

A View from the Trenches: A Reply to Professor Waller’s *How Much Health Care Antitrust Is Really Antitrust?*

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INTRODUCTION

Beginning in 1975, with the Supreme Court’s ruling in *Goldfarb v. Virginia State Bar*,¹ it became clear that the “learned professions” were subject to the federal antitrust laws.² Prior to that time, it was widely believed that federal antitrust laws did not apply to health care professionals because they were considered learned professionals regulated by the states.³ Over the years, antitrust regulators and federal

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1. 421 U.S. 773 (1975).

2. Section 1 of the Sherman Act provides that “every contract, combination . . . or conspiracy, in restraint of trade or commerce . . . is declared to be illegal.” 15 U.S.C. § 1 (2004). In *Goldfarb v. Virginia State Bar*, the County Bar argued unsuccessfully that Congress never intended to include learned professions in the Sherman Act, which involved trade or commerce. 421 U.S. at 787. According to the County Bar, competition was inconsistent with a profession because “enhancing profit is not the goal of the professional activities.” *Id.* at 786.

3. In addition, until the decision in *Summit Health, Ltd. v. Pinhas*, there was a question as to whether the challenged activities took place in interstate commerce. 500 U.S. 322, 329 (1991). In

courts attempted to apply antitrust principles to the health care industry. Professor Spencer Waller questioned how much of antitrust is really antitrust, and argued that the lower courts have conducted a guerrilla warfare against Supreme Court precedent by carving out their own peculiar body of law in four key areas: interstate commerce, boycotts, price fixing, and hospital mergers.⁴

The purpose of this Article is to provide a different perspective from the viewpoint of a private lawyer who counsels clients about recent developments in health care antitrust. From this perspective, antitrust health care is all about preserving competition in the midst of an industry and a profession beset by rules and regulations.

As a starting point, it is important to note that numerous antitrust decisions from the Supreme Court involve the health care industry. The list is quite lengthy—covering a wide variety of topics from interstate commerce to boycotts and price fixing, to exclusive contracts to immunities.⁵ These cases played important roles in the development of antitrust law as it is applied not only to the health care industry, but also to antitrust jurisprudence generally.

From a provider's perspective, the most important cases discussed in this Article are those that identify the areas of potential antitrust exposure

Pinhas, the Supreme Court liberally construed the jurisdictional requirement of the Sherman Act, thus resolving a split among the circuit courts. *Id.* at 333. Prior to the case, the Fourth, Seventh, Eighth, and Eleventh Circuits had held that peer review does not affect interstate commerce. *See id.* at 342–43 (citing *Furlong v. Long Island Coll. Hosp.*, 710 F.2d 922, 925–26 (2d Cir. 1983); *Seglin v. Esau*, 769 F.2d 1274, 1283–84 (7th Cir. 1985); *Hayden v. Bracy*, 744 F.2d 1338, 1342–43 (8th Cir. 1984); *Cordova & Simonpietri Ins. Agency Inc. v. Chase Manhattan Bank N.A.*, 649 F.2d 36, 45 (1st Cir. 1981); *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715, 725 (10th Cir. 1980)); *Thompson v. Wise Gen. Hosp.*, 707 F. Supp. 849, 854–56 (W.D. Va. 1989). In *Pinhas*, the Supreme Court concluded that denial of privileges would have an effect on the entire hospital staff, which in turn would affect interstate commerce. *Pinhas*, 500 U.S. at 329–30. In this way, *Pinhas* removed the jurisdictional issue pertaining to peer review and paved the way for plaintiffs-physicians to sue in federal court.

4. Spencer Waller, *How Much of Health Care Antitrust Is Really Antitrust?*, 48 LOY. U. CHI. L.J. (forthcoming May 2017).

5. *See generally* N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101 (2015) (deciphering whether nonsovereign actors' conduct can be considered state action); *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003 (2012) (discussing the state action immunity doctrine); *Cal. Dental Ass'n v. FTC*, 526 U.S. 756 (1999) (using a quick look analysis for advertising restrictions); *Patrick v. Burget*, 486 U.S. 94 (1988) (discussing state action immunity); *Pinhas*, 500 U.S. 322 (1991) (discussing the interstate commerce requirement for a Sherman Act violation); *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447 (1986) (using the rule of reason analysis for concerted refusal to deal); *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984) (analyzing exclusive contracts); *Arizona v. Maricopa Cty. Med. Soc'y*, 457 U.S. 332 (1982) (discussing price-fixing agreements).

including: peer review (*Patrick v. Burget*),⁶ exclusive contracts (*Jefferson Parish Hospital District No. 2 v. Hyde*),⁷ joint negotiations (*Arizona v. Maricopa County Medical Society*⁸ and *United States v. Alston*),⁹ and provider mergers and joint ventures. Along with the United States Department of Justice (“DOJ”) and the Federal Trade Commission’s (“FTC”) Health Care Policy Statements,¹⁰ Horizontal Merger Guidelines,¹¹ and later Competitor Collaboration Guidelines,¹² these cases provide a solid foundation for antitrust counseling in the health care industry. In each case and guideline, the underlying and controlling principles focus on competition.

That said, the health care industry, like many industries, presents some unique circumstances and challenges that antitrust enforcement agencies and the courts address in a variety of ways. This is not to say that competitive issues have been ignored or even minimized—in fact, antitrust rules have typically emerged as the core principles.

I. PEER REVIEW ASSESSED UNDER A RULE OF REASON

Peer review is consistently viewed as a form of self-regulation whereby physicians who provide unacceptable or substandard patient care are identified by their peers and then appropriately disciplined or sanctioned by the hospital(s) at which they have staff privileges. In other words, peer review is primarily a mechanism by which hospitals can ensure quality of care to the public. While competing doctors can use peer review for anticompetitive purposes, it is an accepted practice that, when properly conducted, serves an important procompetitive function widely recognized and accepted. Most states require hospitals to have medical peer review committees—even the federal government requires

6. 800 F.2d 1498 (9th Cir. 1986), *rev'd*, 486 U.S. 84 (1986).

7. 466 U.S. 2 (1984).

8. 457 U.S. 332 (1982).

9. 974 F.2d 1206 (9th Cir. 1992).

10. U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (Aug. 1996), https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf [hereinafter STATEMENTS OF ANTITRUST ENFORCEMENT].

11. U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES (Aug. 2010), <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

12. U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf.

review committees as a prerequisite for Medicare funding.¹³ Although not often stated, the alternative to peer review would be to rely on medical malpractice suits to identify physicians providing negligent or substandard care. This is less desirable for a number of reasons, not the least of which is the concern that justice in such cases is slow, unpredictable, and not necessarily sufficient to cause the efficient removal of a physician from the hospital's medical staff. In the meantime, the offending physician may continue to provide care that could be substandard during what is often extended litigation.

For this reason, courts often decide that peer review resulting in the denial or removal of staff privileges is subject to a rule of reason,¹⁴ rather than a *per se* rule.¹⁵ With the potential to improve quality and enhance competition, peer review decisions are not inherently suspect.¹⁶ Courts only treat naked restraints on price or output as *per se* illegal without analysis of market power because they offer no redeeming efficiencies or procompetitive benefits. Thus, application of the rule of reason to peer review is not an anomaly in antitrust jurisprudence.

Once it was clear that the antitrust laws applied to medical staff peer review, previously excluded physicians brought forth a number of antitrust cases.¹⁷ Issues that dominated these cases include whether a hospital and its medical staff were a single entity capable of conspiring,¹⁸

13. See generally Condition of Participation: Medical Staff, 42 C.F.R. § 482.22(a) (noting that one condition of participation for hospitals is that the hospital must have an organized medical staff).

14. The rule of reason analysis guides the determination of whether the challenged conduct violates section 1 of the Sherman Act, unless the conduct falls into the category of "agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal [per se] without elaborate inquiry as to the precise harm they have caused or the business excuse for their use." *N. Pac. Ry. Co. v. United States*, 356 U.S. 1, 5 (1958).

15. See, e.g., *Levine v. Cent. Fla. Med. Affiliates, Inc.*, 72 F.3d 1538, 1545-46 (11th Cir. 1996) (applying rule of reason to a physician's denial of membership in a health plan and temporary suspension of hospital privileges); *Lie v. Saint Joseph Hosp.*, 964 F.2d 567, 570 (6th Cir. 1992) (applying rule of reason to denial of hospital staff privileges).

16. See, e.g., *Nw. Wholesale Stationers v. Pac. Stationary & Printing Co.*, 472 U.S. 284, 298 (1985) (holding that *per se* treatment is not warranted where no evidence that the cooperative possessed market power or exclusive access to an element essential to effective competition). Peer review shares similar justifications to many standard setting bodies that develop standards that are subject to a rule of reason analysis.

17. Early cases decided before *Pinhas* include *Oltz v. Saint Peter's Community Hospital*, 861 F.2d 1440, 1450 (9th Cir. 1988); *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986); *Weiss v. York Hospital*, 745 F.2d 786, 815 (3d Cir. 1984); *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 459 U.S. 971 (1982).

18. In *Copperweld Corp. v. Independence Tube Corp.*, the Supreme Court held that an intracorporate agreement between a parent and its wholly owned subsidiary cannot constitute as a

whether a rule of reason or per se rule should apply,¹⁹ whether staff privileges were essential to participation in the market,²⁰ or whether quality considerations should justify a peer review decision.

The seminal case was *Patrick*,²¹ where the district court held for the plaintiff and awarded damages of \$650,000 on the antitrust claims—which, as required by law, were trebled to \$1.959 million plus attorney’s fees. Significantly, the plaintiff brought this case challenging peer review under both sections 1 and 2 of the Sherman Act.²² The Ninth Circuit reversed on state action grounds even though “there was substantial evidence that the [reviewing physicians] had acted in bad faith in the peer-review process[.]” and characterized their conduct as “shabby, unprincipled and unprofessional.”²³ Ultimately, the Supreme Court reversed the Ninth Circuit and reinstated the verdicts against the clinic and the individual doctors (who were jointly and severally liable).²⁴

The reaction in the health care industry to the verdict against the clinic and its doctors was immediately clear. Understandably, the *Patrick* decision had a chilling effect on the willingness of physicians to come forward to express concerns about a fellow physician or colleague, or to participate in peer review proceedings. Across the country, doctors grew concerned about participating in peer review for fear of being sued and found liable in a resulting antitrust case. Interestingly, the defendant physicians in *Patrick* argued, in part, that effective peer review is essential to maintaining high-quality care and that any threat of antitrust liability will prevent physicians from participating in peer review

conspiracy under the Sherman Act. 467 U.S. 752, 771 (1984). Similarly, some courts held that a hospital and its medical staff cannot conspire, whereas other courts held that the physicians were acting in their own economic interest and were therefore capable of conspiring. *Compare* Oksanen v. Page Mem. Hosp., 945 F.2d 696, 706 (4th Cir. 1991) (en banc) (recognizing that the hospital and medical staff are a single entity), with *Oltz v. Saint Peter’s Cmty. Hosp.*, 861 F.2d 1440, 1450 (9th Cir. 1988) (holding that the hospital and members of its medical staff do not share a unitary economic interest).

19. *Compare* Sweeney v. Athens Reg’l Med. Ctr., 709 F. Supp. 1563, 1580 (M.D. Ga. 1989) (suggesting that the per se approach is appropriate), with *Bhan v. NME Hosps., Inc.*, 929 F.2d 1404, 1412 (9th Cir. 1991) (applying a rule of reason to an alleged boycott of nonphysician anesthesiologists), *cert. denied*, 112 S. Ct. 617 (1991).

20. *Cf. Robinson*, 521 F. Supp. at 886 (alleging that access to a hospital was essential to practice as a heart surgeon).

21. *Patrick*, 800 F.2d at 1504–05.

22. *Id.* at 1504. Section 1 of the Sherman Act prohibits contracts, combinations or conspiracies in restraint of trade. 15 U.S.C. § 1 (2004). Section 2 of the Sherman Act prohibits monopolization, attempted monopolization and conspiracies to monopolize. Most cases in the health care industry are brought under section 1 of the Sherman Act. 15 U.S.C. § 2 (2004).

23. *Patrick*, 800 F.2d at 1509.

24. *Patrick v. Burget*, 486 U.S. 94, 106 (1988).

proceedings.²⁵ Therefore, the aftermath of *Patrick* presented a problem for hospitals that were anxious to have incompetent physicians removed from their staffs or sanctioned.

In response to widespread concerns, Representative Ron Wyden of Oregon introduced, and Congress enacted, the Health Care Quality Improvement Act (“HCQIA”), which provides limited immunity for “professional review actions.”²⁶ The HCQIA defines a “professional review action” as an action or recommendation of a professional review which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician . . . and which affects (or may affect) adversely the clinical privileges or membership in a professional society.²⁷ The HCQIA requires that the “professional review action” be:

- in the reasonable belief that the action was in the furtherance of quality health care;
- after a reasonable effort to obtain the facts of the matter;
- after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and
- in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts.²⁸

Additionally, the HCQIA does not prohibit federal or state government enforcement or private injunctive actions. The HCQIA requires health care entities to report adverse professional review actions to the State Board of Medical Examiners,²⁹ which in turn reports to the National Practitioner Data Base, thus addressing some of the concerns regarding the lack of a mechanism to prevent incompetent physicians from easily moving from one health care entity to another. Health care entities that do not comply with this reporting requirement are not entitled to the limited immunity under the HCQIA.³⁰

The concept of the legislation is that by affording certain procedural

25. *Id.* at 105.

26. Health Care Quality Improvement Act of 1986 (“HCQIA”), 42 U.S.C. § 11101 (1986).

27. *Id.* § 11151(9). The HCQIA defines “physician” as a “doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).” *Id.* § 11151(8).

28. *Id.* §§ 11111–13. The HCQIA includes a rebuttable presumption (by a preponderance of the evidence) that the hospital peer review committee complied with these requirements. *Id.* § 11112.

29. *Id.* §§ 11133–35.

30. *Id.* § 11133(c).

rights, including the right to an appeal, an independent appellate review will identify and resolve the cases motivated by anticompetitive concerns (rather than quality concerns), or the cases will be allowed to proceed in private litigation. In addition, the HCQIA specifically states that decisions based on economic or competitive activities by the physician are not to be considered as “professional review actions” within the protection of the HCQIA.³¹ “The intent of the [HCQIA] was not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise.”³² But importantly, the HCQIA was not intended, and did not serve, to immunize anticompetitive conduct. It also does not provide immunization from a lawsuit.³³ Although the HCQIA provides for immunity from damages, peer review actions that present antitrust concerns can still be addressed by injunctive relief, and states can opt out, prompting antitrust actions to then be brought under state antitrust laws.

While the HCQIA did not address all of the physicians’ concerns about participating in peer review proceedings, it went a long way in alleviating their apprehensions, facilitating legitimate peer review, and minimizing anticompetitive conduct without completely immunizing it.³⁴

II. EXCLUSIVE CONTRACTS SUBJECT TO A RULE OF REASON

Hospitals routinely enter into contracts with hospital-based physicians and others for the right to be the exclusive provider of a particular service at the facility, in exchange for the group agreeing to provide and manage all aspects of that service within the hospital. These “exclusive contracts” generally result in the department being closed off to physicians who are not part of the contracting group. Although these agreements may appear to be anticompetitive, most courts rejected antitrust challenges to exclusive contracts because of the inherent benefits to the hospital and patients under its care and the minimal effect on competition.

31. *Id.* § 11151(9).

32. *Bryan v. James E. Holmes Reg’l Med. Ctr.*, 33 F.3d 1318, 1337 (11th Cir. 1994) (quoting *Mahmoodian v. United Hosp. Ctr., Inc.*, 404 S.E.2d 750, 756, *cert. denied*, 502 U.S. 863 (1991)).

33. *See, e.g., Poliner v. Tex. Health Sys.*, 537 F.3d 368, 370 (5th Cir. 2008) (finding that summary suspension under the HCQIA raised a triable issue for the jury); *Wahi v. Charleston Area Med. Ctr.*, 453 F. Supp. 2d 942, 948 (S.D. W. Va. 2006), *aff’d*, 562 F.3d 599 (4th Cir. 2009) (granting the motion to dismiss in part, but allowing discovery related to the HCQIA).

34. The HCQIA could serve as a starting point for other legitimate self-regulation previously thought to be, but no longer, subject to state action protection. *See N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1117 (2015) (holding that actions by state boards are no longer subject to protection under the state action doctrine).

Many cases were brought by excluded physicians who alleged that the exclusive contracts were in violation of the Sherman Act. In some cases, these physicians alleged that the exclusive contract resulted from a group boycott by the contracting physicians.³⁵ In others, they alleged an unlawful tying of the physician's services to the hospital in violation of the Sherman Act.³⁶ Significantly, in *Hyde*, the Supreme Court noted that an exclusive contract may impact two different segments of the economy: consumers and competing providers of the service.³⁷ With respect to the effect on consumers, the Court focused on the tying aspect of the arrangement because patients who required surgery were required to use the anesthesiologists under contract with the hospital.³⁸ The Court considered whether the arrangement involved the use of market power to force patients to buy services that they would not otherwise purchase. The Court further concluded that because 70 percent of the patients chose other hospitals, there was insufficient evidence that the hospital possessed sufficient market power to force its contracted anesthesiologists on an unwilling patient.³⁹ The Court also provided criteria by which to determine whether hospital-based services would be considered separate products from hospital services.⁴⁰

In considering the effect of the exclusive contract on excluded physicians, the Court concluded there was insufficient evidence that the contract unreasonably restrained competition in any relevant market.⁴¹ In short, the Court said, "there is no evidence that any patient who was sophisticated enough to know the difference between two anesthesiologists was not able to go to a hospital that would provide him with the anesthesiologist of his choice."⁴² In her concurring opinion, Justice Sandra Day O'Connor disagreed that there were two separate

35. See, e.g., *Collins v. Associated Pathologists, Ltd.*, 844 F.2d 473, 479–80 (7th Cir. 1988), cert. denied, 488 U.S. 852 (1988) (finding that an exclusive contract did not constitute a group boycott in violation of section 1 of the Sherman Act).

36. See, e.g., *Beard v. Parkview Hosp.*, 912 F.2d 138, 144 (6th Cir. 1990) (finding that an exclusive radiology service contract did not constitute an alleged tying agreement in violation of section 1 of the Sherman Act); *Collins*, 844 F.2d at 477–78 (finding that an exclusive anesthesiology contract did not constitute an unlawful tying arrangement).

37. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 7 (1984).

38. *Id.* at 18–26. To establish an unlawful tying arrangement under section 1 of the Sherman Act, there must be two separate products or services and the purchase of one must be conditioned on the purchase of the other. *Id.*

39. *Id.* at 26–27.

40. *Id.* at 21 ("In this case[,] no tying arrangement can exist unless there is sufficient demand for the anesthesiology services separate from the hospital services.").

41. *Id.* at 29–30.

42. *Id.* at 30.

products involved, thus claiming that the conduct should not be considered the tying of two separate services.⁴³ But in viewing the arrangement as an exclusive contract, she agreed that an arrangement foreclosing “only a small fraction of the markets in which anesthesiologists may sell their services” was insufficient to establish an unreasonable restraint of trade.⁴⁴

While *Hyde* remains important in antitrust jurisprudence for explaining the relationship between tying arrangements and exclusive dealing contracts both in and outside the health care context, it is important to view the analysis of tying arrangements, exclusive contracts, and group boycotts as separate offenses. Most cases already do this. In the health care industry, so-called tying arrangements typically arise because of exclusive arrangements,⁴⁵ but exclusive contracts can and should be analyzed separately. In addition, the Supreme Court counseled against enlarging the “‘boycott’ pigeon hole” by invoking the per se rule,⁴⁶ and limited application of the per se rule to boycotts that enforce agreements that are themselves illegal.⁴⁷

III. PHYSICIAN NEGOTIATIONS RAISE SIGNIFICANT ANTITRUST CONCERNS

Another area of concern involves physician negotiations with insurers. Physicians continue to view the efforts of insurers to reduce their reimbursement as unfair and unwarranted. In *Maricopa*, the Supreme Court dealt with the issue of joint negotiation by independent physicians and held that the physicians engaged in per se illegal price fixing.⁴⁸ The case was important for establishing this per se rule in the health care

43. *Id.* at 43–44 (O’Connor, J., concurring).

44. *Id.* at 46–47.

45. *See, e.g.*, *Collins v. Associated Pathologists, Ltd.*, 844 F.2d 473, 477–78 (7th Cir. 1988) (finding that an exclusive anesthesiology contract did not constitute as an unlawful tying arrangement); *Konik v. Champlain Valley Physicians Hosp. Med. Ctr.*, 733 F.2d 1007, 1014–15 (2d Cir. 1984), *cert. denied*, 469 U.S. 884 (1984) (finding that the anesthesiologists’ exclusive arrangement with the hospital was not an unlawful tying arrangement).

46. *See* *FTC v. Ind. Fed’n of Dentists*, 476 U.S. 447, 458 (1986) (refusing to expand the “‘boycott’ pigeon hole,” which would have meant applying a per se rule to the dentists’ refusal to provide their patients’ x-rays to their patients’ insurance companies).

47. *FTC v. Superior Trial Court Lawyers Ass’n*, 493 U.S. 411, 423–24 (1990). *See also* *Collins*, 844 F.2d at 479 (noting that boycotts are only illegal per se if used to enforce agreements that are themselves illegal per se) (citing *Wilk v. Am. Med. Ass’n*, 719 F.2d 207, 221 (7th Cir. 1983) (providing the same holding regarding boycotts as per se illegal)); *U.S. Trotting Ass’n v. Chi. Downs Ass’n*, 665 F.2d 781, 787–90 (7th Cir. 1981) (en banc) (noting the same requirement for finding boycotts as per se illegal)).

48. *Arizona v. Maricopa Cty. Med. Soc’y*, 457 U.S. 332, 332 (1982).

industry. It provided the requisite support for continued counseling of the risks associated with joint negotiations. It also led the way for criminal prosecution by the DOJ some years later and established a framework for agency guidelines with provider networks.

Following the Supreme Court's decision in *Maricopa* in 1982, the DOJ and FTC issued guidelines that elaborated on the financial integration necessary to establish a legitimate joint venture.⁴⁹ Independent physician associations ("IPA") were common, but did not necessarily involve economic risk sharing. The guidelines also addressed clinical integration, which was not commonly found. The DOJ and the FTC further provided guidance on both clinical integration⁵⁰ and the so-called messenger model.⁵¹ This was an important development as these guidelines provided much-needed guidance as to how physicians and other providers could integrate their practices and jointly negotiate with insurers without violating the antitrust laws. Counseling took on a new dimension upon the issuance of these new guidelines.

Although the federal antitrust agencies issued many business review letters and advisory opinions on these topics, only two cases were litigated challenging this conduct: one was the criminal indictment of three dentists for price fixing in *Alston*,⁵² and the second was the FTC's challenge in *North Texas Specialty Physicians v. FTC* to a physician group's joint negotiation over payor rates, which was condemned under a "quick look" analysis.⁵³

49. STATEMENTS OF ANTITRUST ENFORCEMENT, *supra* note 10, at 61–141 (noting Statement 8 and Statement 9).

50. Letter from Jeffrey W. Brennan, Assistant Dir., Bureau of Competition, Fed. Trade Comm'n, to John J. Miles, Ober, Kaler, Grimes and Shriver (Feb. 19, 2002) (Staff Advisory Opinion to MedSouth, Inc.); Letter from Markus H. Meier, Assistant Dir., Health Care Div., Fed. Trade Comm'n, to John J. Miles, Ober, Kaler, Grimes and Shriver (June 18, 2007) (Follow-Up to 2002 Staff Advisory Opinion to MedSouth, Inc.); *see also* Letter from Markus H. Meier, Assistant Dir., Health Care Div., Fed. Trade Comm'n, to Michael E. Joseph, McAfee & Taft (Staff Advisory Opinion to Norman PHO) (Feb. 13, 2013); Letter from Markus H. Meier, Assistant Dir., Health Care Div., Fed. Trade Comm'n, to Christi J. Braun, Ober, Kaler, Grimes and Shriver (Staff Advisory Opinion to TriState Health Partners, Inc.) (Apr. 13, 2009); Letter from Markus H. Meier, Assistant Dir., Health Care Div., Fed. Trade Comm'n, to Christi J. Braun and John J. Miles, Ober, Kaler, Grimes and Shriver (Advisory Opinion to Greater Rochester Independent Practice Association, Inc.) (Sept. 17, 2007).

51. Traditionally, the messenger model was a way for physician networks to use a single agent to relay contract information between a payor and individual physicians, but not allow the group to negotiate or set contract terms.

52. *United States v. Alston*, 1991-1 Trade Cas. (CCH) ¶ 69,366 (D. Ariz. 1990), *aff'd in part, vacated in part*, 974 F.2d 1206 (9th Cir. 1992); *United States v. Alston*, No. CR-10-042-Tuc (D.C. Ariz. Jan. 15, 1993) (plea agreement).

53. 528 F.3d 346, 363 (5th Cir. 2008).

Prior to 1990, the DOJ's Antitrust Division brought only two criminal indictments in the health care industry, one against an association of medical professionals⁵⁴ and another against a pharmaceutical association.⁵⁵ Aside from these two cases, the DOJ brought only civil antitrust cases in the health care field.

The DOJ launched three grand jury investigations of physicians and dentists in 1988. Two of the investigations resulted in civil complaints,⁵⁶ but the third resulted in *Alston*, a criminal case in which the DOJ charged three dentists with illegal price fixing.⁵⁷ Although the jury found the dentists guilty, the trial judge ordered acquittal of two of the defendants and a new trial for one—Dr. Alston.⁵⁸ On appeal, the Ninth Circuit reversed and remanded to the district court for a new trial.⁵⁹ The case was ultimately settled with a plea agreement.⁶⁰ While the DOJ claimed that the Ninth Circuit's decision was a significant legal victory, the DOJ did not retry the case before the trial judge who had previously entered judgments notwithstanding the verdict.

While the DOJ initiated several other criminal investigations in the health care industry,⁶¹ it is fair to say that the DOJ focused on civil enforcement for antitrust violations in the health care industry and the FTC followed its guidance with numerous civil charges and consent

54. *Am. Med. Ass'n v. United States*, 317 U.S. 519, 531–36 (1943) (criminally convicting the America Medical Association for conspiracy to obstruct the operation of Group Health Association). Significantly, twenty-two individuals were indicted, but were either found not guilty or received a directed verdict. *Id.*

55. *N. Cal. Pharm. Ass'n v. United States*, 306 F.2d 379, 385–86 (9th Cir. 1962), *cert. denied*, 371 U.S. 862 (1962) (noting a criminal conviction for price fixing).

56. *See, e.g., United States v. Mass. Allergy Soc'y*, 1992-1 Trade Cas. (CCH) ¶ 69,846 (D. Mass. 1992) (alleging that a society and its individual members agreed on fees to a Health Maintenance Organization (“HMO”), which resulted in a consent agreement); *United States v. Burgstiner*, 1991-1 Trade Cas. (CCH) ¶ 69,422 (1991) (noting a civil consent decree entered against obstetricians and gynecologists in Savannah, Georgia, who allegedly exchanged fee information, resulting in higher fees for their services).

57. *United States v. Alston*, 974 F.2d 1206, 1208 (9th Cir. 1992).

58. *United States v. Alston*, 1991-1 Trade Cas. (CCH) ¶ 69,366 (D. Ariz. 1990), *aff'd in part, vacated in part*, 974 F.2d 1206 (9th Cir. 1992).

59. *Alston*, 974 F.2d at 1215.

60. *United States v. Alston*, No. CR-10-042-Tuc (D.C. Ariz., Jan. 15, 1993) (plea agreement).

61. *United States v. Bolar Pharm. Co., Inc.*, Crim. No. 92-0454 (D. Md. filed Dec. 17, 1992) (charging two generic drug companies and their presidents with illegal price fixing). A criminal investigation of Pediatric Faculty Physicians, a group of approximately ninety pediatricians in Salt Lake City who practice at both the University of Utah Hospital and the Primary Children's Medical Center, never resulted in an indictment. *Utah v. Univ. of Utah*, 1994-1 Trade Cas. ¶ 70,550 (1994). Similarly, a criminal investigation into nurses' wages ultimately resulted in a civil action by the United States Department of Justice (“DOJ”). *United States v. Utah Soc'y for Healthcare Human Res. Admin.*, et al., 1994-1 Trade Cas. (CCH) ¶ 70,751–53 (D. C. Utah 1994).

decrees. Although within its prosecutorial discretion, the DOJ never fully explained the reasons for its decision. Was it the bad precedent set by the district court in *Alston*? Was it the consequences to the providers that would result from criminal prosecution? Was it the countervailing bargaining power of insurers? Was it the controversy that followed over whether the DOJ should be bringing criminal cases against individual practitioners in the health care industry? Or was it some combination of those factors?

In deciding whether to prosecute a case criminally or civilly, the DOJ's policy is to bring criminal indictments when the violation is clear and intentional. The DOJ's decision to proceed civilly or criminally has significant consequences for individuals. In a civil case, defendants are typically enjoined from engaging in the prohibited activity. In contrast, criminal defendants can be imprisoned for up to ten years, fined up to \$1 million or twice the gain or loss, or both.⁶² Further, those found guilty of a criminal violation may have their licenses revoked by the state and may be debarred from participating in government programs—like Medicare. A criminal conviction is also prima facie evidence of liability in a subsequent civil suit by injured parties seeking treble damages (plus attorney's fees).

Whatever the reasoning, the DOJ's prosecutorial discretion in bringing only civil cases now extends to other conduct involving market allocations and other agreements not to compete in the health care industry.⁶³ One example is the alleged market allocation agreement between two West Virginia hospitals, agreeing that one would not open a competing cardiac surgery program, which was challenged by the DOJ in a civil (rather than criminal) suit and settled by consent decree.⁶⁴ Typically, in these cases the DOJ obtained consent decrees to stop the illegal conduct,⁶⁵ which, for counseling purposes, sufficed as examples

62. Criminal Fine Improvements Act of 1987, Pub. L. No. 100–185, 101 Stat. 1279 (1987).

63. See *United States v. Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, 2017 WL 1206015, at *2 (W.D.N.C. Mar. 30, 2017) (alleging steering restrictions by an allegedly dominant health care system in a civil suit); *United States v. Charleston Area Med. Ctr., Inc. & Saint Mary's Med. Ctr., Inc.*, No. 2:16-cv-03664-JTC, 2016 WL 6828307, at *2 (S.D. W. Va. Oct. 21, 2016) (alleging an agreement not to advertise in a civil suit); *Complaint, United States & State of Mich. v. Hillsdale Cmty. Health Ctr.*, No. 2:15-cv-12311, 2015 WL 4724523 (E.D. Mich. June 23, 2015) (alleging in a civil suit an agreement not to advertise); *Complaint, United States v. Bluefield Reg'l Med. Ctr., Inc.*, No. 1:05-0234, 2015 WL 3299362 (S.D. W. Va. Mar. 21, 2005) (alleging illegal price fixing and service allocation in a civil suit).

64. *Charleston Area Med. Ctr.*, 2016 WL 6828307, at *2–3.

65. The one notable exception is *United States v. Charlotte-Mecklenburg Hospital Authority*, which is currently in litigation. 2017 WL 1206015.

of illegal conduct that the DOJ will challenge in civil actions.

Coincidentally, the only exception to this appears in the Joint Guidance that the DOJ and FTC issued recently, which indicates that the DOJ intends to investigate criminally “naked no-poaching and wage-fixing agreements that are unrelated or unnecessary to a larger legitimate collaboration between the employers.”⁶⁶ Because its nurse-wage fixing investigation and the Health Care Policy Statements are mentioned in the Joint Guidance, criminal prosecution for these offenses is now likely to occur in the health care industry.⁶⁷

66. U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, ANTITRUST GUIDANCE FOR HUMAN RESOURCE PROFESSIONALS (Oct. 2016), <https://www.justice.gov/atr/file/903511/download>.

67. Professor Waller also cites the legislation passed in response to *Jung v. Association of American Medical Colleges*, 339 F. Supp. 2d 26 (D.D.C. 2004), as a further indication of antitrust health care exceptionalism. Waller, *supra* note 4. In *Jung*, a group of medical school graduates sued in a class action alleging wage fixing against the National Resident Matching Program (“NRMP”) and a nationwide class of teaching hospitals, even though the NRMP does not include any wage information in its matching program or set any working conditions for medical residents. 339 F. Supp. 2d 26, 37–38 (D.D.C. 2004). The court dismissed the litigation when legislation was introduced and passed that exempted matches like the NRMP match from antitrust challenge. 15 U.S.C. § 37b (2004). The stated purposes of the law were to

confirm that the antitrust laws do not prohibit sponsoring, conducting, or participating in a graduate medical education residency matching program, or agreeing to do so; and . . . [to] ensure that those who sponsor, conduct or participate in such matching programs are not subjected to the burden and expense of defending against litigation that challenges such matching programs under the antitrust laws.

Id. § 37b(a)(2)(A)–(B). Significantly, section 207 of this statute created a price-fixing exemption for a certain class of antitrust claims, providing that “[n]othing in this section shall be construed to exempt from the antitrust laws any agreement on the part of 2 or more graduate medical education programs to fix the amount of the stipend or other benefits received by students participating in such programs.” *Id.* § 37b(b)(3). But as the court found, the plaintiffs’ pleading did not allege an agreement among residency programs to fix wages paid to residents. *Jung*, 339 F. Supp. 2d at 39–40. In passing the legislation, Congress recognized the unique circumstances presented: to create a level playing field and prevent overreaching by hospitals, medical school graduates all need to connect with a residency at the same time:

Before such matching programs were instituted, medical students often felt pressure, at an unreasonably early stage of their medical education, to seek admission to, and accept offers from, residency programs. As a result, medical students often made binding commitments before they were in a position to make an informed decision about a medical specialty or a residency program and before residency programs could make an informed assessment of a student’s qualifications. This situation was inefficient, chaotic, and unfair and it often led to placements that did not serve the interests of either medical students or residency programs.

15 U.S.C. § 37(a)(1)(B) (1997). Alvin E. Roth—who later received the Nobel Prize in Economic Sciences for his work in game theory—designed the algorithm used in the match program to optimize choice on the part of both the buyer and seller. The reasons stated for the legislation were not to avoid antitrust principles or antitrust challenge, but rather to avoid the lengthy litigation that would have followed. As the law indicated:

Antitrust lawsuits challenging the matching process, regardless of their merit or lack thereof, have the potential to undermine this highly efficient, pro-competitive, and long-

IV. JOINT VENTURES AMONG PROVIDERS

Based on the *Maricopa* ruling, physician and hospital networks presented another slightly different antitrust issue. The Court in *Maricopa* said that physicians who share the profits and losses are considered a single entity incapable of conspiring.⁶⁸ Aside from the issue of joint negotiation, this reference to sharing profits and losses raised the question of permissible joint ventures between competing providers. The issues relating to joint ventures and joint conduct by providers necessarily overlapped. If the parties did not form a legitimate joint venture, their conduct in dividing the market or fixing prices was per se illegal. Two cases illustrate this: *New York v. Saint Francis Hospital*, where a joint operating agreement between two hospitals was per se illegal due to insufficient integration,⁶⁹ and *Health America Pennsylvania v. Susquehanna*, where the joint operating agreement was permissible under a rule of reason analysis because of sufficient integration.⁷⁰ Admittedly, District Court Judge William Conner struggled with the decision in *Saint Francis Hospital*, saying:

The Court fully realizes that this decision will cause economic hardship to defendants. Competition does that; but it serves what Congress and the State Legislature deem the higher purpose of reducing prices to consumers. There is even a possibility that could ultimately lead to the demise of one of [sic] defendants, which ironically would result in the end of local competition and an increase in prices . . . Perhaps the State will consider such long-term effects of rigid enforcement of the antitrust laws, and allow defendants to share other capital-intensive so that they may both continue to provide, on a not-for-profit basis, much needed, high quality medical care in the Poughkeepsie area.⁷¹

Subsequent cases outside the health care industry continue to address this area of the law.⁷²

standing process. The costs of defending such litigation would divert the scarce resources of our country's teaching hospitals and medical schools from their crucial missions of patient care, physician training, and medical research. In addition, such costs may lead to abandonment of the matching process, which has effectively served the interests of medical students, teaching hospitals, and patients for over half a century.

Id. § 37b(a)(1)(E). Ms. Busey was an attorney of record for the NRMP in the Match litigation.

68. *Arizona v. Maricopa Cty. Med. Soc'y*, 457 U.S. 332, 356–57 (1982).

69. 94 F. Supp. 2d 399, 411–12 (S.D.N.Y. 2000).

70. 278 F. Supp. 2d 423, 436–37 (M.D. Pa. 2003).

71. *Saint Francis Hosp.*, 94 F. Supp. 2d at 402.

72. *See, e.g., Am. Needle, Inc. v. Nat'l Football League*, 560 U.S. 183, 185 (2010) (finding that the National Football League ("NFL") teams are separate, profit-maximizing entities, and their interests in licensing team trademarks are not necessarily aligned); *Texaco Inc. v. Dagher*, 547 U.S. 1, 3 (2006) (holding that it is permissible for an economically integrated joint venture to set the prices at which it sells its products).

V. CHALLENGES TO MERGER CASES

Consolidation in the health care industry has led to many hospital mergers and acquisitions. Challenges to these transactions are difficult for enforcement agencies for a variety of reasons. For one, product markets for hospital mergers are usually defined as a cluster of services, and geographic markets vary due to these clusters of services. In addition, hospital mergers are unique in terms of traditional economic and business considerations because of the hospital's obligation to provide care regardless of the patient's ability to pay, and many hospitals also provide charity care as part of their missions.

Agency challenges to these mergers have taken many twists and turns, and the cases consistently reflect an effort to apply traditional antitrust principles to these health care transactions and a win-loss ratio that does not suggest abandonment of antitrust principles by the courts.

To recap, from the 1980s to 1994, the FTC and DOJ brought six cases to enjoin hospital mergers—they won four and lost two.⁷³ From 1995 to 1999, the FTC and DOJ lost the six cases they litigated.⁷⁴ In 2002, the FTC conducted a retrospective study that led to the FTC's successful challenge in 2004 of the consummated Evanston Northwestern Healthcare Corp. and Highland Park Hospital merger in Chicago's suburbs.⁷⁵ The FTC relied on documents and actual pricing behavior to show an effect on prices after the systems gained market power after the merger.⁷⁶

Since 2004, the FTC has successfully challenged eight hospital mergers resulting in either an injunction in federal court or abandonment

73. *FTC v. Hosp. Bd. of Dirs. of Lee Cty.*, 38 F.3d 1184, 1185 (11th Cir. 1994); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1209 (11th Cir. 1991); *In re Adventist Health Sys./W.*, 117 F.T.C. 224, 285 (1994); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1286 (7th Cir. 1990), *cert. denied*, 111 S. Ct. 295 (1990); *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 849 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989); *FTC v. Hosp. Corp. of Am.*, 106 F.T.C. 361, 69 (1985), *aff'd*, 807 F.2d 1381, 1387 (7th Cir. 1986), *cert. denied*, 481 U.S. 1039 (1987).

74. *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 69 F.3d 260, 273 (8th Cir. 1995); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1085 (N.D. Cal. 2000), *amended by*, 130 F. Supp. 2d 1109, 1137 (N.D. Cal. 2001); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1302–03 (W.D. Mich. 1996), *aff'd per curiam*, 121 F.3d 708 (6th Cir. 1997); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632, 637 (8th Cir. 1997).

75. *Evanston Nw. Healthcare Corp.*, No. 9315, 2017 WL 2286196 (F.T.C. Aug. 6, 2007) (opinion of the Commission).

76. *Commission Rules that Evanston Northwestern Healthcare Corp.'s Acquisition of Highland Park Hospital Was Anticompetitive*, FED. TRADE COMM'N (Aug. 6, 2007), <https://www.ftc.gov/news-events/press-releases/2007/08/commission-rules-evanston-northwestern-healthcare-corps>.

by the parties.⁷⁷ The Seventh Circuit just remanded another case the FTC lost in the district court,⁷⁸ and yet another case, *FTC v. Cabell Huntington Hospital and Saint Mary's Medical Center*,⁷⁹ was abandoned due to the enactment of a Certificate of Public Advantage (“COPA”) law and a state decision to approve the cooperative agreement between the parties.⁸⁰ Thus, health care providers today understand that the FTC will carefully scrutinize mergers and acquisitions and challenge them when the agency believes they present an antitrust concern.⁸¹

That said, the FTC faces new challenges in its efforts to prevent anticompetitive hospital mergers. One challenge is the enactment of COPA laws by several states, which minimize or deviate from federal antitrust law.⁸² For example, in *Cabell Huntington Hospital*, after the FTC filed an administrative complaint to enjoin the transaction, the State of West Virginia passed a COPA law that effectively precluded

77. *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003, 1005 (2012); *Saint Alphonus Med. Ctr.-Nampa Inc. v. Saint Luke's Health Sys., Ltd.*, 778 F.3d 775, 781 (9th Cir. 2015); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 561 (2014) (6th Cir. 2013); *FTC v. Penn State Hershey Med. Ctr.*, 185 F. Supp. 3d 552, 554 (M.D. Pa. May 9, 2016) (denying FTC's motion for preliminary injunction), *rev'd on appeal*, 838 F.3d 327 (3d Cir. 2016); *FTC v. OSF Health Sys.*, 852 F. Supp. 2d 1069, 1071 (N.D. Ill. 2012); *Reading Health Sys., & Surgical Inst. of Reading*, Docket No. 9353, 2012 WL 6188557 (F.T.C. Dec. 7, 2012) (dismissing the action when the transaction was abandoned); *Inova Health Sys. Found. & Prince William Health Sys., Inc.*, Docket No. 9326, 2008 WL 2556051 (F.T.C. June 17, 2008) (dismissing FTC's complaint upon the parties abandoning their transaction). *See also* *Renown Health*, Docket No. C-4366, 2012 WL 618850 (F.T.C. Dec. 4, 2012) (settling the FTC's allegations that Renown Health's acquisition of two cardiology groups reduced competition in Reno, Nevada).

78. *FTC & State of Ill. v. Advocate Health Care Network*, No. 15 C 11472, 2016 WL 3387163 (N.D. Ill. June 20, 2016) (denying the Federal Trade Commission (“FTC”)’s motion for a preliminary injunction), *rev'd and remanded*, 841 F.3d 460 (7th Cir. 2016).

79. *Cabell Huntington Hosp., Inc.-Saint Mary's Med. Ctr.*, Docket No. 9366 (F.T.C. July 6, 2016) (dismissing the administrative complaint against the proposed acquisition after legislation was enacted). The FTC's challenge came just three months after the attorney general's office approved the merger.

80. STATEMENT OF THE FEDERAL TRADE COMMISSION IN THE MATTER OF *CABELL HUNTINGTON HOSPITAL, INC.*, DOCKET NO. 9366 (July 6, 2016), https://www.ftc.gov/system/files/documents/public_statements/969783/160706cabellcommstmt.pdf [hereinafter *FTC STATEMENT*].

81. The DOJ has also successfully challenged two recent health insurance mergers. *See United States v. Anthem*, No. 16-1493, 2017 WL 685563 (D.D.C. Feb. 21, 2017) (enjoining the Anthem-Cigna merger) (on appeal); *United States v. Aetna*, No. 16-1494, 2017 WL 325189 (D.D.C. Jan. 23, 2017) (enjoining the Aetna-Humana merger).

82. *See* Edith Ramirez, Chairwoman, Fed. Trade Comm'n, Keynote Address at the Antitrust in Healthcare Conference 5–6 (May 12, 2016), https://www.ftc.gov/system/files/documents/public_statements/950143/160519antitrusthealthcare_keynote.pdf [hereinafter *Ramirez, Keynote*] (saying that arrangements that sidestep antitrust enforcement “generally fail to replicate the benefits of competition”).

consideration of the FTC's concerns.⁸³ While competition policy should have been considered, the fact that the FTC viewed the transaction as anticompetitive was either ignored or outweighed by other considerations deemed appropriate by the State.⁸⁴ Other states have passed similar laws.⁸⁵

Another challenge is the Affordable Care Act ("ACA"),⁸⁶ which was raised, albeit unsuccessfully, as a defense in several cases.⁸⁷ Recognizing that the lack of integration in the nation's health care system was a major source of inefficiency, the ACA encouraged integration and consolidation with resulting efficiencies that defense lawyers argued the antitrust laws should also take into account. This necessarily created a tension between the importance of integration encouraged by the ACA and the potential antitrust concern should the integration result in too much market power for the parties to the integration. Unlike the COPA laws that have actually dissuaded the FTC from bringing some challenges or caused the FTC to abandon them, the ACA defense has not yet been successful. This may be, in part, because when the ACA was passed, the antitrust enforcement agencies issued guidelines expressly recognizing the importance of competition in health care reform.⁸⁸

83. See FTC STATEMENT, *supra* note 80 (dismissing an administrative claim without prejudice "in light of the passage of West Virginia Senate Bill 597 ("SB 597") and the West Virginia Health Care Authority's decision to approve Cabell's cooperative agreement with [Saint] Mary's, with which the West Virginia Attorney General concurred").

84. Though the West Virginia law mandates that state authorities give "deference" to policy statements of the FTC, the law deliberately blocks federal antitrust review of certain hospital mergers.

85. Ramirez, Keynote, *supra* note 82, at 6–7. To date comments have been submitted by the FTC in opposition to state Certificate of Public Advantage ("COPA") laws in New York, Virginia, Tennessee, West Virginia, and Alabama.

86. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010) (codified as 42 U.S.C. 18001).

87. See, e.g., FTC v. Penn State Hershey Med. Ctr., 185 F. Supp. 3d 552 (M.D. Pa. 2016) (denying the FTC's motion for a preliminary injunction), *rev'd and remanded*, 838 F.3d 327 (3d Cir. 2016); Saint Alphonus Med. Ctr.-Nampa Inc. v. Saint Luke's Health Sys., Ltd., No. 1:12-CV-00560-BLW, 2014 WL 407446 (D. Idaho Jan. 24, 2014), *aff'd sub nom.* 778 F.3d 775 (9th Cir. 2015) (affirming the injunction and rejecting the efficiency arguments).

88. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011). Among other things, the statement by the FTC and DOJ regarding their enforcement policy provides a rule of reason analysis for accountable care organizations ("ACOs") that are financially or clinically integrated and a "safety zone" for networks that enjoy 30 percent or less for each service provided by two or more of the ACO providers. *Id.* It also sets forth the conduct that may be suspect for ACOs with high PSA shares. *Id.*

VI. A VIEW FROM THE TRENCHES

Professor Waller presented two options in his article:

Either we return to a basic antitrust approach with the same basic antitrust rules of the road as in other industries, subject to occasional exemptions and immunities, or we consciously work toward creating a more sector-specific health care antitrust policy with a deliberate blend of regulation and competition to create the desired goals of coverage, cost, competition, and compensation to providers.⁸⁹

Theoretically, the second option of creating a blend of regulation and competition to provide the best health care to everyone at the lowest cost may sound desirable, but the lack of a single overriding principle is likely to produce even more tension, more confusion, and less resolution.

Considering the challenges in applying antitrust principles to the health care industry, the question may not be “are we at a fork in the road?” but rather: “Is the full potential of antitrust realized in the health care industry?” This is a tall order and one that cannot easily be answered—but it is fair to say that it is not for lack of trying. Many constituencies are involved—federal, state, and private enforcers, and the judicial system—and some are more supportive of antitrust principles than others. The one notable exception may be the criminal prosecution of price fixing where, except with respect to the recent pronouncement on wage fixing and poaching agreements, the DOJ chose to bring civil rather than criminal actions.

Health care has presented many “forks in the road.” In response, Professor Waller cites Yogi Berra who once told a journalist how to find his home in Montclair, New Jersey: “When you come to the fork in the road, take it.”⁹⁰ But Yogi Berra lived on a cul-de-sac so either way you went, you got there!⁹¹

89. Waller, *supra* note 4.

90. *Id.* (citing to Yogi Berra).

91. Allen Barra, *Yogi Berra Knew How to Catch and Even Better How to Deliver*, DAILY BEAST (Sept. 23, 2015), <http://www.thedailybeast.com/articles/2015/09/23/yogi-berra-knew-how-to-catch-and-even-better-how-to-deliver.html>.