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Recommended Citation

Joseph P. Bauer, *South Bend, Indiana: A Case Study of the Possibilities and Realities of Hospital Cooperation*, 8 Loy. Consumer L. Rep. 143 (1995-1996).
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FEATURE ARTICLE

South Bend, Indiana: A Case Study Of The Possibilities And Realities Of Hospital Cooperation

by Joseph P. Bauer

South Bend, the county seat of St. Joseph County, Indiana, is a city with a population of slightly more than 100,000.[1] Located about 100 miles from Chicago, it serves many of the educational, financial and health care needs of a five county metropolitan area of over 700,000 people.[2] South Bend and its "sister city," Mishawaka,[3] are served by four general hospitals. The two largest each have about 40 percent of the available beds in the community. One of them, Memorial Hospital of South Bend, is a not-for-profit corporation which is unaffiliated with any other hospital; the other large hospital, St. Joseph's Medical Center, is a Catholic hospital which is part of the Holy Cross Health System Corp.[4] The other two hospitals, Michiana Community Hospital[5] and St. Joseph Hospital of Mishawaka,[6] each have roughly 10 percent of the available beds in the community.[7]

In 1992, the intense level of discussion of health care issues in the presidential elections, coupled with enhanced pressure from several large local employers for greater steps to achieve containment of costs in the delivery of health care, led to the creation of a Health Care Task Force in St. Joseph County. Then, in 1993, acting in part in response to grants from the National Civic League and a local foundation, the South Bend-Mishawaka Area Chamber of Commerce coordinated the transformation of this Task Force into a multi-level project, designed to attempt to identify, and then meet, a variety of community needs on a systematic and cooperative basis among many of the educational, religious and social service organizations in the community. Named the Healthy Communities Initiative, it was intended to facilitate mechanisms for the promotion of the physical and mental well-being of all the citizens of the County. About 95 persons drawn from various sectors of the community, called stakeholders, agreed to be founding members of this organization, and to draw on their experiences, contacts and other resources to implement its goals. Because its constituency was broadly based, among its implicit goals was to give an endorsement to the assessment of the needs of the community, including existing gaps, and to solutions for addressing those needs. The Healthy Communities Initiative is not targeted merely at the

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delivery of traditional health care; instead, it is intended to address the many areas which impact on "health." Therefore, it includes within the ambit of its interests such diverse, but important, components as education, housing, jobs, crime, drugs, education and so forth.

My involvement with the antitrust aspects of this Initiative began at the behest of my wife, one of its stakeholders and the associate director of Madison Center and Hospital, the area's principal community mental health provider.[8] Correctly recognizing that the intersection of health care and antitrust would continue to be a "cutting edge" area in the coming years, she urged me to meet with various participants in the Initiative involved in the health care area. My invitation to this Conference, which is examining this important area, became the final prod to consider one aspect of this topic, the antitrust implications of joint, or cooperative, ventures by health care providers.

Let me begin by describing my antitrust philosophy, and thus my initial views of this area. I am unabashedly "liberal," or, to translate into the antitrust lingo, enforcement-minded. Instinctively, I look askance at the justifications often offered by competitors for their joint undertakings, and am instead inclined to prefer rules which induce individual efforts by competitors. Furthermore, much of the antitrust litigation against entities in the health care industry, be they hospitals, providers or organizations, has involved instances of cooperative activity constituting price fixing or other forms of horizontal restraints, thereby crossing the lines of legality.[9] Thus, my initial suspicion was that the hospitals (and perhaps other health care providers) in St. Joseph County might attempt to use the umbrella of the Healthy Communities Initiative as an opportunity to undertake activities which might well be prohibited by the Sherman Act[10].

In fact, my conversations and involvement with this project indicate that quite the opposite is true. While a few cooperative projects have been initiated, some even before the Healthy Communities Initiative was formed, and some other useful ideas are now being discussed, these have, at least to date, fallen far short of the kinds of ventures which would raise antitrust concerns. It is clear that the antitrust laws have not been violated. If anything, a combination of fear and possible misapprehension of the limits of the law, as well as some other factors to be described below, have inhibited forms of cooperation which could enhance both the health and financial wellbeing of the citizens of St. Joseph County and the surrounding area.

To date, some of the joint ventures which have been undertaken, sometimes by the two largest hospitals and sometimes by all four, have actually involved comparatively significant areas. For example, the principal magnetic resonance imaging center in the community is co-owned by Memorial Hospital, St. Joseph's Medical Center, and two groups of radiologists. The hospitals have also implemented joint guidelines for credentialing certain physician specialties; have jointly recruited a physician in a specialized field; have shared certain rarely used equipment; and have arranged for combined ambulance services or cardiac transport services. Whether by agreement or merely in recognition of the needs of the community, a number of medical services are offered at fewer than all of the hospitals in the community.[11] The hospitals have also begun the formation of a Health Care Services Council, in an attempt to determine what gaps exist in the provision of medical care. While

still in the study stage, this Council has been attempting to draft common clinical standards, to develop a common intake form, to share certain patient information, and to develop uniform ethical guidelines.

Other cooperative ventures have been more modest. These have included producing joint brochures; undertaking coordinated seminars, education programs or health fairs, both for health care professionals and for various sectors of the community; and providing backup care for certain medical specialties.

Several other cooperative projects will either be undertaken shortly or are in the discussion or planning stages. These include programs to promote infant immunization and to expand mammography screening; a forum on teen pregnancy; and, perhaps most important, the development of a joint community needs assessment. Yet, problems in implementing these last two projects also illustrate the difficulties inherent in cooperation.

Several months ago, under the auspices of the Healthy Communities Initiative, the four hospitals in South Bend began planning a joint program for the fall of 1996 to address the various problems associated with teen pregnancy, including a public forum to be held in the local convention center. Only recently, however, the two Catholic hospitals announced that they could not sponsor any program at which family planning and contraception were to be discussed. It now appears that the program will be held, under the sponsorship only of Memorial Hospital and the United Way, with participation by the other hospitals limited to appearances by some of their representatives.

Since fulfillment of the governmentally-imposed requirement that every hospital must perform an assessment of community needs requires gathering and then analysis of much of the same data, such a project seemingly would present another opportunity for cooperation. But, in fact, since the assessment process would also require each hospital to share information both of perceived gaps in local coverage and potential areas of overlap or redundancy, there has been some reluctance by the larger two hospitals to make this a common undertaking.

In the fall of 1994, the U.S. Department of Justice and the Federal Trade Commission issued a series of nine joint Policy Statements regarding the applicability of the antitrust laws to the health care industry.[12] The rationale for the promulgation of these Policy Statements is that certain characteristics of the health care industry[13] justify according it special (and this is translated as more favorable) treatment under the antitrust laws.

An examination of these Statements suggests that a rather broad range of possibilities exists for quite lawful joint ventures by competing health care providers. It would appear, however, that many of these have, at least to date, not been discussed, much less implemented, by the four hospitals in St. Joseph County. Among the kinds of conduct identified in these Statements which hospitals might undertake are joint ventures involving high technology or other expensive equipment; joint ventures involving specialized clinical or other expensive health care services; the collective provision of certain information, both fee- and non-fee-related, to consumers of health care services; participation in exchanges of price and cost information; and joint purchasing arrangements. Other cooperative undertakings not directly covered by these Statements could include sharing personnel in

specialty areas; joint negotiations with third party payors; and development of planning or needs assessment projects.

On the other hand, although inter-hospital cooperation is more limited than the Policy Statements seemingly would permit, there is evidence that the hospitals in South Bend are engaged in a wide variety of cooperative relations both with other sectors of the health care industry and with other organizations in the community. These include participation in networks with physicians and other health care providers; affiliation with preferred provider organizations (PPOs); long-term contracts with, or even acquisitions of, groups of physicians; programs with schools, social service organizations and other community groups;[14] various contractual relationships with insurers; and agreements both with smaller general hospitals in adjacent counties and with mental health facilities. This trend, towards treating the delivery of health care as a package or system, with hospitals being responsible principally for providing one of its components, acute care and other procedures requiring costly facilities, is likely to be the "wave of the future" for cooperative efforts.

Nonetheless, a clear theme of the Policy Statements is that many cooperative arrangements between otherwise competing hospitals can be pro-competitive (or at worst benign), and can enhance efficiency, reduce costs, and increase the quality and diversity of health care services at prices which on average will be lower. Because uncertainty or fear may discourage hospitals from engaging in desirable cooperative ventures, the Statements set forth a number of "antitrust safety zones," identifying circumstances under which the two agencies will *not* challenge conduct under the antitrust laws. The statements also seek to make clear that other conduct, falling outside these safety zones, is not necessarily unlawful. Recognizing that antitrust analysis is inherently fact-intensive, the Statements set forth various factors to be used by the agencies to evaluate the lawfulness of that other conduct. Finally, the Justice Department and FTC offer business review and advisory opinion procedures, permitting parties to proposed transactions to obtain an evaluation of their specific proposals, to learn of the agencies' enforcement intentions. The combination of these substantive standards and procedural vehicles are intended to encourage broader implementation of a variety of concerted activities by otherwise competing hospitals.[15]

In light of the permissive antitrust climate in the "real world,"[16] one might ask why more extensive cooperation has not occurred among the hospitals in St. Joseph County (and apparently in most other communities, for that matter). First, the lack of a history of significant joint ventures, and inexperience with intensive cooperation, may simply take time to overcome. Thus, one can hope that a combination of developing a tradition of cooperation, and the confidence-building which should result from those first steps, will lead to yet more extensive cooperative efforts.

Some representatives of the hospital sector of the industry urge that the antitrust laws, even as unenforced as they are in the present climate, are still unduly restrictive of cooperation,[17] and that competition, which is the core value underlying antitrust, is itself part of the problem.[18] Not surprisingly, I disagree.[19] In fact, there probably are few, if any, joint ventures which would truly benefit consumers, which are actually being inhibited by any limitations imposed by the

antitrust laws.[20] To the contrary, today, the possibility of challenges under the antitrust laws almost always only serves to limit genuinely anticompetitive conduct.[21] In any event, as I describe below, because of other factors, it is not at all clear that even if the antitrust laws were completely repealed today, significantly enhanced levels of desirable cooperation would break out tomorrow.[22] Thus, I firmly reject these calls for even greater permissiveness for the health care industry[23] as the prescription for its ills.[24]

However, there are a number of other reasons for the tentative steps to date towards cooperation. These take a variety of political, legal, economic and strategic forms. First of all, as suggested above, I believe that a misunderstanding of the already liberal boundaries of the antitrust laws is a significant explanation for the absence of greater cooperation.[25] Thus, for example, in this exploding age of computerization, information storage and retrieval systems are becoming increasing costly, complicated and critical. Although it is far from clear that development of a common system would raise antitrust problems, the very possibility of illegality may result in a reluctance to discuss such a joint venture.

Hospitals are living today in an environment of intense competition, for patients, for affiliations with individual providers, for consummation of long-term relationships with insurance companies and with employers seeking lower health insurance costs, for access to technological advances, for cost-reduction methods, and so forth.[26] Part of this competition is designed to maintain, or even increase, each hospital's share of the health care market. As individual patient choice, rather than the decision of an admitting physician, increasingly affects the selection of a hospital, advertising and other forms of marketing by hospitals have become common practices.[27] At the same time, the very nature of the health care industry is evolving.[28] In this setting, at least certain types of cooperative ventures with competitors, which might leave each in a status quo situation without obvious increases in profitability, or perhaps even worse off than a competitor, understandably might have a diminished attractiveness.

This emphasis on profitability may offer another possible explanation for diminished cooperation. If the principal operating officers of a hospital are compensated in part based on performance, cooperation with other hospitals, which will lower costs, but may not necessarily enhance profits, has less attractiveness.

Yet another explanation for the lack of greater cooperation may be insurance requirements or governmental and regulatory mandates. Although usually intended to reduce costs, these sometimes may require the duplication of facilities or programs.[29]

The operators of the hospitals, their boards, trustees or other supervising officials, may also have conflicting interests. The difficulties in implementing the teen pregnancy program described above, because of the philosophical differences between Memorial Hospital and the Catholic-affiliated hospitals, offer one stark illustration of these difficulties. It is unclear whether other joint projects have also not gotten off the drawing boards, for a variety of possible philosophical conflicts.

What lessons may be drawn from this experience? If cooperative ventures among hospitals, or between hospitals and other members of the health care industry, are desirable from a health care policy perspective, and if they are

also procompetitive, or at worst benign, from an antitrust perspective, then it is probably not enough simply to inform hospitals, through the Policy Statements and otherwise, that these undertakings are permissible. Coaxing, rewarding, or even mandating this conduct may become necessary. The safe harbors created by the Statements are the first step. I hope that this Conference will also contribute to the dialogue. But, if my limited experiences with the microcosm of St. Joseph County are reflective of similar conditions in other communities, it will probably be necessary to consider other mechanisms, both inside and outside the antitrust framework, to stimulate the number and diversity of such joint undertakings.

Some of this stimulation will be private. Since cooperation can lead to reduced costs, both insurance companies and the employers who frequently pay their employees' premiums have incentives to urge it. Since cooperation will also increase the availability of medical services, underserved members of the community may well also press for additional steps.

Other stimulation may come from the government, either at the federal or state level. State legislation and regulation, including health planning statutes or certificate of need laws, are likely to lead to some instances of cooperation as a way of satisfying requirements imposed on hospitals.[30] Proposed reforms to the government programs providing reimbursement for health care expenses, which will increase the incentives on hospitals to control costs even more in the future, will probably make it more important to cut those costs through cooperative ventures.[31] Yet another stimulus to cooperation may be found in the tax laws. One of the requirements for the preservation of a hospital's tax-exempt status is that it must offer a certain level of community benefits. Frequently, it may turn out that these can be done most efficiently on a cooperative basis. Even the repeal of various kinds of restrictive legislation, for example, the remaining certificate-of-need laws, state statutes prohibiting corporations from providing medical services, or laws which limit the kinds of services which certain providers may offer, could open the door to new forms of horizontal or vertical cooperation.

Another possible stimulus to cooperation is a common external "enemy," the specter that one or more of the hospitals in an area might be acquired by a for-profit, investor-owned enterprise. In a number of communities, an attempted takeover has led the non-profit entities to unite to counter that threat. This could then lead, alternatively, to cooperation on other fronts as well, or to a focus on the takeover, to the exclusion of all other concerns.

Although fraught with potential danger, yet another vehicle for facilitating cooperation are statutes which have recently been enacted in a number of states, authorizing certain horizontal agreements by hospitals and sometimes other health care providers, for sharing or allocating various equipment, facilities or programs, or even for consummating certain mergers.[32] These statutes are designed to allow these entities to enjoy the shield of the state action doctrine,[33] which is available to private parties undertaking conduct which has been the product of a "clearly articulated and affirmatively expressed state policy," which is "actively supervised by" the state.[34]

Finally, I do not want to be misunderstood as forsaking my basic, pro-enforcement, procompetition orientation. As stated above, I believe that calls for yet further relaxation in the

enforcement of the antitrust laws must be rejected. To the contrary, great care must be exercised to insure that the stifling of competition, which I earlier alluded to as my initial concern about cooperation, does not become a by-product of the already permissive environment.

It then follows that policy-makers must exercise great caution with respect to any particularized relaxation of antitrust enforcement for this industry. Furthermore, since this special treatment would result in the displacement of the market forces which otherwise act as constraints on anti-competitive conduct, other mechanisms to protect the public might have to be created.

One possibility sometimes suggested is that various forms of centralized planning and regulation should be substituted both for antitrust enforcement and for market forces such as competition. However, any regulatory scheme will inevitably carry with it the costs and delays incident to any elaborate governmental structure. In the present political climate, however, the mood is to dismantle, rather than to erect, regulatory systems.[35] Because of those consequences and the public's antipathy to additional governmental intervention, if the competition that the antitrust laws otherwise attempt to insure were to be displaced, the implementation of some of these private alternatives, which would be regarded by most people as preferable to regulation, would be necessary.[36] Having said that, the absence of public accountability by many private forces is itself a strong argument for continuation of the present antitrust regime.[37]

Conclusion

Continued enforcement of the antitrust laws, with a view towards prohibiting those collusive acts among health care providers which are designed to stifle competition, remains important. However, more often than not, cooperation can prove pro-competitive, and therefore beneficial to both consumers of, and payors for, medical care. The discussion above makes clear that such cooperation often will not take place without encouragement or even mandate. Further analysis is therefore necessary, both regarding desirable forms of cooperation and of the steps, short of creating antitrust immunity for the health care industry, which will make them more frequent.

ENDNOTES

[1] St. Joseph County had a 1990 population of about 250,000. THE WORLD ALMANAC AND BOOK OF FACTS 397 (1995).

[2] This area includes Elkhart County to the east (1990 population of 156,000), Laporte County to the west (107,000), Marshall County to the south (42,000), all in Indiana, and Berrien County, Michigan, to the north (160,000). There is at least one general hospital in each of these counties. *Id.* at 422, 425.

[3] Mishawaka, a city of approximately 40,000, is also in St. Joseph County, immediately to the east of South Bend. *Id.* at 397.

[4] Holy Cross Health System Corp. has its headquarters in South Bend. It operates approximately a dozen hospitals around the country.

[5] Until a few years ago, this hospital was known as the Osteopathic Hospital of South Bend. There are a large number of osteopathically-trained physicians in the community.

[6] This institution, which is also a Catholic hospital, is uncon-

nected to the other local hospital of similar name. Instead, it is part of Ancilla Systems, which is headquartered in Hobart, Indiana and which operates six hospitals in northern Indiana.

[7] These two hospitals agreed to merge, effective January, 1996. They now operate as part of a new regional health care organization, called Ancilla Health Care, which will also include a separate outpatient facility, a clinic providing primary care and social services to the underserved, a behavioral health complex and a center for needy, pregnant women.

[8] Madison Center and Hospital is the largest provider of mental health services in the region. A not-for-profit corporation, it offers a full range of psychiatric services, including inpatient, partial hospitalization, residential and outpatient services to over 7,000 children, adolescents and adults each year.

[9] *See, e.g.*, FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986) (dentists' refusal to submit x-rays to insurers for use in determining benefits was unlawful concerted refusal to deal); Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) (maximum horizontal price fixing by groups of doctors organized in medical societies and "foundations for medical care" was unlawful per se); American Medical Ass'n v. United States, 317 U.S. 519 (1943) (restraints on operations of nonprofit group health plan, offering prepaid health care services, violated Sherman Act's criminal provisions); American Medical Ass'n v. FTC, 638 F.2d 443 (2d Cir. 1980), *aff'd*, 455 U.S. 676 (1982) (canons of ethics which restricted advertising and solicitation of patients, and which limited doctors' ability to engage in non-traditional forms of medical practice, violated FTC Act § 5).

See also Summit Health, Ltd. v. Pinhas, 500 U.S. 322 (1992) (physician's challenge to hospital's decision to release results of allegedly unfairly conducted peer review proceeding asserted claim in or affecting interstate commerce); Patrick v. Burget, 486 U.S. 94 (1988) (physician's challenge to complaints filed by other physicians, and subsequent revocation of his hospital staff privileges based on peer review proceedings, was not immunized by state action doctrine). *Cf.*, Jefferson Parish Hospital Dist. No. 2 v. Hyde, 466 U.S. 2 (1984) (contract between hospital and group of anesthesiologists, requiring patients in hospital to use services of that group of doctors, and promising not to hire other radiologists, was not unlawful either as tying arrangement or as exclusive dealing contract).

See generally John Flynn, *Antitrust Policy and Health Care Reform*, 39 Antitrust Bull. 59, 70-107 (1993) (discussing cases).

[10] 15 U.S.C. §§ 1-7 (1988).

[11] For example, while Memorial Hospital, but not St. Joseph's Medical Center, has in-patient psychiatric services, the latter hospital has the only kidney unit with a lithotriptor in the county.

[12] Department of Justice and Federal Trade Commission Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, *reprinted in* 67 Antitrust & Trade Reg. Rep. (BNA), No. 1682 (1994).

[13] Among these characteristics are that at least certain medical procedures, services, drugs and so forth are necessities, which must be used irrespective of their cost; that access to many other forms of medical care are viewed by most people in our society as fundamental rights, often to be supported by governmental programs; that perhaps the majority of medical care is paid for by persons other than the consumer, whether it be third party insurance or various governmental programs; and that most consumers are unable to evaluate the necessity for, and compare the quality of, much medical care.

[14] For example, in 1993, Memorial Hospital implemented a "tithing" system, under which it will reserve 10% of the previous year's surplus for community benefits projects. Qualifying programs must be collaborative, involving schools, churches, neighborhood organizations or social service agencies. Intended to address an unmet need among underserved populations, the projects which have already been funded have included health screening, educational programs, immunization, provision of nursing care and clinics.

[15] The Statements are directed primarily at horizontal cooperative arrangements. However, as noted above, market forces are increasingly making vertical integration both desirable and necessary. Because of the competitive disadvantages that less-than-fully-integrated participants will incur if they are left out of these cooperative ventures, serious attention will have to be given to the adverse effects on competition from agreements involving health care providers at different levels of the industry.

[16] Just one example of the agencies' encouraging tone, designed to convey their generally permissive attitude toward concerted activities by hospitals, is the following statement about mergers: "Antitrust challenges to hospital mergers are relatively rare. Of the hundreds of hospital mergers in the United States since 1987, the Agencies challenged only a handful, and in several cases sought relief only as to part of the transaction." *See supra* note 12 at 1.B. It is almost as if the government is taking pride in how little is being done to enforce Section 7 of the Clayton Act.

Indeed, this permissive attitude was again manifested by the October, 1995, agreement by the FTC, to permit the merger of the nation's two largest hospital chains — Columbia/HCA Healthcare Corp. and Healthtrust Inc. When concluded, the transaction, which is the biggest hospital merger in history, will result in a corporation with 320 hospitals and more than 100 outpatient surgery centers in 36 states.

See Fredric J. Entin, Tracey L. Fletcher & Jeffrey M. Teske, *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 Wake Forest L. Rev. 107, 119 (1994) (identifying six mergers, of the only two hospitals in the community, which went unchallenged by enforcement agencies). *But see*, FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991) (successful challenge to merger of two hospitals in Augusta, Georgia, which would have resulted in combined market share of 43%); United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir.) (successful challenge to merger of two hospitals in Rockford, Illinois, which would have resulted in combined market share of 64-72%, and post-merger market share of 90% by three largest hospitals), *cert. denied*, 498 U.S. 920 (1990).

See generally Thomas Campbell & James W. Teevans, *Mixed Signals: Recent Cases Make the Legality of Future Hospital Mergers Less Predictable*, 59 Antitrust L.J. 1005 (1991).

[17] *See, e.g.*, Entin, *supra* note 16, at 110 ("The antitrust laws, as currently enforced, are inappropriately inhibiting the rational restructuring of the health care system through collaborative efforts.") (article by present and former counsel of American Hospital Association).

[18] "For hospitals, competitively structured markets may not produce an optimal allocation of resources.... To the extent that competition among hospitals fosters creation of this excess capacity, the normal competitive paradigm may, in fact, impose costs on purchasers of hospital care." *Id.* at 123.

However, as discussed below, if it were true that competition is inappropriate to the health care industry, and that the antitrust laws need to be displaced, some other mechanisms, statutory or regulatory, would need to be inserted to protect consumer interests. In all likelihood, hospitals would find these alternatives even less desirable.

[19] One aspect of the problem is that antitrust's goal of preventing certain kinds of private interference with market forces is intended in large measure to reduce costs and prices. However, hospitals and other providers assert that these objectives are often inconsistent with the provision of the highest quality of medical care, and furthermore that they, in the exercise of their professional judgment, and acting in the best interest of their patients, are in the best position to make these determinations.

[20] I believe that at most, uncertainty about whether proposed conduct violates the antitrust laws may make it somewhat more time-consuming and expensive to implement certain cooperative activity. The enforcement agencies have already taken important steps to reduce some of these uncertainties by the issuance of the Policy Statements, frequent speeches to industry, congressional testimony, and offers of expedited business review procedures.

While not denying that there still are costs associated with complying with the antitrust laws, they are no different in kind than the costs hospitals face in complying with labor laws, occupational safety requirements, or any other body of law designed to protect employees or the general public. And, there is no more justification for special treatment for hospitals under the antitrust laws, merely to reduce costs, than it would be to allow hospitals to pay employees less than a minimum wage to accomplish the same goals. Therefore, although some uncertainty admittedly remains, the costs to society of removing the health care industry from the ambit of the antitrust laws would far outweigh its benefits.

See generally Kevin E. Grady, *A Framework for Antitrust Analysis of Health Care Joint Ventures*, 61 ANTITRUST L.J. 765 (1993) (recognizing occasional uncertainty, but suggesting factors making legality of joint venture proposals more predictable).

[21] In fact, given the historical opposition by physicians and other providers to the introduction of non-traditional means of health care delivery, it is arguable that were it not for the protection afforded to competition by the antitrust laws, some of the innovative and cost-cutting measures that have been recently adopted, including various insurance products and managed care plans, might never have gotten off the ground.

[22] Although impossible to predict, in the absence of the antitrust laws, perhaps the most likely scenario in St. Joseph County would be a further merger by one of the two larger hospitals with the recently merged Michiana Community-St. Joseph Mishawaka Hospitals. Although detailed study of the actual impact on health care users and payors of such a transaction would of course be necessary, I strongly doubt that the reduction of South Bend to a two hospital community would be desirable.

[23] Congress has already enacted one relatively narrow exemption for the health care industry. The Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101-11152 (1988), provides antitrust immunity for certain peer review proceedings undertaken by hospitals and physicians. *See generally* Earl W. Kintner & Joseph P. Bauer, 10 Federal Antitrust Law § 75.5 (1994).

[24] *See generally* Thomas L. Greaney, *When Politics and Law Collide: Why Health Care Reform Does Not Need Antitrust 'Reform,'* 39 ST. LOUIS U.L.J. 135 (1994) (rejecting arguments for changes in antitrust treatment of health care industry).

[25] A different, and alternative, explanation is that the antitrust laws are sometimes used as an excuse not to cooperate, even though those laws would not in fact proscribe the activity in question. Thus, a hypothetical repeal of the antitrust laws would take away this "cover."

[26] It is worth noting that while the primary interest of payors is in cost-reduction, by contrast, consumers of health care often may prefer more advanced or innovative, but also more costly, health care. Thus, while it can be expected that government, insurance companies and employers will look to competition to result in a greater number of less expensive providers, consumers instead hope competition will yield the "best" providers and services, with cost being only one of the factors determining quality.

[27] This trend is further accelerated by the increasing offering of out-patient services by hospitals.

[28] Three of the most prominent of these changes include the need for providers to be part of a "system," offering a full range of medical services; new payment methods, as exemplified by the trend towards "capitation;" and efforts to limit both perceived overutilization of medical services and oversupply of medical facilities.

[29] An example of one such step was the opening by St. Joseph's Medical Center in 1992 of an obstetrics unit, which had been closed almost twenty years earlier. One explanation given for this move was that insurance companies require contracting providers to offer a full line of certain commonly used and essential services.

[30] A similar push towards cooperation at the federal level resulted from the ill-fated National Health Planning and Resources Development Act of 1974 (NHPRDA), Pub. L. No. 93-641, 88 Stat. 2225 (1975), which required the establishment of state and regional health planning and development agencies. Through control of the issuance of certificates of need, these agencies were charged, in part, with responsibility for controlling the supply of hospital beds, the acquisition of expensive equipment, and the expansion of facilities and programs. That statute was criticized, however, in part because it was felt that market forces were preferable to planning under gov-

ernment auspices as a means of allocating health resources; it was repealed, effective in 1987, by the Health Programs Act of 1986, Pub. L. No. 99-660, § 701(a), 100 Stat. 3743, 3799 (1987). *See also,* National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378 (1981) (NHPRDA did not create implied antitrust immunity against claim arising out of local health system agency's refusal to grant approval for construction of hospital facilities). *See generally* Maja Campbell-Eaton, Note, *Antitrust and Certificates of Need: A Doubtful Prognosis*, 69 IOWA L. REV. 1451 (1984) (describing and criticizing NHPRDA).

[31] Certainly a critical step in this direction were the Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, which replaced the retrospective approach to reimbursement of hospitals, based on costs and other defined charges, with a prospective, fixed price system for payment of many of the services provided by hospitals. Since a hospital now has to bear the difference if its own costs exceed that fixed price, and can keep the difference if its costs fall below that price, there is an obvious, substantial incentive to control costs in those areas.

[32] *See, e.g.,* COLO. REV. STAT. § 25.5-1-501 et seq. (West 1995); ME. REV. STAT. ANN. TIT. 22, § 1883 (West 1992 & Supp. 1994); 7 MINN. STAT. ANNOT. § 62J.2911 (Supp. 1995); N.C. GEN. STAT. § 131E-192.3 et seq. (1994); N.D. CENT. CODE § 23-17.5 (Supp. 1995); OHIO REV. CODE ANN. TIT. 37, § 3727.21-.24 (1992); WASH. REV. CODE ANN. § 70.44.450 (Supp. 1995); WISC. STAT. ANN. § 150.85 (Supp. 1994). *See* James Blumstein, *Assessing Hospital Cooperation Laws*, 8 LOY. CONSUMER L. REP. 98 (identifying statutes in nineteen states, and questioning use of state action doctrine to undermine competitive forces in health care industry). *See generally* Sarah S. Vance, *Immunity for State-Sanctioned Provider Collaboration after Ticor*, 62 ANTITRUST L.J. 409, 432-33 (1994) (summarizing key requirements of thirteen state statutes).

[33] This doctrine was first articulated in Parker v. Brown, 317 U.S. 341 (1943). Its possible applicability to the conduct of private parties was first recognized by the U.S. Supreme Court in Cantor v. Detroit Edison Co., 428 U.S. 579 (1976). The two-part test for its availability was refined in California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980). *See generally,* Earl W. Kintner & Joseph P. Bauer, 10 Federal Antitrust Law § 76 (1994).

[34] *See* James F. Blumstein, *National Health Care Reform on Trial: Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1486-1505 (1994) (criticizing statutory approach both for introduction of inappropriate, non-competitive considerations and for failure to comply with *Parker-Midcal* requirements); David L. Meyer & Charles F. Rule, *Health Care Collaboration Does not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 208-11 (1994) (criticizing use of statutes, which attempt to exempt otherwise problematic collaborative efforts); Joshua Rosenstein, Comment, *Active Supervision of Health Care Cooperative Ventures Seeking State Action Antitrust Immunity*, 18 SEATTLE U.L.REV. 329 (1995) (analyzing Wash. statute).

[35] Thus, one of the objections to the state statutes described above, *see supra* notes 32-34 and accompanying text, is that their success depends on "active supervision" by the state, which may require the detailed regulation which is the object of so much contemporary public condemnation.

[36] The health care reform package proposed by the Clinton administration in 1993, its so-called Health Security Act, contained some recognition of this need. The Clinton plan relied on the creation of a small number of large groups of providers to lower costs and produce other efficiencies. The very term used to describe the means of achieving the objectives of the plan, "managed competition," which may in fact be an oxymoron, was evidence both of the value of competition and of the need to recreate it in somewhat different form. Managed competition sought to address both the anomalies of competition in the health care industry, and the market power that these groups of providers would enjoy, by creating countervailing power on the part of consumers (or more importantly, insurers), who were to be grouped in health care alliances. The expectation was that this would encourage vigorous bargaining between them. *See generally* Frances H. Miller, *National Health Care Reform on Trial; Health Insurance Purchasing Alliances: Monopsony Threat or Procompetitive Rx for Health Sector Ills?*, 79 Cornell L. Rev. 1546 (1994)(concluding that concentrated buying power growing out of statutorily mandated alliances would have significant *anti*-competitive effect).

[37] *See generally* Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507 (1994) (because of market imperfections in health care industry, managed competition regime will require combination of regulation and antitrust enforcement).