

COMMENTS

Active Supervision of Health Care Cooperative Ventures Seeking State Action Antitrust Immunity

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I. INTRODUCTION

Suffering the greatest crisis¹ in its history, the American health care delivery system is awash with reform efforts. The federal government and many states are trying to balance individuals' needs with the demands of divergent interest groups, while at the same time alleviating the horrific complexity of the current health system.²

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1. For a framework describing the problems facing the United States' health delivery system, see the N.Y. TIMES five-part series, *The Price of Health* (Tamar Lewin, *High Medical Costs Hurt Growing Numbers in U.S.*, N.Y. TIMES, Apr. 28, 1991, at A1; Andrew Pollack, *Medical Technology 'Arms Race' Adds Billions to the Nation's Bills*, N.Y. TIMES, Apr. 29, 1991, at A1; Elisabeth Rosenthal, *In Canada, a Government System That Provides Health Care to All*, N.Y. TIMES, Apr. 30, 1991, at A1; Louis Uchitelle, *Insurance Linked to Jobs: System Showing Its Age*, N.Y. TIMES, May 1, 1991, at A1; Erik Eckholm, *Rescuing Health Care*, N.Y. TIMES, May 2, 1991, at A1). For a statistical review of the state of health care in the United States, see SYSTEM IN CRISIS: THE CASE FOR HEALTH CARE REFORM (Robert J. Blendon & Jennifer Edwards eds., 1991). Indicative of the crisis is the fact that at least 34 million Americans are without health care coverage, many of whom are working. See PETER RIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADVANCE DATA NO. 201, CHARACTERISTICS OF PERSONS WITH AND WITHOUT HEALTH CARE COVERAGE: UNITED STATES, 1989, at 1 (June 18, 1991). Rising costs are also straining business. See Milt Freudenheim, *Health Care A Growing Burden*, N.Y. TIMES, Jan. 29, 1991, at C1 (citing Foster Higgins & Co. survey's finding of a 17.1% increase in health care coverage costs to \$3,217 per employee in 1990).

2. Erik Eckholm, *Rescuing Health Care*, N.Y. TIMES, May 2, 1991, at A1. For a simple and clear framing of the issue and alternative solutions, see Edmund Faltermayer, *Let's Really Cure the Health System*, FORTUNE, Mar. 23, 1992, at 46, 50.

Despite political setbacks at the national level,³ a new model of health delivery is likely to take shape with or without government leadership.

Preferred by President Clinton⁴ and some states, the "managed competition" model⁵ has risen to the surface as a popular alternative. Regardless of its particular form, managed competition contemplates large purchasing cooperatives (large businesses or consumer collectives) and large competing provider organizations (sponsored by insurance companies, hospitals, or doctors).⁶ In theory, encouraging larger buyers and sellers with market power through a managed competition model will compensate for competitive distortions inherent in our current system.⁷ Of course, federal antitrust policy, which is designed

3. President Clinton's American Health Security Act or any major compromise version of health care reform failed to win passage in Congress before the 103d Congress adjourned.

4. H.R. 3600, 103d Cong., 1st Sess. (1993). See also Neal Baker, *Health Care Reform: Summary of the Clinton Administration's Health Reform Plan*, 26 J. HEALTH & HOSP. L. 289 (1993).

5. ALAIN C. ENTHOVEN, THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE (1988) [hereinafter ENTHOVEN, MANAGED COMPETITION]. See also Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1 (1994); John K. Iglehart, *Health Policy Report: Managed Competition*, 328 NEW ENG. J. MED. 1209 (1993); Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 24 [hereinafter Enthoven, *Principles of Managed Competition*]; Alain C. Enthoven, *Managed Competition: An Agenda for Action*, HEALTH AFF., Summer 1988, at 25; Alain C. Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy* (pts. 1 & 2), 320 NEW ENG. J. MED. 29 (1989) [hereinafter Enthoven & Kronick, *Consumer-Choice*, pt. 1], 320 NEW ENG. J. MED. 94 (1989) [hereinafter Enthoven & Kronick, *Consumer-Choice*, pt. 2]; Victor R. Fuchs, *The "Competition Revolution" in Health Care*, HEALTH AFF., Summer 1988, at 5.

6. "[T]he concept of competition that can achieve a reasonable degree of efficiency and equity is *managed* competition, in which there are intelligent active collective agents on the demand side, which [Enthoven] call[s] sponsors, who contract with the competing health care plans and continuously structure and adjust the market to overcome its tendencies to failure." ENTHOVEN, MANAGED COMPETITION, *supra* note 5, at 82.

7. *Id.*

The principles of [our current noncompetitive] system and their economic consequences are as follows: (1) Free choice of doctor by the patient, which means that the insurer has no bargaining power with the doctor; (2) free choice of prescription by the doctor, which prevents the insurer from applying quality assurance or review of appropriateness; (3) direct negotiation between doctor and patient regarding fees, which excludes the third-party payer, who would like to have information, bargaining power, and an incentive to negotiate to hold down fees; (4) fee-for-service payment, which allows physicians maximum control over their incomes by increasing services provided; and (5) solo practice, because multispecialty group practice constitutes a break in the seamless web of mutual coercion through control of referrals that the medical profession has used to enforce the guild system.

Enthoven, *Principles of Managed Competition*, *supra* note 5, at 25.

to encourage competition,⁸ is potentially at odds with the anticompetitive effect of fewer market participants through consolidation.⁹ In tacit admission of the reform model's anticompetitive effects, some reform proposals rely on immunity from federal antitrust laws.¹⁰ Other than a Congressional exemption, the only immunizing theory that is feasible is the state action doctrine.¹¹

The judicially-created state action doctrine allows immunity from federal antitrust laws on the principle that Congress did not intend to interfere with states' regulatory programs when it created the antitrust laws.¹² Some states have tried explicitly to exempt their health reform programs from federal antitrust laws, even stating in their statutes that they intend to take advantage of state action immunity.¹³ Since first recognizing the state action doctrine fifty years ago,¹⁴ the Supreme Court has refined the requirements.¹⁵ Following a recent Court decision of *Ticor*, states should now pay special attention to a requirement that state-authorized anticompetitive programs be "actively supervised."¹⁶ To qualify for active supervision, a state must create and maintain a legitimate supervisory program, give its officials sufficient authority over private actors, and participate in private activity through ongoing, substantive review.¹⁷

8. 1 JULIAN O. VON KALINOWSKI, ANTITRUST LAWS AND TRADE REGULATION § 2.01 (1994).

9. One commentator believes that, in general, the federal antitrust laws will not compromise legitimate, pro-competitive cooperative ventures between doctors and hospitals. See Robert J. Enders, *Antitrust Laws: Considerations But Not Barriers to Integration*, HEALTH CARE L. NEWSL., Oct. 1993, at 20. Even so, the commentator recognizes that per se antitrust violations, such as price negotiations and service allocations among competing providers, would require antitrust immunity. *Id.* at 27.

10. Howard Feller, *Healthcare Reform and Antitrust Immunities/Exceptions—Federal and State*, at 9-27 (1994) (unpublished manuscript delivered at Nat'l Health Lawyers Ass'n conference "Antitrust in the Healthcare Field," on file with the *Seattle University Law Review*) (reviewing state legislation in Colorado, Florida, Kansas, Maine, Minnesota, Montana, North Carolina, North Dakota, Ohio, Tennessee, Texas, Washington, and Wisconsin, which rely on antitrust immunity in health reform).

11. For a general background of the state action doctrine, see 6 VON KALINOWSKI, *supra* note 8, §§ 40.01-05 (1994).

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

13. MONT. CODE ANN. §§ 50-4-601 to -612 (1993) (health care cooperative ventures obtaining certificate of public advantage shall have state action immunity); N.C. GEN. STAT. § 131E-1923 (1994) (state legislature intends immunity from federal antitrust laws); WASH. REV. CODE §§ 43.72.300-.310 (1994) (establishing legislative intent and procedures for obtaining state action immunity).

14. *Parker*, 317 U.S. at 350-52.

15. See *FTC v. Ticor Title Ins. Co.*, 112 S. Ct. 2169 (1992); *Patrick v. Burget*, 486 U.S. 94 (1988); *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

16. *Ticor*, 112 S. Ct. at 2177-80.

17. *Id.*

The Washington Health Services Act of 1993¹⁸ statutorily satisfies the requirements for state action immunity, but regulations promulgated to implement it must conform with the currently vague judicial standards for active supervision. Because the managed competition approach to health reform depends on antitrust immunity, reform initiatives would stall if, as a result of uncertain effectiveness of the state reform laws, private actors hesitate to embrace reform opportunities out of fear of potential federal antitrust action.

Parts I and II of this Comment review the foundations of the state action doctrine and focus on the development of statutory and regulatory requirements of active supervision. Next, Part III discusses the two primary components of active supervision, control and involvement, in light of the current status of state action immunity. Part IV then examines Washington State's managed competition-based reform plan as an example of an attempt to secure state action immunity for private actors. Part IV also describes the Washington state action antitrust immunity provision in some detail. Finally, Part V provides a case illustration for effective state action immunity, including suggestions for attributes of active supervision necessary to ensure immunity.

II. THE STATE ACTION DOCTRINE: IMMUNITY FROM FEDERAL ANTITRUST LAWS

The state action doctrine was first fully developed in *Parker v. Brown*,¹⁹ although several earlier cases suggested that Congress did not intend to interfere with state regulatory programs through the federal antitrust laws.²⁰ In *Parker*, the Court grounded antitrust immunity for state actors on principles of federalism.²¹ The Court reasoned that under both a facial reading of the statute and the

18. Washington Health Services Act of 1993, ch. 492, 1993 Wash. Laws 2070. This Comment refers to this legislation by the title suggested within the Act itself. See ch. 492, § 487, 1993 Wash. Laws 2209.

19. 317 U.S. 341 (1943). *Parker* involved an antitrust challenge by a raisin producer and packer against a state-sponsored raisin marketing program. *Id.* at 344. Raisin Proration Zone No. 1 was created pursuant to a California law which was intended "to restrict competition among the growers and maintain prices in the distribution of their commodities to packers," and to "prevent economic waste in the marketing of agricultural products" in the state. *Id.* at 346.

20. 6 VON KALINOWSKI, *supra* note 8, § 40.02 n.1; James F. Ponsoldt, *Immunity Doctrine, Efficiency Promotion, and the Applicability of Federal Antitrust Law to State-Approved Hospital Acquisitions*, 12 J. CORP. L. 37 (1986).

21. "In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly attributed to Congress." *Parker*, 317 U.S. at 351; see also *Midcal*, 445 U.S. at 104.

legislative history of the Sherman Act,²² Congress did not intend the antitrust laws to restrain state efforts to regulate trade. Thus, federal antitrust laws were not intended by Congress to interfere with state actions if "[t]he state itself exercises its legislative authority in making the regulation and in prescribing the conditions of its application."²³

Recently, the Court reinforced the principle that state actions should be immunized from federal antitrust laws, stating that "[i]mmunity is conferred out of respect for ongoing regulation by the State, not out of respect for the economics of price restraint."²⁴ However, the economic justification for the state action doctrine has been widely debated in academic circles.²⁵

For several decades after *Parker*, development of state action immunity by the Court lapsed.²⁶ In 1980, however, in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*,²⁷ the Court developed a definitive two-prong test. To qualify for immunity from federal antitrust laws, a state must (1) articulate a clear and affirmative policy to displace competition with regulation, and (2) provide active supervision of immunized conduct undertaken by private actors.²⁸

Controversy over the "clear and affirmative policy" prong of the test has been limited, and the Court has focused on the "active

22. 15 U.S.C. §§ 1-7 (1988).

23. *Parker*, 317 U.S. at 352 (emphasis added).

24. *Ticor*, 112 S. Ct. at 2177.

25. See, e.g., John S. Wiley, *A Capture Theory of Antitrust Federalism*, 99 HARV. L. REV. 713 (1986); Frank H. Easterbrook, *Forward: The Court and the Economic System*, 98 HARV. L. REV. 4 (1984); John Cirace, *An Economic Analysis of the "State-Municipal Action" Antitrust Cases*, 61 TEX. L. REV. 481 (1982); cf. Merrick B. Garland, *Antitrust and State Action: Economic Efficiency and the Political Process*, 96 YALE L.J. 486 (1986) (arguing that revisionist analysis of state action doctrine is wrong on descriptive and prescriptive levels).

26. *Cine 42nd St. Theatre Corp. v. Nederlander Org., Inc.*, 790 F.2d 1032, 1040 (2d Cir. 1985). See also William H. Page, *State Action and "Active Supervision": An Antitrust Anomaly*, 35 ANTITRUST BULL. 745, 748 (1990).

27. 445 U.S. 97 (1980). In *Midcal*, California required all wine producers, wholesalers, and rectifiers to file either a fair trade contract or a resale price schedule with the state. *Id.* at 99. The pricing program standardized prices for each brand within each of three trading areas. *Id.* Wine producers or wholesalers who refused to comply with the established prices could be fined, subjected to private damages suits, or face license suspension or revocation. *Id.* at 100. *Midcal Aluminum*, a wholesaler, was charged with selling twenty-seven cases of wine below the established price schedule price. *Id.* *Midcal* claimed that the state's program violated the Sherman Act, and sought an injunction against the pricing system. *Id.*

28. *Id.* at 105.

supervision" requirement.²⁹ Defining the "active supervision" requirement, however, has proven to be problematic.

To fulfill the requirements of active supervision, the second prong has been narrowly construed to ensure that actions immune from antitrust laws are those which actually further state policies, not those that further solely private interests.³⁰ The active supervision prong is intended to "determine whether the State has exercised sufficient independent judgment and control so that the details of the [anti-competitive activity] have been established as a product of deliberate state intervention, not simply by agreement among private parties."³¹ To satisfy the active supervision requirement, state officials must "have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy."³² Thus, state-sanctioned anticompetitive activities must be approved and supervised as a quasi-official action of the state itself; simple approval of private actions will not suffice.

One commentator believes that in the ten years following *Midcal*, the Court loosened the oversight requirements and made state action immunity easier to obtain.³³ Recently, however, in *FTC v. Ticor Title Insurance Co.*, the Court stated that the state must play a "substantial role in determining the specifics of the economic policy" to ensure state action immunity.³⁴ A state scheme that provides for the *potential* to actively supervise possible anticompetitive activity is insufficient; supervision must include actual involvement and decisions by the

29. Sarah S. Vance, *Immunity for State-Sanctioned Provider Collaboration After Ticor*, 62 ANTITRUST L.J. 409, 421-23 (1994). See *Midcal*, 445 U.S. at 105 (stating that the Court was satisfied with articulation of policy stating only that "[t]he legislative policy is forthrightly stated and clear in its purpose to permit [the immunized program]."); *Patrick*, 486 U.S. at 100 ("In this case, we need not consider the 'clear articulation' prong of the *Midcal* test, because the 'active supervision' requirement is not satisfied."); *North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, 740 F.2d 274, 277 (4th Cir. 1984). For an example of analysis under the clear articulation prong, see *Hass v. Oregon State Bar*, 883 F.2d 1453, 1457-59 (9th Cir. 1989).

30. *Patrick*, 486 U.S. at 100-01.

31. *Ticor*, 112 S. Ct. at 2177. For a sharp criticism of the active supervision requirement, see Page, *supra* note 26 (arguing active supervision is inconsistent with policies of state action doctrine); see also William H. Page, *Antitrust, Federalism, and the Regulatory Process: A Reconstruction and Critique of the State Action Exemption After Midcal Aluminum*, 61 B.U. L. REV. 1099 (1981).

32. *Patrick*, 486 U.S. at 101.

33. Richard Quaresima, *State Action Doctrine: State Agencies Exempt from the Active Supervision Prong of the Midcal Test*, 22 RUTGERS L.J. 525, 530 (1991).

34. *Ticor*, 112 S. Ct. at 2177.

state.³⁵ *Ticor* arguably signals increasing scrutiny of state attempts to shield entities from federal antitrust prohibitions.³⁶

In summary, courts require "true state regulation" as compared to "mere state authorization" before allowing immunity from federal antitrust laws.³⁷ If the important economic and social goals of federal antitrust laws, such as competitive markets and access to goods and services, are to be set aside by states, then it is reasonable to require that states be vigilant in their oversight of authorized schemes or ventures. The two most important attributes of oversight are control and involvement, which are discussed in Part III.

III. ACTIVE SUPERVISION REQUIREMENTS

Although there is a well-developed line of cases discussing state action immunity questions, the Supreme Court has not expressly adopted criteria for the second of the two *Midcal* requirements, active supervision. However, two elements may increase the likelihood of a court's approval of state-sanctioned, privately-administered operations, control and involvement.³⁸

A. Control

Fundamentally, the state must exercise "ultimate control" over authorized anticompetitive conduct.³⁹ In *Patrick v. Burget*, a case in which a peer review program was challenged as anticompetitive, ultimate control consisted of the statutory power (1) to review decisions made by the private entities, and (2) to overturn them if they do not adhere to state policy.⁴⁰ Because the state lacked the necessary statutory power to review private decisions and withdraw approval if necessary, the peer review program did not satisfy the active supervision prong.⁴¹

Further, while not expressly reaching the question of what amount of state supervision would be adequate, the Court held that the state judiciary's availability to review decisions made by a private, state-

35. *Id.* at 2179.

36. Vance, *supra* note 29, at 417.

37. Garland, *supra* note 25, at 501.

38. Theodore N. McDowell & J. Marbury Rainer, *The State Action Doctrine and the Local Government Antitrust Act: The Restructured Public Hospital Model*, 14 AM. J.L. & MED. 171, 202 (1988).

39. *Patrick*, 486 U.S. at 101; see also *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 51 (1985).

40. *Patrick*, 486 U.S. at 102.

41. *Id.* at 102-03.

authorized board was insufficient supervision to satisfy the state action doctrine.⁴² Although stopping short of holding that judicial review could never satisfy active supervision requirements, the Court stated that the haziness of Oregon law providing for judicial review of peer review decisions⁴³ and the limited nature of judicial review in Oregon⁴⁴ indicated that judicial review did not satisfy active supervision in this case.

Thus, by implication the control requirement for active supervision contemplates a state program which has continuing, tangible state participation in the activities of private actors. Neither potential state involvement nor the substitution of the judiciary for regulatory involvement is enough. To ensure immunity, state regulators necessarily must have, and must exercise, the authority to control private activity.

B. Involvement

The other component of active supervision is state involvement in private activities. When formulating the *Midcal* test, the Court's primary consideration was "whether the State's involvement . . . [was] sufficient to establish anti-trust immunity under *Parker v. Brown*."⁴⁵ Thus, without involvement by state regulators, the active supervision element cannot be met.

For example, in *Ticor*, a "negative-option" scheme⁴⁶ for approval of private rate setting was held to be insufficient for active supervision.⁴⁷ Holding that a five-part test applied by the First⁴⁸ and Third⁴⁹ Circuit Courts was inadequate, the Supreme Court required

42. *Id.* at 103-05. For a discussion of judicial review as an element of active supervision, see Note, *Judicial Review as Midcal Active Supervision: Immunizing Private Parties from Antitrust Liability*, 57 FORDHAM L. REV. 403 (1988).

43. "[W]e are aware of no case in which an Oregon court has held that judicial review of peer-review decisions is available." *Patrick*, 486 U.S. at 104.

44. *E.g.*, "[I]t would be unwise for a court to do more than to make sure that some sort of reasonable procedure was afforded" *Id.* at 104-05 (quoting *Straube v. Emanuel Lutheran Charity Bd.*, 287 Or. 375, 384, 600 P.2d 381, 386 (1979)).

45. *Midcal*, 445 U.S. at 103.

46. In a negative-option scheme, jointly established rates or other suspect actions are submitted to a state regulatory body; the regulatory body then has a defined length of time in which to respond to the proposal. If the body does not respond within the prescribed response period, then the proposal automatically goes into effect. *Ticor*, 112 S. Ct. at 2174.

47. *Id.* at 2179-80.

48. *Ticor Title Ins. Co. v. FTC*, 922 F.2d 1122, 1136 (3d Cir. 1991), *rev'd*, 112 S. Ct. 2169 (1992).

49. *New England Motor Rate Bureau, Inc. v. FTC*, 908 F.2d 1064, 1071 (1st Cir. 1990).

"active supervision in fact."⁵⁰ Upon review, the Supreme Court found the circuit courts' test to be theoretically consistent with precedent;⁵¹ however, because mere potential state supervision could satisfy the five-part test, the test failed to ensure that the requisite supervision actually occurred.⁵²

Nonetheless, the test applied by the circuit courts is instructive because it signals the elements for partial fulfillment of the active supervision requirement.⁵³ Specifically, the test would approve a state's program if it:

[1] is in place, [2] is staffed and funded, [3] grants to the state officials ample power and the duty to regulate pursuant to declared standards of state policy, [4] is enforceable in the state courts, and [5] demonstrates some basic level of activity directed towards seeing that the private actors carry out the state's policy and not simply [the private actor's] own policy⁵⁴

The Supreme Court affirmed the standard as a "beginning point," but held that the Circuit courts' threshold for active supervision, the "basic level of activity," was too low, and required greater state involvement.⁵⁵ Thus, although insufficient in and of itself, the Circuit court's test provides a framework under which a preliminary analysis can be conducted.

The five-part test's deficiency could be the absence of a threshold for intensity of a state's monitoring activity after a private program is initially approved. For example, finding that California did not monitor market conditions or conduct a "pointed reexamination" of the approved program, the Court held in *Midcal* that the state failed to attain the minimum involvement necessary for active supervision.⁵⁶ Similarly, in *North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, North Carolina authorized an acquisition of a psychiatric hospital under a certificate of need program.⁵⁷ The Fourth Circuit decided that because the state did not monitor the conduct of the parties after

50. *Ticor*, 112 S. Ct. at 2179.

51. *Id.*

52. *Id.*

53. "The criteria set forth by the First Circuit may have some relevance as the beginning point of the active supervision inquiry, but the analysis cannot end there The mere potential for state supervision is not an adequate substitute for a decision by the State." *Id.*

54. *Id.* (quoting *Ticor*, 922 F.2d at 1136).

55. *Ticor*, 112 S. Ct. at 2179.

56. *Midcal*, 445 U.S. at 105-06.

57. 740 F.2d 274, 274 (4th Cir. 1984).

the acquisition, there was "no active supervision at all," and therefore, no antitrust immunity.⁵⁸

Thus, the active supervision prong's involvement criteria contemplate affirmative approval by the state. Approving a program that qualifies for *Parker* immunity must be more than a routine process; careful and deliberate approval, coupled with adequate depth of research, is required. Finally, continuing supervision of the approved activity is crucial. States attempting to grant immunity to private parties must be able to assert sufficient control over the activity and must remain sufficiently involved with the activity following initial approval in order to ensure that the state is an active participant. Despite the stringent requirements for effective immunity, to encourage health care reform many states are attempting to shield health care providers from federal antitrust laws.

IV. CURRENT STATE ATTEMPTS TO ALLOW PRIVATE ANTICOMPETITIVE ACTIVITY PURSUANT TO STATE HEALTH REFORM POLICY

Realizing that state residents are suffering from the malaise of the health delivery system, several states⁵⁹ are formulating reform measures designed to increase access, contain costs, and maintain or improve quality.⁶⁰ Some of these state reform plans reflect a belief

58. *Id.* at 278-79.

59. While federal health reform legislation is not the focus of this Comment, many members of Congress have recognized the tension between federal antitrust laws and health reform, and have introduced measures to grant immunity. See American Health Security Act of 1993, H.R. 3600, 103d Cong., 2d Sess. (1993); Managed Competition Act of 1993, H.R. 3222, 103d Cong., 2d Sess., and S. 1579, 103d Cong., 1st Sess. (1993); Health Care Antitrust Improvements Act of 1993, H.R. 3486, 103d Cong., 2d Sess., and S. 1658, 103d Cong., 1st Sess. (1993); Antitrust Exemption for Medical Self-Regulatory Agencies, H.R. 47, 103d Cong., 1st Sess. (1993); Hospital Cooperative Agreement Act, H.R. 286 and S. 493, 103d Cong., 1st Sess. (1993); Hospital Antitrust Fairness Act, H.R. 1765, 103d Cong., 1st Sess. (1993); Health Care Cooperative Antitrust Protection Act of 1993, H.R. 2640, 103d Cong., 1st Sess. (1993).

60. States have taken very different approaches to health reform. For example, Oregon extended Medicaid to cover almost all of the state's uninsured, low income residents, but it then reduced the number of health care services for which it would pay. The Oregon system, which has so far failed to obtain necessary waivers from the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461, has been labeled a "rationing" scheme. See generally Howard M. Leichter, *Rationing of Health Care: Oregon Comes Out of the Closet*, in *HEALTH POLICY REFORM IN AMERICA: INNOVATIONS FROM THE STATES* (Howard M. Leichter ed., 1992).

In 1974, Hawaii mandated universal health insurance coverage. See HAW. REV. STAT. §§ 393-01 to 393-51 (1994). Employers must provide health insurance for all employees not subject to a collective bargaining agreement, although employees share in the cost. More recently, a program was created to allow Hawaiians who are not employed to enroll in a state-sponsored health insurance plan. Premiums are subsidized by the state so that anyone below 300% of the poverty level who does not qualify for another federal medical program can qualify. The program

that antitrust curbs on anticompetitive behavior will stall health reform.⁶¹ Therefore, some state plans, especially those explicitly following a managed competition model, rely on government intervention in the marketplace in the form of market incentives or regulations.⁶²

A. Managed Competition

Some state plans⁶³ and the failed Clinton national health reform plan⁶⁴ follow the "managed competition" model.⁶⁵ As a partial remedy for misplaced economic incentives,⁶⁶ managed competition models encourage, through government regulation and example, large groups of health care buyers and sellers.⁶⁷

Managed competition attempts to bring the buyers and sellers into closer proximity, to allow them a better opportunity to negotiate, and therefore, to create a more competitive market.⁶⁸ Primarily, this is accomplished by implementing state-sponsored or state-encouraged purchasing cooperatives. Members of purchasing cooperatives will be the state (e.g., health coverage for state employees, Medicaid, Medicare), currently uninsured individuals not qualifying for state assistance, small businesses, and midsized businesses.⁶⁹ While competing to offer the most attractive health packages to these large cooperative buying groups, health care providers will either vertically or horizontal-

relies heavily on preventive care. See generally Deane Neubauer, *Hawaii: The Health State*, in *HEALTH POLICY REFORM IN AMERICA: INNOVATIONS FROM THE STATES* (Howard M. Leichter ed., 1992).

Washington's health reform plan is probably the purest adoption of managed competition principles. See Washington Health Services Act of 1993, ch. 492, § 447, 1993 Wash. Laws 2070, 2181-82, (codified at WASH. REV. CODE § 43.72.300 (1994)).

61. See Feller, *supra* note 10, at 1.

62. *Id.*

63. See, e.g., WASH. REV. CODE § 43.72.300(1) (1994).

64. President Clinton's proposal also is based on managed competition principals. See Health Security Act, H.R. 3600, 103d Cong., 1st Sess. (1993). For a concise review of President Clinton's health reform proposal and a comparison to other proposals, see Baker, *supra* note 4; see also Hilary Stout & Rick Wartzman, *Clinton's Health-Care Bill is Delivered to Congress*, WALL ST. J., Oct. 28, 1993, at A3.

65. See generally ENTHOVEN, *MANAGED COMPETITION*, *supra* note 5; Hall, *supra* note 5.

66. "For the most part, there is no incentive [in the United States health care economy] to find and use medical practices that produce the same health outcome at less cost." Enthoven & Kronick, *Consumer-Choice*, pt. 1, *supra* note 5, at 29.

67. In Professor Enthoven's terminology, government-created "public sponsor" agencies for the uninsured and for small businesses would perform the health care contracting activities performed by large employers. *Id.* at 31.

68. Enthoven, *Principles of Managed Competition*, *supra* note 5, at 29-35.

69. Enthoven & Kronick, *Consumer-Choice* pt. 1, *supra* note 5, at 31-32.

ly integrate to form larger groups themselves.⁷⁰ By directly negotiating with each other on price, quality standards, and access guarantees, these large groups will bring competition to the health care market.⁷¹

In addition, consumers do not have the ability or the incentive⁷² to make the choices necessary to allow efficient operation of a competitive free market.⁷³ Because the party most sensitive to price (i.e. the payer, such as the government or private insurer) is removed from the point-of-purchase buyer (i.e., the treating physician or patient), economic incentives are distorted.⁷⁴ Physicians and patients make "purchase" decisions knowing that someone else will pick up the tab and, in practical terms, patients have little power to intervene before purchase decisions are made.

This reform model raises questions about the anticompetitive effects of both purchasing cooperatives and larger delivery networks. Under traditional antitrust analysis, larger purchaser and provider entities appear to be anticompetitive because they decrease the number of competitors in the marketplace, allow competitors to share key data, and create a monopolistic potential. Despite the apparent anticompetitive effects, many states are explicitly attempting to grant immunity from federal antitrust laws in order to accomplish their important goal of health care cost containment. Washington State's health reform plan incorporates many of the managed competition ideals, and attempts to grant antitrust immunity.

B. Washington State Health Care Reform and Antitrust Immunity

The boldest attempt to incorporate state action immunity into health reform legislation is the Washington Health Services Act of 1993.⁷⁵ The sections granting limited antitrust immunity were drafted

70. *Id.* at 31.

71. "There is good reason to believe that competition to serve cost-conscious purchasers could motivate cost-reducing innovation and slow the growth of health care spending." *Id.*

72. "Cost consciousness" is a cornerstone of the consumer-choice health plan. Enthoven & Kronick, *Consumer-Choice* pt. 1, *supra* note 5, at 29, 33.

73. See Fuchs, *supra* note 5, at 6-9; ENTHOVEN, MANAGED COMPETITION, *supra* note 5, at 12 ("[The health insurance and health care] markets are not naturally competitive.")

74. "[S]ick, non-expert patients and their families are in a particularly poor position to make wise decisions about long lists of individual services they might or might not need. They need to rely on their doctors to advise what services are appropriate and on their health plans to get good prices. For economical behavior to occur, doctors must be motivated to prescribe economically." Enthoven, *Principles of Managed Competition*, *supra* note 5, at 29.

75. See Washington Health Service Act of 1993, ch. 492, §§ 447-48, 1993 Wash. Laws 2070, 2181-84 (codified at WASH. REV. CODE §§ 43.72.300-.310 (1994)).

with the *Midcal* two-prong test⁷⁶ in mind.⁷⁷

The first *Midcal* prong requires that the state articulate a clear and affirmative policy to allow the anticompetitive conduct.⁷⁸ To satisfy this requirement, the Washington Act sets out at length the policy reasons for providing limited immunity.⁷⁹ These reasons consider the needs of patients, providers, and insurers. To ensure that the state policy is clear, the Act also states that the legislature "intends to exempt from state anti-trust laws, and to provide immunity from federal anti-trust laws through the state action doctrine for activities approved under this chapter"⁸⁰ This subsection then enumerates the many reasons for the state policy, including cost containment, universal access, and risk sharing.⁸¹

The Act excludes per se violations of federal and state antitrust laws, such as conspiracies to fix prices, allocate markets, and exclude competitors, from authorization unless explicitly permitted by the state.⁸² This exclusion may signal the state's intention to monitor serious anticompetitive activities more closely than less serious threats to competition.

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

77. Interview with John S. Conniff, Washington State Deputy Insurance Commissioner, Health Insurance Reform, in Tacoma, Wash. (Nov. 4, 1993). Mr. Conniff was Special Counsel to the Health Care Committee of the Washington State House of Representatives at the time the Act was drafted and passed.

78. See *supra* note 29 and accompanying text.

79. [T]he legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

WASH. REV. CODE § 43.72.300(1) (1994).

80. WASH. REV. CODE § 43.72.300(2) (1994).

81. The relevant language states that the exemption is provided to contain the aggregate cost of health care services; to promote the development of comprehensive, integrated, and cost-effective health care delivery systems through cooperative activities among health care providers and facilities; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure universal access to a publicly determined, uniform package of health benefits; and to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of care, payers of health care services, providers of health care services, health care facilities, and Washington residents. *Id.*

82. WASH. REV. CODE § 43.72.300(3) (1994).

The mechanics of obtaining and maintaining immunity for anticompetitive activities is addressed in section 448 of the Act.⁸³ Upon showing that an activity will fulfill the policy goals outlined in the Act, the Health Services Commission⁸⁴ ("the Commission") may authorize anticompetitive conduct.⁸⁵ A provider or health plan may petition the Commission directly or it may request that the Commission seek an informal opinion from the Attorney General.⁸⁶ In either case, the Commission must consult with the Attorney General, although it is unclear whether it is required to follow the Attorney General's advice.⁸⁷ In making its approval decision, the Commission must consider the benefits offered from allowing the anticompetitive conduct to proceed.⁸⁸ The relevant potential benefits include quality enhancement, cost efficiency improvements, service utilization improvements, and avoidance of administrative duplication.⁸⁹ Conduct authorized by the Commission is to be deemed to be in furtherance of public policy.⁹⁰

Once the Commission has determined that authorization of an anticompetitive activity is warranted, it must actively supervise the activity "to determine whether such conduct or rules permitting certain

83. Washington Health Services Act of 1993, ch. 492, § 448, 1993 Wash. Laws 2070, 2183-84 (codified at WASH. REV. CODE § 43.72.310 (1994)).

84. WASH. REV. CODE §§ 43.72.020-.070 (1994). The Health Services Commission will have broad powers to create and enforce the mandates of the Act, including, among other responsibilities: ensuring access to all Washington residents, designing and implementing the Uniform Benefits Package (a prescribed list of minimum health services that insurers will be allowed to offer to subscribers, *see* WASH. REV. CODE § 43.72.130 (1994)), establishing a yearly community-rated maximum premium for the Uniform Benefits Package, determining medical risk adjustments to offset the effects of adverse selection on providers, assessing technology, certifying health plans, and maintaining health data bases.

85. WASH. REV. CODE § 43.72.310(2)(a) (1994).

86. *Id.* §§ 43.72.310(1), (2).

87. Under WASH. REV. CODE § 43.72.310(1) (1994), an entity seeking antitrust immunity submits a request to the Health Care Commission for an information authorization opinion from the Attorney General. If the entity disagrees with a negative opinion from the Attorney General, it may petition the Commission for approval directly. *Id.* This provision implies that the Commission need not accept the Attorney General's recommendation. *Id.*; *id.* § 43.72.310(3). However, in another subsection, the Commission is permitted to authorize conduct that "could tend to lessen competition" only "[a]fter obtaining the written opinion of the [A]ttorney [G]eneral and consistent with such opinion" WASH. REV. CODE § 43.72.310(2) (1994). The confusion is not helped by subsections (4) and (6), which establish factors for review of anticompetitive conduct and mandate active supervision of authorized conduct, respectively, with the "advice" and "assistance" of the Attorney General. *Id.* §§ 43.72.310(4), (6). Although the review factors and supervision are both mandatory, the language does not suggest mandatory compliance with the Attorney General's advice and assistance.

88. WASH. REV. CODE § 43.72.310(4) (1994).

89. *Id.* § 43.72.310(2).

90. *Id.* § 43.72.310(5).

conduct should be continued and whether a more competitive alternative is practical."⁹¹ The Act mandates annual progress reports, and requires reviews for consistency with the original petition and for a continuing balance in favor of the advantages over the disadvantages.⁹² If the Commission determines that any changes to the cost-benefit analysis have occurred, then it must order a change or a halt to the activity.⁹³

Although other states have also attempted to provide antitrust immunity for health reform activities,⁹⁴ the Washington legislation is the most progressive, and other states may find that their attempts do not grant as broad an immunity as they contemplated.⁹⁵ To ensure that intended immunity is effective, the state must actively supervise in a manner appropriate for the authorized health care activity.

V. SUGGESTED CHARACTERISTICS OF RULES PROMULGATED TO ENSURE "ACTIVE SUPERVISION" IN THE HEALTH REFORM CONTEXT

As discussed above, some states or private actors may intend that state action immunity applies to shield private actors from federal antitrust laws.⁹⁶ However, the Supreme Court's requirements that a clear state policy be asserted and that the state actively supervise the activity have left some attempts to obtain state action immunity open

91. *Id.* § 43.72.310(6).

92. *Id.*

93. *Id.*

94. See Feller, *supra* note 10; MONT. CODE ANN. § 50-4-101 (1993); N.C. GEN. STAT. § 131E-192.3 (1994); WASH. REV. CODE § 43.72.300-.310 (1994).

95. Kevin E. Grady, *A Framework for Antitrust Analysis of Health Care Joint Ventures*, 61 ANTITRUST L.J. 765, 769 (1993); Vance, *supra* note 29, at 428-29.

For example, the Vermont legislature allowed the Health Care Authority to authorize health care provider bargaining groups to negotiate on behalf of participating providers. However, there is no articulation of the policy served by allowing collective bargaining, nor is there a provision for oversight, state intervention, or rescission of authority. The statute gives authority for rule-making in several areas, but does not direct the Health Care Authority to actively supervise authorized anticompetitive activities. See VT. STAT. ANN. tit. 18, § 9409(a) (Butterworth Supp. 1994).

Under the Ohio scheme, following a request for approval of "cooperative action," there is no requirement for active supervision. Instead, the director of health "may request written updates," although neither the interval nor contents are specified. Also, the Attorney General is to review any requests made to the Director of Health for antitrust concerns. If the Attorney General does not respond within thirty days, then the request is deemed approved. OHIO REV. CODE ANN. §§ 3727.21, .22 (Anderson Supp. 1993).

96. See Feller, *supra* note 10, at 9-27; Vance, *supra* note 29, at 420-30.

to successful anticompetitive challenges.⁹⁷ Often, the state's policy is sufficiently clear, and therefore the first prong of the test is met, but the state has not done enough to demonstrate "deliberate state intervention."⁹⁸ Thus, it is of critical importance which supervisory activities are "active" enough to satisfy the second *Midcal* prong.

A. *Active Supervision and Antitrust Immunity in the Washington Health Services Act of 1993*

The State of Washington's Health Services Act unequivocally attempts to obtain state action immunity for health care providers operating under the authority of the Health Services Commission.⁹⁹ The Washington Health Services Act proclaims that its intention is to immunize under the state action doctrine anticompetitive activities that meet the state's public policy objectives.¹⁰⁰

Given the relative lack of controversy over the first prong of the *Midcal* test, the prong appears to be satisfied by the recitation of Washington's policy objectives in the Act.¹⁰¹ The policy goals enumerated in the section—cost containment, universal access, and risk sharing—are legitimate objectives given the state of health care delivery. The clarity with which they are articulated in the statute lends credence to the legislature's intention to base immunity on state goals. Also, deeming any conduct authorized by the Commission as "in furtherance of the state's public purposes"¹⁰² demonstrates the legislature's awareness and approval of Commission regulation of anticompetitive activities. In all, the statute's clear and legitimate goals should satisfy the first *Midcal* prong.

The second requirement, active supervision, is not as easy to satisfy. Active supervision has both a statutory and a regulatory aspect: Not only must the statute be written so it passes a *prima facie* examination by the courts, but also the regulations developed by the Health Services Commission and implemented by the Commission's bureaucracy must also survive scrutiny.

First, the statutory provisions of the Act establish adequate authority for state regulatory bodies to supervise private activities in conformance with state action immunity standards as established by

97. David L. Mayer & Charles F. Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 209 (1994).

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

99. See *supra* notes 75-95 and accompanying text.

100. WASH. REV. CODE § 43.72.300(2) (1994).

101. *Id.*

102. *Id.* § 43.72.310(5).

the United States Supreme Court in *Midcal*, *Patrick*, and *Ticor*. For instance, the mandatory consultation with the Attorney General,¹⁰³ the official charged with enforcing antitrust laws, allows for an initial second opinion on the effect the activity will have on competition. The second opinion will lend credibility to the Commission's decision on the importance of allowing the activity to improve health care delivery.

The Act also outlines which factors the Commission must use in its evaluation of private parties' applications.¹⁰⁴ The pre-approval cost-benefit analysis requires that the Commission become intimately familiar with the applying organization and its relevant market. Without intimate knowledge of the private actors and the market, active supervision would be nearly impossible.

The Act grants the Commission "ample power," as required in the Circuit courts' five-part test,¹⁰⁵ to grant or withdraw authority for immunity. Under section 448(6), the Commission must order a change in the activity or withdraw its approval if it determines that the anticompetitive effects of the immunity outweigh the benefits. This statutory authority fulfills the *Patrick* requirement that the state exercise ultimate control over authorized anticompetitive activity.¹⁰⁶

Judicial enforceability is not mentioned in the two relevant sections of the Act.¹⁰⁷ Unlike the Oregon peer review program in *Patrick*, the Act does not rely on judicial enforcement for supervision of immunized private activities. Rather than relying on judicial enforcement, the Act legislatively spells out supervision requirements. Legislative enactment is more likely to satisfy the Court's concerns about the availability and limited nature of review by the state's judiciary.¹⁰⁸

Second, the supervisory scheme developed by the Commission under its rulemaking and regulatory powers will be scrutinized separately from the statutory provisions. In its regulations, the Commission must take care to exert adequate on-going control and involvement to ensure effective *Parker* immunity. The Health Services Act has few guidelines for supervision once the activity has been approved,¹⁰⁹ and lack of adequate continuing supervision can be fatal

103. *Id.*

104. See *supra* note 89 and accompanying text.

105. See *supra* notes 48-54 and accompanying text.

106. See *supra* note 39 and accompanying text.

107. WASH. REV. CODE §§ 43.72.300-.310 (1994).

108. *Patrick v. Burget*, 486 U.S. 94, 103-05 (1987).

109. See *supra* notes 91-93 and accompanying text.

to immunity as the defendant title companies learned from the *Ticor* decision.

Because the negative-option scheme in *Ticor* failed to pass the Court's scrutiny, affirmative responses to all applications seem to be required. Unlike the *Ticor* scheme, the Washington law does not incorporate any negative-option provisions. Instead, it mandates annual progress reports and reviews for consistency. Under the Act, if the Commission finds that the parties no longer comply, it *must* revoke or modify their immunity.¹¹⁰

However, because the case law leaves unclear exactly what "basic level of activity" will satisfy the second prong,¹¹¹ the adequacy of the Washington provisions will probably turn on their implementation in regulations and their enforcement. This subject is discussed next.

B. Active Supervision Illustration—A Hospital Merger Case Study

The health care context is undoubtedly unique, and many of the indicators of a competitive market will be unfamiliar to regulators, enforcement bodies, and the courts. A case study illustrating active supervision in a realistic health care setting may be helpful. The following case, while based on an agreement of an actual hospital merger, has not been brought before the Washington Health Services Commission, antitrust immunity has not been granted, nor have either of the hospitals conducted themselves in any way that would bring their activities under scrutiny for violation of antitrust laws. The case is used only as an illustration of the type of situation which is likely to present itself in the future.

Therefore, imagine that the Commission has promulgated supervision guidelines for approved anticompetitive activities that, on their face, meet the requirements discussed above.¹¹² Further imagine that the Settlement Agreement, described below, is an ostensible Grant of Immunity issued by the Commission to Providence Hospital and General Hospital Medical Center, both in Everett,

110. See WASH. REV. CODE § 43.72.310(6) (1994).

111. *Ticor*, 922 F.2d at 1136; see *supra* note 55 and accompanying text.

112. The Washington Health Services Act of 1993 requires that rules on antitrust immunity be promulgated in draft form and sent to the Legislature by December 1, 1994. WASH. REV. CODE § 43.72.030(3) (1994). The Health Services Commission took a dry run at a set of procedural rules, Wash. St. Reg. 94-12-078 (to be codified at WASH. ADMIN. CODE §§ 245-02-100 to -180) (proposed May 31, 1994) and substantive rules, Wash. St. Reg. 94-12-081 (to be codified at WASH. ADMIN. CODE §§ 245-02-101 to -090) (proposed May 31, 1994), but the proposed rules were withdrawn and the hearings canceled. Wash. St. Reg. 94-17-179 (filed August 24, 1994).

Washington, under the authority of section 447 of the Health Services Act.¹¹³

The case¹¹⁴ used here as an illustration developed as follows: In early 1993, Providence Hospital began merger negotiations with the only other hospital in Everett, General Hospital Medical Center. Everett is approximately thirty miles from Seattle, and there are several hospitals, many offering major tertiary care¹¹⁵ programs, within a forty-five minute drive of both Providence and General Hospitals. Providence Hospital is a subsidiary of a large, vertically integrated health care system that operates, among other things, managed care health insurance plans. Everett General is an independent hospital without affiliates or subsidiaries. Realizing that antitrust concerns were likely to be expressed by either state or federal officials, the hospitals approached the Washington Attorney General and the Department of Justice for guidance. After lengthy negotiations, the State of Washington and the hospitals reached a Settlement Agreement.¹¹⁶

In its relevant parts, the Settlement Agreement includes several provisions attempting to ensure that undue market power is not exercised by the merged Providence Hospital and General Hospital ("Providence-General Hospital").¹¹⁷ First, several non-discrimination provisions prohibit the hospitals from favoring the Providence-owned health plans, especially on price and contract terms, at the expense of other health plans.¹¹⁸ This is an attempt to inhibit price discrimination. Second, focusing on ease of entry and exit from the market, the hospitals are forbidden from restricting physicians' right to provide services at locations other than Providence-General, unless the physician is an employee of or under contract to Providence-General.¹¹⁹ Finally, to limit the exercise of monopoly pricing power,

113. Washington Health Services Act of 1993, ch. 492, § 447, 1993 Wash. Laws 2070, 2181-82 (codified at WASH. REV. CODE § 43.72.300 (1994)).

114. Interview with Duane S. Thurman, Assistant Attorney General for the State of Washington, Antitrust Division, in Seattle, Wash. (Jan. 27, 1994) (background information on the Settlement Agreement).

115. Tertiary care consists of the most intensive hospital services, usually requiring extensive staffing and advanced technological capabilities. Examples are open-heart surgery and neo-natal care. VERGIL N. SLEE & DEBORA A. SLEE, *HEALTH CARE TERMS* 435 (2d ed. 1991).

116. Settlement Agreement between Attorney General of the State of Washington, Sisters of Providence in Washington, and General Hospital Medical Center (Dec. 16, 1993) (text on file with *Seattle University Law Review*) [hereinafter Settlement Agreement].

117. *Id.* at 3-4, ¶¶ 1.1-1.7.

118. *Id.* at 3-4, ¶¶ 1.1-1.5.

119. *Id.* at 4, ¶ 1.6.

Providence-General's net revenue from operations is not allowed to increase at a rate greater than a prescribed inflation index.¹²⁰

Given the intent of the parties agreeing to the hypothetical "Grant of Immunity," they will be interested in ensuring that the continuing supervision conducted by the Commission and the Attorney General is adequate to withstand antitrust challenge. The most important feature for maintaining federal antitrust immunity is the Commission's continued involvement in the private parties' activities. Suggestions for Commission involvement of the three relevant provisions in the Grant of Immunity are discussed below.

C. Periodic Review of Providence-General's "Grant of Immunity" for Continuing Antitrust Immunity

While reviewing the adequacy of ongoing state supervision of private actors' anticompetitive activities, courts and federal agencies should identify the extent of control exercised by the state and the state's involvement in approved cooperative ventures. Establishing supervisory timetables and criteria at the time a Grant of Immunity is given will not only demonstrate active state supervision to federal antitrust enforcement agencies, but will enable private actors to plan for compliance.

The Health Services Act mandates yearly progress reports from immunized parties, but only "periodic" Commission review.¹²¹ Because health care markets are evolving rapidly, yearly Commission reviews are appropriate as well, even though the law does not require them. If reviews occurred less frequently, important changes in the market could take place without state involvement, and immunity may be jeopardized. In addition, because health care organizations are on an annual financial cycle, the burden of producing records would be lower if it coincided with other reporting activities.

Additionally, when the Commission first considers Providence-General's proposal for approval, it is critical that the Commission define the relevant market.¹²² Market characterization will determine

120. *Id.* at 4-5, ¶ 2.

121. WASH. REV. CODE § 43.72.310(6) (1994).

122. The National Association of Attorneys General Guidelines uses a customer-based definition. See NATIONAL ASSOCIATION OF ATTORNEYS GENERAL, HORIZONTAL MERGER GUIDELINES OF THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL, reprinted in 64 ANTITRUST & TRADE REG. REP. (The Bureau of National Affairs, Inc., Wash., D.C.), Apr. 1, 1993, Special Supp. at S-5 [hereinafter NAAG MERGER GUIDELINES]. The market is the geographic area in which customers purchase seventy-five percent of the product. *Id.* Federal guidelines prescribe a test for the cross-elasticity of demand (the degree to which the changes in price of one product affect changes in demand of another, related product), essentially a measure

which market features, products, and actors are within the granted immunity.¹²³ Defining the characteristics at the outset will limit the scope of the immunity to those activities approved by the state and will prevent resource-intensive reevaluation of irrelevant factors.

Review of immunized activities should be in three fundamental areas. First, the Commission must ensure that no discrimination in favor of proprietary health insurance plans occurs. Second, it is important that physician practice decisions remain free of undue control by the hospital. Finally, exercise of monopoly pricing power must be monitored. Each of these areas is discussed in turn.

1. Non-Discrimination Between Contracting Health Insurance Plans

One of the Commission's objectives is to make sure that no "sweetheart deals" are granted to Certified Health Plans¹²⁴ or other insurers. Special attention should be paid to insurance plans owned by the Providence-General parent organization. As the only provider of hospital services in Everett, Providence-General could restrict market access to only health plans with whom Providence-General has a proprietary relationship, thereby establishing significant entry barriers for other health plans. Appropriate subjects for supervision of the relationship between the merged hospital and contracting health plans include service agreements, market share, performance statistics, "unwritten" policies, and marketing materials.

of substitution:

A market is defined as a product or group of products and a geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future producer or seller of those products in that area likely would impose at least a 'small but significant and non-transitory' increase in price, assuming the terms of sale of all other products are held constant.

U.S. DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, THE U.S. DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION HORIZONTAL MERGER GUIDELINES 13 (Apr. 2, 1992) [hereinafter DOJ/FTC MERGER GUIDELINES]; see also *The Structure of the Hospital Industry in the 21st Century: Hearings Before the Joint Economic Comm.*, 102d Cong., 2d Sess. 279-80 (1992) (statement of Charles James, Acting Assistant Attorney General, Antitrust Division, U.S. Department of Justice).

123. Although market characterization is undoubtedly a crucial aspect of competitive analysis, because of its inherent complexity it will not be discussed in this Comment.

124. Certified Health Plans ("CHPs") are organizations of insurers, health service providers, health maintenance organizations, and others certified by the state Insurance Commissioner. CHPs will offer the Uniform Benefit Package at or below the maximum premium, and will use a managed care operational structure. No CHP enrollee may be denied health benefits because of health status. Washington Health Services Act of 1993, ch. 492, §§ 427-46, 1993 Wash. Laws, 2070, 2167-81.

Supervision should start with annual reviews of agreements between the immunized entity and health plans, certified or otherwise. Requiring agreements to contain identical terms would unduly restrict Providence-General's ability to negotiate and hence compete with other regional hospitals. Thus, the Commission should look for agreement terms which are markedly different between provider agreements. Of particular interest to the Commission are pricing, termination clauses, exclusive provider relationships, depth and breadth of services, and risk-assumption provisions in contracts between Providence-General and health plans. Any glaring inconsistencies would suggest that a deeper investigation is needed.

A second area to examine is market share. Stable market share among health plans competing in the Everett market is unlikely, so the Commission will have to determine if increases in market share favorable to Providence-owned plans resulted from successful competition or from advantages arising out of their kinship. Market share changes by themselves are not conclusive of undue favoritism, but may be indicative of anticompetitive activities beyond the scope of the conduct authorized by the Grant of Immunity.

A third area that should be examined is the Providence health plans' records. Access to these records will also yield relevant information for supervision. Using data from the health plans, the Commission should compare profit margins, administrative costs, marketing budgets, and subscriber demographic profiles between Providence-General and other facilities. Using these statistics, hidden subsidies provided by the health plans to the hospital, in the form of abnormal returns or artificially low operating costs, could be identified. Because of the value of health plan data, the Grant of Immunity should be conditioned on access to the records of any proprietary health plan.

Finally, two other areas should be of interest to the Commission. First, interviewing hospital and health plan staff, especially billing clerks and contract negotiators, may bring offending practices, such as internal policies favoring their proprietary health plans, to light. Second, marketing efforts should be surveyed for favoritism towards their health plans. For instance, special prominence in brochures and advertisements, and promotions providing benefits only to proprietary health plans, would be a type of entry barrier for non-proprietary health plans.

2. Undue Control Over Physician Practice Decisions

Because Providence-General is the only place for some physicians to practice, the hospital could demand that physicians use its facilities exclusively. The Commission must be sure that Providence-General does not dominate physician practice decisions beyond the scope contemplated by the Grant of Immunity. In addition to affecting the hospital economically, hospital interference with physicians' decisions may present quality concerns for patients. In most hospitals, patient care decisions are made autonomously by physicians; however, when a hospital is able to exert market power over physicians, the physicians' patient care decisions may be tainted by economic influences. Thus, the Commission must look at both objective data and subjective indicators when supervising physician independence issues.

Economic credentialing,¹²⁵ the use of indicators other than quality of care for granting hospital privileges, is a good place to start the Commission's supervision over physician practice decisions. Traditionally, hospitals have deferred to decisions of independent Medical Staff Credentialing Committees on the award of staff privileges.¹²⁶ Some hospitals, though, review physicians' use of hospital facilities for loyalty and economic efficiency.¹²⁷ Only those physicians who meet minimum cost or volume standards are granted privileges.

Clearly, a hospital with a market to itself could set more demanding economic standards for physicians. Thus, the first place the Commission should look is at the credentialing decisions, both granting and denying, made since the previous review. Especially telling are decisions denying hospital privileges to physicians who had been in good standing. Decisions that can be explained only on

125. Economic credentialing, one of the hottest topics in hospital-physician relations, has one of two meanings. Under one definition, it refers to "a system that evaluates physicians based on explicit costs or charge parameters, and those factors become the key elements in credentialing decisions." John D. Blum, *Economic Credentialing: A New Twist in Hospital Appraisal Processes*, 12 J. LEGAL MED. 427, 428 (1991). On the other hand, it "involves an evaluation of physicians based on individual utilization data, which serves to illustrate not only individual financial issues in a particular physician's practice, but quality of care issues as well." *Id.* at 428-29. See also Kevin E. Grady, *Current Topics in Medical Staff Development and Credentialing*, 26 J. HEALTH & HOSP. L. 193, 194-95 (1993); Michael J. Baxter, *Exclusive Contracting: The Original Economic Credentialing*, 26 J. HEALTH & HOSP. L. 97 (1993); Terese Hudson, *Factoring in the Financials; Court Gives Nod to Economic Credentialing*, HOSPITALS, Apr. 5, 1993, at 36.

126. William S. Brewbaker III, *Antitrust Conspiracy Doctrine and the Hospital Enterprise*, 74 B.U. L. REV. 67, 72-73 (1994).

127. Grady, *supra* note 125, at 193.

economic grounds are highly suspect, and may very well indicate an unauthorized use of market power.

Other economic factors will also show exercise of market power. Each physician's utilization statistics, including the number of patients admitted, referral trends, intensity of services ordered (the type and number of tests, procedures, and other services per patient), and length of stay are relevant factors. These factors can help identify whether the hospital is using its influence to pressure physicians and, thus, capture the market.

However, these factors cannot be examined in a vacuum. The dynamic nature of health research and technology, the unsettled reform environment, and the broad changes in the economic structure of the industry profoundly affect the same factors indicative of market power. For example, advances in technology have fundamentally lowered hospitals' average length of stay¹²⁸ by allowing for fewer invasive procedures, better home care, and more effective drug interventions. Thus, the Commission must try to determine the relative effects of a changing health care environment and the use of market power.

Subjective factors should also be considered by the Commission. To complement statistical and market reviews, the Commission should conduct interviews with physicians and hospital staff. Although relations between physicians and hospitals have been notoriously strained, extraordinary hospital decisions, indicating an unauthorized use of market power, may come to light. Because physicians tend to be assertive about issues important to them, probably only a few well-placed interviews are needed to bring legitimate grievances to light.

In addition to identifying economic abuses, physician interviews should be a part of the Commission's review of quality factors. Physician control of patient care remains the standard for health care delivery, and excessive interference from economic influences may be a serious threat to quality. However, given burgeoning costs and the nature of managed competition, cost control is a primary objective for the Commission. Balancing cost and quality is undoubtedly one of the hardest parts of the Commission's supervisory responsibilities, mostly because the allowable trade-offs are highly subjective. Given this subjectivity, the Commission should approach each situation on a case-by-case basis. Because the *Midcal* active supervision prong only

128. See, e.g., Howard J. Anderson, *Decline in Stays for Births Will Bottom Out; Hospital Stays for Vaginal Deliveries Without Complications*, HOSPITALS, Mar. 20, 1991, at 50; Shari Roan, *Alternative Care for Mentally Ill; Health: Programs Allow Patients to Forgo Lengthy Hospital Stays for Nights at Home and a Chance to Practice What They've Learned*, L.A. TIMES, August 3, 1993, at E1.

requires "active supervision," and not a particular result, if the Commission vigilantly investigates undue hospital control over physician practice decisions, it is likely to satisfy *Parker* immunity requirements.

3. Exercise of Monopoly Pricing Power

The most obvious exercise of market power is price discrimination: charging higher prices because buyers have little or no alternative in the market place.¹²⁹ To prevent monopoly pricing, the Grant of Immunity provides that Providence-General's net revenue¹³⁰ will not exceed the combined net revenue of Providence Hospital and General Hospital for the preceding year.¹³¹ In essence, Providence-General has submitted itself to price controls.¹³² The Grant allows for adjustments to revenue based on a national inflation factor, the Producer Price Index for General Medical and Surgical Hospitals-Inpatient Treatments. The effects of new services on revenue are excluded.¹³³

To ensure compliance with the price controls in the Grant, the Commission should sample a different random subset of prices at each yearly review. Because of the enormous number of hospital services and the complexity of hospital pricing, reviewing all prices would be prohibitively burdensome for Providence-General. The random subset, though, should be sure to include prices from all major service categories, including at least per diem room and board, supplies,

129. When fully implemented, the Washington Health Services Act will establish a price cap for the Uniform Benefits Package. See WASH. REV. CODE §§ 43.72.040(6), 43.72.170(1) (1994). The price cap will also limit the monopoly power exercised by health plans. However, in a competitive market, prices will fall below the allowable ceiling if there is adequate competition. If no real competition exists, prices will always be at the maximum permitted.

130. Specifically, the Settlement Agreement provides that the case mix adjusted net inpatient revenue, excluding revenue from capitated arrangements, will not exceed the combined case mix adjusted net inpatient revenue, excluding revenue from capitated arrangements, from prior years. Settlement Agreement, *supra* note 116, at 4, ¶ 2.1. "Case mix adjusted net inpatient revenue, excluding revenue from capitated arrangements" is a method of adjusting gross revenue for extrinsic, uncontrollable variables.

131. *Id.*

132. The Settlement Agreement was negotiated prior to the implementation of the Uniform Benefits Package, codified at WASH. REV. CODE § 43.72.130 (1994), and thus at that time was not subject to the premium cap mandated in the Health Services Act. Once a premium cap is established, concerns over monopoly pricing power will be less relevant because monopoly providers will not be able to raise prices above the established ceiling. However, for the purposes of illustrating an important aspect of active supervision, this Comment will assume that no premium cap is in place.

133. Settlement Agreement, *supra* note 116, at 4-5, ¶¶ 2.2-2.3.

operating room, emergency room, pharmaceuticals, diagnostic tests, and skilled nursing.

Using a nationally-based inflation factor fails to reflect unique aspects of the local health care market. Reform initiatives, varying customary medical practices, the degree of provider integration, and the penetration of managed care systems in the market all make a significant difference in the cost structures of different areas. Under the Grant of Immunity, therefore, the index can be changed to a local index if one is developed.¹³⁴ The Commission should try to find an alternative index as soon as possible; the inapplicability of a national index either disadvantages Providence-General because of slow growth nationally and rapid growth in its market, or allows it a windfall if the opposite is true.

One likely source for a substitute inflation factor is the statewide health care data system, which the Commission is empowered to establish, and which, at the Commission's discretion, may include financial data.¹³⁵ As an independent third party, the Commission can maintain confidentiality of the data, avoiding concerns about trade secrets and anticompetitive collusion. Over time, the data can be assembled to establish a reliable inflation tracking indicator.

VI. CONCLUSION

Despite guidelines published by regulating agencies,¹³⁶ uncertainty in the application of antitrust laws is not a new phenomenon. Uncertainty may have a dampening effect on reform as otherwise desirable cooperative ventures fail to crystallize for fear of running awry of the antitrust laws. The critical need for health reform demands clarification of the application of antitrust laws in this area.

In particular, state action immunity is critical to the success of managed competition, because once the government begins to "manage" markets, anticompetitive outcomes are inevitable. However, the requirements to satisfy the active supervision prong of the state action doctrine are not clear, especially with respect to continuing supervision requirements. Thus, the doctors, hospitals, and insurers that will lead reform efforts must depend on an uncertain grant of immunity before undertaking the most significant and abrupt changes in health care delivery in years.

134. *Id.* at 4, ¶ 2.2.

135. See WASH. REV. CODE § 70.170.100 (1994).

136. See, e.g., NAAG Merger Guidelines, *supra* note 122, and DOJ/FTC Merger Guidelines, *supra* note 122.

Antitrust immunity provisions in the Washington Health Services Act are a good beginning, but adequate regulations and follow-through must be forthcoming to ensure their effectiveness. The quality and the content of the review performed under the auspices of the Health Services Commission will be determinative of the success of grants of immunity to providers and insurers.

As demonstrated in the Providence-General Hospital "Grant of Immunity" illustration, active supervision entails extensive and pointed review of the Grant. The review must be tailored to the actors and particular circumstances. In the case of a hospital merger, relevant factors include entry barriers, influence over physician practice decisions, and monopoly pricing. Establishing factors at the time immunity is granted will allow the actors involved to proceed with greater security that their grant of immunity will withstand antitrust challenge.