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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

COMMISSION AUTHORIZED

March 8, 1993

The Honorable David W. Huey
Assistant Attorney General
State Capitol
600 East Boulevard
Bismarck, North Dakota 58505-0040

Dear Mr. Huey:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on Senate Bills 2295 and 2426, which would authorize certain cooperative agreements among hospitals or other health care providers and immunize those agreements from antitrust liability. Competition in health care markets has benefited consumers, and antitrust enforcement has been a significant factor in the emergence of potentially procompetitive methods of delivering health care services, such as managed care. Statutory antitrust exemptions could permit behavior that injures consumers and the economy. We know of no instances of antitrust challenges to cooperative agreements to improve efficiency or enhance the quality of care; thus, we question whether granting antitrust immunity is necessary to achieve the goals sought. Because it may be difficult to ensure that these agreements, once authorized, continue to operate as intended, we recommend that, if programs such as these bills would authorize are nonetheless adopted, measures be taken to make it easier to terminate agreements that fail to achieve those goals.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, and in the delivery of health care services generally, to the maximum extent

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

[2] 15 U.S.C. §§ 41 et seq.

compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of business practices of hospitals and health care professionals.[3] The Commission has investigated and taken action concerning the competitive effects of mergers between hospitals.[4] The staff of the Commission has also commented, in response to requests, on legislative and regulatory proposals that may affect competition and consumer interests. On several occasions, the staff of the Commission has commented on the effects of state certificate-of-need ("CON") laws on competition among hospitals and other health care providers.[5] The staff of the Commission has authored three studies dealing with CON regulation.[6]

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[3] See, e.g., American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d. 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676 (1982); Medical Staff of Doctors' Hospital of Price George's County, 110 F.T.C. 476 (1988); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988); Medical Staff of Holy Cross Hospital, No. C-3345 (consent order, Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991).

[4] See, e.g., FTC v. Columbia Hospital Corp., No. 93-30-CIV-FTM-23D (M.D.Fla., complaint filed February, 1993); FTC v. University Health, Inc., 1991-1 Trade Cas. (CCH) ¶69,400, 69,444 (S.D. Ga.), rev'd, 938 F. 2d 1206 (11th Cir. 1991); Hospital Corporation of America, 106 F.T.C. 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987); American Medical Int'l, 104 F.T.C. 1 (1984).

[5] See, e.g., Comments to the Maryland Health Resources Planning Commission (August 6, 1987); Georgia Senate (March 4, 1988); Michigan House of Representatives (March 7, 1988); Pennsylvania House of Representatives (March 30, 1988); Georgia Senate (February 6, 1989); Nebraska Senate (February 22, 1989). See also Statement of Keith B. Anderson, Special Assistant to the Director, Bureau of Economics, Federal Trade Commission, before the North Carolina State Goals and Policy Board (March 6, 1989); Testimony of Mark D. Kindt, Regional Director, Cleveland Regional Office, Federal Trade Commission, before the Ohio Senate Health and Human Services Committee (June 21, 1989).

[6] Keith B. Anderson and David I. Kass, Certificate of Need Regulation of Entry into Home Health Care: A Multi-Product Cost Function Analysis, FTC Bureau of Economics Staff Report (1986); Monica Noether, Competition Among Hospitals, FTC Bureau of Economics Staff Report (1987); Daniel Sherman, The Effect of State Certificate of Need Laws on Hospital Costs: An Economic Policy Analysis (1988).

II. Description of S.B. 2295 and S.B. 2426.

Each of these bills provides a means for issuing a "certificate of public advantage" to a cooperative agreement among health care providers. The intended effect of these certificates, which is explicit in S.B. 2295 and implicit in S.B. 2426, would be to immunize these agreements against antitrust liability.

A. S.B. 2295.

Under this bill, institutional health care providers may, through their boards and directors, negotiate with each other about allocating equipment or services, immune from state or federal antitrust liability so long as their discussions are designed to reduce costs, improve access, or improve quality of care.[7] Immunity would not extend to discussions that involved predatory pricing or price fixing.[8] Parties reaching a cooperative agreement through such negotiations could obtain a "certificate of public advantage" for it from the state attorney general, which would immunize the agreement from state or federal antitrust liability.[9] The agreement could deal with sharing or allocating patients, personnel, programs, support services, facilities, or procedures.[10] A certificate would be issued if the attorney general determined that the benefits likely to result from the agreement substantially outweighed any disadvantages attributable to a reduction in competition likely to result, and that any such reduction in competition was reasonably necessary to obtain the likely benefits.[11] The likely benefits must include at least one of the following: enhanced quality of care, preservation of facilities, increased cost efficiency, improved use of resources and equipment, or avoidance of duplicated resources.[12] In determining whether the reduction in competition is necessary, the attorney general must

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[7] S.B. 2295, 53rd Legis. Assembly, §2. (1993).

[8] Id.

[9] Id. §3. It is not clear whether the final agreements, unlike the negotiations leading to them, could encompass price fixing or predatory pricing and still retain antitrust immunity.

[10] Id. §1(2).

[11] Id. §4(1).

[12] Id. §4(2).

consider the impact on payors' ability to negotiate "optimal payment and service arrangements", possible reductions in competition among other health care providers, and whether there are less anticompetitive alternatives.[13] The certificates would apparently be of indefinite duration.[14]

B. S.B. 2426, §§6-16.

These provisions[15] of this bill are substantively nearly the same as S.B. 2295, but it differs from S.B. 2295 in some details, particularly concerning coverage and procedures. Although S.B. 2426 does not confer antitrust immunity as explicitly as S.B. 2295 does, that appears to be its intention.[16] S.B. 2426 would apply only to hospitals and their affiliates, and would not apply to mergers or other outright transfers of control.[17] Certificates would be issued by the department of health, although applications would also be filed with the attorney general, who must be consulted about possible reductions in competition and would be notified of the action taken.[18] Hearings would be required before certificates were issued,[19] and a certificate could be issued only if the applicants carry the burden of showing, by "clear and convincing

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[13] Id. §4(3).

[14] The attorney general could revoke a certificate on determining that the balance no longer favored the reduction in competition, but the certificate holder could contest that action. Id. § 5.

[15] The rest of the bill proposes other changes in health insurance and health care services.

[16] The scope of the immunity it would grant to the negotiation process is slightly different. S.B. 2426, 53rd Legis. Assembly, §§ 8, 16 (1993). Under S.B. 2426, the conduct of the parties in negotiating an agreement would be "lawful conduct" if an application for a certificate is filed (even if the certificate is not ultimately issued); by contrast, S.B. 2295 does not condition immunity for negotiations on filing an application for a certificate. On the other hand, S.B. 2426 does not identify price fixing or predatory pricing as matters that could not be discussed without losing immunity.

[17] Id., § 16.

[18] Id., §§8, 9.

[19] Id., §8.

evidence," that the likely advantages outweighed the disadvantages from reduction in competition.[20] The lists of possible benefits and disadvantages are essentially the same as in S.B. 2295, except that S.B. 2426 also calls for considering possible adverse effects on the quality, availability, and price of health care services.

S.B. 2426 also sets out detailed procedures and standards for actions by the attorney general to enjoin and cancel agreements. In an action to enjoin an agreement for which an application has been filed, the parties would bear the burden of demonstrating that it passed the cost-benefit test by clear and convincing evidence; in considering the possible reduction in competition, the court would consider whether it constituted an unreasonable restraint of trade under state or federal law.[21] In an action to cancel an agreement after a certificate is issued, the attorney general would bear the burden of showing, by a preponderance of the evidence, that because of changed circumstances, the benefits of maintaining the agreement (plus the unavoidable costs of cancelling it) were outweighed by the disadvantages of the loss of competition.[22] The parties to an agreement shown to have been obtained by fraud or coercion could salvage it by demonstrating, by clear and convincing evidence, that it passed the cost-benefit test.[23]

III. Hospital competition, joint ventures, and mergers.

The premise of each of these bills appears to be that antitrust litigation or prosecution, or the fear of antitrust liability, prevents or inhibits beneficial agreements among hospitals or other providers of health care services. We believe it would be useful to review the record of antitrust enforcement involving hospital mergers and cooperative agreements, to show

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[20] Id., §9.

[21] Id., §13.

[22] It would apparently not be possible for the attorney general to initiate a challenge to a certificated agreement on the grounds that the grant of the certificate had been in error, unless the action is brought within 40 days after the department of health issues the certificate. Id., §§ 13, 14. It is unclear whether showing changed circumstances would also be necessary for the department of health to revoke a certificate. Id., § 10.

[23] Id., §14.

how the kinds of benefits described in S.B. 2295 and S.B. 2426 have been considered in that process.[24]

The Commission's antitrust enforcement activities concerning hospital mergers and joint ventures attempt to maintain the competitive market forces needed to make the current health care system work, and provide opportunities for improvements in the system to make it work better.[25] The Commission believes that competition significantly improves the performance of hospitals within the existing health care system. Competition will continue to play such a role in foreseeable circumstances.

The clearest benefit to consumers of competition in the hospital industry results from the ability of third-party payers, such as health maintenance organizations and preferred provider plans, to contain costs. Under various forms of "managed care," health plans use their ability to contract selectively with hospitals, and their extensive knowledge of hospitals' prices and quality of care, to direct their beneficiaries to the hospitals offering the best combination of cost-effectiveness and quality of care reasonably available to them. This strategy encourages hospitals to reduce costs (while maintaining acceptable levels of quality of care), by rewarding hospitals that do so with additional patients, or at least by steering patients away from high-cost institutions. Consumers benefit from this process in two ways: from how it may tend to control increasing hospital costs generally, and from the ability to choose health care payment plans that offer cost-reducing features.

Managed care competition for hospital and other health services is becoming increasingly widespread, and many efforts to reform America's health care system would rely more heavily upon

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[24] The following discussion is based on a statement the Commission recently submitted to a joint committee of Congress concerning antitrust enforcement in health care. Testimony of the Federal Trade Commission, Before Subcommittee on Investment, Jobs and Prices, Joint Economic Committee (June 24, 1992).

[25] The Commission is not in a position to make broad predictions or recommendations about what the hospital industry will or should look like in the next century. The Commission's involvement in the health care field is limited to the enforcement of certain antitrust and consumer protection statutes. While that role is important, the Commission's experience with and expertise in health care is limited and specialized, as compared to agencies such as the Department of Health and Human Services, whose regulatory responsibilities are much broader and more extensive and which is also responsible for the formulation of general health care policy.

it. The information gathered in our investigations, where we frequently obtain the perspective of managed care payers, generally indicates that managed care slows hospital price increases where health plans have at least several hospitals to choose from in the markets they serve. This occurs because the plans can engage hospitals in a competitive process to obtain low prices, and can avoid doing business with those hospitals unwilling or unable to offer cost-effective care.[26] The Commission places particular importance in its hospital merger enforcement activities on the preservation of the hospital alternatives needed to make competition work.

The benefits of competition to the American health care system extend even to markets where managed care has not taken hold. For example, even the less intensive price competition that prevails in non-managed care markets places additional pressure on unusually high-cost hospitals to confront their inefficiencies and take the steps necessary to contain their costs.

This will be of particular importance as the Medicare system, and other payers with aggressive cost-containment programs, place more stringent reimbursement limitations on inefficient hospitals. Medicare in particular, through its prospective reimbursement system, is already forcing hospitals to absorb excessive operating costs rather than pass them on to the federal government. Medicare has also started moving in the same direction with respect to excessive capital costs, which may by the 21st century also be denied Medicare reimbursement. This strategy provides powerful incentives for hospitals to reexamine their operations and take the sometimes painful steps needed to eliminate inefficiencies. But those incentives would be undermined if high-cost hospitals could freely "cost-shift" onto private payers the excessive costs Medicare refuses to pay for, without competition from hospitals with lower costs and more reasonable prices. It has been our experience that the presence of lower-priced competitors to whom consumers can turn

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[26] Some economic studies also indicate that managed care can substantially constrain hospital prices or costs, at least when managed care health plans can choose among a wide range of hospitals available to their beneficiaries. See, e.g., Glenn A. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. Health Econ. 217 (1992); J. Robinson, HMO Market Penetration and Hospital Cost Inflation in California, J. Am. Med. Ass'n (November 20, 1991); J. Zwanziger and G. Melnick, The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California, 7 J. Health Econ. 301 (1988).

significantly helps motivate inefficient hospitals to confront and overcome their inefficiencies and contain their costs.

Some in the hospital industry and elsewhere apparently believe that antitrust enforcement effort impedes rather than promotes the provision of economical, high-quality hospital care, because it blocks or discourages efficient mergers and joint ventures among hospitals. Indeed, it is said that the Commission's focus on preserving competitive hospital markets is at odds with other policies being implemented by HHS that encourage hospitals to become more efficient.

But sound antitrust policy does not conflict with health care cost containment efforts. HHS seeks to promote low-cost, high-quality hospital care. So does the Commission, in its health care antitrust enforcement program.

The Commission and the Justice Department have jointly issued merger guidelines which set forth the analytical framework the agencies use in determining whether a merger is likely to lessen competition.[27] Those Guidelines emphasize the need to look beyond market concentration to determine whether a particular merger is inconsistent with the federal antitrust laws' objective of preserving competition and thereby promoting low-priced, high-quality goods and services for the consumer. In any industry, it is necessary to look at a broad range of market characteristics to determine whether the increase in concentration and the elimination of a competitor through a merger would likely threaten consumer interests.[28] These other factors include efficiencies and other consumer benefits that the merger might make possible.[29] The Commission accordingly is

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[27] Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines (April 2, 1992).

[28] Id.

[29] Claims of efficiencies will only be considered if they are realistic and supported by the evidence. Notably, in three of the four hospital merger cases decided after litigation in which potential efficiencies were a significant issue, the hospitals' arguments on that issue were rejected as factually unpersuasive. See FTC v. University Health, Inc., 938 F.2d 1206, 1223-24 (11th Cir. 1991); United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1287-91 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir.), cert. denied, 111 S.Ct. 295 (1990); American Medical Int'l, 104 F.T.C. 1, 148-155, 218-20 (1984). However, the Commission has weighed potential efficiencies in reaching its decision not to challenge certain hospital transactions.

careful to make sure that its enforcement actions in hospital markets in fact serve consumer interests.

The federal agencies' enforcement record reflects their recognition that most mergers and joint ventures, in the hospital industry as in any other, are likely to help (or at least not harm) consumers. Out of approximately 50-100 hospital mergers and similar transactions each year (including leases, management contracts, and other non-purchase, non-merger transactions consolidating the operations of previously independent hospitals), on average only a handful are investigated by either the Commission or the Justice Department. And less than once a year has the Commission actually challenged a hospital merger as anticompetitive. Moreover, neither the Commission nor the Justice Department has ever challenged any of the numerous joint ventures among hospitals. Indeed, when they have challenged proposed mergers, the agencies have identified joint ventures--for example, an existing magnetic resonance imaging ("MRI") service shared between two hospitals in Augusta, Georgia, where the Commission challenged a proposed hospital merger[30]--as desirable alternatives for hospitals to achieve efficiencies to improve specific services without sacrificing the larger benefits of price and quality competition by merging their entire operations.[31] Consequently, the vast majority of the more than five thousand hospitals in the United States are able to go about their business and pursue whatever cost-containment measures they find necessary without any intervention from the antitrust enforcement agencies.

The Commission not only has limited its enforcement actions to hospital mergers that could have been genuinely harmful, but also has made considerable efforts to publicize and clarify its enforcement policies in that area so as not to discourage legal,

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[30] FTC v. University Health, Inc., 1991-1 Trade Cases (CCH) ¶¶ 69,400, 69,444 (S.D. Ga.), rev'd, 938 F.2d 1206 (11th Cir. 1991).

[31] See Reading Hospital, 55 Fed. Reg. 3264, 3266, 15290 (1990) (consent order) (Commission determined that voluntary separation of merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in a hospital-sponsored health plan joint venture, and to share laundry, laboratory and biomedical equipment repair services). In addition, the consent order to settle the administrative proceedings in University Health, Inc., FTC Docket No. 9246, 57 Fed. Reg. 29,084, 44,748 (1992) exempts a wide range of support service joint ventures between hospitals from the order's provisions for Commission oversight of respondents' future hospital mergers and joint ventures.

beneficial transactions. The court and Commission decisions in litigated hospital merger cases explain in great detail how to apply antitrust principles to such transactions. These decisions are amply supplemented by formal statements, such as the 1992 Merger Guidelines issued by the Department of Justice and the Federal Trade Commission, and also by well over a dozen speeches by senior agency officials discussing hospital mergers and joint ventures,[32] as well as the hospital industry's own efforts to educate itself on how the antitrust laws apply to mergers and joint ventures.[33] And the Commission's staff is readily available for informal consultation to provide additional clarification and assistance to hospital officials thinking about a merger or joint venture. All of these resources are available to help hospital executives ensure that their proposed mergers and joint ventures comply with the antitrust laws, and dispel any unwarranted fears to the contrary.

Antitrust enforcement has played an important role in facilitating reforms in the health care sector and the hospital industry in particular, by removing obstacles to the use of innovations such as managed care to take advantage of competition to contain costs and overcome some of the inefficiencies of health care markets. It continues to have a useful role in improving the performance of the hospital industry as it is now structured, and also in leaving the door open to further reforms of the health care system that would rely even more heavily on competition as a cost-containment strategy.

IV. Effects of Senate Bills 2295 and 2426.

We believe that antitrust enforcement action has not prevented cooperative agreements among hospitals or other health care institutions that would have been beneficial to consumers.[34] To the extent that the proposed legislation would

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[32] See, e.g., Speech by Janet Steiger, Chairman, FTC, to the National Health Lawyers Association (February 19, 1993).

[33] See, e.g., American Hospital Ass'n, Hospital Mergers: An Executive's Guide through the Antitrust Thicket (Sept. 1989).

[34] We know of no antitrust actions brought by private parties against cooperative agreements of the kind contemplated by these two bills. In theory, the risk of facing the costs of antitrust litigation or enforcement could discourage even some joint arrangements that would not be found illegal. In practice, though, the threat of government or private antitrust action has not, to

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merely authorize the kinds of agreements that would not have been subject to antitrust challenge anyway, the legislation would have no adverse effect on competition. However, the provisions of these bills could be interpreted to encourage or permit agreements that are more explicitly anticompetitive in intention and effect than those contemplated before.[35] The chief source of concern would be agreements to allocate responsibilities that did not reflect efficiency-enhancing integration and coordination of capacities, but instead amounted to agreements to divide markets and refrain from competition. Such division and allocation of markets can be just as harmful to consumers as explicit price-fixing.

We recognize that policy concerns other than those considered in competition law enforcement may be important here. Some of the considerations that the bills list as possible benefits to be weighed against the disadvantages of reducing competition may indeed be such different and independent considerations. Many of them, though, describe the kinds of issues that the Commission considers in its competition enforcement decisions. For example, two factors, increased cost efficiency and improved use of resources, could include the kinds of considerations of true efficiencies that the Commission usually considers in antitrust analysis.[36] Others may be

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[34](...continued)
our knowledge, discouraged beneficial cooperative arrangements. Reports in trade journals suggest that the threat of antitrust action has not chilled collaborations. See, e.g., D. Burda, Mergers thrive despite wailing about adversity, Modern Healthcare (October 12, 1992).

[35] One kind of agreement among hospitals that was actually found to violate the antitrust laws would not have been protected from liability by either of these bills. See United States v. North Dakota Hospital Ass'n, 640 F.Supp. 1028 (D.N.D., 1986). The hospitals agreed not to negotiate contracts with the Indian Health Service that contained certain kinds of discount terms. This agreement did not involve any collaboration to offer services or combine operations to improve efficiency. The court found that this agreement violated the Sherman Act.

[36] For examples of consideration of such efficiencies in particular hospital mergers, see the cases cited in n. 29, supra. See generally Massachusetts Board of Registration in Optometry, 110 F.T.C. 549 (1988), for a discussion of how the Commission considers factors such as these in deciding other kinds of antitrust cases. These factors would not be considered in a case of pure price fixing among competitors, but would be important in a case involving a joint venture or other combination.

ambiguous. "Preservation of facilities" and "avoidance of duplication", although perhaps intended to include similar issues of efficiency, might include less clearly desirable results as well. Preservation of facilities may not be beneficial if the facilities are uneconomic or inefficient. Thus, in some circumstances eliminating redundant, underused facilities can improve the efficiency of operating those that remain. But the goal of avoiding duplication, to improve efficiency, may contradict the goal of preserving facilities.[37] Moreover, care may be needed to ensure that "avoiding duplication" does not become simply "avoiding competition" -- that is, the "avoiding duplication" goal might be interpreted, paradoxically, to suggest that a reduction in competition should be counted as a benefit, to be weighed against itself as a cost.

Because an informed assessment would conclude that antitrust risks are not inhibiting desirable cooperative agreements, and because permitting the health care industry to become accustomed to agreements to eliminate competition could harm consumers' interests without producing clear countervailing benefits, we recommend caution in proceeding with programs such as these bills propose. The process of negotiation among competitors could lead to anticompetitive understandings and market behavior even where no agreement is ever requested and no certificate is granted. And once certificates are granted, it will be more difficult to ensure that the agreements are implemented in ways that maintain the balance that justified their issuance.

The law sets two requirements for state action to remove the risk of federal antitrust liability for private actions such as these cooperative agreements among health care providers. First, the actions must be taken pursuant to a clearly articulated state policy to displace competition; and second, the state must actively supervise the policy.[38] The "active supervision"

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[37] Economic theory has suggested some specific, unusual circumstances, such as conditions of unsustainable natural monopoly, in which agreements or regulations preventing the entry of new capacity might prevent inefficiencies. See J. C. Panzer and R. D. Willig, Free Entry and the Sustainability of Natural Monopoly, 8 Bell J. of Econ. 1 (1977); see generally R. R. Braeutigam, Optimal Policies for Natural Monopolies, in R. Schmalensee and R. D. Willig, eds., 2 Handbook of Industrial Organization 1289 (1989). In such circumstances, theory would support the claim that preventing duplication would be consistent with promoting efficiency. But it has not been established whether these circumstances apply in health care or hospital markets.

[38] See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980).

requirement means that supervision must extend to specifics of implementation.[39] The Supreme Court has said that the purpose of the requirement is to ensure that the state has determined the specific details of a scheme that supplants competition; the mere potential for a state supervisory action is not enough.[40] Applying this requirement to health care, it has been held that an authorizing certificate would not confer antitrust immunity, in the absence of post-certificate monitoring of the parties' conduct to ensure that it was consistent with the state's policies.[41] Both of these bills would require that applications for certificates be reviewed and specifically approved before the certificates would be issued, but neither calls for subsequent scrutiny of the parties' actual operation, except by providing generally for the possibility of reexamination and revocation.[42] More particularized scrutiny of actual conduct under these agreements may not only be desirable to ensure that they continue to serve their intended purposes, but might also be necessary to accomplish the apparent goal of conferring antitrust immunity.

One additional way to reduce the risk that anticompetitive agreements would become institutionalized would be to issue certificates only for defined, limited terms. The burden would then clearly be on the parties, not the attorney general or the

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[39] F.T.C. v. Ticor Title Insurance Co., 112 S. Ct. 2169 (1992).

[40] Ticor, supra n. 39 at 2177 (the state must have exercised independent judgment and control "so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties"), 2179.

[41] See P.I.A. Asheville, Inc. v. North Carolina, 740 F.2d 274, 278 (4th Cir. 1984), cert. denied, 471 S. Ct 1003 (1985) (CON approval for hospital acquisition did not immunize from antitrust challenge; there was no active supervision of post-certificate conduct, and the federal program that the CON process implemented did not displace the antitrust laws).

[42] S.B. 2295 authorizes actions by the attorney general to revoke certificates, but does not specify whether the attorney general or the certificate holders have the burden of proof in an ensuing challenge to the revocation. S.B. 2295, §5(2). And although S.B. 2426 contains detailed provisions about challenges by the attorney general, the section that provides for the department of health to "initiate proceedings to terminate" a certificate (on finding that the benefits no longer outweigh the disadvantages) establishes no standards or procedures for its decision in those proceedings. S.B. 2426, §10.

department of health, to demonstrate that the benefits continue to outweigh the disadvantages.

V. Conclusion.

In summary, we believe that competition has been an important factor in bringing about beneficial changes in how health care services are delivered to consumers. Experience does not demonstrate that immunity from antitrust liability is necessary to permit hospitals or other institutional providers to undertake cooperative arrangements to improve the quality of care they provide and make their operations more efficient. Thus, we recommend that, if measures such as these bills are nonetheless considered desirable for other policy reasons, measures be included to make it easier, rather than more difficult, to terminate "agreements" whose net effect is detrimental to consumers' interests. We hope these comments are of assistance.

Sincerely,

Michael O. Wise
Acting Director