ANTITRUST ENFORCEMENT IN IMPERFECT HEALTH CARE MARKETS: A STATE PERSPECTIVE

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I. INTRODUCTION

It is an honor to appear here before such an impressive group of practitioners and government enforcers to discuss the sometimes difficult and perplexing issues regarding antitrust enforcement in health care markets.

Because these markets tend to be local in character, and extremely important to consumers in our states, state antitrust enforcers give high priority to health care matters. The modern era of antitrust enforcement in health care began, of course, when the Arizona Attorney General challenged the maximum price fixing schemes of two medical societies in Maricopa and Pima Counties,[2] in Arizona. Since then, it is probably fair to say that most people in state enforcement offices take for granted that competition is, and ought to be, the primary force dictating the price and quality of services in these markets. The failure of national health care reform has left the states with no choice but to look for market-based solutions to providing cost-effective health care for all of our citizens.

But, I think it is vitally important for everyone to understand that "competition" as the organizer of health care markets is a fairly recent development. Before the deregulation fervor of the late 1970's and early 1980's, it was commonly assumed that competition would not work, or would not work very well, in health care markets because the markets were dysfunctional in a number of ways. The fact that the actual consumers of health care often do not pay for the services

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rendered, that much of health care is purchased directly by the government on behalf of unpaying consumers, and that providing quality health care service often involves an intricate web of provider relationships, all suggested that the neoclassical model of perfect competition did not and does not fit health care markets very well. Even though we all went charging into the brave new world of competitive health care markets (and many government enforcers view it as their mission in life to ensure that competition continues in these markets) it is important to understand that there are many who viewed these markets even today as dysfunctional in significant respects. It is equally important to understand that state attorneys general have enforcement and advisory roles regarding health care issues that go beyond antitrust enforcement. Antitrust enforcement is critically important to meeting some of these goals. But meeting *all* the goals, such as universal coverage or even rectifying certain structural market defects, will require more substantive reform.

My goal today is to put state health care antitrust enforcement in the context of the broader mission of state attorneys general. First, I will briefly describe the evolution of state antitrust enforcement in health care markets over the past few years. Second, I will briefly describe the concomitant lessening of state regulation of the health care system and the attorney generals' role in these systems using Wisconsin as a case in point. Finally, I will discuss how, notwithstanding the multiple "health care" hats worn by state attorneys general, antitrust enforcement in the health care arena is conducted in a professional but creative manner.

II. OVERVIEW OF STATE ENFORCEMENT

As everyone in attendance will recall, it was 1982 when the Supreme Court in *Maricopa* initiated the modern era of health care antitrust enforcement by rejecting the claims of two physician groups that their attempt to fix maximum prices should be exempt from the *per se* rule because

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[2] *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982).

medicine was a "learned profession" and for a variety of other reasons. The decision put to rest lingering questions as to whether a physician's medical practice constituted "trade" under the Sherman Act and decided once and for all that the antitrust laws could be applied to the activities of the health care professions generally.[3]

In the wake of *Maricopa*, many of us in state antitrust enforcement offices were inundated with requests for appearances before medical groups seeking to understand the new world of antitrust enforcement in the medical profession. I was not a terribly popular speaker back then as I delivered my "shock therapy" message of possible prison terms, huge fines and forfeitures and triple damages for doctors and other professionals who dared to talk to their now "competing" doctors about prices and other aspects of their businesses.

The health care community's worst fears about antitrust enforcement seemed to be coming true as state enforcers began addressing violations that came to their attention. For example, during the 1980s, Washington brought a number of cases against health insurance plans in which providers were determining the reimbursement rates.[4] Other states addressed boycott conduct by competing doctors who refused to join newly-emergent HMOs[5] or were more directly attempting to coordinate physician pricing.[6] Other states brought actions resulting in consent orders barring doctors from

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[3]*Compare Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982) with *American Med. Ass'n v. United States*, 317 U.S. 519, 528 (1943) (antitrust laws applied to American Medical Association, but unclear to what extent law would apply to health care professions generally).

[4]*See, e.g., State of Washington v. Watcom Medical Bureau*, No. 85-2-00516-0 (1985); *State of Washington v. Skagit County Medical Bureau*, No. 85-2-19549-3 (King County Superior Court 1985).

[5]*See, e.g., State of Wisconsin v. Arellano*, Case No. 88-CV-378 (Wis. Cir. Ct. Dodge County 1987).

[6]*Minnesota v. Central Minnesota Health Care Alliance*, No. 73-CO-92-001109 (Stearns County District Court 1992); *Minnesota v. Mid-Minnesota Associated Physicians*, 1991-2 Trade Cas. (CCH) ¶ 69,531 (Douglas County District Court 1991); *Minnesota v. Southern Minnesota Health Alliance*, No. C090766 (Blue Earth County District Court 1990) (consent decrees required dissolution of collective bargaining organization for competing providers).

engaging in attempts to raise prices through boycotts targeting insurers.[7] (Just ten days ago, the New York attorney general challenged the alleged price fixing by two hospitals in Poughkeepsie via a joint agent used by the hospitals.) Yet, notwithstanding these civil actions, there has been a notable absence of state criminal antitrust cases in the health care area and a notable presence of judicious use of civil remedies by state enforcers in these quickly evolving markets. This suggests to me that we were successful in getting the message out to the health care community and that the fears of the health care community about antitrust enforcement were largely overstated.

Similarly, prior to 1990, the states often worked informally with hospitals contemplating mergers to ensure that the charitable, non-profit nature of the merging hospitals would be maintained.[8] With the Supreme Court's pronouncement in the *American Stores*[9] decision in 1990 that the states could obtain divestiture and other injunctive relief under section 16 of the Clayton Act, the states began in earnest to review and, where appropriate, to challenge mergers between hospitals and mergers involving other health care entities. Many state-negotiated consent decrees permitted mergers to proceed conditioned on language restricting or prohibiting certain exclusionary or discriminatory conduct.[10] Certain decrees allowed hospital mergers to proceed

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[7] *Colorado, ex rel. Woodard v. Colorado Union of Physicians*, 1990-1 Trade Cas. (CCH) ¶ 68,968 (1990); *Minnesota v. Mid-Minnesota Associated Physicians*, 1991-2 Trade Cas. (CCH) ¶ 69,531 (1992).

[8] *See, e.g., Sisters of St. Joseph/St. Luke's Hospital*, (Memorandum of Understanding with Washington Attorney General 1989) (MOU allowed merger but required continuation of non-profit status, local control, minimum amounts of charity care and revenue caps and prohibited discriminatory and predatory conduct).

[9] *California v. American Stores Co.*, 495 U.S. 271 (1990).

[10] *See, e.g., Partners Healthcare System/North Shore Med. Ctr.*, No. 96-1713B (Mass. 1996) (merger permitted subject to limitations on percentage of primary care physicians acquired and related referral restrictions); *Minnesota v. Children's Health of Saint Paul*, No. 4-94-CV-513 (D. Minn. 1995) (consent judgment permitting merger also required open staff and good faith negotiations with purchasers, restricted exclusive contracting and self referrals, and prohibited discrimination against low paying patients); *Daughters of Charity/Baptist Health System* (Settlement Agreement--Florida) (1995) (hospital affiliation permitted provided hospitals do not condition contracts for essential hospital services on purchasing other services); *Texas v. Columbia/HCA Healthcare Corp.*, No. 9504873 (Travis County District Court 1995) (consent judgment permitted acquisition but required certain divestiture, limited managed care contracting, and restricted tying and exclusive contracting arrangements); *Burbank Hosp./Leominster Hosp.* (Settlement Agreement--Massachusetts) (hospital affiliation permitted provided hospitals spend specified amounts on charity care).

provided the merged entity observed revenue caps.[11] Even hospital mergers approved pursuant to state Certificate of Public Advantage ("COPA") statutes have incorporated various prospective, mandatory injunctive relief provisions.[12] In many cases, these hospital merger investigations were jointly undertaken by a federal agency and the state involved.[13] However, such joint investigations do not always lead to identical enforcement decisions as was recently the case in the *Long Island Jewish Hospital* case brought by the Antitrust Division but not joined by the New York Attorney General.[14] The norm, however, is that the state and federal agencies work closely together supporting each others cases.[15]

More recently, state enforcers have reviewed various physician practice mergers,[16] and

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[11]*State of Wisconsin v. Kenosha Hospital & Medical Center*, 1997-1 Trade Cas. (CCH) ¶ 71,669 (E.D. Wis. 1996) (consent decree permitted merger conditioned on return of claimed efficiencies to consumers and restrictions on discriminatory and exclusionary conduct); *Commonwealth of Pennsylvania v. Capital Health System Services*, 1995-2 Trade Cas. (CCH) ¶ 71,205 (M.D. Pa. 1995) (consent decree permitted merger conditioned on return of claimed efficiencies to consumers, revenue caps and prohibition of certain exclusionary conduct); *Southcoast Health System*, No. 96-13190F (Mass. 1996) (merger permitted provided rate free effective for three years and community-based board maintained); *Commonwealth of Pennsylvania v. Providence Health System, Inc.*, 1994-1 Trade Cas. (CCH) ¶ 70,603 (M.D. Pa. 1994) (consent decree similar to *Capital Health*); *Cape Ann & Northeast Health Systems, Inc.*, No. 94-3286 (Mass. 1994) (assurance of voluntary compliance); *State of Minnesota, ex rel Humphrey v. Health One Corp.*, 1992-2 Trade Cas. ¶ 69,986 (D. Minn. 1992) (consent decree imposed cap on inpatient revenues).

[12]*Richland Memorial Hosp./Baptist Med. Ctr* (Certificate of Public Advantage--South Carolina 1997) (COPA permitted hospital partnership conditioned on five-year rate freeze, achievement of cost savings and funding of charity care); *Deaconess Med. Ctr./Columbus Hosp.* (Certificate of Public Advantage--Montana 1996) (COPA permitted merger but imposed cost, margin and revenue controls and prohibited certain discriminatory and exclusionary conduct); *Memorial Mission Hosp./St. Joseph's Hosp.* (Certificate of Public Advantage--North Carolina 1995)(COPA permitted joint operating agreement conditioned on profit and revenue limits, provision of charity care, and restrictions on exclusivity and discriminatory conduct). *See also Maine v. Central and Western Maine Reg'l PHO*, 1996-1 Trade Cas. (CCH) ¶ 71,320 (Me. 1996) (consent order sets terms for cooperative agreement among four hospitals to jointly negotiate with payers and prohibits exclusivity and tying arrangements). *See also Benefits Health Care* (opinion letter from Montana Attorney General Joseph P. Mazurek, November 24, 1997) Antitrust & Trade Reg. Rep. (BNA) No. 1843, at Vol. 74 (January 15, 1998).

[13]*See, e.g., United States v. Morton Plant Health System*, 1994-2 Trade Cas. (CCH) ¶ 70,759 (M.D. Fla. 1994) (consent decree enjoins merger but allows combination of some services but requires inpatient acute care services to remain separate).

[14]*United States v. Long Island Jewish Medical Center*, 1997-2 Trade Cas. (CCH) ¶ 71,960 (E.D.N.Y. 1997).

[15]The states have filed amicus briefs in appeals from significant hospital merger decisions. *See, e.g., FTC v. Butterworth Health Corp.*, 1992-2 Trade Cas (CCH) ¶ 71,571 (W.D. Mich. 1996), aff'd, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. Mich. 1997); *U.S. Mercy Health Services*, 1995-2 Trade Cas. (CCH) ¶ 71,162 (N.D. Iowa 1995), *vacated as moot*, 1997-1 Trade Cas. (CCH) ¶ 71,729 (8th Cir. 1997).

[16]*See, e.g., State of Wisconsin v. Marshfield Clinic*, 1997-1 Trade Cas. (CCH) ¶ 71,855 (W.D. Wis. 1997) (consent decree permitted merger of two multispecialty clinics but prohibits acquisition of additional primary and specialty care practices of varying periods and limits exclusive contracting and covenants not to compete).

conditioned some on rate limitations.[17] Mergers among health plans have similarly been addressed by state enforcers.[18]

Suffice to say the enforcement of the states has been quite extensive and reflects the belief of state antitrust enforcers that competition can provide price discipline in health care markets and positively impact consumer choice. Indeed, as antitrust enforcers we like to believe that antitrust enforcement can cure most of what ails a particular market, sort of a governmental "chicken soup." We do not always know how competition works or how it ultimately will benefit consumers but we have a belief that it is at least better than the alternatives: regulation of markets by government bureaucrats or collusion by self-interested market participants.

III. STATE REGULATION -- A PARALLEL UNIVERSE TO STATE ANTITRUST ENFORCEMENT

Coupled with the increase in state antitrust enforcement in the 1980's was a sometimes fitful but steady diminution in the degree of state regulation of the health care system. Poorly conceived state regulatory schemes were gradually dismantled as we came to rely increasingly on the market to price and allocate health care services. Yet, because certain key market imperfections in health care markets continued to exist, it is likely that deregulation probably went too far in some cases.

A. The Wisconsin Deregulation Experience

For example, at a policy level there was an aura of unreality to the introduction of competition (enforced through the antitrust laws) to the Wisconsin health care system because so

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[17] *See, e.g., State of Maine v. Maine Heart Surgical Associates, P.A.*, 1996-2 Trade Cas. (CCH) ¶ 71,653 (Me. Ct. 1996) (consent agreement permits physician merger provided physicians limit rates to those paid by managed care plans in the Boston area).

[18] *See, e.g., Harvard Community Health Plan, Inc./Pilgrim Health Care, Inc.* (Assurance of Discontinuance 1995) (two health plans permitted to merge but required to return claimed savings to consumers and provide various types of charitable care and to submit to some oversight by attorney general regarding physician practice contracts and acquisitions); *Blue Shield/Baystate* (Settlement Agreement--Massachusetts 1992) (health plan merger permitted conditioned on payment of $2 million into fund for uninsured children and funding of study reasons for failure of

much of that system was, in the mid-1980's regulated by the state. For example, prior to 1983, no health care plan could operate in Wisconsin unless every doctor was permitted to participate in that health care plan. Moreover, hospital rates were, more often than not, controlled or influenced by state officials usually in consultation with representative hospitals which often competed with each other. Hence, even as we contemplated a huge new enforcement effort in health care markets, we realized that the state action doctrine, in a narrow sense, and public policy deregulating health care markets, in a larger sense, would also play a significant role in these rapidly evolving markets.

Our office became directly involved in the public policy debate which led, in 1983, to the repeal of the state prohibition on closed panel plans and, through an aggressive state bidding process for health insurance for state employees, provided the stimulus for aggressive competition among newly-formed, closed panel HMOs and PPOs. These two state law changes caused a massive reorganization of the health care markets in Madison, where a high proportion of the residents were state employees, and to a lesser extent in Milwaukee, the state's largest urban center.

But, even as the state was deregulating doctor services aggressively, it continued an ambivalent posture towards competition among hospitals and certain other health care entities. In the mid-1980s, hospitals were permitted to coordinate their pricing through hospital rate-setting agreements promulgated by a committee consisting primarily of hospital representatives, but also including certain state officials. When it became apparent that there were obvious antitrust problems with an arrangement, where although state officials sat at the table, the private parties essentially decided what the prices would be, the state lurched to the other extreme and set up a hospital Rate-Setting Commission similar in structure to state Public Service Commissions to

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Baystate).

dictate rates to state hospitals.[19]

The lack of confidence in competitive hospital rate-setting implicit in this approach flew in the face of the state's attempts to deregulate other parts of the health care industry. Indeed, the mind set of the people who ran the Wisconsin Hospital Rate-Setting Commission in the mid-1980s, could only be described as antithetical to competition. The general counsel for that commission once told me in a moment of candor that he would just as soon prefer that all the hospitals in the state merge into one entity because his job would be a lot easier if he could determine prices for one entity, rather than for several hundred. Moreover, even as it became apparent that direct price controls on hospitals were not the answer to escalating costs in the health care industry, the state somewhat bizarrely decided to continue price controls on urban hospitals (which faced intense competition from their rivals) even while relaxing price controls on rural hospitals (which typically did not have much competition at all). Fortunately, this commission was abolished and replaced by a much less regulatory Cost Containment Commission which could not control the economic decisions of health care entities beyond certain capital expenditures. Eventually, even the Cost Containment Commission was abolished.

Lest one concludes that the schizophrenia in state health care regulation is a distant memory, I should remind you of the adoption by approximately twenty states of Certificate of Public Advantage ("COPA") statutes. These statutes purport to provide immunity to certain health care actors when they collaborate with competitors under certain circumstances. The apparent purpose behind many of these statutes is that enforcement of the antitrust laws against certain types of collaboration among health care providers may inhibit necessary or socially useful collaboration by

[19]I should note that our experiences in this area led us to co-author an amicus brief in support of the Commission in *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621 (1992) arguing essentially that the level of supervision of title insurer ratemaking by the Wisconsin Office of the Commissioner of Insurance was not sufficiently active to invoke the state action doctrine.

such providers.[20] The statutes purport to give immunity from state antitrust law and, in most cases, from federal antitrust liability via the state action doctrine. However, in many cases, including Wisconsin,[21] the "active supervision" required by the state action doctrine appears to be lacking.[22] In many respects, COPA legislation is an attempt by competitors in health care markets to roll back antitrust enforcement usually without a commensurate increase in state regulation, thereby leaving the markets subject to regulation by the market participants themselves.

B. Market Imperfections and Non-Market Goals

I recount this history of somewhat indecisive and, indeed, somewhat schizophrenic state regulatory policy because we ought not lose sight of the fact that antitrust enforcement does not exist in a vacuum. Even as we have come to rely more on the market mechanism to price and allocate health care services, state policy appears at times to grope for ways to soften the impact of market forces and to meet other non-market goals. Even if there was time to do so, I would not attempt to defend some of these more current attempts at state regulation. However, these attempts may reflect a lack of ease with a purely market-driven health care system for two primary reasons.

First, most of the market imperfections which existed in health care markets prior to deregulation, and, in fact, were the reason for much of the regulation, continue to exist. For example, health care consumers often have little ability, or incentive, to shop for low-priced health care because their employer, or the government, usually foots the bill. Similarly, it is notoriously

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[20] *See* T. Kondo & D. Forster, *The Role of Antitrust Immunity in the Washington State Health Care Market*, Report to the Washington State Legislature, at 57-58 (December 15, 1995).

[21] Wis. Stats. § 150.85 (1999-2000)

[22] *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621 (1992). It should be noted that over thirty states filed an amicus brief in support of the Federal Trade Commission before the Supreme Court arguing that the Insurance Commissioners in Wisconsin and Montana had not "actively supervised" the conduct of the title insurance companies involved sufficient to meet the "active supervision" prong of the state action doctrine test.

difficult for consumers to assess the quality of their health care providers in advance of needing the services. In recent years, consumers have increasingly been asked to internalize pricing decisions (through increasing deductibles and co-pays) and improvements have been made in quality reporting enabling consumers to make better judgments about alternative providers. Yet, even as this progress is made, recent studies have shown as deductibles and co-pays have increased, more and more consumers, especially the healthy ones, have voluntarily opted out of their employer's health insurance plans.

This leads to a second, perhaps more important point that we all recognize that there is something fundamentally different about health care than most other goods and services. Our health care system has, for generations, been designed to serve everyone, regardless of ability to pay. Although never totally successful, the system has been designed to serve these noble ends through an intricate array of subsidies and institutional arrangements unlike any other industry. In short, we are reluctant to deny service to people who need it and yet there is no universal mechanism to force every person (or their proxy in the form of the government or employer) to pay for such services *ex ante*.

In workably competitive markets, we assume that a large number of consumers will choose not to purchase a product at the prevailing market price (often represented as the demand curve to the right of the market clearing price). But, with respect to health care, we are unwilling to countenance a health care system which makes needed services unavailable to those lacking in the means, or the foresight, to purchase them in a pure market setting. Hence, through a complex network of state and federal government programs, charitable institutions, teaching hospitals, and intricate arrangements among providers, cobbled together a system which attempts to achieve the conflicting goals of optimal cost and quality and universal availability.

In essence, we say to our health care system: "Minimize costs, maximize quality and choices, and provide services for everybody, regardless of the ability (or willingness) to pay." We do not ask any other market to do this.

But antitrust enforcement alone cannot reform these markets such that these goals are met in full. Antitrust enforcement attempts to prevent anticompetitive conduct within an existing market and attempts to prevent the emergence of market power through mergers and other anticompetitive acts. It can only, very indirectly, alter the conditions under which those markets operate.[23] In short, antitrust law takes markets essentially as they are, warts and all.

IV. MULTIPLE ROLES OF STATE ATTORNEYS GENERAL

Even as health care markets were deregulated at the state level, and traditional competition policy was engrafted onto the health care system, the longstanding market imperfections and non-market goals inherent in the health care system remained apparent to the attorneys general. These somewhat contradictory forces caused an inherent schizophrenia in the system. Even as state attorneys general began to enforce the antitrust laws with vigor in health care markets, state legislatures struggled with the appropriate mix of market and regulatory tools needed to meet all of the goals expected to be realized by the health care system. As a result, they often imposed a wide variety of enforcement and advisory roles on their state attorneys general.

In essence, state attorneys general were required to wear multiple hats when dealing with the health care industry. Not only do state attorneys general enforce the antitrust laws, they also often: represent their Departments of Health; actively participate in the Certificate of Public Advantage and Certificate of Need processes (if they exist in their state); possess both statutory and

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[23]Peter C. Carstensen, *The Reconstruction of Legal-Economic Relations: Achieving Workable Competition*, 8 Loy. Consumer L. Rev. 153 (1995-96).

equitable powers to protect the integrity of charitable trusts which run most health care institutions, especially hospitals; represent large university teaching and research hospitals and related doctor groups; prosecute health care fraud and abuse; defend state-employed health care providers in malpractice claims, and represent and advocate before state insurance commissioners regarding health insurance matters.

Given this parallel universe of responsibilities, it is not surprising that state attorneys general often surface in a number of capacities regarding particular health care transactions. Notwithstanding this, it has been my experience, generally, that antitrust enforcers in state attorneys general's offices approach antitrust investigations, especially merger investigations, from the fairly narrow, but professional, perspective as to whether a violation of law can be established. Most state antitrust enforcers have become quite familiar and skilled at applying the NAAG Horizontal Merger Guidelines.[24] Simply put, because any challenge to a merger, or other potential violation, would have to meet the standards imposed by the antitrust law, there is not a lot of room for consideration of other concerns in making the initial cut as to whether a violation can be proved.

On the other hand, in those situations where a transaction may cause anticompetitive effects, state enforcers may be quite creative in working out relief provisions which can, at least temporarily, restrain the exercise of market power. Such criticisms generally have in mind provisions such as those contained in consent judgments entered in hospital merger cases such as the one involving the two hospitals in Kenosha, Wisconsin.[25] Some have suggested that these decrees are often "regulatory" in nature, apparently suggesting that they intrude too greatly on the post-merger

[24] 4 Trade Reg. Rep. (CCH) ¶ 13,406 (1993).
[25] *See* cases cited *supra* note 11.

business decisions of the merged entity.[26] As conditions permitting the merger to proceed, these provisions typically require the merged entity to:

1. Return efficiencies claimed by the parties to be specific to the merger;

2. Maintain an open hospital staff; and

3. Refrain from certain forms of tying and discrimination conduct.

The greater willingness on the part of the states, as compared to the federal agencies, to consider such provisions has led to the criticism that these decrees are "regulatory" or somehow vaguely inappropriate in a consent decree. I believe this view is misplaced. These provisions can be defended on strictly antitrust grounds. But I do think it is fair to say that state attorneys general are more willing to accept such provisions because of our multifaceted role in health care matters in our states. Notwithstanding this, I think it is important before this group to respond to the criticism directly.

First, it is obvious that the transactions involved are not initiated by the government, but by the parties involved. Moreover, the alternative to a negotiated settlement was, in virtually every case, a challenge to the transaction itself. In short, the state's role in these cases has been reactive, not proactive in a regulatory sense.

Second, these kinds of consent judgments are only worked out in cases where there is significant anticompetitive issues. Appealing once again to my Wisconsin experience, I can tell you that, more often than not, we simply close an investigation without further action. We do not use the threat of litigation in marginal cases to obtain onerous consent judgment provisions. For example, just within the past few weeks, our office closed an investigation of the merger of two

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[26] *Compare* R. Langer, *State Attorneys General and Hospital Mergers*, Health Care Chronicle (Summer 1997) *with* C. Hisiro & K. O'Connor, *State Attorneys General and Hospital Mergers: A Response*, Health Care Chronicle (Fall 1997).

large, multi-specialty physician practices in Madison. The University of Wisconsin Medical Foundation, the Physician Practice Group of the University of Wisconsin, consisting of over six hundred doctors, acquired a two hundred plus doctor multi-specialty clinic with the principle business and academic purpose of augmenting their primary care practice system. Although the merger raised some issues within the City of Madison, it appeared to be procompetitive in the twelve counties surrounding Madison.

Similarly, with respect to the multi-specialty physician practice merger initiated by Marshfield Clinic in north central Wisconsin, we concluded that the most serious potential anticompetitive effect of the merger was the possibility that the market would "tip" to Marshfield's benefit in the Wausau area, given Marshfield's dominance in the area surrounding Marshfield.[27] The consent judgment in that case was narrowly tailored to prevent certain acquisitions by Marshfield over the next few years, so as to prevent that tipping. Although we could have conceivably obtained additional provisions, we had little interest in becoming a regulator of these markets. On the other hand, we thought it very important for the public interest that we preserve the conditions necessary for some degree of competition.

Third, the relief provisions in the hospital merger cases I mentioned, can all be defended on the grounds that they are tailored to specifically address possible anticompetitive effects of the proposed transaction. Most of the provisions requiring an open hospital staff and restricting tying of services and discrimination against certain purchasers, are fairly standard safeguards of the competitive process. Indeed, in the Kenosha Hospital case, we had been investigating complaints that the Kenosha Hospital had been excluding rivals from various essential services in the City of Kenosha prior to the announcement of the merger.

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[27] *See State of Wisconsin v. Marshfield Clinic,* 1997-1 Trade Cas. (CCH) ¶ 71, 855 (W.D. Wis. 1997).

Fourth, the provisions requiring the return of efficiencies and capping prices are also defensible as a restraint on the increased market power that the merged entity may enjoy after the merger at least for the short to intermediate run. In fact, as you know, enforcement decisions in these areas essentially turn on predictions as to whether the merged hospitals can exercise market power. This issue is, in turn, closely related to the size of the relevant geographic market and the likelihood of entry. Even though the discharge data may suggest a relatively small geographic market, the emergence of managed care suggests that the geographic market and the likely participants in it might expand greatly over the intermediate to long run. Although we can debate whether the geographic market ought to be a circle with a radius of twenty miles, forty miles or one hundred miles, we ought not lose sight of the fact that, at least in the short run, the merged entity is likely to have significant additional market power in those communities where the merger involves the only two competing hospitals. In short, provisions capping hospital prices and requiring the return of efficiencies, are an attempt to simulate in the short to intermediate run what the merged parties often contend will be the long term result of the merger, *i.e.*, that is, a more competitive market. The fact that such price caps and efficiency returns are also consistent with other state goals for the health care system -- such as provision of charity care -- is an added bonus, but not the primary focus of state antitrust enforcers.

Fifth, another factor driving these consent judgments is the lingering uncertainty surrounding some of the decisional law regarding mergers. These include not only the typical hospital merger battleground issues of geographic market definition and efficiencies, but now, apparently, at least in the Sixth Circuit, the non-profit status of the merging parties and their subjective intents post merger.[28] Frankly, with the federal agencies losing their last four hospital merger cases, the consent

[28] *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997).

judgments in state merger cases appear to be a very positive contribution to the public interest. I believe the difficulties the federal agencies have had challenging hospital mergers are reflective of the federal courts' uneasiness about whether health care systems can, or even ought, to operate in a purely market-driven environment. For example, the *Butterworth* court rather explicitly brought into play the subjective, non-traditional criteria of the non-profit status of the merging entities. In the face of this type of judicial indecision and lack of discipline applying antitrust principles, I think it is perfectly appropriate for the states to entertain creative mandatory injunctive relief provisions that are in the public interest. The idea that antitrust enforcement can only be effective if it is a binary choice -- challenge or don't challenge -- may miss opportunities for outcomes in the public interest.[29]

CONCLUSION

My goal today has been to put state health care antitrust enforcement in the context of the broader mission of state attorneys general. As is apparent, notwithstanding the multiple hats worn by attorneys general, the states will continue to be aggressive enforcers of the antitrust laws and advocates for sound competition policies at the state level.

As a final note, I should underscore that notwithstanding the difference in approach between the federal agencies and the states on some of these matters, the states and the federal agencies work together very closely in many of these investigations. We often do interviews together, share experts and develop case theories in tandem. Indeed, NAAG, DOJ and the FTC recently adopted a joint statement concerning the conduct of merger investigations and settlement discussions in all merger cases, including those involving health care markets. Hence, even though it is probably fair

[29]Some have suggested that the federal agencies approach merger enforcement from this binary perspective. Although this is true to some extent, one need only look at the *Morton Plant* consent judgment (*see* case cited *supra* note 13) to see that the federal agencies are at least as creative as the states in their use of injunctive relief provisions in their consent judgments.

to say as a general matter the states are more willing to take "half a loaf" during the end game of a merger investigation, we will continue to work together to serve the public interest.[30]

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[30]The views contained herein are those of the author only and not necessarily the views of any state attorney general or the National Association of Attorneys General.