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HEALTH CARE AND THE FEDERAL ANTITRUST LAWS: THE LIKELIHOOD OF A HARMONIOUS COEXISTENCE

Robin E. Remis

The application of antitrust to transactions in the health care field has proceeded on the essential premise, shared by antitrust enforcers and the courts, that safeguarding economic competition is as important to health care as other industries.¹

The health care industry has witnessed dramatic change over the past decade resulting in a transformation of the structure of the medical system in the United States.² In response to intensive competition in the health care sector of the economy, consolidated health care facilities,³ managed care schemes,⁴ and integrated delivery systems⁵ have emerged increasingly to the forefront.⁶ The possibility of decreased competition

4. The managed care paradigm consists of prepayment by consumers to plan providers who contract with health care providers to render services at a capitated rate for each plan member. See generally Robert J. Enders, Alternative Delivery Systems, in ANTITRUST HEALTH CARE ENFORCEMENT AND ANALYSIS 195 (M. Elizabeth Gee ed., 1992). The most common types of plan providers are preferred provider organizations (PPO’s) and Health Maintenance Organizations (HMO’s). Id.
5. Integrated delivery systems entail packaging of services by hospitals and physicians in order to compete for contracts with third party payors. Dean M. Harris, State Action Immunity From Antitrust Law for Public Hospitals: The Hidden Time Bomb for Health Care Reform 1 (unpublished manuscript, on file with author).
6. See Stephens, supra note 3, at 478. See also Erik Eckholm, While Congress Remains Silent, Health Care Transforms Itself, N.Y. Times, Dec. 18, 1994, at A1. During 1993 and 1994, a majority of Americans with private health insurance were enrolled in managed care plans that limited their choice of doctors and treatments, while 65% of Americans employed by medium and large companies were enrolled in similar plans by 1994. Additionally, at least three quarters of all physicians entered into contracts which cut their fees and accepted oversight of their medical decisions; eighty-nine percent of physicians in
due to such activity has led to heightened scrutiny of health care providers in light of the current federal antitrust laws.

The very framework of the restructured entities in the health care industry has provoked antitrust concerns. Hospital mergers are one example of the manner in which the health care industry has been transforming. While mergers may result in some procompetitive benefits such as efficiencies in the form of economies of scale, reductions in overhead expenses, and better integration of production facilities, the merging of two or more hospitals in a relevant market may also decrease competition. Antitrust enforcers are concerned with increased market concentration of the merging entities, as well as the likelihood of a consequential reduction in the number of competitors. Similar concern exists regarding alternative delivery systems which pose potential antitrust violations such as group boycotts, tying arrangements, monopolization, exclusive dealing arrangements, and price-fixing.

Antitrust laws were enacted to promote efficiency and encourage competition while simultaneously protecting the public from anti-competitive practices. Fostering these goals is critical to effectuating a competitive marketplace, free from self-serving conduct which would otherwise prove detrimental to the public interest.

The federal antitrust laws do not supplant the police power of a state to regulate the public health, safety, and welfare of its citizens. Under the state action doctrine, a state acting in its sovereign capacity may negate the application of the federal antitrust laws by authorizing a state policy

group practice were parties to managed care contracts by 1993, as opposed to 56% in 1992. Id.
7. See generally Toby G. Singer, Current Issues in Hospital Merger Analysis, in ANTITRUST PROBLEMS AND SOLUTIONS IN A CHANGING HEALTH CARE SYSTEM 127 (Suzanne Smith & John J. Miles eds., 1994) (presenting a brief history of antitrust enforcement in hospital mergers and the effect of the hospital's financial condition and role of efficiencies on antitrust analysis).
8. Id. at 137-38.
9. Id. at 134.
12. Id.
which may displace competition. At least eighteen states have enacted
legislation providing antitrust immunity for various sectors of the health
care industry pursuant to the state action exemption. "Existing law rec-
ognizes that antitrust principles must yield when a state . . . regulatory
regime displaces competition."  

Advocates for the reformation of the antitrust laws argue that the only
method of resolving the conflict between the antitrust laws and the struc-
ture of the health care industry entails a reexamination of the application
of the current antitrust laws. This position, however, fails to acknowl-
edge the importance and the underlying purpose of the federal antitrust
laws. Reformation of the antitrust laws is unnecessary to respond to the
changes occurring in the health care industry. The federal antitrust laws,
as presently written and enforced, "provide a great degree of flexibility
for private collaborative efforts aimed at achieving more efficient and less
costly delivery of health care services" and thus, should be applied to
safeguard economic competition in the health care industry. The flexi-
bility of the federal antitrust laws, coupled with the ability of states to
replace competition with state regulation under the state action doctrine,
support the thesis that there should not be blanket immunity from the
federal antitrust laws for the health care industry as proposed by many
economists and health care professionals.

This Article analyzes the efficacy of the state action doctrine as a mech-
anism for state regulation of the health care industry. Part I examines the
pertinent federal antitrust laws and the rationale underlying these laws.
Part II traces the roots of the state action doctrine and evaluates the spe-
cific components required to qualify for immunity. Part III appraises the
immunization of state regulatory programs under the state action exemp-
tion, as illustrated by the health care legislation enacted in Oregon. Fi-
ally, this Article concludes that the health care industry may respond

15. See generally 1 Phillip E. Areeda & Donald F. Turner, ANTITRUST LAW: AN
ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION §§ 211-212 (1978) (provid-
ing a detailed analysis of the mechanics of the state action doctrine). See also 6 Julian O.
von Kalinowski, ANTITRUST LAWS AND TRADE REGULATION §§ 40.01-05 (1995) (providing
information on the origin and elements of the state action doctrine).
16. Harris, supra note 5, at 3.
17. Meyer & Rule, supra note 1, at 171 n.7.
18. See, e.g., Fredric J. Entin et al., Hospital Collaboration: The Need for an Appropria-
tate Antitrust Policy, 29 WAKE FOREST L. REV. 107 (1994). See also Brian McCormick,
Some New Antitrust Leeway: But AMA Says Updated Federal Rules Still Too Narrow for
20. Id.
effectively to new trends in the market without an unqualified exemption for the health care industry from the federal antitrust laws.

I. THE FEDERAL ANTITRUST LAWS AS RELATED TO REGULATION OF COMPETITION IN THE HEALTH CARE INDUSTRY

[Federal antitrust law] rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions.21

Competition is the product of efficient production of quality goods and services by sellers at prices that consumers are willing to pay.22 "A central goal of the antitrust laws is to permit markets to operate in a manner which results in the setting of competitive prices."23

The health care market is unique, albeit imperfect, in that the services rendered to consumers are frequently paid for through health insurance plans or by third-party payors, thus insulating consumers from the actual cost of such services.24 In addition, consumers often rely on health care providers to recommend purchases because many patients are incapable of assessing the quality and necessity of services.25 Consequently, there has been less pressure for health care providers to offer services at reduced prices in order to maintain market shares and maximize profits.26

Thus, because of the presence of third-party payors, the price of health services is not the product of horizontal competition among sellers or purchasers and vertical bargaining between sellers and purchasers.

Recently, the structural changes in the health care industry have made the marketplace more competitive. Anti-competitive mergers and collusive behavior have become more prevalent, however, as a result of increased competition.27 Such practices have jeopardized the future of health care reform as well as provoked concern among antitrust enforcers. "[C]ompetition in health care must be preserved and enhanced, de-

23. Craig D. Bachman, Per Se Offenses, in ANTITRUST HEALTH CARE ENFORCEMENT AND ANALYSIS, supra note 4, at 4.
24. Harris, supra note 5, at 11.
25. Id.
26. Id.
27. Id. at 14.
spite the need for some regulatory controls to remedy imperfections in the market."\textsuperscript{28} The means by which competition should be preserved is by enforcement of the antitrust laws, which were enacted for exactly that purpose.

\section*{A. The Relevant Federal Antitrust Laws}

The Sherman Antitrust Act, the first federal antitrust statute, was passed in 1890 to block combinations formed "with the purpose or effect of restraining trade."\textsuperscript{29} Section 1 of the Sherman Act prohibits agreements that unreasonably restrain trade.\textsuperscript{30} As provided in the Act, "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."\textsuperscript{31} Section 2 outlaws monopolies as well as attempts or conspiracies to monopolize.\textsuperscript{32}

The Clayton Act was enacted approximately twenty-five years after the adoption of the Sherman Act in order to "arrest the creation of trusts, conspiracies, and monopolies in their incipiency and before consummation."\textsuperscript{33} Section 2 of the Clayton Act, which was replaced by Section 1 of the Robinson-Patman Act, prohibits:

\begin{quote}
discriminat[ion] in price between different purchasers of commodities of like grade and quality . . . where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly . . . or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them.\textsuperscript{34}
\end{quote}

Section 3 of the Act prohibits tying and exclusive dealing agreements where the effect may be to "substantially lessen competition or tend to

\begin{flushleft}\textsuperscript{28} Id. at 10.\textsuperscript{29} Stephens, \textit{supra} note 3, at 483.\textsuperscript{30} 15 U.S.C. § 1 (1994).\textsuperscript{31} Id.\textsuperscript{32} Id. at § 2. Section 2 provides: Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.\textsuperscript{33} S. REP. No. 63-698, at 1 (1914).\textsuperscript{34} 15 U.S.C. § 13 (1996).\end{flushleft}
create a monopoly." Finally, Section 7 outlaws certain acquisitions of stock or assets of one business by another, having an anti-competitive effect on the market. In order to invalidate conduct pursuant to the Clayton Act, there must exist a reasonable probability, as opposed to a theoretical possibility, that the challenged conduct may "substantially lessen competition or tend to create a monopoly in any line of commerce."

1. The Per Se Analysis

There are two types of inquiries by which courts analyze the unreasonableness of restraints. Some restraints are considered per se unlawful "because of their pernicious effect on competition and lack of any redeeming virtue [and thus] are conclusively presumed to be unreasonable." Courts do not evaluate the factual circumstances in determining the reasonableness of such restraints, but focus solely on whether conduct occurred which is known to pose a serious threat to competition. The per se rule rests on the inherent unreasonableness of certain activities that "raise extreme risk of antitrust liability without regard to [their] actual measured effect on competition and without regard to the purpose, however laudable, with which [such activities were] undertaken." Price-fixing, division of markets, and boycotts are examples of per se violations.

2. The Rule of Reason Analysis

The reasonableness of other activities is determined under the rule of reason analysis. Under this approach, courts evaluate the relevant circumstances and determine whether the anti-competitive effects outweigh the procompetitive benefits. Factors considered in the rule of reason analysis include market share, the impact of the challenged restraint on price and output, the ease of entry into the market for new participants,
and the exigency of the restriction for reaching efficiency goals.\textsuperscript{44}

\textbf{B. Application of the Federal Antitrust Laws to the Health Care Industry}

The Supreme Court rejected the argument that learned professions should be exempt from the federal antitrust laws,\textsuperscript{45} and consequently held that the antitrust laws apply to the health care industry.\textsuperscript{46} The Court noted, however, that special accommodations may be necessary concerning practices by professions.\textsuperscript{47}

The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.\textsuperscript{48}

The health care industry has received special attention from antitrust enforcers, as evidenced by the issuance of the Department of Justice and Federal Trade Commission Antitrust Enforcement Policy Statements in the Health Care Area.\textsuperscript{49} These new policy guidelines establish "antitrust safety zones" for six specific areas of the industry, delineating areas that will not face scrutiny by the agencies, except in "extraordinary circumstances."\textsuperscript{50}

[Both the FTC and the Antitrust Division have acted on several]

\textsuperscript{44} Gellhorn \& Kovacic, supra note 42, at 169.
\textsuperscript{45} Goldfarb v. Virginia State Bar, 421 U.S. 771, 773 (1975). The Court concluded that "[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act ... nor is the public-service aspect of professional practice controlling in determining whether §1 includes professions." Id. at 787.
\textsuperscript{46} See Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982) (holding that an agreement setting maximum prices charged to policy holders among physicians was per se unlawful).
\textsuperscript{47} Goldfarb, 421 U.S. at 787 n.17.
\textsuperscript{48} Id.
\textsuperscript{49} Dep't of Justice \& FTC Statements of Antitrust Enforcement Policy Statements in the Health Care Area, 4 Trade Reg. Rep. (CCH) ¶¶ 13,150-51 (Sept. 15, 1993) [hereinafter Dep't of Justice \& FTC Statements].
\textsuperscript{50} Id. See generally Roxane Busey et al., Analysis of Department of Justice and Federal Trade Commission's Antitrust Enforcement Policy Statements in the Health Care Area, in Antitrust Problems and Solutions in a Changing Health Care System, supra
occasions to eliminate boycotts by physicians and other professionals of innovative alternatives to traditional fee-for-service medicine. "These enforcement actions implicitly manifest a strong desire to encourage rather than prohibit or chill the formation of efficient provider networks."\textsuperscript{51}

The Local Government Antitrust Act of 1984 provides additional protection by shielding local government agencies, including municipal hospitals, from liability in antitrust suits.\textsuperscript{52} The Joint Statements are designed to achieve a "balance between efficient integrations which can benefit consumers and anti-competitive concentrations of market power."\textsuperscript{53}

In the context of the health care industry, several activities pose potential antitrust problems. Examples of challenged conduct include cooperative agreements and integration among competitors,\textsuperscript{54} collusive horizontal agreements disguised as joint ventures, concerted refusals to deal,\textsuperscript{55} and mergers.\textsuperscript{56} While it may seem likely that many activities will be challenged by antitrust enforcement agencies, this is not the case. These agencies recognize that some of the requisite factors for establishing a claim would be lacking,\textsuperscript{57} or that the procompetitive benefits of much of this conduct would outweigh the anti-competitive effects.\textsuperscript{58} Moreover, the existence of "antitrust safety zones" announced in the Department of Justice and Federal Trade Commission Antitrust Enforcement Policy Statements confirms that activities falling within such zones

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{51} Meyer & Rule, \textit{supra} note 1, at 184.
\item \textsuperscript{53} Janet L. McDavid, \textit{Antitrust Issues in Health Care Reform}, 43 \textit{DePaul L. Rev.} 1045, 1067 (1994).
\item \textsuperscript{54} \textit{See, e.g.}, Medical Staff of Broward Gen. Medical Ctr. & Medical Staff of Holy Cross Hosp.; Prohibited Trade Practices and Affirmative Corrective Actions, 56 Fed. Reg. 49,184 (1991) (precluding medical staffs from entering or attempting to enter into agreements that would restrict other providers from offering or rendering health care services).
\item \textsuperscript{55} \textit{See, e.g.}, Debes Corp.: Proposed Consent Agreement with Analysis to Aid Public Comment, 57 Fed. Reg. 39, 205 (1992) (banning a boycott of certain nurse registries by a nursing home); Medical Staff of Doctors' Hosp. of Prince George's County, 110 F.T.C. 476 (1988) (prohibiting the boycott of a hospital intending to open an HMO).
\item \textsuperscript{56} \textit{See McDavid, supra} note 53, at 1061-66.
\item \textsuperscript{57} \textit{See American Bar Association Working Group on Health Care Reform, Antitrust Implications of Health Care Reform 1 n.2 (1993) (noting that antitrust enforcers have not challenged most hospital mergers because it is likely that they would lack sufficient market power to exclude competition or raise prices) (on file with author).}
\item \textsuperscript{58} \textit{See supra} note 49, at ¶ 13,151 (reporting that only 8 of 200 hospital mergers have been challenged from 1990 - 1994).
\end{enumerate}
\end{footnotesize}
will not be challenged.\textsuperscript{59} The antitrust laws safeguard competition in the health care sector while simultaneously allowing the industry to respond to recent structural changes, and thus a harmonious coexistence is both possible and beneficial.

II. \textbf{IMMUNIZATION FROM THE FEDERAL ANTITRUST LAWS UNDER THE STATE ACTION DOCTRINE}

The power of the states to promote the health and welfare of their citizens has not been superseded by the federal antitrust laws.\textsuperscript{60} "In the American federalist system, the states have the power and the right to regulate their internal markets in matters constituting their local concern . . . ."\textsuperscript{61} The antitrust laws may be preempted under the state action doctrine upon a finding that a state regulatory scheme which displaces competition is clearly articulated by a state acting in its sovereign capacity. "[F]rom its inception, the state action doctrine has been rooted in federalism principles that value deference to the economic self-determination of states."\textsuperscript{62}

\textbf{A. Establishment of the State Action Doctrine}

The state action doctrine was instituted in 1943, in \textit{Parker v. Brown}, where the Supreme Court announced that the Sherman Act was not intended to quash the regulatory power of the states.\textsuperscript{63} "We find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature."\textsuperscript{64} In \textit{Parker}, the Court upheld a restraint on trade that was imposed by the California legislature, noting that the Sherman Act did not render the state regulation unlawful because the Act is a "prohibition of individual and not state action."\textsuperscript{65}

In \textit{California Retail Liquor Dealers Ass'n. v. Midcal Aluminum, Inc.}, the Supreme Court set forth the "Midcal two prong test" which is applied in evaluating whether conduct falls within the state action exemption.\textsuperscript{66}

\begin{itemize}
\item \textsuperscript{59} Goldfarb v. Virginia State Bar, 421 U.S. 773, 788-89 n.17 (1975).
\item \textsuperscript{60} BARRY KELLMAN, PRIVATE ANTITRUST LITIGATION 198 (1985).
\item \textsuperscript{61} Id.
\item \textsuperscript{63} Parker v. Brown, 317 U.S. 341 (1943).
\item \textsuperscript{64} Id. at 350-51.
\item \textsuperscript{65} Id. at 352.
\item \textsuperscript{66} California Retail Liquor Dealers Ass'n. v. Midcal Aluminum, Inc., 445 U.S. 97 (1980).
\end{itemize}
Depending on the characterization of the actor, a reviewing court must initially determine the status of the actor, and subsequently evaluate the challenged restraint, either solely under the first prong or under both prongs of the *Midcal* test.

The first prong requires that the challenged restraint be "one clearly articulated and affirmatively expressed as state policy." These two requirements ensure that the state authorized the challenged conduct by displacing competition with regulation, while retaining ultimate control in policing this conduct, and thus protecting the interests of the public.

The purpose of the antitrust laws, to safeguard the public by preserving a competitive marketplace, is not compromised by the availability of the state action exemption from the antitrust laws. There is a presumption that states act in the public interest, and thus, the purpose is not thwarted upon preemption of the antitrust laws. The danger of public harm increases the more removed the actor, engaged in anti-competitive conduct, is from the state.

Where a private party is engaging in the anti-competitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State. Where the actor is a municipality, the only real danger is that it will seek to further purely parochial public interests at the expense of more overriding state goals.

Recognition of this principle has prompted the Supreme Court to refine the requirements for qualification under the state action exemption since its inception over fifty years ago.

**B. Three Categories of Actors Under State Action Inquiry**

Entities have been divided into three categories for purposes of judicial

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67. Id. at 105 (quoting Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978)).
68. Id.
70. Hallie, 471 U.S. at 47.
review: states acting pursuant to sovereign powers; public entities acting pursuant to state-delegated authority; and, private actors.  

1. States Acting as Sovereign

There are three separate tests employed to determine if a restraint qualifies for state action immunity, depending on the status of the entity engaged in the challenged conduct. The first category involves direct acts of a state as sovereign, which are deemed per se immune from antitrust scrutiny. State legislatures and state supreme courts, acting in a legislative capacity, are entitled to ipso facto exemption from the operation of the federal antitrust laws. "When the conduct is that of the sovereign itself[,] . . . the danger of unauthorized restraint of trade does not arise."  

2. Public Entities Acting Pursuant to State-Delegated Authority

When states delegate to public entities such as municipalities or public hospitals, the authority to engage in anti-competitive behavior, such entities must act pursuant to a "clearly articulated and affirmatively expressed state policy' to replace competition with regulation" in order to enjoy immunity under the state action doctrine. Public entities do not enjoy absolute immunity from the antitrust laws solely by virtue of their status. "If municipalities were free to make economic choices counseled solely by their own parochial interests and without regard to their anti-competitive effects, a serious chink in the armor of antitrust protection would be introduced at odds with the comprehensive national policy

73. Id.
74. Parker, 317 U.S. at 351.
75. Bates, 433 U.S. at 360 (holding that a state supreme court acting in a legislative, rather than judicial capacity, is exempt from Sherman Act liability under the state action doctrine).
76. Hoover, 466 U.S. at 569.
77. Id. (quoting Community Communications Co. v. Boulder, 455 U.S. 40, 54 (1982)).

When cities, each of the same status under state law, are equally free to approach a policy decision in their own way, the anti-competitive restraints adopted as policy by any one of them, may express its own preference, rather than that of the State. Therefore, in the absence of evidence that the State authorized or directed a given municipality to act as it did, the actions of a particular city hardly can be found to be pursuant to the "state's command," or to be restraints that the "state as . . . sovereign" imposed.

Id. at 414.
Congress established."79

To receive immunity from the antitrust laws, a municipality must demonstrate that its anti-competitive conduct clearly was authorized by the state.80 "The determination that a municipality's activities constitute state action is not a purely formalistic inquiry; the State may not validate a municipality's anti-competitive conduct simply by declaring it to be lawful."81 Rather, it must demonstrate that a clearly expressed state policy to displace competition exists.82

In assessing whether a political subdivision is acting pursuant to specific state authorization, it is unnecessary for the municipality to "be able to point to a specific, detailed legislative authorization."83 Requiring courts to delve into the intent of the state legislature "would embroil the federal courts in the unnecessary interpretation of state statutes . . . [and] would undercut the fundamental policy of Parker and the state action doctrine of immunizing state action from federal antitrust scrutiny."84 The state policy simply must evidence "that the legislature contemplated the kind of action complained of."85 Upon demonstrating that such conduct was foreseeable by the state in delegating its authority, the "clear articulation" requirement is satisfied.86

Foreseeability does not have to be expressly declared by the state legislature, but may be inferred from statutory structure. In Hallie v. Eau Claire, the Supreme Court analyzed a Wisconsin statute regulating the provision of sewage services by municipalities, which was alleged to unlawfully replace competition with regulation.87 The Court, concluding that the challenged statutes "clearly contemplate that a city may engage in anti-competitive conduct" because such conduct was the foreseeable result of the power delegated to the municipality by the state legislature, held that the municipality satisfied this first prong of the Midcal test.88

The danger of harm inflicted on the public due to anti-competitive con-

79. Id. at 407.
81. Id. at 39.
82. Id. at 40. See Community Communications Co. v. Boulder, 455 U.S. 40 (1982) (holding that Colorado's delegation of general authority to a municipality was neutral and thus failed to satisfy the "clear articulation" component of the state action test).
83. Lafayette, 435 U.S. at 415.
84. Hallie, 471 U.S. at 44 n.7.
85. Lafayette, 435 U.S. at 415 (quoting 532 F.2d 431, 434 (5th Cir. 1976)).
86. Hallie, 471 U.S. at 43.
87. Id. at 47.
88. Id. at 42.
duct by a public entity is minimal. "[B]ecause a municipality is an arm of the [s]tate, [the courts] ... may presume, absent a showing to the contrary, that the municipality acts in the public interest."\textsuperscript{89} Consequently, it is unnecessary for a state to supervise actively the conduct of public entities acting pursuant to a clearly articulated state policy.\textsuperscript{90} In dispensing with this requirement, the Supreme Court stated that "[o]nce it is clear that state authorization exists, there is no need to require the [s]tate to supervise actively the municipality's execution of what is a properly delegated function."\textsuperscript{91} Thus, public entities must satisfy only the first prong of the \textit{Midcal} test in order to receive state action immunity.

3. \textit{Private Actors Engaging in Anti-competitive Behavior}

Private parties engaged in anti-competitive conduct pose a more serious threat to the public interest. "Where a private party is engaging in the anti-competitive activity, there is a real danger that he is acting to further his own interests ... ."\textsuperscript{92} As a result, both prongs of the \textit{Midcal} test must be satisfied in order for a private party to be entitled to state action immunity.\textsuperscript{93} "For States which do choose to displace the free market with regulation, [the] insistence on real compliance with both parts of the \textit{Midcal} test will serve to make clear that the State is responsible for the [anti-competitive activity] it has sanctioned and undertaken to control."\textsuperscript{94} A state's ultimate control over private conduct will ensure that only certain anti-competitive activities of private parties are authorized by the state and actually further state regulatory policies. Thus, the underlying purpose of the antitrust laws is still being served.\textsuperscript{95}

"[W]hile a State may not confer antitrust immunity on private persons by fiat, it may displace competition ... if the displacement is both intended by the State and implemented in its specific details."\textsuperscript{96} A state must create the machinery for establishing a program that foreseeably may displace competition in a particular industry in order to satisfy the

\textsuperscript{89} Id. at 45.
\textsuperscript{90} Id. at 47.
\textsuperscript{91} Id.
\textsuperscript{92} Id.
\textsuperscript{94} Ticor, 504 U.S. at 636.
\textsuperscript{95} Patrick, 486 U.S. at 100-01 (quoting \textit{Hallie}, 471 U.S. at 46-47).
first prong of the Midcal test.\textsuperscript{97} "[A] state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful."\textsuperscript{98} To confer immunity upon a private party, the court must be convinced that the party specifically was authorized by a clearly articulated and affirmatively expressed state policy, and not acting pursuant to a facially neutral statute.

The active supervision prong guarantees that a state retains ultimate control and plays a substantial role in carrying out the state policy.\textsuperscript{99} As illustrated by case law,

\begin{quote}
[t]he active supervision prong of the Midcal test requires that state officials have and exercise power to review particular anti-competitive acts of private parties and disapprove those that fail to accord with state policy. Absent such a program of supervision, there is no realistic assurance that a private party's anti-competitive conduct promotes state policy, rather than merely the party's individual interests.\textsuperscript{100}
\end{quote}

Thus, a state may not simply relinquish its power in authorizing certain anti-competitive activities; it must review continuously such activities and remain empowered to withdraw its authorization upon a finding that state regulatory policies are no longer being furthered.

In \textit{Patrick v. Burget}, the Supreme Court concluded that the activities of hospital peer review committees were not subject to adequate state supervision, and thus not entitled to state action immunity.\textsuperscript{101} Stating that the mere presence of some state involvement will not suffice to demonstrate active supervision,\textsuperscript{102} the Court noted that the Oregon statute failed to establish a scheme by which state actors could review "private decisions regarding hospital privileges to determine whether such decisions comport with state regulatory policy and to correct abuses."\textsuperscript{103}

The active supervision requirement commands that the state retain ultimate control.\textsuperscript{104}

Where . . . the state's program is in place, is staffed and funded,
grants to the state officials ample power and the duty to regulate pursuant to declared standards of state policy, is enforceable in the state's courts, and demonstrates some basic level of activity directed towards seeing that the private actors carry out the state's policy and not simply their own policy, more need not be established.\textsuperscript{105}

Such protracted control by the state assures that the purpose of the antitrust laws will not be extinguished by private parties acting to the detriment of the public while simultaneously furthering their own interests.

\section{State Action Immunity in the Health Care Sector}

In the context of the health care industry, the state action doctrine has been raised successfully as a defense in litigation concerning activities of health care purchasers, sellers, and suppliers.\textsuperscript{106} More than one-third of the states have provided state action immunity pursuant to regulatory programs authorizing cooperative activities such as joint ventures and hospital mergers.\textsuperscript{107} While some critics assert that the prerequisites for immunization under the state action doctrine are ambiguous and thus do not assure exemption from the antitrust laws,\textsuperscript{108} this contention is fallacious. The requirements for qualification have been clearly set forth and refined by the Supreme Court since the establishment of the state action exemption in \textit{Parker}.\textsuperscript{109} For states that enact programs in accordance with these requirements, the state action doctrine provides a viable and efficacious means of furnishing immunity from the antitrust laws for both public and private entities in the health care industry.\textsuperscript{110}

\textsuperscript{105} \textit{Ticor}, 504 U.S. at 637 (quoting New England Motor Rate Bureau, Inc. v. Federal Trade Comm'n, 908 F.2d 1064, 1071 (9th Cir. 1990)).

\textsuperscript{106} Harris, \textit{supra} note 5, at 24.


\textsuperscript{108} Harris, \textit{supra} note 5, at 43.


\textsuperscript{110} \textit{See, e.g.}, Sandy River Nursing Care v. Aetna Casualty, 985 F.2d 1138, 1146-47 (1st Cir. 1993) (upholding state insurance rate making system on grounds of state action immunity); Cohn v. Bond, 953 F.2d 154 (4th Cir. 1991), \textit{cert. denied}, 505 U.S. 1230 (1992) (affirming summary judgment for public hospitals and its medical staff pursuant to the state action doctrine); Brazil v. Arkansas Bd. of Dental Examiners, 593 F. Supp. 1354 (E.D. Ark. 1984) (holding a private state dental association that recommended appointments to the state board pursuant to state law was immune from antitrust scrutiny).
III. STATE HEALTH CARE REFORM LEGISLATION

There is a myriad of legislation that has been enacted by states to influence activity in the health care marketplace. "Any willing provider" laws are one example of legislative relief for health care providers. Such legislation requires third-party payors to permit any provider willing to accept the rates agreed upon between the payor and preferred providers to participate in the health plan. Such legislation may have anti-competitive effects because:

there is less incentive for any facility or practitioner to give a discount in order to become a 'preferred provider.' Therefore, this type of law makes it more difficult for the payor to obtain a discount from any provider, and interferes with the competitive bidding process in managed care contracting.

A. Antitrust Immunity Provisions in Health Care Legislation

Under the Midcal two prong test, a state regulatory program will qualify for state action exemption upon a finding that there exists a "clearly articulated and affirmatively expressed" state policy to replace competition with regulation. In the case of private actors, the state also must be engaged in active supervision and retain "ultimate control" over the anti-competitive restraint.

Many states have enacted statutes providing legislative relief for health care programs that potentially may conflict with the federal antitrust laws. The regulatory programs which have been created provide health care market participants with the requisite flexibility necessary to respond to increased competition by authorizing cooperative action under the state action doctrine in particularized situations. To ensure that the


113. Harris, supra note 5, at 20-21.


laws promulgated will pass muster, some states have expressly included in
the statute their intentions to immunize certain conduct from antitrust
scrutiny pursuant to the state action doctrine. Thus, the state intention
to displace competition is articulated clearly, expressed affirmatively, and
there is no ambiguity concerning whether the anti-competitive effects
were foreseeable.

Antitrust immunity provisions should address three specific areas to
help assure that the Midcal two prong test is satisfied. The legislation
should include "[a] detailed statutory scheme framing the immunity pro-
cess requirements." While specific, detailed legislative authorization is
not a prerequisite to a finding of a clearly articulated state policy, such
a pronounced delineation would guarantee a finding that the state in-
tended to displace competition. "As long as the State as sovereign clearly
intends to displace competition in a particular field with a regulatory
structure, the first prong of the Midcal test is satisfied."

Secondly, a state regulatory scheme should enumerate "the goals that
the anti-competitive conduct is to achieve and requir[e] that a number of
those goals be met." Announcing such goals and defining a minimum
that must be satisfied in order to enjoy immunity pursuant to the state
policy illustrates that the state is actively involved and is seeking to fur-
ther the public interest. "The requirement is designed to ensure that
the state action doctrine will shelter only the particular anti-competitive
acts ... that, in the judgment of the State, actually further state regulatory
policies."

Finally, the state policy should set forth "a detailed application, ap-
proval, and review process that focuses on the public interest." Such
evidence will demonstrate that the state retains ultimate control over the
authorized anti-competitive conduct. The state scheme must provide
more than the potential to supervise the activity; there must be evidence
of actual state involvement and decision making authority. One exam-

117. Rosenstein, supra note 3, at 331.
119. Stephanie M. Harper, Quest for Antitrust Immunity: Oregon, Health Care, and the
122. See generally Harper, supra note 119, at 116.
123. Id. at 112.
126. Rosenstein, supra note 3, at 336.
role of state control, which has been found to satisfy the active supervision requirement, is explicit statutory authorization to review decisions made by those engaged in the anti-competitive conduct, coupled with the power to overturn those activities that do not adhere to the goals of the state policy.\textsuperscript{127}

Some critics claim that inconsistent legal standards are applied by the courts leaving the state action doctrine unpredictable, and thus another solution should be sought.\textsuperscript{128} The courts have defined, however, the elements required for qualification during the evolution of the state action doctrine and have clearly spelled out what will suffice in fulfilling these elements. Satisfaction of the components of the \textit{Midcal} test will provide adequate security for states seeking to regulate particular facets of industries under the state action doctrine.

Many commentators defend the \textit{Midcal} test as a "relatively sensible compromise between the judiciary's obligation to respect the results of the democratic process at the state level and its obligation to respect that same process at the national level."\textsuperscript{129} So long as states clearly set forth their intentions to displace competition and provide adequate supervision where necessary, there shall be no ambiguity concerning qualification for state action immunity.

\textbf{B. The Oregon Health Plan}

Oregon has enacted a regulatory program that illustrates the framework through which a state may confer state action immunity to further the public interest by permitting conduct that may otherwise violate the antitrust laws.\textsuperscript{130} In seeking to protect the public interest, Oregon has attempted to regulate the transplant market by enacting a cooperative heart and kidney transplant program.\textsuperscript{131}

The transplant market is unique in that the number of organ transplants that may be performed is strictly limited by the supply of organs. Health care providers therefore lack the freedom to respond to demand because they exercise no control over the supply. In addition, the gravity of the activity mandates that transplant centers offer high quality services. As a result, fostering competition in this market would prove detrimental.

\textsuperscript{128} Harris, \textit{supra} note 5, at 23.
\textsuperscript{130} \textit{OR. REV. STAT.} § 442.715 (1995).
\textsuperscript{131} \textit{Id.} §§ 442.700 - 442.760.
to the public because an increased number of market participants would result in a duplication of services of potentially lower caliber performance, causing increased prices and inefficiency.\textsuperscript{132} The Oregon state legislature intervened by adopting legislation that authorizes the formation of cooperative programs thereby displacing competition among health care providers.\textsuperscript{134} The statute specifies that only Oregon Health Sciences University, originally the sole provider of heart and kidney transplant services, and those entities operating at least three hospitals in a single urban area qualify for eligibility in the cooperative program.\textsuperscript{135} Thus by limiting participation in the program, the legislature clearly intended to replace competition with regulation. Because the state legislature clearly contemplated that participants in the program may engage in anti-competitive conduct, the state policy satisfies the first prong of the \textit{Midcal} test.\textsuperscript{136}

The Oregon legislature explicated the goals of the cooperative program and established a minimum number that must be fulfilled.\textsuperscript{137} The stated goals are:

(a) reduction of, or protection against, rising costs of heart and kidney transplant services;
(b) reduction of, or protection against, rising prices for heart and kidney transplant services;
(c) improvement or maintenance of the quality of heart and kidney transplant services provided in this state;
(d) reduction of, or protection against, duplication of resources including, without limitation, expensive medical specialists, medical equipment and sites of service;
(e) improvement or maintenance of efficiency in the delivery of heart and kidney transplant services;
(f) improvement or maintenance of public access to heart and kidney transplant services;
(g) increase in donations of organs for transplantation; and
(h) improvement in the continuity of patient care.\textsuperscript{138}

\textsuperscript{132} See Jeffrey D. Hosenpud, M.D. et al., \textit{The Effect of Transplant Center Volume on Cardiac Transplant Outcome}, 271 JAMA 1844, 1847-48 (1994).
\textsuperscript{133} Harper, \textit{supra} note 119, at 104.
\textsuperscript{134} \textsc{Or. Rev. Stat.} § 442.705(1).
\textsuperscript{135} \textit{Id.}
\textsuperscript{136} Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 415 (1978) (quoting 532 F.2d 431, 434 (5th Cir. 1976)).
\textsuperscript{137} \textsc{Or. Rev. Stat.} § 442.710(4)(a).
\textsuperscript{138} \textit{Id.} § 442.705(2).
If a participant fails to demonstrate that certain goals have been or will be achieved, eligibility will be abrogated. The goals clearly indicate that the program will serve the public interest, and unconditional disqualification of an entity failing to act in the public interest provides an adequate measure for safeguarding the state’s purpose behind the regulation.

The legislation sets forth specific application requirements for potential participants, including a description by participants, of potential anti-competitive activities in which they foresee engaging. The Director of the Department of Human Resources (hereinafter “Director”) reviews all applications and issues an order to those applicants satisfying the requirements of the state policy.

Upon a finding that the program’s goals further the state policy and serve the public interest, the director issues an order stating such conclusions. The order authorizes participants to engage in certain anti-competitive conduct, while delineating the limits of such authorization. The Oregon legislation clearly illustrates affirmative action by the state as required for state action immunity.

The compliance and enforcement provisions of the statute provide unequivocal evidence of active state supervision. The statute mandates the establishment of a board of governors, comprised of executive officers of each health care provider participant and the Director, who must devise program policies and a budget. The Director retains power to veto the budget proposal if it is found to conflict with the goals of the state program. The Director also reviews annual reports submitted by the board describing the extent to which the programs comply with the order and attain state goals.

The Director exercises ultimate authority over the implementation of the program. The Director is empowered to impose such remedies as issuing cease and desist orders or withdrawing immunity from any parties

139. Id. §§ 442.710 (5), (8).
140. Id. § 442.710(4).
141. Id. §§ 442.710(4)(a), (b).
142. Id. § 442.710(7)(e).
143. Id. §§ 442.710(7)(a), (b).
144. Id. § 442.710(6).
145. Id. § 442.710(6).
146. See Hoover v. Ronwin, 466 U.S. 558, 574 (1984) (“The reason that state action is immune from Sherman Act liability is not that the State has chosen to act in an anti-competitive fashion, but that the State itself has chosen to act.”) (emphasis added).
147. Id. §§ 442.720(2)(a), (b).
148. Id. § 442.720(4).
149. Id. §§ 442.725(1), (2); § 442.730(1)(a).
acting beyond the scope of the order.\textsuperscript{150} Such protective measures thwart the threat of harm to the public, stemming from unauthorized behavior. The Oregon legislation clearly satisfies the second prong of the \textit{Midcal} test as evidenced by the fact that the director "ha[s] and exercise[s] power to review particular anti-competitive acts of private parties and [to] disapprove those that fail to accord with state policy."\textsuperscript{151}

The Oregon transplant program is an exemplary model of a state policy to replace competition with regulation which is entitled to state action immunity. The legislation possesses the essential elements for antitrust immunity as set forth in \textit{Midcal}.\textsuperscript{152} As evidenced by the legislative scheme adopted in Oregon, the state action doctrine is a viable option for states seeking to regulate the health care industry.\textsuperscript{153}

\section*{IV. Conclusion}

Unqualified exemption from the federal antitrust laws for the health care industry is unnecessary to safeguard public welfare. Health care programs established in response to the dramatic changes that have been occurring recently will not be \textit{per se} invalidated due to antitrust concerns. Both the antitrust safety zones set forth in the Department of Justice and Federal Trade Commission Antitrust Enforcement Policy Statements,\textsuperscript{154} and the availability of exemption from the antitrust laws under the state action doctrine\textsuperscript{155} strike an acceptable balance between the underlying purpose of the antitrust laws and the need to displace competition in the health care industry.\textsuperscript{156} Blanket immunity from the federal antitrust laws is both unnecessary and inordinate.

The goal of the antitrust laws is to promote efficiency, while simultaneously protecting the public from anti-competitive practices.\textsuperscript{157} This goal may be realized in the health care industry despite the fact that the choices of consumers are often controlled by external variables that do

\begin{itemize}
  \item \textsuperscript{150} \textit{Id.} §§ 442.740(1)(b),(4),(6).
  \item \textsuperscript{151} Patrick v. Burget, 486 U.S. 94, 101 (1988).
  \item \textsuperscript{152} California Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).
  \item \textsuperscript{153} Other states have successfully enacted health care legislation containing state action immunity provisions. See COLO. REV. STAT. ANN. §§ 24-32-2701 - 24-32-3715 (West Supp. 1994); MINN. STAT. ANN. §§ 62J.2911 - 62J.46 (West Supp. 1994); WASH. REV. CODE ANN. §§ 43.72.005 to 43.72.914 (West Supp. 1994).
  \item \textsuperscript{154} Dep't of Justice & FTC Statements, \textit{supra} note 49, at 13,150.
  \item \textsuperscript{155} Harris, \textit{supra} note 5, at 3.
  \item \textsuperscript{156} \textit{See} Jorde, \textit{supra} note 62, at 229, 247-50.
  \item \textsuperscript{157} \textit{See} POSNER, \textit{supra} note 14.
\end{itemize}
not exist in other markets. However, under some circumstances, displacing competition in the health care market may sometimes prove beneficial to the public. Pursuant to such a finding, the state may intervene and replace competition with regulation. In such instances, the federal antitrust laws shall be set aside and the conduct authorized by the state will be insulated from antitrust scrutiny.

The state action doctrine exempts both state and private conduct carried out pursuant to a clearly articulated state policy. Private conduct must be "actively supervised" by the state and shall be subject to continuous scrutiny in order to qualify for immunity from the antitrust laws. "Only if an anti-competitive act of a private party meets both of these requirements is it fairly attributable to the State." Some argue that the elements for exemption as set out in Midcal are unclear, and thus, there is no guarantee of immunity for anti-competitive conduct undertaken upon reliance on the state action doctrine. While the courts have not laid out an exact formula defining what constitutes the requisite factors guaranteeing immunity under the Midcal test, the ingredients needed to satisfy the Midcal test have been illustrated and refined by the courts in recent years. As demonstrated by the Oregon legislature, it is possible to enact a state policy displacing competition so long as the legislative intent is clear, and the state retains ultimate control over such activity. Thus, the state action doctrine safely may be relied upon as a mechanism for addressing the issues that arise in the health care marketplace.

In drafting legislation, states may guarantee antitrust immunity by expressly conveying their intent to displace competition in an antitrust immunity provision. There will be no ambiguity as to the intentions of the state, and the first prong of the Midcal test undoubtedly will be satis-

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158. Harris, supra note 5, at 11.
161. Id. at 29.
162. Rosenstein, supra note 3, at 331; see generally Federal Trade Comm’n v. Ticor Title Ins. Co., 504 U.S. 621, 633 (1992) (reiterating the two-part test applicable to action by private parties adopted by the United States Supreme Court in Midcal).
164. Harris, supra note 5, at 23.
165. See generally Hallie v. Eau Claire, 471 U.S. 34 (1985) (holding that active state supervision is not a prerequisite to exemption from the antitrust laws where the actor is a municipality rather than a private party).
The second prong of the *Midcal* test assuredly will be met by a statutory grant of ultimate control to a supervisory state entity authorized to continuously review conduct and overturn any activities that do not further the goals of the state policy. So long as legislation contains such safeguards, the state action exemption may be relied upon without hesitation.

Relaxation of the federal antitrust laws is not the solution for the health care industry to successfully adapt to recent structural changes. "Competition, nurtured by sound antitrust policy, has resulted in innovations that offer great potential to provide health care more efficiently . . . ."168 In those circumstances where competition would not be beneficial to the public, the state, pursuant to the state action exemption, shall remedy the imperfections as it deems necessary. Thus, the federal antitrust laws and state action immunity shall coexist harmoniously in policing the health care industry.

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