The Merits of State Action Immunity to Promote Hospital Collaboration

Indiana State Department of Health
1330 West Michigan Street
P.O. Box 1964
Indianapolis, IN 46206-1964

Evan Bayh
Governor

John C. Bailey, M.D.
State Health Commissioner
TO: Interested Parties
FROM: John C. Bailey, M.D.
State Health Commissioner
SUBJECT: State Action Immunity under Federal Antitrust Laws

Enclosed for your information is a copy of The Merits of State Action Immunity to Promote Hospital Collaboration: Report of the Hospital Antitrust Task Force to the Indiana State Department of Health (December 1993). This Task Force was composed of experts in antitrust and health care law who represent providers, purchasers, and regulators of health care. It was convened to address the concerns of health care providers in this State that are considering innovative ways to collaborate and achieve quality, cost-effective delivery of care. This report summarizes the deliberations, findings, and conclusions of the Task Force.

First, the report reviews relevant principles of antitrust law affecting hospital collaborative efforts. Second, the report sets forth information about similar antitrust reform measures proposed by other commissions, proposals adopted in other states, proposals in the Health Security Act, and proposals of trade organizations. Third, this report presents its findings with respect to Indiana health care providers and whether and how legislatively created state action could facilitate collaborative projects.

The Indiana State Department of Health would like to thank Professor Eleanor Kinney, Director; Lisa Copp; and Marcia Gonzales from the Center for Law and Health at Indiana University School of Law - Indianapolis, for coordinating the Task Force and producing this synopsis, as well as the other members whose participation was invaluable.

If you have additional questions about this report, please contact:

Nancy Blough (317) 633-0877 or
Valita Freeland (317) 633-0189 FAX # (317) 633-0779
Indiana State Department of Health
1330 West Michigan Street
P.O. Box 1964
Indianapolis, IN 46206-1964

Enclosure

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.”
Disraeli
THE MERITS OF STATE ACTION IMMUNITY TO PROMOTE HOSPITAL
COLLABORATION: REPORT OF THE HOSPITAL ANTITRUST TASK
FORCE TO THE INDIANA STATE DEPARTMENT OF HEALTH

by

Eleanor D. Kinney, J.D., M.P.H.
Professor of Law and Director
The Center for Law and Health
Indiana University School of Law -- Indianapolis

Lisa Clark Copp, J.D.
Assistant Director
The Center for Law and Health
Indiana University School of Law -- Indianapolis

Marcia Gonzales, J.D.
Senior Research Associate
The Center for Law and Health
Indiana University School of Law -- Indianapolis

January 1994
# TABLE OF CONTENTS

I. Executive Summary .......................................................... i

II. Introduction ...................................................................... 1

III. Applicable Principles of Antitrust Law .............................. 2
    A. Antitrust Statutes .......................................................... 3
        1. Federal Antitrust Statutes ............................................ 3
        2. State Antitrust Laws ................................................... 4
    B. Antitrust Analysis Under Section 1 of the Sherman Act ....... 5
    C. Defenses in Antitrust Actions ........................................... 6
        1. Interstate Commerce ................................................... 6
        2. Learned Professions Exemption and the Per Se Application .... 6
    D. State Action Immunity .................................................... 8
        1. Clear Articulation of State Policy ................................. 8
        2. Active Supervision ...................................................... 9

IV. Antitrust Developments at the Federal Level ...................... 9
    A. Department of Justice Guidelines on Mergers and Acquisitions .... 10
    B. Department of Justice/Federal Trade Commission Safety Zones ...... 10
    C. President Clinton's Health Reform Proposal: The Health Security Act
       Impact on Antitrust Enforcement ...................................... 11
    D. Other Federal Health Care Proposals that Address Antitrust
       Enforcement .................................................................. 13
        1. Hospital Cooperative Agreement Act ............................. 13
        2. Managed Competition Act of 1993 ................................. 13
        3. Access to Affordable Health Care Act ............................. 14
        4. Affordable Health Care Now Act of 1993 ....................... 14
        5. Health Care Antitrust Improvements Act ....................... 15
    E. National Trade Associations Proposals .............................. 16
        1. The American Hospital Association ............................... 16
        2. The American Medical Association ............................... 17
    F. Antitrust Reforms at the State Level .................................. 17

V. Developmental Efforts in Indiana Relating to Modification of Federal
   Antitrust Law .................................................................. 19
    A. Indiana Commission on State Health Policy ....................... 19
    B. Indiana Legislative Action .............................................. 20

VI. Deliberations of the Hospital Antitrust Task Force ............... 21
    A. Fact Finding Activities .................................................. 21
        1. Consultation with Indiana Constituencies ........................ 21
        2. Consultation with Professor James F. Blumstein .............. 22
        3. Important Findings Reported in National Media ............. 22
I. Executive Summary

In summary, the Task Force addressed three questions in its deliberations concerning whether a state action exemption to the federal antitrust laws serves the best interest of the residents of Indiana.

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

The Task Force was reluctant to recommend a change in the economic rules which define how health care providers relate to one another, especially in a changing environment as exists in the health care system today. The Task Force, however, recognized that future action regarding the antitrust laws may be appropriate and did not "close the door" on the concept of state action immunity for Indiana.

The Task Force also concluded that, unless the state could accomplish specific, positive goals for health reform without an extensive state regulatory program of the type clearly contemplated in Federal Trade Commission v. Ticor Insurance Co.,\(^1\) the state should not proceed with a state action exemption and associated regulatory program. In other words, the state should not engage in the same type of antitrust review as the federal government does now without seeking to achieve additional positive goals.

Adopting a recommendation for creating a state action exemption is not to be made lightly. The state involvement necessary for a state action exemption would require Indiana to dedicate significant resources for continuing oversight of collaborators. While several other states have adopted these statutes, they are untested under the guidelines set out by the Ticor decision. If the process of collaborating under the exemption were rigorous, potential collaborators would likely choose traditional review of their proposal by the DOJ and the FTC, due to the risk of federal antitrust exposure because of the untested nature of the exemption.

Another reason for the Task Force's decision to refrain from recommending state action immunity legislation at this time is that some experts question whether the state action immunity statutes of other states will actually confer state action immunity when challenged by either the federal government or, more probably, competitors in private antitrust actions.\(^2\) The Task Force thought it desirable to wait and examine how courts rule on existing state action immunity statutes before proceeding with such a statute in Indiana. Further, it would be desirable to see how state action immunity statutes in other states are used by providers and whether the resulting collaborations are, in fact, beneficial to the health care system.

---

\(^1\)See, infra note 34.

\(^2\)See, infra note 62.
(2) If so, what activities and persons should be exempted?

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

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

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

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

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

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

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

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

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

Antitrust analysis distinguishes between two types of restraints that are important in understanding hospital collaboration issues. Horizontal restraints are combinations among competitors at the same level of production or distribution. Applicable examples of horizontal restraints in the hospital field include agreements among hospitals to charge the same rates for hospital services or not to develop ancillary services offered by the other. Further, various combinations of physicians on the same hospital medical staff to exclude patients of non-physician health care professionals or inappropriately exclude physicians from membership on the medical staff may constitute horizontal restraints. Vertical restraints involve concerted action between competitors at different levels of production or distribution, such as between buyers and sellers or manufacturers and retailers. In the health care field, the combination of hospitals with other types of health care providers, e.g., physicians, long-term care facilities, etc., would constitute vertical restraints. Generally, horizontal restraints are more offensive under the antitrust laws than vertical restraints.

At one time, the federal antitrust laws did not often apply to the field of health care because of the operation of various defenses to the antitrust laws outlined below, e.g., the learned professions doctrine, the interstate commerce requirement, and the exemption for the

---

business of insurance. However, in a number of cases since 1975, including *Goldfarb v. Virginia State Bar*, *Arizona v. Maricopa County Medical Society*, and *Patrick v. Burget*, the Supreme Court has made it clear that the health care industry will be treated the same as any other industry.

A. Antitrust Statutes

1. Federal Antitrust Statutes

The Sherman Act. The most important antitrust statute pertaining to hospital collaboration is Section 1 of the Sherman Act which provides: "Every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is hereby declared to be illegal." This section requires the participation of two or more entities which can be a person, corporation, partnership or association. Proscribed activities under the Sherman Act must occur in interstate commerce. The analysis of the Sherman Act Section 1 violations is described below.

Section 2 of the Sherman Act prohibits monopolization and attempts to monopolize. To prove a Section 2 violation of illegal monopolization requires a demonstration that the offending competitor has sufficient market power to enable it to preclude competition or control price. To succeed under Section 2, the plaintiff must also establish an actual intent to control the market on the part of the defendant and that the defendant's expansion is not due to growth or development resulting from a superior product or business acumen.

The Sherman Act can be enforced in three ways. First are civil suits brought by the U.S. Department of Justice's Antitrust Division (DOJ). Second are private suits brought by damaged competitors who can recover treble damages if successful. The Federal Trade Commission (FTC) also enforces the Sherman Act in the manner described below. The Sherman Act also imposes criminal liability for especially egregious violations. Private actions by disappointed competitors, rather than government prosecution, pose a graver threat to hospital collaborators, which is a factor important to appreciate in assessing potential antitrust exposure from a hospital collaboration.

The Clayton Act. Section 3 of the Clayton Act prohibits a seller from dealing with a customer on the conditions that the customer not deal in goods of a competitor, where the

---


effect of such a transaction may be substantially to lessen competition or tend to create a monopoly in any type of commerce. Exclusive dealing contracts, tying arrangements, requirements contracts, and other related agreements are covered by this provision.

Section 7 of the Clayton Act prohibits mergers and acquisitions "where in any line of commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." Since Section 7 applies to "incipient" or developing violations, demonstrating actual anticompetitive effects may not be necessary. An acquisition is unlawful if the anticompetitive effect is reasonably probable.

The Clayton Act is enforced through civil suits for injunctions or damages brought by the DOJ, FTC enforcement proceedings, and private suits for treble damages. The Clayton Act does not provide for criminal liability.

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

2. State Antitrust Laws

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

---


10Hospital Corporation of America, 3 Trade Reg. Rep. (CCH) ¶ 22,301 (FTC Oct. 25, 1985).


13IND. CODE ANN. § 24-1-1-1 et. seq. (Burns 1993).

B. Antitrust Analysis Under Section 1 of the Sherman Act

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

Activities which are not within the per se offenses are subject to greater inquiry under the "rule of reason" analysis. The classic articulation of the rule of reason analysis is found in Justice Brandeis' opinion in Chicago Board of Trade v. United States, in which he stated that:

The true test of legality is whether the restraint imposed is such as merely regulates and perhaps promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business . . . 15

The application of the rule of reason requires a balancing of a restraint's pro-competitive effects against its anticompetitive effects. This analysis focuses on the challenged restraint's impact on competition and, thus, the relevant factors in a rule of reason inquiry are those which relate to the competitive consequences of the restraint. They include: the purpose of the particular arrangement, the market power of the parties, whether a less restrictive alternative is available, and the arrangement's pro-competitive and anticompetitive effects. The purpose of the analysis is not to decide whether the policy of the antitrust laws promoting competition is in the public interest as this decision is reserved for Congress.16

An analysis of market power has assumed increasing importance in the resolution of health care antitrust cases under the rule of reason, and in merger and monopolization cases.17 Market power is the ability of the parties to a restraint, acting collectively, to raise prices or otherwise determine terms of trade in the market. A proper market definition permits determination of how much of the market is supplied by the defendant, and how easily the defendant can manipulate price and output, i.e., exercise market power.

15246 U.S. 231, 238 (1918).


Measurement of market power is technically difficult requiring consideration of many issues. Further, the law pertaining to market definition and power has changed considerably in recent years. A full analysis of market definition and power is beyond the scope of this report; several articles provide an excellent discussion of the issues involved in determining market definition and power.\(^{18}\)

It is noteworthy that two antitrust cases involving Indiana health care providers have been very important in the development of the law on the definition of markets in health care antitrust cases.\(^{19}\)

C. **Defenses in Antitrust Actions**

1. **Interstate Commerce**

Congress' power to restrain business activities under the federal antitrust laws is derived from its authority to regulate interstate commerce. In *Hospital Building Co. v. Trustees of Rex Hospitals*,\(^{20}\) the Supreme Court ruled that the interstate commerce defense did not preclude application of the antitrust laws operating in small geographic areas within one state. Consequently, general, collaborative efforts involving hospitals have the requisite effect on interstate commerce to come under the antitrust laws.\(^{21}\)

2. **Learned Professions Exemption and the Per Se Application**

In *Goldfarb v. Virginia State Bar*,\(^{22}\) the Supreme Court stated that the learned professions are not exempt from the antitrust laws. Although the courts are reluctant to carve out a definite exemption for conduct of the learned professions, they have held that in regard to professional associations "the nature and extent of the restraint's anti-competitive effect was

---


\(^{19}\)See Indiana Federation of Dentists v. Federal Trade Commission 745 F.2d 1124 (7th Cir. 1984); and Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc. 784 F.2d 1325 (7th Cir. 1986).


\(^{22}\)See supra note 2.
too uncertain to warrant per se treatment."\(^{23}\) This is not to say that learned professions are exempt from the per se application. Rather, it is more accurate to state that, where learned professions are involved, the courts are less likely to apply the per se rule. In *Arizona v. Maricopa County Medical Society*\(^ {24}\), the Court stated that conduct which was traditionally subject to per se condemnation under Section 1 of the Sherman Act would instead be subject to the rule of reason analysis where the conduct was "premised on public service or ethical norms."\(^ {25}\) As such, the courts have been generally reluctant to make a per se application to a significant number of health care circumstances.

3. **Business of Insurance Defense**

The McCarran-Ferguson Act\(^ {26}\) provides an exemption from federal antitrust laws for the "business of insurance."\(^ {27}\) To fall within this exemption, the challenged activity must: (1) constitute the business of insurance, (2) be regulated under state law, and (3) not constitute a boycott, coercion, or intimidation. The exemption will apply only to conduct that specifically involves the spreading and taking of risk and not cost containment practices of health insurers.\(^ {28}\)

4. **Implied Repeal**

Another important defense to the federal antitrust laws is "implied repeal" which arises when Congress has adopted a comprehensive regulatory scheme that is inconsistent with the antitrust laws. It is noteworthy that the Supreme Court refused to find that the federally-mandated health planning and Certificate of Need program established by the National Health Planning and Resources Development Act of 1974\(^ {29}\) did not constitute an implied


\(^{24}\)457 U.S. 332 (1982).

\(^{25}\)Id. at 348-349.


\(^{27}\)15 U.S.C. § 1012(b).

\(^{28}\)See, *e.g.*, Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979) (The Court applied three criteria for determining whether a particular practice is exempt as the "business of insurance." Whether the practice has an effect of spreading or underwriting risk, whether it is an integral part of the policy relationship between the insurer and the insured and whether it is limited to the insurance industry.): *See also*, Union Labor Life Insurance Co. v. Royal Pireno, 458 U.S. 119 (1982) (The Court held that the use of peer review committees did not constitute the spreading or underwriting of risk.)

repeal of the federal antitrust laws. 30

D. State Action Immunity

In  

Parker v. Brown,  

the Supreme Court articulated the state action exemption under the federal antitrust laws. This case involved a California program that regulated production and marketing of raisins by the state's growers. The state legislature delegated implementation of the program to a commission, which was authorized to adopt programs to restrict competition among growers and to maintain prices in the distribution of raisins to packers. The purpose of the statute was to conserve agricultural wealth to prevent economic waste. The Supreme Court held that the Sherman Act did not apply since the program derived its authority from the legislative command of the state. 31

The two requirements for state action immunity which were pronounced in  

Parker v. Brown  

were more specifically expressed in  

California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.  

First, the restraint must be one clearly articulated and affirmatively expressed as state policy, and second, the policy must be "actively supervised" by the state itself. These requirements are discussed below.

1. Clear Articulation of State Policy

In  

Southern Motor Carriers Rate Conference v. United States  

the Supreme Court discussed the first prong of the  

Midcal  

test in determining that the collective rate-making regulatory structure of the states involved were entitled to state action immunity. The Court stated that "a private party acting pursuant to an anticompetitive regulatory program need not point to a specific, detailed legislative authorization for its challenged conduct. As long as the State as a sovereign clearly intends to displace competition in a particular field with a regulatory structure, the first prong of the  

Midcal  
test is satisfied." 35 If a state's intent to establish an anti-competitive regulatory program is clear, the state's failure to describe the implementation of its policy in detail will not subject the program to the restraints of the federal antitrust laws.

32317 U.S. 341 (1943).
33100 S.Ct. 937 (1980).
2. Active Supervision

In *Federal Trade Commission v. Ticor Insurance Co.*, the Supreme Court held that the purpose of the active supervision inquiry is not to determine whether the state has met some normative standard, such as efficiency, in its regulatory practices but whether the state has exercised sufficient judgment and control.\(^{36}\) Under *Ticor*, the active supervision requirement mandates that the state exercise ultimate control over the challenged anticompetitive conduct; mere presence of some state involvement or monitoring does not suffice.

In *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*,\(^{37}\) the Supreme Court held that no antitrust immunity had been conferred since the state did not actively supervise the policy. Specifically, the Court found that the state did not establish prices, review the reasonableness of price standards, regulate terms of fair trade contracts, monitor market conditions, or engage in any pointed reexamination of the program. As a result, no state action immunity existed. Further, the court stated that "it is not enough that anti-competitive conduct is prompted by state action; rather, anti-competitive activities must be compelled by direction of the State acting as a sovereign."\(^{38}\)

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

IV. Antitrust Developments at the Federal Level

The policy goals of the federal antitrust laws are currently in flux.\(^{40}\) Specifically, some have argued that efficiency should be an important criterion in assessing whether a merger or other combination conforms to the antitrust laws. This position greatly influenced antitrust enforcement during the Reagan-Bush years. Others have attacked this emphasis on efficiency and urge that antitrust enforcement promote more consumer-oriented goals

---


\(^{37}\) 100 S.Ct. 937 (1980).

\(^{38}\) Id. (citing Goldfarb v. Virginia, 95 S.Ct. 2004 (1975)).


\(^{40}\) Baker, *supra* note 1, at 100-106.
as prevention of anti-competitive conduct. Given the election of a Democratic administration, there may be revisions in policy goals in the enforcement of the antitrust laws at the federal level. In any event, the basic tenets of antitrust policy are unsettled causing uncertainty about how antitrust principles will be applied to hospital mergers and other collaborative efforts.

A. Department of Justice Guidelines on Mergers and Acquisitions

In 1968, the Department of Justice developed Merger Guidelines for the purpose of evaluating the potentially anticompetitive effects of mergers. Subsequently, the DOJ issued guidelines in 1982, which were revised in 1984. These Guidelines outline the present enforcement of the DOJ and the FTC concerning horizontal acquisitions and mergers subject to Section 7 of the Clayton Act, Section 1 of the Sherman Act, and Section 5 of the FTC Act. The 1984 revision of the 1982 DOJ Guidelines on Mergers and Acquisitions reflects the policy goal of efficiency discussed above. The 1992 DOJ merger guidelines, however, do not reflect major policy shifts.

B. Department of Justice/Federal Trade Commission Safety Zones

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

(1) Mergers between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the most three recent years;

(2) Any joint venture among hospitals to purchase, operate, and market the services of high-technology or other expensive medical equipment if the joint venture includes only the number of hospitals whose participation is needed to support the equipment...;

(3) Physicians' collective provision of information that may improve purchasers' resolution of issues relating to the mode, quality, or efficiency of treatment...;

---


(4) Participation by competing hospitals in surveys of prices for hospital services, or surveys of salaries, wages or benefits of hospital personnel... so long as certain conditions are satisfied:

(5) Any joint purchasing arrangement among health care providers where two conditions are present: (1) the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement;

(6) A physician network comprised of 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market and share substantial financial risk.

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

The President's health proposal maintains the federal antitrust laws should ensure that the new health care system remains competitive, and acknowledges that the antitrust laws must be clarified to give providers confidence that their collaborative activities are legal. The President's Proposal to Congress contains the following references to antitrust reform:

(1) Hospital Mergers

Hospitals smaller than a certain size, as measured, for example, by number of beds or patient census, require certainty that they will not be challenged by the federal government if they attempt to merge. Such hospitals often are sole community providers that do not compete with other hospitals. The Clinton proposal refers to DOJ/FTC guidelines that provide safety zones for such mergers and an expedited business review or advisory opinion procedure through which the parties to such mergers can obtain timely (i.e., within 90 days) additional assurance that their merger will not be challenged. Guidelines also will provide the analysis the agencies use to evaluate mergers among larger hospitals.

(2) Hospital Joint Ventures and Purchasing Arrangements

Hospitals may enter into joint ventures involving high technology or expensive

---

equipment and ancillary services, as well as joint purchasing arrangements involving the goods and services they need. The Clinton proposal refers to the DOJ/FTC "safety zone" guidelines to give guidance to this type of collaboration.

(3)  
**Physician Network Joint Ventures**

Physicians and other providers require additional guidance regarding the application of the antitrust laws to their formation of provider networks that would negotiate effectively with health plans, and the proposal looks to the DOJ/FTC "safety zones" for guidance.

(4)  
**Provider Collaboration**

During the transition to the new health care system, physicians and other providers may require some protection to negotiate effectively with health plans and to form their own plans. To protect physicians from the market power of third party payers forming health plans, providers are provided a narrow safe harbor to establish and negotiate prices if the providers share financial risk. The financial risk may not simply be fee discounting.

Physicians who provide health services for the benefit package may combine to establish or negotiate prices for the health services offered if the providers share risk and if the combined market power of the providers does not exceed 20 percent. This safe harbor does not apply to the implicit or explicit threat of a boycott.

(5)  
**State Action Immunity**

The DOJ and the FTC publish guidelines that apply the "state action doctrine" where a state seeks to grant antitrust immunity to hospitals and other institutional health providers.

If a state establishes a clearly articulated and affirmatively expressed policy to replace competition with regulation and actively supervises the arrangements, the hospitals and other institutional providers involved will have certainty that they will not face enforcement action by the federal government.

(6)  
**Provider Fee Schedule Negotiation**

The DOJ and the FTC publish guidelines that describe, under existing law, the ability of providers to collectively negotiate fee schedules with the alliances.

Alliances, as established and supervised under state law, are required under federal law to establish a fee schedule for fee-for-service plans, and providers in order to
participate in the negotiation process need certainty that their actions will not violate the antitrust laws.

(7) McCarran-Ferguson

Both the President's health care proposal and H.R. 3600\textsuperscript{44} repeal the current exemption from the antitrust laws that is enjoyed by health insurers. Amending the McCarran-Ferguson Act in this way eliminates the ability of health plans to collectively determine the rates they charge and other terms of their relationship with providers.

D. Other Federal Health Care Proposals that Address Antitrust Enforcement

1. Hospital Cooperative Agreement Act

The Hospital Cooperative Agreement Act\textsuperscript{45} would establish a demonstration program with grants for collaboration among hospitals regarding the provision of expensive, capital-intensive medical technology or other highly resource-intensive services. Three of these grants must be used to demonstrate how the collaborative agreements will be used to increase access or quality in rural areas. The purpose of this Act is to encourage cooperation among hospitals in order to contain costs and achieve a more efficient health care delivery system by eliminating unnecessary duplication and an increase of costly medical or high technology services or equipment. The Act states that it shall not be an antitrust violation for a hospital to enter into and carry out activities under a cooperative agreement if it meets the Act's specifications. This Act requires that projects be designed to demonstrate a reduction in costs, an increase in access to care, and improvements in the quality of care.

2. Managed Competition Act of 1993

The Managed Competition Act of 1993\textsuperscript{46} is targeted at promoting pure managed competition where greater reliance is placed more on the private sector to provide care, reduce costs and limit government control. The bill contains many health reform features as the President's proposal, e.g. creation of accountable health plans and health insurance purchasing organizations. The bill requires the administration provide guidelines regarding

\textsuperscript{44}H.R. 3600, 103rd Congress 1st Sess. (1993). (Introduced under the short title of Health Security Act by Rep. Richard Gephardt, D-Mo, on behalf of President Clinton.)


the application of antitrust statutes to the accountable health plans in review by the DOJ. Joint ventures can be entered into for the purpose of sharing the provision of health care services which would involve substantial integration or financial risk sharing. However, the exchange of information or engaging in conduct which is not necessary in carrying out the venture will be excluded. A certificate of public advantage must be obtained which must show that the likely benefits will outweigh the reduction in competition that will result. This certificate of public advantage will be issued by the DOJ to the approved venture which would preclude any exposure to antitrust liability. This certification will be issued within 30 days of application. An appeals process will be structured in the event that a denial or revocation of the certificate arises.

3. **Access to Affordable Health Care Act**

Title IV of the Access to Affordable Health Care Act,\(^47\) titled "Cooperative Agreements Between Hospitals," purports to encourage cooperation between hospitals in order to contain costs and achieve a more efficient health care delivery system through the elimination of unnecessary duplication and proliferation of expensive medical or high technology services or equipment. The U.S. Attorney General may grant a waiver of the antitrust laws, to permit two or more hospitals to enter into a voluntary cooperative agreement under which such hospitals provide for the sharing of medical technology and services. The administrator of the Agency for Health Care Policy and Research shall evaluate applications waiver approval within 90 days. Approval of the waiver will depend on whether cost reduction, quality enhancement, improvements in cost-effectiveness of high technology services, the avoidance of duplication, and efficient utilization of hospital resources will likely result.

4. **Affordable Health Care Now Act of 1993**

The Affordable Health Care Now Act of 1993\(^48\) would allow health care providers entering into joint ventures to receive antitrust exemptions. The "Removing Antitrust Impediments" section describes a system in which the U.S. Attorney General would develop guidelines where parties could apply for a limited exemption. The applications will be reviewed and responded to within 30 days. A statement must accompany a disapproval and notice will be published in the Federal Register. Information relating to the joint venture must be publicly available unless otherwise necessary to assist with a legal investigation or for a judicial or administrative proceeding.

The guidelines for implementation would be developed in conjunction with the Secretary of

---


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

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

5. **Health Care Antitrust Improvements Act**

The Health Care Antitrust Improvements Act\(^49\) would allow an exemption from antitrust laws if the activity falls under one of the prescribed safe harbors listed in the Act, an "additional safe harbor" designated by the U.S. Attorney General or is within the parameters of the specified activities stated in the certificate of review issued by the U.S. Attorney General. The safe harbors listed under Section 5 of the Act are:

1. combinations where each type or specialty provider in question does not exceed 20 percent of the total number of such type of specialty in the relevant market area.
2. activities of medical self-regulatory entities relating to the standard setting or enforcement activities designed to promote quality of care.
3. participation in surveys regarding the price of services, reimbursement levels or the compensation and benefits of employees and personnel if the survey is conducted in an unbiased manner by a third party and the information is based on prior and not current charges or benefits.
4. joint ventures for high technology and costly equipment and services if the number

---

of participants in the venture does not exceed the lowest number necessary to support the venture.

(5) hospital mergers relating to two hospitals if within the three-year period prior to the merger, at least one hospital had an average of 150 or fewer operational beds and the average inpatient use was less than 50 percent.

(6) joint purchasing arrangements if the total sales of the product or service is less than 35 percent of the relevant market.

(7) any good faith negotiations necessary to carry out any of the activities within the safe harbors listed or designated by the U.S. Attorney General or activities that are the subject of an application for a certificate of review.

In determining whether an additional safe harbor will be established, the U.S. Attorney General shall take into account the extent to whether the collaborative activity will result in increased access, quality, cost efficiencies, the ability to provide services in medically underserved areas, and improved utilization of health care resources. Further, criteria to be considered are whether the activity will improve payment and service arrangements so as to reduce cost, that competition will not be unduly restricted, that no comparable efficiencies exist, and that the activity will not unreasonably foreclose competition.

E. National Trade Associations Proposals

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

1. The American Hospital Association

The AHA has been both pursuing antitrust relief on the federal level and urging hospitals to collaborate with each other, other health care providers and schools, businesses, and community organizations to improve quality and access, and reducing the rise of health care related costs.50 However, many such activities have been inhibited due to the real and perceived barriers of the federal antitrust laws.

The AHA is currently attempting to further educate providers about the risks of antitrust enforcement to provider collaboration. The association has issued several documents addressing these issues recently. But the AHA cites that no amount of educational efforts can resolve the uncertainties which are inherent in the federal antitrust laws or change the laws' preference for competition even when such competition results in a wasteful use of

resources.

The AHA examination of the methods of antitrust analysis is especially mindful of the unique characteristics of hospital markets. Hospital markets have traditionally deviated from the competitive paradigm in several important respects. Consumers are insulated from market prices by third-party insurance and lack of information. Due to the large amount of government purchased medical care, which is paid for on a set basis, hospitals with market power may be constrained to exercise such power. In addition, a hospital's mission may limit its ability to exercise market power. Moreover, the AHA recognizes that antitrust policy must be sensitive to noneconomic priorities in health care. For example, the operation of market forces may not ensure that the right hospitals stay open and the right hospitals close. Hospital closures in underserved areas will complicate already serious problems with access to quality health care.

2. The American Medical Association

In the spring of 1993, the AMA addressed the Subcommittee on Antitrust, Monopolies and Business Rights of the Judiciary Committee of the United States Senate on the subject of antitrust relief for the health care industry.\textsuperscript{51} In its proposal, the AMA did not seek an exemption for federal antitrust laws. Rather, the association recommended that federal antitrust laws be clarified by statutory enactment to allow physicians to form networks and otherwise engage in collaborative activities with health care providers.

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

F. Antitrust Reforms at the State Level

To date, there are more than a dozen states that have legislatively exempted health care collaborative activities from the coverage of the federal antitrust laws in one form or another.\textsuperscript{52} The primary bases for creating a state action exemption from federal and state antitrust laws in each of these states have been relatively consistent.

\textsuperscript{51} American Medical Association, Statement to the Subcommittee on Antitrust, Monopolies and Business Rights, Judiciary Committee, United States Senate (March 23, 1993).

\textsuperscript{52} States which have enacted statutes which allowed cooperative activity among hospitals include: Colorado, Florida, Iowa, Kansas, Maine, Minnesota, Montana, North Carolina, North Dakota, Ohio, Oregon, Tennessee, Texas, Washington, and Wisconsin.
Various legislatures have concluded the competitive model has not been effective in controlling the rising cost of health care or the inefficiencies of duplicated facilities and services. Although the technological and scientific advancements in the health care industry have improved the potential of increasing quality of care to the public, the cost of such improvements has made it difficult to provide this care in an affordable manner. Further, states have found that the boundaries of existing state and federal health care statutes have suppressed the ability of health care providers, specifically hospitals, to acquire and develop new equipment and methodologies in the delivery of health care services. Therefore, the states have enacted legislation creating regulatory programs which allow health care providers to cooperate to the extent that the positive effects such as the quality, access, and delivery of health care services do not outweigh the potential adverse effects of reducing competition.

Maine enacted the Hospital Cooperation Act of 199253 which became effective in April the same year. The law allows hospitals to enter into cooperative agreements with other state-based hospitals if the potential benefits outweigh the disadvantages which may result from the reduction in competition. The benefits listed include quality, cost efficiency, avoidance of duplication, improvements in utilization, and preservation of hospital facilities. The disadvantages to be considered include the likely adverse impact on the ability of managed care entities and payers to negotiate optimal payment and service arrangements with hospitals or other health providers; the reduction in competition and the likely adverse impact on patients in the quality, availability, and price of health care services, as well as the availability of less restrictive arrangements which can achieve the same or more favorable benefits. Those seeking to enter into cooperative agreements must demonstrate by clear and convincing evidence that the likely benefits of the proposed arrangement outweigh the attributable disadvantages in the reduction of competition. The Act defines a cooperative agreement among hospitals as the "sharing, allocation or referral" of patients, personnel, services, procedures and facilities traditionally offered by hospitals.

Similarly in Minnesota,54 the legislature's pronounced purpose behind the enactment of the "Antitrust Exceptions" statute is to "substitute regulation for competition" when the proposed arrangement is "likely" to result in "greater access or quality" than what would otherwise occur in the current competitive market.

In Ohio,55 recent legislation has allowed hospitals to conduct negotiations involving the allocation of health care services or equipment to the extent that such negotiations do not involve price-fixing or "predatory pricing," and are "designed to achieve" one of the following goals: the reduction of health care costs, improvement of access to health services, or the


improvement of the quality of patient care.

In Washington,\textsuperscript{56} legislation was enacted to specifically enhance rural health development. The legislature pronounced that the primary goal of state health policy was on the maintenance of the health care service delivery in rural areas. The intent of the statute is to "foster the development of cooperative and collaborative arrangements" among the rural public hospital districts. The legislature further determined that it is "not cost-effective, practical or desirable" to provide quality health care services on a competitive level in rural areas because of the limited patient volume and geographic isolation.

In Wisconsin,\textsuperscript{57} the Health Care Cooperatives Agreement statute is less limiting as it allows health care providers, not just hospitals, to negotiate and voluntarily enter into cooperative agreements. The law defines cooperative agreements as the sharing, allocation, or referral of patients; or the sharing or allocation of personnel, services and medical, diagnostic, or laboratory facilities or procedures or other services "customarily" provided by health care providers.

V. Developmental Efforts in Indiana Relating to Modification of Federal Antitrust Law

A. Indiana Commission on State Health Policy

In 1989, the Indiana General Assembly created the Indiana Commission on State Health Policy,\textsuperscript{58} which was directed to study Indiana health policy and make recommendations in order to improve the effectiveness of Indiana's health care delivery system. The Commission issued a report titled \textit{HoosierHealth Reform}, which summarized the findings of the Commission.

Among the findings were many references to the much-needed removal of federal antitrust barriers which prevent Indiana health care reform from progressing as desired by the Commission. The Commission recommended that the federal government create an exemption for hospitals who engage in certain collaborative relationships from federal antitrust laws under state supervision.\textsuperscript{59} This immunity should be applied to all collaborative activities except those that involve price-fixing, predatory pricing, or group boycotts. The Commission recommended the exemption not be as stringent as the requirements under the state action immunity doctrine.

The Commission found that removing federal antitrust barriers would have many benefits.

\textsuperscript{56}WASH. REV. CODE § 39.34 (1993).

\textsuperscript{57}WIS. STAT. §§ 150.84-150.86 (1992).

\textsuperscript{58}Ind. P.L. 327-1989.

\textsuperscript{59}Indiana Commission on State Health Policy, \textit{HoosierHealth Reform} (Nov. 1992).
Merger and collaboration in the hospital industry was found to be in the public's best interest due to tremendous duplication of services and facilities that are costly to the health care system. The Commission cited a recent study which found that hospitals in more than three fourths of communities nationwide would be at risk of violating federal antitrust guidelines if they merged. It also found that a decided trend toward more stringent enforcement of antitrust legislation exists in the health care field, and many collaborative arrangements between providers have the potential to trigger an antitrust challenge under federal guidelines.

Among the benefits the Commission attributed to collaboration between health care providers were that rural hospitals would be able to merge or form networks with larger tertiary hospitals or other rural hospitals in their geographic areas. This would eliminate the duplication of health care technologies and facilities that currently exist and would provide tremendous cost savings.

Hospitals would also be able to establish networks and systems to provide a continuum of care for patients, with rural hospitals providing basic acute care, long-term care, and ambulatory care, and more specialized needs being provided by larger hospitals belonging to the network. The Commission stated there was ample evidence that an increased volume of specialized care available in fewer settings promotes quality of care.

Access to capital markets would also be more available to smaller hospitals if those providers were linked with larger hospitals due to the financial strength of the larger institution. The Commission cited the capital needs of smaller hospitals to upgrade facilities and shift missions to provide different types of care such as ambulatory care, long-term care, and other less specialized care.

B. Indiana Legislative Action

Governor Evan Bayh addressed the need for removal of federal antitrust barriers to the Indiana community of health care providers in his 1993 State of the State address, Cornerstones of Progress. Because of the explosion of medical technology which has increased the cost of health care, hospitals are competing to have the most up-to-date equipment. It is difficult for rural hospitals to compete with larger, more urban hospitals in two ways -- availability of high-tech medical equipment and attracting physicians to accept lower salaries and longer hours. Affiliation of rural providers with larger hospitals may increase access to capital, promote recruitment of physicians, and lower operating costs. He proposed: (1) eliminating antitrust barriers that prevent effective coordination of services among health care providers; (2) establishing criteria and procedures for two or more hospitals to voluntarily request approval for a cooperative or collaborative project; and (3) articulating public policy, encouraging collaborative activities to reduce costs, improve access

---

The name of this study was not cited by the Commission.
and quality, and reduce duplication.  

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

The Indiana Hospital Association (IHA) drafted related legislation, H.B. 1800, to create a limited exemption from the federal antitrust laws for various types of collaborative activity among independent hospitals. House Bill 1800 would have allowed hospitals to enter into collaborative agreements if certain conditions were met to ensure that the benefits of provider collaboration outweighed the disadvantages resulting from a reduction in competition. Such collaboration between providers was encouraged under the measure if the agreements materially contributed to cost containment, improved access, reduction in duplicity of services, equipment or facilities, and also promoted efficiency. This legislative attempt to facilitate provider collaboration was not successful, and was no similar was considered in the most recent legislative session.  

VI. Deliberations of the Hospital Antitrust Task Force  

A. Fact Finding Activities  

1. Consultation with Indiana Constituencies  

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

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

Mr. Farris subsequently sent a letter to the Task Force in which he noted that if a state exemption to federal antitrust laws were more burdensome than the

---

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


current system of federal review, health care providers would be better served by utilizing the existing federal review process. Similarly, he recommended that any state antitrust exemption be optional, rather than mandatory. He felt that a state action exemption would be of greatest benefit to smaller regional providers, who currently desire to discuss ways in which they can collaborate to serve the needs of their local community.

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

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

2. **Consultation with Professor James F. Blumstein**

The Task Force also consulted with Professor James F. Blumstein, Vanderbilt University School of Law, about the general desirability of state action exemptions to the federal antitrust laws. Professor Blumstein is a prominent scholar in the field of health care antitrust.  

Professor Blumstein has been a strong advocate of free markets and competition in the health care industry. The Task Force wanted the perspective of such a scholar to explore the potential downsides of a state action exemption to the antitrust laws as fully as possible. Professor Blumstein gave the Task Force a thoughtful presentation on the state action exemption and was most helpful to the Task Force in its deliberations.

3. **Important Findings Reported in National Media**

Experience with hospital mergers across the country is noteworthy. On average, 65 percent of hospitals nationwide have entered into some type of collaborative arrangement in the last

---


two years.\textsuperscript{66} Between 1987 and 1991, there were more than 229 hospital mergers in the United States of which 27 generated federal antitrust investigations with only five antitrust challenges.\textsuperscript{67}

B. Task Force Findings and Conclusions

1. Problematic Collaborative Activities

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

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

St. Vincent Hospital and Health Centers and Methodist Hospital of Indiana, Inc., have also collaborated in the formation and operation of a rehabilitation hospital which involved, in their judgment, virtually no significant exposure under the antitrust laws. Specifically, the Rehabilitation Hospital of Indiana, Inc., was created as a 50-50 subsidiary of entities controlled by both Methodist and St. Vincent in 1990, because the parties determined that there was a substantial need for additional rehabilitation beds in central Indiana. Without substantial time or expense, the antitrust analysis was performed by Methodist in-house counsel and by local counsel for St. Vincent, and a determination was quickly made that no federal antitrust review of this new venture to collaboratively own and operate a new $20 million rehabilitation facility was required.

Not all proposed mergers of Indiana hospitals have avoided antitrust problems. In fall 1990, two 300-plus bed, not-for-profit hospitals in Fort Wayne (St. Joseph Medical Center and Lutheran Hospital of Indiana) announced plans to consolidate in order to reduce their

\textsuperscript{66}Hospital Collaboration Delivers Efficient Care, According to Survey, PR Newswire Association, Inc. (Oct. 25, 1993).

\textsuperscript{67}See David Marx, Jr., State Hospital Cooperation Acts: Are They Sufficient Antitrust Shelter for Hospital Collaborations?, HealthSpan, Vol. 10 No. 9, (Oct. 1993).
management teams by approximately 20 percent and eventually consolidate their medical staffs. The hospitals declared that the affiliation would reduce duplicative medical equipment, technology, programs, and services in Fort Wayne and place the hospitals in a better position to serve indigent patients. Expecting review by the DOJ to be "smooth sailing," the hospitals called off their merger plans one year later in the face of a widening antitrust investigation by the DOJ. Had the merger taken place, it would have given the two hospitals control of 56 percent of the private acute-care hospital beds in Fort Wayne, Indiana, which has a population of 173,000.

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

(1) Mergers and/or coordination of services by providers in small towns.

The safe harbor provisions of the DOJ/FTC Guidelines as delineated in *Statements of Antitrust Enforcement Policy in the Health Care Area* do not cover the potential collaboration of two financially healthy and well-utilized hospitals in a smaller community. The DOJ/FTC Guidelines are really restricted to small or failing institutions with low occupancy.

Further, the Task Force could not determine whether it would be desirable to promote mergers of multiple hospitals in smaller communities or whether pluralism in the provision of services in these communities might have added benefits or might promote the operation of two statewide networks in a community, thereby assuring residents choices among providers and other benefits of competition.

(2) Consultation between hospitals and other providers about the desirability of collaborative efforts.

The Task Force discussed several options which would allow providers to examine whether collaborative activity is in the best public interest, such as a "time out," an exempt period from antitrust exposure allowing potential collaborators to discuss the benefits of a proposed collaboration that otherwise constitutes a potential violation of the antitrust laws. For example, providers forming alliances to bid to become Indiana Medicaid managed care contractors could well have utilized this protection.

---


70See *supra* note 42.
However, the Task Force concluded that simply allowing parties to talk under the ostensible sponsorship of a state agency would probably not be sufficient to meet the supervised activity requirements of state action required in the Ticor decision. Providing such protection to providers that are exploring collaboration without an extensive state regulatory program currently required for state action exemptions, may be an appropriate reform under federal health reform proposals or possibly a DOJ/FTC "safe harbor" protection. It is noteworthy that the Clinton health care proposal, The Health Security Act, included such relief in its proposed antitrust reforms.

(3) Estimating savings of combined clinical departments when two hospitals collaborate in a common network.

It is important to recognize that the benefits to a health care provider of clinical combinations or reduction in the duplicity of expensive medical equipment are financial savings. Discussions between providers of savings estimates which would result from collaborations are clearly constrained by both state and federal antitrust laws.

2. The Required State Regulatory Program for a State Action Exemption

As stated in greater depth above, the Supreme Court has recently outlined specific requirements to create a state action exemption from the federal antitrust laws. A state must: (1) clearly articulate its public policy to be furthered by the exemption and (2) actively supervise its review process which includes allowing the state to review, regulate, and deny potential collaborative arrangements.71

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

3. The State's Interest in Promoting a State Action Program

The Task Force concluded that the state has an interest in a rational health care system that assures high quality health care services to all citizens at a reasonable cost. How the state would accomplish these goals in a state regulatory program posed a confounding problem in the Task Force's judgment. These goals, the Task Force recognized, were quite similar

---

to the goals of the health planning and Certificate of Need (CON) programs -- mandated by Congress in the National Health Planning and Resources Development Act of 1979.72 Yet the Task Force unanimously opposed creating a regulatory scheme like the CON program.

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

4. Task Force Observations on the Merits of a State Action Exemption

Below are listed some of the more important points made by Task Force members that influenced the Task Force's recommendations:

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

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

- Indiana should not duplicate, on the state level, the antitrust analysis presently conducted on the federal level. Rather, Indiana should act only if there are clearly identifiable social policy issues on which there is broad consensus, and the achievement of which would be so significant as to justify conduct which might

---

otherwise be considered anti-competitive and/or illegal, and which would also justify
the state's establishment of a new review mechanism to determine whether or not
such social policies are, in fact, achieved.

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

When H.B. 1800 was introduced last year, business was very interested in encouraging
provider collaboration in one form or another.73 This year, the business community
appears more skeptical about the benefits of collaboration that might otherwise be
proscribed under the antitrust laws.

VII. The Merits of a State Action Exemption

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

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

The Task Force was reluctant to recommend a change in the economic rules which define how
health care providers relate to one another, especially in a changing environment as exists in the
health care system today. The Task Force, however, recognized that future action regarding the
antitrust laws may be appropriate and did not "close the door" on the concept of state action
immunity for Indiana.

The Task Force also concluded that, unless the state could accomplish specific, positive goals for
health care reform without an extensive state regulatory program of the type clearly
contemplated in Ticor, the state should not proceed with a state action exemption and associated
regulatory program. In other words, the state should not engage in the same type of antitrust
review as the federal government does now without seeking to achieve additional positive goals.

Adopting a recommendation for creating a state action exemption is not to be made lightly. The
state involvement necessary for a state action exemption would require Indiana to dedicate
significant resources for continuing oversight of collaborators. While several other states have

73See, supra note 62.
adopted these statutes, they are untested under the guidelines set out by the Ticor decision. If the process of collaborating under the exemption were rigorous, potential collaborators would likely choose traditional review of their proposal by the DOJ and the FTC, due to the risk of federal antitrust exposure because of the untested nature of the exemption.

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

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

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

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

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

To conclude, the Task Force recommends that Indiana policymakers consider a state-action immunity statute as one of many goals for the health care system, making sure that it coordinates a state action immunity doctrine with other important health related policy goals. For example, other ways to make health care providers more efficient could include making the state a better purchaser of health care services for the individuals that it insures. The state is already doing this with its Medicaid managed care program. It should consider adopting a similar strategy for other groups for whom it provides or mandates health insurance, e.g., state employees or the beneficiaries of the Indiana Comprehensive Health Insurance Association.

Finally, the market for health care services is extremely complex and unique. For some services, e.g., expensive, high technology services for the catastrophically ill, cooperation among providers seems intuitively desirable. However, for other services provided to the general population, competition among providers may be desirable as a way to keep costs down and service quality high.

---

54See, supra note 62.