

Public Policy and Antitrust Enforcement in the Health Care Industry

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I. INTRODUCTION

In recent years there has been a veritable flood of antitrust litigation in the health care field. Because of the unique nature of the health care industry and its importance to the quality of life of every American, antitrust enforcement in this industry has raised an unprecedented debate over the usefulness and/or desirability of antitrust enforcement in this field.

Two recent decisions arising in Indiana illustrate two of the many public policy questions generated in this area. These decisions are *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*¹ and *Marrese v. Interqual, Inc.*²

II. CHALLENGES TO PREFERRED PROVIDER ORGANIZATIONS

Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance raises questions regarding the validity under the antitrust laws of so-called preferred provider organizations, commonly referred to as "PPO's." While the term PPO encompasses a wide variety of arrangements, a PPO is essentially a program where the preferred providers give favorable rates or terms to an employer, insurer, or other purchaser of health care services. The purchasers in turn create incentives for their members or insureds to use these "preferred providers" rather than other providers.³ PPO's are perceived to be one means of reducing costs in the health care industry.⁴

In *Ball Memorial*, the plaintiffs, eighty Indiana hospitals, challenged the legality of a preferred provider program that defendants Blue Cross of Indiana and Blue Shield of Indiana⁵ were planning to implement.

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¹603 F. Supp. 1077 (S.D. Ind. 1985), *affirmed*, No. 85-1481 (7th Cir. Mar. 4, 1986). Barnes & Thornburg represents one of the hospitals in this litigation on a counterclaim filed against it by the defendants.

²748 F.2d 373 (7th Cir. 1984), *cert. denied*, 105 S. Ct. 3501 (1985).

³For a more detailed definition of a PPO and the various types of arrangement the term includes, see T. FOX & A. WEISMAN, *PREFERRED PROVIDER ORGANIZATIONS* (1984).

⁴*See, e.g., Ball Memorial*, 603 F. Supp. at 1084.

⁵The actual defendants were Mutual Hospital Insurance, Inc., doing business as Blue

Among other things, the suit questioned the legality of the proposed plan under the provisions of both federal and state antitrust laws.⁶

The plaintiffs requested preliminary relief to prevent implementation of the PPO plan and also to prevent a proposed merger by the defendants. A hearing on the motion commenced January 7, 1985, and extended over a period of eleven days. On March 1, 1985, Judge Steckler of the Southern District of Indiana issued findings of fact and conclusions of law denying the preliminary relief. The Seventh Circuit affirmed the decision.⁷

The plaintiffs challenged the proposed PPO under both sections one and two of the Sherman Act and the corresponding provisions of the Indiana Code.⁸

A. Section One Challenge

Section one of the Sherman Act prohibits conspiracies in restraint of trade and prohibits many "classic" anticompetitive practices such as price fixing among competitors,⁹ market allocation among competitors,¹⁰ and concerted refusals to deal, otherwise known as group boycotts.¹¹

PPO's operated by insurance companies have been previously attacked as illegal price fixing agreements because the insurance company and the provider agree on the price to be charged the insured. However, courts have uniformly held this does not constitute illegal price fixing because the courts have characterized the insurance company, not the insured, as being the real purchaser of the health care services.¹²

Cross of Indiana and Mutual Medical Insurance, Inc., doing business as Blue Shield of Indiana.

⁶The antitrust claims alleged violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2 (1982), and sections 1 and 2 of the Indiana Anti-Monopoly Act, IND. CODE §§ 24-1-2-1, -2 (1982). The original complaint alleged violations of the Indiana Hospital Statutes, IND. CODE § 16-12.1-1-1 (1982). The complaint was filed November 14, 1984. The complaint was later amended to eliminate these claims. The amended complaint was filed March 8, 1985. In any event, the state hospital law claims were never before the court on the motion for preliminary relief.

⁷No. 85-1481, March 4, 1986.

⁸See *supra* note 6. The Indiana state antitrust laws are modeled on the federal laws and are interpreted accordingly. *Photomat Corp. v. Photovest Corp.*, 606 F.2d 704, 721 n.27 (7th Cir. 1979), *cert. denied*, 445 U.S. 917 (1980).

⁹See, e.g., *United States v. Socony Vacuum Oil Co.*, 310 U.S. 150 (1940).

¹⁰See, e.g., *United States v. Topco Associates*, 405 U.S. 596 (1972).

¹¹See, e.g., *Fashion Originator's Guild v. Federal Trade Commission*, 312 U.S. 457 (1941).

¹²See *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1978); *Brillhart v. Mutual Medicine Insurance, Inc.*, 768 F.2d 196 (7th Cir. 1985); *Sausolito Pharmacy, Inc. v. Blue Shield of California*, 544 F. Supp. 230, 233 (N.D. Cal.), *aff'd per curiam*, 677 F.2d 47 (9th Cir. 1981), *cert. denied*, 459 U.S. 1016 (1982).

Courts have routinely held it is not a violation of the antitrust laws for a buyer and seller to agree on what price the buyer will pay.¹³ Any other rule would wreak havoc on our economy because it is impossible for any commercial transaction to proceed without some agreement among the parties as to the price to be paid. Thus, Judge Steckler concluded there was little likelihood that plaintiffs' section one claim would be successful on the merits.¹⁴

B. Section Two Challenge: Abuse of Monopsony Power

The more interesting questions raised by this litigation involve the legality of the preferred provider organization under section two of the Sherman Act. Section two prohibits monopolization, which is defined as the willful maintenance or acquisition of monopoly power.¹⁵

The plaintiffs argued that Blue Cross/Blue Shield had violated section two by abusing its alleged *monopsony* power.¹⁶ While a monopolist possesses the power to raise prices above a competitive level to its customers, a monopsonist possesses the power to force its suppliers to lower their prices below competitive levels.¹⁷ Plaintiffs argued Blue Cross/Blue Shield possessed sufficient monopsony power to force the hospitals who supplied services to Blue Cross/Blue Shield to lower their prices to unremuneratively low levels and that this constituted a violation of section two of the Sherman Act.

Abuse of monopsony power is an unexplored frontier in antitrust law. Prior to *Ball Memorial*, at least one federal court had wrestled with the concept and concluded that unilateral monopsony pricing did not violate the antitrust law. That case, *Kartell v. Blue Shield of Massachusetts*,¹⁸ involved facts very similar to those in *Ball Memorial*. In *Kartell*, a group of physicians challenged an insurer's ban on balance billing. (Balance billing is the practice of billing the insured directly for amounts not covered by insurance). In *Kartell*, the insurance company prohibited this practice and this prohibition was challenged as, *inter alia*, a violation of section

¹³See, e.g., *Brillhart v. Mutual Medicine Insurance, Inc.*, 768 F.2d 196 (7th Cir. 1985); *Quality Auto Body, Inc. v. Allstate Insurance Co.*, 660 F.2d 1195, 1203 (7th Cir. 1981); *Sausolito Pharmacy, Inc. v. Blue Shield*, 544 F. Supp. 230, 235 (N.D. Cal.), *aff'd per curiam*, 677 F.2d 47 (9th Cir. 1981), *cert. denied*, 459 U.S. 1016 (1982).

¹⁴*Ball Memorial*, 603 F. Supp. at 1086.

¹⁵*Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 274 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980).

¹⁶Plaintiffs' Memorandum in Opposition to Defendants' Motion to Dismiss the Complaint at 7-24, *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*, 603 F. Supp. 1077 (S.D. Ind. 1985), *affirmed*, No. 85-1481 (7th Cir. March 4, 1986).

¹⁷See *Permian Basin Area Rate Cases*, 390 U.S. 747, 794 n.64 (1968); *Vogel v. American Society of Appraisers*, 675 F.2d 502, 601 (7th Cir. 1982).

¹⁸749 F.2d 922 (1st Cir. 1984), *cert. denied*, 105 S. Ct. 2010 (1985).

two of the Sherman Act because it forced the doctors to accept unreasonably low prices.

The Second Circuit found monopsony pricing did not violate section two of the Sherman Act,¹⁹ relying on its earlier decision in *Berkey Photo, Inc. v. Eastman Kodak Co.*,²⁰ in reaching this conclusion. In *Berkey Photo*, the Second Circuit held that monopoly pricing by a monopolist that had lawfully obtained its monopoly did not violate section two.²¹

The Second Circuit concluded that the same rationale it had previously used to permit monopoly pricing by a lawful monopolist would also favor permitting monopsony pricing. The court identified the reasons underlying this principle to include "judicial reluctance to deprive the lawful monopolist . . . of its lawful rewards, and a judicial recognition of the practical difficulties of determining what is a 'reasonable' or 'competitive' price."²²

Clearly the latter point, that it is difficult to distinguish a competitive price from a monopoly price, is equally applicable to distinguishing a competitive price from a monopsony price. On the other hand, there is no reason to believe this task is any harder than distinguishing a competitive price from a predatory price, a job which courts have undertaken despite the acknowledged difficulty.²³

Moreover, it is not inevitable that the ability to monopsony price should be a reward for the legitimate attainment of a monopoly. One could argue that permitting monopoly pricing was reward enough and, as such, there is no legitimate reason to allow a monopsonist to injure its suppliers by forcing their prices below remunerative levels, perhaps even forcing them out of business completely.

Finally, the *Kartell* court failed to discuss another rationale set forth by the court in *Berkey Photo* for permitting monopoly pricing, i.e., that monopoly pricing tends to encourage competitors who will challenge the monopoly. "[A]lthough a monopolist may be expected to charge a somewhat higher price than would prevail in a competitive market, there

¹⁹*Kartell*, 749 F.2d at 929.

²⁰603 F.2d 263 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980).

Section two of the Sherman Act provides:

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

²¹*Berkey Photo*, 603 F.2d at 294.

²²*Kartell*, 749 F.2d at 927.

²³*See, e.g., MCI Communications Corp. v. American Telephone & Telegraph Co.*, 708 F.2d 1081 (7th Cir.), *cert. denied*, 464 U.S. 891 (1983).

is probably no better way for it to guarantee that its dominance will be challenged than by greedily extracting the highest price it can."²⁴ This simply means that a monopolist who prices above the competitive level may sow the seeds of its own destruction.

Monopsony pricing, on the other hand, may enhance the monopolist's market power. If the monopolist can wring concessions from its suppliers that are not available to its competitors, the monopolist may be able to undercut its competitors and eliminate them entirely.

There are many problems with this analysis, however. First, by obtaining concessions not available to its competitors, a monopsonist could violate the Robinson-Patman Act.²⁵ Second, assuming such pricing did enhance the monopolist's market share, it is not clear the supplier would incur an injury against which the antitrust laws would protect.²⁶

The United States Supreme Court denied certiorari in the *Kartell* case.²⁷ Nevertheless, the novel issues raised by that decision may not be fully resolved. It is entirely possible that the Court could be persuaded that monopsony pricing should not be equated with monopoly pricing.

However, this issue was neither central to nor examined in any depth in the *Ball Memorial* opinion. The court concluded, without citation, "Blue Cross/Blue Shield cannot, as a matter of law, monopolize or attempt to monopolize the hospital services industry because Blue Cross/Blue Shield has never and does not now compete in that market."²⁸ Presumably, the court must have concluded that monopsony pricing cannot constitute a violation of section two because a monopsonist does not compete with its suppliers.

The real issue, however, is not whether the monopsonist competes in the market it monopsonizes, but whether monopsony pricing enhances the monopsonist's market share in any market in which it does compete.

The plaintiffs argued that Blue Cross/Blue Shield could enhance its market share by demanding concessions not available to its competitors. The court rejected this argument, concluding, "Blue Cross/Blue Shield cannot coerce unfavorable contract terms, cause cost-shifting or force price discrimination from a preferred hospital. All pricing decisions are within the exclusive business judgment of each hospital."²⁹ Thus, the court apparently concluded that even if the exercise of monopsony power did

²⁴*Berkey Photo*, 603 F.2d at 294.

²⁵15 U.S.C. § 13 (1982). The Robinson-Patman Act prohibits discrimination between purchasers of goods of "like grade and quality." It is a violation of the Robinson-Patman Act for a purchaser to demand and/or receive price concessions not available to its competitors.

²⁶*See Brunswick Corp. v. Pueblo Bowl-O-Mat*, 429 U.S. 477 (1977).

²⁷105 S. Ct. 2040 (1985).

²⁸*Ball Memorial*, 603 F. Supp. at 1087.

²⁹*Id.*

violate section two, there was no violation in this case because Blue Cross/Blue Shield did not exercise this power.

However, the court made no factual findings to support this essentially factual conclusion. This conclusion *assumes* Blue Cross/Blue Shield does not possess monopsony power. The court's factual findings support the conclusion that Blue Cross/Blue Shield has no *monopoly* power in the market for health care financing for consumers. However, the factual findings do not address the question whether Blue Cross/Blue Shield had *monopsony* power in the market for purchasing health care services.³⁰

C. Policy Considerations

This litigation also raises interesting policy questions such as whether introducing "competition" to hospitals will cause hospitals to increase their charges. The plaintiffs argued that Blue Cross/Blue Shield's PPO would cause hospitals to charge higher prices to other patients in order to offer lower prices to Blue Cross/Blue Shield patients as a result of Blue Cross/Blue Shield's monopsony power.³¹

Normally, such cost shifting is not possible in a competitive market. Classic economic theory teaches that a profit-maximizing competitor will charge a price fixed by the forces of supply and demand and that competitive forces will prevent it from raising its price above a competitive level.³² Thus, in a competitive market, competitive forces would not allow the hospital to shift the costs by raising prices to others. Rather, the hospital would have to absorb the losses or increase its efficiency.

The flaw in this argument is that it assumes the hospital functions as a profit-maximizing entity. In fact, many hospitals are not-for-profit organizations and thus may not be charging what the market can bear. Therefore, if they are charging below the competitive rate they can increase their charges to non-PPO members and shift costs to these patients. The net result could be that competition, which forces prices to a competitive level, causes an increase, not a decrease, in the cost of medical care.

It is not clear that causing prices to rise to a competitive level poses an antitrust concern because the antitrust laws are generally concerned with schemes which will raise prices above the competitive level, at least eventually.³³ However, it clearly raises a serious public policy concern.

³⁰See *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pennsylvania*, 574 F. Supp. 457, 469-70 (M.D. Pa. 1983), *aff'd without opinion*, 722 F.2d 733 (3d Cir. 1983).

³¹See, e.g., Plaintiffs' Memorandum in Opposition to Defendants' Motion to Dismiss the Complaint at 7-24, *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*, 603 F. Supp. 1077 (S.D. Ind. 1985), *affirmed*, No. 85-1481 (7th Cir. March 4, 1986).

³²M. SAMUELSON, *ECONOMICS* 39-40, 57-58 (1980).

³³Even where the defendant is charged with pricing below cost, the ultimate competitive concern is that the predator will succeed in driving out its rivals and then raising prices.

If competition causes prices to *rise*, it may be undesirable to force competition upon this industry.

Perhaps a more significant public policy concern is the question of who is to bear the cost of medical care for those who cannot afford it. For years, indigent care has essentially been subsidized by hospitals by shifting the cost of care to patients who can pay. As illustrated above, Blue Cross/Blue Shield may have sufficient market power to force hospitals to shift the cost of subsidization to other patients. Alternatively, the hospital may have to absorb the costs or simply stop providing these services. In any event, this potential cost shifting raises the question of what services will be available to the indigent and from what source such services will be remunerated.

Judge Steckler's decision in *Ball Memorial* makes it unlikely that PPO's in Indiana will be further challenged on antitrust grounds. Thus, to the extent these organizations really act to lower costs to consumers, PPO's can be expected to flourish. The opinion fails to deal with the public policy questions raised by these organizations, such as who, if anyone, is to pay for the care to the indigent, but these questions may well be outside the scope of the judicial branch, in any event.

III. CHALLENGES TO DENIALS OF STAFF PRIVILEGES

While the health care industry has experienced an explosion in antitrust litigation generally, the majority of cases filed involve hospital decisions to deny staff privileges to physicians and other health care providers.³⁴

There can be no question that review of physician performance is desirable and necessary to ensure high quality health care. Nevertheless, attempts to limit staff privileges raise serious anticompetitive problems. Such decisions are usually made with input from, and often at the instance of, the hospital's medical staff.³⁵ Medical staffs may well have anticompetitive reasons to limit access of competing physicians to the hospital.³⁶ Difficult public policy problems are raised by attempts to balance the need for physician review against the potential anticompetitive dangers arising therefrom.

³⁴Undated Press Release by National Health Lawyers Association (available at *Indiana Law Review* Office).

³⁵A hospital's medical staff is a conglomeration of independent competing physicians best viewed for antitrust purposes as a "walking conspiracy." See *Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980); *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia*, 498 F. Supp. 63 (E.D. Va. 1980).

³⁶For example, the medical staff may seek to restrict artificially the supply of doctors to increase prices, or it may seek to exclude known price cutters.

The Seventh Circuit recently grappled with this issue in *Marrese v. Interqual, Inc.*³⁷ In that case, Dr. Marrese, a physician, sued Deaconess Hospital in Evansville, Indiana, its board of directors, and various other persons and entities, alleging that the proposed revocation of his hospital staff privileges violated the antitrust laws. The defendants moved to dismiss the complaint for lack of subject matter jurisdiction, arguing that the allegedly illegal activities did not have sufficient effect on interstate commerce. The district court agreed and dismissed the complaint. Dr. Marrese appealed to the Seventh Circuit.

The Seventh Circuit held that the lower court erred in dismissing the complaint on jurisdictional grounds, but held that the complaint should nevertheless have been dismissed because the allegedly illegal conduct was exempt under the so-called state action doctrine.³⁸

The state action doctrine was first articulated by the United States Supreme Court in *Parker v. Brown*.³⁹ In that case, the Court held that the federal antitrust laws did not prohibit a state, its officers, or agents from engaging in anticompetitive activities directed by the state legislature.⁴⁰ Thus, this doctrine creates an "exemption" for otherwise illegal conduct carried out by the state. This exemption has subsequently been extended to private parties acting at state direction.⁴¹

To fall within the doctrine, the conduct must meet two tests. First, the challenged restraint must be clearly articulated and affirmatively expressed as state policy. Second, the policy must be actively supervised by the state itself.⁴²

Dr. Marrese's privileges were revoked after a substantial review by both the hospital and the hospital's medical staff. A special committee had been formed, composed of selected members of the medical staff, to audit surgical back procedures performed by Dr. Marrese. The results of the review raised questions regarding the appropriateness of the surgeries performed by Dr. Marrese.⁴³ The committee recommended certain procedures be implemented to monitor surgery performed by Dr. Marrese.⁴⁴

The committee later retained an outside consultant engaged in the business of performing medical audits to audit further Dr. Marrese's surgical procedures.⁴⁵ Based on the findings of the consultant, the com-

³⁷748 F.2d 373 (7th Cir. 1984).

³⁸*Id.* at 374.

³⁹317 U.S. 341 (1943).

⁴⁰*Id.* at 352.

⁴¹*See* *Southern Motor Carriers Rate Conference, Inc. v. United States*, 105 S. Ct. 1721 (1985).

⁴²*Marrese*, 748 F.2d at 375.

⁴³*Id.*

⁴⁴*Id.*

⁴⁵*Id.*

mittee recommended to the Medical Staff Executive Council that Dr. Marrese's privileges be revoked.⁴⁶ The recommendation was adopted by the council, but was stayed pending an evidentiary hearing which was required by the hospital's administrative procedure.⁴⁷

Prior to the hearing, Dr. Marrese filed suit, alleging the attempts to deny him staff privileges constituted a conspiracy in restraint of trade in violation of section one of the Sherman Act and monopolization in violation of section two.⁴⁸

In finding that the defendants' conduct was "state action," the court relied on Indiana Code section 16-10-1-6.5, which provides:

The medical staff of a hospital shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the governing board, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital.⁴⁹

The court also found:

To implement this review process, the statutory scheme provides that hospitals establish a peer review committee that shall have "the responsibility of evaluation of qualifications of professional health care providers, or of patient care rendered by professional health care providers, or of the merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint."⁵⁰

In fact, the statutory scheme *does not require* hospitals to establish peer review committees.⁵¹ Rather, Indiana Code section 34-4-12.6-1, relied upon by the Seventh Circuit for its conclusion that "the statutory scheme provides that hospitals establish a peer review committee,"⁵² simply sets forth an evidentiary privilege for communications made to such committees. This should be obvious from the language of the statute and its

⁴⁶*Id.*

⁴⁷*Id.*

⁴⁸*Id.* at 377.

⁴⁹IND. CODE § 16-10-1-6.5 (1982).

⁵⁰*Marrese*, 748 F.2d at 388 (quoting IND. CODE § 34-4-12.6-1).

⁵¹However, the Seventh Circuit apparently read the statute to mandate such a committee. *Id.* at 387.

⁵²*Id.* at 388.

presence in Title 34 of the Indiana Code relating to civil procedure rather than in either Title 16, relating to Health and Hospitals, or Title 25, which includes the licensing requirements for physicians.

Thus, the statutory scheme is permissive rather than mandatory. Nevertheless, the court's conclusion that this statutory scheme constituted a clearly articulated state policy may be correct, particularly in light of the Supreme Court's recent decision in *Southern Motor Carriers Rate Conference, Inc. v. United States*. In that case, the Court held that a permissive scheme could meet the clear articulation standard, stating, "The federal antitrust laws do not forbid the States to adopt policies that permit, but do not compel, anticompetitive conduct by regulated private parties."⁵³

Because the statutory scheme clearly contemplates that some review activity would occur, the fact that peer review committees are not mandated is presumably not crucial in determining whether the standard has been met. However, it is not obvious that the statutory scheme was intended to displace competition or to shield anticompetitive activity.

In *Southern Motor Carriers*, the Court concluded that the statutory scheme clearly intended to replace competition with regulation even though it did not expressly set forth what conduct would be permitted.⁵⁴

Thus, in *Quinn v. Kent General Hospital, Inc.*,⁵⁵ the district court of Delaware rejected the state action defense where there was no evidence the statute supposedly conferring immunity was intended to displace competition. That case also involved a denial of hospital staff privileges. The hospital asserted that denial was protected state action because of a Delaware peer review statute.

The district court rejected the Seventh Circuit's reasoning in *Marrese* and found the statute did not confer immunity.

The question confronting the Court is not merely whether Delaware has adopted a clearly articulated policy of promoting the medical peer review process but whether the legislature intended to displace *competition* in the market for hospital facilities. . . . While it is true that the clear articulation test does not require that the legislature "expressly state in a statute or its legislative history that it intends for the delegated action to have anticompetitive effects . . ." there is not even a hint in the Delaware statute that the peer review process will be promoted by conferring a monopoly upon those physicians with entrenched positions on hospital staffs. Nor is there any reason why promotion of the peer review process should require any additional restriction of competition.⁵⁶

⁵³105 S. Ct. 1721, 1728 (1985).

⁵⁴*Id.* at 1731.

⁵⁵617 F. Supp. 1226 (D. Del. 1985).

⁵⁶*Id.* at 1238-39. See also *Coastal Neuro-Psychiatric Associates v. Onslow Memorial Hospital, Inc.*, 1985-1 Trade Cas. (CCH) ¶ 66,432 (E.D.N.C. 1985).

Thus, the Seventh Circuit's conclusion in *Marrese* that the statutory scheme satisfied the first prong of the test can be criticized, but the law in this area is sufficiently nebulous so that this result is not clearly wrong.

The Seventh Circuit's conclusion that the state actively supervised this activity, however, seems much less sound. The court based this conclusion on the fact that state law provides for regulation of hospitals and doctors and that the boards that perform this regulatory supervision have access to peer review committee records.⁵⁷ State law, however, does not require these boards to monitor the peer review process, and, because the case came before the court on the allegations of the complaint as a result of a motion to dismiss, there could be no evidence that these boards did in fact monitor these proceedings.

Thus, the Seventh Circuit, in essence, held there was active state supervision because a statutory scheme existed pursuant to which the state *could* supervise these activities if it so chose. This hardly seems consistent with the ordinary meaning of the words "active state supervision."⁵⁸ Moreover, the analysis of two leading antitrust commentators, Phil Areeda and Don Turner, suggests this would not be active state supervision.⁵⁹ While acknowledging that the law is unclear, Areeda and Turner argue that the key question in determining adequate state supervision should be "whether the operative decisions about the challenged conduct are made by public authorities or by the private parties themselves."⁶⁰ Areeda and Turner conclude that "[a]gency inaction is not sufficient to justify immunity. . . ."⁶¹

There can be no question that the Seventh Circuit's decision was motivated, at least in part, by the court's undoubtedly correct assertion that "peer review is essential to the very lifeblood and heartbeat of medical competency and quality medical care in the State of Indiana and throughout the nation,"⁶² and further that

the threat of a federal antitrust lawsuit will compel able and qualified physicians . . . to abdicate their participation in the medical peer review process. The overall effect will be to destroy the intended purpose of medical peer review; to assure Indiana citizens of quality medical care and protect them from incompetent, unqualified medical treatment.⁶³

⁵⁷*Marrese*, 748 F.2d at 389-90.

⁵⁸*See, e.g.,* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980); Cantor v. Detroit Edison Co., 428 U.S. 579 (1976).

⁵⁹I P. AREEDA & D. TURNER, ANTITRUST LAW ¶ 213b (1978).

⁶⁰*Id.* ¶ 213b at 73.

⁶¹*Id.* ¶ 213f at 78.

⁶²*Marrese*, 748 F.2d at 392.

⁶³*Id.* at 391-92. The court also cited reasons of judicial economy and due process standards in its disposition of Dr. Marrese's antitrust claims. The court stated:

As a matter of judicial economy, the Federal court must not be further burdened by complex antitrust litigation when the alleged illegal conduct is mandated and

While it is easy to agree with the Seventh Circuit that antitrust challenges to the peer review process raise many public policy questions, it is not equally clear that this process is exempt state action. Thus, the Seventh Circuit's reasoning in *Marrese* may be seriously criticized. Nevertheless, the decision should effectively preclude antitrust challenges to the peer review process in Indiana.⁶⁴

In any event, the Seventh Circuit's decision in *Marrese* enables Indiana hospitals to maintain medical staff review committees which may revoke or deny staff privileges to physicians. This may be accomplished even in light of the potential anticompetitive implications such action entails. While further judicial review may find this activity not countenanced under the state action doctrine, it is clear, for the moment, that the Indiana statutory scheme provides an avenue for state supervision sufficient to justify application of the doctrine.

supervised by the state and, furthermore, the plaintiff is afforded the due process safeguards of hearings and state court review. Common sense dictates that a cause of action under the Sherman Act is not created every time a lawyer, accountant, or architect is denied partnership status in a national firm, a business executive is fired or denied a promotion by a national corporation, or a physician, surgeon, or specialist has hospital staff privileges denied or revoked. In the instant case, Dr. Marrese is entitled to challenge the defendants' motives and conduct in a hearing before the Deaconess medical staff, a review hearing before the joint conference committee of the hospital, and finally through proceedings in the Indiana state court system. Just as a disgruntled state bar applicant who is denied admission to a state bar has no cause of action under the Sherman Act against a state mandated and supervised bar review committee. . . .

Id. at 393.

⁶⁴See *Lombardo v. Sisters of Mercy Health Corp.*, 1985-2 Trade Cas. (CCH) ¶ 66,749 (N.D. Ind. 1985); *Ezpeleta v. Sisters of Mercy Health Corp.*, 1985-2 Trade Cas. (CCH) ¶ 66,746 (N.D. Ind. 1985).