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FEDERAL TRADE COMMISSION
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PREPARED STATEMENT(1)
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BEFORE THE
JOINT COMMITTEE ON THE PUBLIC INTEREST
IN COMPETITIVE PRACTICES IN HEALTHCARE
OF THE VERMONT LEGISLATURE

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Madam Chairman and Members of the Committee: I am pleased to appear before you today to discuss competition and antitrust enforcement in health care markets. This testimony and my responses to your questions represent the views of the staff of the Federal Trade Commission. They are not necessarily the views of the Commission or any individual Commissioner.

Competition in health care markets has benefited consumers. 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 antitrust orders prohibiting 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, once agreements are authorized under programs such as the proposal under consideration here, the agreements continue to operate as intended, we recommend that, if such programs 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 to the maximum extent 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 concerning the health care industries that may affect competition and consumer interests.(5)

II. Proposed Antitrust Exemption For Cooperative Agreements in Health Care Industries.

One of the subjects of this hearing, and the one on which I will focus, is a proposal to grant immunity from antitrust oversight to certain kinds of cooperative agreements among hospitals or other health care providers.(6) The proposal would have the legislature find that, to implement strategies to reduce costs, improve access to services, and enhance prospects for further improvement in quality of care, cooperation among health care facilities and providers must be encouraged by state legislation.(7) The Secretary of the Agency of Human Services would be authorized to issue a "certificate of public advantage" covering such a proposed agreement if the applicants demonstrate, by clear and convincing evidence, that the likely benefits of the agreement outweigh disadvantages attributable to reduction in competition.(8)

The "cooperative agreements" subject to the proposal could deal with sharing, integration, allocation, or referral of patients, personnel, instructional programs, equipment, laboratory facilities or procedures or other services.(9) The possible benefits to be considered include enhancement of quality of health care, preservation of facilities near communities they have traditionally served, improvements in cost efficiency, improvements in resource utilization, avoidance of duplication of resources, and improved access to providers and services.(10) The possible disadvantages from reduction in competition to be considered include impairing the ability of HMO's, PPO's, managed care firms or other payors to negotiate payment and service arrangements, reduction in competition among providers or facilities (including providers or facilities that compete with, or supply goods or services to, those involved in the agreement itself), adverse impact on quality, availability, or price of health care services, and the availability of less restrictive arrangements.(11)

The intention is that a certificate would confer "state action" immunity from antitrust oversight.(12) The certificate would be subject to review every three years, and could be revoked, after notice and hearing, if the Secretary found that the benefits no longer outweigh the disadvantages.(13)

III. Competition and Antitrust Enforcement in Health Care.

Before examining this proposal more closely, let me set out the perspective we bring to the issues. The FTC enforces the antitrust laws to ensure that competitive forces will allow the development of health care delivery desired by consumers. The Commission does not favor one type of health care delivery system over another. The Commission does not advocate that consumers choose a managed care plan over a fee-for-service health care plan. Nor does the Commission take a position on which kind of health care plan provides better quality health care at lower prices. Instead, the Commission tries to ensure that each plan may develop and grow as it meets the wants and needs of consumers. The Commission seeks to ensure that anticompetitive behavior does not impede the development of health care alternatives that consumers might elect to use.

Many of the various health care reform proposals have envisioned some exemption from antitrust review for the health care industry. The Federal Trade Commission has taken the position that such exemptions are unwarranted and unwise.(14) The Commission believes that antitrust law enforcement has played a key role in opening up the industry for competition, and will be important to the success of any competition-based model for the future health care market.

The antitrust laws have been described by the United States Supreme Court as the "Magna Carta of our free enterprise system.(15) These laws reflect a judgment that competition generally promotes consumer welfare and produces the best mix of quality goods and services at the lowest prices. The antitrust laws also assure business people an opportunity to offer their goods and services in the marketplace, and to have their success or failure determined by consumers' preferences, not by the abuse of other competitors' market power. Indeed, experience from the Commission's health care enforcement program suggests that antitrust law enforcement plays an important role in preventing organized efforts to reduce price competition and to thwart cost containment efforts. For example, antitrust law enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers.(16) Other examples include Commission enforcement actions that have challenged anticompetitive rules

that prohibited physicians from affiliating with health care plans, and enforcement actions that have halted organized boycotts by some health care providers against newly developing health care arrangements.(17)

The Commission's experience in health care markets has shown that, without the protection that antitrust law provides, efforts to contain health care costs, and to create innovative delivery systems to better serve consumers, sometimes can be frustrated by provider opposition. More broadly, to the extent that health care reform depends on market mechanisms to improve the price and quality of the health care Americans receive, antitrust enforcement will help make reform work by promoting and maintaining competitive health care markets.

IV. Consideration of Benefits and Costs in Health Care Antitrust Law Enforcement.

The premise of this proposal, and others similar to it, 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. It would be useful to review the record of antitrust law enforcement involving hospital mergers and cooperative agreements, to show how the kinds of benefits described in the proposal have been considered in that process.

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.(18) 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 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.(19) 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 competitively-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.(20) These other factors include efficiencies and other consumer benefits that the merger might make possible.(21) The Commission accordingly is careful to make sure that its enforcement actions in hospital markets in fact serve consumer interests.

Sound antitrust enforcement does not hinder efficient, procompetitive collaborations. This issue needs consideration in perspective. In a typical year, there are about 50 to 100 hospital mergers or other arrangements consolidating previously independent hospitals. Review of these transactions by Commission staff normally entails minimal or no direct contact with the parties and no delay in the transaction beyond statutory Hart-Scott-Rodino requirements. In the past decade, the Commission has conducted only about thirty formal investigations, mostly involving larger metropolitan hospitals, and, even after the recent flurry of merger activity, has challenged only about a dozen hospital mergers.(22)

The Commission's assessment of the impact of antitrust enforcement on hospital collaborations has been confirmed both by a substantial increase in such activity recently — which suggests that fear of antitrust enforcement has not dampened hospital mergers generally — and by other observers. A Health Care Task Force of the American Bar Association concluded that, "Overall antitrust enforcement has not deterred hospital mergers and in fact, the hospital industry has seen a recent wave of mergers.(23) Similarly, a Department of Health and Human Services task force examined the claim that enforcement agencies have become too adversarial in challenging hospital mergers, concluding that the assertion was not supported by the evidence.(24)

The enforcement record on hospital joint ventures similarly should not evoke concern. To date, the Commission has not challenged a single joint venture among hospitals. Indeed, in the context of merger enforcement, the Commission has taken particular care not to restrict types of hospital joint ventures that are unlikely to raise serious antitrust

concerns. In a recent order blocking a hospital merger in a highly concentrated market, the Commission exempted from the order's reporting requirements any prospective joint ventures the hospitals might decide to undertake to provide data processing, laboratory testing, and health care financing.(25) These joint ventures appeared likely to achieve efficiencies and improve specific services, without endangering price and quality competition for other services, as a complete merger could.

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, beneficial transactions. The Federal Trade Commission and the Department of Justice have issued Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust specifically addressing areas of concern to members of the health care industry. A set of six statements was issued a year ago; last month, those statements were updated and expanded.

The "antitrust safety zones" that are included in most of the policy statements describe the circumstances under which the federal antitrust law enforcement agencies will not challenge certain collaborative activities by hospitals, doctors, and other health care providers. The policy statements go on to explain in detail, using illustrative examples, how the agencies analyze conduct that falls outside a safety zone. They emphasize that many activities falling outside a safety zone nevertheless are lawful and permissible.

Under the safety zone for mergers, the agencies will not challenge, except in extraordinary circumstances, hospital mergers where one hospital has fewer than 100 beds and fewer than 40 patients a day, and is more than five years old. They will not challenge joint ventures among hospitals to purchase or support high-technology or other expensive health care equipment, that involve only the number of hospitals necessary to support the equipment. If more hospitals are included, but the additional hospitals could not support the equipment on their own or through a competing joint venture, the agencies will not challenge the venture. One of two new examples with this statement explains how the agencies analyze joint ventures involving existing equipment in rural areas.

The statements make clear that the agencies will not challenge joint purchasing arrangements among health care providers, as long as they meet conditions designed to ensure they do not become vehicles for collusive purchasing or for price fixing. The purchases must account for less than 35 percent of the total market for the purchased items and, for arrangements among direct competitors, the cost of the jointly-purchased items must account for less than 20 percent of the total revenues of each purchaser. An example focusing on analysis of rural joint purchasing arrangements is now included.

The agencies will not challenge an exclusive physician network joint venture (that is, a venture that restricts the ability of physicians to affiliate with other such ventures or to contract individually with health insurance plans), as long as the physicians share substantial financial risk and the venture comprises 20 percent or fewer of the physicians in each specialty with active hospital privileges in the geographic market.(26) The agencies will not challenge a non-exclusive physician network joint venture (that is, a venture that does not involve limitations on the ability of participating physicians to affiliate with other ventures or to contract individually with health plans), as long as the physicians share substantial financial risk, and the venture comprises no more than 30 percent of the physicians in each specialty with active hospital privileges in the geographic market.(27) This safety zone has been expanded to reflect the agencies' experience that truly non-exclusive joint ventures generally raise less risk of foreclosure of competing plans than do exclusive joint ventures.

The agencies also have added a new statement that explains how they will analyze hospital joint ventures to provide specialized clinical or other expensive health care services. Under a "rule-of-reason" analysis, the agencies define the relevant market, determine how the venture would affect competition in that market, weigh any anticompetitive effects against any procompetitive efficiencies generated by the venture, and examine whether collateral restraints, if any, are in fact necessary to achieve the efficiencies sought by the venture. To date, neither agency has challenged an integrated joint venture to provide such services.

A statement has been added explaining how the agencies analyze multiprovider networks, which are ventures among providers to jointly market their services to health benefits plans and others. If such networks involve agreements that allocate markets, fix prices or similarly restrict competition, the agencies will examine whether the members are sufficiently integrated to allow the agencies to weigh the anticompetitive effects and competitive benefits of the agreements. (Otherwise, such agreements would be illegal on their face.) If the networks are integrated, the agencies then will define the markets where the networks operate and have substantial impact, and examine the competitive effects of the networks in each of these markets. That examination will take into account any cost savings or other efficiencies that will be attributable to such networks.

The safety zones make explicit what our law enforcement activities have demonstrated: that we do not challenge activities unless they threaten competition or consumers, and that health care providers seeking to improve efficiency, reduce costs, or otherwise benefit consumers and competition through joint activities, need not be concerned about antitrust enforcement. Moreover, the policy statements commit the federal antitrust enforcement agencies to responding quickly to requests to review the legality of proposed activity through the FTC's advisory opinion and the Department of Justice's business review letter processes.

V. Effects of Proposed Antitrust Exemption.

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.(28) To the extent that the proposal would merely authorize the kinds of agreements that would not have been subject to antitrust challenge anyway, it would have no adverse effect on competition. However, the proposal could be interpreted to encourage or permit agreements that are more explicitly anticompetitive in intention and effect than those contemplated before. The chief source of concern would be agreements to allocate responsibilities that did not reflect efficiency-enhancing integration, 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 listed 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.(29) Others may be 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. The goal of avoiding duplication, to improve efficiency, may contradict the goal of preserving facilities. 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 this proposal. The very 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 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.(30) The "active supervision" requirement means that supervision must extend to specifics of implementation.(31) 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.(32) 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 regulation of the parties' conduct to ensure that it was consistent with the state's policies.(33)

This proposal would require that applications for certificates be reviewed and specifically approved before the certificates would be issued, but does not call for subsequent scrutiny or regulation of the parties' actual operation, except by providing generally for "review" and the possibility of reexamination and revocation. More particularized scrutiny or regulation 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 to demonstrate that the benefits continue to outweigh the disadvantages.

VI. 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 antitrust immunity is nonetheless considered desirable for other policy reasons, effective measures be included to ensure scrutiny of "agreements" and to terminate "agreements" whose net effect is detrimental to consumers' interests. We hope these comments are of assistance.

(1) This testimony represents the views of the staff of the Federal Trade Commission.

(2) 15 U.S.C. §§ 41 *et. seq.*

(3) *See, e.g.,* American Medical Ass'n, 94. F.T.C. 701 (1979); Iowa Chapter of American Physical Therapy Ass'n, 111 F.T.C. 199 (1988) (consent agreement); Wyoming State Bd. of Chiropractic Examiners, 110 F.T.C. 145 (1988) (consent order); Connecticut Chiropractic Ass'n, 114 F.T.C. 708 (1991); American Psychological Ass'n, C-3406 (consent order issued December 16, 1992), 58 Fed. Reg. 557 (January 6, 1993)); Texas Bd. of Chiropractic Examiners, C-3379 (consent order issued, April 21, 1992, 57 Fed. Reg. 20279 (May 12, 1992)); National Ass'n of Social Workers, C-3416 (consent order issued March 3, 1992, 58 Fed. Reg. 17411 (April 2, 1993)); California Dental Ass'n, D-9259 (administrative complaint issued July 9, 1993); and McLean County Chiropractic Ass'n, C-3491, 59 Fed. Reg. 22163 (April 29, 1994) (consent order).

(4) *See, e.g.,* Columbia Hospital Corporation, D. 9256 (complaint issued February 18, 1993; consent order, 59 Fed. Reg. 33296 (June 28, 1994)); FTC v. Columbia Hospital Corp., No 93- 30-CIV-FTM-23D (M.D. Fla., preliminary injunction issued May 21, 1993); University Health, Inc., D. 9246 (consent order issued September 9, 1992, 57 Fed. Reg. 44748 (Sept. 29, 1992)); 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.*, letter to North Dakota Assistant Attorney General David Huey (March 8, 1993) (concerning bills, similar to the proposal being considered here, to grant antitrust exemptions to certain cooperative agreements among hospitals or other providers); letter to Illinois State Senator Judy Baar Topinka (March 12, 1993) (concerning bill to establish demonstration program to test feasibility of alternative health care delivery system).

(6) Another subject of this hearing is a bill about pharmacies and prescription drugs that was considered in the last legislative session and is expected to be introduced again in the next one. The staff of the Commission has commented several times, in other jurisdictions, about “any willing provider” features comparable to those in this bill. Copies of those recent comments are attached to this statement for your information.

(7) Proposed Section 9460.

(8) Proposed Section 9462(d).

(9) Proposed Section 9461(a).

(10) Proposed Section 9462(d)(1).

(11) Proposed Section 9462(d)(2).

(12) Proposed Sections 9460, 9465(a).

(13) Proposed Section 9462(e). Certificates would be granted only if “clear and convincing” evidence showed that benefits outweighed disadvantages, but they could be revoked if only a preponderance of the evidence showed that the balance had shifted the other way. Proposed Section 9465(b).

(14) See letters from Federal Trade Commission concerning H.R. 3486 and S. 1658 to The Honorable Jack Brooks, Chairman, Committee on the Judiciary, United States House of Representatives, and The Honorable Howard M. Metzenbaum, Chairman, Subcommittee on Antitrust, Monopolies, and Business Rights, Committee on the Judiciary, United States Senate (June 10, 1994). The Department of Justice has also taken a similar position. See letter from Anne K. Bingaman, Assistant Attorney General, U.S. Department of Justice, Antitrust Division, to The Honorable Howard M. Metzenbaum, (April 14, 1994).

(15)” *U.S. v. Topco Associates, Inc.*, 405 U.S. 596, 610 (1972).

(16) *See e.g.,* the “Cleveland Clinic” cases: Medical Staff of Holy Cross Hospital, FTC Docket No. C-3345, 56 Fed. Reg. 49184 (1991) (consent order); Medical Staff of Broward General Medical Center, FTC Docket No. C-3344, 56 Fed. Reg. 49184 (1991) (consent order); Diran Seropian, M.D., FTC Docket No. 9248, 57 Fed. Reg. 44748 (1992) (consent order).

(17) *See e.g.*, Baltimore Metropolitan Pharmaceutical Association, Inc., FTC Docket No. D- 9262, 59 Fed. Reg. 15733 (1994).

(18) 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.

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

(20) *Id.*

(21) 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.

(22) A recent GAO study compiled the enforcement records of both federal antirust enforcement agencies. It found that, of the 397 hospital combinations for which pre-merger filings had been made between 1991 and 1993, only 28 resulted in formal "second requests" for additional information, and only 15 of those were challenged. United States General Accounting Office, Federal and State Antitrust Actions Concerning the Health Care Industry (August 5, 1994). The figures do not include combinations that did not require pre-merger filings.

(23)" American Bar Association Working Group on Health Care Reform, "Antitrust Implications of Health Care Reform" (May 14, 1993) at 4.

(24) Report of the Secretary's Task Force on Hospital Mergers, at 11 (Jan. 1993). The HHS task force specifically addressed the issue of rural hospital mergers. It found that there was no evidence that the possibility of scrutiny by the antitrust enforcement agencies adversely affected consolidation among hospitals in rural markets. The task force also found that very few such mergers are investigated, and concluded that there was "no need to exempt and therefore tacitly encourage mergers among hospitals in rural or ?small' urban settings." Id.

(25) University Health, Inc., D. 9246, 57 Fed. Reg. 44748 (1992) (consent order) (exempting a wide range of support service joint ventures). *See also* The Reading Hospital, 113 F.T.C. 285 (1990) (consent order) (the Commission determined that voluntary separation of the merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continue to participate in hospital-sponsored health plan joint ventures, and to share laundry, laboratory, and biomedical equipment repair services).

(26) If there are fewer than five of one type of specialist in the market, the venture may include one of them on a non-exclusive basis.

(27) If there are fewer than four of one type of specialist in the market, the venture may include one of them.

(28) We know of no antitrust actions brought by private parties against cooperative agreements of the kind contemplated by this proposal. 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 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).

(29) For examples of consideration of such efficiencies in particular hospital mergers, see the cases cited in n. 21, supra. *See generally* Massachusetts Bd. 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.

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

(31) *F.T.C. v. Ticor Title Insurance Co.,* 112 S.Ct. 2169 (1992).

(32) Ticor, *supra* n. 31 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.

(33) *See P.I.A. Asheville, Inc. v. North Carolina,* 740 F.2d 274, 278 (4th Cir. 1984), *cert. denied,* 471 S.Ct. 1003 (1985) (certificate of need 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 certificate of need process implemented did not displace the antitrust laws).