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HEALTH CARE REFORM AND COMPETING VISIONS OF MEDICAL CARE: ANTITRUST AND STATE PROVIDER COOPERATION LEGISLATION

James F. Blumstein†

INTRODUCTION

This Article examines the competing visions of medical care represented by the professional paradigm and the market-based economic paradigm and considers the implications of those visions for the development of public policy. The first Part identifies the premises underlying the professional model and the influences that have bolstered each model. Notably, application of antitrust law to the health care marketplace has contributed to the growing role of the market paradigm in the health care industry and thus has figured largely in the debate over health care reform. The second Part discusses recently enacted state legislation designed to facilitate cooperation among health care providers such as hospitals. These laws purport to provide antitrust immunity under the "state action" doctrine.

The professional and market-based economic paradigms are broad conceptual categories. Realistically, the health care arena does not demand an either-or choice among competing policy options.¹ Elements of both visions may be present when one thinks about the health care marketplace. Historically, the professional paradigm dominated perception and policy prescription.² But now, in the world of managed care and health care reform, many doctors are frustrated by the perceived inroads on their professional autonomy and

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¹ See generally Randall R. Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965 (1981).

² See generally ELIOT FREIDSON, *PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE* (1970). For a passionate defense of the professional model and a critique of perceived inroads of the market-based model, see Arnold S. Relman, *The New Medical Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980).

challenges to the professional orientation of medical care delivery.³ The key to health care reform is striking the appropriate balance between these competing policies.⁴

This Article discusses a number of policies that have contributed to the increased importance of the market paradigm in medical care. In this regard, the Article argues that the application of antitrust principles to, and the enforcement of those policies in, the health care marketplace have driven a shift in paradigms—from exclusive reliance on the professional model to a more balanced blend of the professional with the market model.⁵

The emerging consensus that the market paradigm and the antitrust laws play a fundamental role in the evolution of the nation's health care system⁶ is reflected in the Clinton Administration's original health care reform proposal. At least in its rhetoric, it was influenced by a market-based model. It called for the development and dissemination of consumer information, the development and utilization of outcomes research, and greater participation of consumers in decisionmaking.⁷ Importantly, there was no broad antitrust exemption in the Clinton plan.⁸

³ For an expression of physician concern, see Arnold S. Relman, *Medical Practice under the Clinton Reforms—Avoiding Domination by Business*, 329 NEW ENG. J. MED. 1574 (1993). For a skeptical discussion of the effect of financial incentives in clinical decision-making, see David M. Frankford, *Managing Medical Clinicians' Work Through the Use of Financial Incentives*, 29 WAKE FOREST L. REV. 71 (1994).

⁴ See, e.g., James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 17-29 (1994) [hereinafter *Health Care Reform*].

⁵ There have been a number of important contributing factors to the increased role of markets in medical care. Antitrust doctrine is foundational, however, because of its cultural statement that markets must be allowed to function in the health care industry. Further and pragmatically, other developments, such as shifts in payment systems and in the organization of medical practice, have been facilitated by the ban on collective resistance to potentially threatening changes on the demand side of the market. For example, in *AMA v. United States*, 317 U.S. 519 (1943), the AMA and its Washington, D.C. affiliate conspired to obstruct an early health maintenance organization (the Group Health Association) from attracting and retaining physicians. See also *Wilk v. AMA*, 895 F.2d 352 (7th Cir.), cert. denied, 111 S. Ct. 513 (1990); *AMA v. FTC*, 638 F.2d 443 (2d Cir. 1980), *aff'd mem.* by an equally divided court, 455 U.S. 676 (1982); *Group Health Coop. of Puget Sound v. King County Medical Soc'y*, 237 P.2d 737 (Wash. 1951).

⁶ The Congressional debates concerning the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101, demonstrate the importance that members of Congress attached to antitrust in the health care industry. Even regarding statutory immunization of such a seemingly benign practice as professional peer review, "[c]onsiderable concern was expressed about abuse of peer-review processes to achieve anticompetitive objectives." James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, 51 LAW & CONTEMP. PROBS. 7, 71 (Spring 1988) [hereinafter *Hospital Peer Review*]. See 141 CONG. REC. H9957 (daily ed. Oct. 14, 1986) (statement of Rep. Waxman); *id.* at H9960-61 (statement of Rep. Edwards); *id.* at H9963 (statement of Rep. Tauke).

⁷ See Blumstein, *Health Care Reform*, *supra* note 4, at 20 n.24.

⁸ For a brief discussion of the antitrust dimensions of the Clinton Administration's original health care reform proposals, see James F. Blumstein, *The Clinton Administration*

In September 1993, prior to the announcement of the Clinton plan, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) set out enforcement guidelines under the antitrust laws.⁹ These included so-called "safety zones," which would not trigger antitrust enforcement action by either the DOJ or the FTC.¹⁰ De-

Health Care Reform Plan: Some Preliminary Thoughts, 19 J. OF HEALTH POL., POL'Y & L. 201, 204 (1994) [hereinafter *Preliminary Thoughts*].

⁹ U.S. Dept. of Justice & Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in the Health Care Area (Sept. 15, 1993), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,151, at 20,755-68. These guidelines were revised and expanded in September 1994. 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) [hereinafter *Health Care Antitrust Guidelines*].

¹⁰ These enforcement guidelines covered six categories of antitrust enforcement policies regarding mergers and various joint activities in the health care area and set forth safety zones and explanations of the agencies' analysis of activities which fall outside the antitrust safety zones. The revised 1994 Enforcement Policy Statements, *see* *Health Care Antitrust Guidelines*, *supra* note 9, cover nine categories: the six covered by the 1993 Guidelines, some of which are modified, and three new ones. The nine categories are as follows: (1) hospital mergers (essentially unchanged from 1993), (2) hospital joint ventures involving high technology or other expensive medical equipment (expanded to include existing as well as new equipment), (3) hospital joint ventures involving specialized clinical or other expensive health care services (new with no safety zone provided), (4) providers' collective provision of non-fee-related information to purchasers of health care services (expanded from physicians to providers but limited to non-fee-related information), (5) providers collective provision of fee-related information to purchasers of health care services (new), (6) provider participation in exchanges of price and cost information (expanded from hospital to provider), (7) joint purchasing arrangements among health care providers (essentially unchanged), (8) policy on physician network joint ventures (essentially unchanged), and (9) analytical principles relating to multiprovider networks (new with no safety zone provided). Additionally, except for mergers outside the safety zone, the agencies commit themselves to respond to business review or advisory opinion requests within 90 days after receiving all necessary information. For example, the enforcement agencies will not challenge any merger between two general acute-care hospitals where one of the hospitals over the last three years has an average of fewer than 100 licensed beds, has an average daily inpatient census of fewer than 40 patients, and the hospital is more than four years old, absent extraordinary circumstances.

As another example, the enforcement agencies will not challenge 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, absent extraordinary circumstances.

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, allowing the hospitals to provide services jointly in areas where there are numerous competitors. These areas include some outpatient services, open heart surgery, laboratory and diagnostic services, some specialized high technology services, and others. Additionally, the hospitals may 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 to reduce costs by increasing utilization and may improve outcomes by allowing the same personnel to work together more frequently. The agreement prevents the two systems from discussing managed care contracting, pricing, or marketing. *Landmark Federal-State Settlement Clears way for Innovative Partnership*, 3 Health L. Rep. 830-31 (1994).

spite the positions pressed by the hospital industry and physician groups for broad antitrust immunity, the Clinton Administration did not embrace this policy as part of its health reform plan. The rhetoric and the ideology of the DOJ-FTC enforcement guidelines were not at odds with fundamental antitrust policies.¹¹ The "safety zones," encompassing such activities as mergers and joint ventures,¹² were deemed by the DOJ and the FTC to identify conduct likely to be pro-competitive and efficiency creating. Thus, the conduct falling within the safety zones would not offend antitrust principles. The safety zones were packaged and promulgated not as exceptions to, but as enforcement guidelines within, the framework of antitrust policies.¹³

While antitrust enforcement at the federal level has played an important role in the evolution of the market paradigm in the health care industry, and such enforcement seems to have achieved considerable political support among influential national policymakers, a policy counterpoint has recently emerged at the state level. A large number of states have enacted hospital cooperation legislation designed to use the state action antitrust immunity doctrine, under

¹¹ This point was reinforced by a statement issued at the time of announcement by Senator Howard Metzenbaum: "We're going to solve a problem in the antitrust field without changing one word, one comma, or one semicolon of the antitrust laws. . . . We are here today to clear up confusion among doctors and hospitals about how these laws apply to them. We want to end their uncertainty. . . . These policy guidelines are proof positive that we can make our laws work to accommodate business when their concerns have logic and merit." Statement by Sen. Howard M. Metzenbaum (Sept. 15, 1993), *Press Conference with U.S. Att'y Gen. Janet Reno, First Lady Hillary Clinton, Janet Steiger, Chair, Federal Trade Commission*, Fed. News Service, Sept. 15, 1993, available in LEXIS, News Library, CURNEWS file. However, Commissioner Deborah K. Owen disagreed and stated that the risks of higher prices and reduced output or lower quality of care posed to health care consumers by the proposal outweighed any benefits generated. Furthermore, she took issue with the premise that sufficient guidance was not available and that the agencies' past enforcement efforts had been unreasonable. She considered the guidelines to be a special interest antitrust exemption that should be enacted only legislatively. She particularly disagreed with the merger guideline, which she said could not be reconciled with the analysis set forth in the 1992 Merger Guidelines (U.S. Dep't of Justice & Fed. Trade Comm'n Horizontal Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13,104 (Apr. 2, 1991)). She pointed out that the merger safety zone is not limited in applicability to rural hospitals operating in isolation nor is there any consideration of the identity of the purchaser; thus, a large competitor could purchase all the small hospitals in a market area that met the criteria. *Id.* ¶ 13,235.

¹² See *supra* note 10.

¹³ Although it retained antitrust enforcement as an important part of its mission and ideology, the original Clinton Administration health care reform plan did embrace an exception. It provided for immunity for doctors who engaged in collective negotiation with regional alliances for fee-for-service fee schedules. Limited immunity for collective negotiation was granted, but no immunity for a boycott or a threat of boycott on the part of physicians, both of which are antitrust violations, was included. This provision could be characterized as a form of "smoke but don't inhale" or "enforce-but-don't-pursue" immunity. There was a nice little legal-political minuet going on, but it was not clear what the parameters of the immunity were or how it would play out in practice. See Blumstein, *Preliminary Thoughts*, *supra* note 8, at 204.

Parker v. Brown,¹⁴ as a way of overcoming antitrust requirements by allowing states to substitute regulation for competition.¹⁵

The Article describes briefly those provisions in a paradigmatic form and evaluates them from a policy perspective. Although such legislation purportedly aims to achieve economic efficiency, any existing market flaws can be addressed more effectively in other ways, such as through changes in payment mechanisms. In addition, some of these state laws authorizing cooperation among health care institutions identify goals other than economic efficiency. However, these other objectives are too amorphous to be balanced fairly against antitrust law's goal of promoting competition. The use of unidentified and often unquantified revenue transfers to pursue ambiguous policy goals may stand in the way of political accountability. Further, these provisions are unlikely to provide an adequate forum for the representation of unconcentrated political interests such as those of consumers and taxpayers.

This Article concludes by analyzing whether these laws comply with the requirements of *Parker* immunity. For a state to establish a *Parker* defense for private conduct, it must clearly articulate a policy supporting the substitution of regulation for competition, and it must actively supervise private conduct to assure that state objectives are being pursued and fulfilled.¹⁶ The *Parker* doctrine allows states to countermand the federal antitrust policy of procompetition only when active supervision assures that the authorized private activity achieves public rather than private purposes.

I

COMPETING VISIONS OF MEDICAL CARE: THE PROFESSIONAL AND THE MARKET PARADIGMS

Historically, medical care has been characterized by a professional dominance on the part of physicians.¹⁷ While many factors

¹⁴ 317 U.S. 341 (1943).

¹⁵ The General Accounting Office reports that, as of May 1994, "18 states have attempted to provide immunity from federal and state antitrust laws for some activities of hospitals and other health care providers." U.S. General Accounting Office, *Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry*, at 10 (August 1994) [hereinafter *GAO Report*]. The GAO lists the following states: Colorado, Florida, Georgia, Idaho, Kansas, Maine, Minnesota, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, Tennessee, Texas, Washington, and Wisconsin. Some commentators have reported that California, Iowa, and Vermont also have enacted such legislation, see Robert E. Bloch & Donald M. Falk, *Antitrust, Competition, and Health Care Reform*, 13 HEALTH AFFAIRS 206, 229 n.29 (Spring 1994), but the GAO does not list those states. See *infra* part II.B.

¹⁶ See *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

¹⁷ See PAUL STARR, *THE TRANSFORMATION OF AMERICAN MEDICINE* 226-27 (1982).

have contributed to this dominance, two primary reasons stand out. First, the professional model has provided the necessary intellectual rationale.¹⁸ Second, physician control of patient referral (that is, control of business for the industry) and patient billing have provided the economic power to implement the professional model, especially vis-a-vis hospitals.¹⁹

Hospitals traditionally have depended on physicians to fill beds. This gives doctors enormous influence on hospital management. Physicians have sought to maintain control over patient billing as part of the practice of medicine. Autonomy in billing assures a physician independence of clinical judgment. But also, quite obviously, such control and autonomy provide physicians with strong economic independence and leverage against other organizational forms in which physician services are marketed as part of an all-inclusive package of prepaid services.²⁰

A. The Premises Underlying the Professional Paradigm

Under traditional economic theory, a smoothly functioning market requires adequate information so that economic actors can behave in an economically rational manner. Perhaps the most important rationale advanced by proponents of the professional model is the asymmetry of information held by doctors and patients.²¹ Critics of the market model in medical care contend that patients are essentially ignorant, whereas doctors are extremely well trained and expert. For advocates of the professional paradigm, what follows from that asymmetry is a justification for disempowering the market model's sovereign consumer. Instead of pursuing a strategy of market improvement—that is, improving the flow of understandable information or otherwise improving the functioning of the market—proponents of the professional model embrace a strategy of market substitution, in which the judgment of the physician is substituted for that of the patient.

¹⁸ Cf. Frankford, *supra* note 3, at 79-83 (describing the belief structure underlying the professional model).

¹⁹ For an example of the importance attributed to professional control of billing, see *State v. Abortion Info. Agency, Inc.*, 330 N.Y.S.2d 927 (App. Div. 1971), *aff'd*, 285 N.E.2d 317 (N.Y. 1972).

²⁰ "The continued ability of physicians to bill separately for services performed in hospitals has not only served to maintain their economic independence of hospitals but their professional independence as well. . . . Since doctors have traditionally referred patients to hospitals, they have controlled the hospitals' clientele. That power over patients adds to physicians' autonomy. Thus, continued independence has given physicians, both individually and collectively, considerable leverage over hospitals." Blumstein & Sloan, *Hospital Peer Review*, *supra* note 6, at 17.

²¹ See generally Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

The doctor's claim of expertise arises from scientific training. The scientific basis of medical training and practice legitimizes professional empowerment. Adoption of the professional model places the professional in a fiduciary relationship with the patient, for whom the professional makes decisions. But it also shifts a power between purchaser and service provider. Surrogate (and necessarily paternalistic) decisionmaking replaces consumer sovereignty. This confers upon the professional the authority to decide important economic questions concerning the demand for services and standards of quality. In an environment characterized by third-party financing, professional control of decisionmaking has led to ever-increasing expenditures in the name of quality, which is the professionals' watchword in combating efforts to rein in escalating costs.²²

Concomitant with the professional model are the duty of professional self-regulation, the commitment to promote and monitor high standards of quality, and the de-emphasis on economic issues.²³ The de-emphasis on economic issues reinforces the professional paradigm by directing attention away from the economic characteristics of medical care service delivery.

Historically, advocates for improved access to care have linked up with the professionals. For example, in 1965 this alliance resulted in the enactment of Medicare and Medicaid.²⁴ The deal assured unrestricted, tax-generated public money to support access for the poor and the elderly in exchange for greater physician autonomy through institutionalized deference to physicians' clinical authority. The doctors were assured that their professional and economic autonomy would be respected, and public dollars would flow to provide medical benefits to underserved groups. The Medicare and Medicaid deal adopted a blank check approach that virtually guaranteed, as commentators predicted,²⁵ that cost escalation would ensue.

The professional paradigm places power paternalistically in physician hands. Physicians perceive themselves as controlling decisionmaking, and that perception is an important part of the professional paradigm. Physicians as professionals also control quality through peer review mechanisms that are part of the professional paradigm.

²² For a general discussion of these issues, see Donald W. Light, *Is Competition Bad?*, 309 NEW ENG. J. MED. 1315 (1983).

²³ See generally William J. Goode, *Community Within a Community: The Professions*, 22 AM. SOC. REV. 194 (1957) (arguing that the socialization that occurs within professional communities serves to curb the abusive potential inherent in a professional's position).

²⁴ For an appeal to professional autonomy in support of the proposed Clinton reforms, see Arnold Epstein, *Changes in the Delivery of Care Under Comprehensive Health Care Reform*, 329 NEW ENG. J. MED. 1672 (1993). See also THEODORE MARMOR & JAN MARMOR, *THE POLITICS OF MEDICARE* (1973).

²⁵ See, e.g., 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, 13-15 (1975).

Because of their expertise and professionalism, physicians look within the profession for their frame of reference regarding quality assurance.

This professional decisionmaking hegemony leads to physician control of costs and output. By shifting control from consumers to physician fiduciaries, the professional model insulates the medical services market from economic trade offs. In the traditional economic marketplace, consumers trade off increments of quality because of cost. Once decisionmaking authority is ceded to professionals, professional standards govern. Decisions are seen as technical and scientific, so that consensus in decisionmaking is professionally oriented. Quality-cost trade offs are attenuated, and trade offs between medical care and other goods or services are precluded by dedicated medical care financing through nontransferable third-party insurance. Under the professional model, economics and trade offs become marginalized in the policy debate. Medical care thus becomes an exclusively technical-scientific enterprise.

B. Techniques for Promoting the Professional Paradigm

This Part identifies four techniques that have been used to promote the professional paradigm. First is freedom of choice of physician for patients, a phenomenon that has been paired with third party payment. Clearly the idea is to keep financial considerations out of the patients' deliberative process. The only thing that matters from a policy perspective is guaranteeing the right of patients to choose their professional provider, who faces minimal resource constraints because of third-party payment. That traditionally has meant that no expense is spared. The medical profession historically has opposed trading off limited physician choice for economic benefits, a hallmark of managed care.²⁶

Second, the professional paradigm has been bolstered by arguments that the imposition of resource constraints and containment of medical care expenditures will lead to lower quality. The threat to quality is perceived as the physicians' silver bullet in the debate about health care policy. In the market, however, the threat of lower quality should not ring the death knell for proposed policy shifts. Cost-benefit and risk-benefit calculations occur constantly and are an integral

²⁶ In some states, this protection of the professional paradigm, accompanied by a healthy dose of economic self-interest from providers facing exclusion from managed care plans, has manifested itself in legislation requiring health plans to contract with any willing provider. In *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 114 S. Ct. 579 (1993), the Fourth Circuit held that Virginia's any-willing-provider law was not preempted by ERISA. The Clinton Administration's original health care reform proposal would have preempted such laws. H.R. 3600, 103d Cong., 1st Sess. § 1407 (1993).

part of the economic marketplace. If lower quality were the death knell, we would not have different segments in the automobile industry—only the Lexus, the Infiniti, and the Mercedes would be manufactured.

In short, policies that lower the quality of care may be rational if higher levels of quality can be achieved only at extremely high costs. Intuitively, we all engage in such balancing. We take prudent (and sometimes even imprudent) risks to achieve objectives that are important to us, or because we believe that the cost of safety is excessive in that it would cause us to forgo other valuable benefits. Indeed, these kinds of economic trade-offs are routinely made in the medical care marketplace, but usually out of the public's sight.²⁷ But only academic types, who are not running for public office, are prepared to state what should be obvious—that it might be socially optimal to have lower quality medical care, at least in some circumstances, if the cost of the highest quality care is too high. In no other marketplace do we say "spare no expense, cost is irrelevant." It is not radical to suggest that the highest levels of quality might be sub-optimal and that the diminution-of-quality argument should not be checkmate in health policy debates.

The third technique often used to promote and protect the professional paradigm is opposition to rationing.²⁸ This is a great rhetorical ploy. We are told rationing is a terrible thing. "Rationing is a bad idea." But in the economic marketplace scarce resources are always allocated to their most beneficial use.

Use of the term "rationing" implies that someone is doing the choosing. But opponents of rationing do not always focus on that technical issue. Instead, they employ the term synonymously with the concept of allocating scarce resources. Yet, the need to allocate resources is a fundamental reality of economic life. Consumers constantly choose among alternatives based upon sensitive consideration of costs, risks, and benefits.

The rhetoric of rationing and denigration of its use suggest that economic trade-offs are inappropriate when it comes to health care. Rationing connotes government control over consumer expenditures. In the private economic marketplace, resources are allocated not by government but by the private choice of atomistic decisionmakers—

²⁷ For example, apparently there are different qualities of artificial hips used in hip replacement surgery. The choice is not always placed before the patient. Other such decisions involve the kind of contrast agent to be used in a radiologic study, the cost differences between ionic and nonionic contrast agents being enormous.

²⁸ See James F. Blumstein, *Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources*, 60 TEX. L. REV. 899 (1982) [hereinafter *Public and Private Medical Resources*]; James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345 (1981) [hereinafter *Rationing*].

households and firms. By failing to recognize that resource allocation is a normal market function, opponents of rationing impliedly suggest that private choice plays no part in the medical care marketplace.²⁹ That form of rhetoric reinforces the tenet of the professional paradigm that medical care service decisions are scientific and technical in character, without a substantial economic dimension.

Fourth and finally in this regard, proponents of the professional model have advocated a unitary standard of practice in the medical services marketplace. In opposing policy proposals to restrain costs, they warn against a two-tier or multi-tier medical system.³⁰ But in the typical economic marketplace there is nothing unusual about the existence of multiple tiers, which may conform to consumer preferences. In the absence of special egalitarian claims, there is nothing inherently wrong with multiple levels of quality or multiple styles of practice.³¹ Presented honestly, the debate is about what degrees of difference society will allow, what obligation society has to finance care for those unable to pay, and who should benefit from public subsidy and in what magnitude. The truth is that serious analysts cannot persuasively defend the principle of total equality of end result. There are only two ways to achieve that kind of end-result equality—leveling up or leveling down (or some hybrid of the two approaches).³²

To achieve single tier equality, one must first establish the level of care required. Will society make it illegal for those seeking a higher standard to purchase additional medical care with their own resources, or for providers to sell those services in the marketplace? Is that the goal? That would be a leveling down scenario, and some coercion would be required to achieve equality given the differences in

²⁹ See Rand Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401 (1981).

³⁰ For a discussion of the medical malpractice issues regarding multiple standards of care, see James F. Blumstein, *Cost Containment and Medical Malpractice*, in HEALTH CARE DELIVERY AND TORT: SYSTEMS ON A COLLISION COURSE? 76, 91-94 (Elizabeth Rolph ed., 1991) [hereinafter *Cost Containment and Medical Malpractice*]; Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297 (1994); Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today To Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755 (1992); E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987); John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439 (1991). Cf. Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L. REV. 1809, 1815-16 (1992) (arguing that the "problem that deserves our attention is not how to accommodate new forms of rationing . . . but how to define necessary as opposed to unneeded care").

³¹ See, e.g., 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, 864-67 (1981) [hereinafter *Redefining Government's Role in Health Care*].

³² See *id.* at 865.

preferences and income/wealth in the nation. When unpacked, the ostensible ideal of a single tier becomes little more than a politically appealing but analytically vapid rhetorical flourish.³³ But facing up to the real debate—what degree of difference in medical services should society accept—poses tough ethical and economic questions that direct attention away from the professional solution, which is to leave the level of services to the discretion of the profession with unlimited public payment.

C. Legal-Institutional Bulwarks of the Professional Model

The professional model is maintained as the historically prevailing paradigm by a number of legal doctrines and institutional structures. This Part canvasses briefly four bulwarks of the professional model.

Licensure laws. Licensure laws are intended as a form of quality assurance.³⁴ Typically, they rely on input measures (educational credentials) and process measures (examinations) as proxies for assuring quality outcomes. An unintended³⁵ consequence of licensure laws is that they can limit competition from other types of potentially lower-cost providers.

Section 1161 of the Clinton Administration's original health care reform plan would have preempted state licensure laws.³⁶ There are some significant federalism issues raised by this preemption proposal,³⁷ but the Clinton scheme would have dramatically altered licensure law as we know it.³⁸

³³ See James F. Blumstein, *Thinking About Government's Role in Medical Care*, 32 ST. LOUIS U. L.J. 853, 859 (1988):

The impracticality [of equality of access] lies in the excessively high cost of *leveling up* to give everybody equal care. This expense would distort our nation's spending priorities. . . . On the other hand, . . . we are not prepared to *level down* either, because leveling down has some very negative consequences. . . . If we tried to prohibit private expenditures in health care, a black market would probably develop.

³⁴ See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 40-42 (1991).

³⁵ The adverse effect on competition is usually unintended in a formal sense. Licensure laws are rarely if ever publicly advocated or defended because of their protective characteristics. However, individuals or professional associations may intend for these anti-competitive features to provide insulation from competitive inroads on turf, much as union-negotiated work rules function in a collective labor agreement. For a review of these issues, see Gary L. Gaumer, *Regulating Health Professionals: A Review of the Empirical Literature*, 62 MILBANK MEM. FUND Q. 380 (1984).

³⁶ H.R. 3600, 103d Cong., 1st Sess. § 1161 (1993).

³⁷ Cf. *California State Bd. of Optometry v. Federal Trade Comm'n*, 910 F.2d 976 (D.C. Cir. 1990) (barring FTC eyeglass regulation and expressing federalism concerns).

³⁸ See Blumstein, *Health Care Reform*, *supra* note 4, at 20 n.23; Blumstein, *Preliminary Thoughts*, *supra* note 8, at 204-05.

Section 1161 of the Clinton health care reform plan provided as follows: "No state may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals." That provision promised a significant assault on the citadel of licensure. Nonphysician health professionals such as nurses could challenge licensure restrictions by asserting that, through "skills and training," they are capable of performing and should be authorized to provide an array of services traditionally considered part of the practice of medicine reserved for physicians. If nonphysicians' "skills and training" would "justif[y]" their performing a task, then the Clinton proposal would abrogate traditional prerequisites imposed by state licensing authorities. This would go a long way toward eroding the turf-based protections that physicians and other licensed health professionals have enjoyed. Such a proposal would be strongly procompetitive and promarket, greatly undermining the professional paradigm.³⁹

Hospital Accreditation. The accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)⁴⁰ institutionalize physician autonomy within hospitals by requiring that the medical staff have an independent⁴¹ organization and structure.⁴² No health care institution besides the hospital is forced by accreditation standards or otherwise to adopt that form of governance arrangement. The required division of authority within the hospital creates potential management problems. Lines of authority and accountability are blurred, even as evolving principles of liability impose greater obligations for risk management and quality assurance on hospital administrators.⁴³ And changes in payment through managed care arrangements, which place hospitals at risk financially, require hospital administrators to control costs. The organizational structure mandated by accreditation standards impedes the ability of hospital administrators to manage their institutions as other economic

³⁹ Section 1161 was drafted in open-ended terms and could have generated excessive litigation. Further, since licensure laws typically carry a criminal penalty, there should be clarification of the boundaries so that professionals will not be at risk of criminal liability.

⁴⁰ The Joint Commission on Accreditation of Hospitals (JCAH) is now the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). See FURROW ET AL., *supra* note 34, at 99-102.

⁴¹ See, e.g., *Saint John's Hosp. Med. Staff v. Saint John's Regional Med. Ctr., Inc.*, 245 N.W.2d 472 (S.D. 1976) (holding that medical staff bylaws constituted a contract with the hospital and could not be amended unilaterally by the hospital).

⁴² For a discussion of the role of the hospital medical staff and its relationship with the hospital board, see Report of the AMA/AHA Joint Task Force on Hospital-Medical Staff Relationships (1985). See generally Timothy S. Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835 (1983).

⁴³ See, e.g., *Thompson v. Nason Hosp.*, 591 A.2d 703 (Pa. 1991); *Pedroza v. Bryant*, 677 P.2d 166 (Wash. 1984); *Johnson v. Misericordia Community Hosp.*, 301 N.W.2d 156 (Wis. 1981).

entities are managed. The institutionalization of physician autonomy is preserved but, in an evolving marketplace, at the risk of poor institutional adaptation.

Corporate Practice Doctrine. The corporate practice doctrine restricts corporations from providing professional medical services.⁴⁴ Some jurisdictions have statutory restrictions, which typically set forth exceptions for certain practices such as health maintenance organizations or academic medical centers.⁴⁵ In most jurisdictions, however, the corporate practice restriction is inferred from the existence of licensure laws. Since only licensed professionals are authorized to practice in these jurisdictions, corporations, which are not licensed professionals, may not engage in the practice of medicine.

In practical terms, the corporate practice doctrine prevents physicians from working within a corporate framework unless statutorily authorized to do so. Billing for services is often considered part of the practice of medicine, so corporate entities such as hospitals may not offer all-inclusive pricing for services that include professional fees.⁴⁶

The corporate practice rule supports the professional paradigm. Physicians must have a direct relationship with their patients unencumbered by financial concerns related to their employment relationship with a corporation. Billing autonomy is part of assuring fiscal and therefore clinical independence.⁴⁷

In the emerging world of managed care and capitation payment, the restriction on corporate billing may discourage a hospital from choosing to become a risk-bearing managed care organization. The corporate practice doctrine can also impede the ability of health care institutions to reduce costs by hiring physicians on their staff. By restricting a form of competition, the corporate practice doctrine insulates physicians from downward pressure on fees.⁴⁸ While the precise status of the corporate practice doctrine is still a matter of some dispute, the residual corporate practice doctrine is a potential legal landmine for an industry seeking to develop new structures and relationships in response to market pressures.⁴⁹ The doctrine serves as a

⁴⁴ See Arnold Rosoff, *The Business of Medicine: Problems with the Corporate Practice Doctrine*, 17 CUMB. L. REV. 485, 490 (1987); Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 446 (1987).

⁴⁵ See, e.g., California Att'y Gen., Op. No. 81-1004 (April 7, 1982).

⁴⁶ See *State v. Abortion Info. Agency, Inc.*, 330 N.Y.S.2d 927 (App. Div. 1971), *aff'd*, 285 N.E.2d 317 (N.Y. 1972).

⁴⁷ See Chase-Lubitz, *supra* note 44.

⁴⁸ See generally Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 510 (1988).

⁴⁹ See *id.* at 509-11.

reminder of the ongoing institutionalization of the professional paradigm.⁵⁰

Fraud and Abuse. The existing federal ban on purported "fraud and abuse" represents an intimidating misnomer and, with respect to some critical provisions, is to a substantial degree an anachronism.⁵¹ Perhaps because the label is so daunting, there have been no serious efforts to modify the policy. Surely it is politically unappealing to face headlines suggesting that one is seeking to water down tough federal laws against fraud and abuse.

Certain portions of existing fraud and abuse legislation, as interpreted by the federal courts⁵² and the United States Department of Health and Human Services,⁵³ are premised on largely outmoded adherence to a hard-core version of the professional paradigm. These provisions have created significant barriers to market-oriented attempts to rationalize the medical care marketplace. The doctrine discourages vertical integration and other forms of cooperative integration. The fraud and abuse laws must be reexamined if market incentives are to succeed within the medical care system. In short, there is a clash of cultures here.

The pivotal case to interpret federal antifraud and abuse law is *United States v. Greber*.⁵⁴ *Greber* illegalized "remuneration" (direct or indirect) aimed at inducing future referrals or purchases.⁵⁵ Even when the services sought or provided are perfectly legitimate (*i.e.*,

⁵⁰ Section 1407 of the Clinton Administration's health reform proposal, H.R. 3600, 103d Cong., 1st Sess. § 1407, provided for the elimination of state laws banning the corporate practice of medicine. In that way the Clinton proposal furthered the market paradigm by leveling the legal playing field, allowing different forms of practice to coexist within the law.

⁵¹ For a conceptual discussion of the anti-fraud and abuse laws, see David M. Frankford, *Creating and Dividing the Fruits of Collective Economic Activity: Referrals Among Health Care Providers*, 89 COLUM. L. REV. 1861 (1989); Mark A. Hall, *Making Sense of Referral Fee Statutes*, 13 J. OF HEALTH POL., POL'Y & L. 623 (1988).

⁵² See *United States v. Greber*, 760 F.2d 86 (3d Cir.), *cert. denied*, 474 U.S. 988 (1985). *Accord*, *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Bay State Ambulance & Hosp. Rental Serv.*, 874 F.2d 20 (1st Cir. 1989).

⁵³ See H.H.S. Proposed Rules Regarding Civil Penalty and Exclusion Authority, 42 C.F.R. pt. 1000, 1001.901 (1990); H.H.S. Proposed Safe Harbor Rules, 42 C.F.R. pt. 1001 (1989). See also Office of Inspector General, *Special Fraud Alert: Joint Venture Arrangements* (Apr. 1989), *reprinted in Medicare & Medicaid Guide* (1992 Transfer Binder) (CCH) ¶ 40,200.

⁵⁴ 760 F.2d 86 (3d Cir. 1985). Although the facts in *Greber* were in some dispute, perhaps implicating an old-fashioned kickback, the Third Circuit assumed in its analysis that more was involved than a question of payment for services not provided.

⁵⁵ The language construed in *Greber* is codified at 42 U.S.C. § 1320a-7b(b)(2) (1988):

Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing . . . of any item or service for which payment may be made . . . under [Medicare] . . . , or

medically indicated) and the fee charged is reasonable and appropriate, there may be a criminal violation.

In *Greber*, a physician recommended that a patient undergo a test. That test needed interpretation, and the testing company (owned by a second physician) paid the referring doctor to perform the interpretation. The court assumed that the referring physician was competent and actually performed the interpretation.

The second physician admitted that one reason for having the referring doctor interpret the test was concern about future referrals. The second physician, who owned the testing company, defended his conduct on the ground that the referring physician had competence to perform the task and already had a relationship with the patient. At the same time, the second physician acknowledged his belief that he would not receive future referrals if he did not request interpretations from the referring physician.

The *Greber* court upheld the second doctor's conviction for violating the fraud and abuse law. It held that a violation is established if a factor in the decisionmaking process was use of "remuneration" (*i.e.*, payment of a legitimate fee) to "induce" future referrals, even if appropriately carried out and medically indicated. The court expressly rejected the argument that such inducement must be a dominant or predominant factor, or that the services provided must be in some way inappropriate. Any economic motivation concerning use of remuneration as an inducement suffices to constitute a violation.

Thus, under *Greber*, which has been followed in two other circuits⁵⁶ and by the Inspector General at the United States Department of Health and Human Services,⁵⁷ a motivation to develop business, to increase the flow of patients, is illegal. Yet, in the economic marketplace the development of business is an ever-present motivation. As interpreted, the fraud and abuse legislation precludes that type of market response, making business development through inducing future referrals a felony.⁵⁸ The fraud and abuse laws therefore serve to support the traditional professional paradigm, which in its hardest-

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made . . . under [Medicare] . . . shall be guilty of a felony . . .

⁵⁶ See *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Bay State Ambulance & Hosp. Rental Serv.*, 874 F.2d 20 (1st Cir. 1989).

⁵⁷ See *supra* note 53.

⁵⁸ Consider the following: A patient approaches his doctor and says: "My daughter is applying to college, will you write a recommendation?" Suppose the doctor says to himself, "if I do not write a letter, this patient may not come back and visit me again and may discontinue sending other patients to me." If that thought becomes a factor in the decision, writing that letter (a form of indirect "remuneration") could be a felony because of the doctor's intent to "induce" future business. This would be the case even if the doctor genuinely wished to support the daughter's application with enthusiasm.

boiled form is impervious to economic trade offs. The fraud and abuse laws criminalize market-adaptive conduct and in that sense warrant thorough reexamination.⁵⁹

D. Inroads on the Professional Model

This Part of the Article discusses six inroads on the professional model that, in a legal or policy sense or both, have contributed to the emergence of market-based competition in the delivery of medical care services.

Informed consent. Common law principles recognize personal autonomy by requiring consent before a physician is authorized to touch a patient. The question commonly posed in tort litigation is whether a patient's consent is effective. To be effective, consent must be "informed."⁶⁰ Although the cause of action for contact without consent originally sounded in battery, the concept largely has evolved into a negligence-based analysis.⁶¹ Still, the question is, what degree of disclosure is required before a patient's consent is deemed effective because informed?⁶²

Originally, the adequacy of disclosure was measured by a professional standard—what the reasonable, prudent physician would disclose to the patient under the circumstances. The frame of reference for determining the adequacy of disclosure to patients was that of a similarly situated physician. However, the law has evolved dramatically, shifting from the reasonable doctor standard, a professional model, to a reasonable patient standard. In the jurisdictions that follow the reasonable patient approach—about half the states⁶³—the inquiry focuses on what information a reasonable patient would want to have disclosed. The analysis no longer relies on what professionals as

⁵⁹ This component of the fraud and abuse laws may be anachronistic in a world of prepayment and capitation. It is premised on the idea that payment of "remuneration" to "induce" future referrals will expand utilization and thereby increase Medicare costs. If payments are fixed in advance, then the opportunity to engage in this type of abuse is largely eliminated. The providers, not the government payor, are financially at risk in such situations.

⁶⁰ See generally Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994) (discussing development and principal theories of the informed consent doctrine).

⁶¹ See *Canterbury v. Spence*, 464 F.2d 772, 793 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). A battery claim does lie, however, where there is a failure to obtain any consent, as when a patient consents to surgery by one doctor but another (different) doctor performs the operation. See *Perna v. Pirozzi*, 457 A.2d 431, 439-40 (N.J. 1983).

⁶² For discussion of the role that a patient-centered informed consent inquiry could have in improving the functioning of the health care marketplace, see Blumstein & Sloan, *Redefining Government's Role in Health Care*, *supra* note 31, at 902-08.

⁶³ See FURROW ET AL., *supra* note 34, at 336.

surrogates and fiduciaries deem appropriate disclosure for their patients.⁶⁴

The impetus for the shift in the informed consent doctrine has three political-analytical tributaries: marketeers advocating expansion of information flow to enhance the role of consumers in the marketplace;⁶⁵ consumer groups advocating the philosophy of personal choice, control of one's own body ("my body, my self"), and individual empowerment;⁶⁶ and antihegemony egalitarian groups that do not want to see excessive power in the hands of professionals at the expense of their patients.⁶⁷ These groups make for an interesting and potentially potent political coalition.

Preliminary evidence shows that as the degree of disclosure expands, patient autonomy and empowerment increase. Greater patient knowledge of the risks and benefits of different surgical procedures in turn affects procedure rates.⁶⁸ For example, when men are told about the consequences of nonmalignant prostate enlargement and the risks and benefits of surgical treatment, prostate surgery rates decrease dramatically.⁶⁹ This evidence supports the view that consumer ignorance in the medical services context can be overcome by the sharing of information. The heightened disclosure brought on in part by revised informed consent rules has facilitated the market paradigm's rise. The professional in this model supports rather than supplants informed patient decisionmaking

Hospital liability. For nearly thirty years, since the Illinois Supreme Court's 1965 decision in *Darling v. Charleston Community Memorial Hospital*,⁷⁰ the issue of hospital liability has been critically important in the malpractice arena. *Darling* underscored the changed role of hospitals by imposing on them a duty to monitor the quality of medical staff selected and retained and the level of care delivered within the institu-

⁶⁴ See Schuck, *supra* note 60, at 916 ("The disclosure standard . . . is that which would be sought by a prudent or reasonable patient, a standard that emphasizes the value of patient autonomy over that of professional judgment.").

⁶⁵ See Blumstein & Sloan, *Redefining Government's Role in Health Care*, *supra* note 31, at 902-08.

⁶⁶ See, e.g., Marjorie Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985); Alexander M. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 365-76 (1973).

⁶⁷ For a description of the egalitarian case against professional prerogatives, see STARR, *supra* note 17, at 389-93.

⁶⁸ Joseph F. Kasper et al., *Developing Shared Decision-Making Programs to Improve the Quality of Health Care*, 18 QUALITY REV. BULL. 183, 184 (June 1992).

⁶⁹ *Id.* Men with a nonmalignant but enlarged prostate are informed that they may have to get up to go to the bathroom once or more at night, watching for potential malignancy or severe enlargement that can interfere with urination. The alternative is surgery, with possible side effects of incontinence, impotency, or both. Increasingly, men appear to choose to get up at night and urinate.

⁷⁰ 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966).

tion. *Darling* recognized that hospitals could no longer be passive participants in the medical services delivery process. Hospitals now have a responsibility to their patients to assure capable medical and nursing staffs. Breach of that duty and resulting injury can subject a hospital to great civil liability.

Whereas *Darling* found liability on the basis of a hospital's breach of a primary duty of quality assurance owed to a patient, subsequent cases in a number of jurisdictions have developed legal theories under which hospitals may be found liable for negligent conduct. The doctrine of ostensible agency, for example, imposes vicarious liability on a hospital based on a patient's reasonable belief that care was being delivered under the supervision of and on behalf of the hospital.⁷¹ Similarly, hospitals have been held responsible for conduct in their emergency rooms, even when the emergency rooms were staffed by independent physician groups functioning as independent contractors.⁷² In a growing number of jurisdictions, courts have adopted the theory of corporate negligence,⁷³ which assigns responsibility for conduct within the hospital even in the absence of a plausible claim of ostensible agency. And, proposals advanced at the national level would assign liability for hospital-based negligence to the institution rather than holding individual physicians liable for malpractice.⁷⁴

As a result of these developments in the law of hospital liability, the duty to screen and monitor quality within hospitals increasingly is

⁷¹ See, e.g., *Grewe v. Mount Clemens Gen. Hosp.*, 273 N.W.2d 429, 433 (Mich. 1978). In these ostensible agency cases, it is unclear whether hospitals could avoid liability by disclosure—*i.e.*, whether this is a transitional doctrine in a movement towards institutional liability. In *Grewe*, the Michigan Supreme Court expressly reserved the question whether a hospital can escape liability where the patient knew or should have known that the physician was not an employee.

⁷² Hospital liability for the negligent conduct of independent contractor physicians in emergency rooms may attach under a theory of ostensible agency, see *Hardy v. Brantley*, 471 So.2d 358, 369 (Miss. 1985), or under a theory of nondelegable duty, see *Jackson v. Power*, 743 P.2d 1376, 1383 (Alaska 1987). The Alaska Supreme Court in *Jackson* applied both theories of liability. The Court made it clear that the doctrine was not one of strict liability but of vicarious liability for the negligence of emergency department personnel, including those with independent contractor status.

⁷³ See, e.g., *Thompson v. Nason Hosp.*, 591 A.2d 703 (Pa. 1991). The hospital's duties are: (1) "to use reasonable care in the maintenance of safe and adequate facilities and equipment"; (2) "to select and retain only competent physicians"; (3) "to oversee all persons who practice medicine within its walls as to patient care"; and (4) "to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients." *Id.* at 707.

⁷⁴ See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381 (1994); Paul Weiler et al., *Proposal for Medical Liability Reform*, 267 JAMA 2355 (1992). The original Clinton Administration health care reform proposal included a demonstration project on enterprise liability. H.R. 3600, 103d Cong., 1st Sess. § 5311 (1993). For a discussion of tort principles applied to integrated health care networks, see Sharon M. Glenn, Comment, *Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability*, 29 WAKE FOREST L. REV. 305 (1994).

thrust on hospital administrators. Hospitals cannot absolve themselves of liability by relying upon their medical staffs. They are, instead, responsible for their staff's activities.

This trend provides a tremendous impetus toward greater hospital management involvement in quality assurance. It puts considerable pressure upon the JCAHO model of hospital accreditation, which calls for medical staff autonomous from hospital management.⁷⁵ Increasingly, well-counseled hospital managers are realizing that they cannot circumvent their quality assurance responsibilities by relying entirely on the hospital's medical staff. Since hospitals increasingly are held liable for medical maloccurrences that occur within their walls, hospital administrators are under enormous legal and institutional pressure to perform quality monitoring and screening functions. In turn, this liability-driven impetus for hospital management oversight threatens physician autonomy and self-regulation. Quality assurance no longer is within the exclusive domain of professional peers. Instead, management of risk and quality is becoming an administrative task much as it is in other economic entities. This phenomenon shifts the medical services sector away from the professional model of peer review and toward a market-based paradigm.

Hospital advertising and marketing. Historically, hospitals have depended on physicians to admit patients. And, under traditional methods of third-party (usually cost-based) financing of hospital care, hospitals were rewarded economically for filling beds. Consequently, hospitals were reliant on physicians to assure their economic well-being. That, coupled with the autonomous status of the medical staff provided for by JCAHO accreditation standards,⁷⁶ has assured physicians great influence in the administration of hospitals.⁷⁷

Through advertising and marketing, hospitals are seeking to establish and maintain a flow of patients on their own. In the evolving managed care environment,⁷⁸ hospitals are developing mechanisms for seeking out patients. Further, to the extent that financing mecha-

⁷⁵ See *supra* notes 40-43 and accompanying text.

⁷⁶ See *supra* notes 40-43 and accompanying text.

⁷⁷ For a general discussion of the various influences on hospitals, see Robert C. Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980); Mark Pauly & Michael Redisch, *The Not-For-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87 (1973).

⁷⁸ In the managed care environment, hospitals perform a variety of roles. Often, they negotiate directly with third-party payors to provide services to the payors' covered population. These services may be traditional hospital inpatient care, or they may represent a continuum of care in which hospitals provide both inpatient and outpatient services. Hospitals seeking to broaden the services they offer can achieve this goal through vertical integration. Under managed care, hospitals also can contract with payors, such as insurance companies, to provide traditional hospital services to insureds. Clearly, hospitals are functioning at different levels in the market, both providing opportunities for and competing with other players in the market. For a description of different organizational forms, see

nisms rely on prepayment at fixed rates, hospitals are starting to view physicians as potential cost escalators rather than as business generators.⁷⁹

In a sense, managed care changes everything. Hospital advertising and marketing and the shift toward fixed payment methods undermine the historically exclusive control exercised by doctors over patient referrals. In an ironic role reversal, as hospitals contract with managed care organizations, the hospitals control the flow of patients to the doctors.⁸⁰ This has dramatically altered the power relationships between hospitals and doctors.⁸¹ In the new economic climate, tensions are bound to erupt⁸² because hospitals are under considerable financial pressure to oversee utilization patterns of physicians, who are now cost enhancers rather than bed fillers.⁸³ And as hospitals continue channeling patients to the doctors rather than vice versa, the hospitals may be in a position to reduce the professional practice autonomy currently enjoyed by physicians in hospitals. This promises further erosion of the professional model and expanded reliance on the cost-benefit calculus of the market paradigm.

Carl H. Hitchner et al., *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273 (1994).

⁷⁹ To the extent that their patients pay hospitals on a traditional fee-for-service basis, physicians remain important business generators. Therefore, a physician's patient mix will have an important impact on the physician's relationship with the hospital where he practices.

⁸⁰ This point is dramatized in the many communities in which hospitals now manage and advertise physician referral programs. Hospital influence over the referrals of patients to doctors effects a shift in the historical physician-hospital relationship.

⁸¹ This power shift is also furthered by the strategy of many hospitals to purchase the practices of primary-care physicians in order to assure a flow of patients. To protect against charges of fraud and abuse in subsequent referrals, the physicians often become employees of the hospital. Employee status is a safe harbor and provides immunity from fraud and abuse violation. See 42 C.F.R. § 1001.952(i). The sale of a practice is only immunized by a fraud and abuse safe harbor if the practice is sold to "another practitioner" and if the selling physician "will not be in a position to make referrals to, or otherwise generate business for, the purchasing practitioner." *Id.* at § 1001.952(e)(2). Of course, the availability of the employee status safe harbor is subject to question in jurisdictions adhering to the ban on the corporate practice of medicine. See *supra* notes 44-50 and accompanying text.

⁸² See, e.g., *Friedman v. Delaware County Memorial Hosp.*, 672 F. Supp. 171 (E.D. Pa. 1987), *aff'd per curiam*, 849 F.2d 600, 603 (3d Cir. 1988); *Knapp v. Palos Community Hosp.*, 465 N.E.2d 554 (Ill. App. Ct. 1984).

⁸³ Thus, competition gives the hospital a practical reason to assert its own interest. . . . [I]f the hospital competes for business on a fixed-price basis, the hospital will not be able to tolerate profligate practices on the part of its admitting physicians. The hospital will not want to keep physicians who engage in apparently wasteful behavior. . . . Therefore, as the market becomes more and more competitive, hospitals increasingly become forced to act in their own institutional self-interest as efficiency-maximizing organizations rather than in the interests of physicians.

Blumstein & Sloan, *Hospital Peer Review*, *supra* note 6, at 59-60.

Clinical uncertainty. The professional paradigm is built on the premise that the practice of medicine is primarily a technical-scientific pursuit. The concept of professional privilege stems from the expertise and technical competence attributed to physicians.⁸⁴ Medical malpractice actions reflect this scientific assumption when evidence is sought from professionals regarding appropriate treatments in given circumstances. The underlying premise of such actions is that there is a single standard of care that professionals are duty bound to follow.⁸⁵

Research findings, however, cast considerable doubt on the viability of this assumption. Evidence shows that clinical uncertainty rather than a single scientific standard governs the actual practice of medicine. There are dramatically different procedure rates in similar regions for similar conditions. When variables are controlled for potentially relevant patient characteristics such as age, education, and income, researchers still observe widely divergent rates for such procedures as tonsillectomies, adenoidectomies, and hysterectomies in demographically comparable regions.⁸⁶

These findings undermine the claim of supreme physician authority based on scientific expertise. The variation in practice styles across regions suggests that clinical uncertainty is a fact of life. The research also makes clear that physicians are unsure about optimal utilization levels for medical resources. Indeed, these findings on clinical uncertainty have triggered concerns regarding clinical efficacy that contribute in large part to the current passion for outcomes research.⁸⁷

In the present context, clinical uncertainty and the lack of scientific consensus on many facets of medical practice suggest that there is a greater role for consumer participation in decisionmaking. The impossibility of precise physician choices based on scientific certainty creates room for consumers to be educated about the factors relevant to their own medical choices.

Many medical decisions are influenced by risk preferences, lifestyle choices, and other nonmedical considerations. These are matters upon which consumers can be, and increasingly are being, consulted for a richer decisionmaking partnership between patients and providers. In this scheme, providers serve as counselors rather

⁸⁴ See Frankford, *supra* note 3, at 86-88 (discussing the myth of "real science" permeating the medical field).

⁸⁵ See Blumstein, *Cost Containment and Medical Malpractice*, *supra* note 30; Hirshfeld, *supra* note 30.

⁸⁶ See, e.g., John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, 3 HEALTH AFF. 6 (Spring 1984).

⁸⁷ See Tavs F. Andersen & Gavin Mooney, *Medical Practice Variations: Where Are We?, in THE CHALLENGES OF MEDICAL PRACTICE VARIATIONS 1* (Tavs F. Andersen & Gavin Mooney eds., 1990).

than decisionmakers.⁸⁸ Further, clinical uncertainty highlights the increasing importance of economic incentives in shaping medical care choices. If there is a range of potentially appropriate options, then economic considerations will play a greater role in the decisionmaking process.

The existence of clinical uncertainty reinforces the importance of consumer involvement and suggests that decisionmaking in medical care is much closer to consumer decisionmaking in other economic sectors than the professional paradigm suggests. The claim to professional privilege based on specialized knowledge and competence is modified by greater patient involvement in decisions affecting life and health, which reflects the move towards a market model.

Cost escalation. Increased public budget costs for the Medicaid and Medicare programs have prompted recent efforts to constrain those costs. Much of the political impetus for health care reform derives from the dramatic cost escalation and resulting strain on public resources stemming from Medicare and Medicaid—the financial Pacmen of public programs.⁸⁹

The health care industry's response to cost-containment initiatives in these public programs was not to develop less costly ways of delivering services, or marginally to reduce quality to contain costs. Instead, the industry treated costs and method of service delivery as constants that would have to be absorbed by other payors.⁹⁰ This response by the industry reflected adherence to a typical professional paradigm.

The cost-shifting strategy indicates the industry's unwillingness to come to grips with the growing societal pressure to contain public resource commitments. Cost-shifting strategies can succeed only if (a) other buyers (onto whom costs are shifted) lack market leverage, or (b) transaction costs of prudent, aggressive purchasing by other buyers exceed potential benefits to those buyers in terms of cost savings.⁹¹ In this sense, cost shifting is an unstable condition since its success

⁸⁸ Gina Kolata, *Their Treatment, Their Lives, Their Decisions*, N.Y. TIMES, Apr. 24, 1994, at G66; Kasper et al., *supra* note 68.

⁸⁹ This is hardly a phenomenon of recent vintage. See Blumstein & Sloan, *Redefining Government's Role in Health Care*, *supra* note 31, at 850-52.

⁹⁰ For a discussion of cost shifting, see 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).

⁹¹ Such transaction costs represent efforts to overcome apathy or ignorance. See generally MICHAEL A. MORRISEY, *COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC* 85-89 (1994) (concluding that hospitals charge insured patients as much as they can, that these higher prices allow hospitals to provide care to uninsured patients, that the existence of more uninsured patients will not result in higher hospital charges, and that increased health insurance coverage for the uninsured will not result in lower hospital prices).

hinges on a passive payor community. As the potential for cost savings increases, the incentives to become knowledgeable and to increase market leverage expand. As private payors become more informed and more aggressive in buying medical services, such cost shifting inevitably becomes more difficult. That, in turn, has led hospitals to seek relief by securing greater public financing.

One interesting approach to dealing with Medicaid cost escalation and the cost-shifting phenomenon is the innovative TennCare program adopted by the State of Tennessee.⁹² TennCare operates as a substitute for Tennessee's Medicaid program, functioning under a waiver from the United States Department of Health and Human Services. TennCare employs a capitated payment approach. The state designates a certain number of dollars per patient (per "covered life," as the industry argot now has it) and contracts with managed care organizations (MCOs), which are responsible for paying or providing for all the services required in the contract's specifications.⁹³

The state leaves the MCOs to figure out how best to provide the specified services and to allocate scarce resources while living within a fixed budget. Practice patterns and utilization rates seem to have been affected by the change in financing. Although the evidence is still preliminary, early reports indicate that emergency room admissions at some major hospitals and intensity of resource utilization for inpatients have declined substantially.⁹⁴

Providers are finding different ways to deliver medical care, changing the technology (the "production function") by which medical care is delivered in response to economic incentives. Under the professional paradigm, which assumes that there is a right way to do things unaffected by considerations of cost, one would not expect cut-backs in payments to alter the product provided. Belief in a single correct approach necessarily creates the expectation that funding must be provided to pay for appropriate levels and styles of service.

⁹² See Blumstein, *Health Care Reform*, *supra* note 4, at 40-42.

⁹³ Uninsured residents of Tennessee may buy into TennCare on the same terms as state employees receive their medical care benefits (with a sliding scale of subsidies for residents with lower income). Access to TennCare for the uninsured was seen as a means of overcoming the problem of hospitals' uncompensated care revenue loss.

⁹⁴ State TennCare Director Manny Martins said a survey commissioned by the state shows that access to care is improving and unnecessary emergency room use has dropped substantially. Dr. Virgil Crowder, President of the Tennessee Medical Association, disputed this, however. Duren Cheek, *TennCare Troubles Persist, IMA President Contends*, THE TENNESSEAN, Sept. 2, 1994, at B5. According to state officials, use of the emergency rooms by people enrolled in a TennCare plan operated by Blue Cross and Blue Shield of Tennessee dropped by 90% in the first five months of the program. That indicates that more patients have access to primary care and that they are being discouraged from using the emergency room for minor problems. Bill Snyder, *TennCare Covering More and Cutting Costs*, NASHVILLE BANNER, Aug. 29, 1994, at A1. Undoubtedly, part of the story is the availability of other sources of primary care.

Adherence to the (misguided) professional model essentially rejects consideration of economic trade offs between quality and cost. It also reflects a rigid (and outmoded) egalitarian idea that all consumers in the marketplace should undergo identical treatments, practice styles, and risk calculations, irrespective of individual tastes and resource availability.

The mindset of the health care industry has been that even if payors reduce payment levels, providers are still going to deliver top levels and style of care. The industry's claim is that society must find a way to pay for the highest possible level of care. That is the thinking of the professional model.

But adjustment to resource constraints, to a world without a subsidized blank check, is what must and will happen in the medical care marketplace. The industry must accommodate this reality by tailoring the delivery of service to the level of resources available. In the United States health care context, the relevant range of discussion does not even contemplate a low or even a moderate level and style of care. The substance of the debate regarding cost containment, even for public beneficiaries, is whether to come down out of the stratosphere and return into the atmosphere. Still, this type of resource-oriented evaluation of costs and benefits is in considerable tension with the professional model and moves policymaking along the continuum towards market-oriented principles.

Antitrust. The law of antitrust has both substantive and symbolic importance in the conflict between the professional and market paradigms. Antitrust law is the virtual engine of the market paradigm. By referring to competition, economic efficiency, and consumer welfare, it shifts the vocabulary of the policy dialogue. In very fundamental ways, application of antitrust principles to the medical care arena transforms thinking about certain issues.

In the past, under the influence of the professional paradigm and in the name of health planning, hospital managers were taught to work together cooperatively, coordinating services with other institutions to improve the health care delivery system and to eliminate "wasteful duplication."⁹⁵ When viewed through the prism of antitrust doctrine, that type of collaborative conduct may appear suspect. It is seen as territorial market division among actual or potential competitors, illegal per se under the antitrust laws.⁹⁶

⁹⁵ See Clark C. Havighurst, *Regulation of Health Facilities and Services By "Certificate of Need,"* 59 VA. L. REV. 1143, 1148-51 (1973).

⁹⁶ See *United States v. Topco Assocs., Inc.*, 405 U.S. 596 (1972). Cf. Havighurst, *supra* note 95, at 1149 ("[M]any of the activities undertaken in the name of planning were indistinguishable from such typical cartel practices as output restriction (collective determination of bed supply) and market division (allocation of areas of responsibility both

Antitrust poses a conflict of cultures and imposes a confrontation between those cultures.⁹⁷ The very same action—filtered through different prisms (the competitive model and the professional model), reflecting different experiences and different policy approaches—is viewed as either appropriate and constructive or as harmful and even felonious.⁹⁸

Doctors historically have acted collectively, as a strategy to assert and retain professional prerogatives. For example, doctors (or dentists) have engaged in group boycotts to resist fee pressures,⁹⁹ have opposed alternative payment mechanisms to stop the growth of HMOs,¹⁰⁰ and have issued collective threats against insurance companies that challenge the blank check approach to payment that assures physician autonomy.¹⁰¹ As with cooperation between hospitals, antitrust doctrine poses a substantive threat to such strategic collective activity.

Antitrust doctrine evaluates collective conduct based on efficiency and consumer welfare.¹⁰² It encourages economic entities to compete away excess (“supranormal”) profits, assuming that competition “promote[s] consumer welfare by compelling producers to offer goods of optimal quality at the lowest price.”¹⁰³ As a result, enforcement of the procompetitive regime envisioned by the antitrust laws reduces opportunities for cross subsidization. In the absence of supranormal returns, economic entities are less able to transfer profits from one area to subsidize other, less profitable services.

geographically and by activity).”). See also Blumstein & Sloan, *Hospital Peer Review*, *supra* note 6, at 8-9 (discussing this dissonance).

⁹⁷ See generally Clark C. Havighurst, *The Antitrust Challenge to the Professional Paradigm of Medical Care*, The Michael M. Davis Lecture, The Center for Health Administration Studies at the University of Chicago (May 4, 1990). Leonard Abramson, Chief Executive Officer of U.S. Healthcare Inc., has cogently stated that “[u]nless you change the culture of the community you’re working in, you’re not changing health care.” See Ron Winslow, *U.S. Healthcare Cuts Costs, Grows Rapidly and Irrks Some Doctors*, WALL ST. J., Sept. 6, 1994, at A1.

⁹⁸ This is something that is hard for people trained in the professional medical paradigm to understand or to accept. For example, acting collectively seems like a natural response to some perceived wrong or inequity. See, e.g., *FTC v. Indiana Fed’n of Dentists*, 476 U.S. 447 (1986) (group boycott of dental insurer seeking to impose cost controls); *Wilk v. AMA*, 895 F.2d 352 (7th Cir.), *cert. denied*, 498 U.S. 982 (1990) (AMA group boycott of chiropractors).

⁹⁹ See, e.g., *In re Michigan State Medical Soc’y*, 101 F.T.C. 191 (1983).

¹⁰⁰ See, e.g., *AMA v. United States*, 317 U.S. 519 (1943).

¹⁰¹ See, e.g., *FTC v. Indiana Fed’n of Dentists*, 476 U.S. 447 (1986). Hospitals, too, have resisted cost cutting measures by payors. See *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins. Co.*, 784 F.2d 1325 (7th Cir. 1986).

¹⁰² See generally David L. Meyer & Charles F. (Rick) Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169 (1994) (arguing that the free-enterprise model, as reflected by existing antitrust law, maximizes efficiency and thereby lowers costs to consumers).

¹⁰³ *Id.* at 176.

The market model encourages competitors to enter markets where supranormal profits are being earned. Under the traditional professional paradigm, which envisioned substantial cross subsidization by hospitals, such competition was viewed pejoratively as "cream-skimming."¹⁰⁴ Competitors that offered profitable services while shunning less profitable market sectors were viewed as threats to institutions that tried to provide the services deemed appropriate even if not economically self-supporting.

What adherence to the professional model fails to realize is that the market model increases efficiency overall. New entry in profitable sectors reduces prices and supranormal profits, thereby improving the welfare of consumers who purchase and pay for the services in which excess profits were being earned. Competition rationalizes pricing by requiring that prices more closely reflect true resource costs. Non-self-supporting services must either find a market to sustain them or appeal on policy grounds for direct subsidy. Marketeers view this dynamic not as "cream-skimming" but as a form of market improvement and price rationalization.

The antitrust laws' focus on efficiency in the economic marketplace reflects the driving policy goal of consumer welfare.¹⁰⁵ In the health care arena, this focus raises tensions because of the sensitive equity issues lurking under the surface of the policy debates.¹⁰⁶ For example, enhanced competition may improve the circumstances of consumers in a particular market, but on its own, market efficiency does not assist economically less-well-off consumers unable to pay even at competitive prices.¹⁰⁷ Further, to the extent that cross subsidization achieves income-redistribution objectives, the elimination of this disguised taxation requires advocates for that redistribution to make their case more directly in the political arena. And political acceptance of redistribution may not always match the inclinations of those in the industry who control cross-subsidization decisions.¹⁰⁸ Thus, if cross subsidization is used to improve access to care by indigent uninsured persons, access egalitarians will be disappointed by

¹⁰⁴ See Havighurst, *supra* note 95, at 1164-65.

¹⁰⁵ *But cf.* Robinson-Patman Act, 15 U.S.C. §§ 13-13b, 21a (1988) (focusing on competitive fairness). See generally PHILLIP AREEDA & DONALD F. TURNER, *ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION* (1986); WILLIAM C. HOLMES, *ANTITRUST LAW HANDBOOK* 425 (1994).

¹⁰⁶ See Meyer & Rule, *supra* note 102, at 170-82.

¹⁰⁷ See Blumstein, *Public and Private Medical Resources*, *supra* note 28, at 902-11; Blumstein, *Rationing*, *supra* note 28, at 1351-52; Blumstein & Sloan, *Redefining Government's Role in Health Care*, *supra* note 31, at 866-67.

¹⁰⁸ See Blumstein, *Public and Private Medical Resources*, *supra* note 28, at 904; James F. Blumstein, *On the Other Hand: Some Comments on Sigelman's Palmistry*, 6 J. OF HEALTH POL., POL'Y & L. 621, 621 (1982).

policies that improve efficiency but deprive hospitals of the resources necessary to support cross subsidization.

In the absence of specific statutory exceptions,¹⁰⁹ the antitrust laws do not allow procompetitive values to be balanced against other objectives, however worthy.¹¹⁰ Under antitrust principles, courts must examine the effect of concerted conduct on competition. A worthy purpose is no defense to an alleged violation of the antitrust laws.¹¹¹

The cultural conflict between the professional paradigm and the antitrust laws thus becomes clear. The professional model recognizes competition as a value that can be offset by other values, such as improved access to and quality of medical care.¹¹² The elimination of the worthy purpose claim as a defense against an antitrust charge undermines the professional model's commitment to quality at any cost. It also comes into conflict with the professional-egalitarian ideal that money should not matter when it comes to the delivery of medical services.

The antitrust laws are important both substantively and symbolically because they eliminate non-efficiency-based criteria from analytical consideration,¹¹³ necessarily submerging equity concerns within the public policy debate.¹¹⁴ The risk of antitrust liability will move the health care marketplace along the continuum toward market-oriented policies restraining anticompetitive collective action by doctors and institutional providers. And they provide further impetus for institutional administrators to perform the traditional management functions of cost containment and economic efficiency. They encourage

¹⁰⁹ See *Patrick v. Burget*, 486 U.S. 94, 105 & n.8 (1988).

¹¹⁰ See generally Thomas Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 CONN. L. REV. 605 (1989) (arguing for limited recognition of "quality-based" factors in antitrust analysis); Thomas E. Kauper, *The Role of Quality of Health Care Considerations in Antitrust Analysis*, 51 LAW & CONTEMP. PROBS. 273 (Spring 1988) (advocating role for "quality-of-care concerns" in antitrust cases in the health care field, limited by a standard of relevance).

¹¹¹ See *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986); *National Society of Professional Eng'rs v. United States*, 435 U.S. 679 (1978); *Blumstein & Sloan, Hospital Peer Review*, *supra* note 6, at 28-32; Kauper, *supra* note 110, at 314-19. *But see* *United States v. Brown Univ.*, 5 F.3d 658 (3d Cir. 1993); *Wilk v. AMA*, 719 F.2d 207 (7th Cir. 1983).

¹¹² This position is advanced by the American Hospital Association in advocating adoption of state laws that authorize collaborative activities among health care providers that might otherwise violate the antitrust laws. See Fredric J. Entin et al., *Hospital Collaboration: The Need For an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107, 127-28, 134 (1994).

¹¹³ See Kauper, *supra* note 110, at 292-93 (asserting that 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"). As Professor Kauper notes, this issue has been much debated. *Id.* at 93 n.82 and accompanying text. See also Meyer & Rule, *supra* note 102, at 172-73 & n.10 (arguing that the "signals on antitrust policy coming from the Clinton Administration have been mixed").

¹¹⁴ This is an explicit concern of market policy critics. See Rand E. Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067, 1110 (1981).

challenges to the traditional professional model's refusal to balance cost and quality.

Because antitrust doctrine impels adherence to the market paradigm, it is important to strengthen the role of antitrust in the medical care marketplace—unless it can be shown that the antitrust laws interfere with economic efficiency because of some unique and irremediable characteristic of this industry.¹¹⁵

II

STATE HOSPITAL COOPERATION LAWS¹¹⁶

In view of the significance of antitrust law to the emergence of market principles in the medical care arena, it is important to consider the impact of widespread state legislation authorizing cooperation among hospitals and other health care providers. The striking thing about such legislation is that it expressly immunizes conduct that otherwise would violate federal antitrust law. Although the Constitution's Supremacy Clause gives primacy to federal laws that conflict with state law, the judicially-created "state action" doctrine in the antitrust context allows states to substitute their own regulations for the regime of competition envisioned by antitrust law.¹¹⁷ The state hospital cooperation laws attempt to use the state action doctrine to confer antitrust immunity on cooperative arrangements among health care providers, even (or especially) if those arrangements might otherwise run afoul of federal antitrust principles.

A. State-conferred Immunity to the Federal Antitrust Laws: The *Parker v. Brown* State Action Doctrine

As a general principle of federalism, state laws that conflict with or that are inconsistent with federal laws are unconstitutional under the Supremacy Clause of the United States Constitution.¹¹⁸ Federal antitrust laws utilize the full extent of Congress' broad authority to

¹¹⁵ This is the precise issue upon which proponents and opponents of broad antitrust immunity for health care provider collaboration disagree. Compare Entin et al., *supra* note 112, at 122-32; Meyer & Rule, *supra* note 102, at 170-82.

¹¹⁶ The term "hospital" is used for convenience. Many of the relevant statutes encompass other health care providers. See *infra* notes 154-55. Colorado, Maine, Montana, North Carolina, Ohio, Tennessee, and Texas require one or both parties to be hospitals or in Montana health care facilities. The statutes of Idaho, Minnesota, North Dakota, Washington, and Wisconsin apply to health care providers; Minnesota also includes purchasers.

¹¹⁷ See James F. Blumstein & Terry Calvani, *State Action as a Shield and a Sword in a Medical Services Antitrust Context: Parker v. Brown in Constitutional Perspective*, 1978 DUKE L.J. 389.

¹¹⁸ U.S. CONST. art. VI ("This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.").

regulate interstate commerce.¹¹⁹ Yet, because of federalism principles,¹²⁰ the Supreme Court has held that the antitrust laws do not apply to "state action."¹²¹ That is, certain state and state-approved anti-competitive private conduct is not prohibited under the federal antitrust laws.

Parker v. Brown,¹²² the case that originated the state action doctrine, considered California's restriction of competition among raisin growers through appropriations of output designed to stabilize prices. The California program "substitute[d] sales quotas and price control—the purest form of economic regulation—for competition in the market for California raisins,"¹²³ yet the Supreme Court found no antitrust violation. Instead, the Court declared that the "federal antitrust laws . . . [are] subject to supersession by state regulatory programs."¹²⁴ Under *Parker*, the federal antitrust laws do not apply "to anticompetitive restraints imposed by the States 'as an act of government.'" ¹²⁵ Thus, collective efforts that would be illegal if engaged in by private entities are permitted when conducted by the state. In effect, *Parker* reverses the traditional rule of federal supremacy.¹²⁶

Parker drew a distinction between state action, which was not covered by the Sherman Act and was therefore effectively immune, and state authorization of private anticompetitive conduct, which was subject to the provisions of the Sherman Act and therefore not immune.¹²⁷ Based on that distinction, Justice Stevens (for a plurality of four justices) once argued that *Parker* immunity afforded no antitrust shield at all to private defendants.¹²⁸ That position has not pre-

¹¹⁹ See, e.g., *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738, 743 n.2 (1976). For a discussion of congressional authority under the Commerce Clause of the federal Constitution, see *Katzenbach v. McClung*, 379 U.S. 294 (1964); *Wickard v. Filburn*, 317 U.S. 111 (1942).

¹²⁰ See *Parker v. Brown*, 317 U.S. 341, 351 (1943).

¹²¹ *Id.*

¹²² 317 U.S. 341 (1943).

¹²³ See *City of Columbia v. Omni Outdoor Advertising, Inc.*, 499 U.S. 365, 388 (1991) (Stevens, J., dissenting).

¹²⁴ *FTC v. Ticor Title Ins. Co.*, 112 S. Ct. 2169, 2177 (1992).

¹²⁵ *City of Columbia v. Omni Outdoor Advertising, Inc.*, 499 U.S. 365, 370 (1991).

¹²⁶ This has been described as a form of "inverse preemption." Frank Easterbrook, *Antitrust and the Economics of Federalism*, 26 J.L. & ECON. 23, 25 (1983). For a critique of this view of the *Parker* doctrine, see Einer R. Elhauge, *The Scope of Antitrust Process*, 104 HARV. L. REV. 668 (1991).

¹²⁷ 317 U.S. at 351.

¹²⁸ See *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 585-92 (1976) (Part II, concurred in by White, Brennan, Marshall, JJ., not concurred in by Burger, C.J.). Justice Stevens contended that *Parker* applied only to actions against state officials in their official capacities. *Id.* at 591. That position was advanced by the Solicitor General. *Id.* at 588-89.

vailed,¹²⁹ as the Court has held that *Parker* immunity can apply to private¹³⁰ as well as governmental¹³¹ defendants.¹³²

The Supreme Court further defined the *Parker* doctrine in its 1980 decision in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*¹³³ That case identified two key elements to the *Parker* immunity analysis: "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the State itself."¹³⁴ Cases after *Midcal* have further refined the analytical prongs. With respect to the first requirement, the Supreme Court has held that a policy merely authorizing or encouraging but not requiring anticompetitive conduct may qualify as "clear articulation" of state policy.¹³⁵

The "active supervision" requirement serves "essentially the evidentiary function of ensuring that the actor is engaging in the challenged conduct pursuant to state policy."¹³⁶ To satisfy the "active supervision" standard, the state must "exercise ultimate control over the challenged anticompetitive conduct. . . . The mere presence of some state involvement or monitoring does not suffice."¹³⁷ With respect to private anticompetitive 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."¹³⁸ Actual, not just potential,¹³⁹ state supervision protects the *Parker* rule from abuse by private

129 See *Patrick v. Burget*, 486 U.S. 94, 99-100 (1988) (*Parker* state-action exemption applies in suits against private parties in appropriate circumstances).

130 See, e.g., *Southern Motor Carriers Rate Conference, Inc., v. United States*, 471 U.S. 48 (1985).

131 "[W]hen a state legislature adopts legislation, its actions constitute those of the State and *ipso facto* are exempt from the operation of the antitrust laws." Hoover v. Ronwin, 466 U.S. 558, 567 (1984).

132 While Justice Stevens' position in *Cantor* did not prevail, the importance of the original *Parker* distinction persists. See *FTC v. Tior Title Ins. Co.*, 112 S. Ct. 2169 (1992).

133 445 U.S. 97 (1980).

134 *Id.* at 105 (quoting *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978) (opinion of Brennan, J.)). The "active supervision" prong of *Midcal* does not apply to conduct by municipalities. *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 46 (1985) ("[T]he active state supervision requirement should not be imposed in cases in which the actor is a municipality.").

135 See *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 59-61 (1985).

136 See *Town of Hallie*, 471 U.S. at 46.

137 *Patrick v. Burget*, 486 U.S. 94, 101 (1988).

138 See *Town of Hallie*, 471 U.S. at 47. That contrasts with the situation where the actor is a municipality. In such situations, "there is little or no [such] danger" and therefore no "active supervision" requirement. *Id.*

139 See *FTC v. Tior Title Ins. Co.*, 112 S. Ct. 2169, 2172 (1992) ("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.").

actors.¹⁴⁰ This means that state officials must not only have authority but they must actually exercise that power “to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.”¹⁴¹

Mere passive ratification of private anticompetitive conduct will not suffice to invoke *Parker's* protection.¹⁴² *Parker* “shelter[s] only the particular anticompetitive acts of private parties that, in the judgment of the State, actually further state regulatory policies.”¹⁴³ Further, and importantly, those specific acts must be subject to “ongoing regulation by the State.”¹⁴⁴

Out of deference to “principles of federalism,”¹⁴⁵ *Parker* allows state preferences for regulation to supersede the national commitment to the “preservation of the free market and of a system of free enterprise.”¹⁴⁶ But *Parker* immunity is “disfavored,”¹⁴⁷ and, to satisfy the *Parker* requirements, the “States must accept political responsibility for actions they intend to undertake.”¹⁴⁸ Thus, the state’s decision to substitute a regime of regulation for the national policy of competition must be “implemented in its specific details”¹⁴⁹ to assure that the “anticompetitive scheme is the State’s own.”¹⁵⁰

B. State *Parker*-immunity Laws Authorizing Health Care Provider Cooperation

Since 1992 eighteen states have enacted legislation that in varying degrees allows cooperative agreements among health care providers.¹⁵¹ The objective of this legislation is to immunize conduct that might otherwise violate federal antitrust laws. The legislation is based

¹⁴⁰ See *Patrick*, 486 U.S. at 101; *Ticor*, 112 S. Ct. at 2172.

¹⁴¹ *Patrick*, 486 U.S. at 101 (“The active supervision prong of the Midcal test requires that state officials have and exercise” such power.).

¹⁴² *Ticor*, 112 S. Ct. at 2177. See also *Patrick*, 486 U.S. at 100-01.

¹⁴³ *Ticor*, 112 S. Ct. at 2177.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.* at 2176.

¹⁴⁷ *Id.* at 2178.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 2176.

¹⁵⁰ *Id.* at 2177.

¹⁵¹ COLO. REV. STAT. ANN. § 24-32-2701 (West 1993); FLA. STAT. ANN. § 395.606 (West 1994); GA. CODE ANN. § 31-7-72 (1994); IDAHO CODE § 39-4901 (1994); 1994 KAN. SESS. LAWS 153; KAN. STAT. ANN. § 65-468 (1992); ME. REV. STAT. ANN. tit. 22, § 1881 (West 1993); MINN. STAT. ANN. § 62J.2911 (West 1994); MONT. CODE ANN. § 50-4-601 (1933); (1993); 1994 NEB. LAWS 1223; N.Y. PUB. HEALTH LAW § 2950 (McKinney 1993); N.C. GEN. STAT. § 131E-192 (1993); N.D. CENT. CODE § 23-17.5-01 (1993); OHIO REV. CODE ANN. § 3727.21 (Baldwin 1993); OR. REV. STAT. § 442.700 (1994); TENN. CODE ANN. § 68-11-1301 (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.001 (West 1994); WASH. REV. CODE ANN. §§ 70.44.450, 43.72.300 (West 1994); WIS. STAT. ANN. § 150.84 (West 1993). See *supra* note 15.

on the premise that in the health care marketplace regulation may be preferable to competition in some circumstances.

Some states have followed what appears to be a legislative model¹⁵² while others have struck out on their own.¹⁵³ However, there are similarities in purpose and procedure in all of them. Generally speaking, the statutes allow hospitals,¹⁵⁴ or more broadly health care providers,¹⁵⁵ to enter into cooperative agreements if the likely benefits outweigh the disadvantages attributable to a reduction in competition.¹⁵⁶ These state hospital cooperation laws overcome market-oriented strategies by invoking the protection of the *Parker* doctrine.

Procedurally, hospitals or health care providers apply for a certificate of public advantage by submitting the agreement and explanatory materials to the department of health and to the state attorney general.¹⁵⁷ The department reviews the agreement and may hold a

The first listed statutes for Kansas and Washington apply only to cooperative agreements among rural public hospitals; the second statutes apply more broadly. The New York and Florida statutes are limited to rural areas; the Georgia statute allows hospital authorities within the same county to consolidate. The Oregon provision covers only heart and kidney transplants.

¹⁵² The states that appear to follow a legislative model are Idaho, Maine, North Carolina, North Dakota, Tennessee, Texas, and Wisconsin. *See supra* note 151. Even within this group, however, the differences between the Wisconsin law, the most abbreviated, and the North Carolina law, the most detailed, are significant.

¹⁵³ *See, for example,* the statutes adopted in Colorado, Minnesota, Montana, Ohio and Washington. *See supra* note 151.

¹⁵⁴ Maine, Montana, Ohio, Tennessee, and Texas allow cooperative agreements among two or more hospitals. *See* ME. REV. STAT. ANN. tit. 22, § 1882(1) (West 1993); MONT. CODE ANN. § 50-4-601 (1993) (health care facilities); OHIO REV. CODE ANN. § 3727.21 (Baldwin 1993); TENN. CODE ANN. § 68-11-1302(2) (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.001(2) (West 1994). Colorado and North Carolina allow cooperative agreements when at least one party is a hospital. *See* COLO. REV. STAT. ANN. § 24-32-2703(2) (West 1993); N.C. GEN. STAT. § 131E-192.2.(2) (1993).

¹⁵⁵ The statutes in the following states apply to health care providers: Idaho, Minnesota, North Dakota, Washington, and Wisconsin. *See* IDAHO CODE § 39-4902(1) (1994); MINN. STAT. ANN. § 62J.2913 subd. 1 (West 1994) (providers and purchasers); N.D. CENT. CODE § 23-17.5-01(1) (1993); WASH. REV. CODE ANN. § 43.72.310(1) (West 1994); WIS. STAT. ANN. § 150.84(1) (West 1993).

¹⁵⁶ IDAHO CODE § 39-4903 (1994); ME. REV. STAT. ANN. tit. 22, § 1883(1) (West 1993); N.D. CENT. CODE § 23-17.5-02 (1993); OHIO REV. CODE ANN. § 3727.22(B) (Baldwin 1993); TENN. CODE ANN. § 68-11-1303 (1993); TEX. HEALTH & SAFETY CODE ANN § 313.002(a) (West 1994); and WIS. STAT. ANN. § 150.85(4)(a) (1) (West 1993). The statutes of other states include a legislative finding or statement of purpose that regulation should supplant competition. *See* COLO. REV. STAT. ANN. § 24-32-2702(1)-(4) (West 1993); MINN. STAT. ANN. § 62J.2911 (West 1994); MONT. CODE ANN. § 50-4-601 (1993); N.C. GEN. STAT. § 131E-192.1 (1993); and WASH. REV. CODE ANN. § 43.72.300(2) (West 1994).

¹⁵⁷ *See, e.g.,* COLO. REV. STAT. ANN. § 24-32-2705(1) (West 1993); IDAHO CODE § 39-4903 (1944) (but only to the attorney general); ME. REV. STAT. ANN. tit. 22, § 1883(2) (West 1993); MINN. STAT. ANN. § 62J.2913 subd. 1 (West 1994); MONT. CODE ANN. § 50-4-603 (1993); N.C. GEN. STAT. § 131E-192.3(b) (1993); N.D. CENT. CODE § 23-17.5-02 (1993); OHIO REV. CODE ANN. § 3727.22 (Baldwin 1993) (submission to the attorney general only after health department approval); TENN. CODE ANN. § 68-11-1303(b) (1993);

public hearing.¹⁵⁸ In states following the legislative model, the applicants must demonstrate by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition.¹⁵⁹

The health department considers whether the following benefits may result: (1) enhancement of quality of care to hospital patients, (2) preservation of hospital facilities in geographic proximity to communities, (3) gains in cost efficiency, (4) improvements in utilization of hospital resources and equipment, and (5) avoidance of duplication of resources.¹⁶⁰ The department also evaluates any disadvantages including, but not limited to, the following: (1) the adverse impact on the ability of HMOs, PPOs or other payors to negotiate optimal payment and service arrangements with hospitals and physicians, (2) the extent of any reduction in competition among physicians or others likely to result from the agreement, (3) the extent of any likely adverse impact on patients in the quality, availability, and price of health

TEX. HEALTH & SAFETY CODE ANN. § 313.002(b) (West 1994); WASH. REV. CODE ANN. § 43.72.310(3) (West 1994) (after prior submission to the attorney general); and WIS. STAT. ANN. § 150.85(2) (West 1993) (submission only to the department of health).

¹⁵⁸ A hearing is required in Montana, North Carolina, and North Dakota. See MONT. CODE ANN. § 50-4-603(2) (1993); N.C. GEN. STAT. § 131E-192.4(b) (1993); N.D. CENT. CODE § 23-17.5-02 (1993). A hearing is optional in Idaho, Maine, Minnesota, Tennessee, and Texas, but public notice is required in Minnesota. See IDAHO CODE § 39-4903(3) (1994); ME. REV. STAT. ANN. tit. 22, § 1883(3) (West 1993); MINN. STAT. ANN. § 62J.2914 subd. 2, § 62J.2916 (West 1994); TENN. CODE ANN. § 68-11-1303(c) (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.002(c) (West 1994). Ohio, Washington, and Wisconsin have no provisions for a hearing; in Wisconsin the application is approved unless it is denied within 30 days of receiving it. See WIS. STAT. ANN. § 150.85(3)(a) (West 1993). In Colorado regulations shall require a public hearing. See COLO. REV. STAT. ANN. § 24-32-2705 (West 1993).

¹⁵⁹ See IDAHO CODE § 39.4903(4) (1994); ME. REV. STAT. ANN. tit. 22, § 1883(4) (West 1993); N.C. GEN. STAT. § 131E-192.4(b) (1993); N.D. CENT. CODE § 23-17.5-03 (1993); TENN. CODE ANN. § 68-11-1303(d) (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.002(d) (West 1994). Wisconsin does not use a clear and convincing standard. See WIS. STAT. ANN. § 150.85(4)(a)(1) (West 1993). The states that do not follow the model do not use a clear and convincing standard. The analysis is whether the benefits are likely to outweigh the disadvantages associated with the reduction in competition. See COLO. REV. STAT. § 24-32-2706(1) (1993); MINN. STAT. ANN. § 62J.2917 Subd. 1 (West 1994); MONT. CODE ANN. § 50-4-603 (1993); OHIO REV. CODE ANN. § 3727.22(B) (Baldwin 1993); WASH. REV. CODE ANN. § 43.72.310(3) (West 1994).

¹⁶⁰ See IDAHO CODE § 39.4903(5) (1994); ME. REV. STAT. ANN. tit. 22, § 1883(4)(A) (West 1993); N.C. GEN. STAT. § 131E-192.4(b) (1993) (also includes the extent to which medically underserved populations are expected to use the services); N.D. CENT. CODE § 23-17.5-03(1) (1993); TENN. CODE ANN. § 68-11-1303(d)(1) (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.002(e) (West 1994); WASH. REV. CODE ANN. § 43.72.310(4) (West 1994) (does not include preserving facilities but does include facilitating information exchange); WIS. STAT. ANN. § 150.85(4)(b) (West 1993). Except for Washington, the states that do not follow the model do not include the list of benefits enumerated in the text. While Colorado has a long list, in general the benefits can be summarized as reduced costs, improved quality and improved access. See COLO. REV. STAT. ANN. § 24-32-2706(2) (West 1993); MINN. STAT. ANN. § 62J.2917 Subd. 2 (West 1994); MONT. CODE ANN. § 50-4-603(2) (1993); OHIO REV. CODE ANN. § 3727.21(A) (Baldwin 1993).

care services, and (4) the availability of arrangements that are less restrictive to competition to achieve the desired benefits.¹⁶¹

In about half of the states the department is required to consult with the attorney general.¹⁶² Subsequent to approval, the department may terminate the certificate, the state attorney general may initiate an investigation, or both.¹⁶³ Some statutes provide directly for immunity from antitrust if a cooperative agreement is approved. Other statutes provide that an agreement which is granted a certificate of public advantage is lawful and the conduct of the parties in negotiating that agreement is lawful.¹⁶⁴ Hospital mergers are exempted from the pro-

¹⁶¹ See IDAHO CODE § 39.4903(5) (1994); ME. REV. STAT. ANN. tit. 22, § 1883(4)(B) (West 1993); N.C. GEN. STAT. § 131E-192.4(b) (1993) (also includes increases in costs at the hospitals party to the agreement and reduction in competition among the parties as criteria); N.D. CENT. CODE § 23-17.5-03(2) (1993); TENN. CODE ANN. § 68-11-1303(d)(2) (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.002(f) (West 1994); WASH. REV. CODE ANN. § 43.73.310(4) (West 1994) (combines criteria (1) and (2) listed in text); WIS. STAT. ANN. § 150.85(4)(c) (West 1993) (adverse-impact-on-patients criterion not included). Except for Washington, the states that do not follow the model do not have a list of disadvantages to be considered other than the disadvantages associated with a reduction in competition; Minnesota lists factors to be considered, some of which are disadvantages. See MINN. STAT. § 62J.2917 subd. 2(a)(6), 2(b)(3), (4), (9) (West 1994).

¹⁶² See IDAHO CODE § 39.4903(4) (1994); ME. REV. STAT. ANN. tit. 22, § 1883(5) (West 1993); TENN. CODE ANN. § 68-11-1303(e) (West 1993); TEX. HEALTH & SAFETY CODE ANN. § 313.002(g) (West 1994); WASH. REV. CODE ANN. § 43.72.310(1), (4) (West 1994). Colorado, North Carolina, and North Dakota do not require such consultation, but the attorney general is sent a copy when the application is filed. See COLO. REV. STAT. ANN. § 24-32-2705(1) (West 1993); N.C. GEN. STAT. § 131E-192.3(b) (1993); N.D. CENT. CODE § 23-17.5-02 (1993). The Montana and Wisconsin statutes do not involve the attorney general. In Minnesota, the attorney general may appear as a party in a contested case. See MINN. STAT. ANN. § 62J.2916 subd. 2(c) (West 1994). In Ohio, if the health department approves the agreement, it is then sent to the attorney general for approval or denial. See OHIO REV. STAT. ANN. § 3727.22 (Baldwin 1993).

¹⁶³ See, e.g., COLO. REV. STAT. ANN. § 24-32-2702 (West 1993); IDAHO CODE § 39-4903(12) (1994); ME. REV. STAT. ANN. tit. 22, § 1883(6) (West 1993); MINN. STAT. ANN. § 62J.2921 (West 1994); MONT. CODE ANN. § 50-4-609 (1993); OHIO REV. CODE ANN. § 3727.22(E), (F) (Baldwin 1993); N.C. GEN. STAT. § 131E-192.8 (1993); N.D. CENT. CODE § 23-17.5-04 (1993); WASH. REV. CODE ANN. § 43.72.310(6) (West 1994); WIS. STAT. ANN. § 150.85(5) (West 1993). Some states require a showing of changed circumstances for the attorney general to bring suit. See ME. REV. STAT. ANN. tit. 22, § 1885(5) (West 1993); N.D. CENT. CODE § 23-17.5-08 (1993); TENN. CODE ANN. § 68-11-1305(e) (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.003(e) (West 1994). In Texas, not only the attorney general but also the health department must show changed circumstances. TEX. HEALTH & SAFETY CODE ANN. § 313.004(a) (West 1994).

¹⁶⁴ The following states use immunity language or state that approval is a defense to antitrust laws: Colorado, Idaho, Minnesota, Montana, North Carolina, and Ohio. See COLO. REV. STAT. ANN. § 24-32-2712(1) (West 1993); IDAHO CODE § 39-4903(7), (10) (1994); MINN. STAT. ANN. § 62J.2913 subd. 2 (West 1994); MONT. CODE ANN. § 50-4-601 (1993); N.C. GEN. STAT. § 131E-192.13 (1993); OHIO REV. CODE § 3727.21 (Baldwin 1993). Washington states that conduct so authorized is taken pursuant to state statute. See WASH. REV. CODE ANN. § 43.72.310(5) (West 1994). The following states use lawful agreement and lawful conduct language: Maine, North Dakota, Tennessee, and Texas. See ME. REV. STAT. ANN. tit. 22, § 1886(1) (West 1993); N.D. CENT. CODE § 23-17.5-10 (1993); TENN.

tection of the statute in some states.¹⁶⁵ There are few provisions requiring ongoing supervision by the department of health or the attorney general of actions taken by parties under the terms of a cooperative agreement.¹⁶⁶

1. *The Rationale for State Hospital Cooperation Laws: Economic Efficiency*

One purported justification for hospital cooperation legislation is economic efficiency. This is an ironic claim because the very heart and soul of antitrust law is its furtherance of competition in the name of economic efficiency.¹⁶⁷ Because their premise is that regulation rather than competition will achieve efficiency in the health care marketplace, these laws strike at the heart of the debate about the role of the market paradigm in medical care.¹⁶⁸

A regulatory regime, by substituting political oversight for market principles, arguably could achieve economic efficiency. The central premise of the antitrust laws, however, is that markets are presumed to be better at achieving efficiency objectives than are the command-and-control political processes inherent in regulation. Surely, in an economy dominated by reliance on markets to achieve the efficient allocation of resources, it is appropriate to place the burden of justification on those who favor a regulatory agenda over market principles in a specific industry or sector of the economy.¹⁶⁹

CODE ANN. § 68-11-1306 (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.006(a) (West 1994).

¹⁶⁵ See, e.g., ME. REV. STAT. ANN. tit. 22, § 1886(4) (West 1993); N.D. CENT. CODE § 23-17.5-10 (1993); TEX. HEALTH & SAFETY CODE ANN. § 313.007 (West 1994). Mergers are not expressly excluded from coverage in Colorado, Idaho, Minnesota, North Dakota, Ohio, Tennessee, Washington, or Wisconsin.

¹⁶⁶ Colorado provides that rules shall require reports. See COLO. REV. STAT. ANN. § 24-32-2708 (West 1993). In Idaho the attorney general may request periodic reports. See IDAHO CODE § 39-4903(8) (1994). Minnesota requires periodic reports. See MINN. STAT. ANN. § 62J.2918 subd. 3, § 62J.2920 (West 1994). North Carolina requires reports every two years. See N.C. GEN. STAT. § 131E-192.9 (1993). Ohio may request updated information and provide supervision by the health department and the attorney general. See OHIO REV. STAT. ANN. § 3727.24 (Baldwin 1993). In Tennessee, the health department and the attorney general are entrusted with the oversight of cooperative agreements but no procedures are set forth. See TENN. CODE ANN. § 68-11-1303(b) (1993). In Texas, the health department may request documents and may terminate the arrangement. See TEX. HEALTH & SAFETY CODE ANN. § 313.004 (West 1994). Washington requires active supervision and periodic reports. See WASH. REV. CODE ANN. § 43.72.310(6) (West 1994). Maine, North Dakota, and Wisconsin only have termination or revocation procedures. See ME. REV. STAT. ANN. tit. 22, §§ 1883(6), 1885(5) (West 1993); N.D. CENT. CODE §§ 23-17.5-04, -08 (1993); WIS. STAT. ANN. § 150.85(5)(a) (West 1993).

¹⁶⁷ See *supra* note 113.

¹⁶⁸ See Meyer & Rule, *supra* note 102, at 176-82.

¹⁶⁹ See James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 3 ("In a nation whose institutions have

Part of the health care reform agenda is the goal of rationalizing the health care marketplace to make it function more like other economic sectors. As described earlier, the health care industry has a history of resistance to market-based principles. Antitrust law, among other policies, has contributed to a shift toward greater reliance on market principles. Regulation in the name of economic efficiency smacks of an earlier era in which health planning was promoted as a means of rationalizing the health care delivery system.¹⁷⁰ That is, the policy reflects a resistance to the shift in paradigms; it assumes that the features of the health care marketplace that impede the proper functioning of the market will remain in place and that regulation is the appropriate means to cope with that market-resistant pattern.

The literature supporting hospital cooperation legislation suggests that competition among hospitals can result in wasteful practices. The argument is that institutional arrangements in the health care marketplace cause¹⁷¹ competition to benefit certain groups (such as providers)¹⁷² at the expense of consumers.¹⁷³ Studies also show, however, that modifications of payment, purchasing practices, and other institutional arrangements, which allow incentives to operate as

relied on market mechanisms for making basic economic choices, governmental imposition of planning bears a burden of persuasion.") [hereinafter *Health Planning*].

¹⁷⁰ See *id.* at 3-7; Havighurst, *supra* note 95, at 1148-52. See also James F. Blumstein, *Effective Health Planning in a Competitive Environment*, in *COST, QUALITY, AND ACCESS IN HEALTH CARE: NEW ROLES FOR HEALTH PLANNING IN A COMPETITIVE ENVIRONMENT* 21 (Frank A. Sloan et al. eds., 1988); Randall Bobbjerg, *New Directions for Health Planning*, in *id.* at 206.

¹⁷¹ Illustrations are the prevalence of third-party payment, the extensive role of non-profit institutions, the presence of the government as payor (Medicaid and Medicare), and the JCAHO requirement of an independent hospital medical staff.

¹⁷² See Clark, *supra* note 77; Philip C. Kissam et al., *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CAL. L. REV. 595, 651-55 (1982).

¹⁷³ See, e.g., James C. Robinson, *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) (evaluating data from 1972 for 5000 community hospitals and finding that hospitals in more competitive local markets manifested significantly higher average costs per case and per day than hospitals in less competitive areas); Harold S. Luft et al., *The Role of Specialized Clinical Services in Competition Among Hospitals*, 23 INQUIRY 83, 93 (1986) (using 1972 data, finding that competition to offer clinical services led to the proliferation of such services, cost inflation, and possibly low surgical volumes and poor surgical outcomes); James C. Robinson & Harold S. Luft, *Competition and the Cost of Hospital Care, 1972 to 1982*, 257 JAMA 3241, 3244 (1987) (attributing higher costs to more competitive markets; consistent with the "medical arms race" hypothesis, competition in the hospital sector took the form of cost-increasing acquisition of new technology rather than changes in efficiency); Wayne Higgins, *Myths of Competitive Reform*, 16 HEALTH CARE MGMT. REV. 65, 69 (1991) (discount contracting in parts of California and in Minneapolis-St. Paul slowed the rate of hospital cost inflation but nonprice competition tends to increase rather than decrease costs); Ngyen Xuan Ngyen & Frederick W. Derrick, *Hospital Markets and Competition: Implications for Antitrust Policy*, 19 HEALTH CARE MGMT. REV. 34, 40-41 (1994) (associating increased hospital competition with higher costs, lower occupancy rates, reduced efficiency, and more service offerings; maintaining lower market concentration through antitrust enforcement risks encouraging nonprice competition and increased hospital expenditures).

in a more traditional market, have countered this negative phenomenon.¹⁷⁴

Advocates of health care reform who emphasize the importance of the market paradigm would agree with the diagnosis of these studies—that structural preconditions are key to a successful market. That means encouraging different forms of payment and different structures for the purchasing of medical care services. As costs have escalated, consumers and payors have begun paying more attention to these issues.¹⁷⁵ Institutional change is a prerequisite to and part of the agenda of market-based reform. Continued rational enforcement of the antitrust laws can only benefit the reformist agenda.¹⁷⁶

From that perspective, the state-based hospital cooperation laws seem counter revolutionary (or at least counter evolutionary). Instead of pursuing a structural reform agenda, which would improve the ability of the market to perform its appropriate resource-allocation function, these laws construct (or reconstruct) a regulatory regime that could frustrate the development of market-based structures and a market-oriented culture in the industry. It could also reinforce the historical professional dominance at the expense of consumer

¹⁷⁴ See, e.g., David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J.L. & ECON. 179, 180-81 (1993) (analyzing data from California showing that shifts in purchasing power from patients and physicians to insurers reduce profit margins; in response to lower margins, hospitals shifted to higher-margin services and more distinctive services); Glenn A. Melnick & Jack Zwanziger, *Hospital Behavior under Competition and Cost-Containment Policies: The California Experience, 1980 to 1985*, 260 JAMA 2669, 2675 (1988) (studying data from California that showed that following the shift from cost-based reimbursement to market price-based contracting, hospitals in the most competitive markets experienced slower cost escalation when compared to hospitals in less competitive markets); James C. Robinson, *HMO Market Penetration and Hospital Cost Inflation in California*, 266 JAMA 2719, 2723 (1991) (identifying indirect effects of HMOs on hospital behavior in the form of more price-competitive behavior; only when health insurance plans are permitted to contract with hospitals on the basis of price can HMO market penetration reduce hospital cost inflation); Jack Zwanziger et al., *Costs and Price Competition in California Hospitals, 1980-1990*, 13 HEALTH AFF. 118 (Fall 1994) (studying data from California from 1980 to 1990 which demonstrates that selective contracting by insurers and HMOs reduced the rate of growth of hospital revenues and costs in competitive hospital markets); Jack Zwanziger & Glenn A. Melnick, *The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California*, 7 J. HEALTH ECON. 301, 316 (1988) (concluding that after California implemented selective contracting in 1983, the nature of hospital competition underwent a structural change and increasingly hospitals competed on a price basis).

¹⁷⁵ See, e.g., Dan Morgan, *The Rise of Corporate Medicine: The 'Managed Care' Bandwagon is Running Traditional Practices Off the Road*, WASH. POST NAT'L WKLY. EDITION, June 20-26, 1994, at 6; Dan Morgan, *Squeezing the Specialists: HMOs and other 'Managed Care' Plans are Changing How They Practice Medicine*, WASH. POST NAT'L WKLY. EDITION, July 25-31, 1994, at 10; George Anders & Hilary Stout, *Dose of Reform: As Clinton Plan Falts, Health Care Is Shaped by the Private Sector*, WALL ST. J., Aug. 26, 1994, at A1; *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994.

¹⁷⁶ See Meyer & Rule, *supra* note 102, at 171 (arguing that the "federal antitrust laws, as . . . sensibly enforced, provide a great degree of flexibility for private collaborative efforts aimed at achieving more efficient and less costly delivery of health care service").

choice and empowerment. These laws might even be labeled revanchist.

Another way of looking at state-based hospital cooperation laws, at least to the extent that they seek to achieve efficiency objectives, is that they are not regulatory in character and reflect no revanchist hostility to a market model for the health care industry. Instead, one might argue that these laws are a response to provider perceptions that federal antitrust policy is being administered poorly.¹⁷⁷ Providers may see federal antitrust enforcement officials as insufficiently versed in the nuances and peculiarities of the industry. Viewed in this way, state hospital cooperation laws may represent an attempt to achieve more sophisticated procompetitive policies. They do not pose a challenge to the market paradigm; rather, it might be argued, they challenge the techniques and standards of antitrust enforcement.¹⁷⁸

Securing a proper understanding of what policies promote economic efficiency is critical to the appropriate enforcement of the antitrust laws. In theory, at least, cooperation that fosters efficiency can coexist peacefully with the procompetitive antitrust laws.¹⁷⁹ Perhaps states view antitrust enforcement as an obstacle to ventures that promote economic efficiency. Since *Parker* immunity allows states to substitute their own enforcement procedures for federal antitrust agency enforcement mechanisms,¹⁸⁰ states may argue that hospital cooperation laws are simply the manifestations of federalism in a specialized industry that is not well suited to federal agency intervention.

Such a rationale for state hospital cooperation laws would not challenge the fundamental role of the market model in the health care arena, but would substitute one enforcement entity (state health departments) for another (federal antitrust enforcement agencies). This justification for state hospital cooperation legislation is not at

¹⁷⁷ See Letter from Fredric J. Entin, Senior Vice President and General Counsel, American Hospital Association, to Anne K. Bingaman, Assistant Attorney General (Antitrust), United States Department of Justice (Jan. 28, 1994).

¹⁷⁸ There has been considerable concern about how product and geographic markets are to be defined in the hospital context. See, e.g., 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 (1988); Michael A. Morrissey et al., *Defining Geographic Markets for Hospital Care*, 51 LAW & CONTEMP. PROBS. 165 (Spring 1988); Jack Zwanziger, *Editorial: Antitrust Considerations and Hospital Markets*, 8 J. HEALTH ECON. 457 (1989); Jack Zwanziger et al., *Hospitals and Antitrust: Defining Markets, Setting Standards*, 19 J. HEALTH POL., POL'Y & L. 423 (1994). For relevant case law, see *Hospital Corp. of Am. v. Federal Trade Comm'n*, 3 Trade Reg. Rep. (CCH) ¶ 22,301 (FTC Oct. 25, 1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987). Compare *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va.), *aff'd without opinion*, 892 F.2d 1042 (4th Cir. 1989); *United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990).

¹⁷⁹ See *supra* note 176.

¹⁸⁰ See, e.g., Hart-Scott-Rodino Act, 15 U.S.C. § 18a (1988).

odds with the health care reform goal of promoting market-oriented policies. Consistent with that rationale, proponents of hospital cooperation laws could argue that, unlike command-and-control regulatory programs, such laws neither prohibit private conduct nor bar access to the market. Failure of a private party to seek or secure state approval under the hospital cooperation laws leaves the private party in the same position that party would be in if the legislation did not exist.

At the same time, entities that obtain approval are secure from what is perceived as unsophisticated or misguided federal antitrust enforcement. From this perspective, the state reviewing agency must act as a surrogate for the federal antitrust authorities, applying the same set of economic criteria—economic efficiency and consumer welfare. The state reviewing entities are typically health departments, which, at least arguably, are more attuned to local market realities. That is, they are in a better position to assess these factors. The state structure, then, would safeguard in-state actors from inappropriate antitrust enforcement while properly weighing at the state level the procompetitive and anticompetitive dimensions of the particular conduct at issue.

This rationale for state hospital cooperation laws, unfortunately, appears to be somewhat of a construct, since these laws typically allow state reviewing authorities to consider factors other than economic efficiency.¹⁸¹ Further, there is a reasonable question whether state health departments are likely to be as institutionally sensitive to concerns regarding competition, especially when many in the health care industry have been taught that competitive principles should play at most an attenuated role in the health care marketplace.¹⁸²

¹⁸¹ Tennessee's statute, which is typical of those states that follow a legislative model, provides for consideration of: (A) enhancement of the quality of hospital care; (B) preservation of hospital facilities; (C) gains in the cost efficiency of services provided; (D) improved utilization of hospital resources; and (E) avoidance of duplication of hospital resources. Quality and preservation of facilities are not efficiency factors while cost efficiency and avoidance of duplication are. Preservation of facilities is not limited necessarily to rural areas and thus may relate to preserving all existing facilities. Improved utilization is ambiguous since it could refer to the elimination of underutilized services, or it could mean improving utilization by promoting greater use, thus spreading the cost over more patients. See TENN. CODE ANN. § 68-11-1303(1) (1993). North Carolina includes an additional consideration: the extent to which medically underserved populations are expected to utilize the proposed services. N.C. GEN. STAT. § 131E-192.4(b) (1993). Minnesota's list of relevant factors includes the extent to which the proposed arrangement is likely to make health care services or products more financially or geographically available to persons who need them. This is an equity rather than an efficiency issue. MINN. STAT. ANN. § 62J.2917 subd. 2(c)(3) (West 1994).

¹⁸² The states' records on regulation, as reflected in statistics on the administration of certificate-of-need laws, is not reassuring. See, e.g., Blumstein & Sloan, *Health Planning*, *supra* note 169, at 19-30. Further, there is a generic problem of regulatory capture, in which "regulatory agencies . . . actively retard desirable changes harmful to the regulated interests." Havighurst, *supra* note 95, at 1204. Thus, the realistic and legitimate concern is

In any event, it is far from clear that the claim of poor administration by federal antitrust enforcers is accurate.¹⁸³ In view of the importance of antitrust law in transforming the operation and culture of the health care industry, it is appropriate for market-oriented health care reformers to remain skeptical about the efficiency-based rationale for state hospital cooperation legislation. After all, there is a nontrivial risk that, despite some overcapacity in the industry, supply-side constraints may increase scarcity and thereby promote both an upward movement of prices and greater economic leverage on the part of health care providers.

On theoretical grounds, antitrust enforcement promotes competition and therefore economic efficiency. To the extent that institutional characteristics of the industry impede the use of market-oriented policies, health care reformers should strive to force institutional change so that traditional economic principles have more direct application. Research studies support the conclusion that shifts in incentives, such as changes in payment methods, effect appropriate competitive responses.¹⁸⁴ The efficiency-based claim for state hospital cooperation legislation would thus seem unproven.

2. *The Rationale for State Hospital Cooperation Laws: Cross Subsidization*

The more plausible rationale for state hospital cooperation laws is not that they are designed to promote economic efficiency but that they represent a provider/access egalitarian response to the consequences of increased competition in the health care industry. The predictable effect of increased competition is the competing away of supranormal returns by health care providers.¹⁸⁵ This in turn reduces the availability of funds for cross subsidization, through which providers transfer rents from one segment of the market to pay for worthy purposes such as specialized services, medical education, or better access for impecunious patients.

Under the market paradigm, economic efficiency is the goal pursued. Antitrust law enforces the norm of competition in order to promote consumer welfare. To the extent that such procompetitive policies keep prices at competitive levels, consumers benefit. Consumers with fewer resources clearly benefit because of the lower prices associated with competitive processes. Nonetheless, efficiency-ori-

that "[i]f the hospital industry becomes subject to exogenous threats or pressures, its regulators could be expected to afford it aid and protection." *Id.* at 1205.

¹⁸³ See generally Meyer & Rule, *supra* note 102. See also Health Care Antitrust Guidelines, *supra* note 9. But see Entin, *supra* note 177; Entin et al., *supra* note 112.

¹⁸⁴ See *supra* note 174.

¹⁸⁵ See Phelps, *supra* note 90, at 121-22; see also MORRISSEY, *supra* note 91, at 71-72.

ented policy “does not directly address the question of equity of access.”¹⁸⁶ It “makes no specific claim about the proper eligibility criteria or level of medical services that society should provide to worthy and needy persons.”¹⁸⁷ That is, it “takes no position on what degree of redistributive munificence is proper in the medical services field.”¹⁸⁸

Thus, to the extent that redistributive goals are part of the health care reform agenda, a program that relies on enhancing efficiency alone may not achieve those goals. Additional resources likely will be needed to improve access for the poor or to develop specialized, expensive services. Traditionally, such additional resources have come from cross subsidization, which requires supranormal returns in some areas to allow transfer to other areas. The absence or reduction of additional funds makes that policy of cross subsidization difficult to achieve.

Assuring a continued flow of monopoly rents for achieving worthy purposes through cross subsidization is perhaps the most plausible policy explanation for the state hospital cooperation legislation, despite statutory language emphasizing efficiency. The statutes explicitly permit consideration of substantive policy goals such as improved access.¹⁸⁹ The provisions call for a balancing, in a legal-administrative setting, of efficiency objectives with ill defined, nonprioritized, and unweighted equity objectives. That type of balancing is beyond the appropriate purview of an antitrust court or enforcement authority. It is reasonable to question whether, in a legal-administrative proceeding, such an intensely political process can be carried out fairly or effectively.

The achievement of access and other political health care reform objectives is certainly a legitimate policy goal for states to pursue. The degree of income or wealth redistribution to be achieved is a quintessential political matter. The problem has been that advocates for increased access—more income redistribution—are much more able to persuade political actors in the abstract of the justice and the wisdom of broader coverage than they are in the practical world of nitty gritty policymaking detail. The devil that lurks in the details is the need to pay for this redistributive munificence, whether through taxes or some hidden form of income generation and transfer. The state hospital cooperation legislation may well represent an effort to return to this type of hidden subsidy by regulation—a response to competitive

186 See Blumstein & Sloan, *Redefining Government's Role in Health Care*, *supra* note 31, at 867.

187 *Id.*

188 *Id.*

189 See *supra* note 181.

pressures that have reduced supracompetitive rents previously available for cross subsidization.

The historical problem for access egalitarian redistributionists has been the mismatch between their ambitious goals and the willingness of political actors (voters and their representatives) to acquiesce openly and directly in such ambitious transfer programs. The initial health care reform program proposed by the Clinton Administration is a good illustration of the hidden subsidy approach to reform. The proposal featured little in the way of direct taxation.¹⁹⁰ The employer mandates were a camouflaged form of taxation, but the in-kind transfers were the heart of the program. The eighty-five percent of the population with health insurance would be lumped together in health alliances with the uninsured, all receiving the same "comprehensive" benefits package. Global cost controls would restrain aggregate expenditures for both those currently with and without insurance. While some efficiencies would undoubtedly accrue, the basic game plan was to spread existing health care dollars over more beneficiaries. To the extent that enhanced efficiencies could not make up for this extra burden on the system, the eighty-five percent of the population currently insured would receive lower quality services. National health insurance in this sense represented a hidden in-kind income transfer program, which, when uncovered and made more explicit, lost much of its political appeal.

The use of regulatory programs to confer monopoly rents for transfer is a throwback to the old way of doing things in the health care arena. It is a program of political obfuscation that Richard Posner many years ago characterized as "taxation by regulation."¹⁹¹

The coalition of access egalitarian redistributionists and health care providers has been a potent one in the political history of health care reform.¹⁹² Hospital cooperation legislation would seem to empower states to substitute regulation for competition and to build in supracompetitive rents for worthy cross-subsidizing objectives. That type of subsidization system makes accountability difficult because true costs are disguised. Policymakers consciously may choose to hide such objectives on the theory that "[a] society that embraces a market approach to most of its daily economic life, including . . . health care, is unlikely to redistribute adequate purchasing power to people in economic need."¹⁹³ By contrast, "market advocates argue . . . that in

¹⁹⁰ See Blumstein, *Preliminary Thoughts*, *supra* note 8, at 202-03 ("Much of the complexity and comprehensiveness of the plan stems from the desire to finance expanded access without putting more money on the table.").

¹⁹¹ Richard Posner, *Taxation by Regulation*, 2 BELL J. ECON. & MGMT. SCI. 22 (1971).

¹⁹² See *supra* note 24.

¹⁹³ Rosenblatt, *supra* note 114, at 1110.

almost all areas of economic life, the government's appropriate role is first to 'make markets work competitively,' and then to supply the poorest people with redistributed purchasing power—if that is seen as politically desirable."¹⁹⁴

While the reinvigoration of cross subsidization through regulation may achieve access egalitarian or provider-protection objectives, or a combination of both, those goals may well be achieved at the expense of the benefits of vibrant competition. Yet, proponents of the legislation are quite correct that balancing of efficiency with other goals is inconsistent with antitrust principles. Worthy goals should be achieved openly and directly through the political process, through overt subsidization, and without the market-distorting effects of hidden taxation and the supersession of federal antitrust law.

These state laws are still relatively new and their impact untested. The degree of re-regulation is therefore still unclear. The question arises as to the nature and degree of regulatory oversight necessary for these statutes successfully to confer *Parker* immunity on the private parties whose conduct is involved.

C. *Parker* Immunity: The Need for Active Supervision

In order for its regulatory scheme successfully to immunize private actors from the antitrust laws, a state must clearly articulate its policy to substitute regulation for competition¹⁹⁵ and it must actively supervise¹⁹⁶—*i.e.*, affirmatively approve or disapprove¹⁹⁷—the "specific details"¹⁹⁸ of the "particular anticompetitive acts of private parties"¹⁹⁹ to assure that the "anticompetitive scheme is the State's own."²⁰⁰

A number of the hospital cooperation statutes express the requisite intent explicitly,²⁰¹ while others do so more implicitly.²⁰² How-

¹⁹⁴ *Id.* at 1109 (citation omitted).

¹⁹⁵ *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

¹⁹⁶ *Id.*

¹⁹⁷ *See Patrick v. Burget*, 486 U.S. 94, 101 (1988) (The state must "review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.").

¹⁹⁸ *FTC v. Tigor Title Ins. Co.*, 112 S. Ct. 2169, 2176 (1992).

¹⁹⁹ *Patrick*, 486 U.S. at 101.

²⁰⁰ *Tigor*, 112 S. Ct. at 2177.

²⁰¹ Several states have a statement of legislative purpose or a legislative finding to the effect that competition should be supplanted by a regulatory program. *See* COLO. REV. STAT. ANN. § 24-32-2702 (1)-(4) (West 1993); MINN. STAT. ANN. § 62J.2911 (West 1994); MONT. CODE ANN. § 50-4-601 (1993); N.C. GEN. STAT. § 131E-192.1 (1993); and WASH. REV. CODE ANN. § 4372.300(2) (West 1994).

²⁰² Statutes such as Tennessee's provide that "[a] hospital may negotiate and enter into cooperative agreements with other hospitals in the state if the likely benefits resulting from the agreements outweigh any disadvantages attributable to a reduction in competi-

ever, all hospital cooperation laws are designed to take advantage of *Parker* immunity for private conduct in the medical marketplace. Therefore, the clear articulation prong of the *Midcal* standard should pose no insuperable obstacle.²⁰³

The "active supervision" component of *Midcal* poses a more interesting and formidable challenge. Two Supreme Court cases, *Patrick v. Burge*²⁰⁴ and *FTC v. Tior Title Insurance Co.*,²⁰⁵ have made it clear that the private conduct immunized under the *Parker* state-action doctrine must reflect and be consistent with articulated state policies. Passive ratification of privately initiated anticompetitive conduct will not satisfy the requirements for immunity. The federalism rationale undergirding *Parker* assigns political accountability to state officials. If a system of regulation at odds with federal procompetitive antitrust policies is to be given effect, state officials must bear direct and visible political responsibility.²⁰⁶ That is, the state policy, for which private conduct is immunized, must be "implemented in its specific details,"²⁰⁷ not at a highly general or abstract level. The key is that the state must "exercise[] sufficient independent judgment and control so that the details . . . have been established as a product of deliberate state intervention."²⁰⁸

What the "active supervision" requirement means is that serious, ongoing state involvement in the nitty gritty of decisionmaking will be a prerequisite to successful conferral of *Parker* immunity. *Tior* makes it clear that the degree of actual state involvement will be scrutinized when private conduct is challenged under the antitrust laws. The strictness of the active supervision requirement means that hospitals should not expect "sweetheart" arrangements with state regulators. Although state policies antithetical to the federal antitrust laws can obtain *Parker* immunity, private conduct largely engaged in without the affirmative and ongoing imprimatur of the state will not be shielded.

In practical terms, then, the price of securing *Parker* immunity for hospitals may be quite substantial, entailing detailed procedural and

tion." TENN. CODE ANN. § 68-11-1301(a) (1993). See also IDAHO CODE § 39-4903 (1994); ME. REV. STAT. ANN. tit. 22, § 1883(4) (West 1993); N.D. CENT. CODE § 23-17.5-02 (1993); OHIO REV. CODE ANN. § 3727.22(B) (Baldwin 1993); TEX. HEALTH & SAFETY CODE ANN. § 313.002(a) (West 1994); WIS. STAT. ANN. § 150.85 (4)(a)(1) (West 1993).

²⁰³ See Sarah S. Vance, *Immunity for State-Sanctioned Provider Collaboration after Tior*, 62 ANTITRUST L.J. 409, 421-23 (1994).

²⁰⁴ 486 U.S. 94, 102 (1988) ("The State does not actively supervise . . . unless a state official has and exercises ultimate authority over private" conduct.).

²⁰⁵ 112 S. Ct. 2169, 2176 (1992) ("Actual state involvement . . . is the precondition for immunity from federal law.").

²⁰⁶ *Id.* at 2178.

²⁰⁷ *Id.* at 2176.

²⁰⁸ *Id.* at 2171.

substantive review with all the associated transaction costs and the potential loss of considerable decisionmaking autonomy. If these laws are going to work on behalf of hospitals, they cannot be shams. The states must actually confront and affirmatively decide the difficult efficiency and nonefficiency questions. Presumably, to satisfy the "active supervision" standard, state health departments must develop and apply criteria for measuring costs and benefits to demonstrate that they have reached a judgment as a matter of state policy—that they are not rubber stamping the decisions of the petitioning hospitals. To the extent that *Ticor* requires states to act affirmatively and in good faith to insure that these decisions are state decisions, proponents of this legislation may be disappointed. This fact suggests that the statutes will not be used routinely by hospitals but will serve as backup alternatives when hospitals are faced with a threat from a federal enforcement agency.²⁰⁹

Perhaps the most important question in light of *Ticor* is whether "active supervision" requires ongoing monitoring of private conduct by state agencies. Where cooperative relationships have an ongoing and potentially damaging effect on competition, *Ticor* seems to man-

²⁰⁹ The Minnesota Commission of Health approved the merger of two hospital systems involving seven hospitals located in the greater Minneapolis and Saint Paul areas. The Minnesota Attorney General raised antitrust objections and reached agreement with the applicant regarding terms and conditions relating to the transaction. The Commissioner found that the merger would result in cost savings to the applicant of about \$30 million, most of which would be passed through to the users of the hospitals. This was shown through affidavits from major purchasers of health care services in the area. These affidavits indicated that through their contract negotiations with the hospitals, savings had been passed on to them. Additionally, no purchasers filed negative comments regarding the merger. The affidavits also gave weight to the argument that even post merger, the market was still competitive. Furthermore, the agreement with the Attorney General placed more stringent limits on revenue growth for some of the hospitals than required by statute. The Commission found no evidence of geographic or financial limitation to health care services that exist or a lessening of the quality of care as a result of the merger. As a part of ongoing supervision, the Commission required periodic reports regarding quality of care, a three-year prohibition against certain mergers, review before exclusive contracting, and an independent auditor to see that growth limits were actually achieved. Findings of Fact, Conclusions, Order and Memorandum issued by Minnesota Commission of Health, *In re Application of HealthSpan Health Systems Corporation* (July 22, 1994).

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 *GAO Report, supra* note 15, at 11.

The extensiveness and thoroughness of the Minnesota decision suggest that, at least in such major matters, a state-based process can carefully evaluate the factors enumerated in the statute for consideration. At the same time, the costs of undergoing such a process are considerable, and there is at least an implicit risk for parties to invoke such a process. Although failure to secure state approval would not necessarily defeat a cooperative arrangement as a matter of law, such a turndown could trigger antitrust enforcement review or provide other stimulus for an antitrust challenge to the conduct reviewed in the state procedure.

date some form of active and "ongoing regulation by the State."²¹⁰ The risk to competition from such activities, and the need to police the details of the implementation of such collective conduct, strongly suggest that ongoing cooperative activities between or among private parties should be subject to ongoing state involvement.

The toughest case is the merger situation, in which no ongoing collective conduct occurs because the preexisting independent entities have been collapsed into a single unit. Large mergers are subject to antitrust enforcement review prior to their culmination under Hart-Scott-Rodino procedures and guidelines.²¹¹ They also are subject to challenge after the fact by private parties if they have monopolized the market.²¹²

In such a situation, it is questionable whether the single act of front-end state regulatory approval would or should suffice under the "active supervision" standard. Some form of ongoing review of pricing, for example, would seem essential to protect the merged business from federal antitrust action when the merged entity exercises sufficient market power to set supracompetitive prices. A state also should guard against the proliferation of artificial barriers to entry. Consumer choices regarding health care services must be respected, as they would be in a competitive market. In short, even mergers justified on grounds of efficiency generate ongoing issues for the state to review. Considerable discretion exists about exiting the market in certain areas and otherwise altering the circumstances that might have existed when the merger was initially approved. These situations all involve private choice without the accountability and oversight that *Ticor* would seem to mandate.

Further, states may approve mergers on grounds other than efficiency—for example, to achieve geographic or other access goals.²¹³ Allowing health care institutions to earn monopoly rents conceivably could conform to state policies designed to facilitate cross subsidization; however, there is a wide range of private discretion in determining the level of cross subsidization and determining the priorities for expending those funds through cross subsidization. Similarly, merg-

²¹⁰ *Ticor*, 112 S. Ct. at 2176.

²¹¹ The Hart-Scott-Rodino Antitrust Improvements Act, 14 U.S.C. § 18a (1988), requires a simultaneous filing with the FTC and the DOJ of any transaction when the parties are engaged in interstate commerce, and where one party has net sales or assets in excess of \$100 million, the other party has net sales or assets in excess of \$10 million, and the transaction involves the acquisition of at least 15% of the acquired party's stock or \$15 million in assets. For a discussion of the DOJ-FTC Joint Enforcement Guidelines, see *supra* note 10.

²¹² The Clayton Act, 15 U.S.C. § 26 (1988), empowers any person threatened with injury by a violation of the Sherman or Clayton Acts to seek relief in the Federal Courts. See HOLMES, *supra* note 105, at 711.

²¹³ See *supra* note 181.

ers to achieve geographic access in rural areas by protecting the economic viability of rural hospitals leave many details to private decisionmaking. What services will the merged institution retain? Which services will be added and under what criteria? Where might the institution locate subsequent clinics or satellite units? What provisions for caring for the underserved will be required? What relationships with the physician community will be made? How will the merged institution structure its participation in projected managed care arrangements?

All of these decisions will be affected by the increased leverage created by an anticompetitive merger. Ongoing oversight of the implementation of a merger deal therefore would seem to be critical. If collective arrangements are to secure immunity from federal antitrust laws, the details of their implementation must be the decision of the state for which the state is politically accountable. Only ongoing and active involvement by the state can assure that the public interest (rather than the private parties' interest) is being served. *Ticor* appears to mandate such an ongoing regulatory and supervisory structure.²¹⁴

CONCLUSION

The health care marketplace is evolving. Market-based principles now have a greater role, in practice, than under the ancien regime of a pure professional model. But the health care arena is still an ongoing ideological battleground. The application of antitrust law to the health care industry has introduced and sustained market principles in that arena.

Still, there remains institutional and doctrinal cacophony in the health care industry. Doctrines, such as certain aspects of the anti-fraud and abuse laws, are premised on a philosophical and institutional regime hostile to market-based principles, yet they coexist with other doctrines, such as antitrust, that are premised on traditional market assumptions. The result is that ensuing legal battles replicate the political battles that are so prevalent in the health care arena. As the reality of the industry changes, leftover legal landmines impede economically rational behavior. These doctrines persist even as their

²¹⁴ *Ticor*, 112 S. Ct. 2169. There is the additional question of the ability of one state to approve a merger when some of the facilities are located in other states. Will one state be able to confer immunity nationwide if a party is incorporated or headquartered in a particular jurisdiction? Compare *Edgar v. MITE Corp.*, 457 U.S. 624 (1982) with *CTS Corp. v. Dynamics Corp.*, 481 U.S. 69 (1987).

underlying premises change and render them somewhat anachronistic.²¹⁵

The state hospital cooperation laws represent a potentially ranchist attempt by the industry to restore professional and provider dominance by reestablishing a more comfortable regime conducive to cross subsidization. It may be that the antitrust enforcers have misunderstood the industry, and that the hospital cooperation legislation truly attempts to preserve efficiency and to advance consumer welfare. But experience with such planning and regulatory efforts has not been reassuring. Promarket advocates are rightly skeptical of initiatives that eliminate antitrust law's assurance of a procompetitive environment. However, stringent state oversight requirements may mean that the costs of implementing this legislation make it difficult to use and therefore less destructive than one might fear.

²¹⁵ Examples of this phenomenon abound. For example, Peer Review Organizations (PROs) were to have a quality assurance but also a utilization review mission. With the advent of prepayment through the diagnosis-related-group (DRG) method, the financial risk shifted to hospitals. The underlying premise of PROs—that hospitals under cost-based reimbursement had an incentive to escalate costs—changed dramatically, and their mission had to be modified. Similarly, the certificate-of-need laws became of questionable application to health maintenance organizations, which faced the constraints of fixed payment. It is now reasonable to question whether the features of the fraud and abuse laws discussed *supra* part I.C are anachronistic in the world of capitated payment and managed care. The same questions arise regarding the corporate practice doctrine considered *supra* part I.C.