.
96. Id. at 1412.
97. Id. at 1413. But see infra part IV.C.2 (arguing that once the HMO submarket has been properly recognized, courts should use the essential facilities doctrine freely within exclusionary relationship cases because of the ease with which one HMO can foreclose access to other HMOs of specialty care in many American communities).
98. Marshfield, 65 F.3d, at 1413.
Marshfield physicians at those hospitals.\textsuperscript{99} Yet the court found legitimate business purposes for all of these activities.\textsuperscript{100} Therefore, regardless of Marshfield’s position as a monopolist, the court would not sustain a Sherman section 2 violation. This court’s holding adds great weight to the precedent set by the \textit{U.S. Healthcare} court.

\section*{B. Regulatory Law}

In 1985, the Department of Justice (DOJ) codified enforcement policies in its Vertical Restraints Guidelines.\textsuperscript{101} The Guidelines have been overruled because of their emphasis on theory over fact.\textsuperscript{102} However, these Guidelines are useful because they delineate a systematic approach for understanding non-price vertical restraints even though the DOJ no longer abides by them. In section three, the Guidelines attempt to prevent both collusion among competitors and the exclusion of rivals from input sources that would raise their costs.\textsuperscript{103} Having acknowledged the potentially anticompetitive effects of vertical restraints on a market, the Guidelines explain how to evaluate whether the market has been adversely affected by them.

As a precursor to its analysis, the Guidelines define the market. Section 6.1 describes how to define the product market.\textsuperscript{104} It begins by narrowly defining the product market and then poses the question of what would happen if a “small but significant and nontransitory” price shift took place.\textsuperscript{105} For

\begin{itemize}
  \item \textsuperscript{99} Id.
  \item \textsuperscript{100} Id. at 1413-14. The court looked at the need for quality physicians as a legitimate reason for limiting staff privileges, the reasonability of acting within one’s own economic self-interest as grounds for avoiding entering into multiple HMO contracts, and the inability of Marshfield physicians to make time commitments to independent physicians as the reason for no cross-coverage. Id.
  \item \textsuperscript{101} Vertical Restraints Guidelines, 50 Fed. Reg. 6263 (1985).
  \item \textsuperscript{102} Assistant Attorney General Anne K. Bingaman, Address to ABA’s Antitrust Section, 65 Antitrust & Trade Reg. Rep. (BNA), No. 967, at 251 (Aug. 12, 1993). Assistant Attorney General Anne Bingaman further added that the DOJ will no longer be as inclined to find that the procompetitive effects of these restraints dominate as the agency had done previously. Id. Thus greater caution is now warranted by private industry.
  \item \textsuperscript{103} Vertical Restraints Guidelines, 50 Fed. Reg. at 6267.
  \item \textsuperscript{104} Id. at 6272. This is consistent with the first part of the test established by the \textit{Tampa Electric} court, discussed \textit{supra} notes 45-52 and accompanying text.
  \item \textsuperscript{105} Vertical Restraints Guidelines, 50 Fed. Reg. at 6272.
\end{itemize}
example, if a large number of people would buy a substitute and exclude any possibility of profitability to the potential monopolist, then that product would be included in the product market. The Guidelines suggest looking at buyer and seller perceptions about the interchangeability of the products as well as the patterns of consumption and the behavior of price over time. These considerations apply to both levels of the restraint.

In an analogous fashion, section 6.2 then defines the relevant geographic market. First, one looks at what would happen if a "small but significant and nontransitory" price shift took place. If a large number of people would buy the product at other locations and detract from the profitability to the potential monopolist, then these other locations should be included in the geographic region. The Guidelines suggest observing present shipment patterns, transportation costs, price behavior, and the capacity of firms within a region. This procedure also applies to both levels of the restraint. Through the careful delineation of the product and geographic markets at both the manufacturer and dealer levels, the Guidelines minimize any underinclusion or overinclusion that might mask effects of inefficiency.

Having defined the market, the Guidelines then use a two-step approach in evaluating its competitive nature. Under section 4.1, market structure is the first aspect examined. The Guidelines examine the market structure by measuring both the

106. Id.
107. Id. at 6272 n.36 (referring the reader to the 1984 Merger Guidelines, 49 Fed. Reg. 26,823, 26,828 § 2.1 for information about how the product market should be defined).
108. Id. at 6272.
109. Id. This accords with the second part of the test established by the Tampa Electric court, discussed supra note 48 and accompanying text. Together with the product market definition, this factor also illustrates the determinants of the elasticity of the consumer demand curve. See supra notes 23-26 and accompanying text (describing the crucial role of the demand curve in the development of the economic model of exclusionary restraints).
111. Id.
112. Id. at 6272 n.37 (referring the reader to the 1984 Merger Guidelines, 49 Fed. Reg. 26,823, 26,829 § 2.3 for information about how the geographic market is defined). The term "shipment patterns" refers to the patterns of movement of buyers, sellers, and goods and services in the course of transactions.
114. Id. at 6268.
vertical restraints index (VRI)\textsuperscript{115} and the coverage ratio.\textsuperscript{116} Within certain limits, the Guidelines do not consider a market to be dangerously anticompetitive;\textsuperscript{117} however, they suggest further investigation outside these limits.

If there is a potential for anticompetitive effects within a vertical restraint, the Guidelines delineate a rule of reason analysis where they consider conditions that might make anticompetitive behavior more or less likely. Primarily, they are concerned with ease of entry.\textsuperscript{118} If exclusion of rivals is

115. Id. The VRI is calculated by first identifying which firms employ vertical restraints. Id. at 6268 n.25. Second, their market shares are determined. Id. Then each of their market shares are squared and added together. Id. For example, if in a given market, only two dealers employ a restraint, one with a 5% and one with a 20% market share, the dealer market VRI would equal $5^2 + 20^2 = 25 + 400 = 425$. Id. If four suppliers, each with a 25% market share, are involved in the restraint, then the supplier market VRI would equal $4(25^2) = 4(625) = 2,500$. Id. Thus in this market, there would be a dealer VRI of 425 and a supplier VRI of 2,500. Id. The maximum VRI would come from one firm controlling all of one of the markets, which would result in a VRI of 10,000 for that market. Id. This attention to both the number of sellers and their respective market shares is consistent with the concurring opinion in Jefferson Parish, discussed supra note 58 and accompanying text.

116. Vertical Restraints Guidelines, 50 Fed. Reg. at 6268. The coverage ratio refers to the sum of all the market shares of the firms participating in vertical restraints at one level. Id. at 6268 n.26. Thus, in a supplier market with 10 suppliers under a vertical restraint, each having five percent of the market, the coverage ratio would equal $10(5) = 50\%$. Id. Between the VRI and the coverage ratio, one can understand more clearly whether real foreclosure has occurred that likely will raise rivals' costs. See supra notes 23-26 and accompanying text (discussing the raising of rivals' costs as a necessary element of a successful exclusionary restraint).

117. Vertical Restraints Guidelines, 50 Fed. Reg. at 6268. When the Guidelines were in force, the DOJ would not have challenged a restraint if it resulted in: 1) 10% or less of the market share in the relevant market for the firm employing the restraint; 2) a VRI under 1200 and a coverage ratio below 60% in the same relevant market; 3) a VRI below 1200 in both markets; or, 4) a coverage ratio below 60% in both markets. Id.

As with the product market definition and the geographic market definition, the market structure analysis considers the dynamics in both the supplier and dealer markets. The U.S. Healthcare court did not examine the provider market at all and only investigated the insurance market in the context of the monopoly cause of action. See supra notes 70-73 and accompanying text. Though perhaps justifiably the court found no market power, it could not completely have understood the way the market operated without having gone through the two-tiered investigation used in these Guidelines. Yet its failure to do so probably resulted more from the plaintiff's inadequate presentation of the case than from an oversight on the part of the court.

It seems likely that the DOJ still examines the market structure at both levels in accordance with this methodology despite the fact that these Guidelines no longer are used. Yet whereas previously firms with satisfactory VRIs and coverage ratios would have escaped prosecution by the DOJ, these safe harbors have been removed by Assistant Attorney General Anne Bingaman. Supra note 102.

118. Vertical Restraints Guidelines, 50 Fed. Reg. at 6270. This factor also concerned Justice O'Connor in Jefferson Parish where she indicated that courts should look at the ease of finding new suppliers or purchasers. See supra note 58 and accompanying text. See also supra notes 23-26 and accompanying text (discussing the significance to the economic model of the rivals' ability to compensate for the foreclosure).
the main concern, then ease of entry is crucial because real foreclosure of a market would be impossible if the market under restraint could expand easily. One important criterion for determining ease of entry is the degree of necessary investment in specialized production equipment or training. The Guidelines also suggest considering the degree to which the VRI and coverage ratios exceed that allowed. Moreover, they look at the length of the restraint’s term because a longer term inhibits rivals from entering into the market. The minimum efficient scale of operations also is important because foreclosure is of lesser importance if a new firm needs only to secure few inputs to run efficiently. Intent of management in entering into the restraint also might be indicative of the effects of the structure. The size of the firms using the restraint similarly is significant because small firms might need restraints to increase efficiency through better product management. With these mitigating factors, the Guidelines can help an adjudicator infer the actual competitive state of a potentially anticompetitive exclusionary vertical restraint.

Not satisfied with the DOJ’s pronouncement, the National Association of Attorneys General (NAAG) developed its own guidelines for examining the anticompetitive effects of a vertical restraint. Although in most respects they are similar, the DOJ and NAAG guidelines differ in some fundamental ways. Most significantly, the NAAG collapses the two-step analysis established by the DOJ into one. Concentration and coverage are considered among a list of discretionary factors as opposed to being a threshold consideration.

119. Vertical Restraints Guidelines, 50 Fed. Reg. at 6270. The Guidelines also list factors related to the ease of collusion, such as the homogeneity of the product and the history of collusion in the industry. Id.
120. Id.
121. Id.
122. Id. at 6270-71.
123. Id. at 6271.
124. Id.
125. Id.
127. Id. at 578-79 (explaining that the NAAG avoids using thresholds, finding them arbitrary and imprecise).
so looks at significant market influences, such as the amount of pressure the dealer placed on the supplier to enter into a restraint,\textsuperscript{128} the rigidity of the restraint,\textsuperscript{129} the actual effect on output,\textsuperscript{130} the effect on consumer choice,\textsuperscript{131} and the regulatory environment of the industry.\textsuperscript{132} Inasmuch as these factors are as significant in potentially anticompetitive industries as the factors enumerated by the DOJ, the courts should thoroughly consider both lists whenever they adjudicate vertical restraint causes of action.

Although not as thoroughly delineated as the 1985 Guidelines, the DOJ and the Federal Trade Commission (FTC) jointly have developed a set of principles for investigating vertical restraints specifically within the health care industry.\textsuperscript{133} The overriding concern of these principles is the degree to which a restraint hampers the ability of competing networks to operate within the market.\textsuperscript{134} The analysis begins with an examination of the concentration within the relevant market.\textsuperscript{135} After analyzing the market structure, the agencies then look at other factors that might lead to anticompetitive effects. These include the ability and willingness of purchasers to switch between different networks, the quality and range of services of other networks, the terms and duration of the exclusionary agreement, the number of providers necessary to establish a viable network, and any justifications for the arrangement.\textsuperscript{136} Because these factors are indicative of anticompetitive effects on

\begin{footnotesize}
\begin{enumerate}
\item[(128)] \textit{Id.} at 575-76.
\item[(129)] \textit{Id.} at 577.
\item[(130)] \textit{Id.} at 580 (describing that it is likely that the restraint will be efficient if a vertical restraint is followed by a subsequent increase in output).
\item[(131)] \textit{Id.} at 581 (explaining that an increase in the number of goods of differing price and quality is a likely indicator of procompetitive effects of a restraint).
\item[(132)] \textit{Id.}
\item[(133)] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST (1994) (addressing nine areas of antitrust enforcement policy regarding mergers and various joint activities in the health care area).
\item[(134)] \textit{Id.} at 101.
\item[(135)] \textit{Id.} at 97. Although these factors are discussed in relation to horizontal restraints, the text describing vertical restraints states that the factors to be considered are largely the same. \textit{Id.} at 101.
\item[(136)] \textit{Id.} at 99-100. Some of these factors are refinements for the health care industry of earlier guidelines proposed by the DOJ and the NAAG. For instance, earlier guidelines included considerations of the rigidity of the restraint, the duration of the restraint, the minimum efficient scale of operations, and the intent of management. \textit{See supra} text accompanying notes 118-32.
\end{enumerate}
\end{footnotesize}
rivals caused by an exclusionary vertical relationship in a health care network, they warrant special attention by adjudicative bodies.

IV. INFERRING INJURY TO CONSUMERS THROUGH THE RAISING OF RIVALS' COSTS IN THE HEALTH CARE SETTING

When examining cases where there is a danger that an HMO has raised its rivals' costs through imposing an exclusionary restraint on its providers, courts should not simply accept the U.S. Healthcare and Marshfield courts' findings in this area. Although these courts only had access to the limited information presented to them in the lower courts' records, there is a vast array of information about the present state of the health care industry that can illustrate fully the possibility of anticompetitive effects arising from exclusionary behavior within a given market. Before an HMO successfully can impose an exclusionary restraint that raises rivals' costs, the market must satisfy all the necessary conditions: i) consumers must be willing to enroll in the HMO that is imposing the exclusionary restraint despite its supracompetitive pricing; ii) the HMO's actions must raise its rivals' costs as an immediate effect; and, iii) its rivals must not be able to respond to any resulting industry shortage through increased production.137 The common law also has expressed a concern for similar conditions,138 and the DOJ, the NAAG, and the FTC have followed Supreme Court precedent by enumerating various benchmarks that indicate the degree to which these conditions are present.139 Within the health care industry context, researchers have developed many tools that make use of these benchmarks in determining the likelihood of anticompetitive tendencies resulting from exclusionary restraints within a given health care market. Thus, when examining exclusionary restraints imposed on providers by HMOs, lawyers and judges

137. See supra notes 23-26 and accompanying text (discussing the significance of these elements to the economic model of the HMO industry).
138. See supra notes 48, 51, and 58 (discussing various criteria used by courts to determine if an antitrust injury exists).
139. See supra part III.B.
should apprise themselves of such analytical tools available to them in order to better conform to the goals of the antitrust laws.

A. Determining Consumer Demand

Before an HMO can charge supracompetitive prices to take advantage of its enhanced position relative to its competitors resulting from its exclusionary restraints, it must be assured that its consumers will not switch to alternative health care financing agents. One can predict the likely consumer reaction to anticompetitive behavior by defining the elasticity of demand. According to the DOJ Guidelines, which follow the common law, the best approach is to examine the product and geographic markets at both levels of the restraint. From this examination, a court can develop a clear picture of how consumers will react to supracompetitive pricing by an anticompetitive HMO imposing an exclusionary restraint on its providers, which helps indicate the likelihood of its success.

1. Product Market Definition

a. The Insurer Market

Though the *U.S. Healthcare* and *Marshfield* courts had insufficient evidence to disprove the existence of cross-elasticity between HMO insurance and traditional FFS insurance, studies indicate that cross-elasticity actually may not exist. When one looks at different studies indicating consumer per-

140. Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406, 1411 (7th Cir. 1995), cert. denied, 116 S. Ct. 1288 (1996) (stating that the trial court record did not provide adequate evidence of a submarket); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 599 (1st Cir. 1993) (claiming that the plaintiff did not argue the point well). *See also supra* note 73 (defining cross-elasticity). In its consideration of the cross-elasticity between these two insurance products, the *U.S. Healthcare* trial court stated that "pointing out the personal preferences of a distinct group of consumers does not suffice for defining a separate product market." *U.S. Healthcare, Inc. v. Healthsource, Inc.*, Civ. No. 91-113-D, 1992 WL 59713, at *6 (D.N.H. Jan. 30, 1992), *aff'd*, 986 F.2d 589 (1st Cir. 1993). The appellate court, however, accepted that preferences as illustrated in customer surveys are one important criterion to consider. *U.S. Healthcare*, 986 F.2d at 599. It also suggested looking at patterns of usage, feature differences, and profits to get at the actual degree of cross-elasticity. *Id*. This view also accords with the DOJ Vertical Restraints Guidelines, which look at buyer and seller perceptions and behavior. *See supra* text accompanying note 107.
ceptions and consumption patterns, there is only minimal evi-
dence of cross-elasticity.

Even if the cost is a perceived difference between HMOs and FFS plans, it is certainly not the only one. In *U.S. Healthcare*, the court described the difference between HMOs and traditional FFS insurance as a tradeoff between price and choice of doctor.\textsuperscript{141} Thus, if consumers found the restriction of the choice of doctor to be valued at roughly the difference in the price of the plans, then they would be cross-elastic. In other words, the HMO could not succeed in raising prices significantly above market price because the elastic demand would mean it would quickly lose market share to FFS insurers. However, one study points out that seventy-five percent of consumers value guaranteed health insurance coverage more than choice of physician.\textsuperscript{142} Since HMOs often provide guaranteed coverage for a large number of services,\textsuperscript{143} it seems likely that this significant segment of the population would value an HMO policy more than a FFS policy, based solely on their differing characteristics, and not on price.\textsuperscript{144} Hence, for this group, HMO financing is not merely an inferior good.

Guaranteed health insurance coverage for a wide range of services is not the only feature that compensates enrollees for foregoing choice of doctor. One study has shown that other services typically important to those who choose HMOs include better preventive care coverage, reduced paperwork, and shorter waiting times in doctors’ offices.\textsuperscript{145} Another study has indicated that HMO consumers also base their decisions on characteristics like twenty-four hour accessibility of providers

\textsuperscript{141} 986 F.2d at 599.

\textsuperscript{142} Consumer Poll: Guaranteed Coverage Outweighs MD Choice, HOSPITALS, Mar. 20, 1994, at 106.

\textsuperscript{143} Berman & Rose, supra note 7, at 64.

\textsuperscript{144} Although guaranteed coverage arguably is related to cost, the HMO also is relieving the consumer of the burden of planning a budget around expected future costs for uncovered procedures. The HMO also removes the consumer’s fear of undergoing a treatment only to discover ex post that it is not covered. Thus there is an emotional benefit here as well as a financial one.

\textsuperscript{145} See Goutam Chakraborty et al., How Consumers Choose Health Insurance, J. HEALTH CARE MARKETING, Spring 1994, at 21, 31 (discussing the features of a health plan important to subjects in one study who did not choose the BC/BS type of FFS insurance from among several different kinds of plans).
and concentration of family practitioners and specialists in the same location. Thus, consumers perceive HMOs and FFS insurance as highly differentiated services.

Behavior patterns also indicate that consumers treat HMO insurance differently from FFS insurance. Since employers are the entities presently most responsible for private insurance coverage, an examination of consumption patterns in the employment environment can illustrate one area where an anti-trust injury could have significant ramifications. Ostensibly, once an employer offers an HMO plan, a certain percentage of employees immediately signs up and continues coverage through the HMO over the course of time. This group of employees does not seem to react to relative changes in price. This lack of cross-elasticity is most clearly evidenced

146. S.E. Berki & Marie L.F. Ashcraft, HMO Enrollment: Who Joins What and Why: A Review of the Literature, 58 MILBANK MEMORIAL FUND Q., HEALTH AND SOCI’Y 588, 620-23 (1980). These characteristics seemingly have evolved to satisfy the needs of a certain type of clientele. An emphasis on preventive care instead of intensive care would appeal more to healthier, and thus to some degree, younger people. With less paperwork, shorter waiting times, and easier access to all of one’s doctors at the same location, HMOs are designed to be convenient. These services have a strong appeal to highly productive people with large opportunity costs. This might hold true more for younger people who are fully employed as opposed to older people who have either retired or entered into semi-retirement. This profile of the healthy, young enrollee is borne out by studies of different enrollee populations. Paul A. Pautler & Michael G. Vita, Hospital Market Structure, Hospital Competition, and Consumer Welfare: What Can the Evidence Tell Us?, 10 J. CONTEMP. HEALTH L. & POL’Y 117, 160 (1994) (comparing health of fee-for-service and HMO populations). For young, mobile people who lack a standing patient-physician relationship because they have recently relocated, lack of a choice of a doctor also will be a less significant factor in the decision-making process. See Berki & Ashcraft, supra note 146, at 622 (indicating studies that show an inverse relationship between length of residence in a community and duration of employment with likelihood of joining an HMO).

147. As pointed out supra notes 2-4 and accompanying text, employer coverage is declining. However, it still accounts for the bulk of insurance coverage for the American populace.

148. See Maureen Cameron, Indemnity Plans Costs Rise While Managed Care Prices Moderate, BUS. & HEALTH, Apr., 1993, at 22 (stating that the growth in managed care enrollment results more from increasing numbers of employers offering these plans than to increasing numbers of enrollees in established managed care plans).

149. Id. at 24. By way of illustration, Cameron points to 1992 statistics. In that year, FFS insurance prices increased six percent more than HMO prices increased (14.2% for FFS insurance and 8.8% for HMO insurance), but HMO enrollment grew only two percent (from 33% to 35%). Id. In the same year, the growth in the percentage of employers who offered HMO insurance plans also was two percent (from 61% to 63%). Id. at 24. Though these figures seem to indicate a distinct consumer preference for HMOs for certain people, there is room for distortion here. In some cases, the behavior patterns do not indicate a choice. Even as recently as 1984, only one-fifth of all employees had at least two choices of health care plans. Richard G. Frank & W.P. Welch, The Competitive Effects of HMOs: A Review of the Evidence, 22 INQUIRY 148, 149 (1985). Hence one must look at behavior patterns for individual markets in any specific case to determine actual behavior patterns within the employment environment in question.
by the fact that many employers have destroyed incentives for their employees to consider price by subsidizing expensive plans to the point that all plans become equally priced.\textsuperscript{150} Thus, employees in this situation choose a plan only along nonprice lines.\textsuperscript{151} Since a distinct group gravitates toward HMOs even when there is no difference in price, it is clear that there is no cross-elasticity for these people.\textsuperscript{152} Absent consumer sensitivity to the price of FFS insurance, an HMO can raise its prices easily and profitably if it has blocked other HMOs from competing in the area. Thus, courts should not include FFS insurance in the relevant product market.

Yet, despite its seeming irrelevance in the choice of a health care financing product, price is a factor for some people in some situations. If price were no consideration, HMO enrollees and FFS plan enrollees would switch freely between plans until they found the plan whose characteristics were the most satisfactory. In other words, they would act as if the prices were exactly the same and thus only the suitability of certain plan features would be important. Yet research in the area of consumer satisfaction is mixed. According to one review, the majority of studies conducted to date indicate that HMO enrollees are not as satisfied with their perceived quality of care or their patient-physician interactions as are enrollees of FFS insurance plans.\textsuperscript{153} Although the majority of the studies showed a lack of satisfaction, several studies showed that


\textsuperscript{151} Enthoven speculates that this pattern is likely to continue because the tax system favors it through its preferential treatment of benefits, and union leaders have always argued for full benefits as an important issue. \textit{Id.} Enthoven also explains that this insurance system allows HMOs to raise their prices to approximate FFS plan prices and thereby extract economic rents from their consumers. \textit{Id.} at 370. He suggests that managed care organizations should stay divided into competing economic units as one way to avoid this problem. \textit{Id.} at 372.

\textsuperscript{152} Two products are cross-elastic only if a slight increase in the competitive price of one leads to an increase in consumption of the other. \textit{Supra note} 73. In other words, each good is considered to offer equal value for its competitive price from the perspective of the consumer. Since the costs of FFS insurance are higher than HMO insurance, a competitive market would always cause FFS insurance to be priced higher than HMO insurance. If the higher price reflects higher value to consumers, they would always choose FFS insurance when it is equally priced with HMO insurance. Since some consumers prefer HMO insurance even when they are equally priced, for them there is little cross-elasticity between these products.

HMO enrollees were highly satisfied with their plans.\textsuperscript{154} Moreover, in all the studies reviewed, HMO enrollees were more satisfied with the financial aspects of their plan than indemnity plan enrollees.\textsuperscript{155} From these data, one can see that there is some trade-off between satisfaction with quality and satisfaction with price which would cause some people to switch to FFS insurance if the price of HMO insurance increased. Yet the present price level already might reflect anticompetitive pricing if the HMO has no competitors that can force it to set its prices competitively.\textsuperscript{156} Even when there are consumers whose dissatisfaction would lead them to switch to FFS insurance when their HMO premium increases slightly, they probably do not account for a large percentage of the consumer market. Other consumers who are mostly satisfied with the quality of their health care will exhibit greater resistance towards switching insurance, depending upon their degree of dissatisfaction with HMO services and with the perceived value of FFS insurance. Since many consumers are not ready to switch when HMO premiums rise slightly, cross-elasticity between these products is far from perfect even where consumers consider these forms of health care financing as substitutes for each other.

When price is an overriding consideration, it is still unlikely to result in perfect cross-elasticity because of imperfect information regarding the actual prices of the different plans.\textsuperscript{157} Thus, cross-elasticity would have to be determined

\begin{itemize}
  \item\textsuperscript{154} Id. In five studies, seven of eight observations showed enrollee dissatisfaction with HMOs relative to FFS enrollees, but in four studies, four of five observations showed high satisfaction with HMOs. Id. Thus in contrast to the \textit{Marshfield} court's assertions, quite a few people are so satisfied with their plans that they probably are not concerned with the incentives to reduce care. \textit{Blue Cross & Blue Shield v. Marshfield Clinic}, 65 F.3d 1406, 1410 (7th Cir. 1995), \textit{cert. denied}, 116 S. Ct. 1288 (1996).
  \item\textsuperscript{155} Miller & Luft, \textit{supra} note 153. \textit{See also} Chakraborty, \textit{supra} note 145, at 31 (stating that premiums are one of several important aspects in the decision-making process of non-BC/BS enrollees). In one study, HMO enrollment increased proportionately to the increase in the cost of FFS insurance when both types of policies were offered by the employer without any subsidies. \textit{Frank & Welch}, \textit{supra} note 149, at 155. Yet this study might not have been based on a typical HMO with all of its unique characteristics. Despite its limitations, this study illustrates that price is definitely a factor to some degree for some employees who bear some of the financial risk for their choice.
  \item\textsuperscript{156} \textit{See supra} note 73 (stating that even if consumers would switch to a substitute when the price of a product rises, this fact does not refute market power because the firm already could be charging supracompetitive prices).
  \item\textsuperscript{157} In determining the expected price of different plans, an enrollee will base his price
\end{itemize}
by perceived price. Even though there are enrollees for whom enrollment is highly price elastic, there likely will be enough enrollees for whom price is neither a major consideration nor accurately determinable, that the HMO has an opportunity to extract economic rents by raising its prices to an above optimal level if its only major competitor is a FFS insurance plan. Thus, FFS insurance plans should not be considered part of the same market when determining the likely consumer reaction to the supracompetitive pricing of an HMO that has successfully driven up the costs of its rivals through the imposition of an exclusionary restraint.

b. The Provider Market

Once the financing product market is defined, the delivery market, the second market affected by the vertical restraint, must be clearly delineated. To raise rivals' costs, an HMO must have exclusive rights over the range of inputs that consumers consider to be a vital part of a functional HMO. Since health care consumers do not pay for services individually, they will not look at services on a treatment-by-treatment basis. For example, they are not likely to choose one plan because of its participating hospital's reputation for appendectomies. Rather, they will look at more global characteristics, such as the reputation of its family doctors, the likelihood that its specialists work with the latest high-tech equipment, and the prestige of the facilities offering the most sophisticated services within the HMO. These are salient characteristics that might become selling points of one HMO as opposed to another. These important distinctions among the plans can be broken evaluations on out-of-pocket expenses for his premium as well as for his copayment and deductible for any medical services he expects to use during his enrollment period. Berki & Ashcraft, supra note 146, at 617. Because an individual might not understand the mechanics of different plans due to imperfect information of the plan features, an insurer can adjust the premium, copayment, and deductibles to hide costs from consumers and thus remove any cross-elasticity based on actual price. See AREEDA & KAPLOW, supra note 73, at 12 (mentioning the imperfect knowledge of buyers as one cause of market distortion). Further, many people are risk averse and thus will overweight the expected costs of copayments and deductibles above their statistical probability.

158. See Jack Zwanziger et al., Hospitals and Antitrust: Defining Markets, Setting Standards, 19 J. HEALTH POL., POL'Y & L. 423, 431 (1994) (claiming that HMOs and PPOs compete along overall level of price, rather than along the price of individual procedures).
down into categories. The perceived quality of an HMO will depend upon the separate credentials of its primary, secondary, and tertiary care centers. Since an HMO restricts its enrollees from seeking medical treatment outside of its provider network, it must offer all three levels of care to attract an adequate client base. The courts must examine each of these product markets separately to determine if rival HMOs have access to enough substitute sources of care to attract enrollees if the anticompetitive HMO increases its prices.

2. Geographic Market Definition

a. The HMO Market

Although there are several nationwide HMOs, any one branch will face competition only in a limited region. Unlike the U.S. Healthcare district court’s finding that the appropriate market should be the whole state of New Hampshire, consumer perceptions and behavior patterns indicate that competition exists only between HMOs whose provider networks are situated in the same narrowly defined geographic area. Since people will not enroll in an HMO if it is inconveniently located, there is no basis for a perception of statewide interchangeability. The perception that only local HMOs are good substitutes for each other manifests itself in consumer behavior. People tend not to go very far to receive the bulk of their health care. An HMO must offer treatment by physicians and hospitals near the consumers it is targeting before it will be successful. An HMO’s geographic market should be defined narrowly when hypothesizing about consumer reactions to supracompetitive pricing to best reflect these perceptions and

159. Id. DRGs encompass all procedures at all levels of care, and thus an examination of groups of DRGs could serve to illustrate consumer consumption of health care services falling into different levels of care. Yet the Marshfield court did not accept their application to product market definition. Marshfield, 65 F.3d at 1411.

160. U.S. Healthcare, Inc. v. Healthsource, Inc., Civ. No. 91-113-D, 1992 WL 59713, at *5 (D.N.H. Jan. 30, 1992), aff'd, 986 F.2d 589 (1st Cir. 1993) (basing its finding on the areas in which the HMOs were recruiting and marketing). When considering the relevant market in its examination of the § 2 violation, the appellate court opted not to question the geographic market because the product market, when defined as all health care financing, was already too large ever to allow monopoly rents. U.S. Healthcare, 986 F.2d at 599.


162. See infra part IV.A.2.b.
behavior patterns.

b. The Provider Market

Since an HMO's geographic market so closely approximates the provider geographic market, the antitrust analyst needs only to study consumer perceptions and behavior in relation to the provider geographic market to determine the range in which an HMO can perpetrate an antitrust injury through raising rivals' costs. Within the provider market, there are different geographic ranges for primary, secondary, and tertiary care. Though consumers might not perceive a local hospital as a reasonable alternative for a distant teaching hospital for tertiary care, they usually will prefer a local hospital for primary or secondary care. When examining behavior, a researcher can benefit from investigatory tools like the Elzinga-Hogarty test. After looking at the data, one can see that there is a correlation between the degree of specialization re-

163. The courts differ on this point. In United States v. Carlilion Health Sys., 707 F. Supp. 840 (W.D. Va. 1989), aff'd, 892 F.2d 1042 (4th Cir. 1989), the court allowed a much vaster market for the defendants' tertiary services than for their primary and secondary services. Id. at 847-48. However, the Rockford Memorial court refused to find that competition between tertiary centers justified distinguishing a separate geographic market. United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1276 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir. 1990), cert. denied, 498 U.S. 920 (1990).


165. The Elzinga-Hogarty test (E-H test) actually consists of an examination of both the "little in from the outside" (LIFO) aspect as well as the "little out from the inside" (LOFI) aspect. The researcher uses these measurements to define a region in which a chosen percentage of the output purchased by customers in the area comes from local producers (LIFO) and in which the same percentage of shipments from firms within the market is to customers within the area (LOFI). Michael A. Morrisey et al., Defining Geographical Markets for Hospital Care, 51 Law & Contemp. Probs. 165, 168-69 (1988). This test is commonly used within the health care litigation context. For example, the FTC used it in In re American Medical International, Inc., 104 F.T.C. 1, 195-96 (1984), and in In re Hospital Corp. of Am., 106 F.T.C. 361, 438 (1985). However, the agency clarified that the test results need to be qualified by adding hospitals that might be used as substitutes when prices rise even if present patient flow patterns do not indicate their use. Id. at 472. The test also was used in United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1267 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir. 1990), cert. denied, 498 U.S. 920 (1990). More recently, the district court in Marshfield admitted E-H results for consideration by the jury in examining the foreclosure of provider services through the clinic's exclusionary restraints. Marshfield, 883 F. Supp. at 1256. The circuit court, however, disapproved of the breakdown of health care services and their concomitant markets along DRG lines. Marshfield, 65 F.3d at 1411.
quired to treat an illness and the distance patients travel to receive care.\textsuperscript{166} For general care, which constitutes the bulk of patient visits, patients are not willing to travel very far.\textsuperscript{167} Because the geographic range of substitutes acceptable to consumers does not extend very far, an HMO could raise its prices without fear of losing its enrollees to rivals by entering into exclusionary agreements that limit rivals' access to primary care providers in a confined region. Similarly, such arguments could be made with secondary or tertiary care providers although in a somewhat broader region.

B. Evaluating the Degree to Which the Exclusionary Restraint Raises Rivals' Costs

Once a court has delineated the range of reasonable substitutes for the consumers in both markets, it must determine the degree to which the anticompetitive HMO's exclusionary conduct imposes costs on its rivals through foreclosure of these markets. Concentration in both markets plays a major role in determining the degree of foreclosure.\textsuperscript{168} However, other as

\textsuperscript{166} Zwanziger et al., supra note 158, at 432. See also Marjorie A. McGuirk & Frank W. Porell, \textit{Spatial Patterns of Hospital Utilization: The Impact of Distance and Time}, 21 INQUIRY 84, 93 (1984) (qualifying the importance of distance by claiming that consumers actually are most reactive to travel time). Though generally there is a correlation between the intensity of care and the distance a consumer is willing to travel to receive it, a subset of the consumer market considers the cost of traveling to providers less important than the value of receiving the best care possible, irrespective of the level of intensity. Thus Morrisey et al. found that some patients traveled long distances even after they excluded those traveling to receive treatment for complex diseases. Morrisey et al., supra note 165, at 189. Yet this group did not account for the bulk of consumers. When setting the E-H test at 75\%, they found that the average market area was 2.5 counties for the area under investigation. \textit{Id.} at 183. However this market expanded more than twofold to six counties when the test was set at 90\%. \textit{Id.} at 181. Since an antitrust injury can occur even if only 75\% of a given market is not willing to travel far to receive health care, it makes more sense not to expand the market too far just for the sake of accuracy. Rather, a realistic approach that accounts for outliers will more effectively define a market for antitrust purposes.

\textsuperscript{167} See Zwanziger et al., supra note 158, at 432. Even though hospitals are not as easily accessible in rural areas, consumers will not travel very far to get primary health care. Thus the county is already too large a measure of the appropriate market based upon behavior. See generally Brigid Goody, \textit{Defining Rural Hospital Markets}, 28 HEALTH SERV. RES. 183 (1993) (describing recent trends in analyzing the rural hospital market by using geographic and socio-economic-demographic factors). One researcher points out that this preference for local providers for primary care is usually a reasonable choice for most people. Because friends and family are less likely to go long distances to pay visits to patients, choosing a nearby provider will mean more emotional support during periods of hospitalization. Morrisey et al., supra note 165, at 170. Likewise, for routine exams, opportunity costs are lower if the doctor is nearby because of the lesser travel time.

\textsuperscript{168} Concentration also indicates market power, which is an element of a Sherman § 1 cause
pects of an HMO's conduct might either mitigate or reinforce the anticompetitive effects of its restraint. These factors also merit consideration by the courts.

1. Dangerous Concentration

a. The HMO Market

Concentration within a market, which was considered the threshold issue in the DOJ Guidelines, plays a significant role in evaluating the tendency towards anticompetitive effects. A high VRI in the HMO financing market indicates that relatively few HMOs employ vertical restraints, but that they constitute a large share of the consumer market. Under these circumstances, the HMOs easily can raise their prices above competitive levels and rely on others to do the same. By imposing exclusionary restraints in concert with each other, even a group of small HMOs can raise the costs of other competitors who become unable to contract with a sufficient number of providers to run efficiently. Conversely, an unconcentrated HMO financing market is ideal because the HMO lacks sufficient bargaining power to impose any significant exclusionary restraints upon providers. Therefore, no individual HMO can raise competitors' costs by preventing access to key inputs. Moreover, each HMO must compete actively against rival HMOs for consumers by keeping its prices down. In this kind of market, the HMO faces competition in both the provider and consumer market, which leads to an efficient industry. Hence, HMO market concentration is one indicator of the likelihood of the success of exclusionary restraints in raising rivals' costs.

of action. See supra note 63 (enumerating the elements of this cause of action). See infra notes 320, 326 (discussing the way courts interpret the relation between market share and monopoly power).

169. See supra note 115 and accompanying text (defining the VRI).

170. See AREEDA & KAPLOW, supra note 73, at 276 (discussing the interdependence engendered by oligopolistic markets).

171. Id.

172. This is only true if competition among HMOs actually results in lower prices. There is some evidence that HMO competition leads to competitive pricing. See Stuart Gannes, Strong Medicine for Health Bills, FORTUNE, Apr. 13, 1987, at 70 (reporting that both Chicago and Miami Beach employers experienced lower health care premiums as a result of increased HMO competition).
b. The Provider Market

High concentration within the provider market is another factor that facilitates the success of an HMO's exclusionary restraint in raising its rivals' costs. The concentration of the provider market, as measured by its VRI, indicates the strength of the firms in it relative to firms in linked markets. Increased provider bargaining power is one source of increased costs for rival HMOs trying to enter the market.173 Thus, there is a question as to how low concentration must be to allow bargaining between providers and insurers that will bring the price of health care to its optimal level. This question is still largely an epistemological one because health care providers have not fit the profile of a competitive industry until recently. Concentration has had no meaning in this setting. When FFS insurance was the only major form of health care financing available, financing agents did not require hospitals or doctors to compete along price lines. They simply passed all costs back to the consumer in the form of higher premiums.174 Without any incentive to contain costs, providers competed for patients along non-price lines.175 In this environment, lower concentration actually meant higher prices.176 With the diffusion of prospective payment and capitation, however, providers are competing

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173. The DOJ Vertical Restraint Guidelines consider only the sum of the squares of the market shares of the firms involved in some kind of vertical restraint. See supra note 115 (defining the VRI). Yet it seems more appropriate to consider the market shares of all the firms in the market when considering the degree to which rivals' costs will be affected. Since the providers not under the restraint will be dealing with a potential entrant into the HMO market, one can infer their bargaining strength by considering the power of all the providers within the market. Adding up the squares of the market shares of all the provider groups, the concentration figure accounts for both the size and number of the provider groups, which in combination creates their power. If the market is dominated by a few providers, they will tend to demand supracompetitive pricing because they know that there are few other choices of providers with whom an HMO can negotiate. This consideration of all the firms within a market resembles the recommended procedure for examining horizontal mergers as announced by the DOJ in its 1992 Horizontal Merger Guidelines, 57 Fed. Reg. 41,552, 41,557 (1992) (proposed Sept. 10, 1992) (describing how to calculate market shares). Within the horizontal restraint context, the measure of concentration is called the Herfindahl-Hirschman Index (HHI), which consists of the sum of the squares of the market shares of all the firms in a market. Id.


175. See Xuan Nguyen Nguyen & Frederick W. Derrick, Hospital Markets and Competition: Implications for Antitrust Policy, HEALTH CARE MGMT. REV., Winter 1994, at 34 (discussing a study which reflects that hospitals in competitive environments have utilized more labor and capital and have had more services than hospitals in non-competitive environments).

176. Id.
along price as well as quality lines.\textsuperscript{177} Since HMO payment mechanisms have helped create this price competition, concentration becomes a meaningful indicator of the ease with which HMOs effectively can keep provider prices down. Even if one HMO is competing with another HMO that has imposed exclusionary restraints upon a group of providers, low concentration in the provider market might signify that rival HMOs still will not experience increased costs.

Nonetheless, the exact effect concentration has on price is still unclear. The studies vary greatly. While one study claimed that there must be at least twenty-four hospitals in an area before there are competitive effects,\textsuperscript{178} another found a difference in competitiveness with only ten hospitals in an area.\textsuperscript{179} Yet another study found that only three hospitals are necessary before some competition exists.\textsuperscript{180} Though these studies cre-

\textsuperscript{177} See Pautler & Vita, supra note 146, at 140 & n.95 (summarizing several recent studies that employed defensible methodologies in researching the connection between price and concentration within the hospital industry).

\textsuperscript{178} James C. Robinson, \textit{HMO Market Penetration and Hospital Cost Inflation in California}, 266 JAMA 2719, 2722 (1991). This study looked at the degree to which lower hospital costs correlate with HMO market penetration to determine if HMOs have had a competitive effect on cost containment. \textit{Id.} at 2719. The product market consisted of various broadly defined services that do not relate directly to primary, secondary, and tertiary care services. \textit{Id.} at 2719. The geographic market consisted of all hospitals within a 24 kilometer radius of the one under investigation, regardless of patient perceptions and behavior patterns. \textit{Id.} All of the hospitals under investigation in the study were in California. \textit{Id.} at 2719. Only with high HMO market penetration and a hospital market with at least 24 neighboring competitors did the study reveal any significant decreasing effect on price. \textit{Id.} If one were to assume that each of these hospitals had an equal share of the market, then the HHI would be $24(4.2)^2 = 201.6$, which is a very low market concentration.

\textsuperscript{179} James C. Robinson & Harold S. Luft, \textit{Competition, Regulation, and Hospital Costs, 1982 to 1986}, 260 JAMA 2676, 2679 (1988) (as evidenced by the data displayed in Table 1). Trying to determine the effect of different regulatory policies on hospital costs, these researchers used data on 5490 hospitals nationwide with no differentiation between different financing mechanisms. Further, there was no differentiation as to the intensity of care provided. \textit{Id.} at 2676. Hospital markets were determined to be those that fell within a 24 kilometer radius of the one under investigation, regardless of patient perceptions and behavior patterns. \textit{Id.} at 2677. The researchers then compared the data on a state-by-state basis simultaneously to examine the effects of different regulatory policies and of market concentration on the increase in costs. \textit{Id.} at 2678-79. Consistently, inflation rates were lower in markets with more than 10 competitors. \textit{Id.} at 2679. If all of the hospitals are assumed to have equal market share, the HHI for this market would be $10(10)^2 = 1000$.

\textsuperscript{180} Glenn A. Melnick et al., \textit{The Effects of Market Structure and Bargaining Position on Hospital Prices}, 11 J. HEALTH ECON. 217, 229 (1992) (finding that a merger of two hospitals in a market of three hospitals of equal market share would raise prices by nine percent). This study set out to find the effects of competition among hospitals on the prices hospitals charge PPOs. \textit{Id.} at 217-18. The researchers based their findings on prices paid by Blue Cross PPO networks to California hospitals. \textit{Id.} at 222. They did not differentiate according to the intensity of care
avage some understanding of the increasingly competitive nature of the provider market, none of them resolve the question of what degree of competition is necessary to avoid excessive bargaining power by providers who remain free of restraints when an HMO imposes an exclusionary contract upon other providers in the market.

In an ideal setting, researchers would examine the effect on price as opposed to cost. They would base their findings exclusively on the prices that hospitals charge third party payors who demand competitive pricing. Moreover, they would study primary, secondary, and tertiary care separately because each reacts differently to concentration. To best reflect realistic market dynamics, they also would use a geographic market based on consumer perceptions and behavior patterns. Once the provider market has been properly delineated, researchers could determine the threshold market concentration that would promote competition within each level of intensity of care. The courts then could use this threshold as a benchmark for analyzing a market in a specific case.181 Until such a threshold has been discovered, the courts should scrutinize carefully any

181. Even if researchers discover the ideal number of competitors, the courts must accept that the maximum amount of competition possible within some markets will be less than this ideal number. This maximum number of sustainable competitors can be evaluated by first looking at ordinary utilization patterns in communities that are the same size as the one under investigation. After calculating how many manhours of service and hospital days would be needed to fulfill the community’s needs, a researcher can account for a reasonable level of capacity. From this figure, the researcher can infer how many providers are needed to take care of a community. This can be done separately for providers at each level of intensity of care. Then the researcher can determine how many providers and facilities need to join together to generate economies of scale. After calculating this figure, the researcher can divide the total number of providers needed by the minimum number needed to achieve economies and derive the maximum number of independent provider networks sustainable within a community. See Carl J. Schramm & Steven C. Renn, Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index, 33 EMORY L.J. 869, 883-86 (1984) (using this method to illustrate the high concentration resulting from ideal capacity in a small market). It is likely that researchers will find that the maximum number of provider networks still is insufficient to generate ideal competition in many small communities which require few hospitals and doctors to handle all the community needs. See id. at 874 (pointing out that consolidation in 80% of all hospital markets would likely be challenged under traditional HHI concentration standards because their premerger concentrations are already very high).
concentration to determine what effect it may have on an HMO trying to enter into agreements with providers.

Consistent with the reasoning of the DOJ Guidelines, lawyers and judges also should examine the coverage ratio of the provider market to determine the likelihood of success in imposing costs on rivals through exclusionary restraints on providers. This measure is useful in demonstrating the degree to which there are free agents left to bargain with HMOs that are not implementing exclusionary restraints. If the providers under a vertical restraint account for too great a share of the market, then the other providers will charge rival HMOs higher rates. This results from the scarcity of supply created by the agreement which allows the other providers' prices to rise. When a vertical restraint is employed in a market that is already heavily concentrated, the providers outside of the restraint have two sources of bargaining power to give them leverage over rival HMOs seeking to enter the market: they benefit both from the artificial scarcity created by the foreclosure of resources tied up in the exclusionary contract and from the enhanced bargaining power of a highly concentrated market. In this scenario, an exclusionary restraint has a dangerous probability of creating anticompetitive effects.

2. The Length of the Term of the Agreement

Once the anticompetitive HMO forecloses a significant portion of the market, it can strengthen its advantage by demanding that the providers adhere to the agreement for a lengthy period of time. The policies established by both the DOJ and the FTC entail examination of the length of the agreement. If an HMO succeeds in obtaining an exclusionary right over the services of a group of providers for several years, it is much worse than obtaining an exclusionary right for only a few months. In *U.S. Healthcare*, the court concluded that the thirty day notice period required for termi-

182. *See supra* note 116 and accompanying text (defining the coverage ratio).
183. Krattenmaker & Salop refer to this combination of a vertical restraint leading to foreclosure of a segment of the supply market with oligopolistic power for the remaining sellers as 'Frankenstein's Monster.' Krattenmaker & Salop, *supra* note 22, at 240-41.
184. *See supra* notes text accompanying notes 122 and 136.
nating the contract had a de minimis effect on competition.\textsuperscript{185} Yet there are cases in the industry where problems have arisen because of substantially longer contracts in which the providers have offered exclusivity to the HMO.\textsuperscript{186} Hence, the temporal characteristics of an agreement play an important role in determining the ability of the exclusionary relationship to raise rivals’ costs.

3. Rigidity of the Restraint

Similar to the length of an agreement, the rigidity with which the exclusionary agreement denies rival HMOs access to providers can significantly affect their degree of foreclosure. The NAAG, DOJ, and FTC consider rigidity of agreements in their interpretation of anticompetitive effects.\textsuperscript{187} Since the defendants in \textit{U.S. Healthcare} entered into an agreement in which they merely had the option of receiving a higher rate of capitation for their services in exchange for exclusivity, the court properly might have concluded that there was no Sherman section 1 violation, absent other evidence of blocked access to providers.\textsuperscript{188} The HMO could have fortified the exclusionary restraint with a stronger clause that entailed a refusal to deal with any provider that offered its services to another HMO. This would have been total foreclosure and a clearer violation of antitrust laws.

4. The Amount of Pressure the Dealer Places on the Supplier

If an HMO is especially aggressive in demanding an exclusionary right over a group of providers, its conduct might indicate that the primary purpose of the relationship is the attainment of a competitive advantage rather than increasing efficiencies through integration. This potential to demonstrate

\textsuperscript{185} U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 596 (1st Cir. 1993). See also Reazin v. Blue Cross & Blue Shield, 663 F. Supp. 1360, 1481 (D. Kan. 1987), aff'd in part and remanded in part, 899 F.2d 951 (10th Cir. 1990), cert. denied, 497 U.S. 1005 (1990) (stating that an agreement between an HMO and a hospital which could be terminated at will posed no antitrust barrier).

\textsuperscript{186} See, e.g., Johnsson, supra note 27, at 23 (discussing PruCare’s five-year exclusive contract with Austin Regional Clinic and the related problems).

\textsuperscript{187} See supra text accompanying notes 129 and 136.

\textsuperscript{188} 986 F.2d at 593-94.
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intent has prompted the NAAG to state that it will examine the degree to which the supplier has been pressured into entering the restraint. When an HMO succeeds in obtaining an exclusionary right over a group of providers by inflicting heavy pressure upon them, a court should strictly scrutinize the ability of the agreement to impose costs on rivals.

5. Intent of Management

A clear statement of an intention to raise its rivals' costs similarly would increase the probability that anticompetitive effects would follow from an exclusionary agreement. The DOJ Guidelines suggest considering this factor. If an HMO expresses a wish to see its competitors go out of business, it likely will use other hostile actions in addition to exclusionary contracts to reach its goals. Likewise, an express intent to create efficiencies might mean that the HMO simply wants to lower its production costs through vertical integration. Courts might choose to give this factor significant weight in determining the likelihood of anticompetitive effects because of its ability to indicate the long-term effects of an exclusionary restraint.

6. Size of Firms

Even if an HMO has exacted an exclusionary right over providers that could raise rivals' costs, its size might indicate that it is incapable of causing any significant anticompetitive effects within the industry. The DOJ Guidelines suggest taking size into account. If a new HMO is small, it may need to enter into an exclusionary agreement with providers to establish immediate goodwill. Since the addition of a new com-

189. See supra text accompanying note 128.
190. See supra text accompanying note 124.
192. See supra notes 27-30 and accompanying text (discussing the production efficiencies that can come out of this kind of vertical relationship).
193. See supra text accompanying note 125.
194. Cf. infra note 201 and accompanying text (discussing the importance of goodwill within the context of setting up physician practices).
petitor into the market will have procompetitive effects, the courts might find that exclusionary contracts in these circumstances do not impose costs on rivals sufficient to offend the antitrust laws.

7. Nature of Purchasers

Similar to the inability of small HMOs to impose costs on rivals, an HMO whose power is checked by large consumers might argue that it is incapable of creating anticompetitive effects within the market. When the consumer market consists mostly of large employers who can purchase en masse, they probably have enough influence to counterbalance the power of the HMOs. They can bypass completely the HMO and negotiate directly with the providers if they believe that the HMO is charging more than an optimal rate for its coverage. Yet size alone is not enough. These large purchasing units must display a desire to get the best buy in health care despite the tendency towards inertia in changing insurance plans. Without this drive for the optimal price, a large company will not benefit from its size. Thus the DOJ and FTC Principles take into account the ability and the willingness of employers to change networks. If the consumer market is filled with large, price-sensitive purchasing units, the HMO might be imposing the restraints to achieve efficiencies that will better serve its demanding customers. Because of this potential to exculpate exclusionary conduct that otherwise raises rivals' costs, courts need to determine what role the purchasers play in the HMO decision-making process.

195. See infra part VIII (concluding that the evolution of payor groups might be one solution to undue insurer power). The integration of several large employers into one buying unit is one of the reasons that health care costs have stayed so low in the Minneapolis-St. Paul region. Leigh Page, Will Too Many Mergers Stifle Competition?, AM. MED. NEWS, July 11, 1994, at 1, 6 (discussing the Business Health Care Action Group, which includes 3M, General Mills, and Pillsbury).

196. Mark V. Pauly, Monopsony Power in Health Insurance: Thinking Straight While Standing on Your Head, 6 J. HEALTH ECON. 73, 80 (1987) [hereinafter Pauly, Monopsony Power] (giving evidence of the "preformed nature" and "persistence in health insurance" that works contrary to purchasing units seeking new plans).

197. See supra note 136 and accompanying text.
C. Determining the Ability of the Industry to Increase Output in Response to Artificial Scarcity

Even if the HMO imposing the exclusionary restraint on its providers succeeds in raising its rivals' costs, this advantage could be mitigated by an increase in the production of HMO services by rivals. The anticompetitive HMO can extract supracompetitive profits from consumers only if its rivals' increased costs and decreased access to providers results in a decrease of HMO services offered to consumers. This decrease in output results in an inflated consumer demand with a concomitant rise in the price of HMO services. However, if the market structure facilitates easy replacement of the foreclosed resources, the HMO would realize only transient success in its exclusionary behavior. Under such market conditions, the rival HMOs soon would produce new HMO services and the market would return to equilibrium. Yet, if there are significant barriers to entry, then courts should infer anticompetitive effects and find antitrust liability because the costs imposed on rivals through the exclusionary restraints likely would be significant and chronic.

1. The Degree of Necessary Investment

One important criterion suggested by the DOJ Guidelines for determining the strength of the barriers to entry into a market is the degree of investment in specialized production equipment or training necessary to become a viable competitor. Though the establishment of an HMO business might not require too much capital, startup costs can be prohibitively high for health care providers. Hospitals have extremely high fixed costs. For secondary and tertiary care centers, the fixed cost problem is naturally even greater. Doctors face high costs when entering a market, partly because of the crucial role of goodwill in developing and maintaining a patient base. As

198. See supra note 26 and accompanying text.
199. See supra text accompanying note 120.
200. Mark V. Pauly, Competition in Health Insurance Markets, 51 LAW & CONTEMP. PROBS. 237, 266 (1988) [hereinafter Pauly, Competition] (arguing that the high fixed costs of hospital construction act as a barrier to HMOs' building their own facilities).
201. See AREEDA & KAPLOW, supra note 73, at 22 (describing the promotional costs asso-
the establishment of goodwill for a new practice can take quite some time, that is, if the doctor is not buying another doctor's practice, the new entrant should expect to sustain significant initial losses due to high operating costs that cannot be covered until a sufficient patient base has been established.\textsuperscript{202}

These high financial costs and the lengthy time commitment required to enter the market successfully might deter the entry of many providers as well as HMOs interested in constructing their own facilities and hiring their own doctors.\textsuperscript{203} Thus, if an HMO acquires an exclusionary right over providers' services, it can deprive rival HMOs of resources that will not be regenerated quickly. This need for intensive investment militates against allowing restrictive practices.

2. The Minimum Efficient Scale of Operations

The DOJ and the FTC in their Principles place emphasis on the role of scale economies in a health care market because it is easier to raise rivals' costs by foreclosing part of the supply market when a firm needs to secure a wide range of inputs to perform efficiently.\textsuperscript{204} In the health care context, an HMO must contract with a vast array of providers representing different levels of intensity of care even if the HMO has few enrollees.\textsuperscript{205} If one assumes that at least three HMOs are necessary to encourage competition among the different firms in

\textsuperscript{202} See Anne Feltus, Health Care Climate Compels More Doctors to Join Forces, HOUSTON BUS. J., July 15-21, 1994, at 26 (stating that one out of three physicians nationwide now belongs to a group practice to counteract the effects of high equipment costs and low rates of reimbursements).

\textsuperscript{203} The U.S. Healthcare court did not mention these factors when it stated that doctors are always coming into the market and thus preventing foreclosure of physician services. U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 596 (1st Cir. 1993). The Marshfield court did not seem concerned with these costs when it stated that an HMO's discouraging hospitals over which it exercised influence from entering into contracts with other HMOs did not rise to the level of an antitrust violation. Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406, 1413 (7th Cir. 1995), cert. denied, 116 S. Ct. 1288 (1996).

\textsuperscript{204} See supra notes 123, 136 and accompanying text.

\textsuperscript{205} See supra part IV.A.1.b (discussing that in order for an HMO to increase its client base, it must contract with a number of different types of health care providers).
the HMO industry, then one group of researchers has estimated that at least 1.2 million people must reside in an area before the three plans could be mutually exclusive.\textsuperscript{206} Thus, one could argue that in any region with a population of less than 1.2 million, there is a need to avoid exclusive contracting due to the potential for foreclosure of essential provider services.\textsuperscript{207} These exclusive contracts are especially detrimental for more intensive levels of care, and even exclusionary contracts binding primary care physicians become suspect as the population of the region decreases.\textsuperscript{208} Only after the courts have examined this demographic information can they accurately detect the inability to set up a competing functional HMO within

\textsuperscript{206} Richard Kronick et al., \textit{The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition}, 328 New Eng. J. Med. 148, 150 (1993). Kronick et al., begin by assuming that three competitors would be necessary to prevent oligopolistic collusion. \textit{Id.} at 149. They then develop some idea of what must be included in an HMO package to be inclusive of all necessary services. \textit{Id.} Looking at present utilization patterns in different HMOs, these researchers estimate how many people would have to enroll in the HMO to allow this essential group of providers to work at maximum efficiency. \textit{Id.} at 149-50. After concluding that 1.2 million people would be necessary to support three independent plans, they found that only 42\% of the American population actually live in such regions. \textit{Id.} at 150. The ability to generalize from these findings must be understood within the context in which the data were collected and analyzed. Since utilization patterns were based on staff HMO utilization, providers within a group HMO or IPA HMO might be able to reach maximum efficiency at a lower number of enrollees through their ability to generate revenue from other financing sources. Though this study limitation indicates that 1.2 million people might represent a number larger than necessary to achieve efficiencies, there is another limitation that counterbalances this first limitation. The 1.2 million figure would hold true if every member of the community belonged to an HMO. Thus in an actual community where people are financed through many different sources such as BC/BS or Medicare, the 1.2 million figure would need to be much higher to account for the fact that only a percentage of the population is covered under some type of HMO plan. As the two limitations counterbalance each other, perhaps the figure of 1.2 million is nearly accurate.

\textsuperscript{207} As already discussed, only 42\% of the country lives in an area where three mutually exclusive plans can be supported. Kronick et al., \textit{supra} note 206, at 150. Thus, in 58\% of the health care markets, exclusionary contracts could lead to detrimental foreclosure.

\textsuperscript{208} Kronick et al., found that if there are only 360,000 people in an area, the plans in the region already would have to share some hospital facilities and contract for tertiary services. \textit{Id.} For a region with 180,000 people, the plans would even need to share such specialized services as cardiology and urology. \textit{Id.}

From this study, it becomes apparent that many specialized health care resources are essential facilities for HMOs entering into most markets. Yet the \textit{Marshfield} court declined to apply this doctrine, primarily because of it failed to find an HMO submarket. \textit{Marshfield}, 65 F.3d at 1413. In deciding the issue this way, the circuit court reversed the district court's denial of Marshfield's motion for judgment as a matter of law on this point. 883 F. Supp. at 1255. The lower court, quoting MCI Communications Corp. v. American Tel. & Tel. Co., 708 F.2d 1081, 1132-33 (7th Cir. 1983), \textit{cert. denied}, 104 S. Ct. 234 (1983), stated that the record showed that BC/BS had proved: "(1) control of the essential facility by a monopolist; (2) a competitor's inability practically or reasonably to duplicate the essential facility; (3) the denial of the use of the facility to a competitor; and (4) the feasibility of providing the facility."
a community.

3. Regulatory Environment

Since government regulatory activities can impose formidable barriers to entry, the NAAG states that it will look at the procompetitive and anticompetitive effects of the interaction between a firm's behavior and its regulatory environment. The health care industry is heavily regulated at both the national and state levels. Once regulatory barriers are erected, an HMO imposing exclusionary restraints upon a group of providers can attain long-term supracompetitive profits because of the inability of its competitors to devise creative ways to overcome their increased costs. Since regulations pose such a significant anticompetitive danger, the courts should examine carefully the effects of each.

Certificate of Need (CON) laws have impacted the health care industry in various ways. Used to prevent the development of overcapacity within the health care industry by requiring an entity to obtain a license before building a health care facility, CON laws often are considered one of the strongest barriers to entry to health care markets. When these laws are in place, providers may be barred from entry into the market. Thus, an

209. See supra text accompanying note 132.

210. Schramm & Renn, supra note 181, at 881. The federal government originally mandated that the states develop CON laws in 42 U.S.C. § 300m, however, as part of a wave of deregulation, these laws were repealed by the Act of Nov. 14, 1986, Pub. L. No. 99-660, 1986 U.S.C.C.A.N. (100 Stat.) 3743, 3799. With this move, Congress has returned the power to the states to decide whether they want to continue these programs.

CON laws only create a barrier because the peculiar economic incentives within some health care markets allow hospitals to profit from duplicative services. Schramm & Renn, supra note 181, at 881. Until recently, health care markets have displayed a tendency for capacity to drive demand. In other words, patients trust their doctors' judgment and undergo treatment if they suggest it. Confronting suboptimal occupancy, hospitals have put pressure on their doctors to fill their beds. This phenomenon is known as Roemer's Law, an effect which CON laws were created to combat. Sylvia A. Law & Barry Ensminger, Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism), 61 N.Y.U. L. Rev. 1, 17-18 & n.93 (1986). However, in competitive markets, CON laws are unnecessary because excess supply alone would deter entry into the market. Schramm & Renn, supra note 181, at 881.

HMO securing an exclusionary right over providers' services can tie up key resources that will not be replenished by the entry of new providers.\textsuperscript{211} Though these laws have been instrumental in creating barriers in some markets, many states are now repealing CON laws and thus creating a freer market.\textsuperscript{212} Where they exist, the courts must analyze carefully their tendency to erect barriers to entry that prevent the growth of rival HMOs.

Another area of regulation that could affect entry into the HMO market is cherry-picking. Cherry-picking refers to the tendency of some insurers selectively to enroll only healthy people.\textsuperscript{213} Some states are starting to forbid insurers from engaging in this selection process.\textsuperscript{214} When a state does not regulate the selection of enrollees, a rival HMO can lower its costs by choosing to insure only healthy groups of people. The savings achieved from this move can counteract the costs stem-

\textsuperscript{211} Although CON laws might block providers from entering a market, HMOs stand in a different position. The original federal CON legislation exempted HMOs from CON requirements under the following conditions: a) they had to have more than 50,000 enrollees; b) the proposed facility had to be geographically accessible to the enrollees; and, c) the enrollees had to comprise at least 75\% of the population using the facility. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, § 1527(b)(1)(A), 93 Stat. 592, 615 (1979).

With the repeal of federal CON laws, states have modified the conditions under which they exempt HMOs from CON requirements. See supra note 210. For instance, Maine requires only that the HMO needs the facility and that it lacks easy access to the facility within the community. ME Rev. Stat. Ann. tit. 22, § 309(3) (West 1994). California has enacted somewhat more stringent requirements, including: a) proof of necessity by the HMO; b) proof of a lack of availability within the community; and, c) proof that the HMO members will account for 75\% of the facility's utilization. CAL. HEALTH & SAFETY CODE § 437.12(b) (West 1990). Going even further in this direction, South Dakota bans outright HMO exemptions from CON laws. S.D. CODIFIED LAWS ANN. § 58-41-14 (1995). As is apparent from this barrage of regulation, HMOs in most states with CON laws hardly are relieved from the barrier to entry they create.

Even when HMOs easily can escape CON requirements, the CON laws still can impose formidable barriers. Although a new HMO might be allowed to purchase equipment for the providers with whom it contracts, an anticompetitive HMO can gain a significant cost advantage by entering into exclusive contracts with providers who already have all the necessary CONs. Thus it does not have to expend resources on accumulating new facilities and equipment for its providers, which lowers its costs relative to its competitors who make these expenditures. As long as the provider market lacks total freedom in the accumulation of facilities, an anticompetitive HMO easily can impose costs on its rivals.

\textsuperscript{212} Baker, supra note 164, at 97. This change in the law partially might be a response to the increasingly greater influence of managed care on many health care delivery markets in controlling overutilization. See infra note 328 (discussing the significant HMO penetration of various markets).


\textsuperscript{214} See id. (stating that Florida has passed a law forbidding discrimination against small employers).
ming from foreclosure of key provider resources to some degree. However, the rival HMO can succeed only if the anticompetitive HMO is not already charging rates that vary with the health of the consumers. Thus, courts ought to investigate state laws concerning cherry-picking as well as the rate-making practices of the anticompetitive HMO to determine how much of a barrier such regulation imposes on a rival HMO trying to gain a share of the market.

Whereas some regulation facilitates the perpetration of antitrust injury by reinforcing barriers to entry, other regulation facilitates such injury by making it unassailable in the courts. The McCarran-Ferguson Act exempts the business of insurance from federal regulation. Yet this exemption has been interpreted narrowly to mean the "spreading and underwriting of a policyholder's risk." The imposition of vertical restraints upon providers exceeds the exemption for mostly actuarial functions, therefore, these relationships probably still will be subject to antitrust scrutiny. Thus although the exemption argument likely will be raised in many cases, precedent supports dismissal of this defense.

Similar to the McCarran-Ferguson defense, a defendant HMO might assert its qualification for a state action exemption from antitrust laws. Immunity could arise from the state's direct supervision of insurance rates. Even if the HMO's rates are set by the state, however, it would never order the HMO to enter into exclusionary agreements with providers. Since these activities inevitably will raise insurance costs in

217. See Reazin v. Blue Cross & Blue Shield, 663 F. Supp. 1360, 1403 (D.Kan. 1987), aff'd in part and remanded in part, 899 F.2d 951 (10th Cir. 1990), cert. denied, 497 U.S. 1005 (1990) (finding that the ramifications of BC/BS's financing of managed care activities extend too far into the provider market to qualify for the exemption when faced with allegations of anticompetitive behavior).
218. See id. at 1418-19 (describing the elements necessary to qualify for state action immunity under Parker v. Brown, 317 U.S. 341 (1943), but ultimately finding that the Office of the Insurance Commissioner had little effect on the conduct of BC/BS's business). Cf. Westchester Radiological Assoc. v. Empire Blue Cross & Blue Shield, 707 F. Supp. 708, 714 (S.D.N.Y. 1989), aff'd, 884 F.2d 707 (2d Cir. 1989), cert. denied, 493 U.S. 1095 (1990) (noting that the state's regulation of BC/BS's rate-setting mechanism was an important factor in its dismissal of this antitrust suit although it did not conclusively bestow state action immunity upon BC/BS for its provider payment policies).
contravention of the state’s rate regulation policies, the state actually has a strong interest in deterring such behavior. Thus, state action immunity is not likely to play a major role in most cases where an HMO has attempted to raise its rivals’ costs.

4. Capacity

Now that the states are repealing CON laws, the competitive market is starting to create similar incentives to avoid overcapacity. If a group of hospital promoters believes that a market is saturated, it might choose not to enter it. Hospital promoters would fear financial loss because overcapacity could lead to weak bargaining power. Even if rival HMOs tried to persuade new hospitals to enter the market to compensate for the artificial scarcity created by the anticompetitive HMO, the hospitals probably would resist. They might contemplate that the exclusive agreement creating the artificial scarcity eventually would end and decrease the hospitals’ bargaining position resulting from overcapacity. Thus, hospital market dynamics can act as a barrier to entry, thereby preventing the expansion of rival HMOs.

5. Nature of competitors

Even if an HMO has deterred entry of most competitors through its exclusionary restraints, there are still conditions under which it might be vulnerable to competition. An HMO that has successfully raised its rivals’ costs still faces competition from an insurer who can withstand a short term loss with the goal of achieving a long term gain. For example, if BC/BS decides to break into the HMO industry in an area where an anticompetitive HMO has exacted an exclusionary right over various providers, it can bear the temporary loss associated with the artificial scarcity created by the agreement. A

219. Cf. Melnick et al., supra note 180, at 227 (explaining that a hospital has increased bargaining power when both the hospital and the health care market have little excess capacity).

220. In Ohio, for instance, BC/BS of Ohio [hereinafter BCBSO] has monetary reserves of $281.9 million, which it can access in entering a new financing product market. 1993 Balance Sheet, BCBSO, Winter 1995, at back cover. This amount compares favorably to many HMOs in the area. For example, Physicians Health Plan of Ohio, Inc., operates on a net income of $21.1 million. Largest Health Maintenance Organizations, CRAIN’S CLEVELAND BUS., Dec. 26, 1994, at 56. This amounts to only a tenth of BCBSO’s reserves. Thus, BCBSO could sustain several years
company like BC/BS also has the necessary goodwill to foster trust among consumers, employers, and providers. This would facilitate its development of both a provider and consumer base. Ultimately, it could succeed in attracting enrollees who previously had no choice but to enroll in the HMO employing the vertical restraint. Thus, it would reintroduce price competition into the market. After the term of the exclusionary contract expired, the providers likely would refuse to enter into another similar agreement because of the potential to benefit from working with both HMOs. Subsequently, the HMOs would earn only competitive profits as opposed to monopolistic, supracompetitive profits. For this scenario to occur, an insurer must be willing to risk a temporary loss, and the providers outside of the restraint must be able to service enough of the population to produce a viable HMO. Otherwise, the anticompetitive HMO would be able to continue to reap supracompetitive profits. Even if these conditions are met, a court might find that a sufficient number of potential competitors have been barred from entry to qualify the behavior as an antitrust violation.

The nature of competing providers also can affect the degree to which an HMO’s anticompetitive strategy attains success. Where there is sufficient residual provider capacity after the vertical restraint results in foreclosure of a significant portion of the market, other providers may not be feasible candidates for joining HMO networks. If the other providers are non-profit organizations, they might prefer not to enter into a capitated agreement with an HMO, which would force them to engage in price competition. Rather, they might prioritize the acquisition of high-tech equipment or highly trained personnel to more cost effective treatment that would allow them to compete along price lines. Thus, they might not be ap-

of losses if it were to compete with Physicians Health Plan in a market where Physicians Health Plan had engaged in exclusionary behavior.

221. 

222. Sunny G. Yoder, Appendix to Chapter 1, in FOR-PROFIT ENTERPRISE IN HEALTH CARE 19, 22 (Bradford H. Gray, ed. 1986). The author argues that the prestige stemming from state-of-the-art technology inures to the benefit of managers in a manner similar to profits in a for-profit organization. Id. The author also postulates that only for-profit organizations can limit this behavior of non-profits by engaging in price competition. Id. However, when a rival hospital’s output is
propriate partners for a rival HMO. Sometimes these non-profit hospitals lose their ability to compete because their mission stipulates that they are devoted to serving the indigent. Consequently, they develop reputations as second-rate caregivers and become unqualified to compete with the hospitals offered by the anticompetitive HMO. Courts should not consider hospitals that do not act competitively to be part of the provider market when analyzing the extent to which rivals effectively can contract with other providers to overcome the increased costs imposed by the HMO with exclusionary restraints.

D. Actual Effect on Output and Consumer Choice

Once the restraint has been in place for some time, its effects can be measured directly. In their assessment of antitrust violations, the DOJ, FTC, and the NAAG take into consideration the actual effects on both output and consumer choice. When evaluating the effects of an HMO’s exclusionary right over a provider’s services, one can compare the numbers of enrollees in rival HMOs’ plans with the number of enrollees in similar plans in other locations with comparable demographic data. If the HMO’s output, that is, its enrollment level, is lower than expected, a court might conclude that the market’s exclusionary restraint has created anticompetitive effects. Similarly, if an area has fewer choices of HMO financing packages than other areas with comparable demographics, a court might infer antitrust injury stemming from the exclusionary behavior. Yet courts should be wary of the value of such data because of the likelihood of intervening variables.

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controlled by an HMO charging monopolistic prices, price competition does not exist. Cf. Hospital Corp. of Am. v. Federal Trade Comm’n, 807 F.2d 1381, 1390 (7th Cir. 1986) (finding that non-profit hospitals were not an effective check on for-profit hospitals’ collusive practices).

223. See Melnick et al., supra note 180, at 229 (discussing how hospitals that primarily serve indigent patients create a distortion in the HHI concentration index because they do not compete effectively for privately insured patients).

224. Supra notes 130, 131, 136 and accompanying text. Through their investigation of the quality and range of services offered by competing networks, the DOJ and FTC principles necessarily lead to a consideration of output and choice.
E. Evaluation of Legal Precedent Examining the Raising of Rival HMO Costs Through Exclusionary Restraints

Once a court has considered all the factors indicating whether the nature of consumer demand, the HMO's conduct, and the market's structure create the conditions necessary to raise rivals' costs successfully through exclusionary restraints on providers, it can make a clear judgment about the likelihood of anticompetitive effects. Though the U.S. Healthcare court might have determined correctly that the minimal nature of the length of the agreement in question, as well as the lack of rigidity of the restraint involved, militated against finding a significant increase in costs to rivals, there might have been other persuasive evidence of anticompetitive tendencies. Absent inquiry into other aspects of the agreement or the provider and consumer markets, it is impossible to tell how accurately the court understood the dynamics of the restraint under investigation. In accordance with the standards for examining anticompetitive effects set up by the common law and government agencies, a court should examine thoroughly consumer preferences, exclusionary conduct, and economic influences that affect health care markets before deciding whether an exclusive agreement between an HMO and a group of providers creates mostly efficiencies or inefficiencies.

Whereas the U.S. Healthcare court did not structure its opinion in a manner that would elucidate any anticompetitive effects of the exclusionary restraint under examination, the Marshfield court's reasoning more closely adhered to formal antitrust analysis. Yet many of the court's findings discord with the present body of research into health care industry dynamics. In examining the health care financing market, the court declined to recognize any distinct HMO characteristics and labeled it a mere method of pricing services. Instead of finding attractive, non-price qualities of HMOs, the court asserts that many consumers likely would switch to FFS-type insurance because they are not attracted to the incentives created within HMOs. Yet this statement seems somewhat contradictory with the court's finding a high rate of return for Marshfield. The court does not explain how Marshfield ever could have sustained a high rate of return when consumers only chose the HMO for its price and likely would switch to FFS insurance with even a small increase above the HMO's competitive price because of their distaste for HMO incentives.

225. Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406, 1409 (7th Cir. 1995), cert. denied, 116 S.Ct. 1288 (1996). Instead of finding attractive, non-price qualities of HMOs, the court asserts that many consumers likely would switch to FFS-type insurance because they are not attracted to the incentives created within HMOs. Id. at 1410. Yet this statement seems somewhat contradictory with the court's finding a high rate of return for Marshfield. Id. at 1411. The court does not explain how Marshfield ever could have sustained a high rate of return when consumers only chose the HMO for its price and likely would switch to FFS insurance with even a small increase above the HMO's competitive price because of their distaste for HMO incentives.
studies of consumer demand indicate that consumers are starting to enroll in HMO plans largely for non-price reasons.\textsuperscript{226} The court also refused to accept DRGs as evidence of different provider products with separate geographic markets.\textsuperscript{227} Although the court recognized that only primary care was delivered locally, it made no indication of what kinds of evidence would serve to delineate secondary and tertiary care markets.\textsuperscript{228} Yet health care industry experts strongly assert that these markets are different from primary care markets.\textsuperscript{229} After its examination of consumer demand, the court discussed potential barriers to entry.\textsuperscript{230} In denying that Marshfield doctors could be considered an essential facility primarily because of a lack of an HMO submarket, the court also stated that competition among providers would not help consumers.\textsuperscript{231} The focus on provider competition is erroneous; rather, the court should have been focused on HMO competition. Had it been looking at this tier of the market, it would have realized that it should have been examining the providers in the region to determine if BC/BS still could develop a minimum efficient scale of operations with the doctors not under Marshfield’s control.\textsuperscript{232} The court also should have attempted to quantify the costs imposed upon BC/BS due to Marshfield’s discouraging its doctors from cross-covering for independent physicians and its hospitals from entering into contracts with rival HMOs.\textsuperscript{233} The costs of establishing alternative provider networks could be insurmountable even for a strong health care financing agent.\textsuperscript{234} Thus even though the \textit{Marshfield} court ap-

\textsuperscript{226} \textit{See supra} part IV.A.1.a.
\textsuperscript{227} \textit{Marshfield}, 65 F.3d at 1411.
\textsuperscript{228} \textit{Id.}
\textsuperscript{229} \textit{See supra} part IV.A.2.b.
\textsuperscript{230} \textit{Marshfield}, 65 F.3d at 1412. The court did not address the degree of foreclosure of BC/BS from health care facilities in the area, as this Note would suggest doing. \textit{See supra} part IV.B. Presumably, as employees of Marshfield Clinic, the doctors had either signed a non-compete clause in an employment contract, or perhaps they simply were aware of how economically disadvantageous it would be to them as owners of Marshfield to allow a rival HMO into the market. In either case, the foreclosure from what is at least a major component of the health care delivery market of the region seemed to have been absolute.
\textsuperscript{231} \textit{Id.} at 1413.
\textsuperscript{232} \textit{See supra} part IV.C.2.
\textsuperscript{233} \textit{See Marshfield}, 65 F.3d at 1413 (giving the court’s reasoning on this conduct).
\textsuperscript{234} \textit{See supra} part IV.C.1.
plied the correct structure to its analysis, its conclusions indicate that it did not take into account many recent developments in the health care industry. Other courts examining similar exclusionary restraints would do well to pay attention to both the organization and quality of information presented to them properly to determine whether a restraint rises to the level of an antitrust violation.

V. INJURY TO CONSUMERS THROUGH CONTROL OVER PROVIDERS' OUTPUT: ECONOMIC THEORY

In addition to potentially raising rivals’ costs, an HMO might seek to impose exclusionary restraints on a group of providers to attain monopsonistic control over their prices and output. This result could occur if the exclusionary relationship foreclosed the bulk of other potential payors for the providers’ services. Courts ought to examine the dynamics of the relationships of the parties to each other and to their environment because the success of this restraint could cause a high degree of market inefficiency.

When an HMO has monopsonistic power over its sellers, it creates inefficiencies in the market that would not exist with perfect competition.\(^{235}\) In an optimal market, the health care consumers, HMOs, and providers will negotiate the price of health care services until an optimal price and quantity, reflecting the relative worth of these services in contrast to all the other goods and services in society, have been established.\(^{236}\) An HMO within this market continues to consume provider services until they cost, in the aggregate, as much as the revenue the HMO expects to generate from its enrollment fees.\(^{237}\)

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235. Monopsony, the opposite of monopoly, refers to a market where there is only one buyer of a product. Jack Hirshleifer, Price Theory and Applications 413 (1980).

236. See Miller & Meiners, supra note 17, at 36-37 (describing the equilibrium price where supply meets demand).

237. Hirshleifer, supra note 235, at 435 (stating that a profit-maximizing firm buys a factor of production until its marginal factor cost (mfc) equals its marginal revenue product (mrp)). Marginal factor cost refers to the incremental cost incurred in consuming one more unit of input. Id. at 415. Within the HMO context, it is the cost of each incremental purchase of health care services. Marginal revenue product (mrp) refers to the result of multiplying the marginal product (the incremental yield produced from consuming the last added unit of input) by the marginal revenue (the revenue associated with the sale of the units produced from the last added unit). Id. For an HMO, it is the amount of enrollment fees generated by the incremental purchase
In such a market, an HMO cannot affect the price of the health care services it consumes by discriminatorily reimbursing the providers for the services from which it derives the most profit as opposed to the full range of services that the provider uses in treating patients. Thus, irrespective of the number of inputs provided by the providers participating in the HMO and consumed by the enrollees of the HMO, the reimbursement rate likely remains constant and represents the rate necessary to cover the whole gamut of services offered by the provider. This homogeneity of the price of services is illustrated in Figure 3 by the horizontal line, which represents both the total factor cost \((tfc)\) and the marginal factor cost \((mfc)\). The HMO continues to consume health care resources up to the point where the revenue they produce equals their cost. This point comes when the cost of the package of provider services, which is the exact cost of each incremental unit of health care services, equals the revenue it generates. Unable to generate separate revenue streams for each individual service a provider can offer enrollees where the services are only available as an integrated package, the incremental revenue generated from consuming provider services necessarily will reflect the revenue of the entire package. Thus under competitive circumstances, the HMO consumes packages of provider services until the revenue they generate as a package equals their cost.

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of the provision of services. The relationship between \(mfc\) and \(mrp\) is illustrated in figure three.

238. Cf. Hirshleifer, supra note 235, at 415 (discussing the inability of a firm in a competitive market to affect its average factor cost through the quantity it consumes).

239. The total factor cost \((tfc)\) refers to the total cost of all the separate components of a provider’s delivery of health care services that comprise the total delivery. As each incremental purchase of health care services consists of the same full package of services offered by the provider, the \(mfc\) equals the \(tfc\).

240. This effect is shown in figure three through the identical nature of the \(mrp\) and total revenue product \((trp)\) curves. \(trp\) refers to the summation of the revenues generated by each component of the package of health care services offered by providers. Since the components are sold in a standard package in competitive circumstances, \(trp\) equals \(mrp\). Thus these two curves coincide in figure 3.
When an HMO extracts an exclusionary agreement from the providers that prevents them from dealing with other HMOs, it may succeed in foreclosing many other potential payors for the providers' services. This monopsonistic power would mean that the HMO could control the price of the services it buys by specifying which services it will allow the providers to give its enrollees. To maximize profits, the HMO would allow the providers to perform only services that are

241. Though one might wonder why physicians ever would want to sacrifice their ability to sell their services to whomever they wanted, many believe that they have no choice. As managed care penetrates deeper into the health care financing market, many physicians will have to enter some groups or they will risk losing all their patients, Jerome P. Kassirer, *Access to Specialty Care*, 331 New Eng. J. Med. 1151, 1151 (1994). Combined with this heavy network formation, providers in some markets can experience decreased bargaining power because of excess capacity in their market that forces them to engage in drastic measures to attract patients. See supra note 219 and accompanying text (discussing capacity as a barrier to entry into the provider market); but see supra note 222 and accompanying text (noting that excess capacity does not mean weakened bargaining power when the excess capacity exists among non-profit hospitals that are not competing for patients along price lines). The problem of excess capacity also could be exacerbated by low concentration in the provider market. See supra part IV.B.1.b (describing the relevance of provider concentration in negotiations between insurers and providers). Though providers might make seemingly unreasonable sacrifices in response to these environmental factors, they might be choosing the only possible way to continue practicing at all.

Even if the arrangement providers enter into does not seem unreasonable initially, it might become so later as the balance of power within the relationship changes. Once 65% of its patient base came from PruCare, Austin Regional Clinic in Austin, Texas developed difficulties fighting to retain control under its exclusionary arrangement with this insurer. Johnsson, supra note 27, at 23. The doctors in the clinic suggest that some of the problems that might arise in an exclusionary agreement include issues about utilization review and quality assurance. Id. at 24. By controlling these aspects of physicians' practices, the HMO essentially is controlling their output.
likely to generate more revenue than cost, and thus the providers no longer would receive reimbursement for the entire packages of services they usually offer their patients. Realizing great savings from its control, the monopsonistic HMO would restrict its consumption of health care resources to a point below the competitive level, as shown in figure four. By offering fewer provider services, the HMO produces a policy with suboptimal features. Hence, despite the HMO’s cost savings, enrollees and providers do not interact to the same extent they would in a competitive environment.


243. Whereas an HMO in a competitive market would consume to \( q^* \), the monopsonistic HMO only consumes to \( q' \).

244. When a monopsonistic HMO starts to restrain the amount of services it purchases, it might cause patients to receive less attention from the doctor per visit, longer waiting times, fewer amenities at the hospital, etc. Pauly, *Competition*, supra note 200, at 260.
An HMO likely would engage in this kind of exclusionary practice if it estimated that the costs of obtaining the concession would be less than the monopsonistic profits it could garner. The HMO could succeed in its anticompetitive strategy only by blocking the providers’ access to a significant number of other payors. To achieve this goal, the HMO first must consume a large portion of the providers’ services itself, which would foster the providers’ reliance on the HMO. This reli-

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245. As the imposition of an exclusionary restraint also can lead to the raising of rivals’ costs, an HMO probably weighs the costs of the restraint against the benefits to be achieved from both sources when deciding whether to engage in this anticompetitive behavior. See Susan E. Foster, *Monopsony and Backward Integration: Section 2 Violations in the Buyer’s Market*, 11 U. Puget Sound L. Rev. 687, 708 (1988) (raising the need to examine the incentives created by the ability to raise rivals’ costs in addition to the ability to achieve monopsonistic rents when considering exclusionary activities).

246. *Cf*. Phillip Areeda & Donald F. Turner, *Antitrust Law* 963 (1980) (arguing that a horizontal merger between two buyers could create anticompetitive, monopsonistic purchasing power only when the merging parties together account for at least 25% of the purchasing market share).
ance would allow the HMO to keep its provider expenses low by dictating the level of service offered by the providers to its enrollees. This reliance would be reinforced if the providers operated in an environment that consisted primarily of HMO-financed health care. In this situation, the terms of their exclusive contract would prevent the providers from finding a significant number of other payors. Without other payors to help defray the costs of providing optimal care, the monopsonistic HMO could refuse to pay the providers enough to develop the ability to provide an acceptable range of services. Furthermore, there must be significant barriers to entry for non-HMO providers into the market. This market condition would prevent deterioration of the monopsonistic HMO's control over its provider group.

In summary, the HMO could achieve monopsonistic power through an exclusionary restraint if: i) it consumes a significant amount of the providers' services; ii) there are few non-HMO health care financing options in the market; and, iii) there are significant barriers to entry for non-HMO financed health care. When all of these elements are present, an HMO like-

247. Cf. Richard A. Posner, Antitrust Cases, Economic Notes, and Other Materials 376 (1974) (stating that a monopolist's large market share is insignificant if competitors easily can expand production and return the price to its optimal level). Within the reverse context of a monopsony market, the strength of a monopsonistic purchaser with a large share of the sellers' output is insignificant if other purchasers easily can expand consumption and return the level of output and its price to its optimal state.

248. Cf. id. at 337 (discussing ease of entry into a market of new producers as limiting monopolistic behavior). For a monopsonist, therefore, ease of entry of new buyers could inhibit monopsonistic behavior.

249. These factors could pose a danger for many different providers. For instance, an obstetrics group practice might derive 80% of its income from an HMO with an exclusionary restraint, preventing the group from contracting with other HMOs. Because it would not be feasible to invest money in resources for which the HMO does not intend to reimburse the providers, they likely would avoid acquiring an MRI to scan women with problem pregnancies without a commitment from the HMO to reimburse them for its use. Even if most obstetric group practices serving other HMOs used MRIs, the monopsonistic conditions would force the group under the restraint to forego providing this optimal level of care. This power would be reinforced if there was heavy HMO penetration of the market. Perhaps the market consists of 50% HMO enrollees, 25% Medicare, and 25% FFS insurance. The obstetricians would find it difficult to increase the amount of services they provided outside the HMO because their exclusionary contract prevents them from working with 50% of the market. Since Medicare patients do not usually require obstetric services due to their age, the obstetricians would have access only to the remaining 25% of the market to compensate for any refusal by the HMO to reimburse them for services they would ideally provide. If the obstetricians tried to encourage entry into the market by a non-HMO network, such as a PPO, perhaps startup costs and other barriers would make the development of this system untenable. Hence the monopsonistic HMO would find it had total
ly would reduce the types of provider services it would buy to achieve its own cost savings.

Such HMO practice could lead to various inefficiencies in the market. The consumers would be deprived of optimal output. Though the monopsonistic HMO would experience lower costs for provider services, it would not pass on these savings to its enrollees. Rather, the enrollees would pay the same amount for enrollment in a monopsonistic HMO as they would for enrollment in a competitive HMO with similar features, even if the competitive HMO had higher costs. Hence, the monopsonistic HMO would not compensate its enrollees for its lower than optimal quantity of services by charging lower than market prices.

The providers also would experience welfare loss as a result of this arrangement. Though they would receive compensation for a full range of services in a competitive environment, the monopsonistic HMO would purchase only a portion of such services. The HMO's exclusionary restraint could deprive the providers of a significant source of income.

Despite the potential for some production efficiencies to offset the allocative inefficiencies, this relationship also would breed production and innovation inefficiencies. One control over the delivery and pricing of the obstetrics group practice.

250. Roger D. Blair & Jeffrey L. Harrison, Antitrust Policy and Monopsony, 76 CORNELL L. REV. 297, 305 (1991). In addition to the examples stated supra note 244, another salient example of the reduction of output among HMOs is the decreasing length of hospital stay (LOS). Some of the better studies in this area have indicated that HMOs have 14% shorter LOS than indemnity plans. Miller & Luft, supra note 153, at 1514. Yet it is questionable whether the consumer actually benefits from a shorter LOS. One study found that a reduction in LOS leads to a greater length of absence from work and a resulting higher expense to the company that more than offsets the reduced LOS's savings. J.B. Silvers, Variation in Inpatient Cost & Net Corporate Value by DRG 9 (1992) (unpublished manuscript). Thus savings achieved through shorter LOS sometimes increase overall costs. This tendency to reduce optimal output will only be reinforced by monopsonistic power over provider services, and the present suboptimal output even could be indicative of a degree of pervasive monopsonistic power that HMOs already possess.

251. See, e.g., Damon Braly, HMOs Increase Profits by Cutting Medical Loss Ratios, Managed Care Report Finds, HEALTH INDUSTRY TODAY, Jan. 1993, at 21 (stating that HMO profits have increased because their medical expenses have decreased relative to their revenues). Thus HMOs already are displaying a tendency to accumulate profits rather than decrease premiums when they save on provider services.

252. See Blair & Harrison, supra note 250, at 305 (asserting that since other competitors would not have the same monopsonistic advantage, the monopsonist could charge this market price and still retain its consumers).

253. Supra notes 27-30 and accompanying text.

254. See supra notes 31-34 and accompanying text (describing the significance of the
production loss stems from the money spent entertaining doctors and hospital management initially to entice them to enter into the agreement and to persuade them to remain in the relationship. This increases the cost of producing services, but does not increase the quality or quantity of the final product.

Moreover, a monopsonist HMO would not be able to induce the providers to develop cheaper production methods because the providers would realize that the HMO might discover their lower costs and demand lower prices for their services. There would be no increase in production efficiency in this relationship. Likewise, the providers would not endeavor to create innovative treatment techniques if they believed the benefits would inure only to the HMO. Innovation efficiency, therefore, would be stifled. As a result of these inefficiencies, an HMO that gained monopsonistic power through its exclusionary restraints would create mostly harm with long-term effects to the health care market in which it operates.

**VI. INJURY TO CONSUMERS THROUGH CONTROL OF PROVIDERS’ OUTPUT: LEGAL DEVELOPMENT**

Although monopsonistic buying power resulting from exclusionary restraints on sellers poses a clear threat of antitrust injury, courts have not developed a substantial body of case law regarding this issue. Irrespective of the source of monopsonistic power, through exclusionary restraints or otherwise, monopsony has not developed into a cohesive common law cause of action. Currently, courts examine each case involving monopsony in the context of another, established antitrust cause of action. Yet even within these established causes of action, there are conflicting judicial interpretations of the law. As a result, no set of elements can lead definitively to liability for an antitrust injury stemming from monopsonistic buying power. Although some courts have interpreted the law

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in a way that overlooks potentially monopsonistic market conditions, others have created precedent that better accords with economic realities. However, no court has applied such insightful analysis to a market in which exclusionary restraints have led to monopsonistic buying power.

Although the Supreme Court has not developed a separate body of antitrust law around the concept of monopsony, in deciding Mandeville Island Farms v. American Crystal Sugar, it recognized that monopsony violates the public policy considerations addressed by the Sherman Act. In Mandeville, sugar refiners who controlled the only market for California sugar beets agreed to adopt uniform pricing for their beets. Since one of the farms would have achieved higher prices in the absence of the agreement, it sued the refiners for the consequent economic injury. After stating that the Sherman Act allowed sellers as well as consumers to sue for treble damages, the Court determined that this arrangement led to anticompetitive control over the quantity and price of the goods offered by the farmers. The Court also determined that this arrangement harmed competition in the final product market.

Although this case seems to lend unqualified support to the notion that sellers are statutorily protected from monopsonistic buying practices, the Court analyzed the refiners’ conduct as collusive price-fixing and cited cases that establish the per se illegality of this offense. Thus, cases that do not involve collusion can be distinguished on these grounds. Mandeville does not stand for the proposition that monopsonistic buying practices, including those that arise from

256. See infra part VI. (discussing the Kartell, Ocean States, and Westchester Radiological cases).
257. See infra part VI (discussing the Ball Memorial and Reazin cases).
259. Id. at 223.
260. Id. at 224.
261. Id. at 235.
262. Id. at 240-41.
263. Id. at 241.
264. Id. at 235.
265. However, when collusion is involved, the DOJ and the FTC have stated that they will challenge such a relationship in the event that it leads to monopsonistic purchasing power. 1992 Horizontal Merger Guidelines, 57 Fed. Reg. at 41,553.
exclusionary restraints, clearly are illegal, but provides limited support for such a finding.

Although the bulk of cases considering monopsonistic purchasing practices are neither Supreme Court cases nor cases involving exclusionary restraints, there are cases that examine monopsony in various health care contexts. A court considering potential monopsonistic control by an HMO over providers through an exclusionary restraint can apply the reasoning of those courts. However, highly inconsistent views have been proffered that could lead to inconsistent results from future courts looking at exclusionary restraints.

In *Kartell v. Blue Shield,* the court considered whether Blue Shield’s ban on physician balanced billing constituted an antitrust violation. Overturning the district court, the First Circuit reasoned that no restraint of trade was possible when Blue Shield is regarded as a buyer of services as opposed to “a ‘third force’, intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains.” Thus, the buyer and seller ought to be allowed to determine for themselves what the price and characteristics of the product should be without the intervention of antitrust law. The doctors argued, however, that one important fact was the market power of Blue Shield. In dictum, the court considered this argument but gave it less weight than Blue Shield’s counterargument that its arrangements neither caused the doctors to forfeit opportunities to treat patients with other insurance nor evidenced any sign of lower output. Further, the

266. 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985).
267. *Id.* at 923. Balance billing refers to the practice of making additional charges to patients above the reimbursement rate by the insurer. The antitrust injury that the court is supposedly examining is a Sherman Act § 1 agreement in restraint of trade. *Id.* at 924.
268. *Id.* at 924. Absent a restraint of trade, the doctors could not prove a Sherman § 1 violation.
269. *Id.* at 925. The court distinguished Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U.S. 219 (1948), by calling it a case of a ‘sham’ organization whose sole purpose was to combine for an anticompetitive purpose. *Id.*
270. *Kartell,* 749 F.2d at 926. Market power, which is a factor in monopoly power, also is an essential element for proving a Sherman § 2 violation. See infra text accompanying note 281 (discussing the *Ocean State* court’s enumeration of the elements of a monopolization cause of action).
271. *Kartell,* 749 F.2d at 927.
court found that the alleged harm of subcompetitive pricing did not constitute an antitrust injury, even if Blue Shield had market power.\textsuperscript{272} Despite many public policy considerations proffered by the doctors,\textsuperscript{273} the court held that the buyer may choose the goods it buys and the price it pays.\textsuperscript{274} With this opinion, the court greatly hinders the ability of providers to raise monopsony as a viable cause of action when suffering anticompetitive losses under an exclusionary restraint.

In deciding \textit{Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield},\textsuperscript{275} the same court had another opportunity to evaluate monopsony in the health care industry. In this case, BC/BS established a most favored nations payment plan in which it informed doctors that they must certify that they are not accepting lower fees from any other insurer.\textsuperscript{276} If they did, BC/BS would lower their rates by twenty percent.\textsuperscript{277} BC/BS instituted this policy in response to the establishment of Ocean State, an IPA HMO that was trying to develop incentives for physicians to keep costs down by withholding twenty percent of physicians' fees. If a profit was realized, Ocean State intended to return a part of the withheld portion.\textsuperscript{278} Upon implementation of the BC/BS policy, almost a third of the Ocean State doctors resigned, ostensibly to avoid BC/BS's payment reductions.\textsuperscript{279} Ocean State and many participating doctors instituted a Sherman section 2 suit against BC/BS claiming that this policy was aimed at inducing physicians to leave Ocean State.\textsuperscript{280}

There are two elements to establish a Sherman section 2 monopolization violation: "(1) the possession of monopoly power in the relevant market and (2) the willful acquisition or

\textsuperscript{272} Id.
\textsuperscript{273} Id. at 929. Some of these rationales dealt with various inefficiencies stemming from Blue Shield's purchasing policy. For instance, the doctors suggested that they had no incentive to experiment with new, expensive outpatient technology that actually might lower overall medical costs. This results in innovation inefficiency. See supra note 255 and accompanying text.
\textsuperscript{274} \textit{Kartell}, 749 F.2d at 929.
\textsuperscript{276} Id. at 1103.
\textsuperscript{277} Id. at 1104.
\textsuperscript{278} Id.
\textsuperscript{279} Id. Arguably, most favored nations clauses can be viewed as exclusionary restraints in that they deter providers from entering into competitive relationships with other financing agents.
\textsuperscript{280} Id.
maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.\textsuperscript{281} Since BC/BS did not dispute that it had monopoly power, the court proceeded to decide whether it had unlawfully maintained this power.\textsuperscript{282} Although it recognized that exclusionary conduct could be anticompetitive,\textsuperscript{283} the court reasoned that paying the same amount for the same service is the essence of true competition.\textsuperscript{284} Focusing solely on the desire to achieve low prices as a legitimate business justification,\textsuperscript{285} the court stated that even a demonstrated intent to crush its rivals did not supersede the presumed lawfulness of BC/BS's act.\textsuperscript{286} Hence, it appears that the court would allow any anticompetitive activity provided that there is some business justification. Through this holding,

\begin{itemize}
\item \textsuperscript{281} Id. at 1110 (citing United States v. Grinnell Corp., 384 U.S. 563, 570-71 (1966)).
\item \textsuperscript{282} Id.
\item \textsuperscript{283} Id. (defining exclusionary conduct as going "beyond the needs of ordinary business dealings, beyond the ambit of ordinary business skill, and 'unnecessarily excluding competition'" (quoting Barry Wright Corp. v. ITT Grinnell Corp., 724 F.2d 227, 230 (1st Cir. 1983)).
\item \textsuperscript{284} Ocean State, 883 F.2d at 1110 (quoting the lower court's opinion). Though this court finds HMO health care delivery to be the same service as FFS delivery, other courts might find delivery within a cost containment environment to be a significantly different product. See supra part IV.A.1.a (discussing the perceptions and behavior patterns of health care consumers as proof of the disparate nature of these two services).
\item \textsuperscript{285} In a footnote, the court states that it is irrelevant that the savings are not being passed along to the customers. Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield, 883 F.2d 1101, 1111 n.11 (1st Cir. 1989), cert. denied, 494 U.S. 1027 (1990). Thus even if the physicians are producing less output because of the monopsonistic purchasing arrangement, the court evidences indifference to whether the insurer compensates the consumers for this allocative inefficiency through lower prices. This lack of concern for the effects of inefficiency on consumers goes against the basic policy considerations underlying the antitrust laws.
\item The court also mentions the possibility that what ordinarily might be deemed competitive conduct could be illegal if taken by a monopolist because of its tendency to destroy competition. Id. at 1112 (quoting Berkey Photo, Inc. v. Eastman Kodak Co., 603 F.2d 263, 274-75 (2d Cir. 1979)). Yet the court qualifies this assertion by accepting such illegal conduct as long as the monopolist acts for "valid business reasons." Id. (distinguishing Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 608 (1985) on the grounds that no efficiency justification was offered in that case). The court seems to have misunderstood the meaning of \textit{Aspen Skiing}. The Supreme Court did not intend to make the lack of a legitimate business reason a \textit{sine qua non} of a \textsection{2} cause of action. Rather, it was one factor to be considered in finding a specific intent to injure rivals. 472 U.S. at 608. Even if there is a legitimate business reason, the Court would allow anticompetitive statements made by officers of a corporation to satisfy the specific intent element. Id. at 608 n.39. Thus the Ocean State case may well have had a different outcome in the hands of the Supreme Court. See \textit{Ocean State}, 883 F.2d at 1112 (describing statements made by a BC/BS executive about Ocean State).
\item \textsuperscript{286} Id. (stating that evidence of the intention of BC/BS's president to 'emasculate' Ocean State was insignificant).
\end{itemize}
the court has significantly strengthened its Kartell position and has created even greater obstacles for providers in bringing a monopsonistic cause of action when experiencing antitrust loss under an exclusionary restraint.

Other courts have reasoned similarly when presented with the possibility of monopsonistic purchasing power over health care providers. In *Westchester Radiological Associates v. Empire Blue Cross & Blue Shield, Inc.*,287 the court examined an arrangement between BC/BS and the hospitals from whom it bought services in which BC/BS insisted that the hospitals provide radiological services as part of a package.288 As a result of this arrangement, radiologists no longer could bill patients directly and suffered a substantial financial loss.289 After dismissing the radiologists' claim of a Sherman section 1 violation,290 the court went on to consider the section 2 violation.

Although the evidence did not clearly show Blue Cross's market power, the court assumed that this element was satisfied.291 Rather than examining potentially predatory conduct by a monopolist,292 the court looked at the Kartell court's reasoning and decided that even buyers with market power have an unqualified right to use their power to negotiate a good price.293 Yet the court failed to mention that the primary reason for the Kartell decision was the lack of evidence of an unreasonable restraint of trade in violation of Sherman section 1.294 By extending this holding to Sherman section 2 claims, the court implied that the elements of a monopolization

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288. Id. at 710.
289. Id. at 709.
290. Id. at 714.
291. Id. at 714-15. In examining market power, the court looked at both the percentage of hospital revenues attributable to BC/BS as well as the percentage of the patient market enrolled in BC/BS. Id. at 715 n.19. These two figures are imperative to understanding the potential for monopsonistic effects. See supra notes 245-49 and accompanying text (discussing the determinants of a successful monopsonistic arrangement).
292. This step would have accorded with the standard analysis of a Sherman § 2 violation. See supra text accompanying note 281 (defining monopoly within the context of the Ocean State case).
294. See supra notes 266-74 and accompanying text.
cause of action never can be satisfied by a monopsonistic pur- 
chasing arrangement between health care insurers and provid-
ers. If other courts followed this reasoning, they would re-
move even the qualified acceptance of the Ocean State court of 
a section 2 violation when the monopsonistic purchaser had no 
legitimate business justification. Thus, an exclusionary restraint 
imposing hardship on providers always would be upheld.

Although some courts have set precedent firmly against 
the recognition of the anticompetitive effects caused by monop-
sonistic insurers under any set of conditions, other courts have 
been willing to consider the possible circumstances which 
could create such market distortion. In Ball Memorial Hospital, 
Inc. v. Mutual Hospital Insurance, Inc., an array of hos-
pitals in Indiana sought to enjoin BC/BS from launching a 
separate PPO product in addition to its standard FFS prod-
uct. Applying a rule of reason analysis, the court stated 
that market power was a threshold element. Despite 
BC/BS’s high market share in some markets, the court 
found no market power because there were no barriers to 
entry into the health care financing market. Rather,

295. One public policy reason that the court found important in justifying this outcome is the need for cost containment in the health care industry. Westchester Radiological Assoc. v. Empire Blue Cross & Blue Shield, 707 F. Supp. 708, 713 (S.D.N.Y. 1989), aff’d, 884 F.2d 707 (2d Cir. 1989), cert. denied, 493 U.S. 1095 (1990). The radiologists asserted that they could claim an extra $25 million if they billed directly. Id. at 710 n.2. The court subsequently used this figure as representative of the savings incurred by consumers. Id. at 714. Yet there is no evidence that BC/BS passed on those savings to the consumer or that this arrangement in any way benefitted the consumer.

296. 784 F.2d 1325 (7th Cir. 1985).

297. Id. at 1331. The hospitals claimed violations of both Sherman § 1 and § 2. Id.

298. Id. at 1334.

299. For some of the hospitals, BC/BS covered about 80% of the patient population. Id. at 1330. It also accounted for about 50% of all hospital revenues in Indiana. Id. This consideration of both the buyer’s market share of the ultimate consumer market and its market share of the providers’ output helps illustrate some of the fundamental sources of monopsony power for the buyer. See supra notes 245-49 and accompanying text (discussing several major factors of monopsonistic power in an exclusionary relationship).

300. The court defines market power as “the ability to raise price significantly higher than the competitive level by restricting output.” Ball Memorial, 784 F.2d at 1331. This is the mirror image of monopsonistic power.

301. The circuit court cited approvingly the district court’s finding that the relevant product market is health care financing. Id. Within this market, it found no evidence that Indiana insurance laws could act as a barrier to other insurers. Id. at 1332.

With the examination of both the consumer market share and the provider market share, looking at barriers to entry gives the court a full understanding of the range of substitute buyers that could prevent monopsonistic buying practices of a powerful buyer. See supra notes 245-49
BC/BS’s size indicated merely that it was satisfying its customers.

Although the court found no market power, it examined the hospital’s assertion of BC/BS’s anticompetitive intent.\(^{302}\) The hospitals asked the court to consider an internal memo circulated in the BC/BS offices that made reference to the need for a more aggressive stand in demanding lower prices from providers as proof of this intent.\(^{303}\) The court, however, did not find this memo to be dispositive and demanded further “objective indicators.”\(^{304}\)

Similarly, the court dismissed the hospitals’ claim that BC/BS was raising its rivals’ costs by placing the hospitals in a position where they would have to shift costs to other providers.\(^{305}\) Without market power, the court did not believe that BC/BS could succeed at this.\(^{306}\) Although ultimately the court found no antitrust violation, its situation-specific analysis of the elements that contribute to monopsonistic injury might guide other courts to be similarly thorough in their analyses when considering the effects of an exclusionary restraint on providers.

The court in *Reazin v. Blue Cross & Blue Shield*,\(^{307}\) found antitrust violations after a close examination of monopsonistic practices not dissimilar to those in *Ball Memorial*. In this case, BC/BS attempted to terminate a Wichita hospital’s provider agreement upon discovering that HCA, a for-profit hospital company, had acquired the hospital in tandem with its acquisition of a powerful HMO.\(^{308}\) Concurrent with its ter-

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302. Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1337 (7th Cir. 1983). Though monopoly power, as opposed to market power, is a necessary element of a Sherman §2 violation, a lack of market power implies a lack of monopoly power, the latter requiring a higher market share than ordinary market power.


304. *Ball Memorial*, 784 F.2d at 1339. The court also distinguished *Mandeville* on the basis of its being illegal per se as a price fixing cartel and required a different standard under §2 for single firms such as BC/BS. *Id.* at 1338.

305. *Id.* at 1339-40.

306. *Id.* at 1340.


308. *Id.* at 958.
mination decision, BC/BS attempted to establish its own integrated network of competing Wichita hospitals. The court found that BC/BS had market power, citing the percentage of insureds covered by BC/BS, as well as the percentage of the plaintiff hospital’s revenues attributable to BC/BS. The court stated further that its market power had been reinforced by various barriers to entry and, therefore, was not merely a transitory high market share.

Having found that strong market power constituted monopoly power, the court also found that BC/BS willfully had maintained its power in violation of Sherman section 2. In showing that a well-reasoned analysis can point out the anticompetitive effects stemming from monopsonistic power, this court’s opinion provides a degree of precedential support for courts searching for an antitrust injury caused by monopsonistic insurers imposing exclusionary restraints on providers.

Although the courts in *Ball Memorial* and *Reazin* illustrat-

309. Id. at 960.

310. Id. at 969. The court defined market power as the “power to control prices” or “the power to exclude competition.” Id. at 966 (quoting *Westman Comm’n Co. v. Hobart Int’l*, 796 F.2d 1216, 1225 n.3 (10th Cir. 1986)). The discussion of market power follows the court’s findings that all the other elements of a Sherman § 1 cause of action had been satisfied, namely, injury, agreement, and unreasonable restraint of trade. Id. at 959-66.

311. Id. at 969. The cited testimony placed the percentage of covered insureds in the range between 47% and 62%. Id. The percentage of the hospital’s revenue coming from BC/BS was stated to be 18%. Id. at 969 n.26. In the examination of these percentages, the court elucidates two crucial factors for determining monopsonistic power. See supra notes 245-49 and accompanying text (discussing the significance to a monopsonistic relationship of both the buyer’s consumption of sellers’ output and the buyer’s share of the consumer market).

312. Id. at 969-72. The court specifically found significance in BC/BS’s historical advantage in the Kansas market and in the most favored nations clause in its provider contracts. Id. The court distinguished *Ocean State* by saying that it was looking at the most favored nations clause from the perspective of a barrier to entry reinforcing market power as opposed to evidence of monopolistic behavior under Sherman § 2. Id. at 971 n.30. The court also distinguished *Ball Memorial* by saying that the insurance landscapes are different in these different states, and it disagreed with any part of the *Ball Memorial* opinion implying that no barrier to the insurance market ever could exist. Id. at 972 n.32.

This examination of potential new entrants, along with BC/BS’s market share of both the supplier and consumer market, illustrates the court’s clear recognition of the market forces necessary to perpetrate an antitrust injury from monopsonistic buying power. See supra notes 245-49 and accompanying text (discussing the necessary conditions to promote monopsonistic power in an exclusionary relationship).

313. *Reazin v. Blue Cross & Blue Shield*, 899 F.2d 951, 973 (10th Cir.), *cert. denied*, 497 U.S. 1005 (1990). In a key letter sent to all Kansas hospitals, BC/BS announced, “if hospitals decide to compete with Blue Cross and Blue Shield in the manner that HCA is competing, Blue Cross and Blue Shield must make a business decision about its future relationship with these entities.” Id. at 958 n.8.
ed the factors necessary to consider in determining monopsony power, the *U.S. Healthcare* court was not compelled to follow their logic in its examination of an HMO's exclusionary restraint over providers. Rather, the disparate court interpretations of potentially monopsonistic situations gave that court great latitude regarding the factors to consider in arriving at its judgment. As mentioned above,\textsuperscript{314} the *U.S. Healthcare* court decided that there are always too many alternative buyers for physician services to allow for a monopsonistic environment in the health care field.\textsuperscript{315} Therefore, it did not consider any of the factors that might illustrate that the HMO in this case wielded monopsony power over its physicians. If other courts were to regard this holding as persuasive, it could severely interfere with their probing deeply into the anticompetitive effects of a monopsonistic purchasing power over a captive group of providers in an exclusionary relationship.

VII. INFERRING INJURY TO CONSUMERS THROUGH CONTROL OF PROVIDERS' OUTPUT IN THE HEALTH CARE SETTING

Although the *U.S. Healthcare* court was not alone when it declined to find monopsony power arising from the exclusionary restraint under investigation, generally courts should be more circumspect in their analysis. Monopsonistic purchasing power of an HMO over providers under an exclusionary restraint can lead to a suboptimal level of provider service and supracompetitive pricing for their services.\textsuperscript{316} As *Mandeville* suggests, control over supplier prices and output offends the principles guiding the application of antitrust law.\textsuperscript{317} Thus, courts must examine carefully the degree to which market conditions create a monopsonistic environment in the context of an exclusionary restraint imposed by an HMO

\textsuperscript{314} See supra notes 69-75 and accompanying text (discussing the *U.S. Healthcare* court's investigation of a Sherman § 2 violation).

\textsuperscript{315} U.S. Healthcare, Inc. v Healthsource, Inc., 986 F.2d 589, 599 (1st Cir. 1993). Like *Kartell* and *Ocean State*, this opinion is from the First Circuit. However, the court does not expressly rely on precedent in its holding.

\textsuperscript{316} See supra part V (depicting these anticompetitive effects).

\textsuperscript{317} See supra notes 258-65 and accompanying text (discussing the *Mandeville* case).
over a group of providers.

Courts can determine the likelihood of anticompetitive services by evaluating: i) the amount of the providers' services consumed by the HMO; ii) the share of the consumer market foreclosed by the HMO's exclusionary practices; and, iii) the existence of barriers to entry that prevent new insurers who are not subject to the exclusionary restraint from entering the market.\(^3\)\(^1\)\(^8\) Despite the inconsistent opinions in this area, several courts have given weight to such factors in understanding potentially monopsonistic situations.\(^3\)\(^1\)\(^9\) In future cases involving the potential for monopsonistic purchasing power in an exclusionary relationship between an HMO and a group of providers, lawyers and judges also should look for indications that these conditions have been met in the subject health care market. Once they have elucidated this aspect of the anticompetitive effects arising out of exclusionary behavior, then the court can adjudicate these cases in a manner that better accords with the goals of antitrust law.

A. HMO Consumption of the Providers' Services

Before an HMO can use its exclusionary restraint to obtain control over its providers' price and output, it first must become a vital part of the providers' normal operations by consuming a significant amount of their services. To determine the importance of an HMO to a group of providers, courts should investigate the percentage of the providers' revenues that come from the potentially monopsonistic HMO.\(^3\)\(^2\)\(^0\) A court might

\(^{318}\) See supra notes 245-49 and accompanying text (illustrating the significance of these elements to the economic model of a monopsonistic HMO).

\(^{319}\) See supra notes 291, 299, 301, 311, and 312.

\(^{320}\) See, e.g., Westchester Radiological Assoc. v. Empire Blue Cross & Blue Shield, 707 F. Supp. 708, 714-15 n.19 (S.D.N.Y. 1989), aff'd, 884 F.2d 707 (2d Cir. 1989), cert. denied, 493 U.S. 1095 (1990) (assuming BC/BS’s market power despite its belief in the inaccuracy of plaintiff’s findings that BC/BS accounted for 30% of the revenues of the hospitals in the relevant market); Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1330 (7th Cir. 1985) (finding a high market share where BC/BS accounted for about 50% of all revenues for hospitals in Indiana); Reazin v. Blue Cross & Blue Shield, 899 F.2d 951, 969 n.26 (10th Cir.), cert. denied, 497 U.S. 1005 (1990) (finding market power where BC/BS controlled 18% of the plaintiff hospital's revenues). Note that Westchester Radiological and Reazin both look at the market power wielded over discrete units of providers. Ball Memorial, however, looked at the statewide average share of the providers' income. The plaintiff's claim in Ball Memorial revolved around many hospitals throughout the state facing different markets. Thus the court had to
decide that these revenues are crucial to the existence of the providers if it found that decreased revenues from the HMO would render the providers financially nonviable.\textsuperscript{321} Such a condition would occur where the providers need the revenue generated by the present consumption of services by the HMO to help cover their high fixed costs.\textsuperscript{322} A court could examine whether a provider could cover its fixed costs regardless of the range of services the HMO demanded.\textsuperscript{323} If the HMO is only a small entity compared to other payors, then the providers might force the HMO to accept the same package of services for its enrollees as that received by every other payor in the market. In that case, the interests of all payors would dominate over the interests of the HMO.\textsuperscript{324} If the providers need the HMO to cover their fixed costs, however, they would be more likely to provide only the services for which the HMO is willing to provide reimbursement. In this way, they would avoid incurring any unrecoverable expenses. Under these cir-

sacrifice the accuracy that comes from a more specific provider-by-provider analysis to accommodate the nature of the parties.

The DOJ and the FTC state that they examine a monopsonistic market in an analogous fashion to a monopolistic market. 1992 Horizontal Merger Guidelines, 57 Fed. Reg. at 41,552 (1992). Since they will calculate a monopolistic market’s concentration by summing the squares of the shares of the consumer market held by all the firms in a market, they will calculate a monopsonistic market’s concentration by summing the squares of the shares of the seller market held by all the firms in a market when considering the effects of a merger between two powerful buyers. \textit{Id.} at 41,557-58. Hence, similar to the court’s examining the percentage of provider revenues coming from a powerful insurer, the DOJ and the FTC also give weight to the degree of the buyers’ consumption of the sellers’ product.

\textsuperscript{321} \textit{Cf.} Pauly, \textit{Monopsony Power,} supra note 196, at 79 (asserting that a necessary precondition of insurer monopsonistic power over providers is that providers are in a worse position with lower patient volume).

\textsuperscript{322} \textit{See supra} notes 200, 202 and accompanying text (discussing the high fixed costs of providers).

\textsuperscript{323} Even if a provider would be unable to cover its fixed costs without the HMO’s current revenues, courts also should look at the ability of the provider to shift its costs onto some of its other payors. \textit{See, e.g., Ball Memorial,} 784 F.2d at 1340 (discussing the tendency among hospitals to shift costs when they do not receive enough reimbursement from a major insurer to cover their costs). Though cost structure analysis can be very informative, courts are reluctant to examine this complicated area. \textit{See, e.g., id.} (discouraging courts from determining if insurance rates are “cost justified”).

\textsuperscript{324} \textit{See} Melnick et al., \textit{supra} note 180, at 231 (suggesting that a PPO should contract with smaller hospitals where the PPO could exert greater leverage in negotiations due to the greater dependence of the hospital on the PPO’s patient volume). A lack of leverage leads to increased provider pricing. \textit{See id.} at 227 (finding that occupancy rate has a positive correlation with hospital rates in a market with little excess capacity). Hence, when faced with unclear cost data, courts also can look at whether the provider is charging the HMO less for its services than it charges other payors as one sign of the increased bargaining power of the HMO relative to other payors.
cumstances, the court should be more willing to find that the exclusionary restraint has led to undue monopsonistic power.

B. Foreclosure of the Patient Market

Even if the providers have developed a dependence on the HMO for their financial well-being, the exclusionary restraint effectively must block access to a large percentage of the patient market before the HMO can control the providers’ output and price. The providers’ ability to find other payors willing to cover the costs of providing optimal care would prevent the potentially monopsonistic HMO from limiting the providers’ range of services through suboptimal pricing unless the HMO truly has foreclosed a large segment of the patient base. A court should examine the share of the enrollee population foreclosed by the potentially monopsonistic HMO. In determining the foreclosed market, courts should use the market definition for providers as delineated in the discussion of raising rivals’ costs, which defines the characteristics of the market in which providers compete for patients. Within this market, courts can measure the degree of foreclosure by adding together the market shares of all the HMOs operating in this market because the exclusionary relationship prevents the providers from accessing the enrollees of other HMOs. If an

325. Cf. Pauly, Monopsony Power, supra note 196, at 79 (stating that providers must not be able to replace their patient base in order to prove monopsonistic power on the part of an insurer).

326. See, e.g., Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield, 692 F. Supp. 52, 52-58 (D.R.I. 1988) aff'd, 883 F.2d 1101 (1st Cir. 1989), cert. denied, 494 U.S. 1027 (1990) (finding market power for BC/BS after establishing that it controlled between 62.8% and 80% of the insured Rhode Island market); Westchester Radiological Assoc. v. Empire Blue Cross & Blue Shield, 707 F. Supp. 708, 714-15 n.19 (S.D.N.Y. 1989), aff'd 884 F.2d 707 (2d Cir. 1989), cert. denied 493 U.S. 1095 (1990) (assuming market power based on plaintiff’s claim that BC/BS controlled 80% to 90% of all insureds in the relevant Downstate market); Ball Memorial, 784 F.2d at 1330 (finding a high market share where BC/BS covered a range of 27% to 80% of all patients, depending upon the hospital’s location); Reazin v. Blue Cross & Blue Shield, 899 F.2d 951, 969 (10th Cir. 1990), cert. denied, 497 U.S. 1005 (1990) (finding market power when BC/BS had control of 47% to 62% of all Kansas insureds). Note that some of these cases look broadly at state markets as opposed to the local markets where the insurer practicably can exert its leverage. Future cases dealing specifically with HMO power might more carefully define the relevant market.

327. See supra parts IV.A.1.b, IV.A.2.b (defining the health care market as three separate product markets for primary, secondary, and tertiary care along with three accompanying geographic markets).

328. In some markets, this foreclosure can be significant. For instance, HMO enrollment figures range from 30% in California to 65% in the District of Columbia. BERMAN & ROSE, supra
exclusionary restraint leads to both the HMO’s consumption of a significant amount of the providers’ services and foreclosure of an appreciable amount of the consumer market, courts should be attentive to the danger of monopsonistic, anticompetitive effects of this agreement.

C. Barriers to Entry

Even where the HMO has succeeded in foreclosing a significant part of the consumer market through its exclusionary restraint, it can exercise monopsonistic power only if there are significant barriers to entry that prevent new insurers not subject to the restraint from altering present enrollment patterns. A new non-HMO insurer would not be subject to the exclusionary restraint because the restraint only forbids the providers from working with other HMOs. If this insurer captured a significant percentage of the HMO enrollee market, then it might request the providers under the restraint to provide an optimal level of care at an optimal price, which would prevent the potentially monopsonistic HMO from exerting its leverage. Thus, barriers to entry to the HMO consumer market are another factor courts must examine to determine the likelihood of success of an HMO’s exclusionary restraint in gaining monopsonistic control.329

Courts should find many such barriers. As HMO enrollees prefer the unique features offered by HMOs,330 consumer preferences act as a major obstacle for non-HMO insurers trying to capture HMO market share. In addition to the loyalty to their present type of insurance, consumers also exhibit a loyalty to their present insurer.331 The strength of these bonds...
would reinforce the barrier to entry for a new non-HMO insurer. Even when consumers are concerned primarily with price, a new non-HMO insurer could not compete effectively because of its higher costs. Initially, a new insurer would face high costs by promoting its product to both providers and consumers. Operationally, a non-HMO insurer likely would experience greater costs if it did not work in a capitation system similar to HMOs. Thus, HMO consumers probably would not be attracted to the prices that a new non-HMO insurer could offer. Without any real threat to its monopsonistic power, an HMO could attain an unfettered ability to reduce its provider costs by reducing their output throughout the existence of the exclusive agreement. Courts should presume antitrust liability under the circumstances because an HMO can create such anticompetitive effects through its consumption of the providers' services and through its exclusion of other actual and potential rival payors.

D. Conduct

Yet even if a court finds this monopsonistic power, it should examine further whether the insurer's conduct in constructing the exclusionary restraint reinforces the tendency towards anticompetitive effects. Such investigation acts as a necessary check to finding liability for what might be legitimate competitive conduct that actually furthers the goals of the antitrust laws by creating efficiency within a market.

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332. See supra notes 200-02 and accompanying text (explaining the costs incurred in attaining goodwill for physicians entering a market); Kuzins, supra note 33 (explaining that HMOs spend enormous amounts on advertising). Recouping these initial expenses also could be a protracted process because consumers usually consider buying new insurance only once a year, which detracts from the net present value of an investment in a new health insurance product. Pauly, Monopsony Power, supra note 196, at 80.

333. As explained supra notes 10-15 and accompanying text, capitation lowers costs from FFS insurance because providers who bear some financial risk usually have an incentive to practice more cost-efficiently. Thus any FFS-based health insurance product likely would experience higher costs than an HMO. As even PPOs work on a discounted FFS basis, they are not likely to be strong competitors with HMOs along price lines. See Freiburg, supra note 10, at 586-87 (describing PPO reimbursement).

334. See, e.g., Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 767 (1984) (stating that "[i]t is not enough that a single firm appears to 'restrain trade' unreasonably, for even a vigorous competitor may leave that impression"). Because sometimes ostensible anticompetitive
In this situation courts may consider factors similar to those suggested in the discussion of raising rivals' costs: i) the length of the term of the agreement; ii) the rigidity of the restraint; iii) the amount of pressure the dealer places on the supplier; iv) the intent of management; v) the size of the firms; and, vi) the nature of the purchasers. If a court finds that the HMO's dealings with its providers are commensurate with its needs to be a viable competitor in the market, it might conclude that the HMO permissibly is trying simply to create synergies through integration. Under such circumstances, the HMO likely will pass on its cost savings to its enrollees. If a court finds, however, that the HMO has imposed restrictions that give it a degree of control in excess of what it needs to remain competitive, the courts could assume that the HMO will use its power to gain illicit monopsonistic profits. This could be accomplished by decreasing the prices it pays for providers' services through decreasing the range of their outputs with no concomitant price reduction for its enrollees. In such situations, the court should consider enjoining the exclusionary restraint imposed by the HMO.

E. Performance

Once an exclusionary restraint has been in place for a sufficient period of time, a court also may look at the effects of the relationship on the market. Specifically, it can exam-
ine the providers' output under the restraint as compared to the output of other similar HMOs. It also can compare the medical loss ratio of the HMO imposing the restraint to that of HMOs without restraints over their providers. If either of these factors are lower than expected, a court might infer that the exclusionary relationship has created anticompetitive effects. A court also must take into account numerous macroeconomic factors that can affect performance indicators.

F. Evaluation of Legal Precedent Examining Monopsony Through Exclusionary Restraints

Similar to its treatment of the issue of raising rivals' costs, the U.S. Healthcare court did not examine in detail the relationship between the HMO and the providers in question to determine if there was the potential for monopsonistic injury in the exclusionary relationship. The court should have examined the importance of the HMO to its providers, its foreclosure of other payors, and the barriers to entry for new payors. Following this investigation, it should have examined the HMO's conduct and the performance of the parties to the relationship. Had it done so, the court might have found a likelihood of anticompetitive effects on consumers and providers. At a minimum, it could not have asserted that there are always other buyers of physician services. The court, however, also qualified its opinion by stating that physician exploitation was not the main issue presented. Other courts have undertaken the investigation of these criteria and have paved the way for more insightful analysis into the potential for anticompetitive effects. When future courts examine cases involving exclusionary restraints imposed by HMOs upon providers, they should follow the heuristic of these well-reasoned opinions and

338. See supra notes 244, 250 (discussing what would indicate lower output in an HMO setting).
339. This discussion only evaluates issues raised in the U.S. Healthcare opinion. The Marshfield court did not have occasion to question the ability of an HMO to have monopsonistic leverage over providers because the employee-physicians owned the Marshfield Clinic. One cannot have monopsonistic power over oneself.
341. See supra note 328 and accompanying text.
explore all of the relevant issues.

VIII. CONCLUSION

This Note has illustrated the dangers to consumers, competitors, and providers of an HMO-provider agreement that prohibits providers from offering their services to other HMOs. It also has shown that proper adjudication of the antitrust laws effectively can expose any danger presented by this situation. As the wave of integration in health care intensifies, the likelihood of antitrust injury also will increase. As a result, the courts will handle an increasing number of the types of cases described herein.

Although this danger exists, the market can correct itself without resorting to the courts if it succeeds in shifting the balance of power from the insurers to all the other players in the industry. If consumers integrate into larger purchasing cooperatives, they can effectively check the power of a large HMO. They can demand concessions, monitor price and performance, and ultimately, threaten to invite a competing HMO into the market if they are not satisfied with the present system. Consumers also can enjoy increased power through laws mandating disclosure about the extent to which HMOs are profiting from cost containment measures. They can use this information to reward with increased enrollment HMOs that provide the most service per premium dollar.

On the provider side, a network of providers who have integrated to form a selling cooperative can restrain anticompetitive HMO activity to some degree. The

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342. See Flynn, supra note 16, at 101 (indicating that exclusionary restraints likely will increase as a source of trouble in the health care setting). Because of this danger, Minnesota has banned exclusive contracts between insurers and providers. Page, supra note 195, at 6.

343. See Mark A. Hall, The Role of Insurance Purchasing Cooperatives in Health Care Reform, 3 KAN. J.L. & PUB. POL'y 95, 98 (1994) (discussing proposals to develop cooperatives that would allow small groups and individuals to buy health care like large groups).

344. See, e.g., Julie Johnsson, Physician and Patient Protection: California Assembly Sends Sweeping Managed Care Law to Governor, AM. MED. NEWS, Sept. 19, 1994, at 3, 7 (explaining one aspect of a California law mandating plans to furnish the state with a detailed account of all revenues and expenses annually).

345. Thus organized medicine has done heavy lobbying to try to get Congress to relax the antitrust laws enough to allow collective negotiations with health plans and payers. John K. Iglehart, Health Policy Report: Physicians and the Growth of Managed Care, 331 NEW ENG. J.
providers’ effectiveness at protecting their market position will
depend upon their ability to represent enough of the market
that the HMO cannot force them to compete too fiercely with
each other. If a balanced playing field evolves, the dangers
suggested by this Note will be diminished. The industry other-
wise will not be able to deflect an upsurge in protracted and
expensive antitrust litigation that will further increase health
care costs.