

ARTICLE

THE MERITS OF STATE ACTION IMMUNITY TO PROMOTE HOSPITAL COLLABORATION: REPORT OF THE HOSPITAL ANTITRUST TASK FORCE TO THE INDIANA STATE DEPARTMENT OF HEALTH

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INTRODUCTION

In the fall of 1993, the Indiana State Department of Health (ISDH) convened the Hospital Antitrust Task Force ("Task Force") under the direction of the Center for Law and Health at Indiana University School of Law—Indianapolis to conduct a formal policy analysis of the impact of federal and state antitrust laws on collaborative efforts among hospitals and other health care providers. The Task Force was comprised of leading Indiana experts on health care antitrust law and key state policy makers.¹

The Task Force engaged in extensive fact-finding efforts to elicit the views of various health system constituencies on the merits of a state action exemption for hospital collaborative efforts under the antitrust laws. These fact-finding activities and the information they provided are described in this Article. The Task Force then developed

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1. Members of the Task Force were: Sydney Arak, Esq., Senior Vice President and General Counsel, Methodist Hospital of Indiana, Inc.; Ron Dyer, Esq., General Counsel, Indiana State Medical Association; John Render, Esq., Hall, Render, Killian, Heath & Lyman; Marc Rodwin, J.D., Ph.D., Associate Professor, Indiana University School of Public and Environmental Affairs; Geoffrey Segar, Esq., Ice, Miller, Donadio & Ryan; and Norman Tabler, Esq., Baker & Daniels. Eleanor D. Kinney, J.D., M.P.H., Professor of Law and Director, the Center for Law and Health, Indiana University School of Law—Indianapolis, chaired the Task Force and otherwise directed the project. Professor Kinney was assisted by Lisa Clark Copp, Assistant Director of the Center for Law and Health, and Marcia Gonzales, Senior Research Associate for the Center for Law and Health, who were responsible for drafting the following report. Task Force members representing the State of Indiana were: Attorney General Pam Carter; Myra Selby, Esq., Director of Health Care Policy, Office of the Governor; Nancy Blough, Esq., Deputy Health Commissioner, ISDH; Valita Fredland, Esq., Senior Policy Analyst, ISDH; and M. Elizabeth Carroll, Esq., Director of the Office of Legal Affairs, ISDH.

recommendations on whether and how to proceed with a state action exemption to promote hospital collaborative activities.

This Article summarizes the deliberations, findings and conclusions of the Task Force. First, this Article reviews relevant principles of antitrust law affecting hospital collaborative efforts. Second, this Article sets forth information about similar antitrust reform measures proposed by the Indiana Commission on State Health Policy, the President's proposed Health Security Act,² other federal legislative proposals before Congress, as well as proposals adopted in other states and proposals of the American Hospital Association and the American Medical Association. Third, this Article presents the Task Force's findings on problems that hospitals and other providers currently face under the antitrust laws in pursuing collaborative projects, and whether and how these projects would be facilitated under a legislatively created state action immunity. Finally, this Article presents the Task Force's conclusions and recommendations.

I. APPLICABLE PRINCIPLES OF ANTITRUST LAW

A dominant economic policy of the United States is to promote the system of free competition in the market place. Federal and state antitrust laws, described below, articulate this economic policy.³ The antitrust laws are designed to protect the economic system of competition and not individuals or economic entities. The specific way in which the antitrust laws accomplish this goal is to prohibit private conduct, particularly joint conduct of competitors, that restrains trade or impedes competition in markets for goods and services. The theory is that competition generates more goods and services at lower prices thus empowering the consumer who has choices about goods and services.

This policy prevails unless Congress or a state legislature determines that the free market is not working to meet consumer needs or other policy goals, and establishes a regulatory program that intervenes in the market and modifies competition in some fashion to achieve another policy goal. The central issue that the Task Force deliberated pertains to whether there is a policy goal besides free competition in the market place that the state of Indiana ought to promote in the market for in-state hospital services.

Antitrust analysis distinguishes between two types of restraints that are important in understanding hospital collaboration issues. Horizontal restraints are combinations among competitors at the same level of production or distribution. Applicable examples of horizontal restraints in the hospital field include agreements among hospitals to charge the

2. H.R. 3600, Health Security Act, 103d Cong., 1st Sess. (1993).

3. We are indebted to several excellent sources for our discussion of the federal antitrust laws. These sources include: AMERICAN HOSPITAL ASSOCIATION, *HOSPITAL COLLABORATION: THE NEED FOR AN APPROPRIATE ANTITRUST POLICY* (1992) [hereinafter *HOSPITAL COLLABORATION*]; BARRY R. FURROW AND SANDRA H. JOHNSON, *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* (1992); CLARK C. HAVIGHURST, *HEALTH CARE LAW AND POLICY* (1988); Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 *LAW & CONTEMP. PROBS.* 93 (1988); Frances H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 *LAW & CONTEMP. PROBS.* 195 (1988); and Donald R. Schmidt, *Hospital Antitrust Compliance Programs*, in *ABA SECTION OF ANTITRUST LAW, ANTITRUST HEALTH CARE: ENFORCEMENT AND ANALYSIS* 275 (1992) [hereinafter *ANTITRUST HEALTH CARE*].

same rates for hospital services or not to develop ancillary services offered by the other. Further, attempts by various combinations of physicians on the same hospital medical staff to exclude patients of non-physician health care professionals or to inappropriately exclude physicians from membership on the medical staff may constitute horizontal restraints. Vertical restraints involve concerted action between competitors at different levels of production or distribution, such as between buyers and sellers or manufacturers and retailers. In the health care field, the combination of hospitals with other types of health care providers, *e.g.*, physicians, long term care facilities, etc., could constitute vertical restraints. Generally, horizontal restraints are more offensive under the antitrust laws than vertical restraints.

At one time, the federal antitrust laws did not regularly apply to the field of health care because of the operation of various defenses to the antitrust laws outlined below, *e.g.*, the learned professions doctrine, the interstate commerce requirement, and the exemption for the business of insurance. However, in a number of cases since 1975, including *Goldfarb v. Virginia State Bar*,⁴ *Arizona v. Maricopa County Medical Society*⁵ and *Patrick v. Burget*,⁶ the Supreme Court has made clear that the health care industry will be treated the same as any other industry.

A. Antitrust Statutes

1. *Federal Antitrust Statutes*.—The most important antitrust statute pertaining to hospital collaboration is section 1 of the Sherman Act, which provides: “Every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is declared to be illegal.”⁷ This section requires the participation of two or more entities, which can be persons, corporations, partnerships or associations. Proscribed activities under the Sherman Act must occur in interstate commerce. The analysis of Sherman Act section 1 violations is described *infra*.⁸ Section 2 of the Sherman Act prohibits monopolization and attempts to monopolize.⁹ To prove a section 2 violation of illegal monopolization requires a demonstration that the offending competitor has sufficient market power to enable it to preclude competition or control price. To succeed under section 2, the plaintiff must also establish an actual intent to control the market on the part of the defendant and that the defendant’s expansion is not due to growth or development resulting from a superior product or business acumen. The Sherman Act can be enforced in three ways. The first way is civil suits brought by the U.S. Department of Justice’s Antitrust Division (DOJ). The second way is private suits brought by damaged competitors who can recover treble damages if successful. The Federal Trade Commission (FTC) also enforces the Sherman Act in the manner described below. The Sherman Act also imposes criminal liability for especially egregious violations. Private actions by disappointed competitors, rather than government prosecution, pose a graver

4. 421 U.S. 773 (1975).

5. 457 U.S. 332 (1982).

6. 486 U.S. 94 (1988).

7. 15 U.S.C. § 1 (Supp. 1994).

8. See *infra* subpart I.B.

9. 15 U.S.C. § 2 (Supp. 1994).

threat to hospital collaborators, which is an important factor in assessing potential antitrust exposure from a hospital collaboration.

Section 3 of the Clayton Act prohibits a seller from dealing with a customer on the conditions that the customer not deal in goods of a competitor, where the effect of such a transaction may substantially lessen competition or tend to create a monopoly in any type of commerce. Exclusive dealing contracts, tying arrangements, requirements contracts, and other related agreements are covered by this provision. Section 7 of the Clayton Act prohibits mergers and acquisitions "where in any line of commerce . . . in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."¹⁰ Since section 7 applies to "incipient" or developing violations, demonstrating actual anti-competitive effects may not be necessary. An acquisition is unlawful if the anti-competitive effect is reasonably probable.¹¹ The Clayton Act is enforced through civil suits for injunctions or damages brought by the DOJ, FTC enforcement proceedings, and private suits for treble damages. The Clayton Act does not provide for criminal liability.

The FTC Act prohibits unfair methods of competition and unfair deceptive acts or practices.¹² Unlike other federal antitrust statutes, the FTC Act is enforced by the FTC, an administrative agency. Section 5 of the FTC Act has been interpreted to grant the FTC authority to enforce the Sherman Act and the Clayton Act. Notably, the FTC has jurisdiction over not-for-profit organizations for purposes of enforcing the merger provisions of the Clayton Act.

2. *State Antitrust Laws.*—State enforcement may be based on either state or federal antitrust laws. All states except Pennsylvania and Vermont have an antitrust statute of general application.¹³ These statutes all contain provisions similar to section 1 of the Sherman Act, and most have sections similar to section 2 of the Sherman Act. Indiana's antitrust statute is similar and promotes the same economic policy, *i.e.*, promotion of free competition in the market.¹⁴ Specifically, Indiana's antitrust statute tracts the language of the Sherman Act section 1.¹⁵ Indiana's statute, like that of most other states, is enforced by the State Attorney General.

B. *Antitrust Analysis Under Section 1 of the Sherman Act*

In analyzing violations of section 1 of the Sherman Act, courts distinguish between two types of violations. *Per se* offenses are agreements that by nature are so plainly anti-competitive that no elaborate inquiry is needed to establish their illegality. Examples of *per se* violations include: price-fixing, division of markets, tying arrangements, and certain boycotts or refusals to deal.

Activities that are not within the *per se* offenses are subject to inquiry under the rule of reason analysis. The classic articulation of the rule of reason analysis is found in

10. 15 U.S.C. § 18 (Supp. 1994).

11. *Hospital Corporation of America*, 3 Trade Reg. Rep. (CCH) ¶ 22,301 (FTC Oct. 25, 1985).

12. 15 U.S.C. § 45 (1988).

13. Ellen S. Cooper, *Trends in State Antitrust Enforcement Related to Health Care*, in ANTITRUST HEALTH CARE, *supra* note 3, at 183.

14. IND. CODE § 24-1-1-1 to 1-6 (1993).

15. *Orion's Belt, Inc. v. Kayser-Roth Corp.*, 433 F. Supp. 301 (S.D. Ind. 1977).

Justice Brandeis's opinion in *Chicago Board of Trade v. United States*, in which he stated that:

The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business.¹⁶

The application of the rule of reason requires a balancing of a restraint's pro-competitive effects against its anti-competitive effects. This analysis focuses on the challenged restraint's impact on competition and, thus, the relevant factors in a rule of reason inquiry are those that relate to the competitive consequences of the restraint. They include: the purpose of the particular arrangement, the market power of the parties, the availability of a less restrictive alternative, and the arrangement's pro-competitive and anti-competitive effects. The purpose of the analysis is not to decide whether the policy of the antitrust laws promoting competition is in the public interest because that decision is reserved for Congress.¹⁷

An analysis of market power has assumed increasing importance in the resolution of health care antitrust cases under the rule of reason, and in merger and monopolization cases.¹⁸ Market power is the ability of the parties to a restraint, acting collectively, to raise prices or otherwise determine terms of trade in the market. A proper market definition permits determination of how much of the market is supplied by the defendant and how easily the defendant can manipulate price and output, *i.e.*, exercise market power. Measurement of market power is technically difficult, requiring consideration of many issues. Further, the law pertaining to market definition and power has changed considerably in recent years. A full analysis of market definition and power is beyond the scope of this article; several other articles provide an excellent discussion of the issues involved in determining market definition and power.¹⁹ Two antitrust cases involving Indiana health care providers have been very important in the development of the law on the definition of markets in health care antitrust cases.²⁰

16. 246 U.S. 231, 238 (1918).

17. See, e.g., *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 689 (1978); *Mardirosian v. American Inst. of Architects*, 474 F. Supp. 628, 649 (D.C. 1979) (A restraint "cannot be justified by reference to social goals other than competition.").

18. For excellent discussions of market issues in antitrust analysis, see, e.g., Neil P. Motenko, *Market Definition and Market Power*, in ANTITRUST HEALTH CARE, *supra* note 3, at 139; William Blumenthal, *Relevant Markets in the Health Care Industry*, in ABA SECTION OF ANTITRUST LAW, DEVELOPMENTS IN ANTITRUST HEALTH CARE LAW (1990).

19. See, e.g., Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 LAW & CONTEMP. PROBS. 93 (1988); Michael Morrissey et al., *Defining Geographic Markets for Hospital Care*, 51 LAW & CONTEMP. PROBS. 165 (1988); Motenko, *supra* note 18; Kevin J. Arquit, *Market Power Analysis in Health Care Cases*, in ANTITRUST HEALTH CARE, *supra* note 3, at 131.

20. See *Indiana Fed'n of Dentists v. Federal Trade Comm'n* 745 F.2d 1124 (7th Cir. 1984); *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986).

C. Defenses in Antitrust Actions

1. *Interstate Commerce*.—Congress's power to restrain business activities under the federal antitrust laws is derived from its authority to regulate interstate commerce. In *Hospital Building Co. v. Trustees of Rex Hospital*,²¹ the Supreme Court ruled that the interstate commerce defense did not preclude application of the antitrust laws to actors, such as hospitals, operating in small geographic areas within one state essentially because of the economic impact of the actors on the national economy. Consequently, general, collaborative efforts involving hospitals have the requisite effect on interstate commerce to come under the antitrust laws.²²

2. *Learned Professions Exemption and the Per Se Application*.—In *Goldfarb v. Virginia State Bar*,²³ the Supreme Court stated that the learned professions are not exempt from the antitrust laws. Although the courts are reluctant to carve out a definite exemption for conduct of the learned professions, they have held that in regard to professional associations the nature and extent of the restraint's anti-competitive effect was too uncertain to warrant per se treatment.²⁴ This is not to say that learned professions are exempt from the per se application. Rather, it is more accurate to state that where learned professions are involved, the courts are less likely to apply the per se rule. In *Arizona v. Maricopa County Medical Society*,²⁵ the Court stated that conduct that was traditionally subject to per se condemnation under section 1 of the Sherman Act would instead be subject to the rule of reason analysis where the conduct was "premised on public service or ethical norms."²⁶ As such, the courts have been generally reluctant to make a per se application to a significant number of health care circumstances.

3. *Business of Insurance Defense*.—The McCarran-Ferguson Act²⁷ provides an exemption from federal antitrust laws for the "business of insurance."²⁸ To fall within this exemption, the challenged activity must: (1) constitute the business of insurance; (2) be regulated under state law; and, (3) not constitute a boycott, coercion, or intimidation. The exemption will apply only to conduct that specifically involves the spreading and taking of risk and not cost containment practices of health insurers.²⁹

21. 425 U.S. 738 (1976).

22. *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991).

23. 421 U.S. 773 (1975).

24. *See, e.g., Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982); *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1978); *Wilk v. AMA*, 895 F.2d 352 (1990).

25. 457 U.S. 332 (1982).

26. *Id.* at 349.

27. 15 U.S.C. §§ 1011-1015 (1988).

28. 15 U.S.C. § 1012(b) (1988).

29. *See, e.g., Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) (The Court applied three criteria for determining whether a particular practice is exempt as the "business of insurance": whether the practice has an effect of spreading or underwriting risk, whether it is an integral part of the policy relationship between the insurer and the insured, and whether it is limited to the insurance industry.); *see also Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982) (The Court held that the use of peer review committees did not constitute the spreading or underwriting of risk.).

4. *Implied Repeal*.—Another important defense to the federal antitrust laws is implied repeal, which arises when Congress has adopted a comprehensive regulatory scheme that is inconsistent with the antitrust laws. The Supreme Court declined to find that the federally mandated health planning and Certificate of Need program established by the National Health Planning and Resources Development Act of 1974³⁰ did not constitute an implied repeal of the federal antitrust laws.³¹

D. State Action Immunity

In *Parker v. Brown*, the Supreme Court articulated the state action exemption under the federal antitrust laws. This case involved a California program that regulated production and marketing of raisins by the state's growers. The state legislature delegated implementation of the program to a commission, which was authorized to adopt programs to restrict competition among growers and to maintain prices in the distribution of raisins to packers. The purpose of the statute was to conserve agricultural wealth and prevent economic waste. The Supreme Court held that the Sherman Act did not apply since the program derived its authority from the state's legislative command.³²

The two requirements for state action immunity that were pronounced in *Parker v. Brown* were more specifically expressed in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*³³ First, the restraint must be clearly articulated and affirmatively expressed as state policy, and second, the policy must be actively supervised by the state itself.

1. *Clear Articulation of State Policy*.—In *Southern Motor Carriers Rate Conference, Inc. v. United States*,³⁴ the Supreme Court discussed the first prong of the *Midcal* test in determining that the collective rate-making regulatory structure of the states involved was entitled to state action immunity. The Court stated: "A private party acting pursuant to an anti-competitive regulatory program need not 'point to a specific, detailed legislative authorization' for its challenged conduct. As long as the State as a sovereign clearly intends to displace competition in a particular field with a regulatory structure, the first prong of the *Midcal* test is satisfied."³⁵ If a state's intent to establish an anti-competitive regulatory program is clear, the state's failure to describe the implementation of its policy in detail will not subject the program to the restraints of the federal antitrust laws.

2. *Active Supervision*.—In *Federal Trade Commission v. Ticor Insurance Co.*, the Supreme Court held that "the purpose of the active supervision inquiry is not to determine whether the state has met some normative standard, such as efficiency, in its regulatory practices," but whether the state has exercised sufficient judgment and control.³⁶ Under *Ticor*, the active supervision requirement mandates that the state exercise ultimate control

30. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

31. National Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross, 452 U.S. 378 (1981).

32. *Parker v. Brown*, 317 U.S. 341 (1943).

33. 445 U.S. 97 (1980).

34. 471 U.S. 48 (1985).

35. *Id.* at 63 (quoting *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 415 (1978)).

36. *Federal Trade Comm'n v. Ticor Ins. Co.*, 504 U.S. 621, 622 (1992).

over the challenged anti-competitive conduct; the mere presence of some state involvement or monitoring does not suffice.

In *Midcal*,³⁷ the Supreme Court held that no antitrust immunity had been conferred since the state did not actively supervise the policy. Specifically, the Court found that the state did not establish prices, review the reasonableness of price standards, regulate terms of fair trade contracts, monitor market conditions nor engage in any pointed reexamination of the program. As a result, no state action immunity existed. Further, the Court stated: "It is not enough that . . . anticompetitive conduct is 'prompted' by state action; rather, anticompetitive activities must be compelled by direction of the State acting as a sovereign."³⁸

In *Patrick v. Burget*,³⁹ the Court refused to find active state supervision where the state agencies lacked the power to review the merits of private peer review decisions or their compliance with peer review procedures. Thus, the Supreme Court held that the state action doctrine did not protect Oregon physicians from antitrust liability for their activities in relation to hospital peer review decision proceedings. *Patrick* further defined the parameters of the active supervision prong of the state action immunity test by requiring that the government have veto power over the specific decisions of private parties on the substantive merits rather than just the procedural adequacies.

II. ANTITRUST DEVELOPMENTS AT THE FEDERAL LEVEL

The policy goals of the federal antitrust laws are currently in flux.⁴⁰ Specifically, some have argued that efficiency should be an important criterion in assessing whether a merger or other combination conforms to the antitrust laws. This position greatly influenced antitrust enforcement during the Reagan-Bush administrations. Others have attacked this emphasis on efficiency and urge that antitrust enforcement promotes more consumer-oriented goals, such as prevention of anti-competitive conduct. Following the election of a Democratic administration, policy goals in the enforcement of the antitrust laws at the federal level may be revised. In any event, the basic tenets of antitrust policy are unsettled, causing uncertainty about how antitrust principles will be applied to hospital mergers and other collaborative efforts.

A. Department of Justice Guidelines on Mergers and Acquisitions

In 1968, the Department of Justice developed Merger Guidelines for the purpose of evaluating the potentially anti-competitive effects of mergers. Subsequently, the DOJ issued guidelines in 1982, which were revised in 1984. These Guidelines outline the present enforcement of the DOJ and the FTC concerning horizontal acquisitions and mergers subject to section 7 of the Clayton Act, section 1 of the Sherman Act, and section 5 of the FTC Act. The 1984 revision of the 1982 DOJ Guidelines on Mergers and

37. 445 U.S. 97 (1980).

38. *Id.* at 104 (quoting *Goldfarb v. Virginia*, 421 U.S. 773, 791 (1975)).

39. 486 U.S. 94 (1988).

40. *Baker*, *supra* note 3, at 100-06.

Acquisitions reflect the policy goal of efficiency discussed above. The 1992 DOJ merger guidelines, however, do not reflect major policy shifts.⁴¹

*B. Department of Justice/Federal Trade Commission Safety Zones
for the Health Care Industry*

In September 1993, the DOJ and FTC issued a set of antitrust enforcement guidelines for the health care industry. These guidelines outline six industry-specific "safety zones."⁴² If a provider's proposed business venture meets the requirements of one of the established safety zones, then neither the DOJ nor FTC will challenge the proposed activity, absent extraordinary circumstances. The six safety zones are as follows:

- (1) Mergers between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than [forty] patients over the most three recent years;
- (2) Any joint venture among hospitals to purchase, operate and market the services of high-technology or other expensive medical equipment if the joint venture includes only the number of hospitals whose participation is needed to support the equipment;
- (3) Physicians' collective provision of information that may improve purchasers' resolution of issues relating to the mode, quality, or efficiency of treatment;
- (4) Participation by competing hospitals in surveys of prices for hospital services, or surveys of salaries, wages or benefits of hospital personnel . . . so long as certain conditions are satisfied;
- (5) Any joint purchasing arrangement among health care providers where two conditions are present: (1) the purchases account for less than [thirty-five] percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts

41. *U.S. Dep't. of Justice Merger Guidelines*, 4 Trade Reg. Rep. (CCH) ¶ 13,104, at 20,569-20,571 (1994).

42. U.S. DEP'T OF JUSTICE & THE FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTHCARE (1993) [hereinafter STATEMENTS]. On September 27, 1994, the U.S. Department of Justice and the Federal Trade Commission issued new statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust. These statements modified several of the six safety zones outlined in its 1993 Statement. One important change was a new guideline explaining the analysis that the FTC and DOJ would use in reviewing hospital joint ventures involving specialized clinical or other expensive health care service. Other provisions provided greater protection for physicians in negotiating with other providers and, particularly, payers. See 1994 WL 642477 (F.T.C.); 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,769-20,798 (1994). For a good review of the 1994 Statements, see Clifton E. Johnson, *Revised Federal Antitrust Enforcement Policy Statements Issued for the Health Care Industry*, HALL, RENDER, KILLIAN, HEATH & LYMAN, DEVELOPMENTS IN HEALTH LAW (Oct. 24, 1994).

for less than [twenty] percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement;

(6) A physician network comprised of [twenty] percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market and share substantial financial risk.⁴³

*C. President Clinton's Health Reform Proposal: The Health Security Act
Impact on Antitrust Enforcement*

The Clinton health plan asserted that the federal antitrust laws will ensure that the new health care system remains in a competitive environment. But the plan acknowledged that the antitrust laws must be clarified to give providers confidence that their collaborative activities are legal.⁴⁴ The Clinton Health Plan references to antitrust reform are as follows:

1. *Hospital Mergers.*—Hospitals smaller than a certain size, as measured, for example, by number of beds or patient census, require certainty that they will not be challenged by the federal government if they attempt to merge. Such hospitals often are sole community providers that do not compete with other hospitals.

The DOJ and the FTC publish guidelines providing safety zones for such mergers and an expedited business review or advisory opinion procedure through which the parties to such mergers can obtain timely (*i.e.*, within ninety days) additional assurance that their merger will not be challenged. Guidelines also would provide the analysis the agencies use to evaluate mergers among larger hospitals.

2. *Hospital Joint Ventures and Purchasing Arrangements.*—Hospitals may enter into joint ventures involving high technology or expensive equipment and ancillary services, as well as joint purchasing arrangements involving the goods and services they need.

The DOJ and the FTC publish guidelines that provide safety zones for such joint ventures and arrangements, examples of ventures that would not be challenged by the agencies and an expedited business review or advisory opinion procedure through which the parties to joint ventures can obtain timely (*i.e.*, within ninety days) advice and assurance as to whether ventures that do not fall within the safety zones will be challenged.

3. *Physician Network Joint Ventures.*—Physicians and other providers require additional guidance regarding the application of the antitrust laws to their formation of provider networks that would negotiate effectively with health plans.

The DOJ and the FTC publish guidelines that provide safety zones for physician network joint ventures that do not possess market power (below twenty percent) and that share financial risk, examples of networks that would not be challenged by the agencies, and an expedited business review or advisory opinion procedure through which the parties to networks that do not fall within the safety zones can obtain timely (*i.e.*, within ninety days) advice and assurance as to whether their network will be challenged.

43. STATEMENTS, *supra* note 42.

44. President Clinton's Health Care Reform Proposal—Preliminary Working Group Draft of September 7, 1993, Appendix A at A-62 - A-64.

Within the safety zones, physicians may bargain collectively with health plans about payment, coverage, decisions about medical care, and other matters without fear of the antitrust laws.

4. *Provider Collaboration.*—During the transition to a new health care system, physicians and other providers may require some protection to negotiate effectively with health plans and to form their own plans. To protect physicians from the market power of third party payers forming health plans, providers are provided a narrow safe harbor within which to establish and negotiate prices if the providers share financial risk. The financial risk may not be simply fee discounting. Physicians who provide health services for the benefit package may combine to establish or negotiate prices for the health services offered if the providers share risk and if the combined market power of the providers does not exceed twenty percent. This safe harbor would not apply to the implicit or explicit threat of a boycott.

5. *State Action Immunity.*—The DOJ and the FTC publish guidelines that apply the state action doctrine where a state seeks to grant antitrust immunity to hospitals and other institutional health providers. If a state establishes a clearly articulated and affirmatively expressed policy to replace competition with regulation and actively supervises the arrangements, the hospitals and other institutional providers involved would have certainty that they will not face enforcement action by the federal government.

6. *Provider Fee Schedule Negotiation.*—The DOJ and the FTC publish guidelines that describe under existing law the ability of providers to collectively negotiate fee schedules with the alliances. Alliances, as established and supervised under state law, are required under federal law to establish a fee schedule for fee-for-service plans, and providers, in order to participate in the negotiation process, need certainty that their actions will not violate the antitrust laws.

7. *McCarran-Ferguson.*—The current exemption from the antitrust laws enjoyed by health insurers under the McCarran-Ferguson Act⁴⁵ would be repealed, eliminating the ability of health plans to collectively determine the rates they charge and other terms of their relationship with providers.

D. Other Federal Health Care Proposals before the 103rd Congress that Addressed Antitrust Enforcement

1. *Hospital Cooperative Agreement Act.*—The Hospital Cooperative Agreement Act,⁴⁶ introduced by Senator Cohen (R-Me.) would have established a demonstration program with grants for collaboration among hospitals regarding the provision of expensive, capital-intensive medical technology or other highly resource-intensive services. Three of these grants must be used to demonstrate how the collaborative agreements will be used to increase access or quality in rural areas. The purpose of this Act was to encourage cooperation among hospitals in order to contain costs and achieve a more efficient health care delivery system by eliminating unnecessary duplication and an increase of costly medical or highly technology services or equipment. The Act stated that it shall not be an antitrust violation for a hospital to enter into and carry out activities under a cooperative agreement if it meets the Act's specifications. This Act required that

45. See *supra* notes 27-28 and accompanying text.

46. Hospital Cooperative Agreement Act, S. 493, 103rd Cong., 1st Sess. (1993).

projects be designed to demonstrate a reduction in costs, an increase in access to care, and improvements in the quality of care.

2. *Managed Competition Act of 1993*.—The Managed Competition Act of 1993,⁴⁷ introduced by Representative Cooper (D-Tenn.) was targeted at promoting pure managed competition where greater reliance is placed on the private sector to provide care, reduce costs and limit government control. The bill contained many health reform features similar to the President's proposal, *e.g.*, creation of accountable health plans and health insurance purchasing organizations. The bill required the administration to provide guidelines regarding the application of antitrust statutes to the accountable health plans in review by the DOJ. Joint ventures could be created for the purpose of sharing the provision of health care services that would involve substantial integration or financial risk-sharing. However, the exchange of information or conduct that is not necessary to the venture would be excluded. A certificate of public advantage must be obtained showing that the likely benefits will outweigh the reduction in competition that will result. This certificate of public advantage would be issued by the DOJ to the approved venture, which would preclude any exposure to antitrust liability. This certification would be issued within thirty days of application. An appeals process would be structured in the event that a denial or revocation of the certificate arises.

3. *Access to Affordable Health Care Act*.—Title IV of the Access to Affordable Health Care Act,⁴⁸ also introduced by Senator Cohen, entitled "Cooperative Agreements Between Hospitals," purported to encourage cooperation between hospitals in order to contain costs and achieve a more efficient health care delivery system through the elimination of unnecessary duplication and proliferation of expensive medical or high technology services or equipment. The United States Attorney General may grant a waiver of the antitrust laws, to permit two or more hospitals to enter into a voluntary cooperative agreement under which such hospitals provide for the sharing of medical technology and services. The administrator of the Agency for Health Care Policy and Research would evaluate applications for waiver approval within ninety days. Approval of the waiver would depend on whether cost reduction, quality enhancement, improvements in cost-effectiveness of high technology services, the avoidance of duplication and efficient utilization of hospital resources would likely result.

4. *Affordable Health Care Now Act of 1993*.—The Affordable Health Care Now Act of 1993,⁴⁹ introduced by Representative Michel (R-Ill.) would allow health care providers entering into joint ventures to receive antitrust exemptions. The "Removing Antitrust Impediments" section describes a system in which the United States Attorney General would develop guidelines where parties could apply for a limited exemption. The applications would be reviewed and answered within thirty days. If the application is denied, the United States Attorney must provide a statement of reasons and must enter notice in the Federal Register. Information relating to the joint venture must be publicly

47. Managed Competition Act of 1993, H.R. 3222, 103rd Cong., 1st Sess. (1993).

48. Access to Affordable Health Care Act, S. 223, 103rd Cong., 1st Sess. (1993).

49. The Affordable Health Care Now Act of 1993, H.R. 3080, 103rd Cong., 1st Sess. (1993). *See also* *Republicans' Health Care Bill Includes Antitrust Exemptions for Joint Ventures*, 65 *Antitrust and Trade Reg. Rep.* (BNA) 393 (Sept. 23, 1993).

available unless otherwise necessary to assist with a legal investigation or for a judicial or administrative proceeding.

The guidelines for implementation would be developed in conjunction with the Secretary of Health and Human Services and an Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care. This advisory committee would include representatives from HHS, the DOJ, the Office of Management and Budget and the FTC. The limited exemption would reduce the actual damages if the conduct resulting in the antitrust claim was within the scope of the joint venture. This conduct would be subject to the rule of reason test,⁵⁰ taking into account all relevant factors affecting competition, including effects on competition in properly defined, relevant research, development, product, process, and service markets.

Additionally, a certificate of public advantage may be issued which would provide complete exemption to joint ventures. In order to receive a certificate of public advantage, it must be shown that the benefits of the joint venture are likely to outweigh the reduction in competition and that the reduction in competition is reasonably necessary to obtain such benefits. In addition, the application for the full exemption must include agreements by the parties that the venture will not foreclose competition through contracts that prevent other health care providers from competing with the venture, and that the venture will submit an annual report that describes its operation and information regarding the impact of the venture on health care and competition in health care. A denial for a certificate can be challenged in a United States District Court.

5. *Health Care Antitrust Improvements Act.*—The Health Care Antitrust Improvements Act,⁵¹ introduced by Senator Hatch (R-Utah) would allow an exemption from antitrust laws if the activity falls under a one of the proscribed safe harbors listed in the Act, an additional safe harbor designated by the United States Attorney General, or is within the parameters of the specified activities stated in the certificate of review issued by the United States Attorney General. The safe harbors listed under section 5 of the Act were:

- (1) Combinations where each type or specialty provider in question does not exceed [twenty] percent of the total number of such type of specialty in the relevant market area;
- (2) Activities of medical self-regulatory entities relating to the standard setting or enforcement activities designed to promote quality of care;
- (3) Participation in surveys regarding the price of services, reimbursement levels or the compensation and benefits of employees and personnel if the survey is conducted in an unbiased manner by a third party and the information is based on prior and not current charges or benefits;
- (4) Joint ventures for high technology and costly equipment and services if the number of participants in the venture does not exceed the lowest number necessary to support the venture;

50. See *supra* subpart I.B.

51. Health Care Antitrust Improvements Act, S. 1658, 103rd Cong., 1st Sess. (1993). See also the companion bill introduced in the House by Rep. Archer, H.R. 3486, 103rd Cong., 1st Sess. (1993).

- (5) Hospital mergers relating to two hospitals if within the three-year period prior to the merger, at least one hospital had an average of 150 or fewer operational beds and the average inpatient use was less than [fifty] percent;
- (6) Joint purchasing arrangements if the total sales of the product or service is less than [thirty-five] percent of the relevant market;
- (7) Any good faith negotiations necessary to carry out any of the activities within the safe harbors listed or designated by the U.S. Attorney General or activities that are the subject of an application for a certificate of review.⁵²

In determining whether an additional safe harbor would be established, the United States Attorney General shall take into account the extent to which the collaborative activity would result in increased access, quality, cost efficiencies, the ability to provide services in medically underserved areas and improved utilization of health care resources. Further, criteria to be considered were whether the activity will improve payment and service arrangements so as to reduce cost, whether competition will be unduly restricted, whether comparable efficiencies exist; and, whether the activity will unreasonably foreclose competition.

E. National Trade Associations Proposals

Both the American Medical Association (AMA) and the American Hospital Association (AHA) have developed recommendations for health reform that include references to federal antitrust laws acting as barriers to collaborative activities by providers.

1. *The American Hospital Association.*—The AHA has been pursuing antitrust relief on the federal level. It has also urged hospitals to collaborate with each other, other health care providers, schools, businesses, and community organizations to improve the quality of and access to health care, and to reduce rising health care-related costs.⁵³ However, many such activities have been inhibited due to the real and perceived barriers of the federal antitrust laws.

The AHA is currently attempting to further educate providers about the risks of antitrust enforcement to provider collaboration. The association has issued several documents addressing these issues recently. But the AHA states that no amount of educational efforts can resolve the uncertainties that are inherent in the federal antitrust laws nor change the laws' preference for competition even when such competition results in a wasteful use of resources.

The AHA's examination of the methods of antitrust analysis is especially mindful of the unique characteristics of hospital markets. Hospital markets have traditionally deviated from the competitive paradigm in several important respects. Consumers are insulated from market prices by third-party insurance and lack of information. Due to the large amount of government-purchased medical care, for which the government pays on a set basis, hospitals with market power may be constrained to exercise such power. In addition, a hospital's mission may limit its ability to exercise market power. Moreover,

52. Health Care Antitrust Improvements Act, S. 1658, 103rd Cong. 1st Sess. (1993).

53. See HOSPITAL COLLABORATION, *supra* note 3.

the AHA recognizes that antitrust policy must be sensitive to non-economic priorities in health care. For example, the operation of market forces may not ensure that the right hospitals stay open and the right hospitals close. Hospital closures in underserved areas will complicate already serious problems with access to quality health care.

2. *The American Medical Association.*—In the spring of 1993, the AMA addressed the Subcommittee on Antitrust, Monopolies and Business Rights of the Judiciary Committee of the United States Senate on the subject of antitrust relief for the health care industry.⁵⁴ In its proposal the AMA did not seek an exemption for federal antitrust laws. Rather, the AMA recommended clarification of federal antitrust laws by statutory enactment.

Because health system reform will begin dictating the use of new pro-competitive approaches to the delivery of affordable medical care, the AMA strongly recommended changes to the current antitrust environment. Under managed competition, substantial efficiencies must be created, making cooperation among providers and physicians imperative. Relief from the barriers of federal antitrust laws will permit physicians to form networks and will provide valuable input into the policy-making activities of managed care plans.

F. Antitrust Reforms at the State Level

To date, more than a dozen states legislatively exempt health care collaborative activities from the coverage of the federal antitrust laws in one form or another.⁵⁵ The primary bases for creating a state action exemption from federal and state antitrust laws in each of these states have been relatively consistent. Various legislatures have concluded that the competitive model has not been effective in controlling the rising cost of health care nor the inefficiencies of duplicative facilities and services. Although technological and scientific advancements in the health care industry have improved the quality of health care, many persons cannot afford to take advantage of these improvements. Further, many states have found that the boundaries of existing state and federal health care statutes have suppressed the ability of health care providers, specifically hospitals, to acquire and develop new equipment and methodologies in the delivery of health care services. Therefore, the states have enacted legislation creating regulatory programs that allow health care providers to cooperate to the extent that the positive effects—such as the quality, access and delivery of health care services—do not outweigh the potential adverse effects of reducing competition.

Maine enacted the Hospital Cooperation Act of 1992,⁵⁶ which became effective in April the same year. This law allows hospitals to enter into cooperative agreements with other state-based hospitals if the potential benefits outweigh the disadvantages that may

54. American Medical Association, Statement to the Subcommittee on Antitrust, Monopolies and Business Rights, Judiciary Committee, United States Senate (March 23, 1993).

55. States that have enacted statutes that allow cooperative activity among hospitals include: Colorado, Florida, Georgia, Idaho, Kansas, Maine, Minnesota, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, Tennessee, Texas, Washington, and Wisconsin. See GENERAL ACCOUNTING OFFICE, HEALTH CARE: FEDERAL AND STATE ANTITRUST ACTIONS CONCERNING THE HEALTH CARE INDUSTRY (August 1994).

56. ME. REV. STAT. ANN. tit. 22, § 1881-1888 (West 1994).

result from the reduction in competition. The benefits listed include quality, cost efficiency, avoidance of duplication, improvements in utilization and preservation of hospital facilities. The disadvantages to be considered include the likely adverse impact on the ability of managed care entities and payers to negotiate optimal payment and service arrangements with hospitals or other health providers; the reduction in competition in the quality, availability and price of health care services; and, the availability of less restrictive arrangements that can achieve the same or more favorable benefits. Those seeking to enter into cooperative agreements must demonstrate by clear and convincing evidence that the likely benefits of the proposed arrangement outweigh the attributable disadvantages in the reduction of competition. The Act defines a cooperative agreement among hospitals as the sharing, allocation or referral of patients, personnel, services, procedures and facilities traditionally offered by hospitals.

Similarly, in Minnesota,⁵⁷ the legislature's pronounced purpose behind the enactment of the "Antitrust Exceptions" statute was to substitute regulation for competition when the proposed arrangement is likely to result in greater access or quality than would otherwise occur in the current competitive market. This statute was repealed in 1993.

In Ohio,⁵⁸ recent legislation allows hospitals to conduct negotiations involving the allocation of health care services or equipment to the extent that such negotiations do not involve price-fixing or predatory pricing, and are designed to achieve one of the following goals: the reduction of health care costs, improvement of access to health services, or the improvement of the quality of patient care.

In Washington,⁵⁹ legislation was enacted to specifically enhance rural health development. The legislature pronounced that the primary goal of state health policy was on the maintenance of the health care service delivery in rural areas. The intent of the statute is to foster the development of cooperative and collaborative arrangements among the rural public hospital districts. The legislature further determined that it is not cost-effective, practical nor desirable to provide quality health care services on a competitive level in rural areas because of the limited patient volume and geographic isolation.

In Wisconsin,⁶⁰ the Health Care Cooperatives Agreement statute is less limiting than others, as it allows health care providers, not just hospitals, to negotiate and voluntarily enter into cooperative agreements. The law defines cooperative agreements as the sharing, allocation or referral of patients, or the sharing or allocation of personnel, services and medical, diagnostic or laboratory facilities or procedures or other services customarily provided by health care providers.

III. DEVELOPMENTAL EFFORTS IN INDIANA RELATING TO MODIFICATION OF FEDERAL ANTITRUST LAW

A. Indiana Commission on State Health Policy

In 1989, the Indiana General Assembly created the Indiana Commission on State Health Policy,⁶¹ which was directed to study Indiana health policy and make

57. MINN. STAT. § 62J.29 (1992).

58. OHIO REV. CODE ANN. § 3727.22 (Baldwin 1995).

59. WASH. REV. CODE §§ 39.34.010-.920 (1995).

60. WIS. STAT. §§ 150.84-.86 (1995).

recommendations in order to improve the effectiveness of Indiana's health care delivery system. The Commission issued a report entitled *Hoosier Health Reform*, which summarized the findings of the Commission.⁶²

Among the findings were many references to the much-needed removal of federal antitrust barriers that prevent Indiana health reform from progressing. The Commission recommended that the federal government create an exemption for hospitals engaging in certain collaborative relationships from federal antitrust laws under state supervision. This immunity should be applied to all collaborative activities except those that involve price-fixing, predatory pricing, or group boycotts. The Commission recommended that the exemption not be as stringent as the requirements under the state action immunity doctrine. The Commission concluded that removing federal antitrust barriers would have many benefits.

Merger and collaboration in the hospital industry were found to be in the public's best interest due to tremendous duplication of services and facilities that are costly to the health care system. The Commission referred to a study⁶³ that found that hospitals in more than three-fourths of communities nation-wide would be at risk of violating federal antitrust guidelines if they merged. It also found that a decided trend toward more stringent enforcement of antitrust legislation exists in the health care field, and many collaborative arrangements between providers have the potential to trigger an antitrust challenge under federal guidelines.

Among the benefits the Commission attributed to collaboration between health care providers were that rural hospitals would be able to merge or form networks with larger tertiary hospitals or other rural hospitals in their geographic areas. This would eliminate the duplication of health care technologies and facilities that currently exist and would provide tremendous cost savings. Hospitals would also be able to establish networks and systems to provide a continuum of care for patients, with rural hospitals providing basic acute care, long-term care and ambulatory care, and more specialized needs being provided by larger hospitals belonging to the network. The Commission found ample evidence to show that an increased volume of specialized care available in fewer settings promotes quality of care. Capital markets would be more accessible to smaller hospitals if those providers were linked with larger hospitals, who are financially stronger. The Commission cited the capital needs of smaller hospitals to upgrade facilities and shift missions to provide different types of care such as ambulatory care, long-term care and other less specialized care.

B. Indiana Legislative Action

Governor Evan Bayh addressed the need for removal of federal antitrust barriers to the Indiana community of health care providers in his 1993 State of the State address, *Cornerstones of Progress*. Because of the explosion of medical technology, which has increased the cost of health care, hospitals are competing to have the most up-to-date equipment. Rural hospitals have difficulty competing with larger more urban hospitals in two ways: availability of high-tech medical equipment and ability to attract physicians

61. Ind. Pub. L. 327-1989.

62. INDIANA COMMISSION ON STATE HEALTH POLICY, *HOOSIER HEALTH REFORM* (Nov. 1992).

63. The name of this study was not cited by the Commission.

willing to accept lower salaries, and longer hours. Affiliation of rural providers with larger hospitals may increase access to capital, promote recruitment of physicians, and lower operating costs. Governor Bayh proposed: (1) eliminating antitrust barriers that prevent effective coordination of services among health providers; (2) establishing criteria and procedures for two or more hospitals to voluntarily request approval for a cooperative or collaborative project; and (3) articulating public policy that encourages collaborative activities to reduce costs, improve access and quality, and reduce duplication.⁶⁴

In the 1993 legislative session, the administration drafted legislation, which, as originally introduced, would have required the ISDH to adopt rules permitting provider collaborative efforts—as permitted under federal antitrust laws—rather than implementing the doctrine of state action immunity.⁶⁵

The Indiana Hospital Association drafted related legislation, H.B. 1800, to create a limited exemption from the federal antitrust laws for various types of collaborative activity among independent hospitals.⁶⁶ H.B. 1800 would have allowed hospitals to enter into collaborative agreements if certain conditions were met to ensure the benefits of provider collaboration outweighed the disadvantages resulting from a reduction in competition. Such collaboration between providers was encouraged under the measure if the agreements materially contributed to cost containment, improved access, reduction in duplicity of services, equipment or facilities, and also promoted efficiency. This legislative attempt to facilitate provider collaboration was not successful, and a similar proposal is likely to be introduced and considered in a future legislative session.⁶⁷

IV. DELIBERATIONS OF THE HOSPITAL ANTITRUST TASK FORCE

A. Fact Finding Activities

1. *Consultation with Indiana Constituencies.*—The Task Force engaged in several efforts to obtain information from affected Indiana constituencies. The major fact-finding activities and the information received are listed below:

- (1) The results of the Indiana Hospital Association Survey of Hospitals on Antitrust Problems Faced by Hospitals in Collaborative Efforts;
- (2) A presentation by Bain Farris, Chief Executive Officer, St. Vincent Hospitals and Health Services, and James Dobson, Esq., General Counsel, Community Hospitals of Indianapolis, on the Collaborative Network between St. Vincent Hospitals and Health Services and Community Hospitals of Indiana;

64. Governor's State of the State Address, *Cornerstones of Progress* (1993).

65. H.B. 1921, 1st Regular Sess., 108th Gen. Assembly (Ind. 1993).

66. H.B. 1800, 1st Reg. Sess., 108th Gen. Assembly (Ind. 1993).

67. In its 1995 session, the General Assembly considered H.B. 1440, which would have authorized hospital collaboration demonstration projects in four Indiana counties if the resulting probable benefits would have outweighed the disadvantages. H.B. 1440, 1st Regular Sess., 109th Gen. Assembly (Ind. 1995). The legislation sought to encourage demonstrations that promoted policy goals such as reduced health care costs, improved access and quality, and greater health system efficiency.

(3) Mr. Farris subsequently sent a letter to the Task Force noting that if a state exemption to federal antitrust laws were more burdensome than the current system of federal review, health care providers would be better served by utilizing the existing federal review process. Similarly, he recommended that any state antitrust exemption be optional, rather than mandatory. He asserted that a state action exemption would be of greatest benefit to smaller regional providers, who currently desire to discuss ways in which they can collaborate to serve the needs of their local community;

(4) Correspondence from Jerry Paine, Secretary/Treasurer, Indiana AFL/CIO, expressing concern about the vertical integration of health care and cautioning about a state antitrust exemption. Mr. Paine adeptly described the inherently conflicting concerns felt by many in labor and industry. Concern exists over expenses caused by duplicity in equipment and services, yet there is equal concern over reducing competition among health care providers;

(5) A presentation by Ron Dyer, Esq., General Counsel, Indiana State Medical Association, regarding physician antitrust concerns. Mr. Dyer subsequently joined the Task Force.

2. *Consultation with Professor James F. Blumstein.*—The Task Force also consulted with James F. Blumstein, Professor, Vanderbilt University School of Law, about the general desirability of state action exemptions to the federal antitrust laws. Professor Blumstein is a prominent scholar in the field of health care antitrust⁶⁸ and has been a strong advocate of free markets and competition in the health care industry.⁶⁹ The Task Force wanted the perspective of such a scholar to help them more fully explore the potential downsides of a state action exemption to the antitrust laws. Professor Blumstein provided the task force a thoughtful presentation on the state action exemption and was most helpful to the Task Force in its deliberations.⁷⁰

3. *Important Findings Reported in National Media.*—On average, sixty-five percent of hospitals nationwide have entered into some type of collaborative arrangement in the

68. His publications include: UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES (James F. Blumstein et al. eds., 1986); COST, QUALITY AND ACCESS IN HEALTH CARE: NEW ROLES FOR HEALTH PLANNING IN A COMPETITIVE ENVIRONMENT (James F. Blumstein et al. eds., 1988); Symposium, *Antitrust and Health Care*, 51:2 LAW & CONTEMP. PROBS. (1988) (James F. Blumstein & Frank A. Sloan, symposium eds.); ORGAN TRANSPLANTATION POLICY: ISSUES AND PROSPECTS (James F. Blumstein & Frank A. Sloan eds., 1989); REDEFINING GOVERNMENT'S ROLE IN HEALTH CARE: IS A DOSE OF COMPETITION WHAT THE DOCTOR SHOULD ORDER? (James F. Blumstein & Frank A. Sloan eds., 1981) [hereinafter REDEFINING GOVERNMENT'S ROLE].

69. See Symposium, *Antitrust and Health Care*, *supra* note 68; REDEFINING GOVERNMENT'S ROLE, *supra* note 68.

70. Following his consultation with the Task Force, Professor Blumstein wrote a major article on state action immunity under the federal antitrust for collaboration among health care providers. See James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459 (1994).

last two years.⁷¹ Between 1987 and 1991, more than 229 hospital merged in the United States of which twenty-seven generated federal antitrust investigations resulting in only five antitrust challenges.⁷²

B. Task Force Findings and Conclusions

1. *Problematic Collaborative Activities.*—The Task Force had difficulty identifying specific types of desirable collaborative activity among hospitals and other health care providers that posed substantial antitrust risks or constrained providers from collaborating because of fear of antitrust exposure. The Task Force was also impressed that many collaborative activities between hospitals and other health care providers are already occurring and are permissible under the antitrust laws.

Specifically, major hospitals in Indianapolis have engaged in a variety of collaborative efforts without finding the antitrust laws such a formidable barrier as to preclude negotiations. For example, St. Vincent Hospital and Health Center and Community Hospitals of Indianapolis established a formal network that functions as much as possible as a single entity without being an actual merger. In this network, revenues exceeding expenses, from each medical center, are combined and allocated according to a formula based on pre-collaborative equity and profit ratios. St. Vincent and Community are currently exploring various clinical and administrative areas for potential consolidation and collaboration.

St. Vincent Hospital and Health Centers and Methodist Hospital of Indiana, Inc. also collaborated in the formation and operation of a rehabilitation hospital that involved, in their judgment, virtually no significant exposure under the antitrust laws. Specifically, the Rehabilitation Hospital of Indiana, Inc. was created as a 50-50 subsidiary of entities controlled by both Methodist and St. Vincent in 1990, because the parties determined that a substantial need for additional rehabilitation beds existed in central Indiana. Without substantial time or expense, the antitrust analysis was performed by Methodist in-house counsel and by local counsel for St. Vincent and a determination was quickly made that federal antitrust review of this new venture to collaboratively own and operate a new \$20 million rehabilitation facility was not required.

Not all proposed mergers of Indiana hospitals have avoided antitrust problems. In the fall of 1990, two 300-plus bed, not-for-profit hospitals in Fort Wayne—St. Joseph Medical Center and Lutheran Hospital of Indiana—announced plans to consolidate in order to reduce their management teams by approximately twenty percent and eventually to consolidate their medical staffs.⁷³ The hospitals declared that the affiliation would reduce duplicative medical equipment, technology, programs and services in Fort Wayne and place the hospitals in a better position to serve indigent patients. Expecting review by the DOJ to be “smooth sailing,” the hospitals cancelled their merger plans one year

71. *Hospital Collaboration Delivers Efficient Care, According to Survey*, PR NEWSWIRE ASSOCIATION, INC., Oct. 25, 1993.

72. See David Marx, Jr., *State Hospital Cooperation Acts: Are They Sufficient Antitrust Shelter for Hospital Collaborations?*, 10:9 HEALTHSPAN 3, Oct. 1993.

73. See David Burda, *Four Hospital Groups Announce Various Form of Merger Deals*, MODERN HEALTHCARE, Oct. 22, 1990.

later in the face of a widening antitrust investigation by the DOJ.⁷⁴ Had the merger taken place it would have given the two hospitals control of fifty-six percent of the private acute-care hospital beds in Fort Wayne, Indiana, which has a population of 173,000.

The Task Force identified three areas of collaboration in which the antitrust laws pose a chilling effect.

(1) Mergers and/or coordination of services by providers in small towns: The safe harbor provisions of the DOJ/FTC Guidelines, as delineated in *Statements of Antitrust Enforcement Policy in Healthcare*,⁷⁵ do not cover the potential collaboration of two financially healthy and well-utilized hospitals in a smaller community. The DOJ/FTC Guidelines are really restricted to small or failing institutions with low occupancy. Further, the Task Force could not determine whether it would be desirable to promote mergers of multiple hospitals in smaller communities or whether pluralism in the provision of services in these communities might produce added benefits or might promote the operation of two state-wide networks in a community, thereby assuring residents choices among providers and other benefits of competition;

(2) Consultation between hospitals and other providers about the desirability of collaborative efforts: The Task Force discussed several options that would allow providers to examine whether collaborative activity is in the best public interest, such as a "time out," which is an exempt period from antitrust exposure allowing potential collaborators to discuss the benefits of a proposed collaboration that otherwise constitutes a potential violation of the antitrust laws. For example, providers forming alliances in order to bid to become Indiana Medicaid managed care contractors could well have utilized this protection. However, the Task Force concluded that simply allowing parties to talk under the ostensible sponsorship of a state agency would probably not be sufficient to meet the supervised activity requirements of state action required in the *Ticor* decision. Allowing such protection to providers that are *exploring* collaboration without an extensive state regulatory program currently required for state action exemptions may be an appropriate reform under federal health reform proposals or possibly a DOJ/FTC safe harbor protection. The Clinton health care proposal, The Health Security Act, included such relief in its proposed antitrust reforms;

(3) Estimating savings of combined clinical departments when two hospitals collaborate in a common network: It is important to recognize that the benefits to a health care provider of clinical combinations or reduction in the duplicity of expensive medical equipment are financial savings. Discussions between providers of savings estimates that would result from collaborations are clearly constrained by both state and federal antitrust laws.

2. *The Required State Regulatory Program for a State Action Exemption.*—As stated in greater depth above, the Supreme Court recently outlined specific requirements to

74. David Burda, *Indiana Hospitals Call Off Merger Following Probe*, MODERN HEALTHCARE, July 1, 1991.

75. See *supra* note 42.

create a state action exemption from the federal antitrust laws. A state must: (1) clearly articulate its public policy to be furthered by the exemption; and (2) actively supervise its review process, which includes allowing the state to review, regulate and deny potential collaborative arrangements.⁷⁶

The Task Force concluded that the legal requirements for a state action exemption, as set out by *Midcal* and clarified by *Ticor*, do not allow Indiana to create the type of antitrust exemption the Task Force could recommend. The Task Force was concerned that the regulatory task would be so great and require such extensive economic and legal expertise that the ISDH or any other state agency, given customary restraints on staff and resources currently experienced by Indiana State agencies, would not be able to conduct the type of regulatory program mandated by the Supreme Court's decisions.

3. *The State's Interest in Promoting a State Action Program.*—The Task Force concluded that the state has an interest in a rational health care system that assures high quality health care services to all citizens at a reasonable cost. The question of how the state would accomplish these goals in a state regulatory program posed a confounding problem in the Task Force's judgment. These goals, the Task Force recognized, were quite similar to the goals of the health planning and Certificate of Need (CON) programs—mandated by Congress in the National Health Planning and Resources Development Act of 1979.⁷⁷ Yet the Task Force unanimously opposed creating a regulatory scheme like the CON program.

The Task Force specifically considered past experiences with health planning and CON in Indiana and the nation. The Task Force noted that federally mandated health planning was not particularly effective in reducing excess capacity or promoting rational development of health care facilities around the state. Further, federal health planning and CON agencies did not effectively administer these programs. Finally, the Task Force agreed, the planning and CON processes simply made disputes between powerful providers over resources and development into political battles that would otherwise be fought through economic competition in a non-regulated market.

4. *Task Force Observations on the Merits of a State Action Exemption.*—Below are listed some of the more important points made by Task Force members that influenced the Task Force's recommendations:

- (1) The Task Force observed that the health care system in Indiana and throughout the United States was in great flux. Hospitals are changing dramatically, particularly in the way that they provide hospital services. Hospitals are joining with physicians and other health care providers to form vertical service delivery networks. National HMOs and other managed care organizations are penetrating Indiana's market for health care services. At the federal level, Congress and the Clinton Administration are considering major legislative proposals for health care reform that would dramatically change the health care system. Given these and other developments, the Task Force was unclear as to the nature of Indiana's future health care delivery system;

76. Federal Trade Comm'n v. Ticor Ins. Co., 504 U.S. 621 (1992).

77. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

(2) Market competition does not necessarily influence hospitals in the same way it influences non-regulated organizations in the business sector. In other words, regulation by the federal government, states and the Joint Commission on Accreditation of Healthcare Organizations imposes requirements on hospitals that preclude hospitals from limiting essential services to communities, and taking other actions that might make them more competitive in a less regulated environment;

(3) Indiana should not duplicate on the state level the antitrust analysis presently conducted on the federal level. Rather, Indiana should act only if there are clearly identifiable social policy issues on which there is broad consensus, and the achievement of which would be so significant as to justify conduct that might otherwise be considered anti-competitive and/or illegal, and that would also justify the state's establishment of a new review mechanism to determine whether or not such social policies are, in fact, achieved;

(4) The foremost question in this analysis is whether the market is currently doing, or has the capacity to do, what the public wants regarding quality, cost and efficiency. Only if a significant disparity exists between the status quo and public demands should the government engage in providing additional regulatory systems that enhance the goals of public policy. This question is complicated as there are no guidelines concerning what the public wants in health care. Similarly, the public is unable to assess whether or not the antitrust laws are a benefit or burden to the public interest;

(5) When H.B. 1800 was introduced in 1993, business was very interested in encouraging provider collaboration in one form or another.⁷⁸ Currently, the business community appears to be more skeptical about the benefits of collaboration that might otherwise be proscribed under the antitrust laws.

V. THE MERITS OF A STATE ACTION EXEMPTION

The Task Force initially posed three questions to answer in its deliberations. The answers to these questions are set forth below.

(1) Is a state action exemption to the federal antitrust laws a good idea?

The Task Force was reluctant to recommend a change in the economic rules that define how health care providers relate to one another, especially in a changing environment as exists in the health care system presently. The Task Force, however, recognized that future action regarding the antitrust laws may be appropriate and did not "close the door" on the concept of state action immunity for Indiana. The Task Force also concluded that, unless the state could accomplish specific, positive goals for health reform without an extensive state regulatory program of the type clearly contemplated in *Ticor*, the state should not proceed with a state action exemption and associated regulatory program. In other words, the state should not engage in the same type of antitrust review

78. See *supra* note 66.

that the federal government does without seeking to achieve additional positive goals. Adoption of a recommendation for creating a state action exemption should not be made lightly. The state involvement necessary for a state action exemption would require Indiana to dedicate significant resources for continuing oversight of collaborators. While several other states have adopted these statutes, they are untested under the guidelines set out by the *Ticor* decision. If the process of collaborating under the exemption was rigorous, potential collaborators would likely choose traditional review of their proposal by the DOJ and the FTC due to the risk of federal antitrust exposure because of the untested nature of the exemption.

Another reason for the Task Force's decision to refrain from recommending state action immunity legislation at this time is that some experts question whether the state action immunity statutes of other states will actually confer state action immunity when challenged by either the federal government or, more probably, competitors in private antitrust actions.⁷⁹ The Task Force thought it desirable to wait and examine how courts rule on existing state action immunity statutes before proceeding with such a statute in Indiana. Further, it would be desirable to see how state action immunity statutes in other states are used by providers and whether the resulting collaborations are, in fact, beneficial to the health care system.

(2) If so, what activities and persons should be exempted?

The answer to this question is unclear and is one of the major reasons that the Task Force recommends deferring a recommendation for a state action exemption.

(3) If so, what should the state's regulatory program look like?

Clearly, the Task Force is hesitant to recommend a rigorous regulatory program for health care providers of the type contemplated by *Ticor*. The chief concern, which prevented the Task Force from embracing the adoption of a state action exemption, was the extensive state regulation that is required by the Supreme Court in *Ticor*.

In conclusion, the Task Force recommends that Indiana policy-makers consider a state action immunity statute as one of many goals for the health care system, making sure that it coordinates a state action immunity doctrine with other important health-related policy goals. For example, other ways to make health care providers more efficient could include making the state a better purchaser of health care services for the individuals that it insures. The state is already doing this with its Medicaid managed care program. It should consider adopting a similar strategy for other groups for whom it provides or mandates health insurance, *e.g.*, state employees or the beneficiaries of the Indiana Comprehensive Health Insurance Association. Finally, the market for health care services is extremely complex and unique. For some services, *e.g.*, expensive, high technology services for the catastrophically ill, cooperation among providers seems intuitively desirable. However, for other services provided to the general population, competition among providers may be desirable as a way to keep costs down and quality of service high.

79. See *supra* note 70.

POSTSCRIPT

Much has happened in the health care field since the Task Force's deliberations and the writing of this Article.⁸⁰ Congress considered and failed to pass proposals for federally mandated comprehensive health reform, including President Clinton's health reform proposal in the Health Security Act.⁸¹ Yet the health care industry is going through enormous change with unprecedented horizontal and vertical mergers and consolidations of health care providers throughout the United States. These transactions often raise important antitrust issues that are confounding to those involved. This analysis of the state action exemption in Indiana is one state's effort to look at the appropriateness of state action immunity from federal antitrust laws for collaborative activities among hospitals. We hope it is helpful.

80. We have tried to indicate more recent developments in the footnotes of this article.

81. H.R. 3600, 103d Cong., 1st Sess. (1993).

