Antitrust Issues in the Joint Purchasing of Health Care

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I. INTRODUCTION

Current developments on the health care scene are calling new attention to antitrust questions that arise when multiple actors combine to purchase goods or services. Although employers have collaborated for mutual assistance in the procurement of health care for their employees since the 1970s, local employer coalitions are becoming increasingly interested in bargaining collectively for the purchase of health coverage or health services.1 The 1990s have also seen a movement to create “purchasing cooperatives” to procure or bargain for health coverage on behalf of small businesses and individuals;2 several states have provided for such cooperatives in

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2. The Institute of Medicine defines “purchasing cooperative” as follows: A term broadly used in discussions of health care reform to describe an entity that would buy health coverage on behalf of some group (e.g., small employers or all residents of a geographic area) and that would generally operate to pool risk, reduce marketing and other administrative costs, provide coverage that was portable from one job to another, and otherwise
legislation. 3 Furthermore, recent reform proposals at the federal level contemplated the creation of new intermediaries to “manage” competition among health plans 4 either for the benefit of all but the largest purchasers 5 or only for small employers and self-employed individuals, 6 although managed competition does not necessarily entail joint purchasing, some versions of the strategy visualize a manager that would bargain aggressively with individual health plans over price. 7 Actual joint purchasing can itself take several


5. The strategy of managed competition, originally devised by Alain Enthoven and popularized by the so-called Jackson Hole Group, received much attention in the health reform debates of 1993–94. See, e.g., Alain C. Enthoven, The History and Principles of Managed Competition, HEALTH AFF., Supp. 1993, at 24 passim (tracing development of managed competition theory).

6. The Clinton administration’s proposed Health Security Act contemplated the creation of so-called “health alliances” as the midmen through which all residents of an area (other than employees of very large employers) could procure private health coverage. H.R. 3600, 103d Cong., 1st Sess. (1993); S. 1757, 103d Cong., 1st Sess. (1993); see also infra note 7 (noting market power health alliances could have exercised if they had been granted freedom to bargain with health plans).

7. The theory of managed competition contemplates only that so-called sponsors would serve as organizers of the market for health coverage, creating menus of standardized options for consumers, providing information, and blocking efforts by competing health plans to select only good risks. Some proponents, however, have focused on sponsors’ potential for exercising market power. Indeed, the health alliances proposed in the Clinton bill would have been such powerful buyers that they were given only limited freedom to bargain with health plans but were instead required to offer every health plan certified by state regulators. See S. 1757, 103d Cong., 1st Sess. § 1321 (1993) (envisioning negotiations between alliances and health plans but stating only two limited conditions under which an “alliance is not required . . . to offer a contract with a health plan”). Health alliances would have been empowered, however, to dictate fee schedules to fee-for-service providers. See id. § 1322(c) (speaking as if fee schedule would be “negotiated” with providers but allowing all-
forms. Used wisely, it can improve the ability of purchasers to secure good health coverage at affordable rates.

This Article focuses on antitrust questions that might be raised in connection with joint purchasing of health coverage. The principal issue in an antitrust analysis of joint buying of health care is its effect on competition as the determinant of prices paid to health plans or health care providers. Although antitrust law has historically been concerned with price fixing and other anticompetitive agreements among sellers, it is equally applicable to price agreements and collaborations among buyers. Monopsony, or buying power, is economically objectionable for the same policy reasons that underlie antitrust law's opposition to monopoly. However, antitrust law has had much less experience with monopsony than with monopoly. The current interest in joint purchasing of health care

ences to promulgate schedule without agreement and preserving antitrust prohibitions against physician strikes). The original proponents of managed competition rejected the Clinton version of the concept as being in reality a regulatory rather than a market-based initiative. See, e.g., Paul M. Ellwood, Clinton Forgets His Health Care Allies, WALL ST. J., Aug. 10, 1993, at A14 (criticizing President Clinton's inconsistent goals of instituting market-driven reform and imposing government spending controls).

8. Joint purchasing raises many other technical and legal issues. See generally HALL, supra note 2, at 47–53, 88–93 (noting fears that cooperatives will act as regulators or refuse to admit employers with undesirable risks; discussing issues of exclusivity, competition, voluntariness, and governance). An earlier study reviewed the full range of antitrust problems facing employer-sponsored coalitions. See H. ROBERT HALPER & JOHN J. MILES, ANTITRUST GUIDE FOR HEALTH CARE COALITIONS (1983). Perhaps reflecting the limited extent of joint purchasing at the time, that study did not treat joint purchasing of health services by coalitions extensively. See id. § 6.3 (concluding "it is dangerous for coalitions to participate in hard negotiations with providers regarding charges and reimbursement methodology").


therefore justifies a close look at the analytical issues raised by collective purchasing.\textsuperscript{11}

Public enforcement officials have evinced a positive disposition toward collective purchasing of health care. Because joint purchasers are generally perceived as fighting battles to control the cost and improve the quality of health care and as seeking to bring a semblance of price competition to markets that have long lacked it, antitrust agencies are unlikely to challenge employer coalitions or purchasing cooperatives unless they clearly step outside the bounds of lawful activity. Indeed, agency officials have taken some pains to ensure that would-be joint purchasers are not discouraged by antitrust fears from pursuing procompetitive activities. Thus, the director of the Federal Trade Commission's Bureau of Competition suggested in 1992 that the best advice to antitrust prosecutors concerned with joint purchasing in the health care sector might be, "don't do something, just stand there."\textsuperscript{12}

But even though a friendly attitude toward joint purchasing on the part of government enforcement agencies is reassuring, there remains the possibility of private antitrust suits by providers or health plans alleging that as sellers they are victims of a buyers' conspiracy to restrain trade. Private antitrust actions are possible wherever a party can claim "antitrust injury"\textsuperscript{13} and substantial damages. Even when joint purchasers are confident of the legality of their effort, the high cost of defending a suit for treble damages must be weighed in the calculus when deciding whether to pursue

in non-health-care contexts.

\textsuperscript{11} For economic and legal analyses of monopsony and collaboration in the purchasing of health services, see 2 JOHN J. MILES, HEALTH CARE & ANTITRUST LAW: PRINCIPLES & PRACTICE § 13.06(1) (1994); Kathryn M. Fenton, Antitrust Implications of Joint Efforts by Third Party Payors to Reduce Costs and Improve the Quality of Health Care, 61 ANTITRUST L.J. 17, 22-37 (1992); Mark V. Pauly, Competition in Health Insurance Markets, 51 LAW & CONTEMP. PROBS., Spring 1988, at 237, 250-55; Jack A. Revene, Monopsony Power in Health Care Markets: Must the Big Buyer Beware Hard Bargaining?, 18 LOY. U. CHI. L.J. 857, 873-85 (1987). Joint purchasing has also raised antitrust issues in other contexts in the health care field, including the collective procurement by hospitals of hospital supplies and nursing services. See infra notes 35, 50 (discussing joint purchasing by hospitals; noting limited circumstances where joint purchasing by hospitals is discouraged).

\textsuperscript{12} Kevin J. Arquit, Health Care Buying Arrangements: FTC Views, Address Before the A.B.A. Section of Antitrust Law (Apr. 2, 1992), in 7 Trade Reg. Rep. (CCH) ¶ 50,080, at 48,802-06. For a summary of statements by government officials indicating similarly favorable attitudes toward employer-sponsored coalitions, see A.B.A. SEC. ANTITRUST L., COMPIEDUM OF INFORMAL ANTITRUST ENFORCEMENT AGENCY ADVICE IN HEALTH CARE 31, 38, 43, 88-92 (1991) (hereinafter COMPIEDUM); see also infra notes 38, 50 (citing positive business reviews of group purchasing proposals).

\textsuperscript{13} See infra note 27 (discussing private antitrust actions).
the benefits of buying coalitions. Therefore, joint purchasers must consider the likelihood of obtaining early dismissal of any private suits by health care providers.

This Article proceeds, after briefly introducing coalitions and purchasing cooperatives, to a structured analysis of the legality of joint purchasing in Parts III–VII. It then offers a more speculative line of defense for joint purchasers that exercise a degree of market power in ways not readily defensible under traditional doctrine. The Article concludes that few employer coalitions or purchaser cooperatives are likely to cross the lines laid down by antitrust law. Indeed, entities following the guidelines in this Article should be reasonably confident of their ability to win summary judgment against antitrust claims. A coalition or cooperative could reasonably expect to prevail if it can show either that it lacked market power in purchasing services or that its members’ practices in conjunction with joint purchasing were such as to obviate concern about buying power misuse.

II. HEALTH CARE COALITIONS AND PURCHASING
COOPERATIVES DESCRIBED

Local health care purchasing coalitions have developed in the last twenty years as part of a general market response to rising health care costs. In the late 1970s and early 1980s, it became apparent that government was unlikely anytime soon either to control costs through comprehensive regulation or to adopt some version of national health insurance. Just as the federal government embarked on an aggressive campaign to control costs of the Medicare and Medicaid programs, private employers, which had previously been accustomed only to paying for their workers’ health benefits and not to selectively purchasing health care in the same manner as other factors of production, began to explore and adopt prudent purchasing techniques. Employers also began to see a need to cooperate in purchasing more intelligently. Local coalitions were formed to help employers meet their perceived need for cooperation, better information, and mutual support in procuring health services for their employees at a reasonable cost.¹⁴

¹⁴. See supra note 1 (citing sources discussing trend toward joint purchasing of health care). In addition to working at the local level, coalitions may cooperate with each other. For example, coalitions have formed the National Business Coalition Forum on Health to serve as a clearinghouse for experiences and as a vehicle for other cooperative efforts. If coalitions should combine their purchasing power in some way, no antitrust problem would arise unless they operated in the same geographic market for some service being jointly purchased.
Employer-sponsored coalitions have performed different functions and taken different forms, reflecting different philosophies about health care. From the beginning, however, all coalitions have collected and disseminated information concerning health care providers. The exchange of information among independent buyers or sellers is a sensitive antitrust issue. To be sure, collection and dissemination of health care information are distinctly procompetitive activities; not only is the information produced by coalitions a useful new product that could not be produced as efficiently without collaboration, but it also facilitates better business decisions. The concern of antitrust law, however, is that the circulation of information among competitors might trigger unlawful concerted action. Thus, the law would generally require that information be acted on by each coalition member individually and independently. If coalition members view the information circulated as a signal for a uniform response, such as a concerted refusal to deal with one or more providers, antitrust liability could follow.

The different philosophies inspiring coalitions have different antitrust implications. For example, some employer-sponsored coalitions have included not only employers but also health care providers and health insurers. Coalitions of this kind may contemplate persuading providers or health plans to cooperate to solve perceived problems. Such coalitions, carrying on the nonmarket tradition of community health planning, would stand in contrast to all-purchaser coalitions that are concerned only with equipping independent actors to purchase services more effectively. A coalition that views

15. See generally HALPER & MILES, supra note 8, §§ 4.1–10 (concluding data dissemination programs are appropriate under antitrust laws except in limited circumstances). See also COMPRENDIUM, supra note 12, at 38, 43 (reprinting assurances by Department of Justice concerning legality of coalitions' data collection efforts); id. at 176–84 (reprinting statements by enforcement officials indicating general agreement with principles stated in text regarding information exchange in coalitions); cf. A.B.A. SEC. ANTITRUST L., INFORMATION SHARING AMONG HEALTH CARE PROVIDERS: AN ANTITRUST ANALYSIS AND PRACTICAL GUIDE 3–19 (1994) (reviewing general principles with specific reference to provider-sponsored information sharing).

16. Some coalitions have recently begun to explore an ambitious new agenda combining extensive electronic data collection and joint purchasing in highly integrated, community-wide, interactive systems for processing insurance claims, managing utilization, monitoring provider performance, and evaluating quality and clinical efficacy. Called Community Health Management Information Systems ("CHMISs"), these initiatives are just getting under way. See CHINs and CHMISs: Networks for Community Health Information and Management, ISSUE BRIEF NO. 657 (Nat'l Health Pol'y F., Washington, D.C.), Oct. 23, 1994, at 3. The antitrust principles applicable to data sharing and management discussed by HALPER & MILES, supra note 8, §§ 4.1–10, should be applied to particular CHMISs; however, the analysis of their joint purchasing features should proceed along the lines sketched in this Article.

17. Like the rest of the American health care system, the coalition movement
itself as engaged in consensual health planning could easily find itself brokering unlawful agreements among providers; for example, an agreement between competing hospitals to specialize in different services would amount to unlawful market division.\textsuperscript{18} Antitrust problems might also arise if coalition members agreed to enforce planning-type decisions by refusing to deal with uncooperative providers, thus participating in an unlawful group boycott.\textsuperscript{19} On the other hand, if a coalition merely petitioned state regulators to take anticompetitive actions under a state certificate-of-need law or other regulatory statute, there would be little danger of antitrust liability.\textsuperscript{20} In general, if a coalition's underlying philosophy contemplates

has reflected the tension between centralized, cooperative decision making and a truly free market featuring independent actors, consumer choice, and competition. The dominant paradigm views medical care as a technical service, the content of which must be centrally prescribed, and not as a consumer good to be purchased in varying configurations and quantities depending upon the preferences and resources of buyers. \textit{See generally} Clark C. Havighurst, \textit{The Professional Paradigm of Medical Care: Obstacle to Decentralization}, 30 \textit{JURIMETRICS} J. 415, 419–29 (1990) (observing how professional paradigm, based on assumptions of irredeemable consumer ignorance and medical profession's reliability as society's agent, inhibits reliance on consumer choice as vehicle for allocating resources to health care uses). The paradigm under which cooperation rather than competition is the norm originally underlay comprehensive health planning—a largely but not entirely discredited model for operating the health care system. Although the repeal in 1986 of federal health planning legislation removed a significant inconsistency in federal health policy, health planning and cooperative decision making remain popular in many states. \textit{See James F. Blumstein, Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation}, 79 \textit{CORNELL L. REV.} 1459, 1486–505 (1994) (discussing recent state legislation based on paradigm of cooperation rather than competition).

\textsuperscript{18} \textit{See generally HALPER & MILES, supra note 8, § 6.6} (discussing health planning activities that create strongest suspicion in antitrust context); \textit{CLARK C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION} 131–37, 159–79 (1982) (concluding it would be bad law and policy to grant exempting powers to health system planners or regulators); \textit{CLARK C. Havighurst, Health Planning and Antitrust Law: The Implied Amendment Doctrine of the Rex Hospital Case, 14 N.C. CENT. L.J. 45} (1983) (arguing against softening antitrust rules to facilitate health planning). \textit{But see Blumstein, supra note 17, at 1486–501} (discussing state laws authorizing health care provider cooperation and offering immunity to federal antitrust law).

\textsuperscript{19} \textit{See HALPER & MILES, supra note 8, app. A § 10(g)} (discussing group boycotts in health care coalition context); \textit{cf.} Radiant Burners, Inc. v. Peoples Gas Light & Coke Co., 364 U.S. 656, 659–60 (1961) (per curiam) (holding utilities agreeing not to supply gas for use in burners lacking association's seal of approval would per se violate Sherman Act); \textit{Fashion Originators' Guild v. FTC, 312 U.S. 457, 464–68} (1941) (condemning coercive boycotts by which industry sought to dictate business methods to suppliers and customers).

solving problems by persuading providers to cooperate among themselves or by coercing them to cooperate with the coalition, antitrust difficulties would arise.

In contrast to coalitions operating in a health-planning mode, purchasing cooperatives comprising only small employers and individuals have a raison d'être that is fully compatible with competition. Cooperatives are a direct response to the substantial disadvantages that individuals and small employers face in purchasing health coverage.\(^{21}\) Unable to achieve the economies of scale associated with large employment groups, such purchasers must pay higher premiums to cover higher administrative and selling costs. Small groups and individuals also present health plans with risks that are much less predictable than those associated with large groups. To protect themselves against adverse selection, health plans must charge such customers higher premiums and must either impose arbitrary criteria for coverage (redlining) or engage in medical underwriting. These defensive strategies make many groups and individuals uninsurable and make health care coverage unaffordable by many more. Small employers themselves incur disproportionate costs in searching the market and in negotiating coverage. Although these problems are severe, many can be overcome by pooling the risks of multiple employers and individuals in a purchasing cooperative. Not only can a cooperative realize scale economies in collecting and evaluating information, but it can also offer health plans a more predictable set of risks. Although any pooling of purchases is subject to scrutiny under antitrust laws,\(^{22}\)

\(^{21}\) See HALL, supra note 2, at 16–22.

\(^{22}\) Employers cannot escape antitrust law's strictures on concerted action by organizing a cooperative or some other distinct corporate entity to pursue their collective objectives. Courts applying § 1 of the Sherman Act will scrutinize, as concerted action, the actions of any nominally discrete entity as long as it is controlled by independent entities having competitive interests of their own. See 7 PHILIP E. AREEDA, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION § 1477, at 343 (1988). On the other hand, if the purchasing cooperative were controlled by interests other than the purchasers themselves, concerted action would have to be proved in another way.

To the extent that a cooperative is a creature of state law, questions of "state action" immunity might arise. The so-called state action doctrine can shelter anticompetitive actions from the federal antitrust laws if those actions were in keeping with a clearly articulated state policy of dispensing with competition and if the state supplied some form of supervision to prevent abuses. See, e.g., California Retail Liquor Dealers Ass'n v. Midsal Aluminum, Inc., 445 U.S. 97, 104–06 (1980) (stating principle and finding state failed to actively supervise).
purchasing cooperatives are in a good position to claim that their purposes are only procompetitive—that is, that they equip small employers and individuals to purchase health coverage intelligently and effectively.

Actions of an employer coalition or purchasing cooperative that involve only "managing" competition to improve the working of the market—by providing information, structuring choices, and removing opportunities for risk selection—should pass antitrust muster rather easily. According to the leading case, Chicago Board of Trade v. United States, "[t]he true test of legality [of restrictive concerted action] is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." Chicago Board of Trade upheld agreements among competitors that, although limiting competition in some minor respects, significantly strengthened it in others by creating a central auction market for commodities. A coalition or cooperative that limits itself to making an efficient market in health plans by "managing competition" seems procompetitive in the same sense.

The activity of employer coalitions and purchasing cooperatives that raises the most obvious antitrust concern is group purchasing of health services. To be sure, many coalitions and cooperatives engage only in managing competition in some way, not in actually negotiating for health care on behalf of a bloc of employers. Moreover, joint purchasing itself encompasses a variety of conduct, not all of which is equally troublesome and some of which achieves significant efficiencies. Nevertheless, the temptation to use the group's aggregate buying power to induce provider concessions on price or other matters would often be very great. For example, an employer coalition in Memphis succeeded in obtaining lower prices from hospitals by steering its business to the lowest bidder. Although such joint purchasing would not necessarily violate the Sherman Act, a careful assessment is needed to distinguish lawful from unlawful conduct. This Article surveys the basic principles under which specific instances of joint purchasing should be analyzed.

23. Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918) (establishing rule of reason applicable to all concerted action under Sherman Act); see also National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 691 (1978) (reiterating test).


III. JOINT PURCHASING IN ANTITRUST PERSPECTIVE

Although joint purchasers of health care are not usually competitors in the markets in which they sell, they may be viewed for antitrust purposes as competitors in purchasing health services.26 Their collective actions therefore must be evaluated to discover whether they illegally restrain trade. Because purchasing health services through a coalition or cooperative necessarily entails some agreement by the members on the prices at which they buy, joint purchasing is analogous to price fixing by competing sellers. Just as colluding sellers exploit customers by charging supracompetitive prices, colluding buyers may exploit suppliers, forcing their prices below competitive levels and depriving them of competitive returns on their investments. Accordingly, if health care providers believed they were being exploited by a combination of their customers, they might bring a private antitrust suit charging the collective exercise of monopoly power.27

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26. See infra notes 35–38 and accompanying text (observing that joint purchasers of health care generally do not compete with each other as sellers).

27. A private party can bring an antitrust action only if the injury complained of is an "antitrust injury"—a harm of the kind that antitrust laws were intended to prevent. Atlantic Richfield Co. v. USA Petroleum Co., 495 U.S. 328, 337–38 (1990) (retail gasoline dealer unsuccessfully challenged major oil refiner's requirement that its dealers, plaintiff's competitors, sell at prices lower than plaintiff wished to charge); Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 489–91 (1977) (barring plaintiff from challenging legality of merger that restored his competitor to health, diminishing his future profits). It might seem that a plaintiff who complains that a combination of buyers deprived him of the opportunity to sell at a high price has not suffered an antitrust injury. Antitrust laws, however, are intended to maintain an uninhibited market, which is presumed to serve general consumer welfare even if particular consumers might benefit from a particular restraint. See, e.g., Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) (finding physician organizations' fixing of maximum prices unlawful). The per se rule against price fixing is "grounded on faith in price competition as a market force [and not] on a policy of low selling prices at the price of eliminating competition." Id. at 349 (quoting James A. Rahl, Price Competition and the Price Fixing Rule—Preface and Perspective, 57 NW. U. L. REV. 137, 142 (1962)). Because group purchasing eliminates competition among buyers and because artificially low selling prices are harmful to the overall economy, private suits contesting unlawful group purchasing vindicate the public interest in preserving unrigged markets and would almost certainly be permitted. See Blair & Harrison, Cooperative Buying, supra note 10, at 365–66. On the other hand, it might be argued that health care providers challenging joint purchasing of health services have suffered no antitrust injury because they are seeking only to restore the uncompetitive conditions that generally prevail with respect to price and utilization in markets for insured fee-for-service health care. Although there is no precedent or solid conceptual basis for such an argument, it might be adopted by a court sympathetic to joint purchasers. Part VIII, infra, however, offers a different kind of market-failure defense for the naked exercise of purchasing power.
Although antitrust law has concentrated principally on protecting the right of buyers to buy in unrigged markets, it also protects sellers against buyer cartels. The reasons why public policy should be concerned about excessive aggregations of buying power are analogous to the reasons why antitrust law fosters competition among sellers. Just as the familiar term "monopoly" describes the position of a single seller vis-à-vis the buyers in a market, the term "monopsony" describes the situation of a single buyer with respect to suppliers. Both monopsonists and monopolists are in a position to increase profits by reducing output of the items whose purchase or sale they dominate. A profit-maximizing monopolist or seller cartel reduces output by raising the selling price, causing a reduction in the amount demanded by customers. (Product demand curves slope downward to the right.) A monopsonist or buyer cartel, on the other hand, can reduce output by lowering the price at which it buys, thus causing a reduction in supply. (Supply curves generally slope upward to the right.) In either event, allocative efficiency is impaired because productive capacity is diverted from producing things that would be produced if prices equalled marginal cost. Society's need to ensure that its productive resources are put to their best uses warrants concern about ill-gotten monopoly and

28. See generally supra note 10 (collecting sources articulating methods for analyzing monopsony power).

29. If the supply curve is relatively flat (elastic), collaborators will be unable to depress price without drying up supply. Thus, they possess less market power than if supply were inelastic. See Jacobson & Dorman, Joint Purchasing, supra note 10, at 12–17 (discussing causes and effects of upward sloping supply curve); infra text at notes 70–75 (discussing market power as a function of supply and demand elasticity).

Likewise, a monopolist's market power is greater where demand is inelastic.

30. Antitrust law appears to treat single-firm monopsony in the same way it treats single-firm monopoly, focusing not on the mere possession of market power but on the legitimacy of the conduct by which that power was obtained. See Kartell v. Blue Shield of Mass., 749 F.2d 922, 929–32 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985). In Kartell, physicians objected to the practice by a very large Blue Shield plan of requiring them, as a condition of eligibility to provide services covered by the plan, to accept the plan's allowances as full payment for their services and not to balance-bill their patients. Id. at 923. The First Circuit held, in an opinion by Judge (now Justice) Breyer, that it was not unlawful for the plan to exercise its lawfully gained buying power to obtain low prices from suppliers. Id. at 929–31. (Similarly, a lawful monopolist may charge monopoly prices). The general test for the legality of dominant market power is whether it was gained improperly, such as by employing "exclusionary practices." United States v. Grinnell Corp., 384 U.S. 563, 570–76 (1966). On the significance of single-firm monopsony power exercised by health insurers, see H.E. Frech III, Monopoly in Health Insurance: The Economics of Kartell v. Blue Shield of Massachusetts, in PACIFIC RESEARCH INST. FOR PUB. POLICY, HEALTH CARE IN AMERICA 293, 316–19 (H.E. Frech III ed., 1988); Pauly, supra note 11.
monopsony power in the economy.

Antitrust law has steadfastly opposed seller cartels because they enrich suppliers at the expense of consumers. It would not be surprising if the law, reflecting political realities, proved somewhat less concerned about wealth redistributions running in the opposite direction—say, from wealthy hospitals and physicians to employers purchasing health services for their workers. Nevertheless, antitrust law embodies a general policy of promoting competitive markets as arenas of fair competition and equal opportunity. Because sellers as well as buyers are entitled to do business in unrigged markets, a claim that joint purchasing enables consumers to exploit health care providers would probably be taken seriously by an antitrust court. One may still wonder, however, whether antitrust enforcers or courts would evince the same hostility toward pro-consumer, price-reducing uses of market power as they have traditionally shown toward sellers’ collective efforts to raise prices.

31. Technically, a monopolist, by raising prices, captures “consumer surplus”—the gain from trade that consumers enjoy in purchasing at competitive prices things they value more highly. Conversely, a monopsonist, by forcing prices down, can capture some “producer surplus”—the excess of the prices that sellers would receive under competition over the minimum prices they would accept. As a product of a populist tradition, antitrust law may embody greater concern about misappropriations of consumer surplus by sellers than about transfers of producer surplus to consumers.

Conceptually, employers engaged in joint purchasing of health care may be viewed either as entities buying for their own account inputs to be incorporated in products they sell downstream or as agents buying health care for their employees, the ultimate consumers. Although neither conceptualization avoids antitrust problems that arise when several employers act in concert, employers collectively purchasing health care might be viewed more sympathetically by antitrust enforcers, juries, and judges if they appeared to be acting as agents of their workers. This conceptualization of the employers’ role is consistent with the economics of the labor market in which employers vie to offer attractive benefit packages. Employers would appear in a less favorable light, however, if their collective effort impairs their independence in competing for workers by offering attractive forms of compensation. See Halper & Miles, supra note 8, § 6.2 (discussing antitrust questions that might arise in labor market from undue standardization of health benefits).

32. See, e.g., United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 221–24 (1940) (making no distinction between seller and buyer cartels when applying per se rule against price fixing); see also infra note 48 (discussing analysis of naked price fixing by buyers).

33. Cf. Kartell, 749 F.2d at 929–32. In Kartell, Judge Breyer rejected the claim that a single powerful health insurer should be prevented under the Sherman Act from exercising its buying power to force physicians to accept its fee schedule. Id. In passing, Judge Breyer observed that Congress visualized the Sherman Act “as a way of protecting consumers against prices that were too high, not too low,” and stated that “courts at least should be cautious—reluctant to condemn too speedily—an arrangement that, on its face, appears to bring low price benefits to the consumer.” Id. at 931.
Judging from both antitrust experience and economic theory, buyer cartels are generally less common and less troublesome than seller cartels. One reason why buyer cartels are relatively rare is that buyers are generally more numerous than sellers and are harder to organize into powerful buying units. For example, if a product has multiple uses, buyers of a high percentage of its output are unlikely to be organized in trade associations or other organizations under whose auspices they might develop effective cartels. Indeed, it appears unusual for firms not competing in downstream markets to jointly purchase an input that each requires. It is a tribute to the high cost and intractable nature of health care that firms having no other affinity or competitive relationship have found it expedient to organize themselves in coalitions or cooperatives to improve their ability to purchase health care.

That joint purchasers of health care generally do not compete with each other downstream is significant for antitrust analysis. In fact, most antitrust cases challenging joint purchasing have involved buyers who were also competitors in downstream markets. And, indeed, cooperative purchasing by firms that also compete as sellers may diminish competition downstream by making the input costs of the collaborators more uniform, thus facilitating coordination of their selling prices. Antitrust enforcers focus on this aspect of joint purchasing by inquiring into the input’s significance as a factor in prices in the downstream market. Because health care

34. See Jacobson & Dorman, Joint Purchasing, supra note 10, at 11–12 (noting buyer concentration generally lower than seller concentration in U.S.).

35. In the health care sector, hospitals (both competing and noncompeting) frequently collaborate in purchasing inputs, raising antitrust questions. Groups organized to purchase hospital supplies may include noncompeting hospitals. See, e.g., White & White, Inc. v. American Hosp. Supply Corp., 723 F.2d 495, 508–09 (8th Cir. 1983) (allowing joint purchasing of supplies by organization with national membership). Although joint purchasing of nursing services is likely to involve competing hospitals, it would probably fall within the safety zone for joint purchasing recognized by antitrust agencies. See infra note 37 (describing parameters of safety zone). In any event, such cases would turn mostly on the exercise of buying power. See, e.g., All Care Nursing Serv. v. Bethesda Memorial Hosp., 887 F.2d 1535, 1539 (11th Cir. 1989) (refusing to apply per se rule to hospital joint purchasing of temporary nursing services from nurse staffing agencies); see also Daniel Sullivan, Monopoly Power in the Market for Nurses, 32 J.L. & ECON. S135, S140 (1989) (finding hospitals enjoy significant monopoly power in purchasing nurses’ services); cf. Utah Hospitals Resolve DOJ Charge of Exchanging Nurse Salary Data, 3 Health L. Rep. (BNA), at 333 (Mar. 17, 1994) (reporting consent decree to protect hospital competition in hiring nurses).

36. Jacobson & Dorman, Joint Purchasing, supra note 10, at 30 (reporting “in most of the cases where joint purchasing has been condemned per se, the illegal activity appears to have been simply one aspect of a sellers’ cartel”).

37. See U.S. Dept of Justice & U.S. Fed. Trade Comm’n, Statements of Enforce-
is only a small proportion of input costs, joint purchasing of health care should raise no antitrust problem of this kind even if some of the collaborating employers—say, several local banks—were also competitors in output markets. 38

Buyer cartels are also uncommon because it is counterproductive in the long run for buyers to exploit their suppliers. Although a buying cartel could deprive sellers of a full return on their past investments, the main result of their effort might be that suppliers leave the market, cease making new investments, or allow quality to deteriorate. In other words, buyers may often find that the elasticity of supply substantially limits their ability to exercise monopsony power. An interesting question is whether, in general, buyers' interests diverge more from each other than sellers' interests, making buyer cartels relatively harder to organize. It seems probable, however, that employers, unless colluding to standardize fringe benefits in the labor market, would usually find it hard to agree on a common cartel policy in purchasing health care.

Although buyer price fixing can sometimes be as objectionable as seller collusion, most economic analysts appear less concerned that buyer cartels will go unpunished under antitrust law than that efficiency-enhancing joint purchasing will be discouraged by antitrust threats. 39 The desirability of purchaser collaboration is particularly clear in the health care sector. Not only would purchasers derive efficiencies from sharing information and from collectively developing and exercising special skills in negotiating and contracting for health care, 40 but the policy objections to the exercise of monopsony power are somewhat weaker in the case of health ser-

38. See Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, to Andrew N. Meyercord, Esq. (Mar. 23, 1994), reprinted in 6 Trade Reg. Rep. (CCH) ¶ 44,094, at 43,337 ("[A]lthough some current Coalition members are direct competitors, the members' cost of purchasing health care benefits accounts for only a small percentage of the selling price of the products and services they provide.").

39. E.g., Jacobson & Dorman, Joint Purchasing, supra note 10, at 79 (concluding "[b]uying-side restraints do not usually harm competition").

40. See infra notes 49–55 and accompanying text (asserting joint purchasing is procompetitive because of scale economies).
vices than in other markets. Indeed, it cannot be assumed that any output reductions resulting from health care purchaser collaboration would represent a loss of efficiency in resource allocation. Although antitrust law should probably not be bent to accommodate this reality, the point needs to be explored.

As it currently operates, the market for health coverage is widely suspected of causing an overcommitment of resources to health care uses. Indeed, a prominent reason for organizing coalitions or cooperatives is that health services are currently overproduced or produced in overly costly forms. Purchasers may therefore actually desire to reduce supply and to discourage of new investment. Even viewing the matter independently in terms of workers’ interests, purchasers might reasonably believe that the highest level of apparent quality in health care is not always worth its marginal cost. They might therefore seek optimal quality not by paying top dollar but by selective purchasing with good information and by concentrating purchases to achieve scale economies. Thus, purchasers may not be troubled by some suppliers’ departure from the market, by output reductions of certain services, or by the discouragement of some new entry or investment. Even though these are the usual consequences of the exercise of monopsony power, such effects from joint purchasing of health care may be evidence of nothing more than an effective demand-side response to the extraordinary difficulty of buying optimal health care.41

Thus, even if joint purchasers exercise some monopsony power, they might argue that it is not being abused and that they are using it only to correct the chronic overproduction of health services induced by third-party payment.42 Although concerted exercise of

41. For a full discussion of “contract failure”—specifically, the practical failure of buyers to write contracts with providers or payers that adequately specify the nature, scope, and content of the services to be supplied and paid for when needs arise—as a principal cause of excessive spending on health care in the United States, see CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 11–38, 110–53 (1995); CLARK C. HAVIGHURST, PROSPECTIVE SELF-DEFEATED: CAN CONSUMERS CONTRACT TODAY TO ACHIEVE HEALTH CARE RATIONING TOMORROW?, 140 U. PA. L. REV. 1755, 1771–82 (1992).

42. For a graphic demonstration of welfare loss resulting from overconsumption induced by moral hazard and underpricing of health services to insured individuals, see CLARK C. HAVIGHURST, THE ROLE OF COMPETITION IN COST CONTAINMENT, IN COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE 359, 361–63 (Warren Greenberg ed., 1978). In theory, a coalition might use its market power solely to offset the chronic misallocative effects of moral hazard and contract failure. As Mark V. Pauly states, however: “Buyer market power may be efficiency-improving if its exercise . . . stops when provider price has been pushed to the competitive level. Unfortunately, there is no particular reason why the buyer should stop at this point.” Pauly, supra note 11, at 259. Nevertheless, there is a good probability that a
market power is usually not defensible on the ground that it is used for socially desirable ends, there is a possibility that courts could be persuaded to tolerate some monopsonistic joint purchasing in the health care sector. Nevertheless, a full-scale economic analysis of the social benefits and harms of health care joint purchasing would be extraordinarily complex. It would, for example, have to recognize that in some circumstances price discrimination can offset the output-limiting effects of market power, thus improving the situation from the standpoint of allocative efficiency. On the other hand, price discrimination by a monopsonist would increase its ability to capture producer surplus and might (or might not) be objectionable on that account.

In any event, because antitrust analysis generally focuses only on effects on competition and not on social welfare, it would be difficult to argue that price discrimination, even if it ameliorates the misallocative effects of market power, excuses its otherwise unlawful exercise. Moreover, the difficulty of making overall welfare as-

collection would leave the allocative situation better than it found it. If so, economic experts might testify that the coalition's efforts were procompetitive in that they produced results closer to those of an efficient market. It remains to be seen, see infra part VIII, whether the law would allow a market-failure defense for the exercise of monopsony power based on the economic theory of "second best." On the problem of second best, see generally F.M. Scherer & David Ross, Industrial Market Structure and Economic Performance 33–38 (3d ed. 1990).

43. In a classic early opinion, Judge William Howard Taft observed that allowing trade to be restrained for any worthy (as opposed to a procompetitive) purpose would be to "set sail on a sea of doubt" and to rely upon "the vague and varying opinion of judges as to how much, on principles of political economy, men ought to be allowed to restrain competition." United States v. Addyston Pipe & Steel Co., 85 Fed. 271, 283–84 (6th Cir. 1898), aff'd, 175 U.S. 211, 246 (1899). In a more recent case, the Supreme Court refused even to listen to a claim by an organization of professional engineers that competitive bidding for engineering services (which the organization had suppressed) would lead to poor quality engineering work and endanger public safety. The Court said that the claim was "nothing less than a frontal assault on the basic policy of the Sherman Act." National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 695 (1978).

44. To the extent that a monopolist can find ways to charge a lower profitable price to potential buyers who resist paying the monopoly price, output need not suffer. Similarly, a monopsonist, identifying sellers unwilling to sell at its profit-maximizing price, should be glad to pay them more to induce a more nearly optimal level of output. See generally Scherer & Ross, supra note 42, at 489–515 (discussing price discrimination by sellers). Although price discrimination is often infeasible because buyers paying low prices can resell to others, such arbitrage is no problem in the health care field where services and not commodities are involved. Not only is some price discrimination feasible in health care markets, but it is also quite common. See infra text at notes 86–87 (discussing why coalitions may engage in price discrimination).

45. See supra note 31 (describing how monopsonists gain "producer surplus" by manipulating prices).
sessments is usually deemed reason enough for not embarking on such inquiries in applying antitrust laws. Even though buyers of health care might argue convincingly that their joint purchasing only offsets the output-increasing effects of moral hazard, antitrust law is incapable, both in principle and in practice, of weighing such a defense.

IV. ESTABLISHING A PROCOMPETITIVE PURPOSE IN HEALTH CARE JOINT PURCHASING

Price fixing by buyers has been subject to many fewer antitrust actions than has price fixing by sellers. Nevertheless, it is clear that at least some naked agreements by buyers to depress sellers' prices are unlawful per se.46 One thorough analysis of the case law concludes that a per se violation is likely to be found when (1) the restraint is naked, lacking a plausible efficiency justification; (2) the collaborators possess substantial buying power; and (3) the collaborators also compete in a downstream output market.47 Although employers jointly purchasing health care might take comfort if the last of these conditions is not satisfied in their case, that condition is not crucial. Moreover, a substantial argument can be made for condemning truly naked joint purchasing per se without regard to the second condition—that is, whether substantial buying power was being exercised in fact.48 Joint purchasing nearly always occurs, however, in a context in which procompetitive justifications

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48. Just as a naked conspiracy to fix selling prices offends the basic policy of preserving independent decision making by competitors, a naked agreement to depress purchase prices may likewise be condemned because it threatens competition. Naked price fixing by sellers is condemned under onerous criminal penalties even if wholly ineffectual, because it threatens "the central nervous system of the economy." United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 234 n.59 (1940); see also id. at 221, 223–24 (formulating per se rule in terms that make no distinction between seller and buyer cartels and that minimize significance of power to "control" market). The leading case condemning a buyer cartel, Mandeville Island Farms, is often construed likewise to focus on nakedness alone. See 334 U.S. at 235. Nevertheless, because nakedness is unlikely to be clear in a joint purchasing case, see infra note 56, a plaintiff would probably be expected to produce evidence of the collaborators' market power to survive summary judgment. See Arquit, supra note 12, at 48,804 ("Substantial evidence that the defendants possessed and exercised monopoly power figured prominently in many of the cases holding purchasing conspiracies unlawful."). In any event, evidence showing market power is helpful in judging the purposes of the collaborators and in estimating the probable effects of their joint action.
are plausible and nakedness can be disputed.\textsuperscript{49} This appears especially true in the case of health care.

Joint purchasing in the health care field is clearly efficiency-enhancing in many circumstances. Thus, hospitals have been permitted to realize scale and other economies through joint purchasing of supplies and other inputs.\textsuperscript{50} Health insurers freely aggregate the purchasing power of individual consumers in acting as bulk purchasers of health services on consumers' behalf.\textsuperscript{51} Employer co-

\textsuperscript{49} The law has had considerable experience with joint selling agencies. In Appalachian Coals, Inc. v. United States, the Supreme Court treated some very minor and otherwise attainable benefits of joint selling in a difficult market as justifications for allowing a high percentage of coal sellers to market through a single agent. 288 U.S. 344, 373–78 (1933). Although joint purchasers of health care could, with much greater plausibility, cite major dysfunctions in the market as potential justifications for joint buying, the Appalachian Coals case is generally understood as an aberration occasioned by the Great Depression. More recent precedent places a heavy burden on joint selling agencies. E.g., Virginia Excelsior Mills, Inc. v. FTC, 256 F.2d 538, 539–41 (4th Cir. 1958). Nevertheless, a joint selling agency is entitled to be evaluated under the rule of reason if its sponsors' purposes are not obviously anticompetitive. E.g., NCAA v. Board of Regents, 468 U.S. 85, 98–104 (1984). In Broadcast Music, Inc. v. CBS, 441 U.S. 1, 21–32 (1979), however, the Supreme Court declared that a performing-rights society was "not really a joint sales agency" and implied such characterization would jeopardize its status; instead, it stressed the society's ability to offer a unique and desirable new product. Joint purchasers of health care could claim a somewhat analogous ability to negotiate collectively for the purchase of a unique mix of health services and cost controls rather than simply agreeing to pay for all conventionally prescribed services.

\textsuperscript{50} See supra note 35 (noting frequent collaborations by hospitals in purchasing inputs). Antitrust enforcement officials have indicated periodically that joint purchasing by hospitals is not discouraged except where market power is present. See Compendium, supra note 12, at 57, 138, 142–44, 179–81; Arquit, supra note 12, at 48,802–06. On the other hand, the agencies have expressed concern about and acted against hospital joint purchasing of temporary nursing services from nurse staffing agencies. See supra note 35 (citing consent decree between DOJ and Utah hospitals regarding sharing of nurse salary data).

\textsuperscript{51} The integration of individual consumers of health care for providing health insurance has an efficiency rationale well beyond the exercise of monopoly power. See, e.g., Kartell v. Blue Shield of Mass., 749 F.2d 922, 924–29 (1st Cir. 1984) (allowing single insurer covering high percentage of consumers in state to act as purchasing agent for those consumers), cert. denied, 471 U.S. 1029 (1985); Webster County Memorial Hosp., v. United Mine Workers Welfare & Retirement Fund, 536 F.2d 419, 420 (D.C. Cir. 1976) (per curiam) (treating labor union's health plan as "a group buying agent negotiating a price for medical care on behalf of its beneficiaries"). A series of decisions have permitted insurers to bargain with competing pharmacies on behalf of their insureds. E.g., Royal Drug Co. v. Group Life & Health Ins. Co., 737 F.2d 1433, 1436–37 (5th Cir. 1984), cert. denied, 469 U.S. 1160 (1985); Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Conn., 518 F. Supp. 1100, 1106 (D. Conn. 1981), aff'd per curiam, 675 F.2d 602, 605–06 (2d Cir. 1982). By vindicating health insurers' efforts to act as purchasing agents for their insureds, these pharmacy cases served as important precedents allowing insurers finally to engage in selective purchasing of hospital and physician services. See, e.g.,
alitions and purchasing cooperatives likewise aggregate purchasing power, again for purposes that are at least arguably procompetitive. By achieving economies of scale in collecting and evaluating cost and quality information, coalitions and cooperatives allow individual purchasers to exercise a higher degree of sophistication in purchasing complex services.

Some of the efficiency claims of employer coalitions and purchasing cooperatives may relate to managing competition and not to actual joint purchasing of health care. Nevertheless, joint purchasing yields significant economies of its own. In the case of health care, it lowers administrative costs for the individual employers who need not employ personnel knowledgeable about health care purchasing and capable of conducting sophisticated negotiations. In addition, joint purchasing may enable purchasers to offset certain inherent advantages that providers of health care enjoy by virtue of the difficulties that purchasers face in writing and administering prospective contracts for health services. Although a purchasing cooperative comprising only small employers and consumers ill-equipped to purchase health care individually could make the strongest claim of procompetitiveness, all health care joint purchasers should be able to arrange their efforts so that courts will regard

Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 353 (1982); Barry v. Blue Cross of Calif., 805 F.2d 866, 872–74 (9th Cir. 1986); Ball Memorial Hosp., v. Mutual Hosp. Ins., 784 F.2d 1325, 1334 (7th Cir. 1986). See generally Rovner, supra note 11, at 873–80 (asserting monopoly power should be accorded per se legal antitrust treatment). The history of private health insurance vividly demonstrates how, without insurer efforts to purchase care from sellers on a competitive basis and to steer insureds to lower-cost providers, health care markets became uncompetitive with dire consequences for the cost of health care. See generally Clark C. Havighurst, The Questionable Cost-Containment Record of Commercial Health Insurers, in HEALTH CARE IN AMERICA, supra note 30, at 221, 224–29.

52. See, e.g., COMPENDIUM, supra note 12, at 31, 35, 43, 88–92 (collecting sources); see also Arquít, supra note 12, at 48,605 ("[A]lthough we [the FTC staff] have acted aggressively against naked conduct [by nursing homes conspiring to reduce payments for nursing services], we have not seen truly integrated group buying activities in health care that have raised competitive concerns.").

53. In Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284 (1985), the Supreme Court acknowledged certain economies associated with group purchasing as follows: "The [cooperative] arrangement permits the participating retailers to achieve economies of scale in both the purchase and warehousing of wholesale supplies, and also ensures ready access to a stock of goods that might otherwise be unavailable on short notice." Id. at 295. Because health care involves services rather than goods, its purchasers cannot demonstrate economies of these precise kinds.

54. See Arquít, supra note 12, at 48,802–03 (observing potential savings by coalitions in transaction costs and benefits sellers can derive from dealing with smaller number of purchasers).

55. See supra note 41 (noting discussions of contract failure).
their basic purposes as procompetitive enough to escape per se illegality. Moreover, the efficiencies derivable from collaboration in purchasing health care are clear enough to carry substantial weight in any balancing of procompetitive and anticompetitive effects under the rule of reason.

V. Measuring Joint Purchasers' Market Power

Analyzed under the rule of reason, the legality of joint purchasing of health care will turn significantly on the degree of buying power the collaborators collectively can wield. Without market power, there is no danger that competition will be harmed. Also, in the absence of market power, courts have every reason to believe that efficiency, not exploitation of sellers, is the parties' true object and the coalition's dominant effect. If the parties do possess some market power, however, their purposes must be scrutinized more closely, and the probable procompetitive effects of their endeavors must

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56. In some recent horizontal restraint cases, the Supreme Court has been careful about automatically applying per se rules. See, e.g., FTC v. Indiana Fed'n of Dentists, 478 U.S. 447, 458–59 (1986); NCAA v. Board of Regents, 468 U.S. 85, 100–01 (1984); CBS, Inc. v. NCAA, 441 U.S. 1, 7–18 (1979). In Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 351–57 (1982), Justice Stevens purported to apply a per se rule but carefully and accurately assessed the defendants' claims of procompetitiveness before rejecting them. In NCAA, the Court refused to condemn automatically the joint marketing of rights to televise college football games even though it perceived that joint marketing served no efficiency-enhancing purpose. 468 U.S. at 98–104. The Court seemed to think that the naked restriction on competitive bidding by colleges should not be subjected to a per se rule because the NCAA served other, clearly procompetitive, functions. Id. Similarly, joint purchasing of health care might escape per se condemnation simply because it serves many procompetitive purposes. Nevertheless, even though the Court in NCAA purported to apply the rule of reason, it ended up rejecting all the defendants' arguments on behalf of their joint marketing scheme for essentially the same reasons that per se rules have traditionally foreclosed such defenses. Id. at 103–12. Indeed, despite what the Court said it was doing, it appears to have applied a close equivalent of a per se rule.

More recently, the Court has applied a per se rule when a closer look was arguably more appropriate. See, e.g., Palmer v. BRG of Ga., Inc., 498 U.S. 46, 49–50 (1990) (per curiam) (treating restraint easily condemned as merely overbroad as a per se violation without regard to business purpose); FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411, 421–25 (1990) (overlooking fact that market power could not be presumed as usual on basis of defendants' attempt to fix prices since defendants had alleged a plausible objective other than restraint of trade). The lesson for joint purchasers of health care is that they must be prepared to demonstrate efficiencies and procompetitiveness specifically attributable to joint purchasing.

For an example of the influence of the recent cases and particularly of Northwest Stationers on the application of per se rules to hospital joint purchasing, see All Care Nursing Serv. v. Bethesda Memorial Hosp., 887 F.2d 1535, 1539–41 (11th Cir. 1989) (Tjoflat, C.J., concurring).
be weighed against the potential for anticompetitive harm. In a proper antitrust analysis, market power is only one element in a complex inquiry, not the bottom line. But there are many instances in which market power will determine the legal outcome.

Antitrust enforcement agencies, courts, and antitrust theorists have had only limited experience in measuring monopsony power and establishing an appropriate antitrust threshold for power exercised by joint purchasers.\(^\text{67}\) The Department of Justice, however, has employed a bright-line test under which collaborating buyers representing no more than thirty-five percent of the purchases in the relevant market are presumed incapable of exercising monopsony power.\(^\text{68}\) Such a test seems precise because it employs hard

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\(^{67}\) Significant progress has been made in recent years in assessing the market power of sellers, especially in the evaluation of horizontal mergers. See U.S. Dept of Justice & U.S. Fed. Trade Comm'n, Horizontal Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13104 (May 5, 1992) [hereinafter Merger Guidelines]. In merger analysis, however, the concern is that concentration in the sellers' market may facilitate various kinds of collusion, including tacit coordination of pricing policies. Because buyers are usually in a poor position to coordinate their offers to sellers, there is less danger of tacit collusion. Thus, tests and thresholds used in merger analysis are inappropriate in assessing the market power of a cooperative purchasing group. See infra text accompanying notes 66–69 (discussing more appropriate indicia of market power such as elasticity of supply and demand).

Economists have also made progress in assessing the market power of putative monopolists. See, e.g., William M. Landes & Richard A. Posner, Market Power in Antitrust Cases, 94 HARV. L. REV. 937, 962–76 (1981) (observing significance of marginal fringe of sellers and of supply and demand elasticity in measurement of single seller's power and suggesting tests for estimating same). Other commentators have adapted such thinking to the task of measuring monopsony power. See Blair & Harrison, Cooperative Buying, supra note 10, at 349–60; Jacobson & Dorman, Joint Purchasing, supra note 10, at 5–16.

\(^{68}\) See 1994 Health Care Policy Statements, supra note 37, at 20,785 (recognizing antitrust safety zone for joint purchasing providers if purchases “account for less than 35 percent of the total sales of the purchased product or service in the relevant market”); COMPENDIUM, supra note 12, at 143 (DOJ official applying 35% test to hospital joint purchasing); Arquit, supra note 12, at 48,804 (observing some cooperatives exceeding 35% threshold may also escape challenge because “the Department examines market structure and performance characteristics in reaching a final judgment”). Additionally, the DOJ uses a 20% test where purchasers are also competitors in downstream markets. See 1994 Health Care Policy Statements, supra note 37, at 20,785; see also COMPENDIUM, supra note 12, at 10–11 (1985 FTC advice letter, approving arrangement under which health insurers accounting for up to 20% of commercial health insurance market combined for purposes of dealing with providers); id. at 14–15 (1986 FTC advice letter, permitting health insurer to represent employers representing up to self-imposed limit of 20% of area population); id. at 16–17 (1986 FTC advice letter, approving arrangement in which all community employers may combine for bargaining with providers but would not represent more than 15% of area's total population; 15% figure noted with approval but not treated as ceiling).

From these and other sources, it appears that lawyers may be advising clients
numbers in the form of market share percentages. These numbers are no more valid as indicators of actual market power, however, than the methodology used to define the relevant market and to assign market shares. Moreover, even with a well-defined market, buying power depends heavily on additional circumstances.

The first question in defining the relevant market is how far to disaggregate into separate markets the different health services being purchased collectively—that is, whether to treat all physician or all hospital services as the relevant product market or to look separately at each discrete service providers offer. As a purely technical matter, antitrust analysis should focus on the joint purchasers' power with respect to each discrete service. It is not clear, however, that courts would refine the issue to that extent. In analyzing hospital mergers, antitrust agencies and courts have tended to focus on so-called "cluster markets," such as all acute inpatient hospital services.\(^5\) Defining the market this way effectively averages market shares in several distinct markets, obscuring the worst effects of the merger and effectively circumventing the general antitrust rule that anticompetitive harms in one market are not redeemable by showing procompetitive benefits in another.\(^6\) It would be unwise to assume, however, that a court would employ the cluster-market approach exclusively in a joint purchasing case, particularly one brought by providers of a specific service. On the other hand, if the joint purchasers negotiated prices on something other than a service-by-service basis, their power might be judged accordingly. Thus, if there were specific markets in which the joint purchasers might be judged to possess market power, they should attempt to

that employers aggregating no more than 20% of the consumers of health care in an area may safely combine for joint purchasing. The Justice Department's 35% rule of thumb suggests, however, that counsel, cautiously relying on instances in which downstream competition was also a concern, may be leaving an unnecessarily large margin for error. In fact, given the prominence of government as a purchaser (and assuming, as discussed below, that government purchases belong in the denominator), few coalitions would be likely to surpass even the 20% market share figure in any market.

For a well-documented argument that the proper threshold of concern about buying power should be in the 40–50% range, see Jacobson & Dorman, Joint Purchasing, supra note 10, at 58–60. Areeda and Turner propose a 25% threshold. 4 Philip Areeda & Donald F. Turner, Antitrust Law: An Analysis of Antitrust Principles and Their Application ¶¶ 964–965 (1980).


60. See infra note 77 and accompanying text (discussing impropriety of netting effects across markets).
package their purchases to avoid the charge that they were exercising that power. 61

Another important factor in assessing joint purchasers’ market power—possibly a crucial one—is whether the denominator used in calculating their market share should include services paid for under government programs or only privately financed services. 62 Because a court is primarily concerned about sellers’ market opportunities, it could probably be persuaded to include purchases by these other buyers in its calculation. 63 In response, physicians and hospitals would probably complain that government programs themselves exercise monopsony power unassailable under antitrust law, even to the extent of necessitating “cost shifting” by exploited hospitals. 64 However, the factual validity and legal relevance of this argument are uncertain.

One issue would be whether letting employers combine for the purpose of joint purchasing would so concentrate the remaining portion of the market that competition would be endangered through a few buyers’ coordinated pricing. Although antitrust law has always been concerned about concentration in sellers’ markets (as distinct from the market share of an individual seller), this concern is prompted by increased danger of collusion and coordi-

61. The less-restrictive-alternative requirement, applied to joint purchasing of health care in Part VI of this Article, might require the bundling of purchases to minimize the effectiveness of market power.

62. Because government finances a large proportion of services, inclusion of its share of purchases would probably dilute the joint purchasers’ market share to a point where it would seem insignificant. For example, in one case a health insurer covering 74% of the privately insured population accounted for only 13–14% of “physician practice revenue.” Kartell v. Blue Shield of Mass., 749 F.2d 922, 924 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985). On the other hand, if the market was disaggregated, there might be some services—e.g., obstetrical care, which Medicare patients have few occasions to consume—of which the joint purchasers were a relatively large buyer.

63. An argument for their exclusion might be based, however, on elasticity of demand. If these other buyers would not step up purchases even if prices fell appreciably, their presence would not represent a significant check on the coalition’s market power. See infra notes 75–76 and accompanying text (discussing demand elasticity and its effect on buying power). This would justify their exclusion from the relevant market. Cf. United States v. Aluminum Co. of Am., 148 F.2d 416, 424–26 (2d Cir. 1945) (excluding recycled aluminum from market in judging Alcoa’s monopoly power; in fact, inclusion of inelastic supply would not have accurately reflected Alcoa’s pricing freedom).

64. Presumably hospitals have no right to use the antitrust laws to keep private-sector purchasers powerless to resist paying supracompetitive prices to finance uncompensated care or to keep themselves solvent in the face of powerful government purchasers. Indeed, unless private purchasers actively resist such impositions, hospitals will have no need to operate efficiently.
nated pricing in oligopolistic markets. Courts, however, have rarely identified comparable risks of undetectable collusion or coordination in markets characterized by oligopsony—that is, a small number of purchasers. Enforcement agencies and courts probably will begin measuring the market power of joint purchasers by referring to their market share only in broadly defined markets.

Although many analysts’ efforts to measure market power seem to stop with the definition of a market and the calculation of the defendants’ market share, these are only the first steps in a sophisticated analysis. In view of the inevitable weakness of any market definition, an analyst must also consider elasticities of supply and demand. One analysis suggests a method for calculating a “buying power index” incorporating these factors. Although calculating actual elasticities is difficult, the approach is useful. Indeed, the referenced source demonstrates how, with different elasticities, a buying group with a twenty-five percent market share in one market could actually exercise more market power than a group making seventy-five percent of the purchases in another market.

Elasticity of supply is the rate at which sellers’ output drops as price is lowered. If supply elasticity is high, the quantity or quali-

65. See, e.g., Merger Guidelines, supra note 57, § 0.1, at 20,571 (“In some circumstances, where only a few firms account for most of the sales of a product, those firms can exercise market power . . . by either explicitly or implicitly coordinating their actions.”).

66. But see id. (noting market power might be exercised by “a coordinating group of buyers” to depress prices). An antitrust issue might arise, however, if joint purchasers act in concert with other large buyers such as Blue Cross and Medicare—for example, by following Medicare’s lead in setting fee schedules for physicians or DRG allowances for hospitals.

67. For instances in which an antitrust agency has evaluated employers’ joint buying of health services by specific reference to the percentage of the total population of the area represented by their covered employees, see supra note 58. Obviously, such a denominator would be highly favorable to joint purchasers. In view of this measure’s weak theoretical basis, however, it would be unwise for joint purchasers to rely on the agencies or courts to employ it in a close case. Agencies and courts are more likely to calculate market shares in terms of dollar volumes or units of specific services (hospital admissions, patient days, office visits, procedures, etc.). Because these measures will not always yield similar market shares, legal advisers should be alert to their significance.

68. Blair & Harrison, Cooperative Buying, supra note 10, at 349–64; see also Pauly, supra note 11, at 263–65 (“Market power . . . varies inversely with the market elasticity of supply and with the input demand elasticity of other firms, and directly with the [monopsonist’s] market share.”).

69. Blair & Harrison, Cooperative Buying, supra note 10, at 358.

70. See supra note 29 (noting price depression reduces elastic supply). Supply elasticity is in part a function of sellers’ marginal costs—that is, the cost at any level of output of producing additional units. As noted by Arquit, “Monopsony power realistically can be exercised to lower price only where marginal costs are increasing,
ty of the goods or services produced would decline significantly as purchasers collectively attempt to drive the price down. In a highly elastic market, purchasers may not possess enough market power to invalidate an otherwise procompetitive collaboration. 71 On the other hand, if purchasers can force prices significantly below competitive levels without drying up supply or eroding quality, their cooperative buying cannot be considered more procompetitive than anticompetitive.

Supply elasticity is a function of technology. It varies with the ability of marginal sellers to put their resources to alternative uses, either producing other products and services or removing their capacity to another geographic market. For example, hospitals may be particularly vulnerable to exploitation by buyers. To the extent that they have substantial investments in highly specialized, immobile equipment, they have no alternative but to continue selling their services as long as they can recover at least their out-of-pocket costs. Because their “sunk costs” will not influence their decisions whether to remain in the market, a powerful purchasing cooperative should be able to extract significant price concessions. Although hospitals facing a monopsonist will be slow to make new capital investments and to replace obsolete equipment, cooperating buyers may still profit in the short run. Indeed, because supply elasticity is quite low for some hospital services, joint purchasers may be in a better position to exercise monopsony power in procuring those services than their market share, standing alone, would indicate.

The supply of most physician services, on the other hand, seems somewhat more elastic than that of many hospital services, making physicians less vulnerable to exploitation. 72 Although many physicians have incurred significant sunk costs in building successful practices, others have a lesser stake and can readily relocate their practices to better markets. In addition, physicians can work shorter hours if prices fall. 73 Finally, a price decline

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71. See Blair & Harrison, Cooperative Buying, supra note 10, at 352 (“[A]s supply elasticity increases, the firm’s monopsony power declines. Put differently, if sellers can curtail their output relatively sharply when buyers offer less, buyers can hardly be said to have much control over price.”).

72. Pauly still sees a problem, however, arguing that “physicians have upward sloping supply curves because of the increasing marginal disutility of work.” Pauly, supra note 11, at 262; cf. Sullivan, supra note 35, at S172–75 (finding hospitals can exercise monopsony power vis-à-vis nurses).

73. Economists have speculated that the supply curve for physician services may
might diminish the flow of new physicians needed to maintain an adequate level of output. In general, because physicians' main investments are in human capital readily transportable to other markets, the ability of cooperating buyers to exploit physicians remains a substantial empirical question.\textsuperscript{74}

Demand elasticity—the willingness of other buyers in the market to increase their purchases if prices fall—is another factor that can affect the market power of a purchasing group. If other buyers would increase their consumption substantially at moderately lower prices, sellers could resist most of the concessions demanded by the purchasing group. As a result, overall output would not fall appreciably. In health care markets, however, demand elasticity is likely to be very low, because most patients have public or private health coverage and are therefore relatively insensitive to price changes.\textsuperscript{75} Although lower prices might enable a few uninsured persons to purchase services they could not previously afford, it does not follow that joint purchasers' market power would be significantly diluted.

Although joint purchasers' buying power will vary from service to service, there might be some discrete markets in which joint purchasers could exercise substantial monopsony power even with a market share below the thirty-five percent threshold employed by the government to evaluate joint purchasing. Specifically, a coalition or cooperative with only a modest market share might be able to control price and reduce output in those markets in which both

be “backward-bending,” meaning that physicians will actually work longer hours if prices fall, in order to maintain their “target income.” See Paul J. Feldstein, Health Care Economics 165–67 (1979). If this condition prevails in fact, joint purchasing of physician services would probably be favorably viewed for antitrust purposes. A countervailing concern, however, is that physicians may step up “unnecessary” services whenever they feel a need to maintain their incomes. See id. at 167. For the beginning of such an analysis, see Pauly, supra note 11, at 282 (considering implications of insurer monopsonist's practices but observing that "even if an insurer was controlled by consumers (as a purchasing cooperative might be deemed to be), it would still behave as a full monopsonist if it acted in consumers' interest").

\textsuperscript{74} Of course, if physicians have been accustomed to supracompetitive profits, they will be inclined to believe that they are being unfairly victimized by joint purchasers and to invoke antitrust laws to protect themselves. Later discussion addresses the prospects for getting such cases dismissed quickly before heavy legal costs are incurred. See infra part VII.

\textsuperscript{75} If providers can control patient demand for their services, they may be able to displace onto other payers the expense of any reduction in output forced upon them by a hard-bargaining coalition or cooperative. If demand elasticity existed because of provider control of demand, it would be proper to conclude that joint purchasers, even with a large market share, lacked the power to dictate price. This empirical issue could become a major battleground in health care joint purchasing litigation. For example, one could question why the power to control demand, if it exists, was not fully exploited previously.
supply and demand elasticity are low, as in the case of some hospital services. Moreover, an antitrust plaintiff may supplement economic evidence of the purchasers' power in such markets with evidence that the purchasers believed they possessed market power. Indeed, it would be nearly impossible to organize a joint purchasing effort without leaving a trail of "intent" evidence, such as written statements by members to the effect that their goal was to exercise bargaining power. To be sure, collaborators may overestimate the advantages of group purchasing or mistakenly attribute to buying power benefits that flow principally from increased sophistication and efficiency. Nevertheless, collaborators' efforts to recruit each other to the collective effort could prove embarrassing when recalled before an antitrust court.76

If joint purchasers wield monopsony power in only one of the many markets in which they purchase, antitrust analysis would be concerned with that market alone. It is settled doctrine that harms to competition in one market cannot be justified by benefits of concerted action in another.77 Thus, joint purchasers must be concerned that even though their effort has many procompetitive features, a court would find that they possess enough market power in one or more markets to permit an antitrust challenge to proceed. It is not entirely safe, therefore, for joint purchasers to rely too heavily upon the Department of Justice's thirty-five-percent safe harbor as assurance that a court would find them incapable of exercising market power.

VI. RECONCILING POWER AND PURPOSE: LOOKING FOR LESS RESTRICTIVE ALTERNATIVES

Many discussions treat market power as determinative of the legality of joint purchasing under the antitrust laws. Disregarding both the uncertainty of power measurements and the fact that mar-

76. Some commentators and courts discount the probative value of intent evidence in antitrust cases, see, e.g., RICHARD A. POSNER, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 189 (1976), but most courts probably would deem such evidence relevant in determining whether individual members joined the coalition for anticompetitive or procompetitive purposes and in determining which effects are most likely to predominate.

77. United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 370 (1963) (rejecting idea that "anticompetitive effects in one market could be justified by procompetitive consequences in another"); see also United States v. Topco Assoc., 405 U.S. 596, 610 (1972) (stating principle but misapplying it to condemn joint venture where joint venture's private-label products were subsumed in grocery market). The principle applied here is essentially the same as that under which courts reject "worthy purposes" as a defense to otherwise unlawful restraints of trade. See supra note 43 and accompanying text (observing origins of worthy purpose defense).
ket power is usually a matter of degree, such discussions commonly imply that power, once found, invalidates the collaborative effort. For example, an FTC staff member, while expressing a generally favorable view of joint purchasing by coalitions, implied in a 1992 statement that, if joint purchasers were deemed to possess market power, their effort would be challenged without regard to any procompetitive effects.79 No doubt enforcement agencies and courts engage in some result-oriented reasoning in such cases, finding power to exist only in those cases where they are unconvinced by the proffered efficiency claims. But joint purchasers must be concerned that a court or enforcement agency would make power in any affected market decisive.

However, a finding that joint purchasers are able to exercise a degree of monopsony power in purchasing one or more health services should not, and probably would not, end an antitrust inquiry. At least in theory, procompetitive effects of a collaboration can outweigh small or speculative anticompetitive effects.79 The legitimacy of letting efficiencies explicitly override some apparent risks to competition can be easily appreciated in antitrust analysis of mergers. Although market power is the central consideration in evaluating horizontal mergers, it is now fairly clear that demonstrable efficiencies can save a merger that would be otherwise condemned.80 If efficiencies can justify putting competition at some risk in merger cases, then efficiencies should be given even greater respect in evaluating competitor joint ventures under the Sherman Act's more liberal rule of reason.81 In principle, joint purchasers should be free

78. Arquít, supra note 12, at 48,804–05; see also HALPER & MILES, supra note 8, § 6.3, at 67–75 (noting antitrust risk associated with purchasing power of coalition).

79. Overcoming the contrary implication in his remarks, see Arquít, supra note 12, at 48,805, Arquít has himself provided a clear statement of the significance and cognizability of efficiencies in restraint-of-trade analysis at the FTC. See Kevin J. Arquít & Joseph Kattan, Efficiency Considerations and Horizontal Restraints, 36 ANTITRUST BULL. 717, 718–21 (1991).

80. The history of the efficiency defense in merger cases is a checkered one, and the issue is not free from controversy. See generally Timothy J. Muris, The Efficiency Defense Under Section 7 of the Clayton Act, 30 CASE W. RES. L. REV. 381, 393–416 (1980); Oliver E. Williamson, Economies as an Antitrust Defense Revisited, 125 U. PA. L. REV. 699, 703–33 (1977); 31 J. REPRINTS FOR ANTITRUST L. & ECON. 435–596 (1992) (reprinting references). Consistent with contemporary thinking and practice, the government's merger guidelines now acknowledge that, although efficiency claims should be viewed skeptically because of their speculative character, they should be given due weight in the final analysis. Merger Guidelines, supra note 57, § 4, at 20,573-11 to 20,574.

81. The legal standard used in merger analysis is more demanding than that used in analyzing concerted action under § 1 of the Sherman Act because of (1) the
to claim that their efficiencies outweigh modest anticompetitive effects. Even if they cannot use efficiencies achieved in purchasing one service to justify harm to competition in purchasing another, joint purchasers should at least be allowed to argue efficiencies within a discrete market. In general, efficiencies represent a legitimate basis for defending joint purchasing and should receive an especially sympathetic hearing from antitrust enforcers and courts when advanced in support of cooperative health care purchases.

Some analysts might ignore the possibility of an efficiencies defense for a powerful purchasing coalition because of a perception that coalition members could achieve the same efficiencies without operating on so large a scale. These analysts might argue that because the purchasers could readily reduce the size of their purchasing group or split into separate groups for bargaining purposes, there is no reason to allow them to exercise any degree of monopsony power. Such an argument invokes the requirement that collaborators pursuing a procompetitive objective must adopt a less restrictive alternative if one is available. Where a powerful joint venture threatens competition, the possibility of a smaller venture, achieving most of the benefits of collaboration without similarly jeopardizing competition, might indeed represent a less restrictive alternative that the parties should be required to adopt.

Although it would be appropriate for a court to analyze joint purchasers' alternatives in this manner, the issue would ultimately be a factual one. Contrary to some analysts' assumption, it cannot be presumed that employers could always achieve the economies of joint purchasing without ever aggregating any purchasing power. Certainly, in smaller communities it might be difficult for employers to overcome their handicaps in buying health care without approaching the threshold of monopsony power. Even in larger communities, the complexities of buying health care might warrant creating an organization large enough to exercise market power.

Clayton Act's more stringent statutory test; (2) the special concern that increased concentration of sellers brought about by mergers will facilitate tacit collusion; and (3) the greater practical and legal difficulty of undoing a merger if efficiencies do not materialize or if harms exceed expectations. On antitrust law's distinctive and favorable attitude toward efficiencies that might be yielded by competitor collaboration, see Arquít & Kattan, supra note 79, at 718–25.

82. See generally 7 AREEDA, supra note 22, ¶ 1505, at 385–89 (discussing requirement of legitimate objective not achievable by less restrictive means).

83. Similarly, merger law rejects large mergers on the ground that smaller mergers or internal growth are still available as less anticompetitive ways to achieve efficiencies of the types alleged. For examples of joint purchasers' self-imposed size limitations, apparently adopted in response to the less-restrictive-alternative requirement, see supra note 58.
Under a realistic application of the rule of reason, therefore, a coalition or cooperative should be allowed to argue that, even though it may jeopardize some competition here or there, its scale is no larger than necessary to achieve its legitimate procompetitive purposes. If the issue were framed in this way, joint purchasers might reasonably hope that the efficiencies gained by joint purchasing in general would be weighed in assessing the reasonableness of any restraint found in a specific market.

In addition to its role in determining the permissible size of a purchasing coalition, the less-restrictive-alternative requirement has an even more important role to play in the antitrust analysis of joint purchasing of health care. To appreciate what may be the most crucial issue of all in evaluating coalitions under antitrust law, it is necessary to describe more precisely what joint purchasing entails. To this point, the discussion has assumed that joint purchasers would bargain as a single unit, offering their business to providers as a block and threatening a boycott of providers who resist the joint purchasers' collective demands. Although useful for testing the legality of joint purchasing under the least-favorable circumstances, this assumption does not accurately reflect joint purchasing in the health care context. Antitrust law's less-restrictive-alternative requirement properly focuses attention on the methods that a purchasing coalition actually employs in joint purchasing. It may compel joint purchasers possessing some market power to achieve their procompetitive objectives by means that minimize its use.84

Because employers have differing preferences and interests with respect to their employees' health benefits, many would be disinclined to join a joint purchasing effort designed to maximize their collective economic advantage over providers. Specifically, employers concerned about their employees' welfare might be reluctant to participate in arrangements that award them as a block to low-bidding providers. Indeed, if a significant number of employers were to cede authority to determine employees' health benefits to a purchasing agent, it might arguably be because they were interested in eliminating health benefits as a basis on which to compete for workers.85 Absent an intent to limit competition in the labor market,

84. See, e.g., Blair & Harrison, Cooperative Buying, supra note 10, at 347 ("[If] the exercise of buying power cannot be divorced from the horizontal integration that yields the procompetitive efficiencies, then the cooperative venture should be accorded rule of reason treatment; otherwise, it is per se unlawful."). Although courts do not regularly discuss issues in these precise terms, it is possible for defendants to frame issues in this way as they attempt to demonstrate compliance with the reasonableness requirement applicable to ancillary (non-naked) restraints.

85. Agreements among employers to standardize health plan offerings could easi-
however, most joint purchasers would probably prefer to realize only procompetitive, efficiency-enhancing objectives and not to engage in collective bargaining with providers on an all-out, take-it-or-leave-it basis. These employers would insist that the coalition leave them free to decide independently whether to make the jointly bargained plan their only offering to employees or to adopt it as one of several options.

Acting independently, most employers would probably refuse to subscribe exclusively to a jointly negotiated plan unless it preserved some freedom for covered employees to patronize providers who had not agreed to the group's demands. Thus, most jointly bargained plans are likely to employ point-of-service options, such as a preferred-provider strategy under which employees may obtain care, at some additional cost, from higher-priced providers. It might appear that preferred-provider strategies represent a less restrictive alternative which defeats any claim that joint purchasing was designed principally to exercise members' buying power. Nevertheless, allowing employees to patronize nonparticipating providers at a higher price might be merely a method of price discrimination by which the coalition or cooperative, as a buyer cartel, minimizes adverse effects on output that would otherwise flow from paying monopsony prices. Indeed, courts could conceivably view joint purchasers' use of a preferred-provider strategy as evidence of a monopsonistic desire to capture producer surplus. It is not certain, therefore, that joint purchasers' adoption of a preferred-provider strategy would establish their lack of monopsonistic intent or the absence of anticompetitive effects.

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ly offend the antitrust laws because of their anticompetitive effects in the labor market without regard to any effects in health care markets. The antitrust issues surrounding explicit and implicit agreements by employers to standardize health benefits are amply discussed in Halper & Miles, supra note 8, § 6.2, at 59-67; see also supra note 31. The risk of antitrust liability for such collusion seems substantial. Indeed, joint purchasers of health care would probably possess greater market power in an unionized labor market than they could exercise in buying health services.

86. Although a cooperative organized specifically to solve the special problems of small employers might elect to engage in all-or-nothing bargaining, such a cooperative would probably do so not to exert market power but to obtain coverage that its members could not obtain individually. Most other employers would be reluctant to surrender to a coalition's full authority to design employee health benefits.

87. See supra notes 44-45 and accompanying text (discussing price discrimination).

88. Because price discrimination can sometimes alleviate adverse effects of monopsony and seems less oppressive of providers, its use might be deemed a less restrictive alternative in some circumstances. Thus, if a court were to allow an employer coalition to exercise some market power under either the ancillary-restraint doctrine or the market-failure defense outlined in Part VIII, it might find it expedi-
In any event, whenever a coalition or cooperative is in a position to exercise some monopsony power, the legality of the coalition's joint purchasing efforts under the rule of reason will probably turn on the extent to which it employs less restrictive alternatives in its dealings with members, providers, and health plans. Consequently, any large coalition or cooperative should ensure that its members retain substantial decision-making independence with respect to their employees' health benefits. Although participating employers could commit themselves in advance to offer the jointly negotiated plan to their employees, employers should not make it their exclusive offering. Thus, the coalition would not be able to promise providers exclusive access to its members' employees as a reward for agreeing to the group's terms. In addition, providers would have a realistic alternative of holding out and would feel no more than the normal competitive pressure to accept the group's offer. The joint purchasers should also refrain from agreeing to subsidize enrollment in the plan because such an agreement would unduly and unnecessarily empower the coalition or cooperative in its dealings with providers. On the other hand, if the joint purchasers agreed only to offer the plan to their employees with encouragement to accept it, and retained complete independence with respect to other matters, no antitrust problem should arise.

An instructive example of a lawful approach to joint purchasing appears in a recent DOJ business review letter approving a joint purchasing proposal by the Bay Area Business Group on Health. The joint purchasers included not only many large private employers but also the California Public Employees Retirement System (CalPERS). Consequently, the coalition represented a substantial percentage of the population eligible to purchase private health

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89. It is not enough for coalition members to avoid explicit agreements on the scope and character of their respective health benefits. They must also avoid the inference that they are colluding as buyers either of labor or of health services. On the proof of collusion by inference from circumstantial evidence, including unanimity of action (so-called "conscious parallelism"), see HALPER & MILES, supra note 8, § 6.2(c), at 62–63, app. A § 5(b), at 96–97. Some special but seemingly manageable complexities could arise if the coalition recommended and employers adopted pricing or other strategies aimed at foreclosing adverse selection in multiple-choice situations.

coverage in several geographic markets (twenty-four percent in Sacramento). Yet, because the coalition left each employer free to choose the specific HMOs (among thirty-five with which the coalition proposed to negotiate) that it would offer its employees at coalition-negotiated prices, the plan did not represent an abuse of market power. In addition, the group would not boycott HMOs that refused to negotiate or did not come to terms. DOJ approval of this potentially powerful joint purchasing effort was possible only because the members refrained from exerting the power they possessed, adopting a less restrictive practice instead. Indeed, the Bay Area initiative is an impressive example of managed competition in action.

In general, legal advisers of a joint purchasing coalition should consider whether the coalition's purchasing practices and the health benefit policies of its members could be altered, without appreciable efficiency loss, to reduce the appearance that joint purchasing was adopted primarily to bring buying power to bear against providers and not to further procompetitive objectives. Additionally, cautious legal counsel might recommend that a jointly negotiated plan employ a reasonable preferred-provider strategy to ensure consumer choice would not be limited unnecessarily and that providers who resisted the group's demands could still attract patrons. It might also be desirable for the joint purchasers to package their purchases in ways that avoid maximizing their buying power with respect to particular services. To be sure, the strategies suggested here would be unnecessary if employers were free to include plans other than the jointly negotiated one on their respective menus of health plan options. These strategies should be strongly recommended, however, where a coalition engages in true group purchasing or takes a more aggressive approach to some providers in reliance on

91. See supra note 58 (discussing 35% safe harbor).
92. Although adoption of a preferred-provider strategy may be a natural profit-maximizing choice by a buyer cartel, it is still a less restrictive alternative in the sense that it leaves providers the option of not submitting to the joint purchasers' demands. Indeed, some courts might conclude—contrary to the suggestion here that preferred-provider arrangements are a necessary but insufficient condition of legality—that any reasonable provision letting consumers choose nonparticipating providers obviates all antitrust concerns.

Under the rule of reason, the question remains of how large a financial penalty can be imposed on a patient for selecting nonparticipating doctors or hospitals before inducements to patronize preferred providers become unreasonably restrictive. Because the test is reasonableness, a full cost justification should probably not be required; however, a plan with some market power should not be entirely arbitrary in differentiating its coverage between par and nonpar providers.
93. See supra note 61 and accompanying text.
the antitrust defense outlined in Part VIII.

If it is accurate that some members of any employer coalition will normally resist carrying joint purchasing of health services far enough to exercise the group’s potential monopsony power, then coalitions and cooperatives can expect to encounter few antitrust risks. In those cases, however, where joint purchasers are tempted to exploit their collective buying power, antitrust law expects that an affirmative effort will be made to resist that temptation. Nevertheless, as long as joint purchasing does not appear as a purposeful effort to exploit providers, firms engaging in it should survive antitrust scrutiny even if there is a question whether they acted reasonably in every respect, showed due restraint in every situation, and adopted every available less restrictive alternative. Unless a coalition or cooperative comes to court as a clear monopsonist, most courts will probably not conclude that modest adverse effects in a few markets condemn what is, on balance, a highly desirable development in the health services market.

VII. Obtaining Summary Judgment for Joint Purchasers

Joint purchasers of health care should be concerned not only about the legality of their actions but also about their exposure to costly antitrust litigation. If joint purchasing is likely to trigger a lawsuit that can be won only by incurring large legal bills, employers and others will be discouraged from taking actions that are procompetitive and beneficial to consumers. It is therefore important to consider the prospects for successful motions for summary judgment in any private antitrust suit that providers might bring to challenge joint purchasing.

In general, the Supreme Court has been more receptive to summary judgment motions in recent years. It has also taken a more skeptical view of private antitrust litigation, specifically approving summary judgment as a way of terminating antitrust cases of improbable merit. Given the immense burdens antitrust litigation
imposes on everyone concerned, courts are now more likely to re-
quire antitrust plaintiffs to demonstrate at an early stage some
ability to carry their burden of proof on each essential element of
the cause of action. In addition, motions for summary judgment
may narrow the focus of complex litigation to one or more potential-
ly dispositive issues. Such a motion may be met under Rule 56(f) of
the Federal Rules of Civil Procedure by a request for extra time for
discovery, which may be limited by the court to establishing only
certain critical facts.

The new hesitancy of courts to invoke per se rules undoubtedly
puts antitrust plaintiffs in a more difficult position at the summary
judgment stage because their proof requirements are correspond-
ingly increased. In particular, the question whether collaborating
defendants possessed enough market power to threaten competition
and consumer welfare has begun to appear in early stages of anti-
trust litigation. Absent this element of proof, most antitrust claims
lose their potency, and it is therefore reasonable to make claimants
address the point early. Because power issues depend on objective
data and expert opinion that can be presented in affidavit form and
tested through depositions, they are often resolvable without trial
and as a matter of law. Health care joint purchasers, relying on
their inability to exercise market power of the magnitude found in
previous joint buying cases, might well succeed in winning summa-
ry judgment in most cases initiated against them.96 Although this
Article suggests that the issues may sometimes be more complex
than indicated by, say, the thirty-five-percent market share safe
harbor recognized by the Department of Justice, those complexities
should rarely preclude a court from granting summary judgment on
the basis of relatively gross market share data.

If summary judgment cannot be obtained on the question of
market power, joint purchasers might still win quick dismissal by
demonstrating that their efforts stopped well short of exerting all
the power the group arguably possessed. Indeed, if members of the
purchasing group and the individual consumers they represent

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96. On the prospects for summary judgment in joint purchasing cases, see Ja-

cobson & Dorman, Joint Purchasing, supra note 10, at 23–38. These authors seek “to

provide a basis for dismissal of most challenges to assertedly monopsonistic practices

at the pleading or summary judgment stages of litigation and to limit trials to those

unusual cases where monopsonistic behavior may cause real injury to consumers.” Id.
at 4.
retain substantial freedom to deal with providers who do not accede to the group's demands, it can be argued that their joint buying involves no appreciable or unreasonable restraint of trade. Again, affidavits and documentary evidence could provide an ample record on which a court could base a summary judgment.

In general, joint purchasers need fear heavy legal expenses and possible liability only when they possess substantial power in recognizable markets and have employed methods that bring such power to bear on identifiable providers. Although ultimate liability conceivably might be avoided by the kinds of arguments and proof discussed in the next section, significant legal costs and significant liability risks would have to be incurred. For this reason, antitrust counsel should review joint purchasers' market position and their specific modes of operation. Most joint purchasers, however, should be able to act without facing undue antitrust burdens and risks.

VIII. A PLAUSIBLE MARKET-Failure DEFENSE FOR OTHERWISE UNLAWFUL JOINT PURCHASING

There remains the possibility that a given purchasing group might sometimes engage in an explicit, perhaps even a naked, effort to exercise its aggregate buying power, eschewing less restrictive alternatives and perhaps pressuring providers. Could such an effort ever be successfully defended? Specifically, could true joint purchasing by a powerful buying group be defended on the ground that the law should sometimes relax its insistence on the traditional model of competition in the market for health care?

A case requiring such a defense might arise, for example, where members of an employer coalition felt a need to use their bargaining power to alter provider behavior in some specific respect ultimately beneficial to consumers. Reportedly, a Memphis coalition obtained its initial breakthrough in bargaining with hospitals by threatening to deny the patronage of virtually all its members' employees to any hospital that refused its price demands.97 It might be argued on behalf of a coalition taking such measures that such a threat was necessary to break down a tacit hospital cartel under which each hospital, counting on its competitors to do likewise, refused to negotiate prices with individual purchasers. If this was the case in Memphis, then the coalition's effort might be viewed as procompetitive because it introduced competition where it had previously been absent. Moreover, once having broken the providers' ranks, the Memphis coalition apparently reverted to using an ordi-

97. See Winslow, supra note 25, at A7.
nary preferred-provider strategy. Thus, its muscle-flexing could be seen, by virtue of its short duration, as a less restrictive method of confronting the hospitals than the more problematic alternatives of bringing a costly and unpromising antitrust suit against them or organizing a permanent demand-side combination to exercise countervailing power. Despite this compelling analysis, however, such a coalition effort might be deemed unlawful buyer price fixing under conventional antitrust doctrine. The law generally does not countenance claims that power existing on one side of the market justifies a restraint of trade on the other. 98

There is one principled basis, however, on which a naked restraint of trade like this might be legally defensible. Specifically, it might be claimed that the restraint was well calculated to overcome a demonstrable market failure not readily correctable by other (including legislative) means. While such a market “failure” defense has no real support in case law, courts have never declared all naked restraints to be illegal per se. If in fact the law permits some purposeful interferences with competition, the question arises: which ones? 99 It is at least arguable that a restraint should be allowed if it could reasonably be expected to produce results actually closer to the efficient result that the market would yield if it functioned smoothly, unimpaired by market failure. 100 Unlike the usual worthy-purpose defense or the “patient-care motive” defense advanced in one now-discredited case, 101 such a market-failure defense would retain the paradigm of competition and efficient markets as the benchmark for evaluating conduct. It would not, therefore, constitute a frontal assault on basic antitrust policy of the kind the Supreme Court rejected in the National Society of Professional

98. Such a defense did succeed in Appalachian Coals, Inc. v. United States, 288 U.S. 344 (1933). But that case is the proverbial exception that proves the usual rule applied today. For the conventional view that naked exercise of monopsony power cannot be justified “even when undertaken to meet monopoly or cartel conditions in the input market and when deemed likely to result in lower prices for consumers,” see Joseph F. Brodley, Joint Ventures and Antitrust Policy, 95 HARV. L. REV. 1521, 1569 (1982). See also Joel Davidow, Antitrust, Foreign Policy, and International Buying Cooperation, 84 YALE L.J. 268, 270–71 (1974).

99. See 7 AREEDA, supra note 22, ¶ 1511, at 427–36.

100. See generally id. at 382–83 (discussing possible market-failure rationale for upholding naked restraint that “actually moves market performance closer to the competitive result”).

To be sure, it would be very rare for competitors to combine to make a market yield results that are more efficient from the standpoint of consumer welfare. Moreover, conventional doctrine says that it is appropriate to ignore remote possibilities of procompetitive results in order to deny would-be conspirators possible pretexts for anticompetitive actions. Nevertheless, there is a good policy reason for letting collaborating competitors advance arguments of this kind. Antitrust law and antitrust enforcement agencies should not seem too mindlessly wedded to an ideological belief that competition always serves consumers well. Indeed, if the law seemed too hidebound in this regard, demands by industry groups for legislative exemptions from or exceptions to antitrust requirements would gain plausibility, with a probable ultimate net loss of competition in the economy as a whole. Antitrust enforcers, perhaps perceiving this political reality, do not in fact dismiss such arguments out of hand. Many courts would be loath to embrace competition for better or for worse where a plausible market-failure defense was offered by defendants whose motives were not inherently untrustworthy.

Although a market-failure defense for restraints of trade that lack any other justification has some theoretical as well as pragmatic merit, it remains true that private parties should rarely be trusted to serve consumers' welfare rather than their own in displacing market forces. For this reason, antitrust enforcers and courts, while they should be willing to listen to such defenses, should rarely accept them. Nevertheless, in the case of joint purchasing of health services, a particularly convincing defense of this kind could be made out on the ground that the joint purchasers truly represent community interests, including the interests of consumers concerned about the quality and accessibility as well as the cost of health care. Because health care markets suffer from some major market imperfections, the concerted efforts of even a powerful

102. 435 U.S. 679 (1978). In Professional Engineers, however, the Court stated that the engineers' ethical canon against competitive bidding could not be upheld because it applied "with equal force to both complicated and simple projects and to both inexperienced and sophisticated customers," id. at 692, implying that a ban that applied only to "complicated" projects and affected only "inexperienced" consumers might stand on a different footing. In any event, a market-failure defense for naked agreements on the forms that competition can and cannot take is most compelling in the case of some (but certainly not all) canons of professional ethics—e.g., against truly deceptive advertising. See generally CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 325–39 (1988) (reviewing rule of reason analysis of ethical codes).
purchasing cooperative could quite reasonably be expected to make market outcomes approximate more closely the efficient outcomes that an efficient market would produce.

Because such a market-failure defense would be largely unprecedented (except insofar as the courts have refrained from condemning all naked restraints out of hand), joint purchasers should probably not rely on it in planning their program. Yet if joint purchasers were sued under the Sherman Act for exercising demonstrable buying power, they might mount a fairly formidable defense based on the difficulties that unorganized buyers have long faced in bargaining with a health care industry not exposed or disposed to effective competition. Although not well provided for in antitrust doctrine, this line of defense could be made quite respectable by economists' testimony on the need to make health care markets more allocatively efficient, as contemplated in the antitrust paradigm.

IX. SUMMARY AND CONCLUSION

The ongoing revolution in the purchasing of health care in the United States has triggered numerous innovations on both the demand and supply sides of the market for health services. This Article has focused on antitrust issues presented by the movement of large and small employers to collaborate in purchasing health coverage or health services for their employees. Although the analysis has taken numerous twists and turns, the conclusion seems clear that joint purchasing will rarely raise antitrust problems of an insurmountable kind.

A price-fixing combination of purchasers can be justified under the antitrust laws only if it yields otherwise unobtainable efficiencies or other procompetitive benefits. Employer coalitions or cooperatives engaged in the joint purchasing of health care can plausibly

103. Because joint purchasers potentially lower prices and restrict output, they would have to persuade courts that even restraints affecting price should sometimes be overlooked because of market failure. This might be difficult to do. Indeed, it is probable that the only naked restraints surviving antitrust scrutiny under a market-failure defense are relatively minor ones affecting elements of competition other than price and output. See 7 AREEDA, supra note 22, ¶ 1511, at 427–36; see, e.g., Allied Tube & Conduit Corp. v. Indian Head, Inc., 486 U.S. 492, 500 (1988) (dictum) ("[A]greement on a product standard is, after all, implicitly an agreement not to manufacture, distribute, or purchase certain types of products."). For a reconciliation of the Allied Tube dictum with conventional antitrust doctrine, see Clark C. Havighurst & Peter M. Brody, Accrediting and the Sherman Act, 57 LAW & CONTEM. PROBS., Autumn 1994, at 199, 212–16.

104. For the economic arguments, see supra notes 42–45 and accompanying text.
promise to achieve efficiencies and to strengthen and better inform the demand side of the health care market, a market that has long been dominated by providers. Employer joint purchasing of health care is therefore almost certain to be evaluated in every case under antitrust law’s rule of reason rather than condemned automatically under a rule of per se illegality.

A critical issue in applying the rule of reason to assess the legality of a particular collaboration of competing buyers is the degree of market power that the collaborators can exercise. Although government prosecutors have recognized a safe harbor for any combination of purchasers that accounts for no more than thirty-five percent of purchases of a particular kind, courts considering whether to condemn a particular employer coalition or cooperative as a buyer cartel might apply a stricter test or adopt a more rigorous methodology. They might focus, for example, not on just the percentage of hospital or physician services purchased by the combination, but on the collaborators’ share of the market for some specific service such as that offered by a provider plaintiff. In a discrete market, such as obstetrical services rarely used by Medicare beneficiaries, joint purchasers might represent a disproportionately large share of purchases, thus inviting closer scrutiny.

A court seeking to detect buying power might also employ measures of power that are more sensitive than a simple market share test. For example, courts might be impressed by economic evidence concerning the elasticity of demand by other potential buyers of the service in question on the theory that, if providers could not attract substantial new business by modest price reductions, providers would be open to exploitation by joint purchasers. Similarly, evidence of inelastic supply of a service would indicate that providers do not have the option of leaving the market altogether rather than accepting a noncompetitive low price from a coalition of buyers. Such evidence might justify a finding of market power where a market share test alone would indicate its absence.

For the foregoing reasons, joint purchasers with an appreciable (fifteen to twenty percent) market share in any specific market should be prepared for the possibility that a court would find them capable of wielding enough market power to raise a question about the legality of their purchasing activities. Nevertheless, a finding of market power alone should not condemn a procompetitive, efficiency-enhancing collaboration. Under the rule of reason, a court should also consider the joint purchasers’ purposes and methods. In order to survive scrutiny, however, the joint purchasers would have to demonstrate the reasonableness of their undertaking in light of the law’s presumption that consumer welfare is best served by preserv-
ing competition.

Thus, joint purchasers possessing a degree of market power should be prepared to show that the efficiencies they seek could not be gained by less oppressive means. Such a showing would be easiest if individual members of the buying group retained (and to some extent exercised) their independent right to purchase health services outside the group by offering their employees health plans or health care options other than the collectively bargained plan. Although use of the preferred-provider technique would be desirable as a way of giving providers more room to refuse the joint purchasers' price demands, adoption of that strategy alone would not necessarily provide an antitrust defense. If the differential treatment of nonpreferred providers was not cost-justified, it might be viewed not as a sign of restraint in the exercise of market power, but as price discrimination by a buyer cartel seeking to minimize the output-depressing effects of low prices.

Because individual employers will generally not want to limit their employees' several health care options too severely, most employer coalitions or cooperatives are unlikely to adopt methods that bring maximum buying power to bear against health plans or providers. On the other hand, if multiple employers do agree to offer their workers only a single coalition-negotiated plan, an antitrust problem might arise not only with respect to their purchasing of health services but also with respect to the effects of their actions in the labor market in which they compete. Barring a conspiracy of employers to eliminate health benefits as a factor in their competition for workers, however, buying groups are unlikely to cross the lines laid out in this Article to ensure that market power is not unlawfully employed. Indeed, joint purchasers following the guidelines in this Article can be reasonably confident of their ability to win summary judgment against antitrust claims made by health care providers. Joint purchasers could reasonably expect to prevail if they could show either that they lacked market power in purchasing services or that their respective practices in conjunction with joint purchasing were such as to obviate concern that buying power was being misused.

This Article has also suggested that there might be rare occasions when, without too much fear of antitrust liability, joint purchasers could use their market power in a somewhat naked fashion to restore competitive conditions in a market where it was lacking. For example, an employer coalition might engage in collective purchasing for the limited purpose of breaking up a provider cartel or overcoming interdependent, noncompetitive behavior that sometimes characterizes oligopolies. Because courts have never said that
all naked restraints of trade are per se violations of the Sherman Act, a particular show of force, if it was of appropriately limited duration, was truly aimed at a procompetitive objective, and was tailored to achieving only that limited objective, might escape antitrust challenge or be upheld if a challenge did occur. Not only would government officials probably not challenge such an effort but the providers targeted also would be in a poor position to object to the defensive actions taken.

In sum, although numerous theoretically interesting antitrust issues are presented by the collective purchasing of health care, employers thinking of pooling their efforts to buy health care more wisely and economically have a great deal of room in which they can operate without fear of antitrust attack.