

# Antitrust Law May Be A Barrier to Collaboration

BY JANE H. WHITE

**T**he United States is unique in its pursuit of "new and improved" competition to reform its healthcare system. Other countries favor more regulatory strategies, such as all-payer rate setting for hospitals and physicians in Germany, and single-payer systems in France and Canada. New data show that the United States continues to spend far more than its Western allies on healthcare—and with less-than-universal coverage (George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Spending, Delivery, and Outcomes in OECD Countries," *Health Affairs*, Summer 1993). U.S. per capita spending on healthcare in 1991 exceeded spending in Canada by 50 percent, in Germany by 73 percent, and in France by 74 percent.

The question now before American policymakers is this: Can the United States correct its failed healthcare markets via "managed competition," keep its healthcare costs in line with those around the world, and still ensure every American timely access to high-quality healthcare?

This new "managed competition" preferred by President Bill Clinton incorporates two seemingly paradoxical philosophies. First is the notion that increased competition among healthcare providers and plans will lower the cost of healthcare and provide more consumer choice. The second idea follows the more collaborative lines of other nations' healthcare systems. Here the goal is to form purchasing cooperatives, alliances, or networks (depending on the terminology at the moment), to improve efficiency in the healthcare system, and to eliminate costly duplication of services and excess capacity.

To make the collaborative part of the plan work, however, major healthcare provider groups and some policy analysts are arguing for reform of the nation's antitrust laws set up to preserve competition. On the other side, some policymakers and lawyers are opposed, in varying degrees, to any changes in the antitrust statutes. The arguments on both sides point to the crux of the



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healthcare reform debate: Can the United States reform healthcare within a competitive market structure that allows the necessary flexibility for collaboration among networks of providers?

Antitrust law and its interpretation thus raise some interesting policy issues that are unique to the U.S. healthcare reform debate. Rather than outline the legal minutiae of the debate, I will examine the related policy issues currently under discussion in Washington, DC.

## ANTITRUST LAW AND HEALTH POLICY

This spring several Senate hearings illuminated the antitrust-healthcare reform debate. On March 23 the Senate Judiciary Subcommittee on Antitrust, Monopolies, and Business Rights held the aptly titled hearing: "Health Care Reform: Do Antitrust Laws Discourage Cost Cutters or Defeat Price Gougers?" Sen. Howard M. Metzenbaum, D-OH, who chairs the subcommittee, is a staunch opponent of changing the current antitrust laws. "I do not believe that there is an inherent conflict between antitrust and health policy," he said in his opening statement. "It has been my experience that the antitrust loopholes sought by businesses are rarely in the best interest of consumers," Metzenbaum concluded.

A May 7 hearing before the Senate Finance Subcommittee on Medicare and Long-Term Care further examined antitrust issues. Although the Finance Committee does not have jurisdiction on antitrust matters, the members will be critically involved in the negotiations over the president's healthcare reform plan. This hearing served an educational purpose on a matter that crosscuts policy lines.

**Antitrust Law in the Healthcare Sector** Antitrust laws in the United States are "very simple statutes in relation to what we often think of as law," Br. Peter Campbell, CFX, senior attorney with the Catholic Health Association (CHA), explained in an interview. Antitrust laws are also long-standing. "The granddaddy of these things [the Sherman Act] is over 100 years old," continued

Br. Campbell. Where the conflicts have arisen is in enforcement of the law. "Enforcement depends on the government in power—not only Democrat or Republican, but the economic philosophy" of those in power, said Br. Campbell. When it comes to healthcare and antitrust law, "we've seen significant adjustments in government's enforcement program over the years," he noted.

A turning point came in 1975 when the Supreme Court in the *Goldfarb* case "overturned the long-standing assumption that the Sherman Act did not apply to the so-called learned professions, as it does to other types of trade or commerce [*Goldfarb v. Virginia State Bar*, 421 U.S. 773, 44 L.Ed. 2d 572, 95 S.Ct. 2004]. The application of antitrust law to healthcare providers following *Goldfarb* dramatically altered the character of the healthcare industry," explained Clark Havighurst, Duke University professor of law. An acknowledged expert in antitrust and healthcare law, Havighurst shared his views at the March 23 Senate hearing.

Thus in the mid-1970s, "anticompetitive concerted action by providers—which had previously been accepted as an immutable feature of the industry—suddenly became unlawful," testified Havighurst. This gave rise to the burst of competition in the healthcare sphere and the increasing market share of managed care entities such as health maintenance and preferred provider organizations. The ruling changed the course of health policy. "Perhaps the most important thing it did was to reverse the presumption, implicit in previous national policy, that competition could serve no useful purpose in the healthcare sector," said Havighurst.

**Antitrust Law: Barrier to Healthcare Reform?** As competition between new healthcare entities flourished in the 1980s, healthcare costs spiraled upward. National healthcare spending tripled during the decade, from \$250.1 billion in 1980 to \$751.8 billion in 1991 (Suzanne W. Letsch, "Health Spending Trends, 1991," *Health Affairs*, Spring 1993, pp. 94-110). Healthcare reform advocates questioned whether the healthcare sector could be treated as a true market and disciplined with competition. Health insurance tends to insulate consumers (patients) from the true cost of healthcare. For the most part, the employer makes the purchasing decision regarding insurance. In addition, physicians are usually responsible for demanding hospital services for their patients, thus further distancing the actual consumer from the decisions. These factors combine to distort the healthcare market.

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Recognizing these quirks, several legislators have sought to modify antitrust laws to allow provider collaborations that might seem anticompetitive in a "typical" market. Sen. William Cohen, R-ME, has introduced two bills in the current Congress to encourage collaborative activity among hospitals. The Access to Affordable Health Care Act (S.223) institutes a provision for hospital waivers from antitrust laws for collaborative activities certified by the secretary of Health and Human Services. The Hospital Cooperative Agreement Act (S.493) authorizes 10 five-year demonstration projects to evaluate the success of hospital collaborative activities.

At the state level, healthcare reform is progressing rapidly. To head off any perceived barriers posed by antitrust law, several states—Kansas, Maine, Minnesota, and Washington—have passed legislation to provide exemptions for certain hospital collaborative activities, especially in rural areas. In April, Washington passed a reform plan based on managed competition—the Washington Health Services Act of 1993. Allowing certain types of "anticompetitive" activities among providers was a critical issue in the state's reform debate, noted William Hagens, senior research analyst with the state's House Health Care Committee.

American Hospital Association (AHA) leaders have waged a campaign to gain such antitrust exemptions at a national level. AHA contends that gray areas in the antitrust laws pose barriers to hospitals' collaborative activities and the formation of networks that are part of the reform strategy under managed competition. The trade group also asserts that misperception of the law has had a chilling effect on hospital mergers and joint activity. Although much of this type of activity is permissible under current law, fear of challenge and the high potential cost of legal argument have deterred some hospitals.

At the March 23 hearing, AHA's General Counsel and Senior Vice President Frederic Entin pointed to two potential antitrust barriers to collaboration: "Under current law, hospitals cannot agree to allocate services among themselves based on location of the type of services provided, even if the allocation is recognized as beneficial by consumers." An example would be where one hospital agrees to purchase a magnetic resonance imager and the other a lithotripter, rather than each purchasing both expensive technologies. "Such an agreement would be considered a 'market division,' a per se violation of the antitrust laws," explained Entin.

A second barrier to collaboration pertains to

mergers, acquisitions, and joint ventures. Antitrust law evaluates this type of activity under the "rule-of-reason" standard. As Entin explained, "The threshold question under the rule of reason is whether the arrangement creates or enhances 'market power.'" The problem for the hospital community is that enforcers employ a rigid definition and tend to focus more on market concentration issues than on whether the joint activity benefits consumers with improved quality and lower cost. "Under the 1992 *Merger Guidelines* issued jointly by the Federal Trade Commission and the Department of Justice, virtually all communities with six or fewer hospitals are 'highly concentrated' markets. Accordingly in more than 80 percent of the United States communities that have more than one hospital, any reduction in the number of hospitals, through merger or acquisition, is presumptively illegal," testified Entin.

**Antitrust Law: Necessary for Healthcare Reform?** At the May 7 hearing, Phillip Proger, a lawyer with the Washington, DC, law firm of Jones, Day, Reavis, & Pogue, argued that antitrust laws and the competitive environment were not barriers to healthcare reform. "Antitrust laws are best understood with reference to their underlying purpose—that is, to protect consumers from the exercise of market power thereby ensuring efficiency, consumer choice, and the lowest possible prices," explained Proger. The issue in healthcare reform is how best to ensure good consumer service and lowest cost. Some analysts prefer a regulatory "watchdog"; market advocates favor competition.

Managed competition reform proposals encourage the formation of integrated networks and alliances. Proger outlined four types of economic integration with potential antitrust implications:

(1) at the local level, the horizontal integration of competing physicians, particularly primary care physicians, into fully or partially integrated units;

(2) at the regional level, the integration of hospitals, some of which will be competitors, into fully or partially integrated units called, for example by the AHA, community care networks;

(3) the integration of hospital and medical services through the formation of fully or partially integrated entities of hospitals and physicians;

(4) the integration of financing and delivery by contractual arrangements between non-fully integrated 'accountable

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health plans' that contract with providers for the delivery of healthcare goods and services.

Proger argued that current antitrust laws "would not be a substantial deterrent." He did acknowledge that some types of hospital agreements, especially for market allocation and reducing perceived duplication, could pose serious legal problems. Rather than change the law, however, he urged the enforcement agencies (Federal Trade Commission and Justice Department) to issue guidelines on how these types of agreements would be analyzed. "Enforcement agencies and courts may have to adjust their thinking to the new economic environment resulting from implementation of managed competition," concluded Proger.

Metzenbaum testified at the May 7 hearing that rural hospitals have raised the most serious complaint against current antitrust law posing a barrier to joint agreements. However, he argued that enough flexibility exists in the law to answer these concerns. Indeed, Metzenbaum posited that "strong antitrust laws will promote—not hinder—reform under the new healthcare system."

In a May 13 letter to Hillary Rodham Clinton, Metzenbaum reiterated his position: "I am particularly concerned about suggestions that the antitrust laws be relaxed for particular provider groups in order to speed healthcare reform." He endorsed a proposal put forth by the healthcare reform task force's Working Group on Antitrust to provide hospitals with more comprehensive and timely guidance on antitrust matters. Explicit guidelines and expedited agency opinion letters on hospital collaborative ventures could forestall the need for change in the law.

#### HOSPITALS AND ANTITRUST POLICY

The precedent for granting hospitals exceptions to antitrust law is mixed. On the one hand, cases exist that point to overbearing enforcement of antitrust law in instances where consumers actually benefited from a hospital merger. On the other hand, some 225 hospital mergers took place between 1987 and 1991 under current law. AHA, nonetheless, proposes that antitrust laws be modified via the establishment of a voluntary waiver program for hospitals.

Other policy analysts agree that modification is necessary for the hospital sector. Economist Gerard Anderson, who directs Johns Hopkins Center for Hospital Finance and Management, said, "Antitrust provisions are going to be a

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taneously bring about fulfillment of community need and collaboration. At the same time, the involvement of local communities provides the forum for gaining both understanding and support for the primary agenda of healthcare reform.

### INITIATE APPROPRIATE PARTNERSHIPS

In the coming months, we will have an unprecedented opportunity to participate in the transformation of the U.S. healthcare system. Catholic healthcare providers play multiple roles in all the arenas healthcare reform will affect:

- We are providers.
- We are purchasers of healthcare for our employees and our families.
- We are consumers who want the most cost-effective and quality-oriented system.
- We are citizens who directly influence the position of our representatives.
- We are believers in human dignity and in every person's right to healthcare.

Creative leaders use the most effective tools available to empower themselves and others. One such tool is CHA's *A Primer on Healthcare Reform* (1993). This primer guides us in initiating dialogue with and furthering the education of our constituencies. It teaches us to speak with a clear and consistent voice on the issues and directions that will be paramount in the reform debate.

With the help of *A Primer on Healthcare Reform*, enterprising leaders can define the appropriate constituencies and collaborate for effective advocacy. Inviting discussion and debate at the local level creates a level playing field for development and support.

Defining appropriate partnerships requires discernment on mission, imagination about the future, and assessment of community needs. Catholic healthcare institutions have

many tools to effectuate this process and need to broaden the arena of participants.

Who are likely partners in a reformed healthcare system that emphasizes collaboration through community care or integrated delivery networks? We must first focus on current participants. Then, by widening the circle around the integrated delivery model, we can include the healthy community model where all the stakeholders share in the vision and power.

### EMPOWER OTHERS THROUGH INTERACTION

The medical model of healthcare often isolates the community from the responsibility for healthcare. Open dialogue through community forums will generate a sense of responsibility that demands action. Sharing this power will result in many more partners committed to quality of life and to a healthy community. Our communities may find it impossible to support healthcare reform if cost is the primary motivation. Understanding that our communities' health affects all dimensions of our lives and determines our future may cause us to look differently at the price we are willing to pay.

The debate around healthcare reform cannot begin solely with a price tag. The debate must appeal to responsible action, since we are the stewards of our creation and the trustees of the next generation.

Interaction and shared power release the dynamic of empowerment. Empowerment carries the vision of hope. I offer this virtue of hope as the primary freedom for the creative and forward-looking leader.

As Sr. Juliana Casey, IHM, has written: "Hope knows no bounds. It promises life when death would seem to conquer. It demands new ways, new worlds, healthcare that is truly witness, truly sacrament" (*Voices of Hope*, CHA, 1991). □

major stumbling block as [hospitals] try to reorganize themselves." He noted that unlike efficient healthcare segments such as the pharmaceutical industry, the hospital sector still has much inefficiency, as evidenced in low occupancy rates.

In a conversation, Anderson explained that healthcare reform aims to create large entities—comprehensive providers of care that include hospitals, nursing homes, and physician groups. Such entities would "clearly be viewed by economists and lawyers as anticompetitive," he noted. In his view, "the law has to change for managed competition to occur."

CHA's Br. Campbell believes we can leave the law alone, but design a system for the defense of hospitals' collaborative activities. He prefers not to "open Pandora's box on antitrust law." The laws are "very general and brief"; the important facet, in Br. Campbell's view, is the level and interpretation of enforcement. There is "no doubt that antitrust creates fear and that defensive activities are expensive"; however, he posits that a key to achieving reform within current law is to "get a mandated structure in place and then say, 'The government made me do it,'" when collaborative activity is challenged on antitrust grounds.

### TIME WILL TELL

As hospitals move down the path of reform, horizontal and vertical integration will be the key to survival. Anderson likened the future scenario to that of a dance. "A lot of hospitals will be left without partners and will go out of business. Hospitals will need to merge to form these health partnerships. There will be some that no one will want to merge with either because they are poor quality, high cost, or both. Those hospitals will be in desperate financial shape," he concluded. As hospitals join together for survival in a reformed healthcare system, the question remains whether current antitrust law will be a critical stumbling block along the way. □