Antitrust Immunity for Health Care Providers in Wisconsin: The State Action Immunity Doctrine and Wisconsin's Health Care Cooperative Agreement Legislation

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ANTITRUST IMMUNITY FOR HEALTH CARE PROVIDERS IN WISCONSIN: THE STATE ACTION IMMUNITY DOCTRINE AND WISCONSIN'S HEALTH CARE COOPERATIVE AGREEMENT LEGISLATION

I. INTRODUCTION

Enforcement of federal antitrust policy in the health care industry is a source of substantial controversy as the nation attempts to reduce health care costs and to enhance access to health care services. Health care providers have identified antitrust laws as a barrier to the pursuit of collaborative activities which they believe could help to achieve these ends.¹ In response to pleas from the health care industry, the Department of Justice and the Federal Trade Commission published enforcement guidelines regarding the application of federal antitrust laws in the health care industry.² The guidelines identified “safety zones” consisting of certain types of collaborative conduct which would not trigger enforcement action by those agencies.³ However, the Clinton administration did not incorporate a permissive antitrust policy into its comprehensive health care reform plan.⁴ Accordingly, health care providers turned to the states in order to obtain exemptions from federal antitrust laws.

Under the “state action immunity doctrine” propounded by the


³. The safety zones include: 1) hospital mergers where one of the merging hospitals has less than 100 licensed beds and an average daily inpatient census of less than 40 patients; 2) hospital joint ventures involving high technology equipment if the joint venture is reasonably necessary to cover the cost and does not include a hospital or group of hospitals that could have offered a competing service; 3) physicians' provision of nonprice information to purchasers of health care services; 4) hospital participation in exchanges of price and cost information where the survey is managed by a third party, the information collected is more than 3 months old, and the price or cost data are based on data from at least 5 hospitals and aggregated so that prices charged by particular hospitals cannot be identified; and 5) joint purchasing arrangements among health care providers if the group's purchases account for less than 35% of the total purchases of the product or service, and the cost of the product or service accounts for less than 20% of each participants' total revenues. Vance, supra note 1, at 409 n.2.

United States Supreme Court in *Parker v. Brown*,⁵ state regulatory programs that authorize anticompetitive conduct in order to further a legitimate state policy do not violate the Sherman Act.⁶ In this vein, many states have enacted legislation aimed at providing antitrust immunity for certain types of cooperative agreements among health care providers by substituting regulation for competition.⁷ State legislatures enacting such legislation believe that their goals of controlling health care costs and improving the quality of and access to health care will be enhanced by allowing collaboration among providers that would otherwise be prohibited by federal antitrust laws.⁸

In order to successfully confer immunity from antitrust laws, a regulatory program must satisfy two requirements. First, the anticompetitive conduct must be clearly articulated and affirmatively expressed as state policy. Second, the program must be actively supervised by the state.⁹ While little controversy surrounds the first requirement, recent Supreme Court decisions are ambiguous regarding what constitutes "active supervision" for purposes of state action immunity.¹⁰ Accordingly, it is difficult to ascertain whether immunity granted under a state regulatory program will be upheld if challenged in court.¹¹

This ambiguity is particularly disconcerting to health care providers hoping to obtain antitrust immunity as they enter cooperative agreements under state regulatory programs. Participation in these cooperative agreements is generally voluntary and subject to approval by the state.¹² Accordingly, health care providers have little incentive to participate in such programs given the threat of litigation and the

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¹⁰. See FTC v. Ticor Title Ins. Co., 504 U.S. 621 (1992) (attempting to clarify the meaning of the two-prong test articulated in *Midcal* and discussing the purpose behind the active supervision requirement).
¹¹. See id. at 646-47 (O'Connor, J., dissenting) (discussing the lack of certainty regarding the meaning of active supervision and arguing that the majority opinion simply contributed to the uncertainty surrounding the active supervision requirement).
potential that they may be subject to treble damages should state action immunity be denied by a federal court.\textsuperscript{13} Several states have enacted legislation permitting health care providers to enter cooperative agreements that seem capable of withstanding attack under the most stringent interpretations of the active supervision requirement.\textsuperscript{14} Wisconsin is among the states that have enacted legislation providing antitrust protection for health care providers choosing to enter cooperative agreements.\textsuperscript{15} However, Wisconsin’s legislation may fail to meet the active supervision requirement under some of the most permissive interpretations.\textsuperscript{16} The Wisconsin act includes what is known as the “negative option,” whereby an application for immunity for a cooperative agreement is deemed approved unless the state denies the application within thirty days of filing.\textsuperscript{17} In \textit{Federal Trade Commission v. Ticor Title Insurance Co.},\textsuperscript{18} the United States Supreme Court specifically stated that a regulatory program approving anticompetitive conduct by negative option does not confer state action immunity.\textsuperscript{19}

Part II of this comment will provide an overview of the state action immunity doctrine and the two part test for determining whether immunity exists. Part III will discuss four state programs which appear to satisfy even the most rigorous construction of the test. Part IV will analyze the effectiveness of the Wisconsin legislation and contrast the Wisconsin legislation with similar, more successful state legislation. Finally, Part V will propose ways in which the Wisconsin legislature may amend its legislation in order to successfully provide state action immunity to health care providers entering health care cooperative agreements that it wishes to protect.

\textsuperscript{13} \textit{Ticor}, 504 U.S. at 646-47 (O’Connor, J., dissenting) (pointing out the disincentives to participating in programs purporting to confer state action immunity).

\textsuperscript{14} Some states have enacted legislation establishing comprehensive approval procedures and mandatory supervisory procedures which states and providers must follow in order to obtain and retain immunity from antitrust laws. See \textit{COLO. REV. STAT. ANN. §§ 25.5-1-501 to -505} (West Supp. 1996); \textit{KAN. STAT. ANN. §§ 65-4955 to -4961} (Supp. 1995); \textit{MINN. STAT. ANN. §§ 62J.2911–2921} (West 1996); \textit{OR. REV. STAT. §§ 442.700–760} (1995).

\textsuperscript{15} \textit{Wis. STAT. ANN. §§ 150.84–.86} (West Supp. 1995).

\textsuperscript{16} The Wisconsin legislation provides for review during the approval process and provides that immunity may be revoked if a cooperative agreement no longer satisfies the objectives of the statute. See \textit{Wis. STAT. ANN. §§ 150.84–.85} (West Supp. 1995). However, it does not provide any indication of how review subsequent to approval may occur and confers no rule making authority on any state agency. \textit{Id.}

\textsuperscript{17} \textit{Id.} § 150.85(3)(a).

\textsuperscript{18} 504 U.S. 621 (1992).

\textsuperscript{19} \textit{Id.} at 638.
II. THE STATE ACTION IMMUNITY DOCTRINE

In *Parker v. Brown*, the United States Supreme Court announced that federal antitrust laws are subject to supersession by state regulatory programs. This doctrine is recognized today as the state action immunity doctrine.

In *Parker*, the Court considered whether the Sherman Act rendered invalid a marketing program implemented pursuant to the California Agricultural Prorate Act (the "Act"). The Act authorized state officials to establish programs for marketing agricultural commodities produced within the state so as to restrict competition among growers and maintain prices in the distribution of their crops to packers. The California legislature declared that the purpose of the Act was to "conserve the agricultural wealth of the State" and to "prevent economic waste" in the marketing of the state's agricultural products. The Act authorized creation of the Agricultural Prorate Advisory Commission whose members would be appointed by the governor, confirmed by the state senate, and required to take an oath of office.

The Act further provided that the Commission may approve prorate marketing plans upon petition by ten producers in the same region for the establishment of such a plan for any commodity within that region. Furthermore, the Act mandated that approval could only be granted after a public hearing and after the Commission made economic findings that adoption of the plan would prevent agricultural waste and conserve the agricultural wealth of the state without permitting unreasonable profits for producers. The Act granted the Commission the authority to modify any proposed plan and approve it as modified. Finally, the Act imposed penalties on persons who violated the terms of an approved prorate plan.

The Supreme Court determined that while the conduct permitted by

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21. 15 U.S.C. §§ 1, 2 (1994) (prohibiting contracts and conspiracies which restrain trade as well as monopolies, attempts to monopolize, and conspiracies to monopolize).
23. *Id.* at 346-47.
24. *Id.*
25. *Id.*
26. *Id.*
27. *Id.*
28. *Id.* at 347.
the Act would violate the Sherman Act if it were organized and implemented by way of contract or conspiracy solely by private persons, the Sherman Act does not prohibit a state from approving an agreement having anticompetitive effects provided that it is implemented by legislative command and designed to further a legitimate state purpose. The Court maintained that there was nothing in the language of the Sherman Act indicating any intention to restrain state action or action directed by a state to regulate its own economy. Rather, the Court found that the purpose of the Sherman Act was to prohibit persons and corporations from engaging in unsanctioned, unsupervised conduct that restrained trade on their own initiative and under their own terms.

The Court stated that under our federalist system of government, the states are sovereign, and an "unexpressed purpose to nullify a state's control over its officers and agents" must not be read into an act of Congress. The Court concluded that California, as sovereign, imposed the restraint "as an act of government which the Sherman Act did not undertake to prohibit."

A. The State Action Immunity Doctrine Today

Since Parker, the United States Supreme Court has considered a number of cases in which defendants asserted state action immunity in defense of antitrust claims. In California Liquor Dealers Ass'n. v. Midcal Aluminum, Inc., the Court established a two-part test for determining the existence of state action immunity when legislation authorizes anticompetitive conduct by private parties. The first prong

29. Id. at 350-52.
30. Id.
31. Id.
32. Id. at 350-51.
33. Id. at 352.
36. Id. at 105. However, when a branch of a state government or a municipality, rather than a private party, claims that its conduct is protected by the state action immunity doctrine, active state supervision of anticompetitive conduct is not a prerequisite to exemption from antitrust laws. Hallie, 471 U.S. at 46-47. In Hallie, the Court stated

Where a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State. Where the actor is a municipality, there is little or no danger
of the test requires that the challenged restraint on trade be one "clearly articulated and affirmatively expressed as state policy."37 The second prong requires that the policy and ensuing conduct be "actively supervised" by the state.38

The Court in Midcal reviewed California legislation designed to permit a resale price maintenance program in the liquor industry.39 It held that the California legislation satisfied the first prong of the test because "the legislative policy is forthrightly stated and clear in its purpose to permit resale price maintenance."40 However, the Court determined that the program failed to meet the second prong of the test because California simply authorized and enforced price setting established by private parties.41

The Court found that the state did not establish price schedules, regulate the terms of contracts formed pursuant to the program, monitor market conditions, or engage in any "pointed reexamination of the program."42 Finally, the Court stated that Parker does not permit a state to grant immunity to persons who violate the Sherman Act by authorizing them to violate it or by declaring that their conduct is lawful.43

The first prong of the Midcal test has generated little controversy. However, after the Court rendered its decision in Midcal, courts have

that it is involved in a private price-fixing arrangement. The only real danger is that it will seek to further purely parochial public interests at the expense of more overriding state goals. This danger is minimal, however, because of the requirement that the municipality act pursuant to a clearly articulated state policy. Once it is clear that State authorization exists, there is no need to require the state to supervise actively the municipality's execution of what is a properly delegated function.

Id. at 47.
38. Id.
39. Id. at 99-100. In Midcal, the Court reviewed section 24866 of the California Business and Professional Code as it was then in place. The statute provided:
Each wine grower, wholesaler licensed to sell wine, wine rectifier, and rectifier shall:
(a) Post a schedule of selling prices of wine to retailers or consumers for which his resale price is not governed by a fair trade contract made by the person who owns or controls the brand.
(b) Make and file a fair trade contract and file a schedule of resale prices, if he owns or controls a brand of wine resold to retailers or consumers.
Id. at 99 n.1 (citing CAL. BUS. & PROF. CODE ANN. § 24866 (West 1964)).
40. Id. at 105.
41. Id.
42. Id. at 106.
43. Id.
struggled in interpreting the active supervision component of the test.\textsuperscript{44}
Although \textit{Midcal} articulated several possible characteristics of a valid regulatory program, the Court never affirmatively stated the amount of supervision or monitoring required to satisfy the second prong of the test.\textsuperscript{45}

The Supreme Court attempted to clarify the meaning of the active supervision requirement in \textit{Federal Trade Commission v. Ticor Title Insurance Co.}\textsuperscript{46} In \textit{Ticor}, the Court reviewed state programs permitting joint rate setting by members of the title insurance industry in Wisconsin and Montana.\textsuperscript{47}

The Court included a statement regarding the purpose behind the active supervision requirement. The Court cited its earlier decision in \textit{Patrick v. Burget},\textsuperscript{48} where it stated that the active supervision requirement is premised on the recognition that when a private party engages in anticompetitive conduct, there is a danger that the party is acting to further its own interests rather than those of the state government.\textsuperscript{49}

The Court in \textit{Patrick} sought to ensure that the state action immunity doctrine "will shelter only the particular anticompetitive acts of private parties that, in the judgement of the State, actually further state regulatory policies."\textsuperscript{50} In \textit{Ticor}, the Court proclaimed:

Our decisions make clear that the purpose of the active supervision inquiry is not to determine whether the State has met some normative standard, such as efficiency, in its regulatory practices. Its purpose is to determine whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliber-

\textsuperscript{44} See FTC v. Ticor Title Ins. Co., 504 U.S. 621, 632-40 (1992) (attempting to explain the rationale behind the two-part test and declaring that there must be active supervision in fact); Patrick v. Burget, 486 U.S. 94, 100-05 (1988) (reviewing physician peer review program and stating that only conduct that in the judgment of the state truly furthers a state regulatory purpose should be immune); North Carolina v. P.I.A. Asheville, Inc., 740 F.2d 274, 276-79 (4th Cir. 1984) (en banc) (holding that approval of certificate of need application regarding health care cooperative agreement absent evidence of subsequent supervision by state does not confer immunity from antitrust laws); General Hosps. of Humana, Inc. v. Baptist Med. Sys., Inc., 1986-1 Trade Cas. (CCH) ¶ 66,996 (E.D. Ark. 1986) (holding that approval of certificate of need application for health care cooperative agreement was sufficient to satisfy active supervision requirement).

\textsuperscript{45} \textit{Midcal}, 445 U.S. at 105-06.

\textsuperscript{46} 504 U.S. 621 (1992).

\textsuperscript{47} Id. at 638.

\textsuperscript{48} 486 U.S. 94 (1988).

\textsuperscript{49} \textit{Ticor}, 504 U.S. at 634-36 (citing Patrick v. Burget, 486 U.S. 94, 101 (1988)).

\textsuperscript{50} \textit{Patrick}, 486 U.S. at 101.
state intervention, not simply by agreement among private parties.\footnote{51}

Additionally, the Court held that the active supervision requirement should be narrowly construed.\footnote{52} The Court opined that broad interpretation of the active supervision requirement would actually restrict the states' regulatory freedom.\footnote{53} If state action immunity were broadly construed, states would open the door to private claims of state action immunity every time they engaged in any form of economic regulation.\footnote{54} However, the court believed that a narrow interpretation would ensure that state action immunity would exist only when states manifested their intention to grant immunity by carefully regulating the conduct of private parties.\footnote{55} The Court believed that a narrow construction would ensure that the states remain responsible and politically accountable for anticompetitive conduct which they may authorize.\footnote{56}

In \textit{Ticor}, the Court denied state action immunity for the Wisconsin and Montana title insurance rate setting programs.\footnote{57} The Court rejected the use of the so-called "negative option" whereby proposals by private parties are accepted unless the state chooses to veto the proposal within a specified period of time.\footnote{58} The Court maintained that the negative option creates only the "potential for state supervision," and that the mere potential of state supervision was not sufficient to confer state action immunity.\footnote{59} Similarly, the Court held that the potential for judicial review is insufficient to satisfy the active supervision requirement.\footnote{60}

The Court ultimately held that in order for state action immunity to exist, there must be active state supervision "in fact."\footnote{61} The Court denied state action immunity because the state agencies' role and participation in the rate setting program were too limited. Accordingly,
the Court concluded that no supervision in fact existed.\textsuperscript{62} The Court found that meaningful monitoring and supervision were lacking.\textsuperscript{63} For instance, in Montana the commissioner of insurance was not provided with information he requested, yet the rate filings were approved.\textsuperscript{64} In Wisconsin, information requested by the commissioner of insurance was provided after a lapse of seven years, yet the rate filing remained effective during the lapse.\textsuperscript{65} In other words, the state had the authority to conduct a meaningful review, but failed to exercise that authority.\textsuperscript{66}

The Supreme Court's decision in \textit{Ticor} fails to clarify the meaning of the active supervision requirement. The Court merely stated that there must be "supervision in fact" in that the state must exercise its regulatory power and that it must be clear that a state exercised sufficient independent judgment to ensure that the anticompetitive conduct is of a kind that will further the state's regulatory goals. However, the Court still did not define the active supervision requirement with precision.

\textbf{B. The Practical Impact of Ticor and Health Care Cooperative Agreement Legislation}

The Supreme Court's decision in \textit{FTC v. Ticor Title Insurance Co.}\textsuperscript{67} raises troubling questions for states and health care providers wishing to participate in regulatory programs purporting to confer state action immunity. Exactly what the Court meant by "supervision in fact" is subject to conflicting interpretations. Perhaps a regulatory program must include a mechanism mandating some level of ongoing monitoring by the state.\textsuperscript{68} If this is the case, the question remains as to how much. Alternatively, perhaps a comprehensive initial review and approval

\begin{itemize}
\item \textsuperscript{62} Id.
\item \textsuperscript{63} Id.
\item \textsuperscript{64} Id.
\item \textsuperscript{65} Id.
\item \textsuperscript{66} Id.
\item \textsuperscript{67} 504 U.S. 621 (1992).
\item \textsuperscript{68} See Yeager's Fuel, Inc. v. Pennsylvania Power & Light Co., 22 F.3d 1260, 1270-72 (3d Cir. 1994) (holding that state action immunity was effective because state statute required state agency to conduct annual review of conduct of private utility companies and agency conducted reviews and created report stating that regulatory goals were achieved); Vance, \textit{supra} note 1, at 417. Vance comments that \textit{Ticor} confers immunity out of "respect for ongoing supervision by the State" and that \textit{Ticor} "suggest[s] that one-time review could be insufficient." \textit{Id.} (quoting Howard Feller, \textit{The Impact of Ticor on State Legislation Authorizing Provider Collaboration}, 7 \textit{ANTITRUST HEALTH CARE CHRONICLE} No. 2 at 7 n.23 (1995)).
\end{itemize}
process is sufficient. However, it is impossible to determine what level of review is sufficient based on the Court's opinion. Furthermore, the cases decided in the federal courts since Ticor provide little guidance, particularly if applied to the health care industry.

Clearly, this uncertainty presents perplexing problems for states wishing to establish regulatory programs granting state action immunity for health care cooperative agreements and the health care providers who may choose to participate. The result may be that states refrain from establishing programs and health care providers refrain from participating due to a fear that the state action immunity may be denied by a federal court.

From the standpoint of the states, they may clearly articulate a policy authorizing certain forms of anticompetitive behavior and establish a system to regulate that behavior, only to have a federal court hold that the supervision was insufficient. Health care providers, on the other hand, may choose to participate in a program which is found by a federal court to provide inadequate supervision and thereby be subjected to

69. See Praxair, Inc. v. Florida Power & Light Co., 64 F.3d 609, 612 (11th Cir. 1995) cert denied, 116 S. Ct. 1678 (1996) (holding that agency approval of agreement by private utility companies constituted an order of the agency and, therefore, satisfied the active supervision requirement); Clary, supra note 8, at 139 (concluding that "[t]he cases do not hold that the state action doctrine generally requires comprehensive ongoing supervision over conduct that already has been approved in fact by a State before implementation.").

70. See cases cited supra notes 68-69. Furthermore, one commentator recognized that these decisions may be of little help to members of the health care industry because many of them involve regulation of agreements between utility companies, which are normally subject to extensive state regulation in the first place. See Vance, supra note 1, at 417. Cases decided since the publication of that article present the same problem because they also involve regulation of agreements between utility companies. See Praxair, 64 F.3d at 609; Columbia Steel Casting Co., v. Portland Gen. Elec. Co., 60 F.3d 1390 (9th Cir. 1995); Yeager's Fuel, 22 F.3d at 1260. However, two pre-Ticor cases interpreted the active supervision requirement with respect to health care cooperative agreements and those courts reached opposite conclusions as well. See North Carolina v. P.I.A. Asheville, Inc., 740 F.2d 274, 278 (4th Cir. 1984) (en banc) (holding that approval of certificate of need application regarding health care cooperative agreement absent evidence of subsequent supervision by state does not confer immunity from antitrust laws); General Hosps. of Humana, Inc. v. Baptist Med. Sys., Inc., 1986-1 Trade Cas. (CCH) ¶ 66,996 (E.D. Ark. 1986) (holding that approval of certificate of need application was sufficient to satisfy active supervision requirement).

71. See FTC v. Ticor Title Ins. Co., 504 U.S. 621, 646-47 (1992) (O'Connor, J., dissenting) (stating general proposition that majority opinion generates such uncertainty regarding the active supervision requirement that individuals in any industry may be frightened to participate in such programs).

72. Id.

73. Id.
treble damages. Consequently, participation may be an incredibly risky venture.

III. STATE HEALTH CARE COOPERATIVE LEGISLATION AND THE STATE ACTION IMMUNITY DOCTRINE

During the past decade, governmental bodies have struggled to find mechanisms to reduce the cost of health care and enhance patient access to health care services while maintaining a high quality of service. The federal government has expressed a desire to reduce costs through increased competition. However, members of the health care industry believe that a policy favoring collaboration, rather than competition, provides the best means for achieving efficiency and containing costs in the health care arena.

For example, some may find that collaboration among a community's hospitals may result in each hospital specializing in certain services and achieving more efficient delivery of those services. Additionally, in situations where two or more hospitals need to acquire expensive equipment, it may be cost effective for the hospitals to purchase the equipment pursuant to a joint agreement. In this case, a community may benefit from access to medical technology that could be cost prohibitive if each hospital had to purchase its own equipment.

Despite the fear engendered by the ambiguities contained in Midcal and Ticor, at least eighteen states have enacted legislation granting state action immunity to health care providers entering into various cooperative agreements. Given the vagary of the Supreme Court's opinions in those cases, there is no guarantee that the immunity conferred will be effective. However, several states have drafted legislation in a manner that maximizes the probability that a grant of state action immunity will withstand judicial scrutiny. For purposes of

74. Id.
75. See generally Blumstein, supra note 4.
76. Id. at 1461.
77. See Vance, supra note 1.
79. Id. at 132.
80. Id.
83. See Blumstein, supra note 4, at 1463 n.15 (citing U.S. GENERAL ACCOUNTING OFFICE, HEALTH CARE: FEDERAL AND STATE ANTITRUST ACTIONS CONCERNING THE HEALTH CARE INDUSTRY, at 10 (August 1994)).
this comment, the legislation enacted by Minnesota, Colorado, Kansas, and Oregon shall serve as models.\textsuperscript{84}

The unifying feature of these statutes is that they address each concern raised by the Court in \textit{Midcal} and \textit{Ticor} with respect to determining compliance with the two prong test.\textsuperscript{85} To begin with, each of these statutes clearly provides a state policy of permitting health care providers to form cooperative agreements that will improve the nature of health care services available within the respective states in satisfaction of the first prong of the test.\textsuperscript{86}

Although there is variation between these states regarding the

\begin{itemize}
\item The relevant concerns are: 1) that the state clearly articulates and affirmatively expresses a state policy of replacing competition with regulated cooperation; 2) that the state regulates the terms of the provider cooperative agreements; 3) that the state engages in meaningful reexamination of programs after they are implemented; 4) that the overall legislative scheme demonstrates that the states exercise sufficient independent judgement and control to ensure that anticompetitive conduct is the product of deliberate state intervention; and 5) that the supervision provided for is in fact carried out. \textit{See Ticor}, 504 U.S. at 633-38; \textit{Midcal}, 445 U.S. at 105-06.
\item Minnesota's statute provides that "the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by cooperative arrangements involving providers or purchasers that might be prohibited by state and federal antitrust laws if undertaken without government involvement." MINN. STAT. ANN. § 62J.2911 (West 1996). Likewise, the Colorado statute provides that:

Federal and state antitrust laws have inhibited the formation of cooperative health care agreements involving hospitals. However, such cooperative agreements are likely to foster improvements in the delivery, quality, or cost effectiveness of health care and improve access to needed services . . . . The general assembly hereby determines that a limited exemption and immunity from the antitrust laws would encourage the development of such health care agreements, to the benefit of the citizens of the state of Colorado.


Similarly, in granting state action immunity, the Kansas legislature proclaimed that, "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, avoid duplication of resources and improve access to needed services in rural areas of Kansas." KAN. STAT. ANN. § 65-4955(b) (Supp. 1995).

Finally, the Oregon legislation provides:

The Legislative Assembly finds that direct competition among health care providers in the field of heart and kidney transplant services may not result in the most cost efficient and least expensive transplant services for the citizens of this state and that it is in the public interest to allow cooperative programs among health care providers providing heart and kidney transplant services.

manner in which each attempts to satisfy the active supervision requirement, there are some common threads. First, these states have adopted comprehensive approval procedures and none provide for approval by negative option.\textsuperscript{87} Second, all four states mandate substantial supervision following approval by requiring that approved agreements be reviewed annually by the state.\textsuperscript{88} Finally, failure to comply with the terms of the agreement or terms of a state order constitute grounds for revocation of antitrust immunity.\textsuperscript{89}

Generally, to obtain state action immunity in Minnesota, Colorado, Kansas, or Oregon, health care providers intending to enter into a cooperative agreement must submit an application that complies with the state’s health care cooperative agreement statute to the designated state agency or board for approval.\textsuperscript{90} The agency or board evaluates the proposed agreement to determine whether operation of the agreement is likely to improve the cost effectiveness, availability, quality, or delivery of hospital or health care services in the state. Then, within a specified period of time, the decision-making body must render a decision in writing either approving or denying the agreement and setting forth the reasons for its decision.\textsuperscript{91} Furthermore, each state requires that any amendment to an approved cooperative agreement be evaluated by the


\textsuperscript{91} KAN. STAT. ANN. § 65-4957 (West 1995); OR. REV. STAT. § 442.710 (1995). Minnesota follows a more complicated procedure. Following a notice and comment period an application to enter a cooperative agreement will be evaluated in one of three ways. MINN. STAT. ANN. § 62J.2916 (2) (West 1996). The Commissioner may issue a written decision on the record, as is the case in Kansas and Oregon. \textit{Id}. Alternatively, the Commissioner may hold a limited hearing at which the applicant may be questioned regarding the agreement. \textit{Id}. The statute also provides that the Commissioner may require, and the applicant may demand, a contested case hearing which shall be tried before an administrative law judge. \textit{Id}. Similarly, Colorado requires the board which reviews proposed agreements to officially publish notice and to conduct a public hearing. COLO. REV. STAT. ANN. § 25.5-1-505(2) (West Supp. 1996).
Filing an agreement with the appropriate agency or board before taking effect. Finally, each provides the decision making body the power to modify an agreement on its own accord.\textsuperscript{92}

Additionally, each of these states requires that all approved cooperative agreements be reviewed annually.\textsuperscript{93} However, the states differ with respect to how such review shall occur.

Minnesota requires that parties to approved cooperative agreements submit data as specified by the Commissioner of Health at least once a year so that the Commissioner may determine whether the agreements continue to enhance the quality, cost effectiveness, and access to health care.\textsuperscript{94} Colorado requires the Cooperative Health Care Agreements Board to promulgate rules requiring the parties to any approved cooperative agreement to submit annual reports that provide information reasonably necessary to enable the board to evaluate the impact of the agreement on the availability, cost effectiveness, quality, and delivery of hospital or health care services and to determine whether such parties have complied with the terms of the agreement and with the order of the board approving such terms.\textsuperscript{95}

Likewise, Kansas requires that the Secretary of Health and the Environment review all approved cooperative agreements annually to determine whether their operation continues to satisfy the purpose of the legislation.\textsuperscript{96}

Finally, Oregon requires the Director of the Department of Health and Human Resources to establish a board of governors to govern each individual cooperative program that the Director approves.\textsuperscript{97} The board must submit annual reports to the Director within sixty days of each anniversary date of the Director's approval of the cooperative agreement.\textsuperscript{98} Then, the Director must decide whether to reapprove, modify, or revoke approval within sixty days of receipt of the report.\textsuperscript{99} In order for the cooperative agreement to remain effective, the Director must find that operation of the agreement is achieving the goals set forth

\textsuperscript{94} MINN. STAT. ANN. § 62J.2920 (West 1996).
\textsuperscript{95} COLO. REV. STAT. ANN. § 25.5-1-508 (West Supp. 1996).
\textsuperscript{96} KAN. STAT. ANN. § 65-4958 (Supp. 1995).
\textsuperscript{97} OR. REV. STAT. § 442.720 (1995).
\textsuperscript{98} Id. § 442.725.
\textsuperscript{99} Id. § 442.730.
by the legislature and that it remains necessary to achieve those goals.100

These statutes also address the issue of political accountability. For instance, Colorado requires that health care cooperative agreements gain approval by a board which is appointed by the governor and subject to consent by the state senate.101 Colorado also requires the board to publish public notice and conduct a public hearing before approving a proposed agreement.102 Similarly, the Kansas statute establishes a committee of health care providers to advise the Secretary of Health and the Environment on matters concerning the administration of its health care cooperative agreement program.103 The statute dictates that the committee be composed of five members.104 The governor, the speaker of the house of representatives, the house minority leader, the president of the senate, and the senate minority leader shall each be permitted to appoint one member of the committee.105 Additionally, Oregon establishes a complaint procedure whereby any person may file a complaint with the Director of Health and Human Resources requesting that any decision of a cooperative program supervised by the Director be reversed or modified.106

Minnesota goes a step further and requires that the Commissioner of Health conduct extensive notice and comment procedures both before and after approval of any health care cooperative agreement.107 Before the Commissioner may evaluate an application, the Commissioner must publish notice of the application and its contents in the State Register and provide the same information to the Minnesota Health Care Commission, the regional coordinating boards for any regions affected by the proposed agreement, and anyone else who requests notice of the application.108 Also, the Commissioner must accept comments filed by interested persons within twenty days of publication of the notice.109 Finally, the Commissioner must conduct the notice and comment procedure at two-year intervals following approval of an application in

100. Id.
102. Id. § 25.5-1-505(2).
104. Id.
105. Id.
108. Id. § 62J.2915.
109. Id.
order to solicit comments from the public concerning the impact the
arrangement has had on the cost, access to, and quality of health
care.\footnote{Id. § 62J.2920 (West 1996).}

Each statute discussed above maximizes the probability that approval
of a health care cooperative agreement by the state will in fact result in
state action immunity for the parties entering the agreement. In each
instance, the state legislature specifically addressed the concerns raised

First, the state policy objectives are “forthrightly stated and clear in
[their] purpose.”\footnote{See id. at 105; statutes cited supra note 86.} Second, each statute requires that the appropriate
state agency or decision-making body participate in and regulate the
establishment of health care cooperative agreements.\footnote{445 U.S. at 106. \textit{See also} statutes cited supra notes 90-91.} Third, each
statute mandates “pointed reexamination” of approved cooperative
agreements to ensure that they continue to carry out the State’s goals as
articulated in the statute.\footnote{445 U.S. at 106. \textit{See also} statutes cited supra notes 93-100.} Fourth, each regulatory scheme goes to
great length to ensure that state actors exercise independent judgment
to make sure that operation of the agreements fulfills the will of the
states and not just the will of the parties to the agreement.\footnote{Ticor, 504 U.S. at 634-36. \textit{See also} statutes cited supra note 90.} Fifth,
each statute makes ongoing supervision mandatory to ensure that
“supervision in fact” does in fact occur.\footnote{Ticor, 504 U.S. 637-38. \textit{See also} statutes cited supra notes 93-100.} Finally, each includes
measures to make members of the state government politically account-
able for their endorsement of the cooperative agreements.\footnote{Ticor, 504 U.S. at 636. \textit{See also} statutes cited supra notes 101-10.}

Thus, health care providers in these states will face considerably less
risk should they choose to participate in these programs. Accordingly,
there is a greater chance that the statutes in these states will succeed in
achieving the legislatures’ goal of inducing collaboration among health
care providers to the benefit of the citizens of their states.

IV. WISCONSIN LEGISLATION REGARDING HEALTH CARE COOPER-
ATIVE AGREEMENTS

Wisconsin has also enacted legislation designed to encourage health
care providers to enter cooperative agreements promising to improve the
nature of health care within the state. On April 27, 1992, Wisconsin Governor Tommy Thompson signed into law 1991 Wisconsin Act 250.\textsuperscript{119} The Act included provisions intended to grant health care providers that voluntarily enter cooperative agreements with other health care providers immunity from federal and state antitrust laws.\textsuperscript{120} However, the statute may fail to encourage any substantial collaboration among health care providers.\textsuperscript{121}

In Wisconsin, health care providers entering cooperative agreements who wish to obtain immunity from antitrust laws must obtain a certificate of public advantage from the Department of Health and Social Services (the "DHSS").\textsuperscript{122} In order to obtain a certificate of public advantage, the parties to the agreement must file an application with the DHSS.\textsuperscript{123} The application must include a signed copy of the proposed agreement and a statement describing the nature and scope of the cooperation contemplated.\textsuperscript{124} If the DHSS does not deny the application within thirty days, the application is approved.\textsuperscript{125} However, if the DHSS denies the application it must issue a statement to the applicants in writing setting forth the reasons for the denial and provide the applicants an opportunity for a hearing.\textsuperscript{126}

The criteria which the DHSS shall use to determine whether it will award a certificate of public advantage are similar to those used by Minnesota, Colorado, Kansas, and Oregon to determine whether to

\textsuperscript{119} Wisconsin Legislative Council, Information Memorandum 92-21, at 19 (July 29, 1992).

\textsuperscript{120} Id. at 20. The provisions regarding health care cooperative agreements are codified at Wis. Stat. Ann. §§ 150.84-.86 (West Supp. 1995). These provisions became effective on May 12, 1992.

\textsuperscript{121} It may be particularly difficult for health care providers in Wisconsin to ascertain the amount of supervision required to withstand scrutiny in the Seventh Circuit. There have been very few decisions rendered by the Seventh Circuit interpreting the active supervision requirement where private actors are involved. However, one published decision indicates that the Seventh Circuit will carefully scrutinize the amount of state supervision present before finding that state action immunity exists for private parties participating in state regulatory programs. See Fuchs v. Rural Electric Convenience Coop. Inc., 858 F.2d 1210, 1213 (7th Cir. 1988) ("[P]rivate actors may be held liable under the antitrust laws unless they are acting pursuant to a 'clearly articulated and affirmatively expressed' state policy to displace competition, and that policy is subject to 'active supervision' by the state itself.") (citing Liquor Corp. v. Duffy, 479 U.S. 335 (1987)).


\textsuperscript{123} Id. § 150.85(2).

\textsuperscript{124} Id.

\textsuperscript{125} Id. § 150.85(3)(a).

\textsuperscript{126} Id. § 150.85(3)(b).
confer antitrust immunity. The DHSS will issue a certificate of public advantage if it finds that the improvement in quality, access to, utilization of, or cost effectiveness of health care likely to result from operation of the cooperative agreement substantially outweighs the disadvantages associated with a reduction in competition. With respect to revocation of a certificate of public advantage, the DHSS may revoke the certificate if it finds that the benefits of the reduction in competition no longer outweigh the disadvantages.

The Wisconsin legislation, however, has problems that indicate that the antitrust immunity granted by the statute may be illusory. Although the policy objectives and purpose are sufficiently clear to satisfy the clear articulation component of the *Midcal* test, the statute fails to ensure that there will be enough government supervision of the parties to cooperative agreements to satisfy the active supervision component of the test.

Although there are similarities between the Wisconsin statute and those examined in Part II, the Wisconsin statute is far less likely to

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127. The Wisconsin statute provides that DHSS shall issue a certificate of public advantage if the benefits likely to result from the agreement substantially outweigh the disadvantages attributable to a reduction in competition. *Id.* § 150.85(4)(a)(1). In order to make this finding, the commissioner must find that one of the following conditions exist:

1. The quality of health care provided to residents of the state will be enhanced. 
2. 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.
3. Services provided by the parties to the cooperative agreement will gain cost efficiency.
4. The utilization of health care resources and equipment in the area likely affected by the cooperative agreement will improve.


130. The statute itself only states that issuance of a certificate of public advantage provides immunity from state antitrust laws included in chapter 133 of the Wisconsin statutes. *See Wis. STAT. ANN.* § 150.85(1) (West Supp. 1995). However, the report of the Wisconsin Legislative Council published subsequent to the enactment of the statute indicates that the legislature intended to confer immunity from federal antitrust laws under the state action immunity doctrine as well. Wisconsin Legislative Council, Information Memorandum 92-21, at 19 (July 29, 1992). Furthermore, the criteria for approval of an application for a certificate of public advantage clearly indicate that the legislature recognized the potential for a reduction in competition. *Wis. STAT. ANN.* § 150.85(4) (West Supp. 1995).
successfully confer state action immunity on those who obtain certificates of public advantage. The statute simply does not dispel the concerns raised by the Supreme Court in *Ticor* and *Midcal* as effectively as the statutes enacted by Minnesota, Colorado, Kansas, and Oregon. Essentially, the Wisconsin statute, on its face, does far less to ensure that the state will actively supervise the operation of approved health care cooperative agreements.

Specifically, Wisconsin's legislation contains at least one fatal flaw. The statute provides that unless the DHSS denies an application for a certificate of public advantage within thirty days of filing, the application is automatically approved. This is substantially the same negative option provision that the Court rejected in *Ticor*. In *Ticor*, the court found that approval of a rate setting scheme as a function of state inaction was insufficient to satisfy the active supervision component of the *Midcal* test.

According to *Ticor*, the existence of this provision raises questions as to the extent that the state will participate in the structuring of the agreements. As the Court stated, the negative option only establishes the potential for state regulation. Hence, a court would most likely find that there is no assurance that the DHSS affirmatively determines whether health care cooperative agreements will further the state's regulatory goals. Accordingly, so long as the Wisconsin statute contains this provision, it is probably destined to fail.

In addition to the negative option problem, the Wisconsin statute has other deficiencies which may inhibit its effectiveness. First, the statute does not require the DHSS to engage in any "pointed reexamination" of previously approved arrangements to ensure that their operation continues to carry out the will of the legislature. Unlike the statutes discussed above, the Wisconsin statute includes no provision requiring that parties to cooperative agreements submit data to the DHSS so that it may evaluate whether the benefits resulting from a cooperative

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133. See discussion supra Parts II.A., III.
136. *Id.*
137. *Id.* *Ticor*, however, dealt with state participation and supervision of a rate-setting program in the title insurance business. See discussion supra Part II.A.
138. 504 U.S. at 638.
139. See discussion supra Part II.A-B.
140. See discussion supra Part II.A-B.
agreement continue to outweigh the disadvantages associated with the reduction in competition.\textsuperscript{141} The statute merely allows the DHSS to revoke a certificate of public advantage; however, it provides the department no means of obtaining any information once a certificate has been issued.\textsuperscript{142}

Nor does the statute provide any measure of political accountability. The statute does not direct the Governor or Secretary of the DHSS to appoint a board to supervise the operation of health care cooperative agreements as do the statutes currently in place in Colorado and Kansas.\textsuperscript{143} Additionally, the statute provides no complaint procedure or notice and comment procedure so that the public may have an opportunity to express its views on the utility of health care provider arrangements.\textsuperscript{144} Currently, the statute only allows holders of and applicants for certificates of public advantage to contest revocation and denial.\textsuperscript{145}

Given the problems discussed above, it is unlikely that state action immunity under the Wisconsin statute would be upheld if attacked in a federal court.\textsuperscript{146} Health care providers will undoubtedly recognize these problems and realize that it is not in their best interests to expose themselves to the danger of federal antitrust liability. Unless the legislature amends the statute so that it affords health care providers a greater degree of certainty that obtaining a certificate of public advantage will in fact provide immunity from federal antitrust laws, providers will refrain from engaging in cooperative arrangements. Until that time, cooperative agreements among health care providers cannot be an effective tool for improving the delivery of health care in this state.

\textsuperscript{141} See discussion supra Part II.
\textsuperscript{142} WIS. STAT. ANN. § 150.85(5)(a) (West Supp. 1995).
\textsuperscript{143} See discussion supra Part II.
\textsuperscript{144} See discussion supra Part II.
\textsuperscript{145} WIS. STAT. ANN. § 150.85(5)(a) (West Supp. 1995).
\textsuperscript{146} Prior to Ticor, two federal courts evaluated regulatory programs governing health care cooperative agreements purporting to confer state action immunity upon issuance of a certificate similar to the Wisconsin legislation and reached opposite conclusions. However, neither confronted a situation involving the use of the negative option present in Wisconsin. See North Carolina v. P.I.A. Asheville, Inc., 740 F.2d 274, 278 (4th Cir. 1984) (en banc) (holding that issuance of certificate of need regarding health care agreement, absent evidence of subsequent supervision by state, does not confer state action immunity); but see General Hosps. of Humana, Inc. v. Baptist Med. Sys., Inc., 1986-1 Trade Cas. (CCH) ¶ 66,996 (E.D. Ark. 1986) (holding that approval of certificate of need application was sufficient to satisfy active supervision requirement).
V. A PROPOSAL TO AMEND WISCONSIN'S HEALTH CARE COOPERATIVE AGREEMENT STATUTE

As discussed in Part II of this comment, a state legislative scheme purporting to confer immunity from federal antitrust laws must dispel the concerns raised in *Federal Trade Commission v. Ticor Title Insurance Co.* and *California Liquor Dealers Ass'n v. Midcal Aluminum, Inc.* in order to assure its effectiveness. Accordingly, the goal of this proposal is to present an alternative that incorporates components of the legislation enacted by Minnesota, Colorado, Kansas, and Oregon and address the concerns expressed in *Ticor* and *Midcal* with respect to both the clear articulation and active supervision requirements.

A. Clear Articulation of Legislative Purpose

As currently drafted, the Wisconsin health care cooperative agreement statute does not explicitly state that approval of an application for a certificate of public advantage confers immunity from federal antitrust laws. However, the report issued by the Wisconsin Legislative Council indicates that the legislature did in fact intend to provide immunity from federal antitrust laws. If this is the legislature's intention, it should say so. Accordingly, the statute should be amended to include statements demonstrating that the legislature believes that cooperation among health care providers has the potential to reduce costs and improve the quality of health care in Wisconsin, and that issuance of a certificate of public advantage confers immunity from federal antitrust laws.

B. Active Supervision

As discussed in Part IV above, the Wisconsin health care cooperative agreement legislation raises questions regarding whether the state will exercise sufficient control over cooperative agreements among health care providers to assure immunity from federal antitrust laws. The amendments recommended below could help provide assurance to health care providers that immunity conferred through issuance of a certificate

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First and foremost, the legislature must do away with the negative option provision. In *Ticor*, the United States Supreme Court unequivocally stated that approval of anticompetitive conduct by negative option does not provide state action immunity. Therefore, Wisconsin should include an amendment requiring the DHSS to issue a written decision articulating findings that it believes operation of a cooperative agreement will help to satisfy the goals of the statute each time it grants a certificate of public advantage. Such an amendment would also ensure that the DHSS only grants certificates of public advantage following deliberation and for conduct that it believes is deserving of immunity.

Second, the legislature should incorporate a provision mandating periodic review of the effects of cooperative agreements after a certificate has been issued. Minnesota's statute provides what appears to be a flexible and effective alternative. Under the Minnesota statute the Commissioner of Health must review annually the manner in which approved cooperative agreements affect the cost, quality, and access to health care in the areas which they operate. However, the statute allows the Commissioner to determine the information that providers must disclose on a case by case basis. Accordingly, the statute makes sure that the state conducts a "pointed re-examination" of the conduct that it has authorized, yet provides the Commissioner the discretion to tailor his or her evaluation such that it is relevant to the circumstances of individual cases.

Third, Wisconsin should place some degree of political accountability on the state actors involved. An amendment requiring the governor or the legislature to appoint a committee comprised of experts in the health care field to advise the DHSS regarding the usefulness of cooperative agreements both before and after approval may help to achieve this end. This committee should be granted the authority to

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151. 504 U.S. at 638.
152. *See* discussion *supra* Part II.A., Part III.
154. *Id.*
155. *Id.*
156. *See* Ticor, 504 U.S. at 636-37.
157. *See* COLO. REV. STAT. ANN. § 25.5-1-504 (West Supp. 1996) (requiring the governor to appoint a committee to rule on applications and promulgate rules regarding annual review of approved health care cooperative agreements); KAN. STAT. ANN. § 65-4961 (1995) (creating a committee to be appointed by the governor and members of legislature to advise the Secretary of Health and the Environment on matters related to health care cooperative agreements).
promulgate rules governing the operation of health care cooperative agreements in the future, in the event that the need for a more comprehensive regulatory program arises. Additionally, the committee should be required to conduct some form of a notice and comment procedure prior to approval of an agreement and at two-year intervals following issuance of a certificate of public advantage so that the public may express its views regarding the impact of the operation of cooperative agreements among health care providers. Finally, the statute should include a complaint procedure that allows citizens harmed by the operation of a cooperative agreement to be heard in addition to applicants who are denied certificates of public advantage.

Incorporation of these or similar amendments would increase the probability that a federal court would hold that Wisconsin's health care cooperative agreement legislation confers immunity from federal antitrust laws. Accordingly, such amendments would provide health care providers greater incentive to pursue cooperative arrangements with one another, and, therefore, provide the state with the opportunity to see if cooperation among health care providers can in fact reduce the cost, improve efficiency, and increase access health care in Wisconsin.

VI. CONCLUSION

Some commentators do not believe that such stringent statutory requirements as discussed above are necessary to confer state action immunity under Ticor. However, the Supreme Court's pronouncements on the active supervision requirement in Ticor are vague. Furthermore, decisions rendered by the lower federal courts on this issue are inconsistent.

Health care providers could be subjected to treble damages if they choose to enter cooperative agreements and state action immunity under the statute is denied by a court. If Wisconsin wishes to encourage collaboration among health care providers by providing immunity from federal antitrust laws, enacting legislation that addresses each concern raised in Ticor provides the greatest assurance that the immunity granted will be meaningful. Accordingly, amending the statute may provide the

159. See Clary, supra note 8, at 139.
160. See discussion supra Part II.B.
161. See cases cited supra notes 68-70, 146.
only effective means of inducing health care providers to enter cooperative agreements.

Implementation of a program to conduct thorough review of health care cooperative agreements and meaningful notice and comment procedures will consume substantial state resources. Therefore, Wisconsin should embark upon the process of amending its legislation and implementing such comprehensive programs only if the state truly intends to make antitrust immunity for health care providers entering cooperative agreements with one another a component of its health care reform program. Hopefully, this comment will induce members of the state government to evaluate the state’s position on health care cooperative agreements, and amend the law accordingly if the state wishes to employ the tool of state action immunity in its health care reform program.

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