Loyola Consumer Law Review

Volume 8 | Issue 2 Article 14

1995

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FEATURE ARTICLE

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Introduction

How to control health care costs while preserving the quality of care has been the focal point of much health policy discussion at the federal and state level for many years and will doubtless continue to be of importance in the future. Philosophically and historically, there has been debate as to the role of market forces and competition in allocating resources in the health care industry. Traditionally, many analysts have viewed the health care arena as inhospitable to the functioning of the economic marketplace. For them, cooperation among health care providers coupled with regulation is an appropriate approach for achieving economic efficiency.[1] More recently, evidence of normal competitive behavior in the health care industry[2] has led many policymakers and analysts to conclude that a dose of competition is what the doctor should order.[3] And, since "[a]ntitrust law is the virtual engine of the market paradigm,"[4] market-oriented, procompetitive policies contemplate an appropriate role for antitrust enforcement to assure a free and competitive marketplace.[5]

The primary purpose of antitrust legislation is to promote competition in the market place in order to achieve economic efficiency and thereby to improve the well being of consumers.[6] Federal antitrust legislation prohibits conspiracies to restrain trade,[7] monopolization and attempts to monopolize,[8] anticompetitive exclusive dealing arrangements,[9] mergers and acquisitions that adversely affect competition,[10] unfair or deceptive practices with a significant impact on competition,[11] and discriminatory pricing that lessens competition.[12] Antitrust laws promote competition in order to achieve an efficient allocation of resources [13] — goods and services should be available to consumers at the lowest price for a given quality level.

In something of a rejection of market-oriented initiatives and a throwback to the traditional regulatory approach, a number of states recently have enacted legislation that authorizes hospitals or health care providers to enter into cooperative agreements. In the absence of such legislation, cooperative agreements among competitors would be subject to federal and state antitrust laws.[14] While these cooperation laws enable cooperative efforts among health care providers,[15] they permit such activity only under certain circumstances. The statutes establish elaborate schemes for securing approval, weighing, among other factors, the possible adverse impact of cooperative conduct on competition.

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State administrators, typically health departments, are allowed to balance the benefits claimed to be achieved through cooperative agreements against possible anticompetitive results. [16]

This paper examines the nature of the health care market and its evolution, explains the legal basis for state conferral of antitrust immunity for hospital cooperative conduct, reviews federal antitrust hospital industry enforcement guidelines, and summarizes the hospital cooperation laws. The paper concludes with a discussion of the likely impact of the hospital cooperation laws on the consumer.

The changing hospital and health care market

The nature of competition in the health care field and among hospitals is changing. Because of the prevalence of nearly complete third-party insurance coverage for hospital services, there was very little price competition until the early 1980s.[17] Because of legislative changes that have encouraged competition and cost control and because of changes in the way health care services are being purchased, price competition exists and has been demonstrated in some areas of the country and seems to have emerged in many more markets in the past few years. Studies regarding price competition have focused on California because data are available and a high percentage of the population is covered by insurers who contract competitively with providers. Since ninety million Americans are covered by HMOs and discount medical networks, [18] price competition is likely to be an important market feature in other parts of the country.

Historical background

Historically, influenced by the institutional structure and environment in which they functioned, hospitals and the markets in which they operate have behaved in a somewhat different manner from other industries and their markets.[19] Until recently, three participants in the hospital market — physicians, patients, and hospitals — operated in an environment in which price was not an overriding consideration; insurance paid for treatment considered appropriate by the physician and paid at a price set by the providers — the physicians and hospitals.[20]

Among the participants in the market, physicians have been the most influential;[21] because of their experience and training, they have much more specialized knowledge and expertise than patients.[22] The professional dominance model[23] has resulted from (and in turn has reinforced)[24] this asymmetry of information.[25] Under the traditional professional paradigm, patients rely on the recommendations of their physician. With the prevalence of third-party insurance for hospital stays, patients could receive hospital services for relatively small out-of-pocket payments.[26] Because of physicians' traditional ability to channel patients, hospitals have been dependent on physicians to admit patients to their facilities.[27] Competition among hospitals has focused on attracting referrals of patients by physicians. In that type of competitive environment, emphasis among competitor hospitals is on the wishes of physicians, and neither the hospital nor the physician in such circumstances has much of an incentive to be responsive to considerations of cost. This general picture is still true in many parts of the United States; in some areas, however, payers — increasingly important, increas-

ingly cost-conscious, and increasingly active participants in the market — exert their influence and change the hospital and the health care market.[28]

Normally, increased competition in a market can be expected to lead to greater efficiency and lower prices.[29] Early studies on the effects of hospital competition led to the seemingly paradoxical conclusion that increased competition led to higher prices.[30] This led to the familiar "medical arms race" hypothesis, where purchases of expensive equipment led to similar purchases by other institutions without respect to cost effectiveness.[31] The tradition of professional dominance, the predominance of third-party insurance, and the overall lack of incentives for cost consciousness meant that cost considerations were not an issue for competitive contesting among hospitals. Competition among hospitals, therefore, did not focus on price but rather on other, non-price dimensions, as in other industries (such as heavily regulated industries) where the terms of competition are constrained. Frequently, competitive activity was directed to providing costly amenities for patients and sophisticated equipment for physicians (with the necessary staff required to operate the equipment).[32] This resulted in increased overhead for each institution and in the unwarranted duplication of services in the marketplace.[33]

The syllogism for competitive success was quite straightforward. Hospitals succeeded by filling beds. Filled beds derived from referrals, since patients traditionally have typically been admitted to a hospital by a physician. Physicians controlled patient flow through control of patient referrals. Hospitals, therefore, competed among themselves for patients by vying for the affiliation of local physicians;[34] to gain physician affiliations, hospitals provided expensive specialized clinical services.[35] Given the structure of the marketplace, and the existing structure of incentives, hospitals in competitive markets had higher costs than those without competitors. Part of the reason for this phenomenon, apparently, was the inappropriate duplication of services.[36] "Hospitals in monopolistic positions within their local area produce[d] their services at significantly lower costs than hospitals in more competitive environments."[37] With payments to hospitals reflecting a cost-based system, in which hospitals were reimbursed for their legitimate expenditures (including capital outlays), there was little incentive for any relevant decisionmaker to take costs into consideration. As a result, the hospital market seemed[38] to function differently from other markets — greater competition correlated with higher rather than lower prices.[39]

Recent market changes

Legislative changes[40] and insurer and employer attention to health care costs[41] have changed the dynamic of the health care industry in some parts of the country. This suggests that when the health care marketplace is restructured to reflect incentives like other markets, health care participants and markets behave in like fashion.

In 1982, California enacted legislation (effective in 1983) that allowed health insurance plans (private third parties and the state Medicaid program) to contract selectively with health care providers.[42] This enabled private insurance plans and Medi-Cal (California's Medicaid program) to channel their beneficiaries to selected providers in exchange for price and other con-

cessions. This change introduced price competition in the California health care market as insurance plans and Medi-Cal bargained with hospitals and other providers.[43] In 1983, federal legislation established the prospective payment system ("PPS") for hospitals treating Medicare patients.[44] Under PPS, hospitals are paid a fixed fee for a range of defined services called diagnosis-related groups ("DRGs").[45] Finally, HMOs[46] and PPOs,[47] entities which bargain for discounts from hospitals, grew rapidly.[48] With the introduction of cost-conscious payers into the health care field, incentives shifted. As a result, price competition as well as quality competition began to emerge.[49]

Data from 1980 through 1985 show that in California the new payment policies, and the concomitant shift in economic incentives for participants in the marketplace, dramatically reduced the rate of increase in total hospital costs and revenues and caused a shift to less expensive outpatient services.[50] About 80 percent of the population of California is covered either by Medicare (and is therefore subject to DRGs) or managed care organizations (with their careful attention to costs); and thus hospitals now have strong incentives to reduce costs.[51] The 1983-85 rate of growth of hospital costs was lower than the 1980-82 rate for all categories except for out-patient services;[52] for hospitals in highly competitive areas, total inpatient costs (adjusted for inflation) declined by 11.3 percent while remaining flat in low-competition markets.[53] In the period from 1983 to 1988, high HMO market penetration stimulated more price competitive behavior on the part of traditional health insurers. When such insurers were permitted to contract with hospitals for discounts, they did so, and that led to a reduction in costs.[54]

Thus, there is reason to think that in competitive hospital markets, when appropriately structured, the standard economic assumption that competition lowers prices or decreases the price/cost margin is true.[55] A payer-driven market is characterized by the presence of purchasers who are motivated and capable[56] price shoppers.[57] The influence of payors is typical in the traditional marketplace, as payors determine the levels (quantity and quality) of services that will be purchased. This reflects a growing influence of market-driven behavior and a parallel erosion of the professional model, in which issues of quality and style of practice are typically decisions of the professional practitioners who act (presumably in a fiduciary capacity) on behalf of their patients (but without incentives for constraining costs).[58]

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Understanding how hospital markets function and how hospitals compete clearly has implications for antitrust policies. If hospitals compete primarily in non-price ways, intensifying competition will very likely increase consumer costs and prices.[59] However, if hospitals can be induced to compete even partially by

price, maintaining potentially competitive markets is important so that consumers may realize the benefits of price competition.[60] Antitrust enforcement will require sensitivity to distinctions between pro and anticompetitive combinations.[61] It seems that existing antitrust doctrine is well equipped to allow the drawing of those distinctions,[62] and recent evidence suggests that the federal antitrust enforcement officials are aware of and sensitive to these concerns.[63]

The conferral of state immunity

The state-enacted hospital cooperation laws, which exempt certain cooperative agreements among hospitals or health care providers from federal antitrust laws, are based on the *Parker v. Brown*[64] state-action immunity doctrine. Although in enacting the antitrust laws, Congress has exercised its constitutional commerce power to the maximum;[65] in *Parker*, the Supreme Court deferred to federalism[66] and established a form of "inverse preemption."[67] By appropriate legislative and regulatory action, a state can immunize the conduct of private parties from the application of the federal antitrust laws. Thus, federal antitrust law is "subject to supersession by state regulatory programs"[68] that substitute regulation for competition, provided that the state clearly articulates its policy and actively supervises it.[69]

Parker v. Brown[70] concerned an antitrust challenge to California's Raisin Proration Program, which authorized the state to appropriate a portion of each producer's output in order to stabilize raisin prices. This was a clear effort by the state to restrict competition among raisin growers[71], yet the Court found no violation of the Sherman Act. The Court reasoned that the Sherman Act prohibited individual action, not state action.[72] Even though the California program would have violated the antitrust laws "if it were organized and made effective solely" by collective action of "private persons," the Sherman Act does not "restrain a state or its officers or agents from activities directed by its legislature"[73] and therefore does not apply "to anticompetitive restraints imposed by the States 'as an act of government.'"[74]

In *California Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*,[75] the Court clarified the requirements for a state to confer antitrust immunity successfully on a private party.[76] Two standards must be satisfied. First, the challenged restraint must be clearly articulated and affirmatively expressed as state policy;[77] in this regard, a state policy that permits but does not compel anticompetitive conduct can be considered "clearly articulated."[78] Second, the policy must be actively supervised by the state itself.[79] Actual[80] and not just potential[81] supervision by the state is required.[82] Because, with respect to private conduct, "there is a real danger that [the private party] is acting to further [its] own interests, rather than the governmental interests of the State,"[83] the state must "exercise ultimate control over the challenged anticompetitive conduct.... The mere presence of some state involvement or monitoring does not suffice."[84]

Thus, passive ratification of private anticompetitive conduct will not suffice to establish *Parker* immunity. *Parker* "shelter[s] only the particular anticompetitive acts of private parties that, in the judgment of the State, actually further state regulatory policies."[85] Further, and of fundamental importance, those specific acts must be subject to "ongoing regulation by the State."[86] The government's duty to supervise

persists if the conferral of immunity is to be effective. Active supervision must be an ongoing process, not a momentary event.

Parker immunity is "disfavored."[87] To satisfy the requirements of *Parker*, "[s]tates must accept political responsibility for actions they intend to undertake."[88] A state's decision to substitute a regime of regulation for the national policy of competition as reflected in the federal antitrust laws must be "implemented in its specific details"[89] to assure that the "anticompetitive scheme is the State's own."[90] The supervision must not merely be that of lip service to the formalities of regulation, thereby hiding inaction by the regulating agencies.[91] The requirement of active state supervision is to prevent private parties from taking advantage of a state regulatory scheme for their own private interests.[92]

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The validity of the hospital cooperation laws is likely to rest on satisfying the "active supervision" standard. Because the laws typically express the desire to supersede the federal antitrust laws in pursuit of statutorily articulated state policy objectives, the clear articulation test is probably met.[93]

State hospital cooperation laws

Despite the positive effects on economic behavior and consumer benefit that the antitrust laws seek to promote, at least nineteen[94] states have enacted laws to immunize behavior by hospitals or health care providers that otherwise might be subject to federal antitrust scrutiny.[95] These laws allow cooperative agreements among hospitals or health care providers based on the *Parker v. Brown*[96] state-action doctrine. These statutes vary significantly in the scope of coverage and the sophistication of approach. Some follow a standardized legislative model while others are unique. Some have broad coverage, others are quite limited in scope.

Although the statutes all differ from one another (even those based on the legislative model), Tennessee's may be used as an example of the provisions and procedures frequently included in the statutes. The Tennessee statute applies to cooperative agreements between or among two or more hospitals regarding the sharing, allocation or referral of patients, personnel, services and facilities; it does not cover other health care providers.[97] There are three specific limitations on the scope of cooperative activity that can be approved under the terms of the statute. The statute does not authorize hospitals pursuant to a cooperation agreement: 1) to operate as health maintenance organizations (HMOs) without being so licensed; 2) to negotiate terms with insurers, HMOs, or PPOs otherwise prohibited under the antitrust laws; or 3) to permit referrals to provider-owned facilities otherwise prohibited by law.[98]

Hospitals may enter into agreements if the likely benefits stemming from the agreements outweigh any disadvantages attributable to a reduction in competition that may result.[99] Parties to such an agreement may apply to the department of health for a certificate of public advantage and must also submit the application to the attorney general. The attorney general and the health department are entrusted with the active and continuing oversight of all cooperative agreements.[100] The department of health reviews the application and may hold a public hearing. The department is required to give public notice and to allow interested parties to intervene. After consultation and agreement with the attorney general, the department may issue a certificate of public advantage for a cooperative agreement if it determines that the applicants have demonstrated by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result.[101]

In evaluating the benefits, the department is required to consider whether one or more of the following benefits may accrue: a) enhanced quality of hospital care; b) preservation of hospital services in geographic proximity to communities traditionally so served; c) gains in cost efficiency of services provided by the hospitals involved; d) improvements in utilization of hospital resources; and e) avoidance of duplication of hospital resources. Additionally the department is required to evaluate at least the following potential disadvantages: 1) the adverse impact on the ability of managed care organizations or other providers to negotiate optimal payment and service arrangements with hospitals and other providers; 2) the extent of any reduction in competition among health care providers other than hospitals that is likely to result; 3) any adverse impact on patients regarding quality, availability and price of health services; and 4) the availability of arrangements that are less restrictive to competition to achieve the benefits sought.[102]

The department of health is required to consult with the state attorney general regarding any potential reduction in competition, and the state attorney general may consult with the United States Department of Justice or the Federal Trade Commission.[103] Provision is made for terminating a certificate of public advantage by the department of health or the state attorney general.[104] Although the statute does not directly invoke the state-action immunity doctrine, it provides that a cooperative agreement approved under procedures it sets forth is a lawful agreement notwithstanding[105] any other provision of law.[106]

The Tennessee statute articulates a state purpose and proposes to substitute state regulation for competition.[107] The first part of the state-action immunity test, requiring clear articulation of a state policy to substitute regulation for competition, would therefore seem to be met. However, the "active supervision" requirement, which mandates ongoing supervision by the state to assure that governmental (not private) policies are being pursued,[108] raises substantial questions. While the attorney general and the health department are entrusted with the active and continuing oversight of cooperative agreements, there are no procedures within the statute that require continuing governmental supervision after the approval process and the issuance of a certificate of public advantage. Proposed Tennessee regulations require every holder of a certificate of public advantage to submit quarterly reports

and compliance certificates to the health department. The health commissioner may require additional information and site visits.[109] Yet actual supervision must exist in fact, not just in theory.[110] Mere passive ratification of private decisions is not enough,[111] and the unexercised power to supervise is also insufficient[112] to confer *Parker* protection.

In the only major action taken under hospital cooperation laws,[113] the Minnesota Commissioner of Health approved an agreement to allow the merger of two hospital systems located in the greater Minneapolis and Saint Paul areas.[114] The hospital systems did not fit within the DOJ/FTC merger safety zone.[115] The Commissioner found that the merger would result in cost savings to the users of the hospitals.[116] This was shown through affidavits from major purchasers of health care services in the area.[117] These affidavits indicated that through their contract negotiations with the hospitals savings had been passed on to them.[118] Additionally, no purchasers filed negative comments regarding the merger.[119] The affidavits also gave weight to the argument that even post-merger, the market was still competitive.[120] Arguably,[121] the existence of the state statute allowed a merger that will achieve cost efficiencies and that, through state oversight, will pass on savings to payers.[122]

Antitrust guidelines for health care

One purpose of the hospital cooperation laws may have been to deal with perceived problems of uneven or inappropriate application of the antitrust laws to hospitals or other health care providers.[123] However, in response to requests and criticisms from providers, in 1993 and again in 1994, the Department of Justice and the Federal Trade Commission issued joint guidelines regarding their antitrust enforcement policies in the health care field.[124]

The 1994 guidelines currently include nine statements on enforcement policy and analytical principles in the following areas:

1) Mergers;
2) Hospital joint ventures involving equipment;
3) Hospital joint ventures involving specialized services;
4) Providers' collective provision of non-fee-related information;
5) Providers' collective provision of fee-related information;
6) Provider participation in exchanges of price and cost information;
7) Joint purchasing arrangements among providers;
8) Policy on physician network joint ventures; and
9) Analytical principles relating to multiprovider networks.

Many of these guidelines apply to areas that might be covered by state legislation concerning cooperative agreements among hospitals or among health care providers, depending on the scope of the particular statute. These guidelines and the accompanying analytical explanations may enable health care providers to proceed with various arrangements that will promote efficiencies in the health care market with some decreased risk of antitrust enforcement.

Thoughtful application of antitrust laws may be an effective way to achieve the goals sought by the state-action immunity laws with fewer unanticipated adverse consequences.[125] The promulgation of these guidelines seems to have lessened the impetus for states to enact hospital cooperation laws. The increased clarity of federal enforcement policy may enable health care providers to achieve the benefits of joint endeavors with less hassle[126] and more certainty[127] than utilizing the state-enacted hospital cooperation laws. Providers will surely try first to fit within the guidelines and only resort to the hospital cooperation laws as a second choice. That there has been only one major use of hospital cooperation legislation (Minnesota's) suggests that these procedures are still less attractive to hospitals than the traditional federal antitrust review process.[128]

The impact of hospital cooperation laws on consumers

A. The hospital cooperation laws may have a negligible impact on consumers as they may be used only infrequently. There are three reasons why this may be so: first, there will be uncertainty that the state procedures will be sufficient to confer antitrust immunity; second, receiving immunity may entail such significant state supervision as to be costly and burdensome; and third, the federal guidelines may provide an alternate and more certain method to achieve the same end.

1. In order to confer immunity under the *Parker* state-action immunity doctrine, a state must clearly articulate its intention to displace competition with regulation and must actively supervise the actions of the parties immunized from antitrust scrutiny. The hospital cooperation laws probably meet the clear articulation test. The active supervision requirement poses the nettlesome problem.

To satisfy the strictures of *Parker*, a state must ensure that the policies being pursued by private parties are those of the government. This requires that the supervision by government be hands-on; actual[129] and ongoing[130] exercise of supervisory authority is necessary for *Parker* immunity to attach.

In Tennessee, by way of example, the statute authorizes active and continuing oversight of cooperative agreements by the department of health and the attorney general, and the proposed regulations require quarterly reports and allow for additional oversight. If the health department actually acts upon the reports and periodically actively reviews the approved cooperative arrangements, that may be sufficient. But to achieve *Parker* immunity, the state would have to affirmatively approve or disapprove[131] the "specific details"[132] of the "particular anticompetitive acts of private parties"[133] to assure that the "anticompetitive scheme is the State's own."[134]

Few of the other states have statutory provisions for active supervision.[135] Because of the lack of statutory provisions, hospitals or health care providers acting cooperatively with the approval of the state health department may nevertheless find themselves subject to antitrust laws because the state supervision was not sufficiently active. It will be difficult for parties to such agreements to know their status with certainty. The parties will have no control over their own supervision; nor will they have the ability to require the state through the health department to exercise active supervision.[136] Because of this

uncertainty, providers have not (and may not) make much use of the state hospital cooperation laws.

2. Even if the statute and regulations provide for adequate supervision to satisfy the *Parker* standards, and even if the state agencies actually exercise their statutorily-conferred supervisory powers, hospitals and other providers may not utilize the state statutes because of the loss of decisionmaking autonomy and the burdensome costs. The intrusiveness and the transaction costs of complying with the required supervision may be greater than the advantage to be gained from the cooperation agreement. That is, merging a service currently offered by two hospitals might be economically efficient for both hospitals. However, the costs of demonstrating the advantages of the collective conduct, of producing on a continuing basis the reports required to show the savings and the use of the savings,[137] and of complying with site visits or any other such requirements might be greater than the savings generated. It may be a Catch 22 situation: if the supervision is sufficient to confer immunity, its costs might exceed the benefits to be gained.

The intrusiveness and the transaction costs of complying with the required supervision may be greater than the advantage to be gained from the cooperation agreement.

3. The federal guidelines remove from DOJ/FTC antitrust enforcement scrutiny many arrangements that the hospital cooperation laws may have been intended to cover. If an agreement fits within the federal guidelines, the federal enforcement agencies have announced that they will not pursue enforcement efforts. In such circumstances, there is a much-reduced antitrust risk. Even though antitrust courts are not bound by the DOJ/FTC guidelines, and private parties can bring antitrust actions, the antitrust risk is likely to be sufficiently small so that a private party will see no compelling reason, as a practical matter, to apply for a state's blessing by complying with the necessarily cumbersome and expensive state procedures. As a result, applications for approval of cooperative agreements likely will involve situations that fall outside the federal guidelines and thus entail more risk of anticompetitive pricing and increased costs to consumers.

Furthermore, the DOJ/FTC guidelines provide an alternative procedure to the state process. Under the guidelines, the federal antitrust enforcement agencies have promised to respond to business review or advisory opinion requests within 90 days after all necessary information is received.[138] Thus, instead of going through the state procedure, the parties may prefer to utilize the federal procedure. It is not clear which procedure will be more time-consuming and costly. The federal review process has the advantage of less uncertainty — assuring parties of the enforcement decision of the federal antitrust agencies. Private antitrust actions, however, remain available. While the state procedures confer immunity if effective, there is always the risk that the supervision by the appropriate state agency will

be inadequate to confer immunity successfully under the *Parker* state-action doctrine.

B. Cooperative agreements may lead to efficiencies, but they also have the potential to be cozy arrangements for the benefit of the participants to the detriment of payers for health care. In most fields, competition is generally regarded as the best method of supplying consumers with goods and services of a given quality at the lowest price. Meaningful price competition among health care providers stimulated by the interest of employers, unions, insurance companies and other payers in containing health care costs is emerging in some areas of the country.[139] Managed care entities that supervise the quality and quantity of care given their enrollees and that, by their aggregation of patients into large groups can bargain effectively with health care providers for reduced rates, are becoming more widespread.[140] The possibility of effectively using market competition to restrain health care costs will be diminished or even eliminated in some areas if states allow cooperative agreements among health care providers to reduce the number of providers so that insufficient numbers remain for competition among them to be effective. States must be cognizant of this problem and not foreclose the possibility of using competition to reduce costs by approving cooperative agreements that eliminate the possibility of competition.[141] Although some commentators assert that the health care industry is different and price competition is not suitable,[142] recent studies[143] and other reported information[144] regarding the effectiveness of competition to reduce costs but maintain quality[145] would seem to counter this argument.[146]

Hospitals traditionally have used their insulation from price competition to cost shift — that is, to charge different payers different prices. Cost shifting enabled hospitals to subsidize indigent care, specialized services, medical education, research or other worthy endeavors. Effective competition reduces the ability of hospitals to cost shift.[147] Hospital cooperation laws may enable hospitals and other health care providers to maintain or reestablish the conditions necessary for cost shifting.[148] If this is the case, application of the hospital cooperation laws may mean increased costs for many payers and increased surpluses for the hospitals. These surpluses would then provide hospitals with funds to apply elsewhere. There is a real problem of accountability in this type of effort. The magnitude of the subsidy is blurred, and careful attention to trade-offs is difficult in this context.[149]

The impact of the hospital cooperation laws on the consumer will also depend on how the health departments and attorneys general evaluate the statutory benefits and disadvantages of the cooperation agreements. Evaluation of the statutory benefits and disadvantages will be difficult and almost any result can probably be justified. For one thing the benefits and disadvantages are not ranked in order of importance. Additionally the statutory benefits themselves are inherently contradictory.[150] Some benefits are directed at increased efficiency and cost control while others are directed at quality and geographic access. Enhancement of the quality of care in hospitals and preservation of geographic access to hospitals are likely to increase costs. However, gains in cost efficiency are likely to reduce costs or slow the rate of cost increase. It is not clear whether the two other benefits increase or decrease costs. Improvements in utilization of hospital resources may be achieved by consolidating under-used services that might lower costs. Subsidizing increased utilization of hospital resources, on the other hand, is likely to

increase costs. Avoiding duplication of hospital resources may serve to increase efficiency and reduce prices, or it may serve to increase market power and increase prices. Since the benefits are not prioritized, the process is highly politicized, with the health department and the attorney general possibly disagreeing on the evaluation of the overall public benefit to be achieved by the cooperative agreement. The resolution of competing statutory goals will take place in a forum where the process could be tilted to favor the highly organized and concentrated interests.

The typical statute does set a standard that the benefits must outweigh the disadvantages by clear and convincing evidence. This gives guidance to those applying the statute that the benefits, which ever ones are decided to be most important, must be significantly greater than the disadvantages. But this is a very hard standard to apply, and judicial review is likely to be extremely deferential. On balance, it is appropriate to view these provider-cooperation statutes with some skepticism, particularly as evidence accrues that competition in the health care industry results in desirable outcomes when properly structured. There is a real risk of market distortion from hidden taxation and the supersession of federal antitrust laws.[151]

Conclusion

There are insufficient data to reach a firm conclusion regarding the benefits to or effects on consumers of hospital or provider cooperation legislation based on the actual application of these laws. The one major decision, Minnesota's decision to allow the merger of two hospital systems in Minneapolis/St. Paul, was reached after consideration of the efficiencies to be realized and of mechanisms to pass the cost savings on to the purchasers of health care. Since this merger was in a major metropolitan area, it is likely that significant competition remained. The Minnesota decision was a thoughtful evaluation of costs and efficiencies and the effect of the merger on the market. But even in that case, a thoughtful and knowledgeable analyst has expressed skepticism about the benefits for consumers.[152]

Competition is working to reduce costs in markets where structures conducive to effective competition exist. This result will likely expand as managed care grows. This is shown in studies of recent data and in anecdotal newspaper coverage. Massachusetts in a short period of time has passed California as the state with the highest percentage of people enrolled in managed care entities.[153] Most people live in population centers which either have competitive health care markets or potentially competitive markets. It is clearly not desirable for state immunity laws to eliminate competition or the possibility of competition in markets where the population is large enough to support competing hospitals or competing managed care plans. Even if price competition is not yet active in an area, foreclosing the possibility eliminates the efficiencies that may be realized in the future. State policy makers should be extremely cautious regarding cooperative agreements among health care providers just as competitive forces are emerging that will rationalize the efficiency of the health care marketplace to the benefit of consumers. This is a time for prudence before reestablishing the regulatory paradigm, based on possibly outdated data, just as newer evidence strongly suggests the viability of and benefits from properly structured competition and appropriate incentives in the health care arena.

ENDNOTES

[1] *Compare* Frederic J. Entin et al., *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107 (1994) *with* David L. Meyer & Charles F. (Rick) Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169 (1994). There is a serious question whether the goals of a regulatory regime are (or can be, politically) confined to the achievement of economic efficiency. Cross-subsidization of preferred services rather than economic efficiency may be the driving force for regulation. That requires the generation and recapturing of supra-competitive returns, which in turn are dependent on and necessitate a less-than-competitive economic environment. *See* James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1498-1501 (1994) [hereinafter Blumstein, *Competing Visions*].

[2] *See infra* text accompanying notes 42 & 43.

[3] For an early discussion of the case for greater emphasis on market-oriented policies in the health care industry, *see* James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849 (1981).

[4] *See* Blumstein, *Competing Visions*, *supra* note 1, at 1482.

[5] *Id.* at 1482-86.

[6] *See* James M. Klingensmith, *Applying Antitrust Concepts to the Acute Care Hospital Industry: Defining the Relevant Market for Hospital Services*, 13 J. HEALTH POL., POL'Y & L. 153, 154 (1988).

[7] Sherman Antitrust Act § 1, 15 U.S.C. § 1 (1988 & Supp. II 1990). *See* Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984).

[8] Sherman Antitrust Act § 2, 15 U.S.C. § 2 (1988 & Supp. II 1990). *See* Morgenstern, M.D. v. Wilson, M.D., 29 F.3d 1291 (8th Cir. 1994).

[9] Clayton Act § 3, 15 U.S.C. § 14 (1988). *See* Barr Lab., Inc. v. Abbott Lab., 978 F.2d 98 (3rd Cir. 1992); Advanced Health-Care Services, Inc. v. Radford Community Hosp., 910 F.2d 139 (4th Cir. 1990).

[10] Clayton Act § 7, 15 U.S.C. § 18 (1988). *See* U.S. v. Carilion Health System, 707 F. Supp. 840 (W.D. Va. 1989); U.S. v. Rockford Memorial Corporation, 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd*, 89 F.2d 1278 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990).

[11] Federal Trade Commission Act § 5, 15 U.S.C.A. § 45 (1995). *See* American Medical Ass'n v. Federal Trade Comm'n, 94 F.T.C. 701 (1979), *affirmed as modified*, 638 F.2d 443 (2d Cir. 1980), *and affirmed by an equally divided court*, 452 U.S. 678 (1982); Federal Trade Comm'n v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).

[12] Robinson-Patman Act § 3, 15 U.S.C. § 13a (1988). The Robinson-Patman provision establishes fairness among competitors rather than economic efficiency as its primary objective. This provision has been much criticized by commentators. *See* Klingensmith, *supra* note 6, at 154-55. To the extent that state provider-cooperation laws immunize conduct that is pro-competitive but that could violate Robinson-Patman, then economic efficiency might well be enhanced.

[13] *See* Meyer & Rule, *supra* note 1, at 179.

[14] The federal antitrust enforcement agencies have formulated guidelines regarding their exercise of prosecutorial discretion in administering the antitrust laws. If conduct falls within the safety zones spelled out in those guidelines, then no enforcement action will be pursued by the agencies. *See* U.S. Dept. of Justice and Federal Trade Comm'n, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust* (Sept. 27, 1994), *reprinted in* 4 TRADE REG. REP. (CCH) ¶ 13,152 at 20,769.

[15] These provider cooperation laws have been enacted under the state-action antitrust immunity doctrine. *See* Parker v. Brown, 317 U.S. 341 (1943). For a discussion of the development of this doctrine, *see infra* text accompanying notes 70-74. Under the Supremacy Clause of the United States Constitution, U.S. Const., art. VI, cl. 2, state laws that conflict with or that are inconsistent with federal laws are unconstitutional. *See, e.g.*, Jones v. Rath Packing Co., 430 U.S. 519 (1977). Under *Parker*, however, federal antitrust laws do not apply to certain state and state-approved anticompetitive private conduct. *Parker* thus reverses the general principle that federal laws prevail over state laws. *See* Blumstein, *Competing Visions*, *supra* note 1 at 1486-87. *See also* James F. Blumstein, *Federalism and Civil Rights: Complementary and Competing Paradigms*, 47 VAND. L. REV. 1251, 1255, 1297-98 (1994).

[16] *See, e.g.*, TENN. CODE ANN. § 68-11-1303(d) (1994). The states of Florida, Idaho, Kansas, Maine, Minnesota, Nebraska, North Carolina, North Dakota, Ohio, Texas, Wisconsin, and Wyoming have similar formulations based on balancing possible benefits against anticompetitive effects. *See infra* Table 1 (Hospital Operation Laws). In contrast to this balancing of overall benefits against anticompetitive effects, antitrust laws eliminate non-efficiency-based criteria from analytical consideration. *See* Thomas E. Kauper, *The Role of Quality of Health Care Considerations in Antitrust Analysis*, 51 LAW & CONTEMP. PROBS. 273, 292-93 (Spring 1988) (asserting consumer welfare model of antitrust enforcement focuses "solely on allocative and productive efficiency," and that "prevailing antitrust standards are largely in accord with this 'consumer welfare model'".)

[17] *See, e.g.*, Harold S. Luft et al, *The Role of Specialized Clinical*

Services in Competition Among Hospitals, 23 INQUIRY 83, 93 (1986) [hereinafter Luft et al., *Specialized Clinical Services*] (asserting that competition among hospitals focused on attracting physicians through the offer of specialized services and that this type of competition led to a proliferation of clinical services and cost inflation); James C. Robinson & Harold Luft, *The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and the Cost of Care*, 4 J. HEALTH ECON. 333, 353-54 (1985) [hereinafter Robinson & Luft, *Hospital Market Structure*] (supporting the hypothesis that in a cost-based mode of reimbursement greater competition is associated with higher rather than lower costs); James C. Robinson & Harold S. Luft, *Competition and the Cost of Hospital Care*, 1972 to 1982, 257 JAMA 3241, 3244 (1987) [hereinafter Robinson & Luft, *Competition and Cost*] (presenting data indicating that hospital costs were substantially higher in more competitive markets consistent with the "medical arms race" hypothesis that competition among hospitals took the form of cost-increasing acquisition of new technology attractive to physicians and patients); J. Micheal Woolley & H.E. Frech, III, *How Hospitals Compete: A Review of the Literature*, 2 U. FLA. J. L. & PUB. POL'Y 57, 65-75 (1988-89) [hereinafter Woolley & Frech, *How Hospitals Compete*] (citing many studies which generally showed under various methodologies that competitive hospital markets had higher prices); Jack Zwanziger and Glenn A. Melnick, *The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California*, 7 J. HEALTH ECON. 301, 301-305 (1988) [hereinafter Zwanziger & Melnick, *Competition and the Medicare PPS Program*] (discussing studies using data from 1970s and early 1980s showing higher costs in competitive markets).

[18] Milt Freudenheim, *Doctors Are Sparring with Insurers over Right to Join Health Networks*, N.Y. TIMES, JULY 12, 1994, at A8.

[19] *See* Woolley & Frech, *How Hospitals Compete*, *supra* note 17, at 58, 61; Robinson & Luft, *Competition and Cost*, *supra* note 17, at 3244; and Luft, et al., *Specialized Clinical Services*, *supra* note 17, at 83.

[20] *See* Larry M. Manheim & Joe Feinglass, *Hospital Cost Incentives in a Fragmented Health Care System*, 19(1) HEALTH CARE MGMT. REV. 56, 56 (1994); David Dranove, et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J. L. & ECON. 179, 179-181 (1993) [hereinafter Dranove et al., *Payer-Driven Competition*]; Woolley & Frech, *How Hospitals Compete*, *supra* note 17, at 60-61.

[21] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 5 (1982); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. Rev. 431, 445-47 (1988).

[22] *See* Woolley & Frech, *How Hospitals Compete*, *supra* note 17, at 59.

[23] *See* Blumstein, *Competing Visions*, *supra* note 1, at 1463-1464.

[24] Starr, *supra* note 21, at 226-27. Starr has argued that the dominance of professionals has perpetuated the imbalance in information available to patients, and thereby has perpetuated professional power vis a vis patients. That is, professionalism may in part be a cause, not just a response, to market failure (the asymmetry of information between physician and patient).

[25] *See* Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 947-49 (1963). (arguing that the professional paradigm is a response to market failure in the medical care marketplace — the unpredictable nature of the need for medical care and the ignorance of the consumer); Starr, *supra* note 21, at 226-27 (noting that uncertainty and consumer ignorance may be promoted by the professional paradigm, thereby perpetuating the empowerment of professionals in medical care decisionmaking).

[26] *See* Luft, et al., *Specialized Clinical Services*, *supra* note 17, at 83; Woolley & Frech, *How Hospitals Compete*, *supra* note 17, at 60-61.

[27] *See* Luft, et al., *Specialized Clinical Services*, *supra* note 17, at 83.

[28] *See* Dranove, et al., *Payer-Driven Competition*, *supra* note 20, at 180; Glenn A. Melnick, *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217, 231 (1992) [hereinafter Melnick, *Market Structure and Bargaining Position*]; James C. Robinson, *HMO Market Penetration and Hospital Cost Inflation in California*, 266 JAMA 2719, 2723 (1991) [hereinafter Robinson, *HMO Market Penetration*]; Zwanziger & Melnick, *Competition and the Medicare PPS Program*, *supra* note 17, at 316; and Jack Zwanziger et al, *Cost and Price Competition in California Hospitals*, 1980-1990, 13 HEALTH AFF. 118, 124 (Fall 1994) [hereinafter Zwanziger et al., *California Hospitals*, 1980-1990].

[29] *See* Robinson & Luft, *Competition and Cost*, *supra* note 17, at 3241.

[30] *See id.* at 3244; Zwanziger & Melnick, *Hospital Competition and the Medicare PPS Program*, *supra* note 17, at 305. For a more generalized discussion of the relationship between the nature of competition and the containment of costs, *see* Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1513-14 (1994).

[31] *See* Luft, et al., *Specialized Clinical Services*, *supra* note 17, at 92.

[32] *See* Luft, et al., *Specialized Clinical Services*, *supra* note 17, at 93; Robinson & Luft, *Competition and Cost*, *supra* note 17, at 3241.

[33] *See* Luft, et al., *Specialized Clinical Services*, *supra* note 17, at 91.

[34] *See generally* Robert C. Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980); Philip C. Kissam et al., *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595 (1982).

[35] *See* Luft, et al., *Specialized Clinical Services*, *supra* note 17, at 83. *See also* Hall, *supra* note 21, at 506.

[36] *See* Luft, et al., *Specialized Clinical Services*, *supra* note 17, at 93.

[37] Robinson & Luft, *Hospital Market Structure*, *supra* note 17, at 342. *See also* United States v. Carilion Health System, 707 F. Supp. 840, 846 (W.D. Va. 1989).

[38] Critics of the use of markets in medical care often have relied on those studies to suggest that the market for medical care was different, that competition could not achieve its traditional objective of economic efficiency. *See, e.g.*, Entin et al., *supra* note 1. As the later studies have shown, *see infra* notes 50-54, and as current anecdotal experience is demonstrating, the market in medical care responds to incentives as in other markets. Where, as in regulated industries, the terms of competition are constrained, the consequences of competition may be socially ill-adaptive. The policy issue then becomes what policy pathway to pursue — give up on the market and impose a regulatory solution that substitutes for the market, or improve the functioning of the market to create an appropriate set of incentives.

[39] *See* Robinson & Luft, *Hospital Market Structure*, *supra* note 17, at 354. An alternative explanation of the evidence might be to focus on market conditions from the position of the dominant physicians. In seemingly competitive markets, conditions were advantageous to physicians upon whose referrals hospitals relied to fill patient beds. In effect, for the physicians prices went down (or value of services went up). In more concentrated markets, the margins available to physicians were recaptured by the hospitals, which had more market leverage. From the perspective of physicians, prices went up in those markets, as there was less surplus made available to referring physicians, upon whom such hospitals were presumably less dependent.

[40] *See infra* notes 94, 95 and accompanying text.

[41] Health care costs rose sufficiently — both in terms of rate of increase and absolute levels of expenditure — to attract serious employer attention. Employers became willing to confront the difficult employee-relationship issues involved in changing or limiting an unconstrained fee-for-service system. Insurance companies modified their range of options to accommodate employer concerns and to compete with HMOs.

Historically, physicians have resisted perceived inroads on their professional autonomy by engaging in collective action. *See, e.g.*, American Medical Ass'n v. United States, 317 U.S. 519 (1943) (holding a refusal by fee-for-service physicians to deal with HMO physicians to be a violation of the Sherman Act). At one time, there was some question about the scope of antitrust applicability to professional activity. *See* United States v. Oregon State Medical Society, 343 U.S. 326, 336 (1952) (stating that "forms of competition usual in the business world may be demoralizing to the ethical standards of a profession"). Faced with this type of potential collective resistance and the uncertain status of antitrust enforcement against such collective physician conduct, payers were understandably reluctant to take aggressive cost-containment measures.

That the antitrust laws apply to professional activity is now settled. National Society of Professional Engineers v. United States, 435 U.S. 679 (1978); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975). Collective action relating to fees, even for purported reasons of improving professional quality, violates the antitrust laws. *See* FTC v. Superior Court Trial Lawyers Ass'n., 493 U.S. 411 (1990) (holding that collective refusal of court-appointed trial lawyers in criminal defenses cases to accept appointment because of low fee levels constituted a per se violation of the antitrust law). *See also* Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (holding maximum fee agreements among physicians, arranged by the Maricopa County Medical Society, to be per se unlawful price fixing agreements); In re Michigan State Medical Society, 101 F.T.C. 191 (1983) (invalidating physicians' collective conduct in negotiating with Blue Cross/Blue Shield regarding the insurer's cost-containment efforts). In a recent example, the Justice Department charged that hospitals in Danbury, Connecticut and St. Joseph, Missouri joined with physicians in illegal price fixing schemes to keep out lower-cost managed care companies. Both hospitals operated in monopoly situations. The cases were settled by consent decrees. *See* Thomas J. Lueck, *Illegal Price-Fixing Charged in Danbury Hospital Suit*, N.Y. Times, Sept. 14, 1995, at B6. For further cases and discussion, *see* Greaney, *supra* note 30, at 1524, and Meyer & Rule, *supra* note 1, at 183-86. These antitrust decisions have limited the ability of physicians and physician organizations to resist competition and inhibit the formation of innovative methods of providing care and containing cost.

[42] *See* Glenn A. Melnick & Jack Zwanziger, *Hospital Behavior under Competition and Cost-Containment Policies: The California Experience, 1980 to 1985*, 260 JAMA 2669, 2669 (1988) [hereinafter Melnick & Zwanziger, *The California Experience, 1980-85*]; Robinson, *HMO Market Penetration*, *supra* note 28, at 2719.

[43] *See* David Dranove & William D. White, *Recent Theory and Evidence on Competition in Hospital Markets*, 3 J. ECON. & MGMT. STRATEGY 169, 193-94 (1994); Melnick & Zwanziger, *The California Experience, 1980 to 1985*, *supra* note 42, at 2669; James C. Robinson & Harold S. Luft, *Competition, Regulation, and Hospital Costs, 1982 to 1986*, 260 JAMA 2676, 2676 (1988) [hereinafter Robinson & Luft, *Competition, Regulation, and Hospital Costs*]; Robinson, HMO Market Penetration, supra note 28, at 2719; Zwanziger & Melnick, *Competition and the Medicare PPS Program*, *supra* note 17, at 316-17; Jack Zwanziger et al, *Hospitals and Antitrust: Defining Markets, Setting Standards*, 19 J. HEALTH POL., POL'Y AND L. 423, 424 (1994) [hereinafter Zwanziger et al., *Defining Markets, Setting Standards*]; Jack Zwanziger et al, *California Hospitals, 1980-1990*, *supra* note 28, at 123.

[44] Social Security Amendments of 1983, § 42 U.S.C.A. 1395ww (West 1992 and Supp. 1995).

[45] Prior to the adoption of PPS, Medicare had reimbursed providers on the basis of their costs. Under cost-based reimbursement, there are no incentives to contain costs; increased costs result in increased reimbursement. DRGs are specified conditions for which Medicare will pay a fixed amount based on the average costs to treat the condition. If a hospital is able to treat the condition for less than the average amount, the hospital may retain the amount. However, the hospital is at risk for treatment costs above the DRG payment. For a description of the DRG system, *see* Kathryn G. Sophy, Comment, *Diagnosis Related Groups and the Price of Cost Containment*, 2 J. CONTEMP. HEALTH L. & POL'Y 305, 306-07 (1986) and Judith R. Lave, *The Impact of the Medicare Prospective Payment System and Recommendations for Change*, 7 YALE J. ON REG. 499, 505-07 (1990).

[46] A Health Maintenance Organization ("HMO") provides comprehensive health services to a defined population, its enroll-

ees, in return for a fixed payment per enrollee. There are several different organizational models for HMOs. The physicians who provide care to the enrollees may be employed by one HMO and only have those HMO enrollees as their patients; alternatively, the physicians may have contractual relationships with one or more HMOs and may see only HMO enrollees or may also see other patients. Some HMOs are mixed models. Since payment to the HMO is fixed regardless of the medical care needed, the HMO has incentives to use cost effective care. Thus HMOs try to reduce hospital based care and specialist care through oversight and economic incentives to providers and try to contract with providers who offer cost effective care. Depending on the type of HMO, enrollees may have to pay entirely or partially for care provided by providers other than HMOs; thus enrollees have great incentives to use the HMO providers. This in turn gives HMOs bargaining power with respect to providers regarding price and quality. *See* Stephen S. Boochever, *Health Maintenance Organizations* in ALTERNATIVE DELIVERY SYSTEMS: HMO's, PPO's AND CMPs (Jeanie M. Johnson, ed. 1986); John F. Shields et al., *The Cost of Legislative Restrictions on Contracting Practices: The Cost to Government, Employers and Families*, Lewin-VHI, Inc., Report to Healthcare Leadership Council, Alliance for Managed Care, and Health Insurance Association of America, ii-iii (June 21, 1995); Lawrence P. Casalino, *Balancing Incentives: How Should Physicians Be Reimbursed?*, 267 JAMA 403, 404 (1992); and Daniel K. Zismer, *Physician Incentives in a Managed Care World*, 37 HEALTHCARE F.J. 39 (Sept./Oct. 1994).

[47] A Preferred Provider Organization ("PPO") is a discounted fee-for-service system with varying degrees of treatment oversight with regard to hospital and specialist use. Providers in the PPO agree to discount the services they provide to a designated population. If those persons insured under a PPO do not use the designated PPO providers, they are required to pay higher co-payments. Providers in a PPO have incentives to provide efficient care because of the discount; however, they also have incentives to increase the volume of care provided. The higher co-payment which PPO insureds are required to pay to non-PPO providers gives the insureds incentives to use PPO providers. This control of patient behavior gives PPOs the ability to bargain with their providers regarding price and quality. *See* Michael F. Anthony, *Preferred Provider Organizations* in ALTERNATIVE DELIVERY SYSTEMS: HMO's, PPO's AND CMP's (Jeanie M. Johnson, ed. 1986); Shields, *supra* note 46, at ii-iii; Casalino, *supra* note 46, at 403; Zismer, *supra* note 46, at 39.

[48] *See* Melnick & Zwanziger, *The California Experience 1980-1985*, *supra* note 42, at 2670. The Federal Health Maintenance Act of 1973 preempts state laws that inhibit or prevent the formation of HMOs. *See* 42 USC § 300e-10 (1988). Some state HMO legislation expands the federal legislation and enables HMOs to employ physicians rather than to contract with a professional corporation of physicians to provide services. Additionally, state HMO legislation allowed business corporations to form HMOs. *See, e.g.*, TENN. CODE ANN. § 56-32-201 to 225 (1994). Although HMOs existed prior to the adoption of the 1973 federal legislation, the federal law (as amended) enabled and stimulated the formation of HMOs, which were organized to compete on the basis of price as well as quality.

[49] *See* Melnick & Zwanziger, *The California Experience, 1980-1985*, *supra* note 42, at 2675; Robinson, *HMO Market Penetration*, *supra* note 28, at 2723; Dranove, et al., *Payer-Driven Competition*, *supra* note 20, at 180-81. The rate of increase in inpatient costs adjusted for inflation increased at an average rate of almost 5% in 1980-82 and decreased by almost 2% in the 1983-85 period. Melnick & Zwanziger, *The California Experience, 1980 to 1985*, *supra* note 42, at 2672.

[50] Melnick & Zwanziger, *The California Experience, 1980-1985*, *supra* note 42, at 2669.

[51] *Id.* at 2670.

[52] *Id.* at 2672.

[53] *Id.* at 2673.

[54] *See* Robinson, *HMO Market Penetration*, *supra* note 28, at 2723. However, the cost reductions achieved (9.4% lower rate of inflation) are to be contrasted with the rate of cost increase per admission during the period (74.5%).

[55] *See* Dranove, et al., *Payer-Driven Competition*, *supra* note 20, at 179 and 182; Melnick, *Market Structure and Bargaining Position*, *supra* note 28, at 231-32; Ron Winslow, *Is Victory in Sight in Health-Care War?*, WALL ST. J., Feb. 28, 1995, at 1 (attributing a 1.1% drop in average costs per employee from a Foster Higgins survey of employers' shifts to enrollment in managed care plans); Zwanziger & Melnick, *Competition and the Medicare PPS Program*, *supra* note 17, at 316; Zwanziger et al., *California Hospitals, 1980-1990*, *supra* note 28, at 123; Zwanziger et al., *Defining Markets, Setting Standards*, *supra* note 43, at 429; and Shields, *supra* note 46, at iv. For recent data on health care cost reductions in California *see* Alain C. Enthoven and Sara J. Singer, *Managed Competition in the California Health Care Economy*, 14 HEALTH AFF. (Winter 1995).

[56] Under traditional health insurance plans, patients do not have the same motivation to be cost conscious. In the absence of substantial deductibles and copayments, patients face little incentive to be cost conscious. Even with co-payments, there is the phenomenon of moral hazard, since patients' co-payments typically amount to 20% of expenses. The divergence between individual cost and actual social cost in such circumstances is graphically depicted in Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 17-18 (1975).

Under traditional fee-for-service payment practices, physicians' economic incentives are aligned with their professional perception that more is better in medical care. Economic incentives for cost constraints are therefore similarly lacking.

[57] *See* Dranove, et al., *Payer-Driven Competition*, *supra* note 20, at 183; Zwanziger et al., *California Hospitals, 1980-1990*, *supra* note 28, at 120; Zwanziger et al., *Defining Markets, Setting Standards*, *supra* note 43, at 427-29. A study of data from California from 1983 to 1988 concluded that under the influence of a payer-driven market, margins, measured using the bargained-for price rather than the list price, were falling in competitive markets. *See* Dranove, et al., *Payer-Driven Competition*, *supra* note 20, at 201. California hospitals with more than ten other hospitals within a fifteen mile radius had

an adjusted inflation rate of 40.5%; California hospitals with fewer than ten hospitals within a fifteen mile radius had an adjusted inflation rate of 62.0%; the adjusted rate in the 43 other states was 58.4%. *See* Robinson & Luft, *Competition, Regulation, and Hospital Costs*, *supra* note 43, at 2679. Another study examined hospital selective contracting by the Blue Cross PPO in California and showed that the PPO was able to secure lower prices for its patients in competitive markets. *See* Melnick, *Market Structure and Bargaining Position*, *supra* note 28, at 229, 231.

[58] *See* Blumstein, *Competing Visions*, *supra* note 1, at 1463-1474.

[59] *See* Robinson & Luft, *Competition and Cost*, *supra* note 17, at 3241.

[60] *See* Zwanziger et al., *Defining Markets, Setting Standards*, *supra* note 43, at 442-44; and Zwanziger et al., *California Hospitals, 1980-1990*, *supra* note 28, at 125.

[61] *See* Zwanziger et al., *Defining Markets, Setting Standards*, *supra* note 43, at 423.

[62] *See* Meyer & Rule, *supra* note 1, at 182-220.

[63] *See* U.S. Dept. Of Justice and Federal Trade Comm'n, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust* (Sept. 27, 1994), *supra* note 14; Commissioner Christine Varney, New Directions at the FTC: Efficiency Justifications in Hospital Mergers and Vertical Integration Concerns, (Remarks Before the Health Care Antitrust Forum (May 2, 1995) (stating that, as a matter of prosecutorial discretion, the FTC should emphasize efficiency justifications in examining hospital mergers, and that such a focus would likely result in fewer challenges to mergers)). For discussion, *see* 4 HEALTH L. REP. 681 (1995).

[64] 317 U.S. 341, 352 (1943).

[65] *See, e.g.*, Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 743 n.2 (1976).

[66] *Parker*, 317 U.S. at 351 ("In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress.").

[67] *See* Frank H. Easterbrook, *Antitrust and the Economics of Federalism*, 26 J. L. & ECON. 23, 25 (1983). *But see* Einer Richard Elhauge, *The Scope of Antitrust Process*, 104 HARV. L. REV. 667, 717-29 (1991) (critiquing this view of the state-action doctrine).

[68] FTC v. Ticor Title Ins. Co., 112 S. Ct. 2169, 2176 (1992).

[69] California Retail Liquor Dealers Ass'n. v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

[70] *Parker*, 317 U.S. 341 (1943).

[71] The raisin proration scheme was a clear effort by California "to substitute sales quotas and price control — the purest form of economic regulation — for competition in the market for California raisins." *See* Columbia v. Omni Outdoor Advertising, Inc., 499 U.S. 365, 388 (1991) (Stevens, J., dissenting).

[72] *Parker*, 317 U.S. at 352.

[73] *Id.* at 350-51.

[74] *Columbia*, 499 U.S. at 370.

[75] California Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 97 (1980).

[76] At one point, it was not clear whether state-action immunity could be conferred by a state on a private party. *See* Cantor v. Detroit Edison Co., 428 U.S. 579, 585-92 (1976) (plurality). Justice Stevens, for a plurality of four justices (Stevens, Brennan, Marshall, and White), concluded that *Parker* immunity could only be extended to state officials in their official capacities. *Id.* at 591. The Solicitor General advocated that position, *id.* at 588-89, but it has not prevailed. *See* Patrick v. Burget, 486 U.S. 94, 99-100 (1988) (stating that the *Parker* doctrine can immunize private parties in appropriate situations). Thus, *Parker* immunity applies to private, as well as governmental defendants, *see* Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985).

[77] *Midcal*, 445 U.S. at 105, quoting City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978).

[78] *Southern Motor Carriers*, 471 U.S. at 61.

[79] *Midcal*, 445 U.S. at 105, quoting City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978).

[80] State officials must "have and [actually] exercise" the power "to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy." Patrick v. Burget, 486 U.S. 94, 101 (1988). Passive ratification of private anticompetitive conduct by government is insufficient.

[81] "The mere potential for state supervision is not an adequate substitute for a decision by the State. In the absence of active supervision in fact, there can be no state-action immunity for what were otherwise private price fixing arrangements." FTC v. Ticor Title Ins. Co., 112 S. Ct. 2169, 2179 (1992).

[82] The "active supervision" requirement serves "essentially the evidentiary function of ensuring that the actor is engaging in the challenged conduct pursuant to state policy." Town of Hallie v. City of Eau Claire, 471 U.S. 34, 46 (1985).

[83] *Id.* at 47. Where the actor is a municipality, "there is little or no [such] danger" and therefore no "active supervision" requirement. *Id.* Thus local government health care providers such as municipal hospitals may need only show a clearly articulated policy to replace competition with regulation (and not active supervision) for them to be within the state-action immunity doctrine.

[84] Patrick v. Burget, 486 U.S. 94, 101 (1988).

[85] *Ticor*, 112 S. Ct. at 2177.

[86] *Id.*

[87] *Id.* at 2178.

[88] *Id.*

[89] *Id.* at 2176.

[90] *Id.* at 2177.

[91] *Id.* at 2179-80.

[92] *Patrick*, 486 U.S. at 100.

[93] *See* Sarah S. Vance, *Immunity for Provider Collaboration*, 62 ANTITRUST L.J. 409, 421-423 (1994).

[94] The General Accounting Office identified eighteen states that had enacted some form of provider cooperation legislation as of May 1994. *See* U.S. General Accounting Office, *Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry*, at 12 (August 1994). Wyoming has enacted provider cooperation legislation in 1995.

[95] *See infra* Table I, Hospital Operation Laws.

[96] *Parker*, 317 U.S. 341 (1943).

[97] TENN. CODE ANN. § 68-11-1302(2) (1994).

[98] TENN. CODE ANN. § 68-11-1308 and 1309.

[99] TENN. CODE ANN. § 68-11-1303(a).

[100] TENN. CODE ANN. § 68-11-1303(b).

[101] TENN. CODE ANN. § 68-11-1303(c) and (d).

[102] TENN. CODE ANN. § 68-11-1303(d)(1) and (2).

[103] TENN. CODE ANN. § 68-11-1303(e).

[104] TENN. CODE ANN. § 68-11-1303(f) (with respect to the health department); TENN. CODE ANN. § 68-11-1305 (with respect to the state attorney general).

[105] *See supra* text accompanying notes 66 & 67. *See also Ticor*, 112 S.Ct. at 2176 ("[F]ederal antitrust laws are subject to supersession by state regulatory programs.").

[106] TENN. CODE ANN. § 68-11-1306(a).

[107] *See* TENN. CODE ANN. §§ 68-11-1303 and 1306.

[108] *Ticor*, 112 S.Ct. at 2177 quoting *Patrick*, 486 U.S. at 100-101.

[109] Proposed Tenn. Dept. of Health, Rules and Regulations Governing the Hospital Cooperation Act of 1993, 1200-24-5-.05.

[110] *Ticor*, 112 S.Ct. at 2179.

[111] *Id.* at 2179-80.

[112] *Id.*

[113] Three other states have used their provider cooperation process. Maine has approved an agreement among three hospitals for the joint operation of a magnetic resonance imaging machine; Oregon has approved a joint kidney transplant program between two hospitals; and Washington has allowed eight rural hospitals to send nonemergency laboratory work to a central laboratory. *See* U.S. General Accounting Office, *Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry*, at 11 (August 1994).

[114] Findings of Fact, Conclusions, Order and Memorandum issued by Minnesota Commissioner of Health, IN RE APPLICATION OF HEALTHSPAN HEALTH SYSTEMS CORPORATION (July 22, 1994) [hereinafter Minn. Memo].

[115] *See infra* text accompanying notes 121 & 122. The merger safety zone provides that absent extraordinary circumstances the FTC and the DOJ will not challenge a merger of two hospitals if one of the hospitals is more than four years old and during the last three years has had an average of fewer than 100 licensed beds and an average daily census of fewer than 40 patients. If a merger is outside the safety zone, the agencies will consider whether competitors remain post merger, whether cost savings will be realized, and whether a failing hospital is involved.

[116] Minn. Memo, *supra* note 114, at 9.

[117] *Id.*

[118] *Id.*

[119] *Id.* at 23.

[120] *Id.* at 10.

[121] It is unclear whether the antitrust laws would have barred a pro-competitive merger in any event. However, without a state process that provides assurance, and in the absence of compliance with DOJ/FTC antitrust enforcement safety zone, the merger might not have taken place as a practical matter because of the risk stemming from legal uncertainty.

[122] Some analysts of the Minnesota hospital merger were skeptical of the consumer benefits. *See* Roger Feldman, *Huge Health Care Mergers Bode Ill*, MNPLS. STAR TRIB., August 8, 1992 at A2. For an analysis of the Greater Minneapolis HMO market and the conclusion that competition leads to lower HMO premiums, *see* Douglas Wholey, Roger Feldman, & Jon B. Christiansen, *The Effect of Market Structure on HMO Premiums*, 14 JOURNAL OF HEALTH ECONS. 81 (1995); Roger Feldman, *The Welfare Economics of a Health Plan Merger*, 6 JOURNAL OF REGULATORY ECONOMICS 67 (1994).

One speculative hypothesis regarding the Minneapolis hospital merger is that the large purchasers with clout in the market were content to accept an arrangement that resulted in lower prices for them, while leaving open the possibility of the merged hospitals using their increased leverage to extract higher prices from less well organized purchasers of services. Widely dispersed consumer interests would not necessarily find their interest served by the costly participation in an administrative/regulatory proceeding. That type of participation, with its attendant costs in legal and economic expert fees, has a public good aspect. Theory would suggest that such an expense will be unlikely to be borne by a single small market participant.

[123] *See* Entin, *supra* note 1, at 118-20. *See also* Nguyen Xuan Nguyen & Frederick W. Derrick, *Hospital Markets and Competition: Implications for Antitrust Policy*, 19 HEALTH CARE MGMT. REV. 35 (1994).

[124] The agencies also may have wanted to avoid having a major industry slip out from under antitrust scrutiny if all states passed hospital cooperation laws and, consistent with the requirements of state-action immunity doctrine, liberally applied them.

[125] *See* Meyer & Rule, *supra* note 1, at 171. ("[T]the sweeping calls for antitrust immunities amount to the proverbial 'throwing the baby out with the bath water' ... [T]he federal antitrust laws ... provide a great degree of flexibility for private collaborative efforts aimed at achieving more efficient and

less costly delivery of health care services.").

[126] The hassle in complying with state provider cooperation laws comes from the detailed presentation that must be made as part of the state's review process. In the absence of a serious and substantive review process, the state provider cooperation laws will not succeed in conferring antitrust immunity on the private parties involved in the joint conduct.

[127] The uncertainty regarding immunity conferred by hospital cooperation legislation derives from the need, in order to establish *Parker*-immunity, for active and ongoing state supervision. The state's issuance of a certificate of public advantage will only be effective as a shield from antitrust enforcement if the state in fact fulfills its supervision responsibility.

[128] In the first case settled since the guidelines were published, the Department of Justice, the Florida Attorney General's office, and two voluntary hospital systems in the St. Petersburg area agreed to a partnership arrangement, but not a merger. That allowed the hospitals to provide services jointly in areas where there are numerous competitors such as some outpatient services, open heart surgery, laboratory and diagnostic services, some specialized high technology services, and others. Additionally, the hospitals were allowed to consolidate administrative services such as accounting, communications, medical staff organization, and medical record keeping. By allowing joint ventures in specialized tertiary care services that compete over a larger geographic market, the agreement has the potential for reducing costs by increasing utilization and may improve outcomes by permitting the same personnel to work together more frequently. The agreement did not allow the two systems to discuss managed care contracting, pricing or marketing. *See Landmark Federal-State Settlement Clears Way for Innovative Partnership*, 3 HEALTH L. REP. 830, 830-31 (1994).

Similarly, the Department of Justice in a business review letter declined to challenge under antitrust law a proposed plan by businesses and health care providers in Birmingham, Ala., to develop a demonstration project to evaluate certain health care services provided by area hospitals. The project called for the hospitals to submit data about the clinical effectiveness and cost of three types of health care services. The information will be collected by an independent corporation and evaluated. *See Justice Department Won't Challenge Health Care Demonstration Project*, 3 HEALTH L. REP. 831, 831 (1994).

[129] *Patrick*, 486 U.S. at 101, "The mere presence of some state involvement or monitoring does not suffice.... The active supervision prong of the *Midcal* test requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy. Absent such a program of supervision, there is no realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests." *Ticor*, 112 S. Ct. at 2176-77. "Actual state involvement ... is the precondition for immunity from federal law." *Id.* at 2179. "The mere potential for state supervision is not an adequate substitute for a decision by the State.... In the absence of active supervision in fact, there can be no state-action immunity for what were otherwise private price fixing arrangements." *Id.*

[130] *Ticor*, 112 S.Ct. at 2177 ("Immunity is conferred out of respect for ongoing regulation by the State, not out of respect for the economics of price restraint.").

[131] *Patrick*, 486 U.S. at 101.

[132] *Ticor*, 112 S. Ct. at 2176.

[133] *Patrick*, 486 U.S. at 101.

[134] *Ticor*, 112 S. Ct. at 2177.

[135] The statutory requirements for ongoing, active supervision vary significantly. In Colorado, annual reports are required by COLO. REV. STAT. ANN. § 24-32-2708 (West 1994); in Florida agency review is required every two years by FLA. STAT. ANN. § 395.606(3) (West 1995); in Georgia there are no supervision provisions; in Idaho the attorney general may request updates by IDAHO CODE § 39-4903(8) (1995) and is required to supervise by § 39-4903(10); in Kansas there is annual review by the health department required by KAN. STAT. ANN. § 65-4958 (1994); in Maine there are no supervision provisions; in Minnesota the Health Department supervises the agreements by MINN. STAT. ANN. § 62J.2920 (West 1995); in Montana there are no supervision provisions; in Nebraska annual reports are required by NEB. REV. STAT. § 71-7708 (1994); in New York there are no supervision provisions; in North Carolina periodic reports with specified information are required by N.C. GEN. STAT. § 131E-192.9 (1994); in North Dakota there are no supervision provisions; in Ohio the Health Department may request updates by OHIO REV. CODE ANN. § 3727.22(D) (Baldwin 1995); in Oregon annual reports are required by OR. REV. STAT. § 442.725 (1994); in Tennessee the Attorney General is entrusted with oversight without further specification by TENN. CODE ANN. § 68-11-1303(b) (1994); in Texas documents may be requested by TEX. HEALTH & SAFETY CODE ANN. § 313.004(b) (West 1995); in Washington annual reports are required by WASH. REV. CODE ANN. § 43.72.310(6) (West 1995); in Wisconsin there are no supervision provisions; and in Wyoming annual reports are required by WYO. STAT. § 35-24-114(b) (1995). The Kansas and Washington statutes, which are limited to rural areas, have no supervision requirement.

[136] *See Ticor*, 112 S.Ct. at 2180 (Scalia, J., concurring); *id.* at 2182 and 2183-84 (dissents).

[137] For example, are the savings being passed through to consumers? If those savings are being used for cross-subsidization, what priorities are being pursued? Presumably, the supervisory state agency would have to review and adopt as its own the targets of cross-subsidization to satisfy the active supervision requirement.

[138] The agencies do not promise to respond in any specified time period to requests which involve mergers outside the safety zone. They promise to respond within 120 days to requests regarding multiprovider networks. For other situations they promise to respond within 90 days. *See* U.S. Department of Justice and Federal Trade Commission, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*, (1994), *supra* note 14.

[139] *See supra* text accompanying notes 55-57.

[140] *See supra* note 48. HMO enrollment in 1993 was more than 45 million and PPO enrollment was 76.6 million, while in

1987 enrollment was 29.3 million and 12.2 million respectively. *See* Barbara Weiss, *Managed Care: There's No Stopping It Now*, 72 MEDICAL ECON. 26, 26 (March 13, 1995). Estimates for 1995 are that 30% of the private group market will be in HMOs, 35% in PPOs and POSs, 30% in managed fee-for-service, and only 5% in unmanaged fee-for-service. *See* Shields et al., *The Cost of Legislative Restrictions on Contracting Practices: The Cost to Governments, Employers and Families*, *supra* note 46, at 9-10.

[141] *See* Zwanziger et al., *California Hospitals, 1980-1990*, *supra* note 28, at 125; Zwanziger et al., *Defining Markets, Setting Standards*, *supra* note 43, at 442-43.

[142] Entin, *supra* note 1, at 122-138.

[143] *See supra* in note 57 (listing studies). *See also* Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980*, 271 JAMA 1512 (1994).

[144] *See* Ron Winslow, *Welfare Recipients Are a Hot Commodity in Managed Care Now*, WALL ST. J., April 12, 1995, at A1. *See also* George Anders & Laurie McGinley, *Managed Eldercare: HMOs Are Signing Up New Class of Member: The Group in Medicare*, WALL ST. J., April 27, 1995, at A1.

[145] "Patient deaths are 8% lower and hospital costs are 11.5% lower than expected in cities with a high penetration of managed care, the survey of 1,300 U.S. hospitals showed." *See* KPMG Peat Marwick, *KPMG Study: Managed Care May Be Beneficial to Your Health and Your Pocketbook* (1993). (Copies available by calling Debbie Dalmand at 714/850-4440) *See also* Mumtaz A. Siddiqui et al., *Insurance-Related Differences in the Risk of Ruptured Appendix*, 331 NEW ENG. J. MED. 332 (1995) (showing patients with HMO coverage had fewer ruptured appendixes than patients with fee-for-service coverage); Arnold S. Relman, *Medical Insurance and Health*, 331 NEW ENG. J. MED. 471 (1994).

[146] *See generally* Wholey, Feldman & Christiansen, *The Effect of Market Structure on HMO Premiums*, *supra* note 122.

[147] *See* MICHAEL A. MORRISEY, COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC (1994) (questioning cost-shifting as a long-term strategy); Charles E. Phelps, *Cross-Subsidies and Charge Shifting in American Hospitals*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 108 (Frank A. Sloan et al. eds., 1986).

[148] *See* Blumstein, *Competing Visions*, *supra* note 1, at 1498-1501.

[149] *Id.*

[150] *See supra* i text accompanying notes 102, 103, 107-111 (summarizing Tennessee's benefits and disadvantages, which are representative of those of other statutes).

[151] *See* Blumstein, *Competing Visions*, *supra* note 1, at 1501.

[152] *See* Feldman, *Huge Health Care Mergers Bode Ill*, *supra* note 122.

[153] *Two Boston Hospitals Merge to Reduce Costs, Overcapacity*, 2 Health L. Rep. 1647 (1993).