

COMMENTS

CAN HMOs WIELD MARKET POWER? ASSESSING ANTITRUST LIABILITY IN THE IMPERFECT MARKET FOR HEALTH CARE FINANCING

MARK L. GLASSMAN*

TABLE OF CONTENTS

Introduction	93
I. Background	102
A. Statutory Basis for Antitrust Offenses	102
B. Judicial Construction of Antitrust Laws	103
1. Monopolization and attempted monopolization: section 2 offenses	103
2. Combinations or contracts in restraint of trade: section 1 offenses	105
C. Recent Application of Antitrust Law to HMOs.	106
II. Lowering the Legal Threshold for Antitrust Liability ..	108
A. Lowering the Threshold for Market Power	108
1. <i>Eastman Kodak Co. v. Image Technical Services,</i> <i>Inc.</i>	108
2. <i>Jefferson Parish Hospital District No. 2 v. Hyde</i>	112
B. Potential Divergence of HMO and Health Care Financing Markets	115
III. Lower Court Assessment of HMO Antitrust Liability ...	118

* Senior Note & Comment Editor, *The American University Law Review*, Volume 46; J.D. Candidate, May 1998, *American University, Washington College of Law*; B.S., 1989, *University of Kansas*. The author wishes to thank Professor Michael S. Jacobs for his invaluable advice and clear guidance during the writing of this Comment. Thanks also to Anita Blumenthal, who reviewed earlier drafts for readability and offered encouragement throughout. Finally, thanks to the many health care and antitrust professionals whose critiques helped refine the arguments advanced in this Comment.

A.	Lower Court Definition of the HMO Market	119
1.	<i>Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic</i>	119
2.	<i>U.S. Healthcare, Inc. v. Healthsource, Inc.</i>	122
B.	Market Power Determinations in Cases Involving HMO or Insurer	126
IV.	Economic Factors Raising Antitrust Liability for HMOs	128
A.	Market Imperfections Increasing HMO Market Power	130
1.	Increased switching costs	131
2.	Information deficiencies	133
3.	Payment policies that reduce price competition	133
4.	Limitation on consumer choice of providers	134
B.	Economic Factors Creating the Potential for a Discrete HMO Market	135
1.	Adverse selection	136
2.	HMO use of exclusive provider contracts	137
3.	Exclusion of coverage for pre-existing conditions	138
C.	Consequences	138
V.	Recommendations	140
A.	Legal Principles to More Accurately Assess Market Power and Define Markets	140
1.	Combine the <i>Kodak</i> and <i>Jefferson Parish</i> tests	140
2.	Adhere to a fact-based, rather than assumption-based, analysis for finding market power and defining markets	141
B.	Economic Solutions to Prevent HMO Acquisition of Market Power	143
1.	Lower switching costs by eliminating coverage exclusions and limiting premium increases based on pre-existing conditions	143
2.	Increase supply elasticity by decreasing adverse selection	143
3.	Increase demand elasticity by fostering price competition	144
a.	Increase availability of information	144
b.	Require employee cost sharing	144
c.	Amend tax laws	145

C. Actions HMOs Can Take to Avoid Antitrust

Liability	146
Conclusion	146

INTRODUCTION

Health Maintenance Organizations ("HMO")¹ and their predecessors have long been quiet fixtures in the market for health care services.² In the past quarter-century, however, HMOs have proliferated rapidly,³ largely in response to the failure of traditional health care financing models to contain costs, foster accountability, and ensure access to a rational system of care.⁴ Critics of the health care

1. HMOs are a form of prepaid health plan in which the enrollee pays a fixed premium to the plan and, in return, receives all the health services he or she requires during the period of enrollment. *See* U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 591 (1st Cir. 1993). These services are delivered by the plan's "panel" or "network" of health providers. HMOs control their financial risk by "managing" care in several ways, some of which include: (1) selective provider contracting—the plan negotiates lower payment rates with health providers who, in turn, become members of the plan's panel and receive higher patient volume; (2) utilization review—the plan carefully scrutinizes bills, refusing to pay for unnecessary services and negotiating lower rates for questionable services; (3) case management—the plan ensures that each enrollee receives services in the most appropriate but least expensive setting; and (4) wellness programs—the plan promotes primary care, under the assumption that this will reduce the subsequent need for costly treatments to cure conditions that could have been avoided. *See id.*; *see also* Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1409 (7th Cir. 1995) (describing method by which HMOs price and deliver medical services), *cert. denied*, 116 S. Ct. 1288 (1996).

2. At the turn of the century, at least two common forms of third-party payment for medicine bore striking similarity to modern HMOs. The first form is "contract practice," in which corporations employed physicians to meet the medical needs of employees. *See* JAMES G. BURROW, ORGANIZED MEDICINE IN THE PROGRESSIVE ERA 119-20 (1977); JOHN S. HALLER, JR., AMERICAN MEDICINE IN TRANSITION, 1840-1910, at 245-47 (1981). The second form is "corporate practice," in which for-profit corporations employing physicians marketed medical services to the public. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 204 (1982). In addition to being structured similarly to modern HMOs, these arrangements frequently employed cost-control mechanisms similar to those employed by HMOs, including second opinions before surgery, review of hospital length of stay, and refusal to pay for services deemed unnecessary. *See id.* at 205.

3. *See* HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 19-20 (1991) [hereinafter HIAA SOURCE BOOK] ("[HMO] enrollment increased from less than two million in the early 1970s to almost 34 million by June 1990." (citing 1990 Study by The InterStudy Edge)). A subsequent study by The InterStudy Competitive Edge (the group changed its name) reports total HMO enrollment of more than 42 million as of July 1993. *See* THE INTERSTUDY COMPETITIVE EDGE, 3 BIENNIAL REPORT OF THE MANAGED HEALTH CARE INDUSTRY no. 2, 1 (1994) [hereinafter 1994 INTERSTUDY REPORT]. By January 1, 1995, 562 HMOs served more than 46 million enrollees. *See* THE INTERSTUDY COMPETITIVE EDGE, 5.2 HMO INDUSTRY REPORT 1 (Nov. 1995) [hereinafter 1995 INTERSTUDY REPORT].

4. *See* Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 25 (describing shortcomings of "traditional" health insurance, characterized by fee-for-service reimbursement, numerous solo practitioners, unlimited choice of provider, and remote "third party" payment).

industry attribute these failures to an imperfect market for health services that places too little emphasis on price competition, gives consumers too little information on which to judge quality, and raises the cost of changing health plans to a prohibitive level for many individuals.⁵ HMOs emerged in the early 1970s as a form of health care financing capable of correcting many of the failures in the market for health care services.⁶ Congress enacted the Health Maintenance Organization Act of 1973⁷ in an effort to make HMOs more widely available,⁸ and HMOs have since become a cornerstone in the burgeoning "managed care" sector of the health care industry.⁹

The rapid growth of the HMO market, ironically, has both underscored the success of HMOs as an economically efficient form of health care financing and raised the specter of anticompetitive market forces that may inflate health care costs.¹⁰ There is now a growing debate over whether HMOs will bring the health care market closer to optimum efficiency,¹¹ or whether—and at what point—their

5. See *id.* at 40 (describing existing health care system as "an extremely wasteful and inefficient system that has been bathed in cost-increasing incentives for over fifty years"); see also Jonathan E. Fielding & Thomas Rice, *Can Managed Competition Solve the Problems of Market Failure?*, HEALTH AFF., Supp. 1993, at 225 (concluding that increased, though not absolute, competition has potential to foster system-wide efficiency in health care market).

6. See Paul M. Ellwood et al., *Health Maintenance Strategy*, 9 MED. CARE 291, 291 (1971) (noting that health policy advocates called for wider utilization of HMOs as solution to growing problems of health care cost and access); Enthoven, *supra* note 4, at 27-28 (stating that in 1973, efforts of many health policy advocates paid off when Congress adopted Health Maintenance Organization Act of 1973).

7. 42 U.S.C. §§ 300e to 300e-17 (1994).

8. The Health Maintenance Organization Act of 1973 requires that all employers of 25 or more employees include HMO enrollment as an option in any employer-sponsored health benefit plan. See *id.* § 300e-9. In addition, The Act places minimum coverage and operating requirements on HMOs. See *id.* §§ 300e to 300e-1.

9. See PROSPECTIVE PAYMENT ASSESSMENT COMM'N, MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM: REPORT TO THE CONGRESS 23 (1995) (stating that in 1988, 73% of individuals insured by private health insurance had traditional indemnity coverage, and 27% were covered by HMOs and other forms of managed care). By 1993, indemnity insurance accounted for only 33% of the private health insurance market, with HMOs and other forms of managed care claiming 65% of the market. See *id.* Hybrid plans, such as "point of service" plans, which combine gatekeeper or network functions of HMOs with partial coverage of out-of-network services, accounted for the remaining portion of the market. See *id.* This trend was largely a response to demands by employers and employees to curb soaring health insurance premiums. See *id.*

10. See Robert E. Bloch & Donald M. Falk, *Antitrust, Competition and Health Care Reform*, 13 HEALTH AFF., Spring (I) 1994, at 206, 207-08 (observing that bringing large groups of consumers and providers together under managed care will introduce substantial market efficiencies, but will pose equally substantial antitrust risks). Two potential anticompetitive consequences of managed care include: (1) alliances of health care providers will have substantial market power, see *id.* at 209; and (2) large health plans will have the potential to foreclose competition from rivals, see *id.* at 212.

11. Although there are many definitions of "optimum efficiency," common ideas embodied in most definitions include: (1) numerous sellers and consumers; (2) homogenous products and services; (3) readily available information about quality and price; (4) ease of entry into the market for sellers; (5) consumer ability to change among like products or services; and (6) low

tendency to concentrate health care resources will threaten market efficiencies.¹² Nowhere is this debate more audible than in the growing field of health care antitrust law.¹³

At the core of this new antitrust debate is an increasing tension among the competing interests involved in managed care. Consumers, including employers, private individuals and government, demand economically feasible health coverage that affords them access to primary care and preventive medicine.¹⁴ Insurers have responded to this demand by structuring managed care arrangements¹⁵ that restrict the consumer's choice of provider while offering patients a more comprehensive set of health benefits.¹⁶ These arrangements enable insurers to negotiate lower rates with a limited number of

transaction costs, or "externalities." See Michael S. Jacobs, *Market Power Through Imperfect Information: The Staggering Implications of Eastman Kodak Co. v. Image Technical Services and a Modest Proposal for Limiting Them*, 52 MD. L. REV. 336, 345 (1993) (citing HERBERT HOVENKAMP, *ECONOMICS AND FEDERAL ANTITRUST LAW* 1-2 (1985); GEORGE J. STIGLER, *THE THEORY OF PRICE* 87 (3d ed. 1966)); Fielding & Rice, *supra* note 5, at 216-17 (citing J.M. HENDERSON & R.E. QUANDT, *MICROECONOMIC THEORY: A MATHEMATICAL APPROACH* (1971)).

12. See Rick Loomis, *Will Giant HMOs Help Health Care?*, L.A. TIMES, Apr. 10, 1995, at D1 (questioning whether pending HMO merger resulting in 4.4 million members, \$5.4 billion in revenues, and gains for executives of more than 10,000% on company shares will work to detriment or benefit of consumers, competition, and cost).

13. See MARK A. HALL & IRA MARK ELLMAN, *HEALTH CARE LAW AND ETHICS* 186 (1990) (noting that, until 1980s, antitrust suits rarely were seen in health care industry). Antitrust litigation now is among the most rapidly growing areas of health care law. See *id.*

14. See Jon Christianson, *Can HMOs Contain Workers' Compensation Medical Care Costs?*, in *REVIEW, REGULATE OR REFORM? WHAT WORKS TO CONTROL WORKERS' COMPENSATION MEDICAL COSTS* 146, 153-54 (Workers' Compensation Res. Inst., Thomas W. Granneman ed., 1994) (noting that from 1988 to 1993, HMO premiums increased at average annual rate of two percent to five percent less than premiums for traditional indemnity insurance or PPO plans despite offering richer benefits, less consumer cost sharing, and no pre-existing condition exclusions). Although some studies suggest HMOs will effect only a temporary reduction in health care inflation, others have shown HMO premium increases as much as 40% below those of standard indemnity plans. See *id.*; see also Barbara Sande Dimmitt, *Managed Care Has Become the Dominant Mode of Health Care Delivery in the United States, and Providers Must Deliver Not Only on Price, But Also on Value, Quality, and Performance*, BUS. & HEALTH, Jan. 1995, at 24 (noting that consumer demand continues to force health care industry to restructure itself to meet imperatives of managed care); cf. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified as amended at 42 U.S.C. §§ 300e to 300e-17 (1994)) (requiring employers of 25 or more employees to offer HMO coverage option to employees).

15. HMOs can be divided into five categories depending on the kind of arrangements under which they contract with providers. See Christianson, *supra* note 14, at 148. These arrangements include: (1) the staff model HMO, which delivers care through physicians who are employees of the HMO; (2) the group model, which contracts with a single multispecialty group of providers to deliver services; (3) the network model, which contracts with multiple groups of physicians, as well as individual physicians; (4) the independent practice association, or "IPA," which contracts directly with individual physicians or physician associations; and (5) the mixed model, which contains elements of the other models. See *id.*

16. See *id.* at 149. The three strategies HMOs use to reduce costs include: (1) reducing health care utilization by enrollees relative to usage by enrollees in fee-for-service plans; (2) negotiating with contracting providers to pay less for services than fee-for-service plans would pay; and (3) "enrolling relatively healthy people who have need for fewer services." *Id.*

providers¹⁷ in return for an assurance of higher patient volume.¹⁸ Providers, seeing their patients enroll in managed care plans in increasing numbers, feel an economic imperative to contract with as many managed care arrangements as possible.¹⁹ The result: an increasingly competitive, and litigious, health care marketplace.²⁰

Not surprisingly, the number of antitrust cases involving HMOs has risen in the last twenty-five years as HMOs have become popular alternatives among consumers and profitable ventures for providers and insurers.²¹ The increase in the number of cases appears to correspond with the rise in HMO enrollment.²² These cases generally fall into four categories. The first category consists of *monopoly* actions, including those brought by: (1) one HMO against another

17. HMOs negotiate with diversely structured groups of health providers over price and terms of membership on HMO panels. See U.S. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, 1996 STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at 20,826-35 [hereinafter DOJ & FTC, ENFORCEMENT POLICY]. These groups are divided into two basic categories for purposes of antitrust review: (1) those involving "horizontal" agreements between or among competitors; and (2) those involving "vertical" agreements between or among parties that are not competitors. See *id.* at 20,828. Each type of group has a different competitive impact and is viewed by enforcers under varying levels of scrutiny. See *id.*

18. See *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 591 (1st Cir. 1993) (stating that HMOs negotiate lower payment rates with health providers who, in turn, become members of plan's panel and receive higher patient volume).

19. See David R. Olmos & Michael A. Hiltzik, *Doctors' Authority, Pay Dwindle Under HMOs*, L.A. TIMES, Aug. 29, 1995, at A1 (describing extreme pressure on doctors to join managed care networks to maintain needed patient base, and loss of autonomy once in network).

20. See *infra* notes 21-22 and accompanying text (comparing rise in HMO-related antitrust litigation to rise in nationwide HMO enrollment).

21. A LEXIS search of federal cases reveals that HMOs were involved in 50 cases brought to trial in federal courts involving antitrust claims under the Sherman or Clayton Acts from January 1, 1970 to January 1, 1994. For the 30-month period from January 1, 1994 to July 1, 1996, the search revealed 12 cases, or a six-year average of approximately 50 cases. The search was performed in five six-year increments and yielded the following results:

January 1, 1970 to January 1, 1976	No cases
January 1, 1976 to January 1, 1982	9 cases
January 1, 1982 to January 1, 1988	13 cases (a 45% increase)
January 1, 1988 to January 1, 1994	28 cases (a 115% increase)
January 1, 1994 to July 1, 1996 (six-year average)	50 cases (an 80% increase).

Search of LEXIS, Genfed Library, Courts File (search criteria: antitrust and (health maintenance organization or HMO) and (Sherman or Clayton)).

22. Enrollment in HMOs and other types of managed care as a percentage of overall private insurance coverage increased from approximately 27% in 1988 to 65% in 1993. See PROSPECTIVE PAYMENT ASSESSMENT COMM'N, *supra* note 9, at 23. Overall enrollment in managed care increased 2200% between 1970 and 1995. See *supra* note 3 (citing studies plotting HMO enrollment from early 1970s to January 1995). HMO enrollment increased at an annual rate of 9.2% from January 1, 1994, to January 1, 1995. See 1995 INTERSTUDY REPORT, *supra* note 3, at 1.

for foreclosure of the market;²³ (2) HMOs against large insurers;²⁴ or (3) health care providers against large insurers for adopting cost-containment strategies involving some elements of managed care.²⁵ The second category includes actions for *tying arrangements* brought by: (1) a small HMO against a larger HMO;²⁶ or (2) physicians against hospitals.²⁷ The third category encompasses actions for *group boycotts* brought by: (1) doctors against hospitals for exclusion from medical staff;²⁸ (2) hospitals against insurers for exclusion from a payment plan;²⁹ or (3) HMOs and other payors against providers for

23. See *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1411-13 (7th Cir. 1995) (finding HMO not liable for monopolization because of lack of market power within relevant product market), *cert. denied*, 116 S. Ct. 1288 (1996); *U.S. Healthcare*, 986 F.2d at 597-99 (finding that HMO lacked sufficient market power within relevant product market to form monopoly).

24. See *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101, 1109-11 (1st Cir. 1989) (holding insurer not liable in suit brought by HMO under Sherman Act § 2 for setting maximum insurance reimbursement at no greater than payment by competing HMO).

25. See *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1335-36 (7th Cir. 1986) (holding that formation of preferred provider organization ("PPO") by large insurer did not violate Sherman Act § 2 in suit brought by hospital because, *inter alia*, ease of entry for competing HMOs prevented attainment of market power); *Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922, 927, 933 (1st Cir. 1984) (stating that despite market power, insurer's prohibition of "balance billing" by participating physicians does not violate Sherman Act § 2 unless payments fall so low as to constitute predatory pricing).

26. See *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, No. 95-1698, 1996 U.S. Dist. LEXIS 6480, at *16-22 (E.D. Pa. May 13, 1996) (denying motion for summary judgment by defendant HMO, U.S. Healthcare, and holding that plaintiff HMO, Brokerage Concepts, presented "legally sufficient evidentiary basis for a reasonable jury to find" that U.S. Healthcare implemented tying arrangement to obtain enrollees).

27. See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 31-32 (1984) (holding hospital not liable for tying arrangement in violation of Sherman Act §§ 1 and 2 after hospital awarded exclusive contract for anesthesiology services to group practice). A tying arrangement occurs when a supplier uses market power over one product to attain power or to otherwise manipulate competition over another product. See *id.* at 12-13 (citing *Fortner Enters. v. United States Steel Corp.*, 394 U.S. 495, 512-14 (1969) (White, J., dissenting)). Such an arrangement exists when the practice in question "link[s] two distinct markets for products that were distinguishable in the eyes of buyers." *Id.* at 19 (citing *Times-Picayune Publishing Co. v. United States*, 345 U.S. 594, 600 (1953)).

28. See *Weiss v. York Hosp.*, 745 F.2d 786, 815 (3d Cir. 1984) (holding physician members of hospital medical staff liable for Sherman Act § 1 group boycott after they denied peer medical staff privileges at hospital, but finding medical staff incapable of conspiring with hospital). But see *Bolt v. Halifax Hosp. Med. Ctr.*, 851 F.2d 1273, 1280 (11th Cir. 1988) (holding that hospital and medical staff are legally capable of conspiring in Sherman Act § 1 violation). Although the courts in *Weiss* and *Bolt* based their analyses primarily on Sherman Act section 1, group boycotts also are prohibited by section 3 of the Clayton Act. See 15 U.S.C. § 14 (1994).

29. See *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 899 F.2d 951, 965-66 (10th Cir. 1990) (finding insurer liable for horizontal group boycott in violation of Sherman Act § 1 under rule of reason when it threatened to terminate contract of hospital recently acquired by competitor and lowered reimbursement of other providers doing business with competitor). But see *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 592-93 (1st Cir. 1993) (finding HMO not liable for horizontal group boycott under *per se* analysis when it offered higher reimbursement to physicians for agreeing not to provide services to any other HMOs).

attempting to inhibit the entry of managed care into the market.³⁰ The fourth category comprises actions for *market division* or *price-fixing* by an HMO, preferred provider organization ("PPO"), or insurer.³¹ Although some of these cases do not directly involve HMOs as parties, many have resulted from the increased concentration HMOs have brought to the health care financing market.³²

These actions, with few exceptions,³³ have in common a single threshold requirement: a defendant will not be found liable for

30. See *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 458-66 (1986) (holding that group of dentists violated Sherman Act § 1 when it concertedly refused to provide x-rays to insurers). The Court in *Indiana Federation of Dentists* struggled with the question of whether the case fit into the group boycott "pigeonhole," *id.* at 458, or whether it was a price-fixing case. *See id.* at 459-61. The Court, however, was interested more in avoiding application of a strict per se test than in finding a perfect label for the case. *See id.* at 458-59. Ultimately, the Court found that it was "not a matter of any great difficulty" to apply a rule of reason balancing test to the facts of the case. *Id.* at 459. The Court thereby engaged in an early application of what now is known as the "quick look" test for determining violations of Sherman Act section 1. *See U.S. Healthcare*, 986 F.2d at 594 (citing *Indiana Fed'n of Dentists* as early example of "quick look" formulation).

Another line of cases involves suits brought by the FTC against the American Medical Association ("AMA") for its attempts to suppress the growth of HMOs and against other health care financing arrangements that restrict choice of provider or promote fee discounts. *See BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 868-69 (2d ed. 1991); *see also AMA v. United States*, 317 U.S. 519, 526 (1943) (holding that AMA violated Sherman Act § 3, which applies Sherman Act § 1 to District of Columbia, when it prevented physicians from accepting employment with or consulting for staff-model HMO); *AMA v. FTC*, 638 F.2d 443, 450 (2d Cir. 1980) (holding AMA liable for violation of § 5 of Federal Trade Commission Act, 15 U.S.C. § 45(a)(1) (1994), when it adopted ethical guidelines discouraging participation in managed care arrangements), *aff'd by an equally divided court*, 455 U.S. 676 (1982).

31. *See Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 342-57 (1982) (holding doctor-initiated PPO liable for per se offense of price fixing under Sherman Act § 1, after physician members of PPO comprising 70% of all those practicing in county, set maximum reimbursement rates); *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1415-16 (7th Cir. 1995) (finding HMO liable for per se offense of market division and price fixing in violation of Sherman Act § 1), *cert. denied*, 116 S. Ct. 1288 (1996); *cf. DOJ & FTC, ENFORCEMENT POLICY*, *supra* note 17, at 20,826 (acknowledging that price fixing and market division are illegal per se, but noting that rule of reason applies to some arrangements under which competitors integrate economically to form joint venture).

32. *See Coffey v. Healthtrust, Inc.*, 955 F.2d 1388, 1392-93 (10th Cir. 1992) (holding that there was no group boycott in violation of § 1 of Sherman Act when partnership of radiologists was excluded from exclusive contract to provide services for hospital). Exclusion of the partnership followed closely on the heels of the partnership's expansion of services to include services formerly available only to inpatients at the Healthtrust-owned hospital. *See id.* at 1390. The reason for the partnership's expansion of services was to attract HMO and PPO clients. *See id.*

33. Price fixing and market division generally are held to be illegal per se under Sherman Act section 1. *See United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218 (1940). This rule obviates the need for a plaintiff to show that a defendant possessed market power and eliminates defenses based on reasonableness. *See id.* at 218. Courts, however, frequently engage in a balancing inquiry to determine whether a certain action can be properly characterized as price fixing. *See HALL & ELLMAN, supra* note 13, at 212-13 (describing weaknesses of *Maricopa County* holding). The Court in *Maricopa County* held a price fixing agreement to be illegal as a matter of law when prices charged by a physician group were set by members of the group. *See id.* On remand, however, the district court held that the arrangement was no longer a price-fixing agreement worthy of per se prohibition when consumers were placed on the price-setting committee. *See id.*

antitrust offenses unless it is shown to possess "market power."³⁴ Market power is defined as "the ability of a firm (or a group of firms, acting jointly) to raise price above the competitive level without losing so many sales so rapidly that the price increase is unprofitable and must be rescinded."³⁵ Such power can be assessed only after a "market" has been appropriately designated.³⁶ The ability to define the relevant product market³⁷ and determine market power within that market,³⁸ therefore, is crucial to virtually all antitrust actions in the health care field.

Courts, to date, have held that HMOs operate within the "health care financing market," which includes traditional indemnity insurance,³⁹ PPOs,⁴⁰ and other forms of payment for health

34. See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 26, 29 (1984) (requiring showing of market power for per se liability to attach under Clayton Act § 3 for tying arrangement, and finding insufficient evidence of market power); *Reazin*, 899 F.2d at 965-66 (applying rule of reason and market power assessment to find insurer liable for horizontal group boycott in violation of Sherman Act § 1 when insurer terminated contract of hospital recently acquired by competitor and discouraged other health service providers from doing business with competing insurers as condition of reimbursement); *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101, 1109-11 (1st Cir. 1989) (holding insurer not liable in suit brought by HMO under Sherman Act § 2 for setting maximum insurance reimbursement at no greater than payment by competing HMO, despite existence of market power); *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc.* 784 F.2d 1325, 1330, 1334-35 (7th Cir. 1986) (requiring market power for violation of Sherman Act § 2, but finding that defendant lacked market power in medical insurance when market share was 27% of patients in Indiana); *Kartell v. Blue Shield of Mass.*, 749 F.2d 922, 924 (1st Cir. 1984) (finding no violation by insurer of Sherman Act § 2 for setting maximum reimbursement amount, despite 74% market share). But see *Marshfield*, 65 F.3d at 1415-16 (finding HMO liable for market division and price fixing in violation of Sherman Act § 1 under per se analysis, without market power analysis).

35. William M. Landes & Richard A. Posner, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937, 937 (1981).

36. See Robert Pitofsky, *New Definitions of Relevant Market and the Assault on Antitrust*, 90 COLUM. L. REV. 1805, 1806-07 (1990) (asserting that definition of relevant product market is crucial to antitrust analysis because determination of liability rests on whether firm has power to raise price above competitive levels without losing customers to competitors operating in same market).

37. See Landes & Posner, *supra* note 35, at 938 (stating that first step in proving market power is defining relevant product and geographic market).

38. See FURROW ET AL., *supra* note 30, at 787-88 ("The concept of market power is critical to most [Sherman Act] Section 1 and all Section 2 claims.").

39. Traditional "indemnity" health insurance differs substantially from managed care. Indemnity plans reimburse (or "indemnify") the patient for money spent to receive covered health care services up to a specified dollar threshold. See HIAA SOURCE BOOK, *supra* note 3, at 1-2. Coverage under traditional indemnity plans typically extends to accidents and illnesses; preventive health care is not emphasized. See *id.* at 2 (describing coverage under early indemnity plans as extending to "common accidents and illnesses" and later expanding to include "extended illnesses or long hospital stays," but not including preventive health care).

40. The PPO is a form of managed care that combines elements of HMO and traditional indemnity coverage. See HIAA SOURCE BOOK, *supra* note 3, at 20. It offers more flexibility than an HMO by giving consumers greater freedom to choose providers, while achieving some savings by directing patients to a network of providers. See *id.* Under a PPO arrangement, an insurer contracts with a panel of providers who provide medical services and agree to be paid according to a negotiated rate. See *id.* Enrollees typically are allowed to receive care from providers who

care.⁴¹ HMOs hold a comparatively low market share when viewed as a component of this broadly defined market and are therefore deemed to have low market power.⁴² The process of defining a relevant product market and assessing market power, however, is especially problematic in fields exhibiting major innovations and rapidly changing products.⁴³ Health care financing has experienced precisely these kinds of changes over the past quarter-century.⁴⁴ This market evolution, coupled with recent Supreme Court precedent for assessing antitrust liability in sophisticated but imperfect markets, threatens to increase the ease with which HMOs can obtain market power, thereby exposing HMOs to an increased risk of antitrust liability.

Part I of this Comment describes the statutory basis for antitrust offenses and the traditional methods for measuring market power and defining product markets. Part II examines how the Supreme Court's decisions in *Eastman Kodak Co. v. Image Technical Services, Inc.*⁴⁵ and *Jefferson Parish Hospital District No. 2 v. Hyde*⁴⁶ raise the threat of antitrust liability for HMOs by lowering the threshold for finding market power in product markets exhibiting imperfections similar to

are not members of the network; however, there is a financial penalty associated with such care. See *id.* PPOs frequently do not exercise the same level of control over health care utilization as HMOs. See AMERICAN MANAGED CARE REVIEW ASSOCIATION, 1994-1995 MANAGED HEALTH CARE OVERVIEW 6 (1995).

41. See generally *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1411 (7th Cir. 1995) (overturning jury verdict and stating that "[w]e thus do not believe that a reasonable jury . . . could find that HMOs constitute a separate market" from other health care financing products), *cert. denied*, 116 S. Ct. 1288 (1996); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 599 (1st Cir. 1993) (upholding lower court ruling that "health care financing is the product market"); *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins. Co.*, 784 F.2d 1325, 1329 (7th Cir. 1986) (considering HMOs to be method of "health care financing" and stating that the HMO "is both a method of joining physicians in a firm . . . and financing their service by selling memberships for stated monthly prices"). But see *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, No. 95-1698, 1996 U.S. Dist. LEXIS 6480, at *18-*19 (E.D. Pa. May 14, 1996) (holding that relevant product market includes all members of single HMO with prescription drug benefits (citing *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 482 (1992))).

42. See *U.S. Healthcare*, 986 F.2d at 599 ("[P]lainly, Healthsource has no monopoly or anything close to it, given the number of other providers in New Hampshire, such as insurers, staff HMOs, Blue Cross/Blue Shield and individual doctors."); cf. *Marshfield*, 65 F.3d at 1409 (stating that defendant HMO did not monopolize HMO services because HMOs are not a market).

43. See Joseph Gregory Sidak, *Debunking Predatory Innovation*, 83 COLUM. L. REV. 1121, 1121-22 (1983) (contending that legal rule governing antitrust liability in innovative industries is inherently difficult to articulate because it must balance public policies encouraging competition and innovation with those discouraging monopolistic behavior).

44. See *supra* notes 1-20 and accompanying text (explaining rise of HMOs as alternative health care financing product over past 25 years and describing innovative techniques employed by HMOs to effect change in price and quality of health care).

45. 504 U.S. 451 (1992).

46. 466 U.S. 2 (1984).

those in the health care financing market. Part III examines how the lower courts have assessed HMO antitrust liability and applied principles of market definition and market power. Part IV discusses how imperfections in the health care financing market could enable small firms to exert market power under the *Kodak* analysis, thereby increasing the risk of antitrust liability for HMOs. Part IV further analyzes how these market imperfections, coupled with current trends in HMO enrollment and provider contracting, could reduce elasticity of supply and demand for HMOs, causing the HMO market to diverge from the health care financing market under traditional principles of market definition.

Part V recommends two legal principles, which, if adopted by courts, would reduce the ability of HMOs to obtain market power illegally and would reduce the threat that antitrust enforcement will undo the efficiencies HMOs have introduced to the health care financing marketplace. First, courts should combine the *Kodak* analysis, focusing on market imperfections that reduce elasticity of demand, with that of *Jefferson Parish*, focusing on elasticity of supply. Under such a hybrid analysis, antitrust liability can attach only where a firm: (1) exploits market imperfections; (2) exhibits the ability to raise prices above the competitive level; and (3) impedes entry of new competitors into the market. Second, in defining markets and assessing market power, courts should adhere to a fact-based, rather than assumption-based, analysis. Such a fact-based analysis emphasizes inquiry into market realities over judicial assumptions about markets.

Part V also recommends a series of economic solutions to remedy market imperfections and lessen the possibility that unwarranted findings of market power will lead to HMO antitrust liability. These recommendations include: (1) lowering "switching costs," or the cost to consumers of changing health plans, through passage of legislation to eliminate pre-existing condition exclusions; (2) preserving supply elasticity through adoption of public policies that decrease adverse selection by HMOs; and (3) preserving demand elasticity by increasing the availability of comparative information about competing health plans through employer policies requiring uniform benefits. Finally, Part V recommends a series of actions to be taken by HMOs in order to avoid liability under antitrust laws.

I. BACKGROUND

A. *Statutory Basis for Antitrust Offenses*

Federal antitrust law has developed primarily around two substantive statutes: the Sherman Antitrust Act⁴⁷ and the Clayton Antitrust Act.⁴⁸ The Sherman Act identifies and prohibits two basic categories of anticompetitive conduct: that of a single firm, proscribed by section 2 of the Sherman Act,⁴⁹ and that of a combination of firms, proscribed by section 1.⁵⁰ A firm found liable for anticompetitive conduct under the Sherman Act is guilty of a felony.⁵¹ The Clayton Act supplements the broad language of the Sherman Act by making four enumerated practices illegal,⁵² although not criminal.⁵³ The Clayton Act additionally supplies a private right of action under which any individual alleging "antitrust injury" can sue for anticompetitive conduct prohibited by either the Sherman or Clayton Act.⁵⁴ The Department of Justice ("DOJ") is charged with public enforcement of the Sherman Act,⁵⁵ while both DOJ and the Federal Trade Commission ("FTC") are charged with public enforcement of the Clayton Act.⁵⁶ In addition, the FTC is authorized to bring actions for

47. 15 U.S.C. §§ 1-7 (1994). Although the Act has been amended repeatedly since its adoption, its two primary provisions, sections 1 and 2, remain substantially intact. Compare 26 Stat. 209 (1890) (providing original language of Sherman Act), with 15 U.S.C. §§ 1-2 (providing current language of Sherman Act).

48. 15 U.S.C. §§ 12-27.

49. See *id.* § 2. Specifically, section 2 states: "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony . . ." *Id.*

50. See *id.* § 1. Specifically, section 1 states:

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony . . .

Id.

51. See *id.* (making combined activities of individual firms in restraint of trade a felony); *id.* § 2 (making monopolization of trade a felony).

52. See *id.* §§ 13-19. Enumerated practices made illegal by the Clayton Act are: (1) price discrimination, see *id.* § 13(a); (2) tying and exclusive dealing contracts, see *id.* § 14; (3) acquisition of competitors, see *id.* § 18; and (4) sharing of board members among competing firms, see *id.* § 19.

53. See ERNEST GELLHORN & WILLIAM E. KOVACIC, *ANTITRUST LAW AND ECONOMICS* 29 (4th ed. 1994).

54. See 15 U.S.C. § 15 ("[A]ny person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor . . .").

55. See *id.* § 4 (charging U.S. Attorney General with responsibility for enforcement of provisions of Sherman Act).

56. See GELLHORN & KOVACIC, *supra* note 53, at 29.

violation of the Sherman Act by virtue of its authority under the Federal Trade Commission Act.⁵⁷

B. Judicial Construction of Antitrust Laws

The nebulous words of the antitrust statutes reflect the ambivalence of Congress and the courts toward resolving the inherent tensions between incentive, efficiency, and competition in the free market.⁵⁸ Through the Act's open-ended provisions,⁵⁹ Congress granted the courts broad discretion to interpret antitrust laws and develop the principles for their enforcement.⁶⁰ This wide berth has allowed courts, over nearly a century, to develop manifold tests to determine whether liability will attach under the Acts for various types of behavior.⁶¹ Moreover, judicial construction has led to the establishment of different standards for reviewing potentially anticompetitive behavior.⁶²

1. Monopolization and attempted monopolization: section 2 offenses

Section 2 of the Sherman Act prohibits the monopolization of trade.⁶³ Courts apply a two-pronged test to determine whether a defendant has violated this section of the Sherman Act. The test asks first whether a defendant has "market power" in the relevant product

57. 15 U.S.C. §§ 41-58. Section 5 of the FTC Act, declares unlawful "unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce." 15 U.S.C. § 45. The Court conferred jurisdiction on the FTC to enforce the Sherman Act by holding that "unfair methods of competition" include violations of the Sherman Act. See *FTC v. Cement Inst.*, 333 U.S. 683 (1948).

58. See *United States v. Aluminum Co. of Am.*, 148 F.2d 416 (2d Cir. 1945) (evaluating monopoly action brought against ALCOA under Sherman Act). Judge Learned Hand observed: "Many people believe that possession of unchallenged economic power deadens initiative, discourages thrift and depresses energy; that immunity from competition is a narcotic, and rivalry is a stimulant, to industrial progress; that the spur of constant stress is necessary to counteract an inevitable disposition to let well enough alone." *Id.* at 427.

Judge Hand acknowledged conversely that "[a] single producer may be the survivor out of a group of active competitors, merely by virtue of his superior skill, foresight and industry. . . . [Such a] successful competitor, having been urged to compete, must not be turned upon when he wins." *Id.* at 430.

59. Chief Justice Hughes wrote for the Court that "[a]s a charter of freedom, the [Sherman] Act has a generality and adaptability comparable to that found to be desirable in constitutional provisions." *Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 359-60 (1933).

60. See *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 386 (1956) (noting that "judicial construction of antitrust legislation generally has been left unchanged by Congress").

61. See *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 593 (noting that plaintiff can prevail under same facts in antitrust action by establishing claim under any one of several rubrics).

62. See *du Pont*, 351 U.S. at 386-87 (declaring that there is no inconsistency between Court's standard requiring examination of particular circumstances and judicial theory making some agreements and practices invalid per se).

63. See 15 U.S.C. § 2 (1994) (making monopolization of trade a felony).

market.⁶⁴ Courts traditionally have used market share as a proxy for market power⁶⁵ in evaluating this prerequisite to a section 2 offense.⁶⁶ The second element of a section 2 offense is anticompetitive conduct.⁶⁷ The purpose of this requirement is to guard against "the willful acquisition of . . . power as distinguished from growth or development as a consequence of superior product, business acumen, or historic accident."⁶⁸ A firm satisfies this element when it acquires monopoly power through unlawful means or wields such power to prevent or impede competition.⁶⁹ A monopolist who innocently obtains market power is liable, therefore, only if it uses the power to restrain competition;⁷⁰ a monopolist who does not exercise market power in an anticompetitive fashion is liable only if it obtained such power through anticompetitive means.⁷¹

Section 2 also prohibits attempted monopolization. This offense includes three elements:⁷² (1) specific intent to control prices or destroy competition within a particular area of commerce; (2)

64. See *Eastman Kodak Co. v. Image Technical Servs.*, 504 U.S. 451, 481 (1992) (enumerating prerequisites to § 2 violation).

65. The "market share proxy" is the traditional test employed by courts to determine whether a defendant has market power. See *Jacobs*, *supra* note 11, at 342 & n.26 (noting that market share has been used as proxy for market power since Judge Learned Hand's seminal decision in *United States v. Aluminum Co. of Am.*, 148 F.2d 416 (2d Cir. 1945)). Under the test, a court considers the percent of market share a defendant holds. See *id.* at 424. If the defendant holds a dominant share of the product market, the court likely will find that it has market power; if the defendant holds an insubstantial share of the market, the court likely will hold that it does not have market power. See *id.*

66. See HERBERT HOVENKAMP, *ECONOMICS AND FEDERAL ANTITRUST LAW* § 6.5, at 168 n.2 (student ed. 1985). Compare *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc.* 784 F.2d 1325, 1335 (7th Cir. 1986) (affirming lower court's finding that defendant lacked market power in medical insurance when market share was 27% of patients in Indiana, new firms could enter market easily, existing firms could expand sales quickly, and there were no barriers to entry), with *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 899 F.2d 951, 969-70 (10th Cir. 1990) (finding defendant had market power in medical insurance, because barrier to entry by competitors was evidenced by 62% market share of patients in Kansas).

67. See *Kodak*, 504 U.S. at 482-83 (describing second element of § 2 claim as "willful acquisition or maintenance of monopoly power").

68. *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71, 576 (1966) (holding firm liable for § 2 offense when it acquired 87% of nation's centralized home protection service market through market allocation, discriminatory pricing designed to eliminate competition, and acquisition of competitors).

69. See *Berkey Photo, Inc. v. Eastman Kodak, Inc.*, 603 F.2d 263, 274 (2d Cir. 1979) (recounting elements of § 2 offense in claim against Kodak for monopolization of film, color print paper, and camera markets (citing *Grinnell*, 384 U.S. at 570-71)); see also *California Computer Prods. v. IBM*, 613 F.2d 727, 735 (9th Cir. 1979) (holding that there are three elements to § 2 antitrust claim: (1) possession of monopoly power; (2) willful acquisition or maintenance of power; and (3) causally related antitrust injury).

70. See *Berkey Photo*, 603 F.2d at 272.

71. See *id.* at 272-74.

72. See *California Computer Prods.*, 613 F.2d at 736 (recounting elements of attempted monopolization in claim against IBM for redesigning its computer products to make them incompatible with peripherals manufactured by competitors (citing *Times-Picayune Publishing Co. v. United States*, 345 U.S. 594, 626 (1953))).

predatory or anticompetitive conduct aimed at accomplishing the unlawful purpose; and (3) a dangerous probability of success.⁷³ The first element of the offense, specific intent, need not be proved through direct evidence, but can be shown through proof of a per se offense under section 1.⁷⁴ The second element, anticompetitive conduct, requires only a showing of some illegal or predatory activity.⁷⁵ The third element can be proved either through direct evidence of market power⁷⁶ or by inference from proof of specific intent.⁷⁷ Because a dangerous probability of success can be demonstrated merely by satisfying the first or second element of the offense, independent proof of the third element is not always essential to establishing attempted monopolization.⁷⁸

2. *Combinations or contracts in restraint of trade: section 1 offenses*

All contracts or combinations restrain trade to some degree.⁷⁹ Courts, therefore, have interpreted section 1 to prohibit only "unreasonable" restraints of trade.⁸⁰ To determine what constitutes an "unreasonable" restraint of trade, courts have developed three tests: (1) the rule of reason;⁸¹ (2) the quick look

73. The court in *California Computer Prods.* added a fourth element, causal antitrust injury, to the analysis. See *California Computer Prods.*, 613 F.2d at 736. This element, however, is not relevant to the subject of this Comment and therefore is not discussed.

74. See *id.* at 737 (holding direct evidence "not always necessary" when claim is based on Sherman Act § 1 violation).

75. See *id.* (noting that predatory or anticompetitive conduct element encompasses more than violations of § 1).

76. See *id.*

77. See *id.*

78. See *id.*

79. See FURROW ET AL., *supra* note 30, at 786 (observing that all contracts between buyers and sellers limit availability of goods to other buyers).

80. See *id.*

81. The rule of reason is applied by courts in evaluating most group boycotts and tying arrangements alleged under section 1. See *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 593 & n.2 (1st Cir. 1993) (noting that tying typically is scrutinized under rule of reason, and that group boycotts are viewed under rule of reason unless they involve "secondary boycotts"). This test balances the efficiencies of concentration against the anticompetitive effects of a contract or combination. See HALL & ELLMAN, *supra* note 13, at 192-93 (citing *Board of Trade of Chicago v. United States*, 246 U.S. 231, 238-41 (1918)). Justice Brandeis first articulated the rule of reason in his oft-quoted passage in *Board of Trade of Chicago*:

The true test of legality is whether the restraint imposed is such as merely regulates and perhaps promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business . . . ; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable.

Id. at 238. The rule of reason today remains substantially the same, applying a multifactor analysis to alleged antitrust offenses. See FURROW ET AL., *supra* note 30, at 786 (noting that courts conduct broader examination of competitive factors under rule of reason and citing *Board of Trade of Chicago* as "classic articulation" of test).

formulation;⁸² and (3) the per se test.⁸³ Courts scrutinize potentially anticompetitive activities under one of these three tests depending on how great a threat to competition the activity poses.⁸⁴ A defendant must possess market power before antitrust liability will attach under section 1 according to all but the per se test.⁸⁵ Courts evaluating antitrust liability under section 1 traditionally have employed the same market share proxy used in section 2 to determine whether a defendant possesses market power.⁸⁶

C. *Recent Application of Antitrust Law to HMOs*

Courts and regulators to date generally have viewed HMO markets as transitional, allowing them to develop free from close antitrust

82. The quick look test is a relatively recent formulation under which courts consider procompetitive justifications for allegedly anticompetitive behavior before deciding whether to apply the per se label. See *FURROW ET AL.*, *supra* note 30, at 787. Similarly, courts occasionally use the "quick look" justification to curtail proceedings under the "rule of reason" after finding convincing proof that a specific behavior unreasonably restrains trade and is devoid of any legitimate justification. See *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986) (holding that concerted refusal by dentists to provide insurer with x-rays for purpose of reviewing effectiveness of treatment was so clearly without quality of care or business benefit as to warrant finding of liability without reaching question of market definition or market power); see also *U.S. Healthcare*, 986 F.2d at 593 n.2 (interpreting *Kodak* as possible example of application of "quasi per se" or quick look test to tying arrangement).

83. The per se label is reserved for behavior so likely to have an anticompetitive effect that no exploration of its justification is warranted. See *FURROW ET AL.*, *supra* note 30, at 786. Today, the only behaviors that qualify for per se illegality are: (1) price or output fixing agreements, see *U.S. Healthcare*, 986 F.2d at 593 & n.2 (noting that price or output fixing agreements are per se illegal, but that group boycotts can be viewed as per se illegal only if they involve "secondary boycotts"); (2) market division, see *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1416-17 (7th Cir. 1995) (upholding jury verdict finding defendant liable for market division), *cert. denied*, 116 S. Ct. 1288 (1996); and (3) horizontal, secondary group boycotts, see *U.S. Healthcare*, 986 F.2d at 593 (noting that per se approach is applied properly to horizontal arrangements between providers of health care if they involve "secondary boycotts").

A secondary boycott occurs when competitors refuse to do business with a third party, such as a distributor or supplier, if it serves another competitor whom they seek to harm. See *Fashion Originators' Guild of Am., Inc. v. FTC*, 312 U.S. 457, 461-62 (1941) (describing arrangement whereby competing designers of clothing agreed not to sell to manufacturers or retailers who dealt with producers of design "copies"). The rule of reason, however, is applied appropriately to vertical arrangements among apparent competitors operating at different levels of production. See *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 212 (1959) (distinguishing boycott from situations in which there is exclusive dealership arrangement or refusal of single trader to deal with another).

84. See *FURROW ET AL.*, *supra* note 30, at 786. Activities proscribed by section 1 include group boycotts, tying arrangements, price fixing, and market division. See *U.S. Healthcare*, 986 F.2d at 593 & n.2 (evaluating appropriateness of applying rule of reason, quick look, and per se test to determine whether various activities violate Sherman Act § 1).

85. See *FURROW ET AL.*, *supra* note 30, at 787 (stating that market power is crucial to most claims under Sherman Act § 1).

86. See *id.* (stating that market power is essential to all claims under Sherman Act § 2 and that courts traditionally use market share as proxy for market power).

scrutiny.⁸⁷ This is at least partly due to the fact that competition on a large scale among health plans is a new feature in health care markets.⁸⁸ In recent years, competition has led to massive growth and consolidation by HMOs in order to maximize economies of scale and resources available to customers.⁸⁹ Both the FTC and DOJ have acknowledged the dramatic changes in the health care market.⁹⁰ In response, they have published joint guidelines to help those involved with managed care steer clear of antitrust liability.⁹¹ Enforcement under these guidelines, however, has been relatively relaxed.⁹² As the health care market matures, this permissive attitude may eventually yield to a more aggressive approach by enforcers,⁹³ as well as successful challenges to HMO behavior under antitrust laws.⁹⁴

87. See DOJ & FTC, ENFORCEMENT POLICY, *supra* note 17, at 20,799 (explaining that joint enforcement guidelines were introduced to guide health care providers through time of "tremendous change," and to prevent any chilling effect "the problem of uncertainty . . . [might have on] activities that could lower health care costs"); Holman W. Jenkins, Jr., *Business World: In Pursuit of Price-Fixing*, WALL ST. J., Apr. 9, 1996, at A19 ("In the medical business . . . trustbusters seem to favor a world in which mighty buyers are posed against small, cloutless sellers.").

88. See Enthoven, *supra* note 4, at 45-46 (describing resurgent popularity in 1992 of "managed competition"—or "value for money competition"—as means to lower health care costs).

89. See Ron Winslow & Leslie Scism, *Aetna Agrees to Acquire U.S. Healthcare; Pact for \$8.9 Billion in Cash and Stock Will Create Leader in Managed Care*, WALL ST. J., Apr. 2, 1996, at A2 (reporting that acquisition will result in creation of managed health care company serving 23 million people).

90. See DOJ & FTC, ENFORCEMENT POLICY, *supra* note 17, at 20,799 (observing that "health care markets have continued to evolve in response to consumer demand and competition in the marketplace").

91. See *id.* Although the DOJ & FTC guidelines do not directly address the activities of HMOs, Statement 9 of the Enforcement Policy establishes "Analytical Principles Relating to Multiprovider Networks." *Id.* at 20,826-35. This Statement establishes principles for review of arrangements that closely resemble and deal directly with HMOs, to be used to determine compliance with antitrust laws. See *id.* The Statement addresses: (1) issues associated with the formation of provider networks, see *id.* at 20,831; and (2) market definition, see *id.* at 20,828.

92. See David Burda, *Docs Get Their Way: Under AMA Attack, Feds Back Off Antitrust Enforcement*, MODERN HEALTHCARE, Jan. 8, 1996, at 40 (reporting that DOJ and FTC gave antitrust clearance to 19 of 23 business arrangements addressed since adoption of Joint Enforcement Policy). The FTC cleared nine of 13 deals among providers it reviewed, and the DOJ cleared all 10 of the deals it reviewed. See *id.* at 41; see also DOJ & FTC, ENFORCEMENT POLICY, *supra* note 17, at 20,827-31 (stressing agencies' intent to apply rule of reason to both horizontal and vertical arrangements among health providers).

93. See Brief of Amicus Curiae, States of Wisconsin, Arizona, Arkansas, Delaware, Florida, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Washington and West Virginia in Support of Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit, *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995) [hereinafter *Marshfield* Brief of Amicus Curiae] (urging Court to grant certiorari to Seventh Circuit and to reverse decision weakening ability of attorneys general to prosecute under antitrust laws).

94. See *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, No. 95-1698, 1996 U.S. Dist. LEXIS 6480 (E.D. Pa. May 13, 1996) (rejecting defendant U.S. Healthcare's motion for judgment as matter of law and paving way for \$1.2 million jury verdict in suit against HMO for tying arrangement); Leslie Scism, *U.S. Healthcare Rival Is Awarded \$1.2 Million in Antitrust Verdict*,

II. LOWERING THE LEGAL THRESHOLD FOR ANTITRUST LIABILITY

A. *Lowering the Threshold for Market Power*I. *Eastman Kodak Co. v. Image Technical Services, Inc.*

The U.S. Supreme Court departed from the previously clear standard of using market share as the proxy for market power in *Eastman Kodak Co. v. Image Technical Services, Inc.*⁹⁵ In so doing, it lowered the threshold for finding that small firms possess market power.⁹⁶

The Court in *Kodak* affirmed the denial of a motion for summary judgment by the defendant, Eastman Kodak Company,⁹⁷ holding that Kodak could be liable for antitrust violations despite the fact that Kodak possessed only a two to twenty-three percent share in the photocopying equipment market.⁹⁸ Prior to *Kodak*, the Supreme Court had never attributed market power to a firm with less than a fifty percent market share.⁹⁹ In turning away from the market share proxy, the Court disregarded precedent dating back to at least 1945.¹⁰⁰

WALL ST. J., May 23, 1996, at B2 (reporting verdict for plaintiff in antitrust suit brought against U.S. Healthcare for tying arrangement).

95. 504 U.S. 451 (1992).

96. See Jacobs, *supra* note 11, at 355-62 (describing Court's movement from traditional market share measurement to new form of market power assessment).

97. *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 486 (1992), *aff'g* 903 F.2d 612 (9th Cir. 1990), *rev'g* 1989-1 Trade Cas. (CCH) ¶ 68,402 (N.D. Cal. 1988).

98. *Image Technical Serv., Inc. v. Eastman Kodak Co.*, 903 F.2d 612, 616 n.3 (9th Cir. 1990) (noting that defendant Kodak had market share of 23% of high-volume copier market, 20% of micrographic equipment market, and less than 2% of plain-paper copier market), *aff'd*, 504 U.S. 451 (1992).

99. See Jacobs, *supra* note 11, at 342 n.27; see also Bloch & Falk, *supra* note 10, at 212 (noting that, under current case law, plan serving less than 30% of consumers in given market is not likely to pose threat of gaining and exercising market power).

100. See Jacobs, *supra* note 11, at 342 & n.26 (noting that market share has been used as proxy for market power since Judge Learned Hand's seminal decision in *United States v. Aluminum Co. of Am.*, 148 F.2d 416 (2d Cir. 1945)). The court in *Aluminum Co. of Am.* held that 90% market share constitutes market power, 60% to 64% likely does not, and less than 33% market share is insufficient to constitute market power. See *id.* at 424; cf. William E. Kovacic, *Failed Expectations: The Troubled Past and Uncertain Future of the Sherman Act as a Tool for Deconcentration*, 74 IOWA L. REV. 1105, 1112-20 (1989) (describing cyclical nature of this country's "efforts to use the Sherman Act to achieve its deconcentration goals . . . when . . . litigation has entered a state of lasting repose"). American jurisprudence has entered three discrete periods characterized by government initiatives to deconcentrate industry in the twentieth century: (1) 1904-1920, see *id.* at 1112-16; (2) 1937-1956, see *id.* at 1116-19; and (3) 1969-1982, see *id.* at 1119-20. Each period followed on the heels of government permissiveness toward the growth of large firms and events that served to discredit the benefits of large concentrations of economic power. See *id.* at 1120.

The Court's purpose in employing a new test for market power was to gain the ability to review potentially anticompetitive behavior by small firms in markets where rational economic explanations, while "perhaps intuitively appealing, may not accurately explain the behavior of the [market]."¹⁰¹ Under the market share proxy, small firms escaped review for violations of antitrust law because they failed to satisfy the threshold requirement of market power. The Court in *Kodak* acknowledged that, in markets made imperfect by certain economic factors, even small firms could possess market power, adopting anticompetitive policies¹⁰² or raising prices above competitive levels.¹⁰³

The plaintiffs in *Kodak* were independent service organizations ("ISO") that repaired and maintained Kodak photocopying equipment.¹⁰⁴ Kodak also serviced its own copiers, providing eighty to ninety-five percent of the maintenance for its machines.¹⁰⁵ Kodak provided these services through annual contracts or on a per-call basis after the initial warranty on its equipment expired.¹⁰⁶ It did not offer a complete package of equipment and maintenance with the initial sale of its equipment, including lifetime parts and service for a single price.¹⁰⁷

The ISOs provided parts and services to owners of Kodak equipment through arrangements similar to those offered by Kodak but at substantially lower prices.¹⁰⁸ ISOs obtained Kodak parts in several ways, including: (1) purchasing them directly from Kodak; (2) purchasing them from independent original-equipment manufacturers ("OEM") who made parts to order for Kodak; (3) reconditioning parts stripped from old Kodak machines; and (4) using parts purchased from Kodak by customers.¹⁰⁹ In response to the competi-

101. *Kodak*, 504 U.S. at 473.

102. See *id.* at 459 (stating that plaintiffs brought suit, in part, for illegal "tying arrangement"). Finding the existence of a tying arrangement, the Court sought to determine whether the arrangement could be characterized as "illegal." See *id.* at 464. It thus examined whether Kodak had market power, or the power to "force a purchaser to do something that he would not do in a competitive market." *Id.* (quoting *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 14 (1984)).

103. See *id.* at 470-71 (observing that increased revenues from supracompetitive pricing could more than offset lost revenues from decreased sales); see also Landes & Posner, *supra* note 35, at 937 (defining "market power" as "the ability of a firm or group of firms, acting jointly to raise the price above competitive level without losing so many sales so rapidly that the price increase is unprofitable and must be rescinded").

104. See *Kodak*, 504 U.S. at 455.

105. See *id.* at 457.

106. See *id.*

107. See *id.*

108. See *id.*

109. See *id.* at 458 & n.2.

tive threat from the ISOs, Kodak implemented several policies designed to inhibit ISOs from selling their services to owners of Kodak machines.¹¹⁰ These policies included selling replacement parts only to owners of Kodak equipment who subscribed to Kodak service arrangements¹¹¹ and forging agreements with OEMs to prevent them from selling Kodak-compatible parts to anyone but Kodak.¹¹²

The ISOs brought suit against Kodak, alleging that its policies violated sections 1 and 2 of the Sherman Act.¹¹³ Specifically, an ISO customer seeking to buy replacement parts for a Kodak machine could do so only if it purchased unwanted repair and maintenance services from Kodak.¹¹⁴ The ISOs alleged that, under section 1, these policies "tied" the sale of Kodak services to the sale of Kodak parts.¹¹⁵ Under section 2, the ISOs alleged that Kodak had attempted to monopolize the sale of service for Kodak machines by implementing its "parts and service policies as part of a scheme of willful acquisition or maintenance of monopoly power."¹¹⁶

In finding that Kodak could possess power in the "after market" for parts and services despite its low market share in the photocopier market, the Court placed great emphasis on the existence of two imperfections in the market for photocopiers: information deficiencies and high switching costs.¹¹⁷ The Court, evaluating the availability of information, noted that Kodak's method of pricing service and parts separately from the initial sale of its machines prevented prospective purchasers from obtaining an accurate estimate of the "lifecycle" cost of a Kodak photocopier.¹¹⁸ Although consumers could accurately assess the cost of the initial purchase of a Kodak machine, information on the cost of servicing the machine over its lifetime was "difficult[—if not] impossible—to acquire at the time of purchase."¹¹⁹ As a result, Kodak could charge subcompetitive prices

110. *See id.* at 458.

111. *See id.*

112. *See id.*

113. *See id.* at 459.

114. *See id.* at 464 (postulating that Kodak had "more than sufficient power in the parts market to force unwanted purchases of the tied market, service").

115. *See id.* at 459.

116. *Id.* at 483.

117. *See id.* at 473 (noting that "existence of significant information and switching costs" are "forceful" reasons for finding market power in absence of high market share).

118. *See id.*

119. *Id.* Information necessary to arrive at an accurate lifecycle price includes "data on price, quality and availability of products needed to operate, upgrade, or enhance the initial equipment, as well as service and repair costs, including estimates of breakdown frequency, nature of repairs, price of service and parts, length of 'down-time' and losses incurred from

for equipment, while recapturing the difference by charging supra-competitive prices later as the sole supplier of parts and service.¹²⁰

In addition, the Court found that high switching costs contributed to Kodak's ability to exercise market power.¹²¹ It noted that "the heavy initial outlay for Kodak equipment" made the cost of switching to a competing product "very high" for Kodak customers.¹²² The Court observed that "consumers who already have purchased the equipment, and are thus 'locked in,' will tolerate some level of service-price increases before changing equipment brands."¹²³ Under this scenario, Kodak could charge competitive prices in the equipment market but charge supracompetitive prices for parts and service.¹²⁴ Due to a lack of information about the high lifecycle cost of owning a Kodak machine, consumers might purchase the Kodak product. By the time they realized the high price of servicing the copier, it would be too late to change brands because the consumers would be "locked in" to the purchase by the "heavy initial outlay" necessary to purchase a new machine.

The Court's ruling meant that Kodak could be held liable for antitrust violations due to the existence of market imperfections it did not create.¹²⁵ The availability of interbrand comparative information about lifecycle prices was not within Kodak's control. Although it could have endeavored to provide lifecycle pricing information for its own products, it could not provide such information for its competitors' products. Likewise, the existence of high switching costs was not under Kodak's control; the high initial purchase cost of photocopying equipment was a reflection of the sophistication and expense of manufacturing such equipment, not of Kodak's anticompetitive behavior in the service market. Furthermore, the initial sale of equipment took place in a competitive interbrand market, which tends to hold prices down.¹²⁶

By introducing a new multi-factored analysis, the Court in *Kodak* moved away from the traditional antitrust analysis, which looked

down-time." *Id.*

120. *See id.* at 472.

121. *See id.* at 476.

122. *See id.* at 477.

123. *Id.* at 476.

124. *See id.* at 478.

125. *See Jacobs, supra* note 11, at 344-45 (stating that Court in *Kodak* rejected market share proxy in favor of market share analysis that examines market imperfections).

126. *See Image Technical Serv., Inc. v. Eastman Kodak Co.*, 903 F.2d 612, 616 & n.3 (9th Cir. 1990) (acknowledging Kodak's lack of market power in interbrand equipment market and noting that competition in this market might prevent Kodak from possessing power in service and parts market), *aff'd*, 504 U.S. 451 (1992).

primarily at the behavior of very large firms in an ostensibly healthy market. It moved instead toward an antitrust policy that gives equal consideration to the behavior of relatively small firms operating in a "pernicious market structure in which the concentration of power saps the salubrious influence of competition."¹²⁷ This new approach could have far-reaching ramifications for HMOs, which currently account for only a small share of the health care financing market.¹²⁸

2. Jefferson Parish Hospital District No. 2 v. Hyde

The Supreme Court, in *Jefferson Parish Hospital District No. 2 v. Hyde*,¹²⁹ upheld a Fifth Circuit ruling that certain imperfections in the health care market could give rise to market power in at least an "abstract sense"¹³⁰ when a defendant's thirty percent market share was insufficient to give rise to market power under the traditional analysis.¹³¹ The imperfections at issue in *Jefferson Parish* included a lack of consumer incentive to compare costs among hospitals¹³² and a lack of adequate information with which to compare quality among hospitals.¹³³ The Court ultimately concluded that, although these imperfections reduced price competition,¹³⁴ their presence alone was insufficient to support a finding of antitrust violation.¹³⁵ It suggested, however, that if these imperfections were accompanied by restraints on consumers' choices of health care providers, antitrust liability could attach.¹³⁶

127. *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 272 (2d Cir. 1979).

128. See Jacobs, *supra* note 11, at 344-45 (noting that this "analytical paradigm . . . can make small firms . . . 'powerful' in the antitrust sense").

129. 466 U.S. 2 (1984).

130. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 27 (1984).

131. See *id.* at 7 (noting that only 30% of residents of Jefferson Parish go to defendant hospital and remaining 70% go to 20 other hospitals in relevant geographic area).

132. See *id.* at 8 (recounting appellate court finding that prevalence of health insurance eliminates patients' incentive to compare costs); see also *id.* at 27-28 (evaluating competitive effect of consumer indifference to price and concluding that such indifference alone will not force consumers to make purchases they otherwise would not make).

133. See *id.* at 8 (reviewing appellate court finding that patients are not sufficiently informed to compare quality); see also *id.* at 27-28 (stating that "if consumers cannot evaluate the quality of . . . services, it follows that they are indifferent" to the choice of such service providers). Further, when consumers are indifferent to the choice of service providers, the policy of a defendant cannot be said to have "foreclosed a choice that otherwise would have been made 'on the merits.'" *Id.* at 28.

134. See *id.* at 27 (noting that prevalence of insurers as third-party payors for health care has led to consumer indifference to price).

135. See *id.* at 27 n.44.

136. See *id.* at 27 (holding that mere information deficiencies making consumers indifferent to price and quality are insufficient to confer market power in absence of any apparent restraints on consumer ability to choose anesthesiologist). The Court noted that, given the lack of incentive to compare costs among hospitals and the lack of information with which to compare

The plaintiff in *Jefferson Parish* was an anesthesiologist who applied for staff privileges at East Jefferson Hospital in Jefferson Parish, Louisiana.¹³⁷ After being approved initially, the anesthesiologist was denied privileges by the Hospital Board because the hospital had signed an exclusive contract with another anesthesiologist.¹³⁸ The plaintiff sued under section 1 of the Sherman Act, alleging that East Jefferson had implemented an illegal tying arrangement by which patients needing surgery at the hospital were forced to purchase anesthesiology services from the exclusive contractor.¹³⁹

The Court first found that, although the exclusive contract was a tying arrangement,¹⁴⁰ it could be illegal only if it forced patients to purchase anesthesiology services they did not need.¹⁴¹ The plaintiff alleged that the contract forced consumers to make such unwanted purchases.¹⁴² He further asserted that the hospital's thirty percent market share indicated that patients preferred East Jefferson to others, and that the lack of consumer incentive to compare cost and quality among hospitals enabled East Jefferson to charge supracompetitive prices.¹⁴³ The Court ultimately concluded that the tying arrangement was not illegal because patients were free to go to twenty other hospitals operating in the region, and empirical evidence indicated that they frequently did so.¹⁴⁴ Thus, although the Court in *Jefferson Parish* acknowledged that market imperfections could give rise to market power, the imperfections present in the case were not of a magnitude sufficient to render rational economic explanations incapable of "accurately explain[ing] the behavior of . . . markets," as was the case in *Kodak*.¹⁴⁵

quality, a consumer would have to be sophisticated to "know the difference between two anesthesiologists." *Id.* at 30 & n.49. However, there "was no evidence that any patient [with the requisite sophistication] was not also able to go to a hospital that would provide him with the anesthesiologist of his choice." *Id.* at 30.

137. *See id.* at 5.

138. *See id.*

139. *See id.* at 8 (reviewing appellate court analysis under which hospital's operating rooms were designated "tying product," and hospital's chosen anesthesia service was designated as "tied product").

140. *See id.* at 23 (noting that there was sufficient demand for purchase of anesthesiological services separate from hospital services and that other hospitals allowed such services to be purchased separately). The Court found that consumers differentiate between anesthesiological services, and that such services are not fungible, but differ slightly from provider to provider. *See id.*

141. *See id.* at 25.

142. *See id.* at 27.

143. *See id.* at 26-27.

144. *See id.* at 27 (noting that 70% of patients residing in Jefferson Parish enter hospitals other than East Jefferson, indicating that hospital's "dominance" is "far from overwhelming").

145. *Id.* at 26-29.

The Court in *Jefferson Parish* also made an important distinction in its analysis of East Jefferson's behavior. It acknowledged that in the field of health care, a potential monopolist often can be regarded as either a seller or buyer of health services.¹⁴⁶ As a seller of health care services, the relevant inquiry would be into conduct by an alleged monopolist that results in a reduction in the ability of competing sellers to enter the market.¹⁴⁷ Such conduct reduces elasticity of supply.¹⁴⁸ As a buyer, the inquiry would be into conduct that reduces the number of buyers available for similar services.¹⁴⁹ The lower courts have employed this dual analysis in cases involving allegedly anticompetitive behavior by HMOs.¹⁵⁰ *Kodak* and *Jefferson Parish* thus identify three imperfections that now could give rise to liability in the absence of substantial market share:¹⁵¹ (1) information deficiencies;¹⁵² (2) high costs for consumers to switch from one

146. See *id.* at 8 & n.8 (noting that court of appeals considered impact of East Jefferson's exclusive contract on patients, but not on anesthesiologists). An important question in evaluating the competitive impact of East Jefferson's behavior as a purchaser of anesthesiology services would be the extent to which excluded anesthesiologists could find other buyers for their services. See *id.* The Court in *Jefferson Parish* found scant evidence on this issue, but ultimately concluded that the presence of numerous hospitals with "open" policies made it likely that a patient with a preference could "go to a hospital that would provide him with the anesthesiologist of his choice." *Id.* at 30.

147. See *id.* at 7-8 & nn.7-8 (considering impact of East Jefferson's contract on patients' ability to obtain anesthesiology services of their choice from sources other than East Jefferson).

148. High supply elasticity means that there are low barriers for firms producing similar goods to increase production in response to an increase in price by a competitor. See Landes & Posner, *supra* note 35, at 945-51 (describing supply elasticity as function of ease with which competitors can enter market).

149. See *Jefferson Parish*, 466 U.S. at 8 & n.8 (noting that there are 156 anesthesiologists and 345 hospitals with operating rooms in Louisiana).

150. See *Blue Cross & Blue Shield of Wis. United v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995) (noting that definition of market "depends on substitutability on the supply side as well as on the demand side"), *cert. denied*, 116 S. Ct. 1288 (1996). A firm can be a monopolist as a purchaser of health services when it forecloses entry into the market by competitors, thereby eliminating substitutability of supply. See *id.* at 1412; see also *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 598 (1st Cir. 1993) (stating that "[o]ne can monopolize a product as either a seller or a buyer"). A firm can be a monopolist as a buyer of health services when it controls a substantial portion of the consumers of health services. See *id.* This could be true of an HMO if it enrolled a substantial portion of the population in a given geographic area. See *id.*; see also *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1329 (7th Cir. 1986) (recognizing that some "financing and insurance package[s] . . . [are] both a method of joining physicians in a firm and a method of financing their service by selling memberships for stated monthly prices").

151. See *Jefferson Parish*, 466 U.S. at 26 (noting that defendant hospital had only 30% market share); *Image Technical Serv., Inc. v. Eastman Kodak Co.*, 903 F.2d 612, 616 n.3, 621 (9th Cir. 1990) (holding Kodak liable for non-competitive activities related to servicing of its copiers, although Kodak's overall share of plain-paper copier market was less than two percent), *aff'd*, 504 U.S. 451 (1992).

152. See *Eastman Kodak Co. v. Image Technical Serv., Inc.*, 504 U.S. 451, 473 (1992) (noting that high cost of obtaining information about products is "forceful" reason for finding market power in absence of high market share).

product to another,¹⁵³ and (3) financing arrangements that reduce price competition, if accompanied by restrictions on consumers' choice of products.¹⁵⁴ The health care market incorporates each of these imperfections to some degree.¹⁵⁵ Under *Kodak*, HMOs may be deemed to possess market power if they are perceived to benefit from these imperfections. Further, HMOs may be found to possess market power under *Jefferson Parish* if certain market trends continue to reduce consumer options in the health care financing market.¹⁵⁶

B. Potential Divergence of HMO and Health Care Financing Markets

To date, courts have included HMOs in a broad product market defined to encompass all "health care financing" products, including traditional indemnity (or "fee-for-service") insurance and PPOs.¹⁵⁷ This definition is based primarily on two factors. First, courts consider consumer perception that HMOs and other forms of health care financing are interchangeable.¹⁵⁸ Such interchangeability reflects the cross-elasticity of demand between HMOs and other forms of health care financing.¹⁵⁹ Second, courts consider the relative ease with which providers of one form of health financing can modify

153. See *id.* at 473 (noting that "existence of significant . . . switching costs" is "forceful" reason for finding market power, even without high market share).

154. See *Jefferson Parish*, 466 U.S. at 27 (noting that prevalence of insurers as third-party payors for health care reduces incentive to compare hospital costs and lack of adequate information to compare quality among hospitals allows hospitals to charge non-competitive prices). The Court held that, at least in an "abstract sense," these factors, if coupled with restraints on consumer choice of provider, could give rise to antitrust liability even in the absence of substantial market share. See *id.*

155. See generally *infra* Part IV (analyzing imperfections in health care financing market).

156. See *infra* notes 252-59 and accompanying text (describing how exclusions on coverage of pre-existing conditions and adverse selection have reduced consumer options in purchase of health care financing products).

157. See *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995) (finding that HMOs belong to same product market as fee-for-service and PPO plans), *cert. denied*, 116 S. Ct. 1288 (1996); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 591 (1st Cir. 1993) (finding that HMOs belong to same product market as indemnity, PPO, Blue Cross/Blue Shield, Medicare and Medicaid plans).

158. See, e.g., *Marshfield*, 65 F.3d at 1410 ("The record shows, what is anyway well known, that individuals, and their employers, and medical insurers . . . regard HMOs as competitive not only with each other but also with the various types of fee-for-service providers."); *U.S. Healthcare*, 986 F.2d at 591 (upholding lower court ruling that HMOs exist in broadly defined health care financing market because they are viewed as interchangeable with fee-for-service arrangements, Blue Cross/Blue Shield Plans, Medicare, and Medicaid); *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins. Inc.*, 784 F.2d 1325, 1332 (7th Cir. 1986) (noting that consumers will switch readily from one form of health care financing to another in response to price increase).

159. See *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 394 (1956) (calling for assessment of cross-elasticity of demand in determining relevant product market for cellophane); Landes & Posner, *supra* note 35, at 945 (describing elasticity of demand as function of consumer perception that goods are interchangeable). High elasticity of demand means that if an HMO raises its price, it will lose a large number of customers; low elasticity means that if an HMO raises its prices, it will lose few customers. See *id.*

production to offer another in response to an increase in prices by a producer of similar goods.¹⁶⁰ This test for "ease of entry" into the market reflects elasticity of supply.¹⁶¹ Applying these principles, courts have found that consumers view HMOs as interchangeable with other forms of health care financing, and that there are low entry barriers for new competitors.¹⁶² Having thus defined the market broadly, courts apply the market share proxy to test for market power. As a component of the "health care financing market," HMOs typically do not hold a sufficient market share to be deemed to possess market power under the traditional analysis.¹⁶³

The potential impact of *Kodak* and *Jefferson Parish* on market definition in HMO cases is that courts, in defining relevant product markets, may no longer place primary emphasis on market share and product interchangeability.¹⁶⁴ They may look instead at the ability of HMOs to exert control over their segment of the health care financing market as a result of market imperfections. While courts traditionally have looked at a firm's ability to exert control over a segment of the market as a secondary component of market definition, they have done so only after finding high market share.¹⁶⁵ A

160. See *Ball Mem'l Hosp.*, 784 F.2d at 1330-32, 1335 (finding that defendant lacked market power in medical insurance where market share was 27% of patients in Indiana, new firms could enter market easily, existing firms could expand sales quickly, and there were no barriers to entry); see also *Marshfield*, 65 F.3d at 1410-11 ("[T]he definition of a market depends on substitutability on the supply side as well as on the demand side.").

Both consumers and insurers view health financing products as interchangeable. See *id.* Thus, if the only HMO in a geographic market raises prices above the competitive level, the market will respond in two ways: (1) consumers will switch to other forms of health care financing that are competitively priced; and (2) producers will take advantage of the opportunity to gain customers by offering HMOs at a competitive price. See *id.*

161. High supply elasticity means that there are low barriers for firms producing similar goods to increase production in response to an increase in price by a competitor. See *Landes & Posner*, *supra* note 35, at 945-51 (describing supply elasticity as function of ease with which competitors can enter market).

162. See generally *Marshfield*, 65 F.3d at 1410 (7th Cir. 1995) (stating that "individuals, and their employers, and medical insurers . . . regard HMOs as competitive not only with each other but also with the various types of" other health care financing products), *cert. denied*, 116 S. Ct. 1288 (1996); *U.S. Healthcare*, 986 F.2d at 591 (noting that "familiar alternatives to HMOs" include fee-for-service arrangements, Blue Cross/Blue Shield plans, Medicare, and Medicaid); *Ball Mem'l Hosp.*, 784 F.2d at 1332 (quoting lower court ruling that "[c]onsumers are extremely price sensitive and will readily switch on the basis of price from one company or form of [health care] financing to another").

163. See *Marshfield*, 65 F.3d at 1413 (holding that even if HMO had 100% of HMO subscribers, its share of health care financing market was inadequate to support finding of market power); *U.S. Healthcare*, 986 F.2d at 597 (holding that sole supplier of HMO services had inadequate market share in health care financing market to support monopolization charge).

164. Cf. *U.S. Healthcare*, 986 F.2d at 598 (lamenting that "[t]here is no subject in antitrust law more confusing than market definition").

165. Compare *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 899 F.2d 951, 956 (10th Cir.) (holding that defendant insurer possessed market power when all hospitals and approximately 90% of physicians in market were under contract with it), with *Ball Mem'l Hosp.*, 784 F.2d at

court, finding that market imperfections enable an HMO to exert control over its segment of the health care financing market, could conclude under *Kodak* that HMOs comprise a separate product market.

Changing conditions in the health care financing market, moreover, could lead courts to perceive a separation of the markets for HMOs and other forms of coverage even under traditional methods of market definition. Rapidly increasing HMO enrollment, coupled with adverse selection and coverage exclusions for pre-existing conditions, could render HMOs and other forms of health care financing non-interchangeable.¹⁶⁶ Disparities in reimbursement, patient volume, and patient type may cause physicians to align with either HMOs or fee-for-service plans.¹⁶⁷ These factors, coupled with the use of exclusivity contracts and the trend toward physician ownership of HMOs, may reduce the supply of physicians available to join newly forming or expanding HMOs.¹⁶⁸ If both demand and supply for HMOs become sufficiently inelastic, courts could begin to view the HMO market as separate from the health care financing market. Each individual HMO would hold substantially higher market share in a product market consisting of only HMOs. In such a divided market, courts could find that HMOs have market power even under the traditional market share proxy.¹⁶⁹

1334, 1335, 1346 (holding that defendant insurer did not have market power when it insured 27% of patients in market). Prior to its decision in *Kodak*, the Supreme Court held that a hospital did not possess market power when it served 30% of the patients in its market area, and the remaining 70% of patients went elsewhere. See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 26-27 (1984); see also *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377 (1956) (using term "monopoly power" synonymously with market power). Justice Reed, delivering the opinion of the Court in *du Pont*, observed:

If cellophane is the "market" that du Pont is found to dominate, it may be assumed it does have monopoly power over that "market." Monopoly power is the power to control prices or exclude competition. . . . [For it] is inconceivable that price could be controlled without power over competition or vice versa.

Id. at 391-92 (footnote omitted).

166. See *infra* notes 252-92 and accompanying text (describing how increasing HMO enrollment, information deficiencies, adverse selection, and pre-existing condition exclusions could make poor substitutes of HMOs and other forms of health care financing).

167. See *Marshfield*, 65 F.3d at 1410 (listing factors physicians may consider in determining whether to associate with HMOs or other health insurance providers).

168. See *infra* notes 293-97 and accompanying text (discussing how physician preferences, ownership of HMOs, and exclusivity contracts could deplete supply of available physician-panelists for newly forming HMOs).

169. See THE INTERSTUDY COMPETITIVE EDGE, 5.2 REGIONAL MARKET ANALYSIS 23 (Nov. 1995) [hereinafter 1995 INTERSTUDY REGIONAL MARKET ANALYSIS] (reporting that most markets have at least one HMO with dominant market share of HMO enrollees). Nearly two-thirds of large markets, three-quarters of medium markets, and four-fifths of small markets have one dominant HMO. See *id.* A dominant HMO is defined as one that commands at least 33% of enrollment in the market. See *id.* at 20. Large markets are those with one million or more residents, medium markets have between 250,000 and one million residents, and small markets have less

III. LOWER COURT ASSESSMENT OF HMO ANTITRUST LIABILITY

The First, Seventh, and Tenth Circuits have ruled on antitrust claims against an HMO or large insurer. In defining the HMO market, the First and Seventh Circuits have relied on traditional concepts of product interchangeability to find that HMOs are a component of the health care financing market.¹⁷⁰ In assessing market power, the First, Seventh, and Tenth Circuits have employed the traditional method of measuring elasticity of supply and demand to arrive at differing conclusions about the market power of insurer-defendants.¹⁷¹

None of the circuits, however, has taken into account the possibility raised in *Kodak* and *Jefferson Parish* that market imperfections could divide the health care financing and HMO markets or confer market power on a defendant who appears to lack such power under traditional analysis.¹⁷² Both the First and Seventh Circuits acknowledged at least the possibility that HMOs could comprise a discrete product market in some circumstances.¹⁷³ Although the Supreme Court recently denied certiorari to the Seventh Circuit in *Blue Cross*

than 250,000 residents. See *id.* at 8.

170. See *Marshfield*, 65 F.3d at 1411 (finding HMO not liable for monopolization and defining HMO product market to include all forms of health care financing); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 597-99 (1st Cir. 1993) (finding HMO not liable for monopolization because of lack of market power within relevant product market).

171. See *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 899 F.2d 951, 965-66, 969 (10th Cir.) (finding that defendant possessed market power in medical insurance where barrier to entry by competitors was evidenced by 62% market share of patients in Kansas); *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101, 1109-11 (1st Cir. 1989) (holding that insurer policy of paying no more for physician services than payment by competing HMO did not violate Sherman Act § 2, despite existence of market power, because insurer did not engage in "predatory" pricing); *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1330, 1334, 1335, 1346 (7th Cir. 1986) (finding that defendant lacked market power in medical insurance although market share was 27% of patients in Indiana).

172. See *supra* notes 95-156 and accompanying text (describing how, under analysis of *Kodak* and *Jefferson Parish*, market imperfections can give rise to market power even without high market share); see also *supra* notes 157-68 and accompanying text (describing how health care market imperfections may cause HMO market to diverge from health care financing market under *Kodak* and *Jefferson Parish* analysis).

173. See *U.S. Healthcare, Inc.*, 986 F.2d at 598 (acknowledging that U.S. Healthcare has at least some basis for asserting that HMOs constitute separate market from other health care service providers); see also Mary Chris Jaklevic, *Court Amends Its Opinion in Marshfield Clinic Ruling*, MODERN HEALTHCARE, Oct. 23, 1995, at 24 (reporting that 7th Circuit amended its original ruling in *Marshfield* to allow for possibility that HMOs could constitute discrete product market). The Seventh Circuit acceded to objections from the DOJ and FTC disputing the court's unqualified statements that HMOs cannot constitute a product market separate from other forms of health care financing. See *id.* The court qualified its position, acknowledging that the terms HMO and PPO "refer to a variety of different types of [plans], which may vary in respects crucial to antitrust liability." *Marshfield*, 65 F.3d at 1411. The court further emphasized that its ruling applied only to the factual record compiled by the district court. See *id.*

and *Blue Shield United of Wisconsin v. Marshfield Clinic*,¹⁷⁴ the questions of how to properly define the HMO market and how to assess market power are likely to be the subject of considerable antitrust litigation in the future.¹⁷⁵ As HMOs continue to consolidate,¹⁷⁶ courts may find the principles of *Kodak* and *Jefferson Parish* more appealing in defining the HMO market and evaluating power within that market.

A. Lower Court Definition of the HMO Market

1. Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic

In *Marshfield*, the Seventh Circuit held that a doctor-owned clinic and its subsidiary HMO, Security, which enrolled nearly ninety percent of all HMO subscribers in the region, did not foreclose the market to new competitors in violation of section 2 of the Sherman Act.¹⁷⁷ The court's holding was based, in large part, on its broad definition of the HMO market to include all forms of health care financing.¹⁷⁸ As a component of this broadly-defined market, Security held less than fifty percent market share, an amount too

174. 65 F.3d 1406 (7th Cir. 1995), cert. denied, 116 S. Ct. 1288 (1996); see also *Blue Cross Granted Time to Go to Supreme Court*, MILWAUKEE J. SENTINEL, Nov. 9, 1995, at B1 (reporting that 7th Circuit granted Blue Cross's request to postpone order for new trial on damages while Blue Cross petitioned Supreme Court for certiorari).

175. See David Burda, *Lax Enforcement Paints Favorable Legal Outlook*, MODERN HEALTHCARE, Jan. 1, 1996, at 49-50 (advising health care industry to "[e]xpect more Marshfield-like antitrust litigation" involving HMOs). Litigation is likely to be brought by private parties, such as insurers who are "locked out of markets by dominant provider groups" or by provider groups that are closed out of other markets by dominant insurers. *Id.* State enforcers also may elect to bring antitrust actions similar to those in *Marshfield*. See *Marshfield* Brief of Amicus Curiae, *supra* note 93, at 2; see also *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, No. 95-1698, 1996 U.S. Dist. LEXIS 6480, at *18-19 (E.D. Pa. May 14, 1996) (rejecting defendant HMO's motion for judgment as matter of law and holding, under *Kodak*, that relevant product market was all members of single dominant HMO).

Urging the Court to grant certiorari to the 7th Circuit, attorneys general representing 26 states asserted that they were "keenly disappointed" that the 7th Circuit departed from Supreme Court antitrust precedent. See *id.* at 3. They argued further that as "the primary public enforcers of the state antitrust laws, which are often required to be interpreted in conformity with federal law," they have a "vital interest" in maintaining antitrust law as applied to health care markets. *Id.* at 2-3.

176. See, e.g., William W. Price III, *Will Giant HMOs Help Health Care? An Executive at Fountain Valley-Based FHP Says That There is Still Plenty of Room for Competition, and that Consumers Could Benefit*, L.A. TIMES, Apr. 10, 1995, at D1 (describing HMO merger resulting in 4.4 million-member HMO); Winslow & Scism, *supra* note 89, at A2 (describing HMO acquisition resulting in managed health care company serving 23 million people).

177. See *Marshfield*, 65 F.3d at 1409, 1412 (finding that Security was not monopolist of HMO services). Under section 2 of the Sherman Act, monopolization of trade between states is a felony. See 15 U.S.C. § 2 (1994).

178. See *Marshfield*, 65 F.3d at 1411 (ruling that no reasonable jury could have found that HMO constituted separate product market).

small to raise an inference of market power.¹⁷⁹ The court's definition of the market relied primarily on two conclusions:¹⁸⁰ (1) consumers of health care financing view HMOs as interchangeable with PPO plans and traditional indemnity insurance;¹⁸¹ and (2) barriers to entry by new HMOs are low.¹⁸² There are several weaknesses in the court's reasoning in *Marshfield* that make its conclusions susceptible to a contrary interpretation under the *Kodak* and *Jefferson Parish* analysis.

First, although the Marshfield Clinic employed all of the physicians in Marshfield and several other towns,¹⁸³ the court in *Marshfield* reasoned that these physicians nevertheless would be willing to serve other HMOs because they were not under exclusive contract to Security and many of them already participated in PPOs.¹⁸⁴ The mere absence of an exclusive contract, however, does not mean that a physician is willing to provide services to an HMO entering the market in response to a price increase by an existing HMO. Many of Security's physician members held an ownership interest in the HMO.¹⁸⁵ These physicians had an economic incentive not to join competing HMOs because the success of other HMOs might threaten

179. See *id.* (holding that plaintiff was unable to show that defendant had market share of 50% in product market and that 50% is below "accepted benchmark" for inferring monopoly power from market share). The court noted that Security "did have a monopoly share of the HMO 'market,' but we have held that that is not a proper market." *Id.* at 1413. Further, the court held that because the plaintiff did not prove monopoly power, it was unnecessary to consider the methods by which Security acquired or maintained it. See *id.*

180. See *id.* at 1410 (analyzing "substitutability on the supply side as well as on the demand side" in determining whether HMOs are definable as separate product market).

181. See *id.* ("The record shows, what is anyway well known, that individuals, and their employers, and medical insurers . . . regard HMOs as competitive not only with each other but also with the various types of fee-for-service provider.").

182. See *id.* at 1410, 1413 (stating that contracts between Security and its physician members did not forbid physicians from joining other HMOs). The court also noted its skepticism that Security's prohibition on "cross coverage" agreements between its physician members and non-members discouraged hospitals from joining HMOs that compete with Security. See *id.* at 1413. Such agreements enable one physician to care for another physician's patients while that physician is out of town. See *id.*

183. See *id.* at 1409 (noting that record did not disclose what percentage of total physician population 400 physicians employed by clinic comprised). The lower court record, however, disclosed that the Marshfield Clinic employed all of the physicians in the town of Marshfield, as well as several other towns. See *id.*

184. See *id.* at 1410 ("All that is needed [to create an HMO] is an array of physicians who among them provide a broad range of medical services, and the same thing is needed for a preferred-provider plan."). The court in *Marshfield* also noted that physicians participating in the Marshfield HMO were not under exclusive contract and could sell their services to other HMOs. See *id.* at 1409-10. The court concluded, therefore, that barriers to entry by new HMOs were low. See *id.* at 1410.

185. See *id.* at 1408 (noting that Marshfield Clinic was owned by its 400 physician-employees and that clinic owned Security HMO).

that of Security.¹⁸⁶ Thus, elasticity of supply might have been low despite the absence of exclusive contracts because physicians voluntarily refused to contract with newly forming HMOs out of economic self-interest.

Second, the mere perception of product interchangeability does not enable consumers to seek alternative coverage in response to a price increase by an HMO. Market imperfections, such as the practice by insurers of excluding coverage of pre-existing conditions, can prevent consumers from seeking alternative coverage despite the perception that products are similar.¹⁸⁷ Such practices can raise consumer "switching costs" by forcing consumers with pre-existing conditions to either accept prices above the competitive level or forego coverage altogether.¹⁸⁸ High switching costs thus decrease elasticity of demand by reducing or eliminating consumer ability to seek alternative coverage in response to a price increase.

Finally, the court held that monopoly power could not be inferred from Security's high prices or high rate of return relative to its competitors because the service it offered was "heterogeneous."¹⁸⁹ Product heterogeneity, however, can be a poor explanation for price differences between a monopoly product and "substitutes" offered by other firms.¹⁹⁰ Courts have held that in a monopoly situation, a

186. See *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 592 (1st Cir. 1993) (describing HMO strategy of encouraging doctors to become shareholders in order to give them incentive to contain costs). But see *Marshfield*, 65 F.3d at 1411 (determining that physician members of Security derived insubstantial sums from their association with Security and Marshfield Clinic, and were not contractually restrained from competing with either entity).

187. See *infra* notes 252-59 and accompanying text (describing how insurance coverage exclusions for pre-existing conditions have caused widespread consumer "lock-in" and "job-lock").

188. See *infra* notes 254-56 and accompanying text (describing severe limitation of coverage options placed on consumers with pre-existing conditions).

189. See *Marshfield*, 65 F.3d at 1411-12 (concluding that clinic's high prices and rate of return could reflect factors other than market power, such as variations in quality or in product itself). The clinic's ability to charge monopoly prices implies that Security also had such an ability. The court proclaimed, however, that "there is not even a good economic theory that associates monopoly power with a high rate of return." *Id.*

This conclusion is contradicted by at least one study of HMO operating margins in small markets. See 1995 INTERSTUDY REGIONAL MARKET ANALYSIS, *supra* note 169, at 35 (Nov. 1995) (examining effects of HMO competition on operating margins). The study found that HMOs serving small markets—those with a population of less than 250,000—have the lowest operating margins when there are at least two significant market shares. See *id.* at 8, 35. Security served a small market, but it held the only significant market share in that market. See *Marshfield*, 65 F.3d at 1409 (noting that "Marshfield is a town of only 20,000 people in a largely rural region"). According to the study, if a competitor were to enter the Marshfield market, Security's rate of return likely would drop. It therefore is reasonable to assume that Security's high rate of return is a result of the absence of competition in the market, and not merely of product heterogeneity.

190. See Gellhorn & Kovacic, *supra* note 53, at 102-03 (describing analytical weakness known as "cellophane fallacy," in which price differences merely indicate that imperfect competition

firm with market power can make its product appear interchangeable with substitutes that are functionally inferior, but more expensive, simply by raising prices to the level of the more expensive product.¹⁹¹

The court's reasoning in *Marshfield* involved the same kind of economic formalism the Supreme Court rejected in *Kodak*¹⁹² and eschewed in *Jefferson Parish*.¹⁹³ The court held that the mere presence of some factors which make supply and demand elastic *in theory*, such as the apparent availability of physicians and consumer perception of product interchangeability, precluded the possibility that market imperfections rendered supply and demand inelastic *in fact*.¹⁹⁴ This weakness in the court's reasoning raises the possibility that courts applying the principles of *Kodak* and *Jefferson Parish* could conclude, under facts similar to those in *Marshfield*, that HMOs constitute a discrete product market.

2. U.S. Healthcare, Inc. v. Healthsource, Inc.

In *U.S. Healthcare, Inc. v. Healthsource, Inc.*,¹⁹⁵ the First Circuit was faced with a suit alleging violations of sections 1 and 2 of the Sherman Act brought by an HMO wishing to enter a market against a dominant HMO already operating in that market.¹⁹⁶ The defen-

has forced consumers to regard poor substitutes as interchangeable products). Commentators first detected this fallacy in *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377 (1956), the Supreme Court's seminal market definition case. The Court failed to consider whether high elasticity of demand among manufacturers of flexible wrapping materials meant only that du Pont, the exclusive manufacturer of cellophane, had already raised prices to monopolistic levels. See Gellhorn & Kovacic, *supra* note 53, at 102-03. The "cellophane fallacy" states that elasticity of demand is an accurate test of whether two products are good substitutes only if competitive prices are being charged for each. See *id.* The court in *Marshfield* assumed that HMOs and other forms of health care financing were good substitutes first, then concluded that any price difference was the result of differences in product or quality. See *Marshfield*, 65 F.3d at 410-12; see also *United States v. Eastman Kodak Co.*, 63 F.3d 95, 105 (2d Cir. 1995) (describing government's contention that consumers' unwillingness to switch away from Kodak film following price increase indicates that Kodak was already pricing film at monopolistic levels).

191. See *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 599 (1st Cir. 1993) (holding that issue in defining HMO product market is "whether a sole supplier of HMO services . . . could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits").

192. See *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 466 (1992) (holding that legal presumptions based on "formalistic distinctions" instead of "market realities" generally are disfavored in antitrust law). Rather than considering only market share, therefore, the Court will consider the "responsiveness of sales of one product to the price changes of the other." *Id.* at 467 (quoting *du Pont*, 351 U.S. at 400).

193. See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 26-29 (1984) (holding that Court will examine economic realities of market at issue).

194. See *Marshfield*, 65 F.3d at 1411-12 (indicating that factors must be viewed in context of circumstances surrounding market in question).

195. 986 F.2d 589 (1st Cir. 1993).

196. See *U.S. Healthcare, Inc.*, 986 F.2d at 591-93.

dant, Healthsource, was the only non-staff-model HMO operating in New Hampshire and had enrolled approximately five percent of the population of the state.¹⁹⁷ Many contracted physicians were stockholders in the company,¹⁹⁸ and eighty-seven percent of them signed exclusive contracts under which they agreed not to serve any other HMO.¹⁹⁹ The plaintiff, U.S. Healthcare, was one of the nation's largest HMOs, with more than one million enrollees but no operations in New Hampshire.²⁰⁰

The court, reviewing U.S. Healthcare's claims under the "rule of reason,"²⁰¹ concentrated on the question of market definition.²⁰²

197. *See id.* at 591 (noting that Healthsource was structured as "IPA" model HMO, contracting directly with independent physicians).

198. *See id.* at 592 (indicating that at least 400 physicians had become stockholders).

199. *See id.* (recounting origin and motivation behind exclusivity clause). Healthsource was planning a public offering of its stock and was aware that HMOs from nearby states were interested in moving into New Hampshire. *See id.* The main concern was that after Healthsource went public, many of the doctor-owners would sell their stock in Healthsource and join multiple HMOs to increase their patient volume. *See id.* In response to this perceived threat, Healthsource offered a new contract option to its physicians, whereby they could receive a 14% increase in reimbursement if they agreed not to serve any other HMO. *See id.* Physicians were free under the agreement to serve patients in various non-HMO health care financing arrangements. *See id.* Ultimately, nearly 87% of Healthsource's physicians opted for exclusivity. *See id.* at 592.

200. *See id.*

201. *See id.* at 595 (concluding that application of "rule of reason" test was proper). The court considered reviewing the claim under the per se, quick look and rule of reason tests, but found the per se and quick look tests to be inappropriate. *See id.* at 593-95. It held that the per se test was not applicable to facts such as those presented in this case, but only to cases involving a "secondary boycott," that is, cases in which competitors agree not to do business with suppliers that deal with competitors they wish to harm. *See id.* at 593 (noting that "per se condemnation is not visited on every arrangement that might, as a matter of language, be called a group boycott"). The court speculated further, saying: "We doubt that the modern Supreme Court would use the boycott label to describe, or the rubric to condemn, a joint venture among competitors in which participation was allowed to some but not all." *Id.* The court thus compared the exclusivity contract to a vertical exclusivity arrangement among sellers at different levels of production, which is not strictly prohibited under antitrust law. *See id.* It stressed that horizontal arrangements among producers competing at the same level of production are prohibited. *See id.*

The court also concluded that the cases relied upon by the plaintiff were inapposite to give rise to use of the quick look test. *See id.* The court explained that the exclusivity clause was not "so patently bad that even a brief glance at its impact, lack of business benefit and anticompetitive intent [would] suffice to condemn it." *Id.*

In applying the rule of reason, the court observed that "[e]xclusive dealing arrangements . . . come in a variety of forms and serve a range of objectives." *Id.* at 595. These arrangements can serve "benign" purposes, such as fostering dealer loyalty or ensuring adequate supply. *See id.* They also can have anticompetitive consequences, however, such as foreclosure of "so much of the available supply or outlet capacity that existing competitors or new entrants may be limited or excluded." *Id.* The propriety of an exclusive dealing arrangement thus depends on the particular circumstances of its use. The court found, therefore, that the rule of reason, which balances the procompetitive and anti-competitive effects of a defendant's conduct, was the most appropriate test under which to review U.S. Healthcare's claims. *See id.*; *see also supra* note 81 (describing rule of reason test).

202. *See U.S. Healthcare, Inc.*, 986 F.2d at 597-98 (noting that trial judge dismissed plaintiff's claims based on his assessment that defendant lacked power within broadly defined "health care

It began by asking whether Healthsource should be viewed as a potential monopolist in the sale of health care services to consumers or in the purchase of health care services from physicians.²⁰³ The court concluded that Healthsource was most appropriately viewed as a seller of services because the potential anticompetitive effect of the exclusivity clause was to foreclose the market to HMOs by eliminating the supply of doctors whose services competing HMOs could sell to consumers.²⁰⁴ Next, the court inquired as to the nature of the product market in which Healthsource operated and, deferring to the trial court ruling, concluded that the market was health care financing.²⁰⁵ Employing the traditional market share proxy, the court held that Healthsource possessed too small a market share to have market power.²⁰⁶ It found, therefore, that Healthsource was not liable under either section 1 or 2 of the Sherman Act.²⁰⁷

The trial court based its broad definition of the HMO market on reasoning similar to that later used by the Seventh Circuit in *Marshfield*, namely, that HMOs are interchangeable with other forms of health care financing.²⁰⁸ While the First Circuit affirmed this interpretation, it acknowledged the possibility that the HMO market

financing" market and that, if this market definition were incorrect, remand might be required).

203. See *id.* at 598 (noting that one can monopolize market as either buyer or seller).

204. See *id.* (affirming correctness of trial judge's analysis of defendant as seller of health services). Courts, in defining markets, must ask themselves *why* they are doing so. See *id.* In this case, U.S. Healthcare asserted that Healthsource had foreclosed the market to other HMOs by "buying" up the supply of doctors whose services could be sold to consumers. See *id.* The court rejected this approach, stating that in order to monopolize the market as a buyer of health services, Healthsource would have to close off the market such that doctors could not find other buyers for their services. See *id.* Because other buyers of physician services, such as fee-for-service plans like Medicare and Medicaid, were not affected by the exclusivity clause, Healthsource could not have used it to foreclose the market as a buyer of health services. See *id.* The appropriate perspective through which to evaluate the impact of Healthsource's exclusivity clause, therefore, was that of a seller of health care services. See *id.*

205. See *id.* at 597-98 (noting that magistrate judge defined relevant product market broadly to include "all health care financing in New Hampshire").

206. See *id.* at 598 (noting that if foreclosure effect of exclusivity clause was greater, it might be possible to describe Healthsource as monopolist or potential monopolist). Evidence presented at trial indicated that Healthsource enrolled only about 5% of the residents of New Hampshire. See *id.* at 591. The magistrate judge believed this was too small a share of the health care financing market to support a monopolization or attempted monopolization charge under Sherman Act § 2. See *id.* at 597. The court held that "[i]f health care financing is the product, as the magistrate judge determined, plainly Healthsource has no monopoly or anything close to it." *Id.* at 599. The court observed, however, that "the only way to cast Healthsource as a monopolist is to argue . . . that HMO services are a separate health care product." *Id.* at 598.

207. See *id.* at 599.

208. See *id.* (noting market definition is "sometimes described as [issue] of interchangeability of products and services"). The court cited the extensive discussion of "cross elasticity of demand" in *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 394-404 (1956) in support of this observation. See *U.S. Healthcare, Inc.*, 986 F.2d at 599.

could be separated from that of other forms of health care financing.²⁰⁹ First, the court observed that the HMO market could diverge from the health care financing market if HMOs could raise and sustain prices above the competitive level long enough to enjoy monopoly profits.²¹⁰ The ability to charge supracompetitive prices without losing customers to other forms of health care financing would indicate inelastic demand.²¹¹

Second, the court held that market separation could occur if a sufficient number of physicians signed exclusive contracts requiring lengthy advance notice before termination.²¹² Such contracts could render supply inelastic by eliminating so much of the available supply of physicians that the ability of competitors to enlist panel doctors to serve new HMOs would be severely limited or foreclosed.²¹³ Finally,

209. See *U.S. Healthcare*, 986 F.2d at 599 (accepting magistrate judge's definition of market as "health care financing market" but implying that U.S. Healthcare might have offered expert testimony to demonstrate that HMOs constitute their own market). The court called U.S. Healthcare's argument that HMOs are distinct from the health care financing market a "legitimate contention." *Id.* at 598. The issue for an expert witness would be "whether a sole supplier of HMO services . . . could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits." *Id.* at 599.

Evidence collected in recent years by independent research groups studying HMO market behavior suggests that a sole supplier of HMO services can raise prices higher above costs than an HMO in a competitive market. See 1995 INTERSTUDY REGIONAL MARKET ANALYSIS, *supra* note 169, at 31 (reporting that in small and large markets dominated by a single HMO, operating margins were higher than in markets supporting rival HMOs). These "dominant" HMOs, however, have not raised prices so far above cost that they could be considered to enjoy monopoly profits. See *id.* For example, operating margins of dominant HMOs typically exceeded the median operating margin by a very small amount. See *id.* at 30-31 (reporting that average HMO operating margin in large cities is 3.28%, while operating margin in large cities with one dominant HMO is 3.7%).

210. See *U.S. Healthcare*, 986 F.2d at 599 (noting that market definition typically is ascertained through expert testimony of economists). The court indicated that "here, the issue for an economist would be whether a sole supplier of HMO services . . . could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits." *Id.* The court's statement starkly contradicts that of the court in *Marshfield*, which proclaimed that "there is not even a good economic theory that associates monopoly power with a high rate of return." *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1412 (7th Cir. 1995), *cert. denied*, 116 S. Ct. 128 (1996).

211. See *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 469 (1992) ("The extent to which one market prevents exploitation of another market depends on the extent to which consumers will change their consumption of one product in response to a price change in another, that is, the 'cross-elasticity of demand.'").

212. See *U.S. Healthcare*, 986 F.2d at 593-98 (acknowledging that it might be possible to describe Healthsource as monopolist, using exclusionary clause to foster or reinforce its power). The court noted that the primary danger of the exclusivity clause was that it could "foreclose" so much of the available supply . . . that existing competitors or new entrants may be limited or excluded." *Id.* at 595.

213. See *id.* (holding that exclusivity clause had not rendered physician pool empty). The court observed that the number of primary care physicians tied to Healthsource through exclusive contracts—25%—left an adequate number of other physicians "available" to contract with competing HMOs. See *id.* at 596. It held further that the 30-day termination notice required by the exclusivity clause was close to a de minimus restraint. See *id.* A 180-day termination notice, however, could frustrate the efforts of new HMOs to enlist panel doctors.

the court acknowledged it was a "legitimate contention" that HMO services and pricing differ enough from other forms of health care financing to support the conclusion that HMOs comprise a separate product market.²¹⁴ Thus, while the court used the traditional method of market definition to find that HMOs are a component of the health care financing market, it acknowledged the possibility that HMOs could comprise a discrete product market under an alternative analysis.

B. Market Power Determinations in Cases Involving HMO or Insurer

The circuits have seen a number of cases during the past decade brought by HMOs or providers against large insurers.²¹⁵ These suits involve allegations that a large insurer is attempting to monopolize the market for health care financing in violation of section 2 of the Sherman Act. The following cases illustrate how the circuits have applied different analyses to determine whether defendants possessed market power and, if so, whether they illegally exercised that market power.

The Tenth Circuit found market share to be more important than ease of entry as a determinant of market power. In *Reazin v. Blue Cross & Blue Shield of Kansas, Inc.*,²¹⁶ the court upheld a jury verdict finding violations of sections 1 and 2 of the Sherman Act by a large insurer.²¹⁷ The defendant insurer had terminated the contract of a hospital that recently had been acquired by a competitor and reduced reimbursement for other hospitals doing business with its competitors.²¹⁸ All hospitals and approximately ninety percent of the physicians in the relevant geographic area were under contract with

See id. Finally, the court acknowledged that Healthsource encouraged doctors to become shareholders to give them "a further stake in Healthsource's success and incentive to contain costs." *Id.* at 592; *see also* Landes & Posner, *supra* note 35, at 950-51 (stating that supply elasticity is measured by ability of new competitors to enter market in response to price increase by potential monopolist). In a market characterized by high elasticity of supply, existing firms, such as fee-for-service insurers, will shift production to offer products similar to those of another firm, such as an HMO, that raises its prices above the competitive level. *See id.* Similarly, new entrants, such as U.S. Healthcare, will be attracted to markets in which a competitor, such as Healthsource, raises prices above the competitive level.

214. *See U.S. Healthcare*, 986 F.2d at 598 (noting that HMOs are often cheaper than other forms of health care financing, emphasize illness and prevention, and utilize cost controls).

215. *See, e.g., Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 899 F.2d 951 (10th Cir. 1990); *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101 (1st Cir. 1989); *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986).

216. 899 F.2d 951 (10th Cir. 1990).

217. *See id.* at 972. For the text of sections 1 and 2 of the Sherman Act, *see supra* notes 49 and 50.

218. *See Reazin*, 899 F.2d at 954.

the defendant at the time;²¹⁹ approximately sixty percent of those insured in the state were insured by the defendant.²²⁰ Examining the insurer as a buyer of health care services, the court held that despite the existence of more than 200 insurers in the state, the defendant possessed market power.²²¹ It concluded that "no other entrant remotely approached [the defendant's] domination of the market" and this was evidence that barriers existed to the entry of new competitors.²²²

A similar situation yielded markedly different results in the Seventh Circuit. In *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*,²²³ the plaintiffs were eighty acute-care hospitals in Indiana seeking to block implementation of a PPO by Blue Cross, an insurer with twenty-seven percent of the patients in the market.²²⁴ The plaintiffs alleged that the defendant insurer's attempt to limit hospital reimbursement under its PPO plan violated sections 1 and 2 of the Sherman Act.²²⁵ In determining whether the defendant possessed market power, the court placed greatest emphasis on the absence of barriers to entry (or high elasticity of supply) that was evidenced by the presence of nearly 500 health care insurers in Indiana.²²⁶ It found that market share was not a relevant determinant of market power when better measures were available.²²⁷ The court held that "ease of entry and the absence of barriers" was a better measure of

219. See *id.* at 956.

220. See *id.* at 969 (noting that estimates of Blue Cross market share ranged from 47% to 62%).

221. See *id.* at 971.

222. *Id.* at 971-72 (noting that, although only capital and licensing were necessary to initially enter market, defendant's enormous size in relation to other insurers "cuts against the argument that entry barriers were insubstantial"). Other factors, such as Blue Cross' unique ability to contract directly with hospitals and the widespread perception that it operated with the endorsement of the legislature, gave added support to the court's finding of market power. See *id.*

223. 784 F.2d 1325 (7th Cir. 1986).

224. See *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1330-31 (7th Cir. 1986).

225. See *id.* at 1331 (pointing out that plan called for 75% reimbursement to hospitals that are not part of PPO, and 100% to hospitals that are within PPO).

226. See *id.* at 1335 (examining whether defendant had market power and finding that, because other firms could provide same services at same price as defendant, there were no barriers to entry). The court found further, that in the medical insurance market, factors suggesting that market share does not imply market power exist. See *id.* These factors include: (1) new firms could easily enter the market; (2) existing firms could easily expand their sales; and (3) insurers needed only a license and capital to operate, and there were examples of firms that had both. See *id.* Finally, the court noted that nearly 1000 firms were licensed to sell health insurance in Indiana, with nearly 500 currently selling policies. See *id.* at 1332.

227. See *id.* at 1336 (stating that "when there are better ways to estimate market power [than market share], the court should use them").

market power and that under these criteria, the defendant insurer did not possess market power.²²⁸

Finally, the First Circuit ruled that a large insurer did not violate section 2 of the Sherman Act by adopting cost containment measures in an attempt to curb the loss of patients to an HMO. In *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island, Inc.*,²²⁹ the plaintiff was a private, upstart HMO that offered more coverage at lower premiums than the defendant, Blue Cross.²³⁰ One way it was able to do this was by negotiating to pay physicians approximately twenty percent less than they received from Blue Cross.²³¹ In response, Blue Cross implemented a "prudent buyer" program under which it paid physicians no more than they accepted from other payors.²³² As a result, more than one quarter of Ocean State's physicians resigned, apparently to avoid a reduction in Blue Cross reimbursement.²³³ The court held that, although Blue Cross had market power,²³⁴ the "prudent buyer" program was not an illegal exercise of that power because it was instituted to promote competition and was not exclusionary or predatory.²³⁵ The court thus held that a monopoly is not prohibited, under the rule of reason, from engaging in honest competition, even if that competition has the effect of harming its competitors.²³⁶

IV. ECONOMIC FACTORS RAISING ANTITRUST LIABILITY FOR HMOs

To date, courts have defined the HMO product market to include all forms of health care financing.²³⁷ HMOs typically possess low

228. See *id.* at 1336-37 ("[M]arket share is just a way of estimating market power."). The court opined, further, that "ease of entry and the absence of barriers" is a more accurate determinant of market power. *Id.* at 1336.

229. 883 F.2d 1101 (1st Cir. 1989).

230. See *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., Inc.*, 883 F.2d 1101, 1113 (1st Cir. 1989) (concluding policy of paying physicians no more than they received from other health payors did not violate § 2 of Sherman Act).

231. See *id.* at 1103-04 (describing structure of Ocean State and fact that it paid physicians approximately 20% less for services than did Blue Cross).

232. See *id.*

233. See *id.* at 1104.

234. See *id.* at 1110 (noting that Blue Cross did not dispute its monopoly power in market for health insurance).

235. See *id.* (stating that § 2 does not prohibit vigorous competition by monopolies, provided that competition is not exclusionary); see also *Kartell v. Blue Shield of Mass.*, 749 F.2d 922, 927 (1st Cir. 1984) (holding that unilateral decision by insurer to ban "balance billing"—practice of billing patients difference between insurance company payments and actual charges—did not violate Sherman Act because it was not "predatory" or below incremental cost).

236. See *Ocean State*, 883 F.2d at 1110.

237. See, e.g., *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1411 (7th Cir. 1995), *cert. denied*, 116 S. Ct. 1288 (1996) (finding that HMOs do not constitute separate market from other health care financing products); *U.S. Healthcare, Inc. v.*

market share as a component of this broadly defined market.²³⁸ Under traditional antitrust analysis, therefore, courts have been reluctant to find that HMOs possess market power.²³⁹ However, emerging economic factors, or "market imperfections," in the health care financing market,²⁴⁰ coupled with the more modern Supreme Court precedent of *Kodak* and *Jefferson Parish*, could lead courts to find that HMOs possess market power despite their small share of the market.²⁴¹

These economic factors could also prompt courts to conclude that HMOs comprise a market separate from that of other forms of health care financing.²⁴² In a market thus divided, each individual HMO

Healthsource, Inc., 986 F.2d 589, 599 (1st Cir. 1993) (holding that "health care financing is the product market"); *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins. Co.*, 784 F.2d 1325, 1329 (7th Cir. 1986) (stating that HMO "is both a method of joining physicians in a firm and financing their services by selling memberships for stated monthly prices").

238. See 1995 INTERSTUDY REGIONAL MARKET ANALYSIS, *supra* note 169, at 9 (stating that average combined market penetration for "pure" HMOs in all U.S. markets is 21.9%); see also PROSPECTIVE PAYMENT ASSESSMENT COMM'N, *supra* note 9, at 23 (noting that in 1988, 73% of individuals insured by private health insurance had traditional indemnity coverage, with 27% covered by HMOs and other forms of managed care). By 1993, HMOs and other forms of managed care accounted for 66% of the private health insurance market, and indemnity insurance accounted for only 33% of the market. See *id.* Hybrid plans, such as "point of service" plans, which combine gatekeeper or network functions of HMOs with partial coverage of out-of-network services, accounted for the remaining portion of the market. See *id.*

239. See *U.S. Healthcare*, 986 F.2d at 599 (noting that multitude of other providers in New Hampshire precluded finding that Healthsource possessed monopoly); cf. *Marshfield*, 65 F.3d at 1412 (7th Cir. 1995) (stating that defendant HMO "is not a monopolist of HMO services . . . because HMOs are not a market").

240. See Enthoven, *supra* note 4, at 25 (articulating flaws in structure of health care financing market). Professor Enthoven describes the imperfections of the traditional health care market, and their perverse economic consequences, as follows:

(1) Free choice of doctor by the patient, which means that the insurer has no bargaining power with the doctor; (2) free choice of prescription by the doctor, which prevents the insurer from applying quality assurance or review of appropriateness; (3) direct negotiation between doctor and patient regarding fees, which excludes the third-party payor, who would be likely to have information, bargaining power, and an incentive to negotiate to hold down fees; (4) fee-for-service payment, which allows physicians maximum control over their incomes by increasing the services provided; and (5) solo practice, because multi-specialty group practice constitutes a break in the seamless web of mutual coercion through control of referrals that the medical profession has used to enforce [its] guild system.

Id.

241. At least one court has already relied on *Kodak* to impute market power to an HMO. See *Brokerage Concepts, Inc.*, No. 95-1698, 1996 U.S. Dist. LEXIS 6480, at *18-19 (E.D. Pa. May 14, 1996) (holding, under *Kodak*, that relevant product market was all members of single dominant HMO); see also Alain C. Enthoven, *Why Managed Care Has Failed to Contain Health Costs*, HEALTH AFF., Fall 1993, at 28-29 (asserting that proliferation of HMOs and PPOs in 1980s failed to contain health costs because of various "artificial market imperfections").

242. See *infra* notes 286-302 and accompanying text (describing how adverse selection, pre-existing condition exclusions, and exclusive provider contracts could reduce elasticity of supply and demand for HMOs, leading to divergence of HMOs from health care financing market).

There is empirical support for the conclusion that HMOs operate in an economically distinct market from other forms of health care financing. See Reed Neil Olsen, *The Impact of Health Maintenance Organizations on Health and Health Care Costs*, 25 APPLIED ECON. 1451, 1451 (1993)

would hold substantially higher market share because the diluting effect of other forms of health care financing would be lost.²⁴³ The divergence of markets, therefore, would increase HMO market power under either traditional²⁴⁴ or modern antitrust principles.²⁴⁵

A. *Market Imperfections Increasing HMO Market Power*

Under traditional economic analysis, use of the "market share proxy" meant that courts were unlikely to find that small firms possessed market power.²⁴⁶ This analysis, however, relied on basic assumptions about the effects of a firm's size on elasticity of supply²⁴⁷ and demand.²⁴⁸ The modern analysis of *Kodak* and *Jefferson Parish* takes a less formalistic approach,²⁴⁹ recognizing that even

(noting that, although HMOs are cheaper than other forms of health care financing, studies have found little evidence that they contain aggregate health costs). Thus, cost containment effected by HMOs does not affect the rate of inflation of other forms of health care financing. See Enthoven, *supra* note 241, at 29 (asserting that competition among HMOs has not reduced growth in total national health expenditures). But cf. Christianson, *supra* note 14, at 155 (stating it has been hypothesized that more conservative style of medical practice fostered by HMOs will "spill over" to other forms of health care financing).

243. Although HMOs account for only 25% of the health care financing products in large markets, most large markets are dominated by only one HMO. See INTERSTUDY REGIONAL MARKET ANALYSIS, *supra* note 169, at 1 (reporting HMO penetration of 25% in large markets and that 74.4% of large markets have one dominant HMO). HMOs account for 17.6% of the health care financing products in medium markets. See *id.* Most medium markets, however, have at least two significant market shares. See *id.* at 33. HMOs account for 12% of the health care financing products in small markets. See *id.* at 1. Forty-two percent of these markets, however, are served by only one HMO. See *id.*

244. See Jacobs, *supra* note 11, at 342 & n.25 (noting that market share traditionally has been used as the proxy for market power).

245. See *id.* at 355-62 (explaining Court's movement in *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451 (1992), from the traditional "market share proxy" to new form of market power assessment). This new assessment looks for explanations of the actual behavior of markets. See *id.* at 473.

246. See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 17 (1984) (explaining that existence of market power ordinarily is inferred from seller's possession of predominant market share). As elasticity of demand decreases, meaning fewer suitable substitute products are available, smaller firms become capable of raising prices above competitive levels without experiencing a loss in sales. See Landes & Posner, *supra* note 35, at 958-59 & tbl. II.

247. Elasticity of supply was the second most important determinant of market power under traditional analysis. See Landes & Posner, *supra* note 35, at 958, tbl. II (demonstrating that firm operating in market with high entry barriers to competitors can raise prices without losing sales only if there are few suitable substitutes available).

248. See *id.* (showing market share necessary for firm to have market power under variety of competitive conditions). Traditional analysis viewed demand elasticity as the most important factor in determining whether a firm could exercise market power. See *id.* Professors Landes and Posner observe that a firm operating in a market with highly elastic demand but inelastic supply must have larger market share in order to raise prices to a monopolistic level than a firm in a market with highly elastic supply but inelastic demand. See *id.*; see also *supra* note 158 (describing emphasis placed on elasticity of demand by courts in *Marshfield, U.S. Healthcare, Inc.*, and *Ball Mem'l Hosp.*).

249. See *Kodak*, 504 U.S. at 466 (holding that legal presumptions based on "formalistic distinctions" instead of "market realities" generally are disfavored in antitrust law). Rather than considering only market share, the Court will consider the "responsiveness of the sales of one

small firms can wield power in markets where imperfections artificially suppress supply and demand.²⁵⁰ Such market imperfections, including high costs for consumers to switch from one product to another, information deficiencies, and financing arrangements that reduce price competition, exist today in the health care financing market.²⁵¹

1. Increased switching costs

Consumers in the health care financing market commonly experience high switching costs when a medical condition, which is covered under their current health plan, is excluded from coverage under a subsequent plan because it is considered a "pre-existing condition."²⁵² Pre-existing condition exclusions raise the cost and risk of switching from one health plan to another because consumers who change plans must pay the costs for future treatment related to the pre-existing condition out of their own pockets.²⁵³ These individuals frequently are charged higher premiums even though coverage of the condition is excluded under the new plan.²⁵⁴ High switching costs in the health care financing market make the cost of changing health plans prohibitive for many individuals; frequently

product to price changes of the other." *Id.* at 467 (quoting *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 400 (1956)); see also *Jefferson Parish*, 466 U.S. at 26-29 (holding that Court will examine economic reality of market at issue).

250. See *Kodak*, 504 U.S. at 477 (holding that it is reasonable to infer Kodak possessed market power because there was evidence of high information costs, locked-in consumers and discriminatory pricing); *Jefferson Parish*, 466 U.S. at 27-28 (suggesting that diminished consumer incentive to compare hospital costs and lack of adequate information to compare quality among hospitals, if coupled with restraints on consumer choice of provider, could give rise to antitrust liability even in the absence of substantial market share).

251. See *supra* notes 151-56 and accompanying text (describing three factors identified in *Kodak* and *Jefferson Parish* that can give rise to market power in absence of significant market share); see also *infra* notes 252-59 and accompanying text (describing how exclusions on pre-existing conditions raise switching costs, causing consumer "lock-in" in health care financing market).

252. See GENERAL ACCOUNTING OFFICE, HEALTH INSURANCE PORTABILITY, REFORM COULD INSURE CONTINUED COVERAGE FOR UP TO 25 MILLION AMERICANS (Sept. 19, 1995) [hereinafter GAO REPORT] (reporting that most private health plans impose waiting periods for new enrollees and limit coverage for pre-existing conditions). Payors impose waiting periods and limitations on coverage of pre-existing conditions to protect themselves against employees who purchase coverage knowing they are already sick. See *id.*

253. See *Health Insurance Reform Act of 1995: Hearings on S. 1028 Before the Senate Comm. on Labor and Human Resources*, 104th Cong. 4 (1995) (statement of Sen. Kennedy) [hereinafter *Health Insurance Reform Act Hearings*] (noting that workers who switch insurance plans during a change of jobs risk losing coverage for pre-existing conditions, the very illnesses for which they are most likely to require care).

254. See *id.* (statement of Sen. Kennedy) (suggesting that employers currently exclude employees with pre-existing conditions from group health plans because such employees raise group health plan costs).

they are so high that consumers refuse to change jobs for fear of also having to change health plans.²⁵⁵

The plight of consumers who develop a pre-existing condition while covered by a health care plan is similar to that of the consumers in *Kodak* who made a large, but seemingly reasonable, initial expenditure to purchase Kodak equipment.²⁵⁶ Consumers with pre-existing conditions cannot "switch" to substitute health plans in response to a price increase without incurring disproportionately high costs.²⁵⁷ Pre-existing condition limitations thus are a market imperfection that increases switching costs and artificially reduces elasticity of demand.²⁵⁸ The Court in *Kodak* held that such an imperfection could confer market power on firms that hold low market share.²⁵⁹

255. See *id.* (statement of Sen. Kennedy) (noting that risk of losing health coverage prevents many workers from changing jobs, a phenomenon called "job lock"). In 1993, 20% of Americans said they or a family member declined a new job opportunity due to fear of losing health benefits. See *Health Insurance Portability: Hearings before the Subcomm. on Health of the Comm. on Ways and Means*, 104th Cong., 1st Sess. 9, 10 (May 12, 1995) (statement of Paul Fronstin, Employee Benefit Research Institute) [hereinafter *Health Insurance Portability Hearings*]. "Job lock" is analogous to the consumer "lock in" that led the Court in *Kodak* to conclude that the defendant had market power despite its lack of significant market share. See *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 476 (1992) (finding that consumers who would lose their large initial investment in Kodak equipment by switching brands faced high switching costs). The effects of job lock could, if pervasive enough, lead courts to conclude that an HMO has market power in the absence of significant market share.

A worker experiencing "job lock" dares not change jobs for fear that a pre-existing condition will make the cost of switching health coverage cost prohibitive, if alternative coverage is available at all. See *Health Insurance Portability Hearings*, *supra*, at 12. The Court in *Kodak* held that consumers who were "locked in" to a Kodak machine because of high switching costs would tolerate larger price increases than other consumers before they changed brands. See *Kodak*, 504 U.S. at 476. The same is true of workers who remain at their jobs solely to enjoy the continued availability of employer-sponsored health coverage. See *Health Insurance Portability Hearings*, *supra*, at 10.

256. See *Kodak*, 504 U.S. at 472 (noting that consumer "lock-in" could allow Kodak to charge competitive prices in the equipment market, but supracompetitive prices in the parts and service market). Similar to the case in *Kodak*, an insurer is able to offer low premiums initially to win the business of customers. If an insured becomes ill, however, the insurer can raise the premium without fear that the insured will seek coverage elsewhere, because coverage for the illness will be excluded by other insurers.

257. See *Health Insurance Reform Act Hearings*, *supra* note 253, at 4 (statement of Sen. Kennedy) (stating that pre-existing conditions make many consumers completely uninsurable). Roughly 81 million Americans have conditions that could subject them to pre-existing condition exclusions. See *id.* (statement of Sen. Kennedy).

258. See *Landes & Posner*, *supra* note 35, at 945 (explaining that elasticity of demand depends on ability of consumers to switch to substitute goods in response to price increase); see also *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 394 (1956) ("[W]here there are market alternatives that buyers may readily use for their purposes . . . [market power] does not exist . . .").

259. See *Kodak*, 504 U.S. at 473 (noting that high switching cost was strong reason for finding market power in absence of high market share). Furthermore, the court observed that "the heavy initial outlay for Kodak equipment" made switching to a competing product very costly for Kodak customers. See *id.* at 477.

2. *Information deficiencies*

The lack of comparative information about health plans and the widely disparate coverage policies offered by such plans are two major barriers to price competition in the health care financing market.²⁶⁰ Most insurers offer arcane coverage provisions that are difficult for consumers to understand.²⁶¹ Quality measures are all but nonexistent, impeding consumer ability to compare the value of plans per dollar charged.²⁶² Consumers frequently are unaware that their health plan excludes coverage of pre-existing conditions or that they can be dropped from the plan if they become ill.²⁶³ Just as in *Kodak*, this absence of uniformity among products, and the inability to predict the "lifecycle" cost of obtaining health coverage under various plans, impedes consumers' ability to make direct price, coverage, and quality comparisons.

3. *Payment policies that reduce price competition*

Employer payment policies and federal tax laws decrease consumer price consciousness in the health care financing market. Employer payment of full premiums for their employees' health coverage reduces employee price consciousness in selecting a health plan.²⁶⁴ Under such arrangements, employers pay the full premium for health coverage regardless of price.²⁶⁵ HMOs thus gain few customers by cutting prices and lose few customers by raising prices,²⁶⁶ making demand inelastic.²⁶⁷ Similar policies, such as those requiring

260. See Enthoven, *supra* note 241, at 38-39 (decrying product differentiation in health care financing market and calling for employer policies requiring standardized coverage contracts); Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1510 (1994) (noting that "prevalence of information gaps, asymmetric information, and agency problems interferes with competitive interactions in the health care marketplace").

261. See Enthoven, *supra* note 241, at 38-39 (noting health insurer practice of offering complex package makes it difficult for people to make cost comparison).

262. See Olsen, *supra* note 242, at 1451 (stating that lack of empirical information on HMO quality is attributable to lack of objective means for measuring health).

263. See *Health Insurance Reform Act Hearings*, *supra* note 253, at 4 (statement of Sen. Kennedy) (noting that those who have paid premiums for years can be dropped because they become ill).

264. See Enthoven, *supra* note 241, at 34 (noting that employer policies of paying full cost of HMO premiums puts HMOs in the same "state of cost-unconscious demand as fee-for-service providers").

265. See *id.* (indicating that employers will pay HMO premiums that do not exceed those of traditional coverage).

266. See *id.*; see also Christianson, *supra* note 14, at 154 (stating that when employees have multiple coverage options, but are required to pay at least part of premium difference, they make price-conscious decisions).

267. See Enthoven, *supra* note 241, at 34 (indicating that employer contribution to employee's health plan creates inelastic demand for HMOs).

employees to make the same premium contribution regardless of the type of plan they choose, can have the same effect.²⁶⁸

The current tax code also understates price competition among health plans.²⁶⁹ Section 125 of the Internal Revenue Code²⁷⁰ allows employers to pay the cost of health premiums in pre-tax dollars.²⁷¹ The pre-tax payment artificially increases the amount of money available to purchase health insurance and reduces the amount of any apparent differences in premiums.²⁷² Thus, an HMO that cuts its price by a certain amount gains only a fraction of the customers it would normally gain with such a price cut.²⁷³ Conversely, an HMO that raises its price loses only a fraction of the customers it would normally lose.²⁷⁴

4. *Limitation on consumer choice of providers*

A second market imperfection, which raises HMO liability under the *Jefferson Parish* analysis, is the tendency of employers to limit the number of HMOs offered in their benefit plans.²⁷⁵ Such limitations reduce price competition among HMOs by allowing the contracting HMO to raise prices to the level of competing fee-for-service plans without losing customers.²⁷⁶ This scenario provides an apt example of the "cellophane fallacy," wherein imperfect competition makes poor substitutes appear interchangeable.²⁷⁷ It is worth noting, however, that the practice of offering a limited number of HMOs to employees does not completely eliminate price competition because employers offering an HMO as a coverage option will often compare rates among competing HMOs before initially signing up a single contractor.

268. See Christianson, *supra* note 14, at 154 (examining effect of employer health premium contribution policies on rate increases).

269. See Enthoven, *supra* note 241, at 36-37 (noting that employer ability to pay for health insurance premiums in pre-tax dollars understates price differences among health plans).

270. 26 U.S.C. § 125 (1994) (making employer payments for health benefits excludable from employee gross income).

271. See Enthoven, *supra* note 241, at 36.

272. See *id.*

273. See *id.* at 37.

274. See *id.*

275. See *id.* at 38 (noting that employer policies restricting choice of HMOs artificially reduce HMO demand elasticity).

276. See *id.*

277. See Gellhorn & Kovacic, *supra* note 53, at 103 (suggesting that, in *du Pont*, Court failed to consider whether high cross-elasticity among manufacturers of flexible wrapping materials meant only that *du Pont*, exclusive manufacturer of cellophane, had already raised prices to monopolistic levels). Cross-elasticity of demand is an accurate test of whether two products are good substitutes only if competitive prices are being charged for each. See *id.*

The Court in *Jefferson Parish* held that small firms could possess power in markets made imperfect by payment policies that reduce price consciousness and restrict consumer choice of provider.²⁷⁸ Employee benefit policies, combined with federal tax laws, have introduced such imperfections to the health care financing market. HMOs operating in these markets, therefore, could be held liable for antitrust offenses under the *Jefferson Parish* analysis.

B. Economic Factors Creating the Potential for a Discrete HMO Market

Market definition relies heavily on principles of elasticity of supply and demand.²⁷⁹ Certain trends accompanying the flood of enrollment in HMOs in recent years,²⁸⁰ coupled with market imperfections, could substantially decrease elasticity of supply and demand, causing the HMO and health care financing markets to diverge for purposes of antitrust analysis.²⁸¹ Specifically, the trend toward adverse selection could create a bifurcated market in which HMOs are the only affordable health care financing product for younger and healthier individuals, while fee-for-service plans present the only viable coverage option for older and sicker individuals.²⁸² Coverage exclusions for pre-existing conditions already have brought about substantial consumer "lock-in."²⁸³ Finally, the use by HMOs of exclusive provider contracts could prevent the entry of new competi-

278. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 27-28 (1984).

279. See *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 395 (1956). The Court explained: "In considering what is the relevant market for determining the control of price and competition, no more definite rule can be declared than that commodities reasonably interchangeable by consumers for the same purposes make up that 'part of trade or commerce,' monopolization of which may be illegal." *Id.*

Measurement of product substitution and elasticity of supply are common to the assessment of both market power and definition. Thus, the Court somewhat circuitously has acknowledged an interrelationship between the ability of a firm to exert power over a market and the definition of that market. See *id.* at 391-92 (using term "monopoly power" synonymously with market power). Justice Reed, delivering the opinion of the Court, observed:

If cellophane is the 'market' that du Pont is found to dominate, it may be assumed it does have monopoly power over that "market." Monopoly power is the power to control prices or exclude competition. . . . It is inconceivable that price could be controlled without power over competition or vice versa.

Id. at 391-92 (citations omitted).

280. See *supra* notes 3 & 22 (noting that HMO enrollment grew from less than two million in early 1970s to more than 46 million in 1995, an increase of 2300%).

281. See *infra* notes 286-302 and accompanying text (describing how increasing HMO enrollment, coupled with adverse selection and exclusions on coverage of pre-existing conditions, could cause HMO market to diverge from health care financing market).

282. See Greaney, *supra* note 260, at 1511 (observing that adverse selection can segment health care market between healthy, or "good risk," and unhealthy, or "bad risk," populations).

283. See *supra* notes 252-59 and accompanying text (comparing circumstances under which pre-existing condition locks consumer into his or her current health plan with consumer "lock-in" under *Kodak* analysis).

tors into the market.²⁸⁴ If both supply and demand become inelastic, courts could conclude that HMOs operate in a market separate from other forms of health care financing.²⁸⁵

1. *Adverse selection*

HMOs have exhibited a tendency to enroll healthier patients, while sicker patients remain in fee-for-service plans.²⁸⁶ This phenomenon, known as "adverse selection,"²⁸⁷ could substantially reduce elasticity of HMO supply if allowed to continue over an extended period. Presently, new entrants to the HMO market enjoy relatively low structural entry barriers.²⁸⁸ New HMOs are able to attract new enrollees from fee-for-service plans easily.²⁸⁹ With continuing mass-enrollment in managed care,²⁹⁰ however, adverse selection could create a structural dichotomy in the health care financing market, whereby a predominant number of healthy patients enroll in HMOs and sicker patients remain in fee-for-service plans.²⁹¹ Adverse selection could eliminate a large portion of the pool of potential new HMO enrollees by making unavailable, or undesirable, those enrolled in fee-for-service plans.²⁹²

284. See Bloch & Falk, *supra* note 10, at 211 (observing that widespread use of exclusivity clauses in given market could make high percentage of physicians unavailable to contract with HMOs wishing to enter market, rendering supply inelastic).

285. See *supra* notes 177-214 and accompanying text (describing courts' emphasis in defining markets on product interchangeability and ease with which producers of similar goods can "switch" production in response to price increase by competitor).

286. See, e.g., Christianson, *supra* note 14, at 149-50 (citing several studies that "conclude that staff and group model HMOs benefit from favorable selection relative to IPA models and indemnity insurance plans"); Enthoven, *supra* note 241, at 39-40 (exploring consequences and methods of avoiding "biased risk selection"); Olsen, *supra* note 242, at 1451 (stating that HMOs tend to enroll healthier patients with substantially lower health care costs).

287. Enthoven, *supra* note 241, at 40.

288. See *Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1335 (7th Cir. 1986) (finding that new firms may enter health care financing market easily). The Court found that firms "need only a license and capital" to enter the market. *Id.* It found, further, that competitors of defendant already had both and could expand their sales quickly. See *id.*

289. See 1994 INTERSTUDY REPORT, *supra* note 3, at 11, fig. 5 (1994) (showing that nearly equal number of HMOs reported new group enrollment from former customers of indemnity insurers versus members of another local HMO).

290. See *supra* notes 3 & 22 (describing managed care enrollment trends).

291. See *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101, 1103 (1st Cir. 1989) (noting under adverse selection, "younger and healthier people opt for HMOs . . . leaving older and sicker people" in the fee-for-service pool).

292. See 1994 INTERSTUDY REPORT, *supra* note 3, at 11, fig. 5 (showing that nearly equal number of HMOs reported enrolling new groups from indemnity insurer versus another local HMO).

2. HMO use of exclusive provider contracts

Physicians who treat the more complex illnesses encountered by fee-for-service patients may be reluctant to enter HMO panels because of HMO pressure to practice a more conservative style of medicine, with higher patient volume and lower per-capita reimbursement.²⁹³ The use of exclusive provider contracts could further decrease elasticity of HMO supply by making unavailable physicians who otherwise would be willing to contract with newly forming HMOs.²⁹⁴ If such physicians are unavailable, competitors will be unable to form new HMOs in response to supracompetitive pricing by existing HMOs. Exclusivity clauses restricting mobility among physicians who treat HMO patients, therefore, could take on heightened significance in the new antitrust analysis.²⁹⁵ Similarly, a preponderance of physician-panelists who hold an ownership interest in their respective HMOs²⁹⁶ could restrict market entry because the economic self-interest of doctor-owners will cause them to refuse to serve other HMOs.²⁹⁷

293. See Christianson, *supra* note 14, at 149 (noting that HMOs recruit physicians who practice conservative style of medicine, involving lower utilization of services); *Ocean State Physicians*, 883 F.2d at 1104 (noting that one-quarter of physicians on HMO panel resigned after competing insurer instituted policy of paying no more than physicians charged HMO); cf. Olsen, *supra* note 242, at 1451 (concluding that HMOs initially cause an increase in utilization, but over time physicians practicing in HMOs learn to practice cost-effective medicine).

294. See Bloch & Falk, *supra* note 10, at 217 (observing that widespread use of exclusivity clauses in given market could make high percentage of physicians unavailable to contract with HMOs wishing to enter market, thereby rendering supply inelastic).

295. See *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 596 (1st Cir. 1993) (calling 25% of physicians in geographic market tied to Healthsource by exclusivity clause "significant"). The court noted that, although it might be proper to exclude many "available" physicians in the market because they were unwilling to serve HMOs, no such showing was made by the plaintiff. See *id.*; see also Anita J. Slomski, *Is this Group an Illegal Doctor Monopoly?* *Marshfield Clinic in Marshfield, Wisconsin*, MEDICAL ECON., Sept. 26, 1994, at 64 (describing plaintiff's allegation that restrictive covenant preventing doctors who leave defendant clinic from practicing within 25-mile radius for three years was evidence of anticompetitive conduct).

296. See Mary Chris Jaklevic, *Docs Try to Own Managed Care: Fed Up With Big For-Profit HMOs, Physicians Across the Nation Are Forming Their Own Plans*, MODERN HEALTHCARE, Apr. 24, 1995, at 63 (noting that physicians who have tired of working for HMOs are increasingly forming their own competing HMOs).

297. See *U.S. Healthcare*, 986 F.2d at 594 (acknowledging that agreement among doctor-stockholders of HMO not to deal with any other HMO could warrant per se condemnation if bereft of joint venture efficiencies); *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 359 (1982) (holding doctor-initiated PPO liable for per se offense of price fixing under Sherman Act § 1, where physician members of PPO, comprising 75% of all those practicing in county, set maximum reimbursement rates).

3. *Exclusion of coverage for pre-existing conditions*

Although exclusions of coverage for pre-existing conditions are prevalent among most forms of health care financing,²⁹⁸ HMOs generally do not exclude coverage of such conditions.²⁹⁹ Consequently, individuals covered by HMOs who develop "pre-existing conditions" can seek coverage from competing HMOs, but their ability to switch from HMOs to alternative forms of health care financing is severely limited.³⁰⁰ While individuals covered by fee-for-service or PPO plans are able to switch to HMOs, the more restrictive benefit policies of HMOs may make them poor substitutes for these other forms of health care financing.³⁰¹ Such non-interchangeability among HMOs and other forms of insurance (or low cross-elasticity of demand) could induce courts to conclude that HMOs constitute a product market separate from health care financing.³⁰²

C. *Consequences*

Relevant factors in determining the existence of market power today include: (1) elasticity of supply,³⁰³ reflected by the ability of

298. See GAO REPORT, *supra* note 252, at 4 (reporting that 59% of indemnity plans, 70% of PPOs, and 56% of point-of-service plans impose exclusions on pre-existing conditions, while HMOs typically do not have such clauses).

299. See *id.* One possible explanation for HMOs' coverage of pre-existing conditions is the fact that HMOs are self-selective and tend to enroll healthier patients. See *supra* notes 285-91 and accompanying text (noting that restrictive benefits of HMOs leads to "adverse selection" whereby HMOs enroll healthier individuals).

300. See GAO REPORT, *supra* note 252, at 4 (reporting that most indemnity and PPO plans impose exclusions on coverage of pre-existing conditions); HEALTH INSURANCE REFORM ACT HEARINGS, *supra* note 253, at 4 (statement of Sen. Kennedy) (stating that some of 81 million consumers with conditions that could be considered "pre-existing" are completely unable to obtain traditional health insurance).

301. See Christianson, *supra* note 14, at 160 (noting that workers may find HMOs to be unattractive option). Many individuals covered by non-HMO plans choose these plans because they offer more generous benefits without restricting choice of provider, and thus are better suited to their more frequent or serious medical needs. See *id.* (noting that hospital admission rates are between 10% and 40% higher in fee-for-service plans than in HMOs). These individuals frequently are older or more prone to illness and perceive HMOs as offering inadequate coverage to suit their needs. See *id.* at 149-50 (noting that HMOs enroll individuals with a low propensity to use their services).

302. See *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 394 (1956) (calling for assessment of "cross-elasticity of demand" in determining relevant product market); Landes & Posner, *supra* note 35, at 945 (concluding that high elasticity of demand implies that good substitutes exist for products sold within market, and presence of good substitutes limits any individual firm's market power).

303. See *Ball Mem'l Hosp. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1335 (7th Cir. 1986) (finding defendant lacked market power where new firms could enter market easily, existing firms could expand sales quickly, and there were no barriers to entry). But see *Reazin v. Blue Cross & Blue Shield of Kan., Inc.* 899 F.2d 951, 971-72 (10th Cir.) (noting that several factors, including insurer's great size in comparison to other insurers, its unique ability to contract directly with hospitals, and widespread perception that it operated with imprimatur of state

firms to shift production to offer a product similar to that of a competitor in response to a price increase;³⁰⁴ (2) elasticity of demand,³⁰⁵ reflected by consumer tendency to purchase "substitute" products in response to a price increase;³⁰⁶ and (3) the existence of market imperfections.³⁰⁷ Market share, while still relevant, is no longer the "proxy" for market power under the modern analysis;³⁰⁸ rather, it is merely a probative indicator of elasticity of demand and supply.³⁰⁹

legislature, tended to indicate that substantial entry barriers existed to competitors).

304. See Landes & Posner, *supra* note 35, at 945 (stating that high elasticity of supply means that even small price increase by one firm will be met with increased output by its competitors). A firm in a market with high elasticity of supply will experience highly elastic demand—customers will quickly change to substitute brands produced by its competitors in response to a price increase. See *id.*

Further, Professors Landes and Posner observe that when supply is highly elastic, that is, competing sellers can expand their sales in response to a price increase by another firm, market share takes on additional significance. See *id.* at 947. If competing firms are very small in comparison to a dominant firm that raises its prices, their ability to increase output also will be small. See *id.* A large firm, therefore, will lose only a small amount of sales in response to a price increase. See *id.* Thus, if a dominant firm has high market share and the "competitive fringe" has low market share, elasticity of demand will be low. See *id.*; see also Reazin, 899 F.2d at 971-72 (noting that insurer's great size in comparison to competing insurers tended to indicate that substantial entry barriers existed to competitors and that it possessed market power).

305. See *du Pont*, 351 U.S. at 394 (calling for assessment of "cross-elasticity of demand" in determining relevant product market). The Court explained, "where there are market alternatives that buyers may readily use for their purposes, illegal monopoly does not exist." *Id.*; see also *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995) (ruling that HMOs are part of health care financing market because individuals and employers, as purchasers of health care financing, regard HMOs as interchangeable with other forms of health care financing), *cert. denied*, 116 S. Ct. 1288 (1996); *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 591 (1st Cir. 1993) (upholding lower court ruling that HMOs exist in broadly defined health care financing market because they are viewed as interchangeable with fee-for-service arrangements, Blue Cross/Blue Shield Plans, Medicare, and Medicaid); *Ball Mem'l Hosp.*, 784 F.2d at 1332 (noting that consumers will readily switch from one form of health care financing to another in response to a price increase).

306. See Landes & Posner, *supra* note 35, at 945 (concluding that high elasticity of demand implies that good substitutes exist for products sold within market, and presence of good substitutes limits any individual firm's market power).

307. See Jacobs, *supra* note 11, at 355-62 (stating that, in *Kodak*, Supreme Court rejected market share proxy in favor of analysis recognizing small firms' ability to obtain power in imperfect market).

308. See *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 466-67 (1992) (holding that legal presumptions based on "formalistic distinctions" instead of "market realities" generally are disfavored in antitrust law). Rather than considering only market share, therefore, the Court will consider the "responsiveness of the sales of one product to price changes of the other." *Id.* at 467 (quoting *E.I. du Pont*, 351 U.S. at 400); see also *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 26-29 (1984) (holding that Court will examine economic reality of market at issue).

309. See *Jefferson Parish*, 466 U.S. at 27 (holding that mere information deficiencies causing consumer indifference to price and quality are insufficient to confer market power where market share of 30% evidenced absence of actual restraints on consumer choice); *Image Technical Serv., Inc. v. Eastman Kodak Co.*, 903 F.2d 612, 617 & n.3 (9th Cir. 1990) (acknowledging that, despite market imperfections, Kodak's small market share in equipment market might prevent it from possessing power in "aftermarket" for parts and service), *aff'd*, 504 U.S. 451 (1992).

The health care financing market exhibits each of the imperfections that portend liability under *Kodak* and *Jefferson Parish*. It has information deficiencies, financing arrangements that reduce price competition, and high costs for consumers to switch from one product to another.³¹⁰ Courts employing the new antitrust analysis, therefore, could hold HMOs liable for antitrust offenses either as small firms operating in the imperfect market for health care financing or as large firms operating in a discrete HMO market.

V. RECOMMENDATIONS

A. *Legal Principles to More Accurately Assess Market Power and Define Markets*

1. *Combine the Kodak and Jefferson Parish tests*

Courts should combine the *Kodak* test, focusing on market imperfections that reduce elasticity of demand, with that of *Jefferson Parish*, focusing on elasticity of supply. Antitrust liability can attach under such a combined test only where a small firm: (1) exploits market imperfections; (2) exhibits the ability to raise prices above the competitive level without losing customers to an existing competitor; and (3) impedes the entry of new competitors into the market. Adoption of such a rule serves three purposes.

First, it creates a competitive market for comparative product information. By acknowledging the competitive significance of information deficiencies, the rule gives insurers the incentive to provide accurate information about the prices and terms of their own products. Further, it allows insurers to police their competitors by encouraging consumers to compare information about their own product with information provided by a competing firm. As a result, it could even create a new "submarket" for comparative information about insurance products.

Second, the rule appropriately contains antitrust liability. It acknowledges that failure to provide product information can be considered an anticompetitive act only if the information deficiency reduces price competition and hinders the entry of new competitors into the market. Moreover, the rule recognizes that sellers are best suited to provide consumers with information about the prices and terms of their own products. The rule would not impose liability on

310. See *supra* notes 151-66 and accompanying text (describing market imperfections giving rise to antitrust liability in absence of market share under *Kodak* and *Jefferson Parish*).

small firms that lawfully attain power in an imperfect market because they failed to provide comparative information about their competitors. Instead, small firms would be liable only if they exploited information deficiencies in order to charge supracompetitive prices and exclude competitors.

Third, the rule is administrable without a re-engineering of traditional antitrust principles. It holds small firms liable for antitrust offenses only when they: (1) obtain market power by virtue of a market imperfection; (2) exercise market power through an anticompetitive act; and (3) cause antitrust injury through unfair prices or terms, or by foreclosing entry of new competitors. The preservation of traditional antitrust principles will afford firms greater certainty in assessing their antitrust exposure.

2. *Adhere to a fact-based, rather than assumption-based, analysis for finding market power and defining markets*

Courts and enforcers should employ a fact-based, rather than assumption-based, analysis to define product markets and measure market power in the health care field.³¹¹ Such an analysis will cut short the unhealthy legacy of *Marshfield* and maintain prevailing Supreme Court precedent, which emphasizes factual inquiry into "market realities" above assumptions or "formalistic distinctions" about markets.³¹² The court in *Marshfield* departed from the norm of relying on juries to find legal meaning in the complex web of factual evidence presented in antitrust cases.³¹³ It resorted instead to declarations based more on intuitive analysis than factual determinations in overturning a jury verdict and placing HMOs squarely in the health care financing market.³¹⁴

311. See *supra* notes 183-93 and accompanying text (critiquing Seventh Circuit's analysis in *Marshfield*, in which court relieved HMO of antitrust liability based on its assumption that it is "well known" that consumers view HMOs and other forms of health coverage as interchangeable); cf. Burda, *supra* note 92, at 40-41 (quoting Robert Bloch, former head of Department of Justice health care antitrust unit, as commenting that DOJ "was willing to make an awful lot of assumptions regarding material issues" in approving plan in which 100% of South Carolina's board certified dermatologists formed network).

312. See *Kodak*, 504 U.S. at 467 (noting Court's preference for resolution of antitrust claims on "case-by-case basis").

313. *Marshfield* Brief of Amicus Curiae, *supra* note 93, at 9; see also *Kodak*, 504 U.S. at 463 (holding that market definition "should be resolved by the trier of fact").

314. See *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995) ("The record shows, what is anyway well known, that individuals, and medical insurers . . . regard HMOs as competitive not only with each other, but also with [fee-for-service plans and PPOs]."), *cert. denied*, 116 S. Ct. 1288 (1996). The court claimed to have searched the record in vain for evidence that would support the jury's finding. See *id.* A search of the court's opinion to determine exactly what was missing, however, yields scant evidence of an inspection of the lower court record, and more general discussion of "contemporary principles of antitrust."

The paradox of the court's approach in *Marshfield* is that much of the economic analysis employed in antitrust law relies on consumers' perceptions about product interchangeability and availability. The court in *Marshfield*, however, discounted the jury's ability to accurately interpret factual evidence on product interchangeability and availability to find the existence of a discrete HMO market and then assess market power.³¹⁵ In essence, the court held that the perceptions and behavior of consumers in the marketplace can be dispositive of a firm's market power and the boundaries of its relevant product market. However, the judgment of these same consumers sitting as jurors is not competent to discern antitrust liability.

The consequences of assuming without significant factual inquiry that the HMO market cannot be separated from that of other forms of health care financing are threefold: (1) it permits large-scale consolidation of HMOs;³¹⁶ (2) it impedes efforts to foster competition by protecting the creation of new HMOs;³¹⁷ and (3) it supplants a particularized analysis by the factfinder of competition in specific markets with what the court considers to be "well known" about markets generally.³¹⁸

By preserving a fact-based antitrust analysis, courts can ensure that the "salubrious effects" of competition are felt in the rapidly developing health care market. Such an analysis, by refusing to define the market unnecessarily broadly, will foster competition among HMOs, not just between HMOs and other forms of health care financing. A fact-based, rather than assumption-based, analysis recognizes that anticompetitive behavior by one HMO directed against another HMO does not lose its legal significance solely because HMOs frequently function alongside other insurance products in the health care financing marketplace. Intra-HMO competition, in turn, will advance the economic goals of managed care by promoting a rational system of health care in which consumers, providers, and payors negotiate over price, benefits, and quality.

Id.; see also *Marshfield* Brief of Amicus Curiae, *supra* note 93, at 9 & n.7 (noting that author of appeals court's *Marshfield* decision is on record questioning ability of juries to sort out factual issues in antitrust cases (citing RICHARD A. POSNER, ANTITRUST LAW, AN ECONOMIC PERSPECTIVE 235 (1976))).

315. See *supra* notes 183-93 and accompanying text (describing court's reasoning in overruling jury verdict and substituting its own intuitive view of HMO market definition).

316. See *Marshfield* Brief of Amicus Curiae, *supra* note 93, at 3-4.

317. See *id.* at 4-5.

318. See *supra* notes 183-93 and accompanying text (describing how Seventh Circuit discarded detailed factual inquiry in *Marshfield* and relied instead on general assumptions about consumers' perception of interchangeability among HMOs and other types of health coverage).

B. Economic Solutions to Prevent HMO Acquisition of Market Power

1. Lower switching costs by eliminating coverage exclusions and limiting premium increases based on pre-existing conditions

The Health Insurance Portability and Accountability Act, enacted during the 104th Congress, prohibits insurers from excluding coverage for pre-existing conditions.³¹⁹ When it takes effect July 1, 1997,³²⁰ the Act will help eliminate the high switching costs that currently prevent many individuals from obtaining new health coverage after an illness or change of jobs. It will preserve competition among HMOs by allowing consumers to obtain new coverage in response to an unfavorable pricing or coverage policy. In addition, it will preserve the existence of a broader "health care financing" market in which HMOs, which do not exclude coverage of pre-existing conditions, compete with other forms of health care financing.

The Act, however, will solve only half the problem of increased switching costs associated with pre-existing conditions. Although it forbids outright refusal to cover individuals with pre-existing conditions, the Act fails to address the problem that arises when health plans charge these individuals a premium so exorbitant that they effectively are excluded from coverage. For these individuals, the cost of changing health plans will remain prohibitive. Congress, therefore, should monitor the behavior of health plans following implementation of the Act and take additional action if necessary.

2. Increase supply elasticity by decreasing adverse selection

Government should adopt reasonable fair marketing standards for those in higher risk categories, such as the poor and the elderly. This will attenuate the effects of adverse selection by preventing HMOs from avoiding enrollment of individuals they consider likely to be above-average utilizers of health care resources. Government, however, should not force affirmative action on HMOs to enroll these higher-risk groups. Adverse selection is, to some degree, the result of rational decisions by consumers that their medical needs will be better served in a fee-for-service plan than an HMO. Affirmative action for high-risk groups might provide irrational incentives for sicker

319. See *Health Insurance Portability and Accountability Act*, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (to be codified in scattered sections of 18, 26, 29, and 42 U.S.C.).

320. See *id.* § 701(g)(1) (forbidding exclusion of coverage for pre-existing conditions after June 30, 1997).

individuals to enroll in HMOs, which would be less suited to provide for their medical needs. Fair marketing standards will ensure that the decision rests with consumers about which type of plan best suits their health care financing needs.

3. *Increase demand elasticity by fostering price competition*

a. *Increase availability of information*

The existence of widely disparate coverage policies among health care financing products is a major barrier to price competition. This disparity suppresses price competition by impeding consumers' ability to make direct price, coverage, and quality comparisons. Large employers can correct this imperfection by offering employees several health coverage choices and requiring insurance companies to offer uniform benefit packages.³²¹ Such uniformity will enable employees to make "apples to apples" comparisons on the price of alternative health coverage plans. State governments can empower consumers on a broader scale through the passage of laws requiring health plans to provide uniform information to consumers or employers.³²² State governments already have succeeded in empowering small employers to provide their employees with multiple coverage options by enacting legislation to authorize the formation of purchasing cooperatives.³²³

b. *Require employee cost sharing*

Employee cost sharing is the most effective means of restoring price competition to the health care financing market and preserving elasticity of demand. Employees are more likely to make rational, market-based decisions if they share in the cost of the health coverage they choose. There are two ways employers can implement cost sharing. First, and most effectively, employers can pay a fixed

321. See *id.* at 39 (citing cost containment success of CalPERS in adopting standardized benefit package).

322. See *Consumer-Oriented Disclosure Law for Health Plans Goes Into Effect*, 4 Health Care Pol'y Rep. (BNA) at 18 (Jan. 1, 1996) (reporting on enactment of Arizona law requiring HMOs to provide employers with uniform information about HMO benefits). Arizona now requires HMOs to provide employers with information including: (1) the full cost of the plan, including premiums, co-pay, and deductible amounts; (2) the health care benefits to which enrollees are entitled; and (3) any limitations on coverage. See *id.* At least seven other states, including California, Oregon, and Texas, are considering the introduction of similar legislation. See *id.*

323. See *Statewide Health Care Pool to Reduce Rates by 6 Percent*, 21 Pens. & Benefits Rptr. (BNA) 671 (Mar. 28, 1994). California was the first state to enact legislation authorizing and funding the formation of a health alliance serving small employers. The plan, called the "California Health Insurance Purchasing Cooperative" ("HIPC"), effected a 6.27% premium cut for small employers in its first year of operation. See *id.* HIPC further reduced premiums by 5% in 1995, its second year of operation. See *California Insurance Plan Negotiates 5 Percent Cut for Average Premium Rate*, Pens. & Benefits Rptr. (BNA), at 785 (Mar. 27, 1995).

premium amount for the employee.³²⁴ The employee then would be responsible for paying the difference between this amount and the price of the health plan he or she chooses.³²⁵ Such a policy would foster a high degree of price consciousness because employees are responsible for the full difference in plan cost.³²⁶ The second way employers can implement cost sharing is through payment of a fixed percentage of employees' health care premiums.³²⁷ Under such a policy, employees would be responsible for only a percentage of the difference in the premium cost of the health plan they choose.³²⁸ While this approach has the advantage of fairness to employees who would benefit from a fee-for-service plan, it fosters a lower level of price consciousness among employees than payment of a fixed premium amount.

c. Amend tax laws

Federal tax policy should foster health plan price competition by encouraging employers to pay a fixed premium amount for employees while making the employee responsible for the remaining amount.³²⁹ The tax code should allow employers to pay a fixed amount of health insurance premiums with pre-tax dollars.³³⁰ This amount could be set at the regional average cost of a health plan minus ten percent. Such a policy would set a "target" pricing level at the average health plan cost. Consumers would pay 100 percent of the cost difference for plans priced above the average health plan cost, and would save 100 percent of the cost difference for plans priced below average. Such a policy would reduce fluctuations in the price of health plans and encourage plans to compete on price until they reach the point of lowest marginal return.³³¹ Allowing employers to pay up to 90 percent of the actual cost of employee health

324. See Enthoven, *supra* note 241, at 34-37 (describing five cost-sharing policies and their effect on appearance of HMO demand curve).

325. See *id.*

326. See *id.*

327. See *id.*

328. See *id.*

329. See 1995 INTERSTUDY REGIONAL MARKET ANALYSIS, *supra* note 169, at 66 (noting that employers can transfer desires for low-cost, high-quality health care to employees by fostering price sensitivity).

330. See *id.* (stating that employers who offer several health plans, but contribute only fixed amount, such as premium amount of lowest cost plan, create most highly elastic demand for health care).

331. See 1994 INTERSTUDY REPORT, *supra* note 3, at 4 (reporting that, as HMO markets become more competitive, relative price and variation in relative price becomes smaller).

insurance premiums provides a second, slightly less effective solution.³³²

C. Actions HMOs Can Take to Avoid Antitrust Liability

HMOs can reduce their antitrust exposure by undertaking some of the measures described above voluntarily, as well as by implementing additional measures to preserve elasticity of supply and demand in the health care financing market. Specifically, HMOs can:

- Limit the use of exclusive contracts and limit the notice required of health care providers to terminate such contracts. This will help ensure that HMO supply remains elastic by preserving an adequate pool of providers willing to contract with newly forming HMOs.
- Provide information about price, benefits, and coverage limitations to employers and employees who subscribe to HMO plans. This will help reduce the substantial cost of obtaining comparative information about health plans. It will increase price sensitivity among consumers and prevent costly "lock ins" due to coverage exclusions that are not easily understood by consumers at the time of enrollment.
- Implement fair marketing procedures to ensure that enrollees represent diverse risk groups rather than only low-risk groups. This will help prevent an artificial division of HMO and fee-for-service product markets, whereby HMOs would offer inadequate coverage for sicker individuals while fee-for-service plans would be prohibitively expensive for healthier individuals.

CONCLUSION

To date, courts have defined the HMO market broadly to include all health care financing products. In most of these markets, one or two firms hold the dominant share of HMO enrollees, although these enrollees account for only a small portion of the total insured population. Dominant HMOs have been protected from liability under traditional antitrust analysis by the "market share proxy," the notion that a firm cannot wield market power unless it also holds a substantial market share.

332. See Enthoven, *supra* note 241, at 34-37 (stating that employer payment of percentage of health plan cost is less effective than payment of fixed premium amount, but more effective than payment of full premium amount, in fostering price sensitivity); see also 1995 INTERSTUDY REGIONAL MARKET ANALYSIS, *supra* note 169, at 66 (reporting that employers who pay premiums regardless of cost create the most inelastic demand).

The Supreme Court, however, announced a new antitrust analysis in *Kodak* and *Jefferson Parish* that attributes market power to small firms operating in markets where certain "imperfections" suppress competition. The health care financing market exhibits such imperfections, including information deficiencies, high consumer switching costs, and financing arrangements that reduce price competition. HMOs, therefore, may be held liable for antitrust offenses under the new analysis despite possessing low market share.

Market imperfections, coupled with increasing HMO enrollment, threaten to suppress elasticity of supply and demand for HMOs, while reducing consumers' ability to choose health plans and providers. Courts, observing such economic inflexibility, may recognize a division of the HMO and health care financing markets. In a market comprised only of other HMOs, each individual HMO will hold a substantially higher market share. A division of markets, therefore, will confer market power on many HMOs even under the traditional "market share proxy."

Increased antitrust liability for HMOs can have both positive and negative consequences. Appropriately applied, it can ensure that the principles of competition and efficiency on which HMOs are founded remain intact. Unwarranted antitrust liability, however, can diminish the benefits HMOs have brought to health care financing, including lower prices and improved access to primary care. Courts, government, and HMOs, therefore, should take specific steps to preserve elasticity of supply and demand for HMOs, protect consumer choice, and ensure that antitrust liability is apportioned appropriately.

