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Report to the Honorable Fortney H. (Pete) Stark, House of Representatives

August 1994

HEALTH CARE

Federal and State Antitrust Actions Concerning the Health Care Industry

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GAO

United States
General Accounting Office
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Health, Education, and
Human Services Division

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August 5, 1994

The Honorable Fortney H. (Pete) Stark
House of Representatives

Dear Mr. Stark:

One of the issues the Congress is concerned about as it debates health care reform is how antitrust laws should be applied to the health care industry. The prospect of national health care reform as well as reforms occurring in a number of states is encouraging change and consolidation in the health care industry. The health care market appears to be evolving toward service networks, where different types of health care providers (such as hospitals, physicians, and allied health professionals) are integrated into networks. Many experts believe that future competition in the health care industry will be among networks, not among providers.

The nation's antitrust laws exist to protect free market competition. Some in the health care industry have argued that competition among hospitals for patients has led to a "medical arms race," which has increased society's overall health care costs. On the other hand, proponents of antitrust enforcement claim that promoting competition has produced a sufficient quantity of high-quality services at reasonable prices.

The American Hospital Association (AHA) has urged the federal government to clarify its policy on hospital mergers and joint ventures and has also urged state associations to promote state action to immunize such agreements from federal antitrust scrutiny. In a 1992 report,[1] AHA stated that there was a need for additional guidance on how the antitrust laws are applied in investigations involving hospital collaborations. A February 1993 memo from the office of AHA's General Counsel to state hospital association officers discussed several issues, including ongoing supervision and the role of the state Attorney General, that should be considered in drafting a statutory scheme intended to immunize hospital cooperative transactions from federal antitrust laws.[2] AHA attached a copy of Maine's "Cooperative Agreement" legislation to this memo. In

[1]Hospital Collaboration: The Need for an Appropriate Antitrust Policy, AHA (Chicago, Ill.: Nov. 1992).

[2]Memo dated February 19, 1993, from AHA's Office of General Council to Allied Hospital Association Chief Executive Officers regarding immunizing hospital cooperative ventures through state action.

March 1993,[3] AHA further claimed that the uncertainty of antitrust policy and the threat of enforcement has had a "chilling effect" on attempts by hospitals to merge providers or to engage in joint ventures.[4] AHA says that additional joint ventures and mergers could promote greater efficiency in the delivery of health care services and help reduce the current oversupply of facilities. Further, AHA says that more mergers and joint ventures will be needed if hospitals are to remain competitive in the health care industry.

You asked us to obtain information on antitrust enforcement actions involving hospitals taken by the Department of Justice (DOJ) and Federal Trade Commission (FTC), the agencies with primary responsibility for enforcing the federal antitrust laws, and to review state legislation that creates regulatory programs for the approval of mergers and joint ventures among health care providers. (Details on our scope and methodology are in app. I.)

Results in Brief

Of 397 acute care hospital mergers reviewed by DOJ or FTC during the 13-year period from fiscal year 1981 through fiscal year 1993, less than 4 percent were challenged.[5] For an additional 13 percent of these mergers, DOJ or FTC conducted a preliminary investigation and then allowed the mergers to go forward. The remaining 83 percent of cases involved no more than the required initial filing of notice of proposed merger; that is, DOJ or FTC did not seek any further data about the mergers and allowed them to go into effect. Neither DOJ nor FTC has ever challenged a hospital joint venture.

Under the state action immunity doctrine established by the Supreme Court, certain anticompetitive conduct regulated by states may be immune from federal antitrust enforcement action. The hospital industry has actively sought enactment of state laws that would confer such antitrust immunity to collaborative actions by hospitals, such as mergers, joint ventures, and sharing of patients and equipment. Since March 1992, 18

[3]Statement of AHA for hearings on antitrust in the health care industry before the Subcommittee on Antitrust, Monopolies and Business Rights, Committee on the Judiciary, United States Senate (Mar. 23, 1993).

[4]Joint ventures include agreements to share patients; personnel; equipment; support services; and medical, diagnostic, or laboratory facilities.

[5]We considered a merger to be challenged if DOJ or FTC sought an administrative action or a formal move in court to block a merger, the parties agreed to a consent decree that prohibited the merger or allowed the merger to proceed with certain modifications, or the parties withdrew a proposed merger after receiving notice that DOJ or FTC planned to issue a second request for information or file suit to block the merger.

states have enacted regulatory programs for state approval of hospital activities that can fall under antitrust statutes.[6]

The 18 state laws vary considerably in the types of providers and activities covered, the state authorities that approve activities, the role of antitrust enforcement officials in approving and monitoring activities, the questions and issues that must be addressed before approval is granted, and the nature and extent of postapproval monitoring or supervision by the state. The following examples illustrate the variations. Oregon's law covers only hospital joint ventures related to heart and kidney transplant services, and each joint venture must include the state teaching hospital. On the other hand, Minnesota's law covers a wide array of providers and activities. Under Idaho's law, the state Attorney General is the approving authority of joint ventures and cooperative agreements among health care providers, while five other state statutes give their Attorney General no specific role in regulating mergers or joint ventures. In the monitoring area, laws in Nebraska and Washington require annual reports and include procedures for revoking the state's approval of agreements, but a number of other state laws do not mention the extent and frequency of monitoring.[7]

Background

Federal Antitrust Laws

The federal antitrust laws reflect a public policy principle that free market competition protects consumers, checks private economic power, and generally produces the best allocation of quality goods and services at the lowest prices. Two major concerns of the antitrust laws are "unreasonable" restraints on trade and monopolies. Section 1 of the Sherman Act[8] prohibits all conspiracies or agreements that restrain trade. As interpreted by the courts, this prohibition applies to agreements that unreasonably restrain trade, which may include agreements or conspiracies to fix prices, divide market territories or groups of customers, boycott other firms, or use coercive tactics with the intent and

[6]Other states may have regulatory programs that predate the current flurry of activity in the hospital antitrust area. For example, Maryland exempts mergers, consolidations, and joint ventures and operations of major medical equipment from its antitrust laws if the activity involved is approved by the state Health Resources Planning Commission.

[7]Although the state laws do not mention specific monitoring requirements, states may establish monitoring procedures through rules or regulations.

[8]July 2, 1890, c.647,1,26 Stat. 209, classified to 15 U.S.C. 1 (Supp. IV 1992).

effect of injuring competition. Section 7 of the Clayton Act[9] prohibits all mergers and acquisitions of stock or assets that may substantially lessen competition or that tend to create a monopoly.[10] Section 5 of the Federal Trade Commission Act[11] prohibits unfair methods of competition.

State Antitrust Laws

Historically, states took the lead in passing antitrust legislation more than a century ago.[12] By 1890, when the Congress passed the Sherman Act, 27 states had either a constitutional or statutory provision banning monopolies or other restraints of trade. Today, all states, with the exception of Pennsylvania and Vermont,[13] have an antitrust law generally applicable to activity within the state. Each of these state antitrust laws contains a provision analogous to section 1 of the Sherman Act. Twelve states' laws have provisions relating to mergers, but only half of those are analogous to section 7 of the Clayton Act.

Application of Antitrust Laws to Hospitals

DOJ and FTC share responsibility for enforcing antitrust laws. DOJ has responsibility for enforcing the Sherman Act, while FTC enforces the Federal Trade Commission Act. Both agencies have jurisdiction under the Clayton Act. Officials of both agencies told us that certain actions, such as agreements among firms to fix prices or divide markets, are on their face antitrust violations. These are called "per se" violations. Actions not considered per se violations are evaluated under the "rule of reason." (See app. II for more details.)

A merger or joint venture between two or more hospitals may be investigated by either DOJ or FTC under the Clayton Act. These agencies have established a procedure for deciding, on the basis of staff expertise, prior dealings with the parties involved, and case load, which will investigate a particular merger or joint venture. While either agency may investigate a merger or joint venture for civil violations, once criminal conduct is suspected, the case is referred to DOJ. Private parties and state

[9]Oct. 15, 1914, c.323,7,38 Stat. 731, classified to 15 U.S.C. 18 (1988).

[10]A monopoly occurs when a single supplier has the power to control prices or restrict output, including lowering quality, without fear of competition.

[11]Sept. 26, 1914, c.311,5,38 Stat. 719, classified to 15 U.S.C. 45 (1988).

[12]This summary of state antitrust laws is condensed from "State Antitrust Law and Its Application to Health Care: An Overview" (a presentation by Michael F. Brockmeyer and Ellen S. Cooper before the National Health Lawyers Association, Washington, D.C., Feb. 15, 1991).

[13]While they do not have a state antitrust law of general applicability, Pennsylvania and Vermont incorporated the provisions of section 1 of the Sherman Act into statutes applying to bid rigging on governmental contracts.

Attorneys General may also sue to block mergers or joint ventures under either the Sherman or Clayton Act.

State Action Immunity Doctrine

Depending on the degree of state supervision and control of hospital activities, hospitals may be immune from federal antitrust enforcement under the state action immunity doctrine. For private anticompetitive conduct to be immune from federal antitrust liability under this doctrine the state must (1) clearly articulate and affirmatively express a policy to displace competition with regulation and (2) actively supervise and control the private anticompetitive conduct.

The state action immunity doctrine originated in 1943 with the Supreme Court's decision in Parker v. Brown.[14] The doctrine has been refined several times, most recently in 1992, in FTC v. Ticor Title Insurance Co.[15] The Ticor case involved state rate approval programs for title search and examination by real estate title insurance companies. Two state programs allowed for approval of rates through a negative option; that is, rates that were initially set by private parties were deemed approved if they were not disallowed by the state within a specific time frame. The Court ruled that this negative option did not meet the active supervision test.

Federal Enforcement Actions

The Hart-Scott-Rodino Antitrust Improvements Act of 1976 (P.L. 94-435, Sept. 30, 1976)[16] requires that parties notify both FTC and DOJ of certain mergers, acquisitions, joint ventures, or tender offers before consummation of the agreements. This filing requirement applies to all parties engaged in such activities, including hospitals, and covers agreements in which the acquiring hospital has net sales or total assets of at least $100 million and the hospital being acquired has assets of at least $10 million. Based on information provided in these filings, DOJ and FTC decide whether to allow the proposed merger to proceed or to open a preliminary investigation. If the preliminary investigation indicates that a potential violation exists, FTC or DOJ may issue a second request for additional information to review before deciding whether to challenge the proposed merger or collaboration as a potential violation of antitrust laws.

[14]317 U.S. 341 (1943).

[15]112 S. Ct. 2169 (1992).

[16]15 U.S.C. 18a.

For the 13-year period covering fiscal year 1981 through fiscal year 1993, DOJ and FTC received 397 Hart-Scott-Rodino filings involving acute care hospital mergers and acquisitions. After initial review of the filings, the two agencies conducted preliminary investigations in 68 cases, or about 17 percent of the total filings. Less than half of these resulted in second requests for information. The final disposition of these cases showed that fewer than 4 percent of all Hart-Scott-Rodino filings actually resulted in court challenge or consent decree, or were withdrawn by the interested parties. This is summarized in table 1.

Table 1: Acute Care Hospital Merger Enforcement Actions Taken by Department of Justice and Federal Trade Commission, Fiscal Years 1981-93

	Number of[a]		
Fiscal year	Hart-Scott-Rodino Act filings	Preliminary investigations	Second requests for information
1981	15	5	1
1982	9	2	1
1983	20	4	1
1984	29	4	1
1985	32	2	1
1986[b]	27	3	
1987	30	5	4
1988	43	5	1
1989	35	3	1
1990	36	9	8
1991	31	4	2
1992	42	9	3
1993	48	13	4
Total	**397**	**68**	**28**

Final disposition of second request cases, as of September 30, 1993[b]			
No challenge; transaction allowed to proceed	Court or administrative challenge	Parties agreed to consent decree	Hart-Scott-Rodino Act filing withdrawn
1			
	1		
	1		
1			
		1	
2	2		
			1
			1
7			1
	1		1
2			1
	2	2	
13	**7[d]**	**3**	**5**

[a]Because little information is retained about transactions in which there was no competitive overlap between the acquiring and the acquired companies, some transactions involving companies in the health care industry that did not involve the acquisition of a general acute care hospital may be included in the total number of transactions. The table does not include transactions unless they were subject to the premerger notification reporting requirements of the Hart-Scott-Rodino Act.

[b]The final disposition of a matter is entered in the year in which the preliminary investigation is opened, even though the final disposition may occur in a later fiscal year.

[c]Data for total filings in fiscal year 1986 are estimated because FTC changed its merger records system, and the information from that year was not put into retrievable form.

[d]Of these cases, the federal enforcement agencies won or obtained settlements for all but one case.

The information in table 1 only reflects mergers. Officials at DOJ and FTC told us that the agencies have never sought to block a hospital joint venture.

DOJ and FTC Issued Antitrust Enforcement Policy Statements for the Health Care Industry

In September 1993, DOJ and FTC issued a joint statement regarding their enforcement policies for mergers and various joint activities by providers in the health care industry.[17] This statement provided information about six "antitrust safety zones" to lessen providers' uncertainty about antitrust enforcement. These policies describe the circumstances under which the agencies will not, as a matter of prosecutorial discretion, challenge the conduct.

The policy statement includes safety zones for (1) certain types of hospital mergers, (2) hospital joint ventures involving high-technology or other expensive medical equipment, (3) physicians' provision of information to purchasers of health care services, (4) hospital participation in exchanges of price and cost information, (5) joint purchasing arrangements among health care providers, and (6) physician network joint ventures. Each of the safety zones is described in appendix II.

The agencies also recognized that, in the light of anticipated health care industry changes, additional antitrust guidance might become desirable. Consequently, the agencies indicated that they would issue additional policy statements as warranted.

AHA officials stated that the guidance in the September 1993 policy statement was a helpful step in recognizing the importance of antitrust issues to hospitals. AHA believes additional guidance is needed and has raised this with DOJ and FTC officials.

Officials of state hospital associations and antitrust attorneys we spoke with in the states we visited also believed that the policy statements were helpful. Some antitrust attorneys also stated that most of the information contained in the policy statements was not new, with the exception of the safety zone for mergers involving hospitals with fewer than 100 beds. In addition, most representatives of state Attorneys General we spoke with said that the information was not new.

States Act to Provide Immunity From Antitrust Laws

Since March 1992, 18 states have attempted to provide immunity from federal and state antitrust laws for some activities of hospitals and other health care providers. As of May 1994, 12 states had passed legislation creating regulatory programs for hospitals forming joint ventures, 5 states created programs for joint ventures and mergers, and the regulatory

[17]"Statements of Antitrust Enforcement Policy in the Health Care Area," issued by DOJ and FTC (Sept. 15, 1993).

program in the 18th state covers only mergers. State hospital associations have actively promoted the establishment of these state programs. All of these state programs appear to have been enacted with the expectation that they would provide an exemption from state antitrust laws and also provide immunity from federal antitrust enforcement under the state action immunity doctrine. None of the states' laws give automatic protection to any specific type of agreement. Each of the laws establishes a voluntary regulatory process,[18] which allows eligible providers to request approval by the designated state regulatory authority.

As of May 1994, Maine, Oregon, and Washington each had approved one agreement. In Maine, two hospitals and an affiliate of one of the hospitals agreed to jointly operate a magnetic resonance imaging (MRI) machine. In Oregon, two hospitals agreed to jointly operate a kidney transplant program. In Washington, eight rural public hospital districts agreed to send their nonemergency laboratory work to a central laboratory. As of July 1994, Minnesota had one agreement under review.

All 18 state programs cover at least some kinds of hospitals, and 10 states cover other health care providers, generally defined as any person or health care facility licensed, registered, or certified by the state to provide health care services. This would generally include physicians, nursing homes, and ambulatory surgical centers. In addition to health care providers involved in the direct delivery of care, laws in Colorado and Nebraska cover negotiations to allocate or consolidate referral of patients, services, or facilities. Oregon's legislation is the least inclusive because it covers only collaboration for kidney and heart transplant services and limits the hospitals that may participate. Key elements of the state programs are summarized in table 2, and appendix III presents more detailed information on each state law.

[18]If providers do not submit agreements for regulatory review, the agreements receive no protection under these laws and run the risk of being challenged on antitrust grounds.

Table 2: Key Features of State Regulatory Programs Concerning Antitrust Enforcement

State	Activities covered	Providers covered	Approval agency	Limitations
Colorado	Joint ventures and agreements for the allocation, consolidation, or referral of patients, services, and facilities	Hospitals	Cooperative Health Care Agreements Board	Program to sunset in July 1998
Florida	Joint ventures	Certified rural hospitals and other certified rural health care providers	Agency for Health Care Administration	Antitrust exemptions apply only to rural health care networks[a]
Georgia	Mergers	Specified hospitals	Governing authority of the county and a majority of each hospital board	Applies only to county hospital authorities in the same county
Idaho	Joint ventures	Hospitals, physicians, and other health care providers	Attorney General	
Kansas	Mergers and joint ventures	Hospitals, physicians, and other health care providers	Secretary of the Department of Health and Environment	
Maine	Joint ventures	Hospitals	Department of Human Services	Program to sunset in July 1995
Minnesota	Mergers and joint ventures	Hospitals, physicians, and other health care providers	Commissioner of Health	
Montana	Joint ventures	Hospitals, physicians, and other health care providers	Health Care Authority	
Nebraska	Joint ventures, and allocation, consolidation, or referral of patients, services, and facilities[b]	Hospitals, physicians, and other health care providers	Department of Health	
New York	Joint ventures	Hospitals, physicians, and other health care providers	Commissioner of the Department of Public Health	Applies only to rural health care networks[a]
North Carolina	Joint ventures	Hospitals	Director of the Department of Human Resources	
North Dakota	Joint ventures	Hospitals, physicians, and other health care providers	Department of Health and Consolidated Laboratories	
Ohio	Joint ventures	Hospitals	Department of Health	
Oregon	Joint ventures	Hospitals	Department of Human Resources	Applies only to heart and kidney transplant services, and must include services at the state teaching hospital
Tennessee	Joint ventures[c]	Hospitals	Department of Health	
Texas	Joint ventures	Hospitals	Department of Health	
Washington	Joint ventures[d]	Hospitals, physicians, and other health care providers	Health Services Commission[e]	Different rules apply to rural public hospital districts[f]
Wisconsin	Joint ventures	Hospitals, physicians, and other health care providers	Department of Health and Social Services	

(Table notes on next page)

[a]A rural health care network means an affiliation of health care providers serving a rural area that plans, coordinates, provides, or arranges for the provision of health care services. In Florida, a rural health network must include a hospital and local rural providers as certified by the state Agency for Health Care Administration; New York defines a rural area as a county with a population less than 200,000.

[b]Although not specifically stated in the legislation, an official of the Nebraska Association of Hospitals and Health Systems said the legislation also covers mergers.

[c]Although not specifically stated in the legislation, the Notice of Proposed Rulemaking states that the law covers hospital mergers.

[d]It is unclear whether the legislation covers mergers. A representative of the state Attorney General told us that this will have to be clarified in the implementing rules being drafted by the Washington Health Services Commission.

[e]Unless the agreement covers services or facilities that a state agency has constitutional or statutory control over, agreements among rural public hospital districts do not need to be approved by a state agency; however, copies of all agreements must be filed with the county auditor and Washington's Secretary of State.

[f]A rural public hospital district is one that is authorized as a hospital district and does not include a city with a population greater than 30,000 within its geographic boundaries.

Most state hospital association officials and private antitrust attorneys we interviewed believed these programs were necessary to alleviate the perceived fear of antitrust liability among hospital officials. The programs are also intended to encourage collaboration among hospitals. Also, one state hospital association representative said that hospital officials sometimes cite fear of antitrust litigation as an excuse for not cooperating, and these state programs eliminated that excuse.

Variation in State Laws

In addition to the variation illustrated in table 2, the state laws exhibit variation in the questions or issues to be addressed before approval is granted. Maine's legislation provides a list of five advantages and four disadvantages that must be considered by the state agency before approval of a joint venture. Florida's law states that any approved cooperative agreement must reduce costs and provides five other criteria for evaluating proposed agreements; however, Florida's law mentions no disadvantages to be considered. Montana's law simply states that the Montana Health Care Authority must weigh the extent to which the proposal is likely to result in lower health care costs, greater access, or greater quality of health care than would occur without the agreement. Georgia's law is silent about advantages and disadvantages to be evaluated before approval of a merger.

Another area in which state laws differ is the role articulated for the state Attorney General. Idaho's law provides that the state Attorney General is the approving authority for cooperative agreements. North Carolina's law includes the state Attorney General in the review process and gives him/her veto power over proposed agreements. Minnesota's legislation gives the state Attorney General an advisory role, permitting him/her to review all applications and to provide written comments to the regulatory agency. The laws of Georgia, Kansas, New York, Oregon, and Wisconsin provide no specific role for the Attorney General in reviewing or approving proposed agreements.

Finally, provisions in the state laws for monitoring approved activities varied from extensive to little or none. Nebraska's law requires the parties to any agreement to report annually on their activities, and the state Department of Health can revoke its approval of agreements if it determines that the likely benefits no longer outweigh the disadvantages. North Carolina's law details the information that the parties to an approved arrangement are required to report to the Department of Human Resources every 2 years. Both Maine's and North Dakota's laws are silent on the extent and frequency of monitoring requirements; however, in each state, the approving state agency may cancel an agreement under certain conditions. Although Tennessee's law does not mention specific monitoring requirements, it states that the Attorney General and the Department of Health are entrusted with active and continuing oversight. The laws in Georgia and Montana do not contain any provisions dealing specifically with monitoring approved activities.

Summary

The hospital industry and others in the health care sector have actively sought the enactment of state laws that would grant immunity from federal and state antitrust enforcement actions related to mergers, joint ventures, and other agreements that could fall under the antitrust statutes. Since March 1992, the states have been relatively active in this area, with 18 states passing laws that have established regulatory programs for a variety of activities in the health care industry as replacements for antitrust enforcement. These laws exhibit considerable variation in their key provisions, ranging from the types of activities covered to the extent of required monitoring of activities that are approved under the laws.

Whether compliance with a regulatory program established under any of the state laws will in fact confer federal antitrust immunity is subject to interpretation by the courts. Moreover, such judicial interpretation is

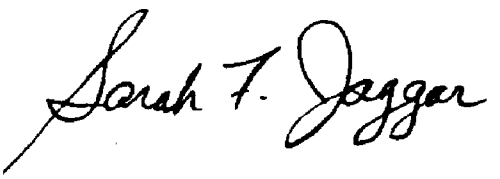
necessarily dependent upon litigation being brought; we are not aware of any such court challenges of these state laws.

Details on our scope and methodology are in appendix I. We did our work between November 1992 and June 1994 in accordance with generally accepted government auditing standards. We discussed a draft of this report with representatives of DOJ and FTC. They generally agreed with the facts as presented, and their comments are reflected in this report where appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days after its issue date. At that time, we will send copies to interested congressional committees; the Director, Office of Management and Budget; the Secretary of Health and Human Services; the U.S. Attorney General; and the Chairman, Federal Trade Commission. We will also make copies available to other interested parties on request.

If you have any questions, please call me at (202) 512-7119. The major contributors to this report are listed in appendix IV.

Sincerely yours,



Sarah F. Jaggar
Director, Health Financing
and Policy Issues

Contents

Tables

Abbreviations

AHA	American Hospital Association
DOJ	Department of Justice
FTC	Federal Trade Commission
MRI	magnetic resonance imaging

Scope and Methodology

We obtained the following information from DOJ and FTC for fiscal year 1981 through fiscal year 1993:

- the number of acute care hospital mergers that were reported to the agencies under the Hart-Scott-Rodino Act,
- the number of mergers that were subject to a preliminary investigation,
- the number of mergers for which a second request for information was issued, and
- the disposition of those merger cases for which a second request for information was issued.

The scope of our work included joint ventures, but neither DOJ nor FTC has ever challenged a hospital joint venture on antitrust grounds.

Since March 1992, 18 states have passed legislation to create a program whereby hospitals and, in some cases, other health care providers may request state review and approval of joint ventures or mergers. For some states, such as Minnesota and Washington, these programs were part of broad health care system reform legislation. For other states, such as Maine, these programs were specifically tailored for joint ventures. All of these state statutes were adopted with the expectation that the state program would confer immunity from federal antitrust scrutiny for activities covered by the state program, under the Supreme Court's state action immunity doctrine.

As agreed with your office, we reviewed hospital exemption legislation and various materials describing programs for the 18 states. Descriptions of state laws are current through May 1994. We compared and contrasted the state programs on these elements:

- the purpose for which the program was created;
- the types and scope of activities covered;
- the approval agency(ies);
- the standards used for evaluating the proposed activity, including both the advantages and the disadvantages evaluated;
- the role and authority of the state Attorney General;
- the monitoring program for approved activities; and
- the provisions for issuing rules and regulations.

Among the states that passed legislation to create a state regulatory program, we visited Colorado, Maine, Minnesota, Oregon, and Washington. During such visits, we met with representatives of the state government

(including representatives of the office of the Attorney General), representatives of the state hospital association, and hospital administrators to discuss the background, purpose, and expected operation of the state program. For all states except Oregon, we also met with officials from the agency or agencies involved in reviewing and approving joint ventures and mergers to discuss the background, purpose, and expected operation of the state program. In addition, in Colorado, Oregon, and Washington we met with private attorneys specializing in antitrust issues to discuss the background, purpose, and expected operation of the state program. Because these state programs are relatively new, there was little history of operations to review. Also, we are not aware of any court challenges testing whether the state programs qualify for exemption from federal antitrust scrutiny under the state action immunity doctrine. The other states with a regulatory program enacted since March 1992 are Florida, Georgia, Idaho, Kansas, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Tennessee, Texas, and Wisconsin.

We also met with representatives of DOJ, FTC, the American Hospital Association, the Federation of American Health Systems, and the Joint Commission on Accreditation of Healthcare Organizations to obtain their views and perspectives on the issues surrounding antitrust scrutiny of mergers and joint ventures within the health care industry.

In August 1993, the Massachusetts Attorney General published antitrust guidelines for reviewing hospital mergers. We reviewed those guidelines and met with representatives of the office of the Attorney General and the Massachusetts Hospital Association to discuss the background, purpose, and expected effect from the implementation of the guidelines.

Application of Antitrust Laws to Hospitals

Antitrust laws, as they apply to hospitals, are intended to promote an efficient and competitive hospital industry in which each hospital has an opportunity to compete on the basis of price, quality, and service. In general, potential antitrust violations are analyzed under one of two rules, depending on the type of conduct or arrangement involved: (1) the "per se" rule and (2) the "rule of reason."

Per Se Rule

"Per se" violations involve certain business arrangements that are so unlikely to produce redeeming consumer benefits that the conduct is presumed illegal. As set out by the Supreme Court, the per se rule applies to "agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to precise harm they have caused or the business excuse for their use."[19] Examples of such agreements include price fixing and agreements to divide markets. Outside legitimate joint ventures, hospitals cannot agree to allocate services or customers among themselves based on location or the types of service provided, even if the allocation is supported by consumers and the business community.[20]

Rule of Reason

Most joint arrangements to achieve market efficiencies, including mergers, acquisitions, and joint ventures, are evaluated under the "rule of reason,"[21] not the per se rule. This distinction arises because mergers and joint ventures involve full or partial integration of ownership and a sharing of economic risk, which might provide incentives for efficiencies that may benefit consumers. Under rule of reason analysis, DOJ and FTC weigh all the factors surrounding an activity to determine whether the arrangement promotes or suppresses competition, and, on balance, is more beneficial than harmful to consumers.

Market power is a principal measure used to determine whether competition will be unduly harmed by joint activities. Market power, often measured by market share and market concentration, exists when a party can increase price above, or decrease services or quality below,

[19]Northern Pacific R. Co. v. United States, 356 U.S. 1, 4-5 (1958).

[20]Hospitals may participate in legitimate joint ventures that could result in the allocation of services or customers if the joint venture creates a new product or other efficiencies that benefit consumers and outweigh any anticompetitive effects. A legitimate joint venture involves financial risk sharing.

[21]This description of the rule of reason is condensed from Hospital Collaboration: The Need for an Appropriate Antitrust Policy, AHA (Chicago, Ill.: Nov. 1992).

competitive levels. Where no market power exists, antitrust risk is remote. To the extent market power is created or enhanced by a collaborative arrangement, if that arrangement is challenged, the parties have the burden of proving that other factors (such as the creation of efficiencies that will benefit consumers) outweigh the threat to competition posed by the increased market power.

DOJ and FTC Health Care Policy Statements

To lessen some uncertainty about antitrust enforcement in the health care industry, DOJ and FTC jointly published policy statements on September 15, 1993. According to the "Statements of Antitrust Enforcement Policy in the Health Care Area," the agencies intended to educate the health care community and to reiterate that they will continue to enforce the antitrust laws to protect consumers from truly anticompetitive behavior.[22] The policy statement includes guidelines describing the circumstances under which the enforcement agencies would not, as a matter of prosecutorial discretion, challenge mergers and various joint ventures in the health care industry.

The guidelines highlight six "antitrust safety zones." DOJ and FTC will not challenge conduct described in these safety zones as violations of the antitrust statutes unless extraordinary circumstances exist:[23]

1. Hospital mergers. A merger of 2 general acute care hospitals will not be challenged if 1 of the hospitals is at least 5 years old, has had an average of fewer than 100 licensed beds over the 3 most recent years, and has been averaging fewer than 40 inpatients a day over the 3 most recent years.

2. Hospital high-technology joint ventures. A joint venture among hospitals to purchase, operate, and market high-technology or other expensive medical equipment (for example, a magnetic resonance imager) is permissible if the joint venture involves no more hospitals than are necessary to support use of the equipment.

3. Physicians' collective provision of information. Physicians' collective provision of underlying medical data that may improve purchasers' resolution of issues relating to the mode, quality, or efficiency of treatment is unlikely to raise any significant antitrust concern. For example, a medical society's collection of outcome data from its members about a

[22]DOJ and FTC (Sept. 15, 1993).

[23]DOJ and FTC did not define "extraordinary circumstances," but they said they expect that such circumstances would be rare.

particular procedure they believe should be covered by a purchaser and the provision of such information to the purchaser will not be challenged.

4. Exchanges of price and cost information among hospitals. Hospital participation in surveys about the prices they charge and the compensation they pay staff will not be challenged, provided that the surveys are managed by a third party, at least five hospitals are included, no hospital represents more than 25 percent (on a weighted basis) of the total for any category of data reported, data are aggregated in a manner that cannot be identified with any particular hospital, and the data are more than 3 months old.

5. Joint purchasing arrangements among health care providers. Joint purchasing arrangements among institutions are protected from prosecution if (1) the purchasing arrangement accounts for less than 35 percent of the total sales for the items in the relevant market and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of each competing participant's total revenues.

6. Physician network joint ventures. Physician network joint ventures will not be challenged if (1) the joint venture includes no more than 20 percent of the physicians in a specialty with active hospital staff privileges practicing in the relevant geographic market and (2) the physicians share substantial financial risk.

Major Features of State Antitrust Legislation

We obtained copies of the laws passed since 1992 concerning mergers or joint ventures among health care providers by the 18 states that have created a regulatory program covering such activities. Each of the laws establishes a voluntary regulatory process that allows eligible providers to request approval by the state regulatory authority. All of these state programs appear to have been enacted with the expectation they would provide an exception from state antitrust laws and provide immunity from federal antitrust laws under the state action immunity doctrine. None of the states' laws give automatic immunity to any specific type of agreement. Certain key features of those state laws are summarized in this appendix. Descriptions of the state laws are current through May 1994. Although we attempted to ensure the accuracy of these descriptions, they were not reviewed by state officials.

Colorado

Title and Effective Date of Legislation

The Hospital Efficiency and Cooperation Act, July 1993 (1993 Colorado Sess. Laws p. 1888; Colorado Rev. Stat. sec. 24-32-2701 (1993))

Stated Purposes of Legislation

The legislation made the following declaration. The normal forces of competition have not been effective in controlling increases in health care costs or inefficient duplication of services. Additionally, state and federal regulations have constrained the ability of hospitals to acquire and develop improved equipment and methods of service. Federal and state antitrust laws have inhibited the formation of cooperative health care agreements; however, cooperative agreements are likely to foster improvements in the delivery, quality, or cost effectiveness of health care; improve access to needed services; enhance the likelihood that rural hospitals in Colorado will remain open to serve their communities; and provide flexibility for local communities to design, foster, and develop programs to meet their specific health care needs. Such cooperative agreements would also facilitate the formation of treatment facilities and the acquisition of needed equipment, promote economies of scale, and prevent the inefficient duplication of services.

The legislation provides a limited exemption and immunity from the antitrust laws to encourage the development of cooperative health care

	agreements and limits regulation to specific cooperative health care agreements that have been submitted voluntarily for approval. Further, it regulates cooperative agreements and displaces any competition that might otherwise exist.
Scope of Coverage	The legislation covers "cooperative agreements," defined as joint ventures or other agreements involving one or more hospitals for the purpose of sharing, allocating, consolidating, or referring • patients, personnel, instructional programs, support services and facilities; • medical, diagnostic, or therapeutic facilities, services, or procedures; and • other services traditionally offered by health care providers.
Approval Agency	Cooperative Health Care Agreements Board, an 11-member board
Standards for Evaluating Proposed Agreements	The agreement will be approved if the agreement is likely to improve the cost effectiveness, availability, quality, or delivery of hospital or health care services and is consistent with other state statutory health care policies and programs.
Advantages Evaluated	The Board must consider whether the agreement would • enhance the availability or quality of hospital or health care provided to Colorado citizens; • preserve hospital or other health care facilities or services within geographic proximity to the communities traditionally serviced by such facilities; • reduce service costs and/or increase the efficiency with which services are provided by the health care providers involved; • avoid unnecessary duplication and improve the utilization of health care resources and capital equipment; • provide services that would not otherwise be available; • affect patients and employees of parties to the agreement; and • affect competition in the health care system, including a consideration of the benefits of any reduction or elimination of competition and whether such benefits equal or exceed the disadvantages of any such reduction or elimination of competition. In addition, the Board must consider the extent of community support for the agreement.

Disadvantages Considered	The legislation does not list any disadvantages that must be specifically evaluated except for the disadvantages of reduced competition mentioned in the previous section.
Role and Authority of the Attorney General	All application agreements must be submitted to the Attorney General for review and approval. Within 30 days after receiving an application for approval, the Attorney General may become a party to any proceedings by filing a written statement with the Board. The Attorney General may request the Board to modify or terminate approval of a cooperative agreement, or appear before the Board in a hearing regarding any request to modify or terminate approval. The Attorney General may request an audit of the documents or of the activities pertaining to the agreement.
Monitoring Requirements	The Board may terminate or modify approval of an agreement. The Board will review annual reports to evaluate the agreement's effect on the availability, cost effectiveness, quality, and delivery of hospital or health care services and to determine whether the parties have complied with the terms of the agreement.
Rules and Regulations	The Board must promulgate rules requiring parties to an agreement to submit annual reports. The Board shall review applications in accordance with the standards listed above and any additional procedures prescribed by its regulations.

Florida

Title and Effective Date of Legislation	Health Reform Act of 1993, April 1993 (1993 Florida Laws ch. 93-129)
Stated Purposes of Legislation	The purposes of the legislation are • to foster the development of rural health networks, replacing competitive market forces with state regulation; • to provide immunity from state antitrust laws for consolidations of hospital services or technologies and cooperative agreements between members of rural health networks when these arrangements improve the

	quality of health care, moderate cost increases, and are made between members of rural health networks; and • to protect these arrangements from federal antitrust laws, subject to the approval of the Agency for Health Care Administration.
Scope of Coverage	The legislation provides for cooperative agreements or joint ventures to consolidate services or technologies among providers who are members of certified rural health networks.
Approval Agency	Florida Agency for Health Care Administration
Standards for Evaluating Proposed Agreements	The likely benefits resulting from the agreement must outweigh any disadvantages attributable to any potential reduction in competition.
Advantages Evaluated	The Agency must determine if the agreement would reduce or moderate costs and meet any of the following criteria: • consolidate services or facilities in a market area used by rural health network patients to avoid duplication; • promote cooperation between rural health network members in the market area; • encourage cost sharing among rural health network facilities; • enhance the quality of rural health care; or • improve utilization of rural health resources and equipment.
Disadvantages Considered	The legislation does not list any disadvantages that must be specifically evaluated except for disadvantages attributable to a reduction in competition.
Role and Authority of the Attorney General	The Department of Legal Affairs (state Attorney General) has an advisory role. It may be consulted when the Agency is reviewing an application for approval.
Monitoring Requirements	The Agency is to review each approved agreement at least once every 2 years to determine if state approval should be continued or proceedings started to terminate the agreement.

Rules and Regulations	The legislation does not mention specific rules and regulations.

Georgia

Title and Effective Date of Legislation	The Hospital Authorities Law, July 1993 (1993 Georgia Laws p. 1020)
Stated Purposes of Legislation	Purposes of the legislation applicable to hospital mergers are • to provide for the merger of certain local governmental hospital authorities and to specify the terms, conditions, and effects of such merger and • to provide that, in the exercise of certain powers, these hospital authorities are acting pursuant to state policy and are immune from antitrust liability to the same extent as the state.
Scope of Coverage	The legislation provides for the merger of specified local governmental hospital authorities in the same county.
Approval Agency	The merger must be approved by both the governing authority of the county and a majority of the board of each hospital authority involved in the merger. The resolution adopted by each board must be filed with the state.
Standards for Evaluating Proposed Agreements	The legislation does not specifically list any advantages or disadvantages that must be evaluated.
Role and Authority of the Attorney General	The legislation does not mention any role or authority for the Attorney General.
Monitoring Requirements	The legislation does not mention any monitoring requirements.
Rules and Regulations	The legislation does not call for separate rule-making; however, the legislation requires the following terms and conditions:

- a merger is not effective until the governing authority of the merging hospitals' county of operation properly appoints the board of the surviving hospital and
- a county whose hospital authorities have merged under the authority shall not thereafter be prohibited from activating another hospital authority.

The legislation further specifies that when a merger takes effect

- each hospital authority that is a party to the merger merges into the surviving hospital authority, and the separate existence of such hospital authorities (except the surviving hospital authority) ceases;
- the ownership of and authority to operate the hospitals owned by each hospital authority, and the title to all real estate and other property owned by each hospital authority that is a party to the merger, is vested in the surviving hospital authority;
- the surviving hospital authority assumes all liabilities and obligations of each hospital authority that is a party to the merger; and
- a proceeding pending against any hospital authority that is a party to the merger may be continued as if the merger did not occur, or the surviving hospital authority may be substituted in the proceeding for the hospital authority whose existence ceased.

Idaho

Title and Effective Date of Legislation

Session Law Chapter 283 Regarding Idaho Health Care Planning Act, July 1994
(1994 Idaho Sess. Laws ch. 283)

Stated Purposes of Legislation

The purposes of the legislation are

- to provide to all Idaho residents a quality health care system for a reasonable cost;
- to prevent the deterioration of the system by the duplication of services or the introduction of new categories of services that are not necessary;
- to promote cooperation among health care providers in health planning activities;
- to provide access to necessary care for all who require it;

- to declare that it is in the public interest of the state to provide for relief from penalties of state and federal law to those cooperative health care planning activities that are likely to benefit the residents of the state; and
- to require the state, through the office of the Attorney General, to provide direction, supervision, and control over approved agreements in order to provide state action immunity under federal antitrust laws to participating health care providers.

Scope of Coverage

The legislation provides for cooperative agreements and agreements for joint ventures involving the sharing, allocation, or referral of patients or the sharing or allocation of personnel, instructional programs, support services and facilities, procedures, or other services customarily offered by health care providers. Health care provider includes any person or health care facility officially recognized by the state to provide health care services.

Approval Agency

Idaho Office of the Attorney General

Standards for Evaluating Proposed Agreements

Applicants must demonstrate by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result.

Advantages Evaluated

The Attorney General must weigh the extent to which the agreement would

- enhance the quality of health care provided to the consumers in the state,
- preserve hospitals and other health care facilities that customarily serve the communities in the area likely to be affected by the cooperative agreement,
- improve the cost efficiency of services provided by the parties to the cooperative agreement, and
- avoid duplication and improve the utilization of health care resources and equipment in the area likely affected by the cooperative agreement.

Disadvantages Considered

The Attorney General must also evaluate the disadvantages attributable to any reduction in competition likely to result from the cooperative agreement, including the extent to which the agreement might

- adversely affect the ability of health maintenance organizations, preferred provider plans, hospital provider organizations, persons performing

	utilization review, or other health care payers to negotiate optimal payment and service arrangements with hospitals and other health care providers; • result in a reduction in competition among physicians, allied health professionals, or other health care providers; and • be more restrictive to competition than other arrangements that could likely achieve substantially the same or more favorable benefits than those achieved from reducing competition.
Role and Authority of the Attorney General	The Attorney General establishes rules, conducts reviews of applications, and issues the certificate of public advantage for approved agreements. The legislation intends that the Attorney General provide direction, supervision, and control over approved cooperative agreements, including revocation of initial approval.
Monitoring Requirements	The Attorney General may request periodic progress reports, at intervals of not less than 90 days, of an approved cooperative agreement.
Rules and Regulations	The legislation authorizes the Attorney General to adopt rules necessary for the implementation of the law, including rules establishing procedures and criteria for the review and evaluation of proposed cooperative agreements.

Kansas

Title and Effective Date of Legislation	Health Care Provider Cooperation Act, House Bill 2709, April 1994 (1994 Kansas Sess. Laws 153)
Stated Purposes of Legislation	The legislation makes the following findings. Cooperative agreements among health care providers concerning the provision of services can foster further improvements in the quality of health care for Kansas citizens; moderate increases in costs; and avoid duplication of resources and improve access to needed services in rural areas. In addition, because cooperative agreements may require health care providers to collaborate on the provision of services, thereby raising the issue of antitrust effects, the legislation finds that regulatory oversight of cooperative agreements is

necessary to ensure that the benefits of agreements outweigh any disadvantage attributable to any reduction in competition resulting from such agreements.

The legislation provides that cooperative agreements approved under the legislation articulate and implement the policy of the state to improve and protect the quality and availability of health care to Kansas citizens and that continued active supervision by the state over all aspects of such agreements will provide protection to the public, offsetting the loss of protection otherwise provided by competition.

Scope of Coverage

The legislation provides for cooperative agreements between two or more health care providers for the sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services traditionally offered by health care providers. It also applies to mergers.

Approval Agency

The Secretary of Health and Environment will evaluate agreements. A state advisory committee appointed by the legislature and the Governor will advise the Secretary on matters concerning the administration of the law and make recommendations to the Secretary concerning applications for approval and termination of agreements.

Standards for Evaluating Proposed Agreements

Advantages Evaluated

In evaluating the agreement the Secretary shall consider whether one or more of the following benefits may result:

- enhancement of the quality of health care provided to Kansas citizens;
- preservation of health care facilities or providers, or both, in geographical proximity to the communities traditionally served by those facilities or providers, or both;
- increased cost efficiency of services provided by the health care providers involved;
- improvements in the utilization of health care resources and equipment; and
- avoidance of duplication of resources.

Disadvantages Considered	The Secretary must also weigh any disadvantages attributable to a reduction in competition likely to result from the agreement, including, but not limited to the following: • the extent of any adverse effect on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payers to negotiate optimal payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers; • the extent of any reduction in competition among health care providers or other persons furnishing goods or services to, or competing with, health care providers that may result directly or indirectly from the cooperative agreement; • the extent of any adverse effect on patients in the quality, availability, and cost of health care services; and • the availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition that may result from the agreement.
Role and Authority of the Attorney General	The legislation does not mention any role or authority for the Attorney General.
Monitoring Requirements	If the Secretary determines at any time that an agreement no longer meets the requirements of the act, the Secretary may initiate proceedings to terminate the agreement. Any agreement approved under the legislation must be reviewed annually by the Secretary.
Rules and Regulations	The legislation does not mention rules or regulations.

Maine

Title and Effective Date of Legislation	Hospital Cooperation Act of 1992, April 1992 (1991 Maine Laws c. 814, sec. 1; Maine Rev. Stat. Ann. ch. 405-D (West 1993))
Stated Purpose of Legislation	The legislation does not contain a specific statement of purpose; however, the state policy is articulated in its standards for certification of

	cooperative agreements among hospitals. Such agreements will be certified if their likely benefits will outweigh the disadvantages attributable to the resulting reduction in competition.
Scope of Coverage	The legislation provides for cooperative agreements for the sharing, allocation, or referral of patients, personnel, instructional programs, laboratory facilities or procedures, or other services traditionally offered by hospitals. It does not apply to merger agreements among hospitals.
Approval Agency	Maine Department of Human Services
Standards for Evaluating Proposed Agreements	Applicants must demonstrate by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a resulting reduction in competition.
Advantages Evaluated	The Department must weigh the extent to which the agreement would • enhance the quality of hospital and hospital-related care provided to Maine citizens; • preserve hospital facilities in geographical proximity to the communities traditionally served by those facilities; • result in gains in cost efficiency of services provided by hospitals involved; • improve the utilization of hospital resources and equipment; and • avoid duplication of hospital resources.
Disadvantages Considered	The Department may also weigh the extent to which the agreement might • adversely affect the ability of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payers to negotiate optimal payment and service arrangements with hospitals, physicians, allied health professionals, or other health care providers; • reduce competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or competing with, hospitals; • adversely affect patients in the quality, availability, and price of health care services; and • restrict competition more than other arrangements that achieve the same or more favorable benefits than those achieved from reducing competition.

Role and Authority of the Attorney General	The Attorney General must be consulted during the review process and may subpoena and require the attendance and testimony of witnesses and the production of documents for the purpose of investigating whether the proposed agreement satisfies the standards contained in law. The Attorney General can also file an action to enjoin the operation of a cooperative agreement no later than 40 days following the Department's approval of an application. Upon filing of the complaint, the Department's certification, if previously issued, must be stayed, and the cooperative agreement is of no further force unless the court orders otherwise or until the action is concluded.
Monitoring Requirements	The legislation does not mention monitoring requirements; however, if the Department determines that the likely benefits no longer outweigh any disadvantages, it may initiate proceedings to terminate the agreement. In addition, the Attorney General may continue to monitor the agreement and, if necessary, file suit to cancel a certificate. The legislation also contains a sunset provision. The Department may not accept any application under this legislation after June 30, 1995. By January 1, 1995, the Attorney General and the Department shall submit recommendations, along with any necessary legislation, to the Maine legislature regarding whether this program should be amended.
Rules and Regulations	The legislation does not mention rules and regulations.

Minnesota

Title and Effective Date of Legislation	The Minnesota Integrated Service Network Act, May 1993 (1993 Minnesota Laws c. 345, art. 6, sec. 14; Minnesota Stat. Ann. sec. 62J.2911 (West 1994))
Stated Purposes of Legislation	The purposes of the legislation are • to support development of integrated service networks to accomplish the purpose of the federal Medicare antikickback statute, which is to reduce overutilization and overcharging;

- to create an opportunity for the state to review proposed cooperative 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; and
- to ensure that approval of such arrangements is accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power, and that an arrangement approved by the state and accompanied by such appropriate conditions, supervision, and regulation shall not be subject to state and federal antitrust liability.

Scope of Coverage

The legislation applies to both providers (hospitals, physicians, and other health care providers) and purchasers of care (for example, HMOs and insurance companies) who enter into cooperative agreements that may be construed as violations of federal antitrust law. Cooperative agreements include both mergers and joint ventures.

Approval Agency

Minnesota Commissioner of Health

Standards for Evaluating Proposed Agreements

The Commissioner cannot approve an application unless it is more likely to result in lower costs, increased access, or increased quality of health care than would otherwise occur under market conditions.

Advantages Evaluated

In making a determination regarding cost, access, and quality, the Commissioner may consider the following factors:

- whether the proposal is compatible with the cost containment plan or other plan of the Minnesota health care commission or the applicable regional plans of the regional coordinating boards;
- market structure, which includes actual and potential sellers and buyers, or providers and purchasers; actual and potential consumers; geographic market area; and entry conditions;
- current market conditions;
- the historical behavior of the market;
- performance of other, similar arrangements;
- whether the proposal unnecessarily restrains competition or restrains competition in ways not reasonably related to the purposes of the law; and
- the financial condition of the applicant.

In making determinations about costs, the Commissioner may consider

- the cost savings likely to result to the applicant;
- the extent to which the cost savings are likely to be passed on to the consumer and in what form;
- the cost of regulation, both for the state and for the applicant; and
- any other factors showing whether the proposed arrangement is likely to reduce cost.

In making a determination about access, the Commissioner may consider the extent to which the proposed arrangement would

- increase or decrease the utilization[24] of needed health care services or products by the intended targeted population,
- make available a new and needed service or product to a certain geographic area, and
- otherwise make health care services or products more available to persons who need them.

In making determinations about quality, the Commissioner may consider the extent to which the proposed arrangement would

- decrease morbidity and mortality,
- result in faster convalescence,
- result in fewer hospital days,
- permit providers to attain needed experience or frequency of treatment likely to lead to better outcomes,
- increase patient satisfaction, and
- have any other features likely to improve or reduce the quality of health care.

Disadvantages Considered

The legislation does not list any specific disadvantages that must be evaluated beyond the comparisons mentioned in the previous section.

Role and Authority of the Attorney General

The Attorney General provides advice to the Commissioner of Health in determining whether the proposed cooperative agreement presents any potential for antitrust liability. The Attorney General can provide written comments after an application is filed for approval or upon request by the Commissioner. Anyone who wishes to submit comments, including the

[24]When a proposed arrangement is likely to increase access in one geographic area by lowering prices or otherwise expanding supply, but limit access in another geographic area by removing service capabilities from that second area, the Commissioner must articulate the criteria employed to balance these effects.

Attorney General, has 20 days from the date a notice is published in the State Register to do so.

The Attorney General's role will depend on the type of review process followed by the Commissioner. The Commissioner can choose one of three different procedures for the review process. First, the Commissioner may issue a decision based only on the application and the comments. Second, the Commissioner may require a limited hearing to discuss a particular issue. Third, the Commissioner may hold a case hearing to review all the relevant issues. If a case hearing is held, the Attorney General may appear as a party to the hearing.

Monitoring Requirements

The Commissioner shall review at least annually data submitted by the parties to the arrangement but may request more frequent data submissions. In addition, the Commissioner is required to publish notice in the State Register 2 years after the date of an order approving an application, and at 2-year intervals thereafter, soliciting comments from the public concerning the effect that the arrangement has had on cost, access, and quality. The Commissioner is also required to study and make recommendations by January 15, 1995, on the appropriate length and scope of active supervision of arrangements approved for exemption from the enforcement of antitrust laws. Under specified conditions, the Commissioner may modify or revoke approval of the agreement.

Rules and Regulations

The legislation does not mention specific rules and regulations.

Montana

Title and Effective Date of Legislation

An Act Providing for Universal Health Care Access, October 1993 (1993 Montana Laws ch. 606)

Stated Purposes of Legislation

The purposes of the legislation are

- to further the goals of controlling health care costs and improving the quality of and access to health care, which will be enhanced in some cases by cooperative agreements among health care facilities;

- to provide the state with direct supervision and control over the implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted; and
- to substitute state regulation for competition over the supervision and control of the implementation of these agreements, thereby granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal antitrust laws, or both.

Scope of Coverage

The legislation provides for cooperative agreements between health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care facilities. It also authorizes the Montana Health Care Authority to create a statewide plan that includes legislation that will enable health care providers and payers, including health insurers and consumers, to enter into a greater number of cooperative agreements than would otherwise occur in the competitive marketplace.

Approval Agency

Montana Health Care Authority, a five-member board appointed by the Governor, is the approval agency. The Authority delegates implementation of certain administrative aspects of the legislation to the Montana Department of Health and Environmental Sciences.

Standards for Evaluating Proposed Agreements

Advantages Evaluated

The Authority must weigh the extent to which the proposal would result in lower health care costs, greater access, or greater quality of health care than would occur without the agreement.

Disadvantages Considered

The legislation does not list any specific disadvantages that must be evaluated.

Role and Authority of the Attorney General

The Attorney General serves as an ex officio, nonvoting member of the Authority for the purpose of the Authority's approval or denial of

	proposals, supervision of agreements, and revocation of a certificate of public advantage.
Monitoring Requirements	The legislation does not mention frequency or terms of monitoring requirements; however, the Authority is charged with adopting rules to effect the active supervision of agreements by the Authority. The rules may include reporting requirements.
Rules and Regulations	The Authority must adopt rules for implementation of the law.

Nebraska

Title and Effective Date of Legislation	The Health Care Facility-Provider Cooperation Act, April 1994 (1994 Nebraska Laws 1223)
Stated Purposes of Legislation	The legislation does not contain a specific statement of purpose. It enables certain health care facilities and certain health care providers to form cooperative agreements and participate in community health planning while maintaining immunity from antitrust enforcement.
Scope of Coverage	The legislation provides for community health planning and cooperative agreements for the sharing, allocation, or referral of patients; personnel; instructional programs; equipment; support services and facilities; or medical, diagnostic, or laboratory facilities or procedures; or other services traditionally offered or purchased by health care facilities or other providers.
Approval Agency	Nebraska Department of Health
Standards for Evaluating Proposed Agreements	Applicants must demonstrate by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result.
Advantages Evaluated	The Department must weigh the extent to which the agreement would

- enhance the quality of health facility and provider care of Nebraska citizens;
- preserve health care facilities, including those in other states, in geographical proximity to the communities traditionally served by such facilities;
- improve the cost efficiency of services provided by health care facilities or providers involved in the state;
- avoid duplication and improve the utilization of health care facility resources and equipment;
- enhance, maintain, or preserve competition for the services or goods involved; and
- mitigate adverse or enhance positive environmental effects.

Disadvantages Considered

The Department may also include in its consideration the extent to which the agreement might

- adversely affect the ability of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payers to negotiate advantageous payment and service arrangements with health care facilities or providers;
- result in a reduction in competition among health care facilities or providers or other persons furnishing goods or services to or in competition with health care facilities that is likely to result directly or indirectly from the cooperative agreement;
- adversely affect patients in the quality, availability, and price of health care services; and
- be more restrictive to competition than other arrangements that achieve the same or more favorable benefits than those achieved from reducing competition.

Role and Authority of the Attorney General

The Attorney General has an advisory role, consulting with the Department during its review regarding any potential reduction in competition resulting from the cooperative agreement.

Monitoring Requirements

The Department must require the parties to the agreement to report annually on their activities. If the Department determines that the likely benefits no longer outweigh the disadvantages, it can initiate proceedings to terminate approval. Any person may petition the Department to make this determination.

Rules and Regulations	The Department may adopt rules and regulations to govern public hearings under the law.

New York

Title and Effective Date of Legislation	Sections 2950 to 2958 of Senate Bill 6226 and Assembly Bill 8936, December 1993 (1993 New York Laws ch. 731)
Stated Purposes of Legislation	The purposes of the legislation are • to encourage the development of rural health network agreements among health care providers serving rural areas and provide funding, • to grant regulatory waivers to providers to successfully implement networks, • to actively provide technical assistance in order to support the creation and operation of rural health networks, • to encourage cooperative arrangements between rural health networks and providers under the active supervision of the Commissioner of the Department of Public Health, • to supplant competition with such arrangements, and • to provide state action immunity under the federal antitrust laws.
Scope of Coverage	The legislation provides for contracts or joint or cooperative agreements between health care providers serving rural areas. Providers covered by the legislation include hospitals, physicians, and other health care providers.
Approval Agency	The Commissioner of the Department of Public Health
Standards for Evaluating Proposed Agreements	Mergers, integration, and coordination must substantially meet the following objectives: • promote sharing of resources and service delivery among providers; • promote cost effectiveness to consumers and providers; • improve accessibility to the full continuum of health care services;

- capitalize on the strengths of existing providers;
- promote linkages, diversifications, or reconfigurations of rural providers; and
- identify methods to address regulatory impediments.

Advantages Evaluated

In addition to the comments of the designated health system agency, the Commissioner will consider whether

- specific objectives of the proposed network would be met, including demonstrated awareness of the level of health care currently being provided within the service area;
- the network would enhance cost efficiency and access of health care to all residents of the area;
- economies of scale in both the supply and demand of services would be addressed;
- information sharing, communication, and cooperation among health care providers, human service entities, and consumers would be fostered;
- the network would contribute to the identification and development of innovative delivery systems;
- the network would enhance the accessibility and quality of services with respect to health care needs, including illness prevention;
- management and continuity of care would be fostered and improved;
- service delivery would be reorganized and the effect such reorganization would have on the health delivery systems in underserved areas;
- providers within the area served by the network would be made aware of and have an effective opportunity to participate in or become members of the network;
- objectives and scope of the network would be reasonably implemented using existing and projected resources;
- participating providers would be equitably represented on governing bodies of the network; and
- consumers within the area served by the network would be made aware of and have an opportunity to provide input in the establishment and operation of the network and network operational plan, as applicable.

Disadvantages Considered

The legislation does not list any specific disadvantages that must be evaluated.

Role and Authority of the Attorney General

The legislation does not mention the role and authority of the Attorney General.

Monitoring Requirements	The legislation allows the Commissioner to withdraw approval of the project and require repayment of all or part of a grant if the Commissioner determines that a grant is being used for purposes that do not comply with the legislation. The Commissioner is also required to establish the type and frequency of reports that grantees must file.
Rules and Regulations	The legislation requires the Commissioner to issue guidelines, in consultation with the New York State Rural Health Council and the Legislative Commission on the Development of Rural Resources. These guidelines shall include at least the duration of network grants and appropriate funding levels. The Commissioner is also authorized to waive, modify, or suspend rules promulgated respective to the legislation.

North Carolina

Title and Effective Date of Legislation	Hospital Cooperation Act of 1993, July 1993 (1993 North Carolina Sess. Laws c. 529)
Stated Purposes of Legislation	The purposes of the legislation are to permit cooperative arrangements that are beneficial to North Carolina citizens and to supplant competition currently mandated by federal and state antitrust laws by a regulatory program. In addition, the legislation is to provide regulatory as well as judicial oversight of cooperative agreements to ensure that the benefits of cooperative agreements permitted and encouraged in North Carolina outweigh any disadvantages attributable to any reduction in competition likely to result from the agreements.
Scope of Coverage	The legislation provides for cooperative agreements for the sharing, allocation, or referral of patients; personnel; instructional programs; support services and facilities; medical, diagnostic, or laboratory facilities, equipment, or procedures; or other services traditionally offered by hospitals. It does not apply to mergers.
Approval Agency	North Carolina Department of Human Resources

Standards for Evaluating Proposed Agreements

The agreement must demonstrate by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to the reduction in competition.

Advantages Evaluated

The Department must weigh the extent to which the agreement would

- enhance the quality of hospital and hospital-related care provided to North Carolina citizens;
- preserve hospital facilities in geographical proximity to the communities traditionally served by those facilities;
- lower costs of, or improve the efficiency of, delivering hospital services; and
- avoid duplication and improve the utilization of hospital resources and equipment.

The Department must also consider whether medically underserved populations are expected to utilize the services that will be provided under the proposal.

Disadvantages Considered

The Department must also consider the extent to which the agreement might

- increase the costs or prices of health care at a hospital that is a party to the cooperative agreement;
- adversely affect patients in the quality, availability, and price of health care services;
- reduce competition among parties to the agreement and the likely effects of this;
- adversely affect the ability of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payers to negotiate optimal payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers;
- reduce competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or competing with, hospitals; and
- be more restrictive to competition than other arrangements that achieve the same or more favorable benefits than those achieved from reducing competition.

Role and Authority of the Attorney General

The Attorney General is part of the review process and has veto power over the agreement. If the Attorney General believes that the applicant has

not demonstrated through clear and convincing evidence that the benefits from the agreement outweigh the likely disadvantages, the Attorney General can object to the approval of the cooperative agreement. The agreement cannot be approved until the Attorney General's objection is addressed and withdrawn. The Attorney General also has the power to revoke a certificate for noncompliance with the terms of the agreement.

Monitoring Requirements

During the time state approval is in effect, the parties to a cooperative agreement must submit a report of activities to the Department every 2 years and must provide a copy to the Attorney General. This report must include

- a description of the activities conducted pursuant to the agreement;
- price and cost information;
- the nature, scope, and likely effect for the next 2 years of the activities pursuant to the agreement;
- a signed certificate by each party to the agreement that the benefits or likely benefits of the cooperative agreement as conditioned continue to outweigh the disadvantages of any reduction in competition from the agreement as conditioned; and
- any additional information requested by the Department of Human Resources or the Attorney General.

In addition, the Department has the power to revoke a certificate for noncompliance with the terms of the agreement.

Rules and Regulations

The legislation authorizes the Department and the Attorney General to adopt rules to conduct a review of applications.

North Dakota

Title and Effective Date of Legislation

Health Care Provider Cooperative Agreements, August 1993 (1993 North Dakota Laws ch. 263)

Stated Purposes of Legislation

The legislation does not contain a specific statement of purpose; however, the state policy is articulated in its standard for approval. Applicants must demonstrate by clear and convincing evidence that the likely benefits

	resulting from the agreement outweigh any disadvantages attributable to the reduction in competition. It establishes and funds a regulatory program for the approval of cooperative agreements among two or more health care providers or third-party payers.
Scope of Coverage	The legislation provides for cooperative agreements for the sharing, allocation, or referral of patients; personnel; instructional programs; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services traditionally offered by health care providers. It does not cover mergers.
Approval Agency	North Dakota Department of Health and Consolidated Laboratories
Standards for Evaluating Proposed Agreements	The agreement must demonstrate by clear and convincing evidence that the likely benefits to health care consumers resulting from the agreement outweigh any disadvantages attributable to any reduction in competition.
Advantages Evaluated	The Department may weigh the extent to which the agreement would • enhance the quality of health care services provided to the residents of North Dakota, • preserve health care facilities in geographical proximity to the communities traditionally served by those facilities, • improve the cost efficiency of services provided by the parties involved, and • avoid duplication and improve the utilization of health care resources and equipment.
Disadvantages Considered	The Department may also weigh the extent to which the agreement might • adversely affect the bargaining power of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payers in negotiating payment and service arrangements with hospitals, physicians, allied health professionals, or other health care providers; • reduce competition among physicians, allied health professionals, other health care providers, or persons furnishing goods or services to, or competing with, providers and third-party payers; • adversely affect patients in the quality, availability, and price of health care services; and

- be more restrictive to competition than other arrangements that achieve the same or more favorable benefits than those achieved from reducing competition.

Role and Authority of the Attorney General	The Attorney General must be consulted regarding the Department's evaluation of the competitive effects of an agreement. The Attorney General may subpoena and require the attendance and testimony of witnesses and the production of documents for the purpose of investigating whether the cooperative agreement satisfies the standards in the legislation. The Attorney General may file an action to enjoin the operation of a cooperative agreement up to 40 days following the Department's approval of the application. If a complaint is filed, the Department's certification, if previously issued, must be stayed and the cooperative agreement is of no further force unless the court orders otherwise or until the action is concluded. The Attorney General is also vested with the authority to terminate a cooperative agreement.
Monitoring Requirements	The legislation is silent on monitoring requirements, except that the Department may cancel an agreement if the likely benefits no longer outweigh the disadvantages or the parties do not conform to the provisions of any conditions attached to the agreement by the Department at the time the application was granted. In addition, the Attorney General may continue to monitor the agreement and, if necessary, file suit to cancel a certificate.
Rules and Regulations	The legislation does not mention rules and regulations.

Ohio

Title and Effective Date of Legislation	Sections 3727.21 to 3727.24 of House Bill 714, October 1992 (1992 H. 714; Ohio Revised Code Ann. sec. 3727.21 (Baldwin))
Stated Purposes of Legislation	The purposes of the legislation are to authorize discussions or negotiations concerning the allocation of health care equipment or services and provide hospitals immunity from civil enforcement and criminal prosecution for the purpose of reducing consumer health care

	costs, improving access to health care services, or improving the quality of patient care.
Scope of Coverage	The legislation provides for discussions or negotiations concerning voluntary cooperative actions among hospitals for the allocation of health care equipment or health care services, provided the actions do not involve price fixing or predatory pricing.
Approval Agency	The Director of the Ohio Department of Health
Standards for Evaluating Proposed Agreements	The legislation does not state specific advantages that must be evaluated, except that the cooperative actions must be designed to reduce health costs, improve access, or improve the quality of care. Also, the Director must determine that the benefits resulting from the cooperative agreement are likely to outweigh the disadvantages attributable to a reduction in competition.
Role and Authority of the Attorney General	The request for an approval of an agreement must be submitted to the Attorney General for an advisory review. The legislation includes a negative option for approval at the Attorney General level. The reasons the Attorney General may advise the Director to deny a request include a determination that the agreement will result in price fixing or predatory pricing.
Monitoring Requirements	The Director may request periodic written progress updates of approved cooperative agreements. The Director also has authority to rescind an order approving an agreement.
Rules and Regulations	The Director may adopt rules for the implementation of this legislation including rules establishing procedures and criteria for the review and evaluation of proposed cooperative agreements.

Oregon

Title and Effective Date of Legislation

Senate Bill 683, 1993 Oregon Legislative Assembly, August 1993 (1993 Oregon Laws c. 769)

Stated Purposes of Legislation

The purposes of the legislation are to declare the state's policy and intent to displace competition among health care providers of heart and kidney services by allowing them to enter into cooperative programs and receive the full benefit of state action immunity in order to achieve the following goals:

- reduce or protect against rising prices and costs for heart and kidney transplant services;
- improve or maintain the quality of heart and kidney transplant services provided in the state;
- reduce or protect against duplication of resources, including expensive medical specialists, medical equipment, and sites of service;
- improve or maintain efficiency in the delivery of heart and kidney transplant services;
- improve or maintain public access to heart and kidney transplant services;
- increase donations of organs for transplantation; and
- improve the continuity of patient care.

Scope of Coverage

The legislation allows cooperative programs for the sharing, allocation, and referral of physicians; patients; personnel; instructional programs; support services and facilities; medical, diagnostic, laboratory, or therapeutic services, equipment, devices, or supplies; and other services traditionally offered by health care providers. The Oregon Health Sciences University and one or more entities, each of which operates at least three hospitals in a single urban area in the state, may apply to the Director of the Oregon Department of Human Resources for approval of a cooperative program.

The legislation allows an approved cooperative program to engage in the following behaviors, which would normally be considered anticompetitive:

- set prices for heart and kidney transplants and all services directly relating to heart and kidney transplants;
- refuse to deal with competitors in the heart and kidney transplant market;

	• allocate product, service, geographic, and patient markets directly relating to heart and kidney transplants; • acquire and maintain a monopoly in heart and kidney transplant services; and • engage in other activities that might give rise to liability under state or federal antitrust laws. It also allows participating physicians to agree among themselves on referrals of nontransplant cardiac surgery patients.
Approval Agency	The Director of the Oregon Department of Human Resources
Standards for Evaluating Proposed Agreements	The cooperative program must achieve at least six of the goals of the legislation, including the first four mentioned.
Advantages Evaluated	The Director is to consider whether • the cooperative program will contribute to or detract from achieving the stated goals and • any alternative arrangements would be less restrictive to competition. The Director may weigh goals relating to existing circumstances and to circumstances that are likely to occur without the cooperative program.
Disadvantages Considered	The legislation does not list any specific disadvantages that must be evaluated.
Role and Authority of the Attorney General	The legislation includes no specific role or authority for the Attorney General.
Monitoring Requirements	The Director is to actively supervise the cooperative program. For each approved cooperative program, the Director is to establish a Board of Governors, consisting of the president or the chief executive officer of each hospital that is a party to the cooperative program agreement and the Director or his/her designee. The Board is not a governmental agency. The Board must develop policies and approve budgets for the implementation of the cooperative program and must deliver an annual report to the Director on the operation of the cooperative program. As part of his/her

	review, the Director has authority to modify or revoke approval of the cooperative program.
Rules and Regulations	The Director is to adopt rules necessary to carry out the legislation.

Tennessee

Title and Effective Date of Legislation	Hospital Cooperation Act of 1993, May 1993 (1993 Tennessee Public Acts ch. 331)
Stated Purposes of Legislation	The legislation does not specifically contain a statement of purpose. It acknowledges that (1) existing laws may constrain hospitals' ability to develop new and improved equipment and services and (2) cooperative agreements may foster further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access, and enhance the likelihood that smaller hospitals will remain open in service to their communities. Because competition is important and some cooperative agreements may have anticompetitive effects, the legislation says oversight is necessary to ensure that the benefits of the agreements outweigh any disadvantages attributable to the reduction in competition.
Scope of Coverage	The legislation provides for cooperative agreements for the sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities, or procedures and other services traditionally offered by hospitals.
Approval Agency	Tennessee Department of Health
Standards for Evaluating Proposed Agreements	The agreement must demonstrate by clear and convincing evidence that the likely benefits from it outweigh the disadvantages attributable to any reduction in competition.
Advantages Evaluated	The Department must weigh the extent to which the agreement would • enhance the quality of hospital and hospital-related care provided to Tennessee citizens,

- preserve hospital facilities in geographical proximity to the communities traditionally served by those facilities,
- achieve gains in the cost efficiency of services provided by hospitals involved, and
- avoid duplication and improve the utilization of hospital resources and equipment.

Disadvantages Considered

The Department must also weigh the extent to which the agreement might

- adversely affect the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payers to negotiate optimal payment and service arrangements with hospitals, physicians, allied health professionals, or other health care providers;
- reduce competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or competing with, hospitals, and the extent of such reduction;
- adversely affect patients in the quality, availability, and price of health care services; and
- be more restrictive to competition than other arrangements that achieve the same or more favorable benefits than those achieved from reducing competition.

Role and Authority of the Attorney General

The Attorney General must be consulted by and agree with the Department for approval of an agreement. The Attorney General may subpoena and require the attendance and testimony of witnesses and the production of documents for the purpose of investigating whether the cooperative agreement satisfies the standards set out by the legislation. The Attorney General may file an action to enjoin the operation of the cooperative agreement up to 30 days following the Department's approval of the application. If a complaint is filed, the Department's certification, if previously issued, must be stayed and the cooperative agreement is of no further force unless the court orders otherwise or until the action is concluded.

Monitoring Requirements

The legislation does not mention specific monitoring requirements; however, it states that the Attorney General and the Department are entrusted with active and continuing oversight.

Rules and Regulations	The legislation authorizes the Department to promulgate the rules and regulations necessary to implement the law.

Texas

Title and Effective Date of Legislation	An Act Relating to Cooperative Agreements Among Hospitals, September 1993 (1993 Texas Sess. Law Serv. ch. 638 (Vernon))
Stated Purposes of Legislation	The legislation does not contain a specific statement of purpose; however, the state policy is articulated in its standards for approval. It allows the approval of cooperative agreements among hospitals if the likely benefits resulting from the agreement outweigh any disadvantages.
Scope of Coverage	The legislation provides for discussions and negotiations concerning cooperative agreements provided that the actions do not involve price fixing or predatory pricing for the allocation or sharing of health care equipment, facilities, personnel, or services among hospitals. It does not apply to mergers.
Approval Agency	Texas Department of Health
Standards for Evaluating Proposed Agreements	The applicants must demonstrate that the benefits resulting from an agreement outweigh any disadvantages attributable to a reduction in competition that may result.
Advantages Evaluated	The Department must weigh the extent to which the agreement would • enhance the quality of hospital and hospital-related care provided to Texas citizens, • preserve hospital facilities in geographical proximity to the communities traditionally served by those facilities, • achieve gains in the cost efficiency of services provided by the hospitals involved, and • avoid duplication and improve the utilization of hospital resources and equipment.

Disadvantages Considered

The Department may also weigh the extent to which the agreement might

- adversely affect the ability of health maintenance organizations, preferred provider organizations, or other health care payers to negotiate optimal payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers;
- reduce competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or competing with, hospitals;
- adversely affect patients in the quality, availability, and price of health care services; and
- be more restrictive to competition than other arrangements that achieve similar benefits.

Role and Authority of the Attorney General

The Attorney General has an advisory role, consulting with the Department of Health regarding any potential reduction in competition that may result from a cooperative agreement. The Attorney General, at any time after an application is filed, may demand the attendance and testimony of witnesses and the production of documents for the purpose of investigating whether the cooperative agreement satisfies the standards required by law. The Attorney General may seek a court order compelling compliance with a demand for testimony or documents or may seek an order to enjoin the operation of the cooperative agreement. The Attorney General may file an action up to 20 days after receipt of a final copy of the Department's decision. The Attorney General may ask for a court order to stay the cooperative agreement pending final disposition of the case or file suit seeking to cancel the certificate of public advantage.

Monitoring Requirements

The Department may initiate proceedings to terminate the certificate of public advantage. The legislation does not mention frequency of monitoring.

Rules and Regulations

The Department must adopt rules to implement the law.

Washington (General Applicability)

Title and Effective Date of Legislation

Sections 447 and 448 of the Washington Health Services Act of 1993, April 1993
(1993 Washington Laws ch. 492)

Stated Purposes of Legislation

The purposes of the legislation are

- to exempt approved cooperative activities from state antitrust laws and to provide immunity from federal antitrust laws for such activities and
- to displace competition in the health care market to achieve a variety of goals to contain costs; promote the development of comprehensive integrated and cost-effective health care delivery systems through cooperative activities; promote comparability of health care coverage; improve cost effectiveness; ensure universal access; and create reasonable equity in the distribution of funds, treatments, and medical risks.

Scope of Coverage

The legislation provides for cooperative agreements among certified health plans, health care facilities including hospitals, health care providers including physicians, or other persons involved in the development, delivery, or marketing of health care services.

Approval Agency

The five-member Washington Health Services Commission is the approval agency. When reviewing proposed agreements, it must obtain the written opinion of the Attorney General and act consistent with such opinion.

Standards for Evaluating Proposed Agreements

Advantages Evaluated

The Commission must weigh the extent to which the agreement would

- enhance the quality of health services to consumers,
- achieve gains in cost efficiency of health services,
- avoid duplication and improve utilization of health services and equipment,

- facilitate the exchange of information relating to performance expectations,
- simplify the negotiation of delivery arrangements and relationships, and
- reduce the transaction costs on the part of certified health plans and providers in negotiating more cost-effective delivery systems.

Disadvantages Considered

The Commission must also consider in its review

- whether the agreement would reduce competition among certified health plans, health care providers, or health care facilities;
- whether the agreement would adversely affect quality, availability, or price of health care services to consumers; and
- the availability of arrangements less restrictive to competition that would achieve the same benefits.

Role and Authority of the Attorney General

The Commission is required to obtain an informal opinion from the Attorney General about whether a proposed cooperative activity would be authorized under the law. If an entity chooses to seek an exemption from antitrust under the legislation, the Attorney General must provide advice to the Commission, if requested.

Monitoring Requirements

With the assistance of the Attorney General's office, the Commission shall actively supervise any conduct authorized under the legislation to determine whether such conduct or rules permitting certain conduct should be continued and whether a more competitive alternative is practical. The Commission must periodically review the operation of cooperative agreements through, at least, annual progress reports from the entities involved. If the Commission determines that the likely benefits of the conduct no longer outweigh the disadvantages attributable to potential reduction in competition, it can order a modification or discontinuance of the conduct.

Rules and Regulations

The Commission is required to adopt rules (1) governing conduct among providers, health care facilities, and certified health plans under the act, including rules pertaining to contracts and cooperative activities, and (2) permitting collective negotiations among health care facilities and providers.

Washington (Rural Hospital Districts)

Title and Effective Date of Legislation	Act relating to cooperative activities of local governments (1992 regular session), March 1992 (1992 Washington Laws ch. 161)
Stated Purpose of Legislation	The purpose of the legislation is to foster the development of cooperative and collaborative arrangements among rural public hospital districts by specifically authorizing cooperative agreements and contracts for these entities under the Interlocal Cooperation Act. Rural public hospital districts are authorized public hospital districts whose geographic boundaries do not include a city with a population greater than 30,000.
Scope of Coverage	The legislation provides for cooperative agreements among rural public hospital districts. The agreements are authorized to include allocation of health care services, combined purchases and allocations of medical equipment and technologies, joint agreements and contracts for health care service delivery and payment with public and private entities, and other cooperative arrangements.
Approval Agency	Most agreements do not need formal approval; however, before their effective date, all agreements made under this legislation must be filed with the county auditor and the Secretary of State. Agreements that deal in whole or in part with the provision of services or facilities for which a state agency has constitutional or statutory powers of control are considered approved unless they are disapproved by that state agency within 90 days of receipt.
Standards for Evaluating Proposed Agreements	The legislation does not mention either advantages that must be evaluated or competitive disadvantages that must be considered.
Role and Authority of the Attorney General	The legislation does not mention any role or authority for the Attorney General.

Monitoring Requirements	The legislation contains no specific requirements for monitoring agreements.
Rules and Regulations	The legislation does not mention rules and regulations.

Wisconsin

Title and Effective Date of Legislation	1991 Wisconsin Act 250 Regarding Health Care Cooperative Agreements, September 1992 (1991 Wisconsin Laws Act 250)
Stated Purposes of Legislation	The legislation does not contain a specific statement of purpose; however, the state policy is articulated in its standards for approval.
Scope of Coverage	The legislation provides for cooperative agreements among health care providers, including hospitals and physicians. Services covered include the sharing, allocation, or referral of patients or the sharing or allocation of personnel; instructional programs; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care providers.
Approval Agency	Wisconsin Department of Health and Social Services
Standards for Evaluating Proposed Agreements	The benefits likely to result from the agreement must substantially outweigh any disadvantages attributable to a reduction in competition, and any reduction in competition likely to result from the agreement must be reasonably necessary to obtain the benefits.
Advantages Evaluated	The Department must find that at least one of the following benefits is likely to result: • the quality of health care provided to residents of the state will be enhanced; • a hospital, if any, and health care facilities that customarily serve the communities in the area likely affected by the cooperative agreement will be preserved;

- services provided by the parties to the cooperative agreement will gain cost efficiency;
- utilization of health care resources and equipment in the area affected by the cooperative agreement will improve; and
- duplication of health care resources in the area likely affected by the cooperative agreement will be avoided.

Disadvantages Considered

The Department must also weigh the extent to which the agreement might

- adversely affect the ability of health maintenance organizations, preferred provider plans, persons performing utilization review, or other health care payers to negotiate optimal payment and service arrangements with hospitals and other health care providers;
- reduce competition among physicians, allied health professionals, or other health care providers; and
- be more restrictive to competition than other arrangements that could likely achieve substantially the same benefits.

Role and Authority of the Attorney General

The legislation does not mention any role or authority for the Attorney General.

Monitoring Requirements

The legislation states that the Department may revoke approval of a cooperative agreement if the Department determines that the benefits resulting from the cooperative agreement no longer outweigh any disadvantages attributable to any actual or potential reduction in competition resulting from the agreement. The legislation contains no procedure or criteria for the Department to use to make this determination.

Rules and Regulations

The legislation does not mention rules or regulations.

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