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State Supervision of Health Care Antitrust Exceptions in Minnesota

A Final Report to the Legislature

January 1998

with assistance from:

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Dear Interested Party:

In 1993, as part of the MinnesotaCare reforms, the Minnesota Legislature passed an antitrust exception law, allowing for certain arrangements between providers or purchasers of health care that might otherwise be prohibited by state or federal antitrust laws (*Minn. Stat.* §§62J.2911-62J.2921). Under the law, the Commissioner of Health was given authority to review proposed health care arrangements and grant an antitrust exception in cases where the arrangement was likely to result in lower costs, higher quality, or better access to care than would otherwise occur in the marketplace. The legislature intended that approved antitrust exceptions be accompanied by appropriate supervision and regulation to protect against abuses of market power, and directed that the Commissioner of Health report back to the Legislature on the appropriate length and scope of supervision for approved arrangements. This report fulfills that mandate.

During the 1997 legislative session, the Minnesota Legislature repealed *Minn. Stat.* §§62J.2911-62J.2921. During the law's existence, one antitrust exception application was received and approved for the merger of two Twin Cities hospital systems. While the legislature has chosen to repeal the ability of the Commissioner of Health to grant antitrust exceptions, the state has implemented some measures intended to achieve similar outcomes. For instance, the ability of providers in rural areas of the state to form networks and directly contract with local businesses was enhanced during the 1997 session through "Accountable Provider Network" legislation.

The release of this study is intended to help provide background and guidance to other states and entities with an antitrust exception statute, or those considering such a statute. We hope that the information contained in the report is valuable and provides some assistance in the area of length and scope of supervision for approved exceptions.

Sincerely,

Anne M. Barry
Commissioner

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STATE SUPERVISION OF HEALTH CARE ANTITRUST EXCEPTIONS IN MINNESOTA

0. INTRODUCTION

In recent years, the Minnesota Legislature has taken an active role in monitoring Minnesota's health care market. Starting in 1992, the legislature has passed a series of comprehensive health care reforms intended to improve access to, and quality of, health care in Minnesota, and to help control costs. The 1993 MinnesotaCare legislation included a provision allowing for health care providers and purchasers to merge, create joint ventures, or reorganize in other ways that would not be permitted under federal or state antitrust laws. The legislature found that the goals of improving quality of care, improving access to care, and controlling the rate of growth of health care costs "will be "significantly enhanced by cooperative arrangements involving providers or purchasers that might be prohibited by state and federal antitrust laws if undertaken without governmental involvement."^{1/} The antitrust exception provisions were codified into law under *Minn. Stat.* §62J.2911 to *Minn. Stat.* §62J.2921, and were intended to give the Commissioner of Health (COH) authority to "review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality, than would otherwise occur in the marketplace."^{2/} As part of the MinnesotaCare legislation, the legislature required the Commissioner of Health to "study and make recommendations...on the appropriate length and scope of supervision of arrangements approved for exception from the antitrust laws."^{3/} This study fulfills this mandate, and provides the framework by which the Commissioner of Health will implement ongoing supervision of health care entities with approved antitrust exceptions. In the course of completing this study, the Department of Health received assistance from Simonetti Samuels, Director of the Health Law Research Institute at Case Western Reserve University and Partner in the law firm Katten Muchin and Zavis and John Nyman, Associate Professor, Institute for Health Services Research, University of Minnesota.

This study begins by detailing some of the policy objectives behind allowing for antitrust exceptions. It then describes the legal requirements for immunity under the state-action doctrine, examines Minnesota's statutory requirements for antitrust exceptions, and provides some guidelines which the COH will follow and examine in determining the length, scope, and intensity of ongoing supervision. The study then examines some of the data that may be required to effectively monitor firms that have been given antitrust immunity, and discusses

^{1/} *Minn. Stat.* §62J.2911

^{2/} *ibid.*

^{3/} *Minn. Stat.* §62J.2920, Subd. 3

some of the issues surrounding data collection and monitoring. Finally, the report concludes by examining issues related to the revocation process for antitrust exceptions.

Policy Objectives Behind Antitrust Exceptions

Minn. Stat. §62J.2911 states that the goals of improving quality of care, improving access to care, and controlling the rate of growth of health care costs would be enhanced by allowing for exceptions to state and federal antitrust laws in certain cases. The following section examines some of the rationale and policy goals behind allowing for antitrust exceptions in Minnesota's health care market.

Market Failure

Antitrust laws are based on the competitive market system whereby markets are the best vehicle to determine the appropriate level of price and output for a given product. In theory, free and competitive markets create incentives for the seller of goods and services to compete for customers by providing the best quality product at the lowest price. Antitrust laws are based on the principle that certain actions by producers or purchasers of products inhibit free markets. These actions may include price fixing, group boycotts, division of markets, and tying arrangements. Antitrust laws are used to stop actions which are perceived to be anticompetitive in an effort to maintain competition in a given market.

The health care market, like many markets, does not function as a perfectly competitive market due to several unique "market failures." That is, although the markets in health care work, they may not be reaching an optimal level of production efficiency and consumer benefit as a more competitive market would. There are key elements of the health care market which lead to market failure: information asymmetry, high levels of insurance coverage, and localized, and frequently small, markets.

One reality of the health care market that leads to market failure is "information asymmetry." Analysts have long pointed out that health care consumers lack sufficient information and knowledge to meaningfully "shop" between various providers. Health care providers have an increased ability to influence the purchasing decision of consumers because of this unequal information between parties, and therefore consumers may not purchase the optimal level of services from health care providers. Even if consumers did have full knowledge and information, their incentive to shop prudently is diminished due to the high level of insurance coverage present in our health care markets. Consumers frequently face little or no out of pocket cost for seeing a health care provider, and therefore have little incentive to consume health care in an efficient manner. Critics have also argued that health care markets tend to be localized and that most markets are too small for competition to work effectively. For example, rural areas of the state often times have only one hospital and a small number of providers. Some analysts have contended that competition among health care providers actually serves to drive up the cost of health care, because providers of care may tend to

compete not on the basis of price, but rather on providing the widest array of services and technology. This last point is discussed in more detail in the following section.

Antitrust Laws Sometimes Not Compatible with Cost Containment

A major concern often cited during debates over health reform is the increasing cost of health care. In Minnesota, the legislature noted that "the staggering growth in health care costs is having a devastating effect on the health and cost of living of Minnesota residents...the legislature further finds that controlling costs is essential to the maintenance of the many factors contributing to the quality of life in Minnesota."^{4/} An area of concern was a sense that providers of health care may not be competing on the basis of price, but rather on the basis of their ability to offer the broadest array of expensive, high technology equipment. It has been argued that this "medical arms race," as it is often called, might diminish were providers able to act in a cooperative manner and jointly purchase certain higher-cost equipment. This would decrease the duplication of resources and may tend to slow the growth of health care costs. In addition, the ability of providers in rural areas of the state to purchase certain high-cost equipment may be enhanced by allowing for pooled purchasing of certain equipment. In other words, it may be in the state's interest to allow a cooperative arrangement between two hospitals, for instance, on the purchase of a certain high-technology, high-cost piece of equipment to ensure that residents of an area have access to high quality care or to avoid the duplication of resources between the two hospitals. In a similar way, allowing providers to combine or merge together to form larger networks may enable them to achieve similar efficiencies in their operations, allowing for lower costs which could be passed on to consumers. These actions by providers may in some cases be violations of federal or state antitrust laws. The antitrust exception statute allows the Commissioner of Health to substitute regulation for competition in situations where the proposed arrangements may violate state or federal antitrust laws, but where the COH has determined that the arrangement, appropriately supervised by the state, is in the state's best interest.

Once an antitrust exception has been granted, the state must determine the appropriate level of monitoring and scrutiny that is necessary to ensure that the merged entity does not abuse its increased market power. In addition, in order for the preemption from federal antitrust laws to apply, the state must "actively supervise" the immunized firm. The following section of the report details the legal requirements for "state-action doctrine" immunity, examines Minnesota's statutory requirements related to the antitrust exception process, and lists some of the factors that the Commissioner of Health is likely to consider in determining the length, scope, and intensity of ongoing supervision.

^{4/} *Minn. Stat.* §62J.015

I. "APPROPRIATE SUPERVISION"

A. Legal Requirements for State-Action Doctrine Immunity

The "state-action doctrine" is a court-created exemption from the application of the federal antitrust laws. It has its origins in *Parker v. Brown*,^{5/} where a producer and seller of raisins in California challenged a legislatively-established program for marketing of agricultural commodities produced in the state as violative of §1 of the Sherman Act. The program in question was authorized by the California Agricultural Prorate Act, which allowed ten producers of any commodity to petition for the establishment of a prorate marketing plan for the commodity within a defined production zone. Upon approval of the petition, it would then become unlawful for any producer to sell or any handler to receive or possess the commodity in violation of the proration program that had been instituted. Parker, a raisin seller, challenged the seasonal proration marketing program for raisins, which hurt his business.^{6/}

In rejecting Parker's challenge, the U.S. Supreme Court noted that:

In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its offer and agents is not lightly to be attributed to Congress. [Paragraph break omitted] The Sherman Act makes no mention of the state as such, and gives no hint that it was intended to restrain state-action or official action directed by a state.^{7/}

The Court refined this doctrine further in *California Retail Liquor Dealers Assoc. v. Midcal Aluminum*.^{8/} In that case, suit was brought challenging California's resale price maintenance and price posting statutes for the wholesale wine trade. Finding that California's system for wine pricing was in violation of the Sherman Act, the Court turned its attention to the question of whether the state's involvement in the price-setting scheme was sufficient to

^{5/} 317 U.S. 341 (1943).

^{6/} Id.

^{7/} Id. at 351.

^{8/} 445 U.S. 97 (1980).

establish immunity under *Parker v. Brown*. Reviewing recent precedent in this area,^{9/} the Court indicated:

These decisions establish two standards for antitrust immunity under *Parker v. Brown*. First, the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy"; second, the policy must be "actively supervised" by the state itself.^{10/}

Although the Court found that the California system satisfied the first prong of *Parker*, the program did not meet the second requirement because the state merely authorized the wine price setting, but did not engage in a "pointed reexamination" of the program.^{11/}

The "active supervision" element of the *Midcal* test appears to be more difficult to satisfy than the "clear articulation" prong. Two more recent Supreme Court cases have notable discussions about the active supervision element -- *Patrick v. Burget*^{12/} and, more recently, *FTC v. Ticor Title Ins. Co.*^{13/} As the Court explained in *Burget*:

The active supervision requirement stems from the recognition that "[w]here 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 interest of the State." [citation omitted] The requirement is designed to ensure that the state-action doctrine will shelter only the particular anti-competitive acts of private parties that, in the

^{9/} See e.g., *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976); *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977); and *New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 439 U.S. 96 (1978).

^{10/} 445 U.S. at 105 (citing *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978) (opinion of Brennan, J.)).

^{11/} *Id.* 105-6. The quotation marks around "pointed reexamination" were in the text of the Court's opinion as well. They apparently are in reference to that term as used in *Bates v. State Bar of Arizona*, 433 U.S. 350, 362 (1977), although the Court does not say as much. See Kevin A. Fowler, "Note: Community Communications Co. v. City of Boulder: The Emasculation of Municipal Immunity from Sherman Act Liability," *Catholic University Law Review* 32 (Winter, 1983) 413, 424 n. 96.

^{12/} 486 U.S. 94 (1988).

^{13/} 112 S. Ct. 2169 (1992).

judgment of the State, actually further state regulatory policies.
[citation omitted]^{14/}

The Court found, however, that "[t]he mere presence of some state involvement or monitoring does not suffice," rather, the state officials must "have and exercise" the power to review the competitive acts.^{15/}

In *F.T.C. v. Ticor Title Ins. Co.*^{16/}, a much talked and written about decision, the Court elaborated further on the active supervision test:

Our decisions make clear that the purpose of the active supervision inquiry is not to determine whether the State has met some normative standard, such as efficiency, in its regulatory practices. Its purpose is to determine whether the State has exercised sufficient independent judgment and control so that the details for the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties . . . the analysis asks whether the State has played a substantial role in determining the specifics of the economic policy.^{17/}

The Court found that two of the four state schemes at issue in this case did not provide the necessary component of active supervision to meet the second prong of the state-action doctrine. The Court noted that regulation is an unsatisfactory substitute for supervision:

...whatever the potential for state regulatory review...[i]n the absence of active supervision in fact, there can be no state-action immunity...^{18/}

^{14/} *Patrick*, 486 U.S. at 100-01.

^{15/} *Id.* at 102. The statutory scheme in Oregon was not found to have established a state program of active supervision over peer review decisions because neither the Health Division, the Board of Medical Examiners, nor the state judiciary was found to have the requisite authority over the actual decisions of the hospital peer review committees. *Id.* at 102-104.

^{16/} 112 S. Ct. 2169 (1992). This case involved "negative opinion" systems for approving title insurance rate filings by rating bureaus. Under a negative option system, the rating bureau filed rates for title insurance and title examinations with the state insurance office and they became effective within a specified period unless the state rejected them.

^{17/} 112 S. Ct. at 2177.

^{18/} *Id.* at 2179.

Beyond *Patrick* and *Ticor*, the case law with respect to what actually constitutes "active supervision" is not very well developed.^{19/} In the health care context, given the rapid promulgation of the antitrust exception legislation, this void becomes a gaping hole with profound implications.^{20/} President Clinton's Health Care Reform Task Force recognized the policy implications of this issue by calling for the development of "guidelines that apply the 'state-action doctrine' where a state seeks to grant antitrust immunity to hospitals and other institutional health providers."^{21/}

Patrick and *Ticor* (as well as other cases involving state-action immunity) can be interpreted to require that the level of supervision necessary to immunize private activity will vary according to the possibility of anti-competitive harm. In other words, the state will be held to a higher standard the greater the potential for efficiency losses arising from the transaction. This in turn will be correlated with both the nature of the transaction/activity and the objective the COH wishes to achieve from the grant of immunity. We will now turn to the statute to determine the types of activity the Minnesota legislature intended to immunize and the objectives it wishes to fulfill.

^{19/} The AHA's February 19, 1993 Memorandum is one of the few placed where a discussion of the health care case law on this issue can be found. "Immunizing Hospital Cooperative Ventures Through State Action," AHA Office of the General Counsel Memorandum (Feb. 19, 1993); see also Vance article, supra note 16. The health care case that has attracted the most attention is *State of North Carolina v. P.I.A., Asheville*, 740 F. 2d 274, 178 (4th Cir. 1984, *en banc.*), *cert. denied*, 471 U.S. 1003 (1985) (holding that the state's post-certificate of need review of proposed acquisitions was *not* sufficient supervision to meet the active supervision prong of the *Midcal* test and that "there is no active supervision at all.").

^{20/} "It would be a terrible result if providers rely upon the antitrust exception statutes in entering into collaborative agreements, and then later learn that their activities are not immune from the federal antitrust laws because the state agencies have not sufficiently monitored or supervised the approved cooperative agreements." Howard Feller, "The Impact of *Ticor* on State Legislation Authorizing Provider Collaboration," Antitrust Health Care Chronicle 7:2 (1993).

^{21/} Summary, "American Health Security Act of 1993," September 7, 1993, p. 171, reprinted in BNA Health Policy Report, (Special Supplement, September 13, 1993). Although the federal enforcement agencies have offered some guidance in this area, see "Letter to the Honorable David W. Huey, Assistant Attorney General, State of North Dakota," from Michael O. Wise, Acting Director, Office of Consumer and Competition Advocacy, Federal Trade Commission (March 18, 1993) (commenting on two bills pending before the North Dakota legislature regarding whether they would provide adequate state supervision to confer state action immunity); and see "Statement before the Joint Committee on the Public Interest in Competitive Practices in Healthcare of the Vermont Legislature," from Michael O. Wise, Associate Director for Advocacy and Legal Counsel, Bureau of Economics, Federal Trade Commission (Oct. 20, 1994), much more can and should be done in this area. The AHA has also called for additional guidelines in this area. See "Letter to Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice," from Fredric J. Entin, Senior Vice-President and General Counsel, AHA at 20-24 (January 28, 1994).

B. Minnesota Statutory Requirements

1. Types of Transactions Covered

The types of transactions eligible to apply for an antitrust exception are specified in *Minn. Stat.* §62J.2913, which defines the scope of the legislation. "Providers or purchasers wishing to engage in contracts, business or financial arrangements, or other activities, practices, or arrangements which might be construed to be violations of state or federal antitrust laws . . ." ^{22/} are eligible to apply for an exception. The scope is very broad, and only one other state, Iowa, has passed legislation covering both purchasers and providers and does not place limitations on the type of activity. (For example, while the State of Washington permits both purchasers and providers to apply for an antitrust exception, the statute specifically excludes hospital mergers or activity which has traditionally been condemned as a per se violation of the antitrust law, namely price-fixing, boycotts and/or divisions of markets.) Most of the states with antitrust exception legislation limit the scope to health care providers; the majority of these states further limit the exception to hospital mergers.

The broad scope of the legislation has significant implications for the COH and administration of the antitrust exception programs. Namely, broad discretion regarding the type of transaction, while providing the COH more latitude in serving the legislature's objectives, may require varying scope and length of supervision to confer immunity. This adds an additional layer of administrative complexity for the COH. However, as will be discussed below, the COH may be able to limit this variability through conditions and objective standards contained in the "decision," ^{23/} and other mechanics.

2. Objectives of the State of Minnesota

The Minnesota Legislature identified the purpose of the antitrust exception legislation as follows:

The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by cooperative arrangements involving providers or purchasers that might be prohibited by state and federal antitrust laws if undertaken without governmental involvement. The purpose of Sections 62J.2911 to 62J.2921 is to create an opportunity for the state to review proposed arrangements and to substitute regulation for

^{22/} *Minn. Stat.* §62J.2913, Subd. 1

^{23/} *Minn. Stat.* §62J.2918

competition when an arrangement is likely to result in lower costs or greater access or quality, than would otherwise occur in the marketplace. The legislature intends that approval of arrangements be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power, and that an arrangement approved by the commissioner and accompanied by such appropriate conditions, supervision, and regulation shall not be subject to state and federal antitrust liability.
(*Minn. Stat.* §62J.2911)

The "Criteria for Decision" (*Minn. Stat.* §62J.2917) provides further elucidation of the legislature's goals. This section repeats the goal articulated above of substituting the regulated arrangement where it "is more likely to result in lower costs, increased access or increased quality of care, than would otherwise occur under existing market conditions or conditions likely to develop without an exemption from state and federal antitrust law."

It is important to note that the legislature gives the COH the flexibility to sacrifice one or two of these criteria (reduced cost improved access and increased quality) if the arrangement is likely to make improvements one or two of the criteria. Under this situation, the COH is permitted to use a cost/benefit analysis to ascertain "that the proposed arrangement, taken as a whole, is likely to substantially further the purpose of this chapter."^{24/} Interestingly, the only mandate imposed on the COH is that in analyzing cost savings, they are considered a benefit of the arrangement only if passed onto the consumer.^{25/}

The legislation therefore appears to give the COH the full range of options, from serving as a more appropriate forum than antitrust enforcement in the state or federal courts to providing cross-subsidization if compatible with state health care goals. As with scope, this flexibility is advantageous to the COH in tailoring the program to meet Minnesota's needs but presents administrative complexity in determining the level of supervision required to confer antitrust immunity.

On the one hand, if a given merger is likely to be pro-competitive and the COH determines that the federal decision-makers erroneously believe that it will be anti-competitive, monitoring and supervision will only be required to demonstrate the pro-competitive impact of the transaction. At this point, both the need for supervision, as well as the value of the antitrust exception, will diminish greatly.

^{24/} *Minn. Stat.* §62J.2917, Subd. 1.

^{25/} However, this may not serve as a significant constraint. As long as there is an effective way for the COH to regulate the parties, any cost savings realized by purchasers or payers can then be redistributed to consumers.

On the other hand, a transaction which confers significant market power with the goal of redistributing some of these profits to other constituents in the state may require extensive supervision to confer immunity. For example, the merger of two rural hospitals may permit the merged entity to raise the price charged to insured patients in exchange for the promise of providing more care to indigent residents in the community. To monitor this agreement requires that the COH be involved in the details of implementation. How will free care be distributed? Which services will the merged entity provide? Over what time period? These, and other details, will need to be explored by the COH, probably imposing significant administrative responsibilities.

An issue raised in a recent article discussing the Minnesota antitrust exception legislation^{26/} is whether "active supervision" requires ongoing supervision to confer immunity. The author suggests that once the state has approved the cooperative health arrangement, a presumption should arise that the second prong of the *Midcal* test, requiring active supervision, has been met. The presumption that the active supervision requirement is met is then qualified by four exceptions: if the parties fail to do what they promised in their application; if the parties do not comply with the conditions of approval; if the conduct approved is vague or only generally specified; or if the conduct immunized would be characterized as naked price fixing amongst direct competitors.

While concurring with the above author that *Midcal*, *Patrick* and *Ticor* may not require ongoing supervision in all cases, the Department of Health believes that the test described above is unworkable in practice. In particular, without ongoing review how would the COH determine whether the parties have failed to do what they promised or to comply with the conditions of the application? Instead, the state contends that Clary's factors clearly should influence the degree of supervision required. In particular, if the objectives are vaguely defined in the application and contract with the state, then the COH will need to monitor the transaction more closely to identify the benefits achieved. If the conduct has a greater risk of anticompetitive harm, such as price fixing, then the state's supervision responsibilities are enhanced. If the parties are not in compliance with the terms or conditions of approval, then the private parties are clearly acting outside the scope of the granted immunity, and the state should either correct this by requiring compliance or revoking the antitrust exception.

While Clary's presumption would reduce the administrative burden for the state, we do not believe that this approach will satisfy the *Midcal* test. Below, we suggest methods for reducing the state's administrative burden while preserving immunity for private health care parties.

^{26/} Bradley G. Clary, "The MinnesotaCare Antitrust Exceptions: A Policy Proposal Regarding the State Action Doctrine as Applied to Healthcare Reform," 18 Hamline Law Review 131.

C. Increasing the Likelihood that Supervision is Adequate and Appropriate

As discussed above, the case law indicates that the level of supervision required to immunize an arrangement will vary according to the activity and the goals to be achieved by the state legislature. This significant flexibility creates a problem of administration, namely, how can the COH supervise or monitor these transactions in a cost-effective way while immunizing the private actors' activities from antitrust scrutiny?

1. Length of Supervision

While under certain circumstances a transaction granted antitrust immunity will not require ongoing supervision, this will be difficult for the COH to determine ex ante. The COH will be in a better position to evaluate whether suspension of continuing supervision is in the best interest of the state after the transaction has been consummated.

Instead, health care providers and payors should anticipate that COH review will continue indefinitely in most circumstances. While there may be unique circumstances where the COH may suspend review, the primary condition for elimination of supervision is when competitive forces serve as an adequate disciplinary mechanism. This may appear to contradict the purpose of the antitrust exception, which is intended to allow transactions which would otherwise not be permitted under the antitrust laws. Therefore, if competitive market forces are sufficient to discipline the parties the exemption would not be required. However, as discussed above, antitrust laws can have the impact of chilling certain arrangements which are of sufficient novelty that the enforcement agencies cannot accurately or adequately assess the potential for anticompetitive harm. Further, technological or market changes may occur after the approval which reduce the potential for anticompetitive harm to a level where it is no longer cost-effective for the state to continue its monitoring efforts.

In most instances, rather than suspend supervision, the Department of Health is likely to consider changing the intensity of the supervision to reflect the potential for anticompetitive harm imposed by parties to the transaction.

2. Intensity of Supervision

There is an efficiency basis for varying the intensity or degree of supervision according to the type of transaction. Due to the considerable administrative burden of reviewing these transactions, the COH is likely to devote more effort to those transactions which pose the greatest threat of anticompetitive harm. While it is difficult to list all factors which the COH will consider in evaluating the intensity of scrutiny, the following is a list of factors which affect the potential for anticompetitive harm:

The Department of Health's ongoing review will likely consider:

- 1) *Size of the transaction/Share of Market.* The COH will consider the share of the market captured by the transacting parties to estimate the potential increases in market power in the relevant market (geographic/service/provider type, etc.). The greater the share, the larger the potential for anticompetitive harm and therefore a closer scrutiny is warranted.
- 2) *Elasticity of demand for services involved.* While the demand for most health care services is inelastic from the consumer's perspective, large purchasers (either government or employer) minimize this distortion through the exertion of buying power. Therefore, if a large percentage of services is purchased by small purchasers, more scrutiny may be required as these groups may bear the burden of price increases.
- 3) *Type of conduct immunized.* As the courts have discussed at length, certain types of conduct, by their nature, are associated with greater risk of anticompetitive harm. In the law where the conduct is inherently found to be anticompetitive in the majority of situations, the courts find the conduct is "per se" illegal without further weighing of the pros and cons of the transaction. Clearly, if the COH decides to immunize a transaction which permits conduct which would otherwise be analyzed under this per se test, a more intensive review of the transaction is likely needed. Similarly, certain types of arrangements may require more detailed supervision than other types of arrangements. For example, a one-time, limited venture with more identifiable outcomes may require a lesser degree of ongoing scrutiny than a full-fledged merger with indefinite future outcomes.
- 4) *Degree of current regulation.* There may be circumstances where the parties to a transaction are already required to meet certain regulatory requirements. In these cases, the COH is likely to consider the current regulatory structure in determining if additional regulations on the approved exception are necessary. For instance, *Minn. Stat. §62J.04* established health care provider revenue growth limits in Minnesota. Those limits provide a certain level of consumer protection. In determining the level of ongoing supervision, the COH is likely to consider whether those revenue limits provide sufficient protection or whether more stringent requirements are necessary. In cases where the current level of regulation is sufficient, no additional regulation in certain areas may be required.

The COH may also consider other factors which contribute to the potential for anticompetitive abuse of the joint venturing parties. In many instances, these concerns will be identified during the COH's initial review and approval process.

3. Scope of Review

In addition to intensity and duration, the COH may need to consider activities of the parties which are beyond the scope of the immunized transaction. The concern here is that the parties not leverage the market power derived from the grant of immunity to the detriment of health care consumers through activities external to the transaction. Not reviewing these activities may permit the parties to take advantage of the grant of immunity in a manner which was not intended by the COH, and result in a shift in the balance between community benefits and costs.

For example, consider the immunized merger of hospitals A and B. The COH places certain requirements on price growth and distribution of the benefits of costs reductions on Hospitals A and B in exchange for the grant of immunity. However, the merged entity then decides to joint venture with hospital C in a particular service line. The Department of Health has a legitimate concern that this joint venture could extend the merged entity's market power beyond the reach of the initial agreement. It is reasonable, therefore, for the COH to require that parties to a transaction notify the Department of Health of activities likely to affect the grant of immunity. These include (but are not limited to) mergers, acquisitions, joint ventures with other health care payors/providers, and changes in ownership.

It is not the intention of the Department of Health to extend supervision and regulation to the subsequent activities of an immunized firm. Rather, the Department of Health has a legitimate interest in gathering the information necessary to determine the impact of subsequent business arrangements of the entity in determining the level of ongoing supervision.

The Department of Health recognizes that these requirements place an additional burden upon the parties. As such, the Department of Health will attempt to identify as many requirements as possible during the approval process so that the parties entering into the immunized transaction understand the extent of their obligations in accepting the grant of immunity. However, a more fluid approach permits the Department of Health to approve projects which are more "experimental" in nature, and allows parties to demonstrate the advantages of these novel transactions after the fact. The Department of Health will consider these trade-offs as well as the administrative costs involved in fashioning a cost-effective, workable arrangement.

Further, in future transactions, the Department of Health will consider the following for reducing the administrative burden of the supervision/monitoring requirement:

a. Recognize the Importance of the Review and Decision Process

Minn. Stat. §62J.2918 requires that the COH identify "objective standards of cost, access and quality by which the success of the arrangement will be measured." Requiring the COH to set an objective standard forces a detailed examination of the likely consequences of the transaction and the benefits to be achieved by the state. While there is always uncertainty, the COH views this as an opportunity to develop a "contract" with the health care providers/purchasers and at least consider (if not resolve) any contingencies. Another problem which arises with requesting data from private parties demonstrating the potential for efficiency enhancement is the asymmetric distribution of information between health providers and regulators. The health care providers clearly have better access to information on potential cost savings, etc. than the state and this puts them at a strategic advantage. Before the antitrust exception is granted the COH has more leverage in specifying conditions and requirements. After the exception is awarded, the private parties have an increased ability to use this asymmetric distribution of information to their advantage. Further, as is noted below, setting clear objectives will reduce the likelihood that revocation will be necessary and if required make it easier for the COH to make its case.

b. Shift the Burden of Analysis to the Private Parties In Complex Transactions

In entering into Advanced Pricing Agreements (APAs), the IRS used to ask companies to submit their financial data and then economists from the IRS would negotiate with company representatives. It was a frustrating process, as the companies were at a significant advantage because they understood their own information to a level of detail and accuracy IRS staff could never achieve. To partially resolve this problem, federal regulations now require the company to submit an opinion letter signed by an outside consultant certifying that the information presented satisfies the requirements of the law.

Similarly, for larger transactions the COH may require that, instead of submitting raw data, the parties submit an analysis conducted by an outside expert approved by the COH. This will reduce the state's administrative burden and probably not increase the parties' costs (because they have undoubtedly retained an expert to assist them anyway) while providing the state with more useful and useable information. The COH may consider exempting small health care entities from this requirement. This would ensure that small providers would not be impeded from accessing this process, particularly in rural areas of the state.

II. DATA ANALYSIS/REQUIREMENTS

In this section, we consider the data requirements necessary to monitor the immune activity.

A. Analytical Concerns

Before discussing specific data elements, we will address the analytical issues of: ideal vs. operational analysis, standardized vs. case-by-case variables, global vs. specific analyses.

1. Ideal v. Operational Analysis.

Developing a conceptual understanding of how the COH of Health would ideally measure the impact of immunized arrangements on consumer welfare helps to articulate and refine the state's policy goals. However, the data and analytical requirements make many of these ideals unrealistic tools for policy makers. Operationality often requires the development of simpler workable proxies for determining whether the policy objectives are likely to be achieved through the grant of immunity.

For example, ideal measures of the impact of immunity would require an analysis of the value of the gains and losses to the various people affected by the arrangement. Economists, however, have not yet developed easily accessible ways of making comparisons of gains or losses between individuals or groups of individuals. As a result, the measures of the impact of any immunity arrangement are less than ideal.

Another example is the cost-benefit analysis which is permitted under *Minn. Stat.* §62J.2917, Subd. 1. The advantage of cost-benefit analyses is that many benefits can be aggregated through their conversion into money value. Economists and others, however, have been critical of these analyses when applied to the health care area because many of the important policy variables (the number of lives saved, the number of sicknesses avoided, etc.) are difficult to evaluate monetarily. Again, instead of the ideal, economists have tended to perform cost-effectiveness or cost-utility analyses, which may not permit aggregation as well as cost-benefit analyses, but result in more acceptable measures of the value of these policy variables.

In the merger guidelines, the enforcement agencies define the economic market as:

a product or group of products and a geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future producer or seller of these products in that area likely would impose at least a "small but significant and non-transitory"^{27/} increase in price, assuming the terms of sale of all other products are held constant. A relevant market is a group of products and a geographic area that is no bigger than necessary to satisfy this test.^{28/}

^{27/} In the 1984 Guidelines the suggested price increase was five percent and the minimum duration of this price increase was one year. 1984 Guidelines § 2.11 & n.7. In the 1992 Guidelines the presumptive five percent figure is maintained but the duration of the price increase is stated to be "the foreseeable future." 1992 Guidelines § 1.11.

^{28/} 1992 Guidelines, § 1.0.

The enforcement agency then asks what would happen if the hypothetical monopolist imposed a "small but significant and non-transitory increase in price" to determine whether the market is defined sufficiently broadly.

While this is the "ideal" measure, it is difficult to operationalize. Therefore, the enforcement agencies, private plaintiffs and defendants instead look at, among other things: whether buyers have shifted purchases between products in response to historical price changes; whether sellers make pricing decisions based on potential substitution of these alternative products; whether it is difficult for buyers to switch products; and whether firms can easily enter the market.

2. Standardized v. Case-By-Case (ad hoc) Variables.

The COH will likely routinely request certain information from all or most parties entering into approved arrangements, while tailoring additional data requirements to the particulars of the specific agreement.

Due to the concerns of increased market power arising from the grant of immunity, the COH will likely standardize its request for data relevant to measuring the market share of the parties to the arrangement. Generally, the COH will conduct this type of analysis during the initial approval process. For cases involving hospitals, for example, the COH will likely collect data on the revenues per admission that the firm expects to realize as a result of the activity for which the immunity is being sought. Accordingly, a standard immunity data request will be for information on revenues at an admission or discharge level in order to be able to adjust for the services received. As an example, we present in Appendix 2 the types of information the COH may consider in a routine request for a hospital merger.^{29/} Further, if there are reports on cost, quality, or access that the facilities must file for other governmental purposes (such as Medicare cost reports), the incremental cost of requesting these data is small and they will likely be asked for.

On the other hand, due to the breadth of the legislation, many of the data items will need to be developed on a case-by-case basis. In each of the four antitrust exceptions approved by the State of Washington, a contract with the organization receiving immunity was developed in which certain conditions were specified that must be met in return for the antitrust exception. These conditions typically are represented by variables that are constrained to certain levels. Each contract has a different list of constrained variables that depends on the issues that are salient in the case. These variables are collected on an ad hoc basis and used in the monitoring process.

^{29/} Similar lists are likely be developed for other types of transactions.

3. Standard of Comparison

Ideally, the COH would want to evaluate the impact of the immunity by comparing the behavior of the firms under the immunized arrangement with the counterfactual of how they would have behaved in the absence of the exception. Determining their behavior under this counterfactual would require a substantial amount of data and complex analyses. Less ideal analyses are available, but their results would be more open to question. An alternative to specifying a counterfactual would be to simply set a specific target level for the variable in question. For example, a percentage price decrease could be specified in lieu of specifying that the decrease in price must be a certain percentage of what the price would have been in the absence of the arrangement.

Three approaches to determining the extent to which the observed prices (or quality or access) are different from what they would have been without the arrangement permitted by the exception are identified below. While each measure is imperfect, they provide workable measures for defining the analytical component of these comparisons.

One approach is to collect information on the same institutions for a number of years and use those data to extrapolate to the present year. Comparing the observed prices with the extrapolated prices will determine the effect of the proposed or immunized arrangement on consumer costs. The advantage of this approach is that it relies on data from the firm in question to determine future consumer costs. Many aspects of the firm would, as a result, be held constant. Its disadvantage is that it does not hold constant any intertemporal changes in the year in question that might impact all firms.

A second approach would be to predict prices of the firm in question using the present behavior of other similar firms. For example, if revenues per patient day of 10 other hospitals rose by 3 percent, this would be used as a benchmark to determine whether the revenues per patient day increased due to the antitrust exception. An often-used standard for such an analysis is the medical care version of the Consumer Price Index (CPI). Alternatively, the American Hospital Association's hospital marketbasket index could be used. The advantage of this second approach is that it uses general behavior of similar firms to determine a standard of comparison. The disadvantage is that it does not take into account the characteristics of the specific hospital, such as the hospital's case mix and the prices of its inputs.

A third approach would be to use a statistical model to predict what prices should be for firms that have the characteristics of the firms in question before they received the antitrust exception, and compare that to their observed revenues. For example, the hospital model used by Connor, et. al. (1996) to predict costs could be modified to predict revenues per admission. The characteristics of the firms could be substituted into this equation and the predicted revenues could be compared with actual revenues.

The approach used will in part depend on the data available, the type of transaction involved, and the objectives to be achieved by the state.

4. Global v. Specific Analyses

For a given transaction, the COH may need to decide whether to perform the analysis using firm-level data or more narrowly focus on specific procedures or service lines. On the cost side, joint production and the ability of providers to utilize different accounting procedures for allocating joint costs makes analyzing cost by service line problematic. Pricing data are often difficult to compare across facilities due to various discounting and bundling practices.

On the other hand, in some instances, it will be important to ascertain the impact of the grant of immunity on a specific service or product line. Additional efforts will need to be made to gather these data recognizing the added administrative costs and increased risk of measurement error. For example, the Department of Justice and Federal Trade Commission have implicitly decided that obtaining service-level information in hospital mergers is cost-effective for the purposes of examining market share as a proxy for market power.

The rest of this section is devoted to a discussion of the three criteria of cost, access and quality, in that order. Finally, we consider the costs to society of the exception process.

B. Measuring Cost, Quality and Access

1. Costs

As defined in statute, "costs" or "costs of health care" refer to "the amount paid by consumers or third party payers for health care service or products."^{30/} The statute goes on to say that the:

"Commissioner's analysis of cost must focus on the individual consumer of health care. Cost savings to be realized by providers, health carriers, group purchasers, or other participants in the health care system are relevant only to the extent that the savings are likely to be passed on to the consumer. However, where an application is submitted by providers or purchasers who are paid primarily by third party payers unaffiliated with the applicant, it is sufficient for the applicant to show that cost savings are likely to be passed on to the unaffiliated third party payer..."^{31/}

^{30/} *Minn. Stat.* §62J.2912, Subd. 6.

^{31/} *Minn. Stat.* §62J.2917, Subd. 2(b).

While all three criteria of state-granted immunity -- lower costs, or greater access or quality - have been studied in the literature, there has been a focus on costs with regard to the types of arrangements likely to seek an exception. Moreover, the type of arrangement that dominates this literature is the merger. With regard to mergers, regardless of the anticipated benefits, the anticipated costs center on the increased market power of the merged firms. The dominant (but not only) way in which this market power manifests itself is in prices to consumers that are higher than they otherwise would be.

a. The Effects of Concentration on Provider Prices. Mergers increase the market power of all the firms in the merged firms' market by increasing concentration in that market. When the market is more concentrated, the consumer has fewer alternatives and therefore fewer opportunities to buy services at a lower price.

A number of studies have looked at the effect of market concentration on hospital prices. Of those, perhaps the most influential is a study by Melnick, Zwanziger, Bamezai and Pattison (1992). In this study, the effect of hospital market power on the prices paid by a managed care insurance plan was examined. More specifically, this study investigated how market concentration among California hospitals affected the per diem price that Blue Cross of California's preferred provider organization (PPO) paid for medical/surgical inpatient services in 1987, market concentration being measured by a weighted Herfindahl-Hirschman Index (HHI).

The basic HHI is the sum of the squared market shares of all the hospitals in a market area. For example, if there were three hospitals in a given market area and each hospital had the same market share (33%), the HHI would be the sum of $(33^2 + 33^2 + 33^2)$ or 3,267. Melnick, et. al. used two alternative calculations for the HHI. One was constructed separately for each hospital based on its own individual market area, the market area being defined using discharge data for the various hospitals in each zip-code area. The second was the same for all hospitals located in the same county.

Using multiple regression techniques to hold constant other potentially confounding variables, the authors found that hospitals in more concentrated markets were able to charge higher prices than those in more competitive, less concentrated markets. Specifically, if it is assumed that all hospitals have equal market shares, an increase in concentration from 3 hospitals in the hospital's individual market area to 2 hospitals would result in a conservatively-estimated price increase of 9 percent. An increase in concentration from 4 hospitals to 3 hospitals resulted in a price increase of about 5 percent, and an increase in concentration from 2 to 1 hospital resulted in a 17 percent increase.

A replication of this study using State of Washington data from 1994 found similar results (Kondo, Arnould, Forster, and DeBrock, 1995). Again assuming equal market shares, an increase in market concentration from 3 to 2 hospitals resulted in a 23 to 26 percent increase in price, depending on the measure of concentration used, and from 2 to 1 resulted in a 39 to

44 percent increase in hospital prices. Clearly, increases of these magnitudes would result in large transfers from consumers to hospitals, and may have efficiency consequences as well.

The relationship between market concentration and physician prices has been studied in regard to whether physicians induce demand. Much of this literature has shown that in areas where the physician to population ratio is high, the number of physician services per population is also high, suggesting that physicians induce demand to raise their income. A portion of this literature, however, also looked at the relationship between number of physicians per population and physician prices. This literature generally finds that higher numbers of physicians per capita (that is, less concentration physician markets) are associated with higher prices, a counter-intuitive result from the perspective of market power.^{32/}

One study that found a positive market concentration effect on prices is Kondo, et. al. (1995). Although their study of physician prices faced many more design limitations than their study of hospital prices, the authors concluded that market concentration (i.e., fewer physicians per person) led to higher prices. Specifically, they found evidence that the smaller number of physicians per capita in a market was correlated with higher physician prices. They also found that prices rose by 0.05 percent when the number of physicians per capita fell by 1 percent. For example, suppose that in a county with 5 physicians, 3 formed a group practice, effectively lowering the number of competing physicians from 5 to 3. If the number of people in the county was 6,000, this 40 percent reduction in physicians per capita could result in an average increase in prices of 2 percent. The authors suggest, however, that for specific procedures, the increase resulting from such a decrease in physicians could range from 2 to 250 percent. The lack of consistent results and the presence of competing behavioral expectations suggest that regulation of this market would be complex.

The effect of market concentration on the prices of nursing home care has been studied by Nyman (1994). Using Wisconsin data from 1988, Nyman found evidence that a doubling of the HHI would result in a 3.4 percent increase in the private prices of nursing home care. This suggests that the adverse effects of market concentration in the nursing home care markets should also be considered.

With regard to the effect of market concentration on access and quality, we know of no studies that have looked at this issue. One obvious problem in the study of market concentration on quality is the lack of consensus on the appropriate measure to use to capture quality differences in the provision of medical and other health care.

^{32/} See, for example, Pauly and Satterthwaite (1981) and Sloan and Feldman (1978).

b. The Effects of Mergers on Provider Prices. Although evidence seems to suggest that higher levels of market concentration leads to higher hospital prices, it is not clear *ex ante* what the expected effect of a *merger* on hospital prices should be in a free market. Clearly, one effect of a merger is to increase prices by reducing the number of competing firms in a market. The other effect of a merger is lower prices because costs have fallen due to the efficiencies gained from a larger operation. The net effect of a merger on free market prices would then depend on the relative size of the price decline due to the cost-reducing efficiencies compared with the price increase due to the increased market power.

The literature on the price effects of mergers is mixed. A number of recent studies have shown lower, or at least not higher, prices because of hospital mergers (Greene, 1990; US DHHS, 1992; and Burke, 1990) and some case studies have shown higher prices (Burda, 1992). The study by Connor, Feldman and Dowd (1996) is perhaps the most recent and persuasive. This study used data from 3,900 short-term general hospitals between 1985 and 1991, and looked at the effect of mergers on the prices charged by the merged hospitals in subsequent years. These data contain information on about two-thirds of all U.S. hospitals and 70 percent of the mergers that occurred during this period. The authors find that although mergers reduce the growth in costs (as measured by expenditures by the hospitals) per admission by 4 percent, price growth (measured by revenues per admission) stays at pre-merger levels. The combination, therefore, results in larger profits.

We know of no literature on mergers of other types of health care providers. Feldman (1994), however, investigated the effect of mergers of health insurance plans and predicted price increases.

It should be noted that most economists are likely to regard as minor the welfare consequences of mergers that lower the expenditures of the hospital but keep the prices that consumers pay hospitals constant. Although there is an increase in the profits of the hospital because the hospitals' expenditures are lower, there is no additional transfer from the consumer to the hospital, compared with before the merger. To the extent that this means an efficiency gain from production, society is better off because fewer resources are used to produce the output, leaving more resources available to provide other things in the society. The only other change is an increase in profits (surpluses) of the hospitals. To determine whether these profits are a societal gain, it must be determined who benefits from these surpluses and how much, and who paid for them. This is a complex problem that economists have traditionally avoided by arguing that profits are neutral to societal welfare.

c. Measures of Costs and Prices. Minnesota statute is somewhat unclear on its definition of "costs." Under *Minn. Stat.* §62J.2912, Subd. 6, cost is defined as "the amount paid by consumers or third party payers for health care services or products." Although in the statutes, the word "costs" is defined as the amount paid by consumers, it appears to have a different meaning later in the statute. Later, however, *Minn. Stat.* §62J.2917, Subd. 2(b) states that "cost savings to be realized by providers, health carriers, group purchasers, or

other participants in the health care system are relevant only to the extent that the savings are likely to be passed on to the consumer." This sentence appears to use the term "costs" to mean the expenditures of the organization in question, and therefore makes a connection between the decline in firm expenditures that occurs as a result of the arrangement and a corresponding decline in consumer prices.

As a result, the data required to monitor immune arrangements consist of two sets of variables. First, the state must determine to what extent the arrangement resulted in lower expenditures to organizations that have been granted immunity and second, to what extent prices to consumers are lower than they otherwise would be. Firms complying with the statute would show consumer prices that fall by an amount that is commensurate with the fall in firm expenditures.

For hospitals, expenditure and price data from the Health Care Cost Information System (HCCIS) could be used to determine price changes. General expenditure and price measures could be used for all cases, and to measure the effect of a merger on the prices of other firms in the market. More product-specific expenditure and price measures might be used to measure the consequences of actions that involve certain hospital services but not others. Other variables, such as expenditures or revenues per discharge by specific DRG category, may need to be collected on an ad hoc basis from the institutions involved.

Table 1
Hospital Expenditures and Price Variables

<u>Variable</u>	<u>Construction</u>
<u>General expenditure measures</u>	
Exps/admit	[0260 Total Operating Expenses + 0330 Total Non-Operating Expenses]/[4320 Total Hospital Acute Care Admissions + 4330 Total Non-Acute Care Hospital Admissions + 4331 Total Births + 4321 Total Nursing Home Admissions + 4332 Total Major Surgical Procedures]
Exps/hosppd	[0260 Total Operating Expenses + 0330 Total Non-Operating Expenses]/[4030 Total Hospital Acute Care Patient Days + 4330 Total Non-Acute Care Hospital Days + 4331 Total Nursery Days + 4321 Total Nursing Home Admissions]
<u>Specific expenditure measures (examples)</u>	
Exps(delv rm)/birth	0927 Delivery Room and Labor Room Ancillary Service Costs/4331 Births
<u>General price measures</u>	
Revs/admit	0219 Net Patient Revenue/[4320 Total Hospital Acute Care Admissions + 4330 Total Non-Acute Care Hospital Admissions + 4331 Total Births + 4321 Total Nursing Home Admissions + 4332 Total Major Surgical Procedures]
Revs(non-NH)/admit	0219 Net Patient Revenue - 0204 Gross Nursing Home Revenue]/[4320 Total Hospital Acute Care Admissions + 4330 Total Non-Acute Care Hospital Admissions + 4331 Total Births + 4332 Total Major Surgical Procedures]
Rev/hosppd	[0219 Net Patient Revenue - 0204 Gross Nursing Home Revenue]/[4030 Total Hospital Acute Care Patient Days + 4330 Total Non-Acute Care Hospital Days + 4331 Total Nursery Days + 4321 Total Nursing Home Admissions]
<u>Specific price measures (examples)</u>	
Revs(A&P)/A&P admit	0701 Adults and Pediatric Revenues/4301 Adult and Pediatric Admissions
<u>Specific price measures (examples)</u>	
Revs(A&P)/A&P pd	0701 Adults and Pediatric Revenues/4001 Adult and Pediatric Patient Days
Revs(nursery)/birth	0711 Nursery (routine) Revenues/4331 Births
Revs(IC)/IC pd	0704 Intensive Care Revenues/4004 Intensive Care Patient Days
<u>Variables collected on an ad hoc basis</u>	
Revs/DRG	For each of the top 10 DRGS in volume, collect total revenues for each and divide by the total number of patients with that DRG, by payer source

For physicians, general physician expense and price data can be collected from the Physician Clinic Revenue and Expense Report (PCRER). For example, revenues per encounter can be constructed by using total patient revenues at a given clinic divided by total encounters by Minnesota and non-Minnesota residents. Specific expenditure and price data may need to be collected on an ad hoc basis. Specific price variables can be defined by the price charged to consumers and insurance plans for specific general CPT-4 procedures. Expenditure data would be more difficult to disaggregate by the number of units of output when output is defined in terms of a specific service.

d. Merger-Related Cost Savings and Consumer Prices. It should be noted that the reduction in price need not be commensurate with the reduction in expenditures. The statute provides that "In the event that a proposed arrangement appears likely to improve one or two of the criteria at the expense of another one or two of the criteria, the COH shall not approve the application unless the COH determines that the proposed arrangement, taken as a whole, is likely to substantially further the purpose of this chapter."^{33/} Thus, it is possible that firm expenditures could decrease, but that the prices charged to consumers or purchasers may not fall commensurately. *Minn. Stat.* §62J.2917 notes that "cost savings are relevant only to the extent that the savings are likely to be passed on to the consumer." Hence the consequence of not fully passing through cost savings to consumers is that those cost-savings not passed through are given no weight in the determination of whether to grant immunity.

The central issue then becomes the extent to which access must be increased or quality raised to "compensate" for not lowering prices commensurately. Although the statute goes on to state that a cost-benefit analysis can be used to determine how much access or quality should be increased, it should be noted that measures of the value of increased access and quality to consumers is not readily available, making it difficult to use a cost-benefit framework for determining the amount of additional access or quality that should be forthcoming.

2. Access

According to the statute, "'Access' means the financial, temporal, and geographic availability of health care to individuals who need it."^{34/} At another point, increased access is specified as increased utilization by targeted groups, increased availability in geographic areas, and increased financial availability.^{35/}

Measures of increased utilization by targeted groups would most likely be developed on an ad hoc basis. Measures of increased availability in geographic areas would also be measured on an ad hoc basis, depending on the agreement with the state. Financial access could be

^{33/} *Minn. Stat.* §62J.2917, Subd. 1.

^{34/} *Minn. Stat.* §62J.2912, Subd. 2.

^{35/} *Minn. Stat.* §62J.2917, Subd. 2(c).

measured by the amount of charity care provided. For example, the state could require a certain increase in charity care, compared to before the new arrangement.

3. Quality

Statute provides specific examples of the measures of quality. According to *Minn. Stat.* §62J.2917, Subd. 2(d), quality is measured by (1) decreased morbidity and mortality, (2) faster convalescence, (3) fewer hospital days, (4) a certain minimum number of procedures done by any one provider, (5) increased patient satisfaction, and others. Some of these variables are already being collected (e.g., average hospital days), while others would need to be collected on an ad hoc basis (e.g., faster convalescence). It is likely that the quality measures used will be determined on an ad hoc basis from the immunity agreement.

C. **Costs of Monitoring**

The monitoring function has costs for the state and ultimately consumers as taxpayers. For example, in mergers, monitoring will require gathering and analyzing data on the prices that firms charge, both for the merged firms and for other similar firms in similar markets. It will also require gathering information on the prices charged by the other firms in the market in which the firm was located because, although the merged firm's price may remain constant, the increased concentration in that market may result in higher prices in the rival firms. Although the merged firm cannot be held responsible for the actions of its rivals, this information will help determine the state's stance on granting antitrust exceptions for other, future mergers.

The cost of regulation is not only the cost to the state of collecting and analyzing the data. There are costs for the regulated firms as well. These costs may include the time and effort of high-level staff involved in ensuring compliance with the regulations and providing the increased documentation required by the regulatory agency. These costs are costs to consumers because they will be incorporated into the merged firm's price structure.

Information on access and quality would also need to be provided. (Of course, in this regard, the exact variables to be used would need to be based on the specifics of the arrangement). There would be costs to the firm of collecting these data and to the state for reviewing and analyzing the data.

While recognizing that monitoring is not costless, ongoing supervision serves to protect consumers of health care services in the state of Minnesota. The substitution of regulation for competition where appropriate allows the COH to permit arrangements that further the public policy goals of the state while also ensuring that the significant market power conferred is not used in a harmful manner.

III. **REVOCATION**

In the third section of the report we examine procedures for revocation of antitrust exceptions which promote fairness and achieve state goals.

A. Revocation Procedures Under Minnesota's Antitrust Exception Legislation

The legislature gives the COH the ability to revoke an antitrust exception only if:

- (1) The arrangement is not in substantial compliance with the terms of the application;
- (2) The arrangement is not in substantial compliance with the conditions of approval;
- (3) The arrangement has not and is not likely to substantially achieve the improvements in cost, access, or quality identified in the approval order as the basis for the COH's approval of the arrangement; or
- (4) The conditions in the marketplace have changed to such an extent that competition would promote reductions in cost and improvements in access and quality better than does the arrangement at issue. In order to revoke on the basis that conditions in the marketplace have changed, the COH's order must identify specific changes in the marketplace and articulate why those changes warrant revocation.
(*Minn. Stat.* § 62J.2921)

While the above appears to grant the COH broad authority for revocation, limitations elsewhere in the statute in fact place significant barriers to revocation. In addition to specifying notice (*Minn. Stat.* §62J.2921, Subd. 2) and procedure (*Minn. Stat.* § 62J.2921, Subd. 3) requirements, the legislature mandates that the COH "take into account the hardship that the revocation may impose on the applicant and any potential disruption of the market as a whole." (*Minn. Stat.* § 62J.2921, Subd. 4). Further "[t]he COH shall not revoke an approval if the arrangement can be modified, restructured or regulated so as to remedy the problem upon which the revocation proceeding is based." (*Id.*) Therefore, a substantial burden is placed upon the COH to show that the agreement cannot be modified. This may lead to additional administrative costs as arrangements are modified into the foreseeable future.

For revocations of arrangements found not to be "in substantial compliance" with either the terms or conditions of approval (reasons (1) and (2) for revocation, above) the legislature has built in additional procedural safeguards for recipients of antitrust exceptions. In particular, during supervision after approval the COH must notify the recipient that the arrangement is not in compliance, and identify the deficiencies. The recipient is given 30 days to respond and may present a proposal to bring the arrangement into compliance. If the COH and applicant cannot come to an agreement, then the applicant still is afforded the procedural safeguards discussed above prior to revocation.

B. Enhancing Fairness and Efficiency of Revocation Process

Current statute places a significant burden upon the COH to revoke the grant of antitrust exception. While it is understandable that the legislature was concerned with dislocations which may occur from "undoing" a transaction, the current legislation may not give COH sufficient clout to discipline applicants effectively. This is especially true for arrangements which are not in "substantial compliance" approval.

The substantial burden placed upon COH for revocation increases the importance of careful consideration of issuing an antitrust exception and monitoring and supervising the transaction. To the extent possible, using the decision and supervision process as an opportunity to set objective goals for cost, quality and/or access improvements will both alert applicants to their responsibilities and provide an objective standard for considering alternative proposals or initiating a revocation proceeding.

When there are reasons (3) and (4) for revocation, it is not as clear what processes will result in fair or efficient procedures. In (3), the arrangement has failed to achieve the goals presumably despite compliance with terms and conditions of the application. In (4), market changes have made the regulatory vs. competition trade-off shift in balance of competition in the market. In these cases, the parties have attempted to fulfill their promises to the state. However, they either misjudged the potential gains from the transaction, or market circumstances have changed. Assuming the parties have acted in good faith, the COH should be more willing to work with the parties to fashion an alternative proposal prior to considering the revocation option. Alternatively, if revocation is the only option, then the COH may want to consider using the supervision process as a mechanism to alert the parties and give them adequate notice -- an opportunity to restructure or find alternative joint venture partners.

C. Revocation as Suspension of Ongoing Supervision

As discussed above in Section I.C, parties should anticipate that supervision will continue indefinitely. However, if competitive market forces no longer make continued supervision necessary the statute permits the Department of Health to "revoke" the antitrust exception.

An issue left open by the legislation is whether the transacting parties may request this type of revocation which is truly a suspension of ongoing supervision. The current legislation does not appear to provide this option, the grounds under which the COH may revoke the antitrust exception are limited in scope and require compliance with significant procedural safeguards. As the legislation stands, the parties could suggest to the COH that market conditions have changed, but the COH would have to initiate the "revocation" process.

While these procedures appear cumbersome for suspension of supervision, it is important to recognize the potential for significant welfare losses if market power accrued under the protection of the state's regulatory process is left unchecked. Requiring notice and public hearings permits community members who will be affected by this change to voice their concerns.

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Appendix 1

III. REQUIREMENTS FOR THE PRIVATE PARTY EXEMPTION UNDER THE STATE ACTION DOCTRINE

A. [4.3] Overview

The current test for when private activity is shielded from federal antitrust scrutiny was first articulated in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 63 L.Ed.2d 233, 100 S.Ct. 937 (1980) (*Midcal*). In that case the Court found that California's resale price maintenance and price posting statutes for the wholesale wine trade were in violation of the Sherman Act. The Court looked at whether the state's involvement in the price-setting scheme was sufficient to establish immunity under *Parker* by reviewing precedent in the area:

[T]wo standards [have been established] for antitrust immunity under *Parker v. Brown*. First, the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy"; second, the policy must be "actively supervised" by the State itself. *Midcal*, 63 L.Ed.2d at 243, citing *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 55 L.Ed.2d 364, 98 S.Ct. 1123 (1978), overruled in part by *Hallie v. Eau Claire*, 471 U.S. 34 (1985).

B. [4.4] Authorization (Clear Articulation)

To clarify the first prong of the *Midcal* test, clear articulation, the courts have raised two issues. First, what governmental entity qualifies as the "state" and can provide the appropriate authorization? Second, how detailed must the authorization be? *Midcal*, 63 L.Ed.2d at 243.

The state itself must authorize the activity. Authorization from a municipality or other governmental unit or subordinate agency is insufficient. *Id.* The courts have clearly determined that the state's legislature and the state's Supreme Court qualify as the "state" for state action purposes. The courts have struggled, however, to distinguish agencies that are the "state itself" from subordinate governmental agencies that lack the ability to authorize anticompetitive activity. In defining the boundary, the courts have considered several factors. These factors include whether the agency has quasi-legislative powers or merely carries out certain functions, whether the agency is made up solely of government officials or includes representatives from the regulated industry, and whether the agency is answerable in some explicit manner to the state legislature, governor, or Supreme Court. *Southern Motor Carriers Rate Conference v. United States*, 471 U.S. 48, 85 L.Ed.2d 36, 105 S.Ct. 1721 (1985) (agency legislative powers); *Cine 42nd Street Theater Corp. v. Nederlander Organization, Inc.*, 790 F.2d 1032 (2d Cir. 1986); *Massachusetts Board of Registration in Optometry*, 110 F.T.C. 549 (1988); *Washington State Electrical Contractors Association v. Forrest*, 930 F.2d 736, 737 (9th Cir.) (agency composition), *cert. denied*, 502 U.S. 968 (1991); *Bolt v. Halifax Hospital Medical Center*, 891 F.2d 810, 824 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990); *Fuchs v. Rural Electric Convenience Cooperative, Inc.*, 858 F.2d 1210, 1217 - 1218 (7th Cir. 1988) (answerability to state government), *cert. denied*, 490 U.S. 1020 (1989); Herbert Hovenkamp, FEDERAL ANTITRUST POLICY THE LAW OF COMPETITION AND ITS PRACTICE §20.4 (1994).

C. [4.5] Active Supervision

The active supervision element of the *Midcal* test appears to be more difficult to satisfy than the clear articulation prong. Although the Court in *Midcal* found that California's system satisfied the first prong of *Parker*, the program did not meet the second requirement because the state merely authorized the wine price setting. It did not engage in a "pointed reexamination" of the program. *Midcal*, 63 L.Ed.2d at 243. Two more recent Supreme Court cases have discussions about the active supervision element: *Patrick v. Burget*, 486 U.S. 94, 100 L.Ed.2d. 83, 108 S.Ct. 1658 (1988), and *FTC v. Ticolor Title Insurance*, 504 U.S. 621, 119 L.Ed.2d 410, 112 S.Ct. 2169 (1992). In *Patrick* the Court explained:

The active supervision requirement stems from the recognition that "[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State." *Hallie v. Eau Claire*, 471 US 34, 47, 85 L Ed 2d 24, 105 S Ct 1713 (1985) [superseded by statute as stated in *Sakamoto v. Duty Free Shoppers, Ltd.*, 764 F.2d 1285 (9th Cir. 1985)] . . . The requirement is designed to ensure that the state-action doctrine will shelter only the particular anticompetitive acts of private parties that, in the judgment of the State, actually further state regulatory policies. [Citation omitted.] 100 L.Ed.2d at 92.

The Court found, however, that "[t]he mere presence of some state involvement or monitoring does not suffice"; rather, the state officials must "have and exercise" the power to review the competitive acts. 100 L.Ed.2d at 92.

In *Ticolor*, *supra*, the Court elaborated further on the active supervision test:

Our decisions make clear that the purpose of the active supervision inquiry is not to determine whether the State has met some normative standard, such as efficiency, in its regulatory practices. Its purpose is to determine whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties . . . the analysis asks whether the State has played a substantial role in determining the specifics of the economic policy. *Ticolor*, 119 L.Ed.2d at 423.

The Court found that two of the four state schemes at issue in this case did not provide the necessary component of active supervision to meet the second prong of the state action doctrine. 119 L.Ed.2d at 426. Beyond *Patrick* and *Ticolor*, case law with respect to what actually constitutes "active supervision" is not very well developed.

If the conduct being challenged is that of a private party, active state supervision is required. See *Midcal*, 63 L.Ed.2d at 243. If the conduct is that of a "governmental party" or the state itself, no supervision is needed. See *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 85 L.Ed.2d 24, 105 S.Ct. 1713 (1985), superseded by statute as stated in *Sakamoto v. Duty Free Shoppers, Ltd.*, 764 F.2d 1285 (9th Cir. 1985); *Wall v. City of Athens*, 663 F.Supp. 747, 762 (M.D.Ga. 1987). The distinction between government and private action is not always clear, however. Before a body can be considered the "state itself," and thus not be in need of supervision, the effective decision-makers must be economically independent of the conduct

that they are regulating. See Einer Richard Elhauge, *The Scope of Antitrust Process*, 104 Harv.L.Rev. 667 (1991). In addition, if a private actor's conduct is determined by statute, leaving that actor with no discretion over which course of action to take, supervision is not required. See *Municipal Utilities Board of Albertville v. Alabama Power Co.*, 934 F.2d 1493, 1497 (11th Cir. 1991).

Source: Samuels, Simonetti. "State Action Considerations," Antitrust and Unfair Competition, 4-1, IICLE, 1996.

Appendix 2

MARKET DATA INFORMATION TO BE PROVIDED

Primary Analysis

1. Most recent patient discharge data for the zip codes comprising the parties' 70%, 80% and 90% service areas. This information should include zip code discharge data for all other hospitals located within the zip codes comprising the parties' 70%, 80% and 90% service combined areas. (See attached model report for format.)
 - If possible, run same report for commercially covered discharges (i.e. excluding all discharges covered by Medicare, Medicaid and other governmental payors, as well as charity and bad debts)
2. Aggregate patient code discharge data, by county, for all hospitals located in counties comprising the parties' 70%, 80% and 90% combined service areas.
3. Aggregate patient zip code discharge data by MDC or category of service. (use same format as 1 above for each MDC or category service, and, if possible, run for commercially covered discharges)
4. Information regarding particular submarkets in which the hospitals may have significant market share.
5. Any memos, studies or other data that include a market analysis, whether generally or by product line. Such reports might include strategic plans and feasibility studies for past ventures.
6. Information regarding other hospitals in the vicinity leased, owned or managed by either of the parties, including whether any of these hospitals are county or municipal hospitals.

Secondary Analysis

1. Information regarding commuting patterns of service area residents.
2. Information regarding the potential efficiencies of the transaction under consideration. Transaction efficiencies are limited to those efficiencies that could not be accomplished by either party on its own.
3. Information regarding physician referral patterns.

4. Information regarding managed care penetration and a history of each hospital experience with managed care, including:
 - A break down of managed care penetration by payor indicating the number of covered lives enrolled in each plan doing business in the area and the type of plan (HMO, PPO, traditional indemnity).
 - A list of each party's current managed care contracts and the basic terms (i.e., exclusivity and payment mechanism).
 - Information regarding managed care contacts that did not result in a final contract including who initiated the contact and why no agreement was reached.
5. Information regarding medical staff overlap.
6. Information regarding competing health care providers and product lines, including:
 - Discharge data regarding competing outpatient facilities in the geographic market.
 - The ability to provide these services without need for hospital backup or the complementary services provided in the hospital.
 - The ability of these competing units to provide their own complementary services.
 - The number and market share of physicians or physician groups providing these competing services at a freestanding or mobile unit or within their offices.
 - A list of services which can be provided on an outpatient basis and are actually provided by competitors.
 - Competing clients(?), independent practice associations, HMOs, and PPOs providing such services.
 - Information regarding home health care agencies.
 - Any studies on patient preference and other factors impacting patient choice.
 - Information regarding other competing providers of healthcare services, i.e., long term care facilities, ambulance companies, and non-health care service, i.e., laundry and food services, which may reduce hospitals overall market share.
 - Percentage of revenue generated by these competitors compared to all health care revenue in the appropriate geographic market.

- Percentage of total revenue that the hospital's out-patient services generate compared to total revenue trended over past 10 years.
 - Evidence of reimbursement policies held by private and public third-party payors, which promote the utilization of out-patient services.
 - Future trends and expansion of new product markets and competitors.
7. Information that helps predict the transaction's probable impact on prices:
- The percentage of each hospital's total revenue that is attributable to each governmental and third-party payor.
 - The percentage of total revenue that is written off for indigent and other related care.
 - A summary of each hospital's overall approach and philosophy toward price increases as reflected in board minutes and policies.
 - Information regarding how community membership on each not-for-profit corporation's board has impacted pricing decisions.
 - Trended data illustrating the growth of revenues controlled by Medicare, Medicaid, and managed care contracts.
 - The factor that price plays in the decision to utilize hospital services. **(better covered during interviews)**
 - The presence of employer coalitions in the area.
 - Other outside factors that affect prices so as to limit the impact of an affiliation.
 - Information regarding any past or ongoing antitrust investigations, enforcement actions or law suits involving any of the parties.

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