Antitrust, competition, and health care reform

Health Affairs 13, no.1 (1994):206-223
doi: 10.1377/hlthaff.13.1.206

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/13/1/206

For Reprints, Links & Permissions:
http://content.healthaffairs.org/1340_reprints.php

Email Alertings:
http://content.healthaffairs.org/subscriptions/etoc.dtl

Not for commercial use or unauthorized distribution
PROLOGUE: The American health care system is moving rapidly into an era in which hospitals, physicians, and other providers of medical services are combining into a variety of larger organizational forms. The momentum for this consolidation results largely from the demands of third-party payers for relief from ever-rising health care costs and the realization by many providers of the need to make a successful transition to this new world, which is usually characterized as “managed competition.” The introduction of the Clinton administration’s health care reform proposal, which encourages collaboration by providers, is accelerating market reform. As these new forms take shape and, in many instances, accumulate market power, attorneys Robert Bloch and Donald Falk emphasize in this paper that antitrust issues will rapidly emerge as “extremely important” in defining the relationships between the major stakeholders. Bloch is a partner in the Washington law firm of Mayer, Brown & Platt, where the principal areas of his practice are antitrust law, health care law, and the defense of individuals and corporations accused of white-collar crime. Before joining the firm this year, Bloch worked for seventeen years as an attorney in the Department of Justice. His last of several senior-level positions was as chief of the Professions and Intellectual Property Section, where he was responsible for supervising the investigation and prosecution of civil and criminal antitrust violations concerning the health care industry, the professions, and several other industries. Donald Falk is an associate at the same firm, specializing in appellate, general litigation, and antitrust matters. Previously, he worked as a law clerk to Judge Douglas H. Ginsburg of the U.S. Court of Appeals.
Abstract: The goals of health care reform and the antitrust laws are similar: promotion of consumer welfare. Under reform, having large groups of consumers and providers will offer substantial efficiencies in purchasing and providing health care services but also will pose some antitrust risks. Health alliances may have excessive market power. Health plans and provider networks may have the potential to foreclose competition from actual or potential rivals. Mergers and joint ventures between providers will proliferate but may raise similar problems. Explicit exemptions from the antitrust laws—through federal or state legislation—may significantly limit the benefits of competition for consumers. A reformed health care system will not reduce the need for antitrust enforcement.

Antitrust issues will be extremely important in defining the legal relationships between the major players in a reformed health care system, and enforcement of the antitrust laws will be important in encouraging competition for the benefit of both consumers and providers. Under the basic framework of the president’s proposed health care system, most of the antitrust issues will focus on three areas: (1) the formation and operation of health alliances; (2) the formation and operation of health plans, provider groups, and networks; and (3) the possible exemption from the antitrust laws of some aspects of the formation or activities of these critical components of a reformed health care system.

Health Alliances As Power Buyers

Health alliances will be large groups of purchasers, including individuals and small employers. If the alliances are created as government entities, they probably will be exempt from the antitrust laws (either expressly or through the operation of the state action immunity doctrine). Nongovernmental alliances such as corporate alliances, whether for-profit or not, will be subject to the antitrust laws.

As purchasing joint ventures, these alliances will integrate purchasing functions, increasing efficiency by reducing transaction costs, and will aggregate market power on the buyers’ side, potentially forcing prices down. The first function should pose few problems under the antitrust laws; the second creates some risk to competition and consumers.¹

The alliances will coordinate several activities for their members. Unless they are merely clearinghouses that offer to consumers all plans that meet minimum federal requirements, the alliances should be able to reduce transaction costs substantially for both purchasers and providers by collecting funds from and acting as brokers for large groups of purchasers. In the latter role, the alliances should be able to conduct centralized negotiations with plans and individual providers.² Alliances also will disseminate information regarding the plans’ benefit packages, making comparison shopping easier for consumers. Finally, they will monitor plan performance, performing quality-control functions that isolated smaller purchasers could not
accomplish cost-effectively.

In sum, the alliances should be able to offer substantial procompetitive, efficiency-enhancing benefits that alliance members could not procure on their own. Under these circumstances, there is no significant risk that a health alliance will be a sham, treated as a cartel, and summarily condemned under the antitrust laws.

If the alliances eliminate too much competition among purchasers, however, they could injure rather than aid consumers. Two issues will be most important: how many alliances are allowed to function in a single market; and which purchasers are required to join an alliance or, conversely, which purchasers may remain in a market in competition with alliances.

Under the president’s plan, consumers whose employers do not form corporate alliances will have access to only a single regional alliance. In contrast to a system that allows as many regional alliances as the market will bear, a single-alliance system might have several advantages unrelated to competition. For example, health care reform likely will require community rating. By centrally allocating all premiums flowing to plans in its region, a single alliance could enforce community rating by adjusting premiums paid to each plan to account for risks associated with that plan’s pool of consumers. Too many alliances might lead to disaggregation of certain parts of a community, which in turn might mean that alliances could not effectively ensure that premiums were community-rated because no alliance would accurately reflect the full population. It is not clear that a purchasing alliance is the best vehicle for enforcing or monitoring community-rated premiums, because the enforcement of community rating appears to be a regulatory rather than a market function. A state agency that certifies plans also might reallocate premiums between plans.

Another possible advantage of a single-alliance system is reduced consumer confusion in decision making. Allowing health alliances to compete for the business of individual consumers could complicate consumers’ roles in two ways. First, each consumer would have to select both an alliance and a plan, rather than choosing only a plan. Second, competing alliances probably would make more plans available to each consumer, including each alliance’s version of some of the same plans. For example, a consumer could face a choice from among thirty plans offered through three alliances rather than from among only ten or fifteen plans offered through a single alliance. The expanded choices could prove bewildering. On the other hand, the paternalistic assumption that consumers are only marginally capable of making informed choices conflicts with the goals of encouraging individual responsibility and accountability—basic tenets of health reform.

If all (or almost all) consumers must channel their purchasing decisions through single, noncompeting alliances, a key component of the health
services market could become a major bottleneck. In some areas the presence of corporate alliances may provide sufficient competition to break up this bottleneck. In most areas, however, a single public alliance will have an overwhelming proportion of consumers, potentially raising three problems.

First, an alliance that does not have to compete for business is likely to become a bureaucracy rather than an efficient purchasing and information-gathering vehicle for consumers. If the alliance does not risk losing consumers because of poor performance, it will have far less incentive to seek out the best-quality plans and to bargain aggressively for the best prices. This problem cannot be solved by the presence of several vibrant corporate alliances in an area, because the single public alliance would not compete with those alliances for members.4

Second, an alliance that has monopsony power (such as a 70 percent market share of purchased services) and can depress prices below competitive levels may force providers to offer fewer services or to cut corners on quality.5 Pricing below competitive levels also would discourage providers from innovation—an effect precisely contrary to the goals of health care reform. In some areas corporate alliances might be large enough to prevent the single public alliance from gaining an excessive market share.

Under the president’s plan, alliances would have to offer consumers access to all qualified plans that want to serve an area (except for those with grossly excessive premiums). The third problem would arise only if the plan were modified to give health alliances the authority to select plans for their members. An alliance that could choose to purchase only from one or a few competing qualified plans might be able to confer market power on those plans, which in turn could limit consumers’ choices. Accordingly, provider involvement in alliance decision making should be limited or prohibited— as it is in the president’s plan—to avoid leveraging of alliance market power into the health plan market.

Multiple (noncorporate) alliances should reduce if not eliminate the risk that any single alliance might possess excessive market power over both consumers and providers. In general, if an alliance serves no more than 25 to 30 percent of purchasers in a market, there is considerably less likelihood that it will be able to exercise its market power anticompetitively.6

As noted above, it is difficult to gauge the significance of the potential competition from large employers that form corporate alliances. By forcing those employers to make a one-time, irrevocable election either to become a corporate alliance or to participate in a regional alliance, the plan undercuts an otherwise significant competitive pressure on regional alliances. If large, independent purchasers retained the ability to leave an alliance (or to join a more efficient one), alliances would have a continuing incentive to offer packages of services that would be attractive to those large purchasers.
The conduct of nonexempt, competing health alliances will be subject to the usual antitrust rules governing agreements between horizontal competitors. If two or more alliances fix fees paid to providers, engage in group boycotts designed to exclude certain providers or to pressure consumers to pay higher premiums, or allocate consumer markets between themselves on a geographical or other basis, those activities will be per se violations of the antitrust laws. In other words, the participants would not be able to escape antitrust liability by showing that under the circumstances the particular challenged practice was procompetitive.

**Joint Provider Activities**

Most of the collaborative activity that providers will undertake as a result of health care reform will be conducted within joint ventures or integrated delivery systems. The collective activity of competitors within a bona fide joint venture or integrated network normally will be analyzed under the rule of reason, in which the procompetitive benefits of the venture are balanced against its actual or potential anticompetitive effects. A critical threshold question is whether a joint venture or network has sufficient economic integration to avoid being considered a cartel. The venturers may achieve this integration by pooling assets in which the venturers share in the risk of profit and loss (financial integration) or by providing a new product or service that individual venturers could not offer on their own.

Joint ventures or networks should produce efficiencies that result in lower costs and lower prices to consumers. Collective activity within a legitimate joint venture or network usually will be lawful, unless the venture or network colludes with a competitor, possesses and exercises excessive market power in a relevant product and geographic market in which its participants compete, or engages in anticompetitive, exclusionary conduct.

Plans will have to integrate vertically so that they can offer a broad range of services, including primary and secondary care, specialty care, and hospitalization, along with claims processing, quality assurance, and utilization review. Plans also will have to integrate horizontally to include enough (otherwise competing) providers in each specialty to serve an alliance’s patient base. To accomplish this task, a plan may include physicians and hospitals (individually, as groups, or as independent provider networks), allied providers such as laboratories and home health services, and possibly an insurer to perform financial, administrative, and marketing functions. The wide array of possible provider organizations will raise antitrust issues in three areas: the creation of plans, the creation and operation of provider networks, and the increase of mergers and joint ventures.

**Health plans.** The size and structure of plans will determine the charac-
ter of the provider market. In addition to health maintenance organizations (HMOs), many other existing entities are well positioned to act as plans. For example, an insurance company can recruit its own network of providers and supply the required financial administration and utilization review, taking only a short step beyond what many do now with their own preferred provider organizations (PPOs). Provider-controlled PPOs, individual practice associations, or physician-hospital organizations can add financial and administrative functions through management services organizations. Hospitals or hospital groups can recruit panels of physicians and simply contract for plan administration. The principal antitrust concerns posed by plans will include the legitimacy of each joint venture or network, the possibility of collusion between plans, and the unreasonable accumulation or exercise of market power by a plan, for example, through an exclusive dealing arrangement that prevents other plans from entering the market. 9

Legitimacy of joint venture. Plans by necessity are likely to integrate enough of their providers’ activities to qualify for more lenient rule-of-reason treatment under the antitrust laws. For example, a plan’s acceptance of a risk-adjusted capitation fee for each alliance member probably will satisfy any minimum risk-sharing requirement to qualify as a joint venture. Within a single integrated plan, joint pricing, resource allocation, and information exchanges among otherwise competing providers generally will be permissible. If, however, a plan involves no integration and is in reality no more than a guise for competing providers to offer their services at a uniform price or to allocate alliances or geographic markets, participants’ activities will be subject to the per se rule rather than the rule of reason.

Collusion. Collusion between two or more competing plans serving a market will be a per se violation of the antitrust laws if the plans rig bids for contracts with alliances or agree to set uniform premiums, capitation fees, or discount levels. Other activities that will be closely examined include competing plans’ dividing local or interstate markets, allocating particular alliances to particular plans, or agreeing on the range of additional services that might be offered to alliances. Agreements not to deal with particular providers, designed to limit the supply in a market or to force providers to participate in plans for lower fees, also will be carefully scrutinized.

Neither the market power nor the sophistication of the health alliances is a guarantee against equally sophisticated providers or plans determined to engage in anticompetitive conduct. 10 While the provision of a uniform package of benefits at a defined price clearly has advantages for consumers, it may have competitive consequences because of an increased risk of collusion. Ironically, by publishing the terms of alliance/plan contracts, and thus causing an indirect exchange of data between plans, alliances could
make collusion easier; depending upon the type of information and the form in which it is provided, such a data exchange could facilitate signaling that would allow competitors to act in concert while appearing to act unilaterally. Clearly, the less differentiation between plans, and the more information about each that is available to competitors, the simpler it will be to devise and enforce a collusive scheme.

These risks can be reduced if plans are not restricted to offering the government-prescribed benefit package through the alliances, but also may offer modified and enhanced plans that incorporate more services, different pricing, and a wider choice of providers. It is unclear whether the gains to be derived from permitting such variation will outweigh possible adverse selection problems. These problems may cause government regulators to take their chances with the risks of collusion and opt for uniform plans. From an antitrust perspective, however, greater differentiation between plans makes it harder to collude.

Accumulation and exercise of market power. The less market power any given plan has, and the more vigorous interplan competition is, the more likely that plans will generate efficiencies that can be passed on to consumers in the form of lower prices. Under current case law, a plan serving fewer than 30 percent of the consumers in a defined relevant market is unlikely to pose a significant threat of gaining and exercising market power.\footnote{11}

If only one or two plans operate in a market, there is greater risk that alliances and consumers will be essentially captive. Under these circumstances, a dominant plan might have the market power to raise prices, exclude providers who want to participate in the plan, exclude current competing plans, or raise barriers to the entry of potentially competing plans, for example, by using exclusive dealing arrangements with providers.

Tying arrangements. One of the ways that a plan might attempt to exercise its market power presents special problems and may require a modified analysis in the context of health plans. In a tying arrangement, a seller uses its market power over one product (good or service) to force buyers to purchase another product from the seller; by tying the second product to a primary product that consumers must buy from the seller, the seller forecloses competition for the second product. Where the seller has market power over the first product, the tying arrangement may be a per se violation. Even if market power cannot be proved, the arrangement may violate the antitrust laws under the rule of reason if competition in the market for the second product is significantly foreclosed.

Plans will be expected to bundle services and will not be allowed to offer services in packages that offer less than the nationally defined minimum coverage. For example, a plan will not be expected to offer the services of its radiologists apart from the other services within the minimum benefit
package, even if the plan has market power in radiology. If every apparent tie-in of services were subject to antitrust challenge (even if ultimately unsuccessful), the entire system could become mired in litigation brought by disappointed competitors. It is quite possible that courts and enforcement agencies will have to permit a higher threshold of market power in particular specialties before allowing plans to be held liable for tying arrangements that offer demonstrable efficiencies.

On the other hand, the accumulation of market power in a key specialty—one that could serve as a tying product—may present competitive problems that cannot be ignored. The anticompetitive danger usually associated with tying—the use of control over a small market to foreclose competitors in a broader market—may be contained by suitable restrictions on exclusive dealing arrangements between plans and providers, so that tie-ins cannot be used effectively to exclude competing plans. If, however, a plan tied some services in a supplemental benefit package to others (for example, tying dental services to optometric services), the usual antitrust analysis of the arrangement would be appropriate. These potential problems are likely to be resolved by market forces if alliances can play one plan against competing plans, or by regulatory forces, if anticompetitive conduct places plans at risk of being sued by alliances or decertified by state agencies.

Provider networks. A plan would save significant transaction costs if it could assemble most or all of its provider panel by contracting with one or only a few preexisting provider groups or networks, rather than with individual providers. Provider networks provide strong incentives for member physicians to practice medicine more efficiently. Networks in areas served by more than one plan might participate in more than one plan or might be bound to a single plan by an exclusive contract.

The threshold question about a provider collaboration of this kind—that is, a network or group that is not itself a plan—will be whether it is an integrated joint venture with a procompetitive purpose and efficiencies, or is merely a device to enable competing providers to engage in collective fee negotiations with plans and should be summarily condemned. (Under the Clinton plan, unintegrated provider groups can negotiate collectively with an alliance over the establishment of a fee-for-service schedule, but this antitrust immunity will not extend to negotiations with health plans.) If the joint venture is legitimate, collaboration between otherwise competing providers within the network is permissible to the extent that the activity is necessary to the operation of the venture and increases its efficiency.

In general, a provider network will be sufficiently integrated to be legitimate if there is substantial shared financial risk or if the network produces substantial efficiencies by providing a “new product,” such as financial administration or utilization review, or by delivering health care in a way
that is materially different from what its members individually offer. An example might be a package of multispecialty services offered at a discount or for a capitation fee.

Because each joint venture and its activities tend to be unique, current case law and prior enforcement policies have not produced a “bright line test” to define the type and amount of integration that is necessary to approve automatically the formation or activities of a joint venture. Consequently, each venture is subject to a fact-specific analysis of its purpose, activities, competitive effects, and efficiencies.

On 15 September 1993 the Department of Justice and the Federal Trade Commission (FTC) issued six policy statements dealing with hospital mergers, joint ventures, and certain types of information exchanges. One policy statement specifically concerns physician network joint ventures. The statement sets forth a “safety zone” that describes physician network joint ventures that will not be challenged, absent extraordinary circumstances; the analysis the agencies will use to review joint ventures that fall outside the safety zone; and a commitment by the agencies to provide advisory opinions about specific proposed joint ventures within ninety days after a request and all necessary information have been received.

Specifically, the safety zone protects physician networks that (1) do not include more than 20 percent of the providers within any specialty in the relevant market (unless there are fewer than five providers of that specialty in the market), and (2) require their members to “share substantial financial risk.” Examples of sufficient risk sharing include an agreement to provide services to a plan at a capitation fee and the use of financial incentives for cost containment, such as withholding a substantial amount (for example, 20 percent of members’ compensation for later distribution only if cost containment goals are met). This safety zone applies equally to “exclusive” and “nonexclusive” joint ventures.

The “20 percent test” is a fairly conservative one under traditional antitrust standards. Nevertheless, this policy statement, the description of the analysis being used by the agencies, and the examples provided draw brighter lines around safe joint provider activities and should make enforcement decisions more understandable and predictable. Perhaps most importantly, it gives providers a vehicle to get a prompt answer from the enforcement agencies about contemplated activity. This in turn should facilitate reform and enhance competition.

In dealing with plans, legitimate provider groups and networks will face the same potential pitfalls they do now in dealing with HMOs, insurance companies, and other payers. For example, if competing provider networks collude, rather than simply responding independently to terms offered by a plan or an alliance, they might be guilty of a per se price-fixing violation.
Competing provider networks also can run afoul of the antitrust laws by conspiring to exclude particular specialists or classes of health care providers (such as nonphysicians) from their networks for anticompetitive reasons. And a network with market power over a particular specialty might violate the antitrust laws if it tied services in that specialty to the purchase of a broader range of separate services from the network.

Like any joint venture, a provider network must ensure that its collective activities are confined to the venture itself. If providers coordinate prices or service offerings outside the scope of the network (for example, by setting fees in their individual private practices, or by dealing collectively with payers that do not contract with the network), the underlying efficiency justifications and the rule-of-reason treatment of the venture and its activities may no longer apply. Because a provider network may have to include a large number of practitioners to be an effective component of a plan, those planning to form networks should expect enforcement authorities to be concerned about the purpose and nature of a network and the possibility that it may develop or exercise market power to raise prices, restrict services, or exclude competitors. Generally, a network with fewer than 30 percent of the physicians in a specialty in a defined geographic market should not be able to exercise market power anticompetitively.

Collective negotiations of fee-for-service schedules. Under the president’s plan, each regional alliance (or state) will establish a uniform payment schedule for care that is provided fee-for-service, creating a regulated market. The plan confers antitrust immunity on providers who collectively negotiate a fee-for-service schedule with an alliance even if they are not part of an integrated joint venture. The immunity does not apply to negotiations with health plans or networks, and its economic effect may be limited if proposed fee-for-service budget caps are enacted and enforced.

Nevertheless, the proposed immunity could have important anticompetitive implications. First, virtually no other group of competing sellers can freely operate as a cartel under similar circumstances. Second, the natural effect of this legalized collusion will be a rise in fee-for-service prices, increasing costs to consumers for whom HMOs or PPOs are inadequate alternatives and diverting consumers who prefer the fee-for-service option into other plans. Third, but perhaps most importantly, the collusive activity sanctioned in the newly regulated fee-for-service market poses a significant threat of spilling over into providers’ negotiations with other plans, thereby increasing providers’ prices to those plans and to all consumers.

The exemption for providers’ collective negotiations appears to respond to the medical community’s concern that alliances will be monopsonists whose significant market power will result from the large number of consumers they will represent. This collective bargaining approach is in-
tended to “level the playing field” for individual providers who negotiate with alliances. Rather than encouraging competing providers to band together into cartels to negotiate with alliances, the better solution would be to limit the market power of the alliances by creating more of them.

Exclusive dealing arrangements. To meet their contractual obligations and to assure alliances of their stability, plans and networks increasingly will use exclusive contracts with individual providers, provider groups, and hospitals. Exclusive dealing arrangements are generally procompetitive. They may help networks to coordinate and maximize the use of personnel and facilities and to ensure that different types of providers are continuously available to provide required care. Exclusive contracts also may help to justify capital expenditures if providers are ensured a certain patient volume. A plan that provides steady patient flow to key providers may be able to pass the benefits of the providers’ increased efficiency on to its members, thereby enhancing the plan’s competitive position. Exclusive contracts also may produce administrative efficiencies and may encourage more cohesive teamwork among providers, which may lead to more efficiently delivered care and better outcomes, all of which may result in lower costs.

Nevertheless, exclusive dealing arrangements can be used to acquire and exercise market power anticompetitively, to create barriers to entry into a market, or to foreclose actual or potential rival providers, networks, or plans from competing. In addition, exclusivity may limit the ability of plans to assemble their preferred panel of providers. Because exclusive dealing arrangements are analyzed under the rule of reason, they are unlawful only if their anticompetitive effects outweigh their procompetitive benefits.  

Exclusive dealing arrangements can take many forms. For example, a specific doctor or group may agree to use only a network’s hospitals or to refer patients only to colleagues within the network; a hospital may agree with a group of specialists not to allow other providers in the same specialty to practice at the hospital. In addition, an exclusive contract may bind a provider to a network, restricting movement between or among other competing networks and creating provider exclusivity.

All exclusive contracts raise similar antitrust issues focusing on foreclosure of actual or potential competition, but the risk of foreclosure stemming from an exclusive arrangement depends on the specific markets affected by the arrangement. The easiest way to understand exclusivity issues is to examine them in the various circumstances in which they arise.

A plan, for example, may attempt to secure its panel of providers by entering into exclusive dealing arrangements with one or more provider networks. A network’s agreement not to contract with other plans could injure competition by preventing rival plans from forming because they could not assemble a competing panel of providers. Similarly, competition
between existing plans might be impaired to the extent that plans could not compete for the services of more proficient provider networks bound to other plans. Either type of foreclosure would require the network to include a substantial number of essential providers (for example, hospitals, primary care physicians, and cardiologists), who in turn were exclusively bound to the network; the critical number will vary from market to market.

These foreclosure effects would be exacerbated if there also were restrictions on a provider’s ability to move between networks. For example, a long-term exclusive contract between a plan and a dominant network might present a serious barrier to the formation of a competing plan if individual providers were required to give a year’s notice or pay substantial liquidated damages to the network before they could join another plan’s panel. Limiting exclusive contracts to one or two years, with no more than three to six months’ notice of termination, would give providers enough flexibility to pursue and be pursued by competing or forming plans.\(^{19}\)

A plan’s agreement not to contract with providers outside a particular network could foreclose entry into the market by a competing network. No rival network could form if it could not gain access to a sufficient number of patients because all (or too many) providers participated in the exclusive plan. Again, there is not likely to be any significant anticompetitive foreclosure unless providers’ freedom of movement between networks is restricted for an unreasonable period, a problem easily remedied by limiting the term and notice period for exclusive arrangements. If a provider could not generate sufficient patient volume without access to the plan’s pool, the same kind of exclusive arrangement between a plan and a network also could foreclose competition by individual providers.

Analogous foreclosure questions arise from exclusive dealing arrangements between plans and individual providers and between networks and individual providers. A plan or network could foreclose competition by actual or potential rivals by locking up a critical mass of essential providers. Conversely, an agreement limiting the plan’s or network’s panel to certain providers could forestall entry into a market if providers could reach a sufficient number of patients only through the plan or network.

Exclusive dealing arrangements are likely to spawn a significant amount of private litigation because of the potential for foreclosure outlined above. Networks or plans that enter into these types of arrangements will have to be extremely careful in establishing the criteria they use to decide which providers will be permitted to join their panels. Organizations will be better able to protect the integrity of their panel-selection decisions if they use objective criteria, based on standards of quality and utilization rather than economic credentialing, and if decisions are made by screening boards that are not controlled by competing providers. In addition, the enforcement
agencies can be expected to scrutinize carefully the exclusive contracts that plans and provider networks enter to be sure they are not used to facilitate collusion between competitors, create or facilitate the exercise of market power to exclude rivals from networks or plans, or foreclose rivals from access to patients. For reformers seeking to avert all of these potential anticompetitive effects, the main challenge will be to minimize the legal and regulatory barriers to plan and network formation.

**Mergers and joint ventures.** Health care reform will produce a significant increase in mergers, consolidations, and affiliations among providers. This wave of consolidation will be directed at reversing the effects of years of inefficient, cost-based reimbursement by eliminating the excess capacity and duplication of services that drove up health care costs, especially in hospitals. The antitrust laws generally prohibit only those transactions that create entities with market power and increase the likelihood that competition will be reduced substantially in a particular market.

Antitrust analyses of mergers and joint ventures are complex, fact-specific undertakings that will not change with the advent of health care reform (unless these transactions are exempted from antitrust scrutiny). Congressional debate will focus on the adequacy of the new health care antitrust enforcement policy statements and the existing Merger Guidelines used by the Department of Justice’s Antitrust Division and the FTC, and whether those agencies should continue to be responsible for analyzing mergers in health care. To date, the antitrust laws have not impeded these types of transactions, despite assertions to the contrary. More hospital mergers have occurred in the past ten years than in any other comparable period, with little interference from enforcement agencies. Of 229 hospital mergers between 1987 and 1991, the FTC and the Department of Justice investigated only twenty-seven and challenged only five (less than 3 percent). The enforcement agencies have never challenged a joint venture between hospitals to share high-tech medical equipment or services.

Nonetheless, the American Hospital Association (AHA) and rural hospital organizations have argued vigorously that hospital mergers and other types of joint ventures should receive more lenient treatment under the antitrust laws and that hospitals should be able to allocate hospital services and procedures to enhance efficiency. Some of these proposals suggest that mergers and joint ventures should be screened by the Department of Health and Human Services (HHS), either directly or through the Health Care Financing Administration (HCFA), rather than by one of the antitrust enforcement agencies, even though neither HHS nor HCFA has any expertise on competition issues. Some states have attempted to follow a similar course, as discussed below. If enacted, such proposals likely would subordinate competition to other policy values, such as access to care.
In anticipation of the structural reform of the health care system, Justice and the FTC issued antitrust enforcement policy statements governing challenges to hospital mergers and hospital joint ventures involving high-tech or other expensive medical equipment. The safety zone for hospital mergers is directed precisely at the small (rural) hospitals that have been seeking more lenient treatment: In the absence of extraordinary circumstances, the agencies will not challenge any merger between two general acute care hospitals when one of the hospitals has an average of fewer than 100 licensed beds over the three most recent years, and has an average daily inpatient census of fewer than forty patients over the same period.

The safety zone for high-tech joint ventures includes any joint venture among hospitals to purchase, operate, and market the services of high-tech 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. A joint venture may include additional hospitals if they could not support the equipment on their own or through the formation of a competing joint venture.

These policy statements should make enforcement decisions concerning small hospital mergers and high-tech joint ventures more predictable and, combined with the enforcement agencies’ record of careful analysis and exercise of prosecutorial discretion, should not inhibit collaboration. The agencies recognize, however, that further enforcement policy statements may be necessary as the health system evolves under reform. Nevertheless, there will continue to be pressure to preempt antitrust enforcement in the field entirely, or at least not to foreclose the states from enacting their own legislation to immunize collective activity among hospitals.

State Action Immunity And Other Exemptions

It is possible that federal health care legislation will displace antitrust directly, either by expressly preemptioning the antitrust laws or by implied repeal. A more likely scenario, however, is that states will cloak certain activities with state action immunity from the antitrust laws without any directive from Congress.

Express exemption. Although a blanket antitrust exemption for all health care activities is unlikely, the president’s plan immunizes providers who collectively negotiate fee-for-service schedules with alliances, without requiring the providers to integrate their activities into a joint venture. The plan also contemplates that alliances may be constituted as quasi-governmental state agencies and thus might have some degree of sovereign immunity. In addition, providers continue to push for more lenient treatment for hospital mergers and joint ventures than is afforded by the enforcement
agencies’ guidelines and the National Cooperative Research and Production Act of 1993, which provides special treatment for health care joint ventures that introduce new technologies by limiting their liability to actual rather than treble damages.\(^{25}\)

The administration’s plan also takes a step in the opposite direction, proposing to do away with one of the broadest express exemptions to the antitrust laws by excluding health insurers from the protection of the McCarran-Ferguson Act. That act provides that the “business of insurance” is not subject to the antitrust laws so long as that “business” is regulated by state law. Removing that exemption would make antitrust law even more central in determining the course of health care reform by exposing all insurance companies’ price-setting functions to antitrust scrutiny.

**Implied repeal.** When a newer federal statute conflicts with the directives of the antitrust laws, courts occasionally have held that the later statute impliedly repealed the antitrust laws to the minimum extent necessary to give effect to the newer law.\(^{26}\) Courts disfavor implied repeal of the antitrust laws, however, and infer it only when the newer law is clearly repugnant to the antitrust laws.\(^{27}\) In the health context, for example, implied repeal might result from reform legislation that, without express reference to the antitrust laws, required alliances or plans to undertake collective activities in ways that violate the antitrust laws. Given the level of debate about antitrust and health, it seems unlikely that Congress will create a conflict with antitrust law that would result in an implied repeal, rather than expressly identifying the scope of any intended immunity.

**State action immunity.** When a state in its sovereign capacity (usually through legislation) clearly articulates and affirmatively expresses an intent to displace competition with regulation in a particular field and actively supervises collective activity delegated to private parties, those regulatory actions are immune from the antitrust laws.\(^{28}\) At least eighteen states have passed legislation seeking to create state action immunity for certain transactions involving health care providers, and several others have legislation pending.\(^{29}\) Many more states are likely to enact similar laws, particularly if federal legislation is delayed well into 1994.

It is not yet clear whether any of these laws actually will supplant the antitrust laws. First, each law involves administrative and practical burdens in dealing with state departments of health and, in some instances, state attorneys general. For example, the Ohio statute permits hospitals to allocate services or equipment with the approval of the state director of health in consultation with the state attorney general, while the Minnesota statute may allow more collaborative activities but also imposes a more complex administrative system involving public notice and comment procedures.\(^{30}\) Second, each state scheme must pass muster under the Supreme Court’s
decision in *FTC v. Ticor*, which allows immunity to attach only to activities that are subject to active, substantive state supervision.\(^3\) If a state inadequately supervises practices that are otherwise anticompetitive, those practices will not be immune from the antitrust laws, and the participants could be enjoined or might have to pay civil penalties or treble damages.

Almost all of the states with these laws require transactions to be submitted to and approved by a state agency that uses some form of rule-of-reason analysis to determine whether the benefits of the transaction outweigh its anticompetitive aspects.\(^3\) It is unclear whether such one-time approval of a transaction suffices to confer state action immunity, or whether the courts will withhold immunity unless the state engages in continuing supervision; some states now compel participants to submit periodic reports on the achievement of the purported goals of a transaction and require review of those reports by a state agency.\(^3\)

Health alliances under the Clinton plan may receive state action immunity if they take the form of state agencies created by state law. If the relevant state law clearly articulates a policy to supplant competition, those entities and their activities could be immune from the antitrust laws under the state action doctrine; “active supervision” is not required when the economic actor is a state agency rather than a regulated private party.\(^3\)

One of Congress’s most important challenges will be to harmonize federal health care reform with state reform efforts. These efforts have taken a variety of forms, from the highly regulatory schemes in New York and Maryland to Florida’s managed competition approach. These diverse reform efforts, coupled with attempts to create state action immunity, may well undermine federal reform efforts and supplant competition. Although Congress can try to prevent the states from undercutting the role of competition in implementing health care reform by legislative preemption, deference to principles of federalism is likely to restrain such efforts.\(^3\) The state/federal balance will be the critical factor to watch as reform unfolds; the states are likely to become the most significant players in shaping the future role of antitrust enforcement in a reformed health care system.

**Conclusion**

Antitrust law has played an important role in promoting competition in the health care industry and in helping consumers derive the full benefit of a health care system that is more responsive to their needs. Competition has always been a catalyst for innovation, which in many ways is at the heart of health care reform. The new entities created by reform will bring together providers in ways that have not been tried before, in an attempt to develop creative methods of delivering health care to more people more
efficiently than ever before. Consumers also should become more accountable for the cost consequences of their health care decisions. These features of health care reform should generate further competition and innovation.

The antitrust laws are uniquely suited to promote the same goals, while preventing the newly created organizations from being exploited as vehicles for collusive and exclusionary activity, which is detrimental to consumers. The challenge for all participants in the reform effort will be to harmonize policy considerations with an understanding of the practical mechanics of the reformed health care system and to tailor antitrust enforcement to the promotion of consumer welfare.

NOTES

2. In addition to a selection of health plans, alliances will have to offer some form of fee-for-service coverage to consumers.
3. Under community rating, plans will have to offer coverage at a single premium to persons in the same area irrespective of age and health status.
4. Health Security Act, S. 1757, 103d Cong., 1st Sess., Section 1311 (1993). Some individuals or married couples with multiple employers may be eligible for coverage through both corporate and regional alliances and may be able to choose their alliance. Health Security Act, Section 1013.
5. Monopsony power is the power held by a dominant buyer to depress prices and exclude competing buyers; it is the purchasing-side analogue to monopoly power.
7. The same antitrust analysis would apply to a horizontal combination between a regional alliance and a corporate alliance, or between competing corporate alliances.
12. Health Security Act, Section 1322(c).


15. See United States v. Alston, 974 F.2d 1206 (9th Cir. 1992).

16. Health Security Act, Section 1322(c).


24. Department of Justice and FTC, Antitrust Enforcement in the Health Care Area, at 4-7 (hospital mergers) and 8-17 (high-technology joint ventures).


27. Ibid., at 388-393.


29. States that have enacted legislation include California, Colorado, Florida, Georgia, Iowa, Kansas, Maine, Minnesota, Montana, North Carolina, North Dakota, Ohio, Oregon, Tennessee, Texas, Vermont, Washington, and Wisconsin. Laws are pending in Illinois, Massachusetts, Michigan, and New York.


32. See, for example, N.D. Cent. Code, Section 23-17.5-03.

33. See, for example, 1993 Or. Laws 769.


35. By contrast, the Health Security Act preempts state laws that would prevent certain exclusive dealing arrangements and other potentially anticompetitive actions by plans (Section 1407) but is silent on the states’ prerogatives to afford plans and providers state action immunity from the federal antitrust laws.