HEALTH INSURANCE PURCHASING ALLIANCES: MONOPSONY THREAT OR PROCOMPETITIVE Rx FOR HEALTH SECTOR ILLS?

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INTRODUCTION

In the fall of 1993 the White House Task Force on Health Care Reform promoted health insurance purchaser alliances as competition-stimulating engines to drive the President’s ambitious plans to restructure the health care sector.¹ These alliances would have consolidated the purchasing power of the nation’s employers, who would have been required to provide health insurance to virtually all of their employees.² The Administration intended these large, state-based buyer coalitions to apply powerful competitive pressures to health insurers. Insurers would then be forced to exert pressure derivatively

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² Id. § 1601.
on providers, who would be compelled to compete vigorously for insurer contracts. This competition would force providers to improve the efficiency of health service delivery. The alliance concept thus allowed President Clinton to assure the country with a straight face that we could achieve universal coverage without (much) need for increased health care spending.

 Barely half a year later, political last rites were administered to the mandatory alliance notion. By July of 1994 the Congressional leadership had informed the President that the Task Force proposal was effectively dead, and by September even the President had thrown in the towel on health reform. An electorate both weary and wary of big government seemed all too eager to accept the allegations of providers, insurers, and others wedded to the status quo that alliances would add a threateningly interventionist layer of bureaucracy to an already complex health care delivery system. The Task Force's turgid 107-page description of alliances and their functions made it absurdly easy for opponents to portray them as a costly and unwarranted bureaucratic obstacle likely to impede patient access to affordable medical services. The public apparently never understood that buyer coalitions were the primary cost containment mechanism of the Clinton plan: Without them Americans could never achieve universal

3 The Administration proposal set forth two forms of purchasing alliances. Regional alliances would be nonprofit organizations, independent state agencies, or agencies of the state. HSA, supra note 1, Title I, Subtitle D, Subpart A, § 1301. Corporate alliances could be sponsored by employers having in excess of 5000 employees, by multiemployer plans covering in excess of 5000 active participants, or by rural cooperatives. Id. Subpart B, § 1311.

4 Clinton Alliances Considered Dead As Democrats Accept Voluntary Pools, 2 Health Care Pol'y Rep. (BNA) 20 (May 16, 1994).


6 See Robert E. Patricelli, Managed Care Perspectives: Why Do We Need Health Alliances?, 13 HEALTH AFF., 239 (Spring 1994).

7 HSA, supra note 1, Title I, Subtitle D, at 114-221. The proposed legislation is not altogether clear about whether alliances would actually purchase insurance for employers, although clearly they would be expected to negotiate the terms and content of purchasing.

8 For example, Alan Katz, former President of the California Association of Health Underwriters, characterized alliances as follows: "From a consumer's point of view the alliances are a Frankenstein monster, the result of stitching together the worst aspects of the public and private sector: bureaucracies and monopolistic cartels. Both lack the incentive to be either cost effective or consumer-friendly." Alan Katz, L.A. TIMES, Feb. 10, 1994, Letters to the Times, at B6.

 Some economists also argued that regional alliances might drive price below marginal cost, reducing health services in the long run because suppliers would leave the market. Warren Greenberg, Monopsony Power and Managed Competition: Do Regional Alliances Make Sense?, 1 J. OF SUBACUTE CARE No. 2, at 37, 40 (1994).
coverage and still escape paying much higher health insurance premiums or taxes or both.\(^9\)

The alliance concept may have perished as a mandatory element of reform on the national level, but its local influence is far from moribund. Many states have enacted legislation designed to spur the creation of health insurance purchaser pools, particularly among small businesses.\(^{10}\) This aggregated purchasing allows companies to maximize their bargaining leverage with insurers. Consequently, an increased percentage of the work force in those states encouraging purchasing pools will theoretically be covered by health insurance offered through their employers, which means that fewer residents will end up on state Medicaid rolls. Even without facilitating legislation, employers throughout the country have voluntarily begun pooling and analyzing information, and coordinating lobbying and purchasing activity.\(^{11}\)

Such recent insurance-purchaser collaboration is a case study of reorganization in the shadow of threatened structural reform. (It also reflects a more sophisticated purchaser appreciation for the economic advantages of collaboration in reducing an input to the cost of labor.) The prospect of government-mandated change spurred a primarily private-sector response that sought the same economic benefits as the proposed federal revisions.\(^{12}\) To the extent that these voluntary state and private-sector initiatives can successfully contain costs while maintaining an acceptable quality of care, the need for federal intervention will diminish accordingly. The access issue may still justify comprehensive national reform, but in the interim, voluntary collaboration among health insurance purchasers will probably become routine.\(^{13}\)

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\(^9\) The price controls set forth in the Administration proposal would have been triggered only in the event that alliances were unable to keep premiums relatively low. HSA, *supra* note 1, Title VI, Subtitle A.

\(^{10}\) See *infra* text accompanying notes 42-64.

\(^{11}\) See, e.g., Charles Stein, *HMO Rate Freeze Sought*, *Boston Globe*, May 27, 1994, at 81 (describing collaborative health care purchasing in Massachusetts); *Health Purchasing Coop System Proposed by State Attorney General*, 3 Health Law Rep. (BNA) 184 (Feb. 10, 1994) (Massachusetts attorney general proposes health insurance purchasing cooperatives for businesses with fewer than 100 employees).


\(^{13}\) Cf. Charles E. Mueller, *Presidency at Risk from an Antitrust Blunder? Health-Care “Consolidation” Poses a ’96 Price Disaster*, 25 *Antitrust & Econ. Rev.* 1 (1994) (arguing that President Clinton’s “consolidation strategy” for the health sector will be counterproductive because doctors and hospitals will consolidate into giant, inefficient provider entities in response to aggregated purchaser power).
Antitrust concerns figured prominently in the immediate and intense political backlash against mandatory alliances. These alliances were portrayed as monopsonistic behemoths that would inevitably coerce health care insurers and providers into restricting necessary services because they would have sufficient power to push prices below competitive levels. Many providers would consequently be forced to exit the market, while those that remained would be compelled to reduce costs at the expense of quality. Some observers therefore asserted that the mandatory purchasing pools should be considered anticompetitive, even though most of them were to operate behind a governmental facade. Antitrust theory provided an expedient instrument for attacking alliances, for it condemns not just agreements among competitors that unlawfully restrain trade, but also the illegal acquisition of monopsony power. At first glance, buyer coalitions look suspiciously like vehicles through which competing purchasers can collude to lower the price they have to pay for health insurance. Moreover, the larger the coalition, the easier it is to characterize its behavior as monopsonistic.

Since huge regional or corporate alliances would have been virtually the only negotiators for health insurance under the Clinton plan, they clearly would have wielded considerable market power. Doctors and hospitals therefore demanded a level antitrust playing field as a matter of fairness. They sought to defend their economic interests by claiming the right to negotiate collectively on price and other issues, even when they ordinarily competed with one another for the same business from the identical insurers and patients. The Task Force implicitly acknowledged the impact of mandatory alliance

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14 Potential for Monopsony Raised by Health Alliances Under Reform Plan, 1 Health Care Pol'y Rep. (BNA) 466 (May 10, 1993).
15 See discussion on implied immunity and the state action exemption infra part IV.B.
17 Id. § 2.
19 Brian McCormick, Managed Care and Medicine in ‘Fairness’ Fight, AM. MED. NEWS, May 9, 1994, at 1.
purchasing muscle on providers not aligned with a health service network to represent them in negotiations with the insurance industry, and threw them an antitrust bone. The administration’s bill permitted those providers choosing to participate in fee-for-service health insurance plans to bargain collectively with regional alliances for fee schedules, purportedly protected from antitrust exposure.

Antitrust liability also lurks as a possible threat to the cooperative efforts of those health insurance buyers who elect on their own to share information, analyze data, lobby, and participate in purchasing syndicates. Such voluntary collective buyer activity presents at least a theoretical risk of violating the Sherman Act’s prohibitions on collusion in restraint of trade. Moreover, so long as

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21 Fee-for-service insurance was expected to be elected by only a small minority of Americans because it was predicted to be more expensive than other plans.

22 HSA, supra note 1, Title I, Subtitle D, § 1322(c)(2)-(7). This convoluted section does not grant antitrust immunity directly, but purports to define certain collective provider activity concerning price as state action, so as to piggyback on the exemption created by the judiciary in Parker v. Brown, 317 U.S. 341 (1943) for state economic regulation. Such doctrinal manipulation by Congress subverts the federalism concerns underlying the constitutional raison d’être for the exemption. See infra text accompanying note 127.

23 See, e.g., Alex Barnum, Corporations Team Up to Battle Health Care Costs, S.F. CHRON., March 18, 1994, at B1; Further Reforms Necessary to Improve Florida Program, Legislator Asserts, 2 Health Care Pol’y Rep. (BNA) 21 (May 23, 1994) (claiming additional legislation required to improve access to coverage in Florida); WASH. REV. CODE § 43.72.080 (Supp. 1994) (establishing an information clearinghouse for purchasing cooperatives).


25 See, e.g., Stein, supra note 11 (describing lobbying activity in Massachusetts).


managed competition remains this country's basic structural mode for delivering medical services, the behavior of those purchaser coalitions possessing market power could be held to constitute illegal monopsonization.\textsuperscript{28} Providers and insurers intent on preventing purchasers from combining to enhance their bargaining leverage have exploited these antitrust uncertainties. Alliance opponents add bite to their antitrust barking by threatening purchasers with the potential for treble damage liability.\textsuperscript{29}

Properly structured and analyzed, collective action by health insurance buyers need not present significant antitrust risk, particularly if encouraged by legislation. But sophisticated economic analysis must be employed to determine the precise impact that collective health insurance purchasing power exerts, particularly as both providers and insurers continue to integrate horizontally and vertically into ever larger service delivery networks.\textsuperscript{30} In point of fact, courts have generally treated large health sector purchasers or purchasing coalitions quite leniently in antitrust cases, even in the absence of facilitating legislation.\textsuperscript{31} This coincides with a legal perception that, notwithstanding pure economic theory (which tends to treat monopsony and monopoly as two sides of the same anticompetitive coin),\textsuperscript{32} buyer power does not generally present the same risks to consumer welfare as does seller domination.\textsuperscript{33}

\textsuperscript{28} Id. § 2.
\textsuperscript{30} See generally Mark A. Hall, Managed Competition and Integrated Health Care Delivery Systems, 29 WAKE FOREST L. REV. 1 (1994) (arguing that managed competition will eliminate solo physician practice, freestanding hospitals, and bright-line divisions between doctors, hospitals, and insurers).
\textsuperscript{31} See, e.g., Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield, 883 F.2d 1101 (1st Cir. 1989), cert. denied, 494 U.S. 1027 (1990) (insurer's HMO "look alike" option with lower cost pricing policy was exempt from antitrust scrutiny, and its "most-favored-nations" clause in providers' contract did not violate the Sherman Act); Ball Memorial Hosp., Inc. v. Mutual Ins., Inc., 784 F.2d 1325 (7th Cir. 1986) (insurer lacking market power cannot be preliminarily enjoined from implementing preferred provider health insurance plan); Kartell v. Blue Shield, Inc., 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985) (insurer's ban on balance billing practices does not unreasonably restrain trade); Webster County Memorial Hosp., Inc. v. United Mine Workers of America Welfare & Retirement Fund of 1950, 536 F.2d 419 (D.C. Cir. 1976) (Union Welfare Fund, providing health care to union members and their families, does not violate antitrust laws).
\textsuperscript{32} GEORGE STIGLER, THE THEORY OF PRICE 205-06 (3d ed. 1966).
\textsuperscript{33} Joint purchasing arrangements are "not a form of concerted activity characteristically likely to result in predominantly anticompetitive effects." Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 295 (1985) (emphasis added). But cf. ROGER D. BLAIR & JEFFREY L. HARRISON, MONOPSONY: ANTITRUST LAW AND ECONOMICS (1993) (examining the theory of monopsony and its effects on social welfare) [hereinafter BLAIR & HARRISON, MONOPSONY]; ROGER D. BLAIR & JEFFREY L. HARRISON, COOPERATIVE BUYING, MONOPSONY POWER, AND ANTITRUST POLICY, 86 U. L. REV. 331 (1992) (analyzing the procompetitive and anticompetitive aspects of monopsony power and concluding that per se treatment is warranted more often than analysts have previously thought) [hereinafter BLAIR & HARRISON, COOPERATIVE BUYING].
This Article focuses specifically on antitrust issues involving alliances collaborating with respect to health insurance purchasing, rather than on the broader issue of group purchases from the health industry generally. It emphasizes the special antitrust problems presented when buyers behave jointly with respect to the health insurance product, either spontaneously or as the result of government prodding. Part I of the Article describes health insurance purchasing generally, to provide a basis for analyzing potential antitrust problems. Part II examines joint health insurance purchaser behavior in light of antitrust principles prohibiting restraints of trade. Part III repeats the exercise with respect to monopsony. Part IV analyzes the special antitrust considerations associated with governmental involvement in purchaser activity. Finally, this Article concludes that short of increasingly unlikely single-payer reform, Americans will probably be better off in the long run with the competing alliance structures springing up spontaneously than they would have been with the huge mandatory alliances envisioned by the Task Force's proposed legislation.

I HEALTH INSURANCE PURCHASING

A. General Background

Health insurance purchasing alliances aim to consolidate sophisticated buying clout for a health service product notoriously difficult to evaluate, price, and police for quality. By pooling information, analyzing joint outcomes data and subscriber satisfaction measures, Federal antitrust enforcers have adopted a safe harbor rule whereby they will not challenge group purchasing arrangements among health care providers if the members collectively account for less than 35% of total sales of the purchased product and the input cost represents less than 20% of the final product sales price. Statements of Antitrust Enforcement in the Health Care Area, Statement No 5, Joint Purchasing Arrangements Among Health Care Providers, U.S. Dept. of Justice, Federal Trade Commission (Sept. 15, 1993), set forth in 65 Antitrust & Trade Reg. Rep. No. 1631 at S-11 (Special Supp.) [hereinafter Statement No. 5]. See also Blair & Harrison, Cooperative Buying, supra note 33; Jonathan M. Jacobson & Gary J. Dorman, Joint Purchasing, Monopsony & Antitrust, 39 ANTITRUST BULL. 1, 4 (1991).


The Health Plan Employer Data and Information Set—Version 2.0 [hereinafter HEDIS 2.0], a system for evaluating health plan performance, has achieved wide employer acceptance. HEDIS 2.0 sets forth five performance measures by which employers can evaluate insurance plans: 1) quality (measures performance in delivering selected services); 2) access and patient satisfaction; 3) membership and utilization (measures membership...
and concentrating buyer strength, employers can bargain more effectively for their workers' health insurance coverage. Theoretically this enhanced purchasing power stimulates intense competition for business primarily among insurers, and secondarily among doctors, hospitals, and other providers. These rivalries should spawn a more responsive and cost-effective medical system.\textsuperscript{38}

Public or private health insurance is now the predominant medium through which payment for medical services flows to providers, and the reform proposals introduced in the 103rd Congress all envisioned a more or less dramatic increase in the number of Americans covered by health insurance. Four of the five bills reported out of committee stopped short of universal coverage, but all sought to cut down the ranks of the uninsured. An expanded number of insureds presents the opportunity for joint insurance purchasing on an even larger scale, but it likewise expands the opportunities for collusive buyer behavior.

To make sense of the intense political reaction against mandatory alliances and the relevance of potential antitrust objections to them, it will be useful to recapitulate the evolution of health care financing. Historically, hospitals and doctors billed patients directly for their services and were free to charge whatever the traffic would bear. They made up for shortfalls with their own Robin Hood pricing methodologies.\textsuperscript{39} When health insurance became increasingly widespread during and after the Great Depression, charges for medical services became somewhat more uniform but insurers still reimbursed providers (or indemnified subscribers) primarily on a cost pass-through basis.\textsuperscript{40}

The advent of Medicare and Medicaid in 1965, as well as the subsequent ascendancy of managed care two decades later, meant that provider independence with regard to pricing became increasingly circumscribed.\textsuperscript{41} Today purchasing alliances are concentrating buyer strength even further and are turning the screws on health insurer pricing flexibility as well. As a consequence, providers fear that their ability to negotiate effectively about how much insurers pay them will
demographics and stability, along with resource allocation within the plan); 4) finance (measures performance in achieving financial stability); and 5) descriptive information on health plan management and activities, such as provider credentialing and utilization review. HEDIS Executive Summary.

\textsuperscript{38} See Kathryn M. Fenton, Antitrust Implications of Joint Efforts by Third Party Payors to Reduce Costs and Improve the Quality of Health Care, 61 Antitrust L.J. 17, 51 (1992).


\textsuperscript{40} See generally Sylvia A. Law, Blue Cross: What Went Wrong 6-18 (1974) (recounting the origins of Blue Cross and its relationships with state regulatory agencies).

\textsuperscript{41} Patients have also become increasingly resistant to paying for medical care or health insurance out-of-pocket.
be completely undermined. Because these coalitions represent a substantial shift of bargaining power away from sellers and toward the intermediate buyers of health services, insurers and providers have a joint economic stake in frustrating alliance formation and operation.

B. Purchasing Alliance Activity: The California Experience

California has been a pioneer in managed care ever since the 1940s, when the Kaiser-Permanente health maintenance organizations ("HMOs") were established.42 Thereafter in 1960 California created the California Public Employees' Retirement System ("CalPERS"), which currently enables 920,000 state employees and retirees to pool their health insurance purchasing power.43 Significantly, President Clinton cited CalPERS as a model for the administration's health sector reforms. Most recently, CalPERS demonstrated its purchasing strength by cajoling the insurers with which it contracts into cutting premiums by one percent.44

Anticipating the administration's plan, California also enacted legislation inviting private businesses to form purchasing alliances.45 The Voluntary Alliance Uniting Employers Purchasing Program, referred to as the Health Insurance Plan of California ("HIPC"), is an optional state program available to small employers with up to 100, or as few as four, employees.46 HIPC is the first voluntary, statewide, health insurance purchasing cooperative in the country and represents a prototype for achieving health insurance reform without mandates.47 Thus far, 2600 small businesses have joined the alliance,48 600 of which did not previously offer health insurance benefits.49 On average, covered employees have six health plans from which to

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42 See Starr, supra note 39, at 322.
43 CAL. GOV'T CODE § 20000 (West 1980); Barnum, supra note 23. See also Duerksen, supra note 26.
44 See Duerksen, supra note 26; see also Alex Barnum, Big Firms Flex Health Muscle; HMOs Cut Rates Up to 10%, S.F. CHRON., June 21, 1994, at DI (discussing success of Bay Area Group on Health, CalPERS, and the Health Insurance Plan of California).
46 CAL. INS. CODE § 10733.5 (West Supp. 1994). Prior to the 1994 revision, a small employer was defined as one with five to fifty employees. California Rules Expand HIPC to Include Associations, Out-of-State Employees, supra note 26.
47 California Rules Expand HIPC to Include Associations, Out-of-State Employees, supra note 26.
48 Id.; Quinn, supra note 26. HIPC covers more than 48,000 Californians throughout the state. Regional Health Alliances Emerging in California on Voluntary Basis, 2 Health Care Pol'y Rep. (BNA) 1300 (July 18, 1994).
49 Robert Hollis, Cheaper Health Insurance; the State's 1-Year-Old Purchasing Alliance Has Driven Costs Down, S.F. EXAMINER, June 23, 1994, at A18. Two-thirds of the six million uninsured Californians work for small businesses, which currently must pay substantially more than large companies for health insurance. See Quinn, supra note 26. As a result, ob-
choose in each region, and a total of twenty-three insurance companies now offer plans to the statewide purchasing pool. Within the alliance, premiums average fifteen percent less than the commercial price of premiums available to small businesses. In 1994 HIPC rates have fallen an average of 6.27 percent, and participating companies estimate they will achieve more than $3.2 million in savings. The alliance thus gives small businesses purchasing clout while preserving consumer choice among plans. The HIPC has also had a broader impact on the whole California insurance industry, forcing nonalliance insurers to lower their prices as well.

Once HIPC demonstrated its purchasing success for small employers, certain larger California businesses developed their own private alliance in an effort to reduce health insurance costs. The Bay Area Business Group on Health ("BBGH"), a nonprofit alliance of nineteen major San Francisco area employers, collectively negotiates contracts with health insurers. BBGH accounts for $3 billion in annual health care spending and currently provides coverage for 2.5 million Californians. Furthermore, BBGH recently received antitrust clearance from the Justice Department with regard to its pooling of health care purchasing power. It has negotiated insurance premium rate reductions of five to ten percent and has extracted other concessions from seventeen HMOs. BBGH appears to be the first private

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50 Regional Health Alliances Emerging in California on a Voluntary Basis, supra note 48. See also Quinn, supra note 26; Hollis, supra note 49 (describing Health Insurance Plan of California).
51 Regional Health Alliances Emerging in California on Voluntary Basis, supra note 48. Although premiums have declined significantly, health insurance costs statewide rose by 6 to 8% over the same period. Hollis, supra note 49.
52 Hollis, supra note 49. Nevertheless, HIPC has its limitations; its plans restrict the number of doctors and hospitals a patient can visit, and often the most prominent specialists are not alliance doctors. Also, the HIPC plans do not cover certain kinds of medicines and procedures. Quinn, supra note 26.
53 For example, Blue Cross, a nonalliance insurer, reduced its rates after the alliance started. Quinn, supra note 26.
54 Barnum, supra note 44. See also Private Sector Purchasing Alliance Negotiates Rate Reductions with HMOs, Health Care Daily (BNA) (June 24, 1994) (eleven member companies conduct pooled purchasing and collective HMO negotiations). In 1995, BBGH will include Bank of America, Bechtel Power Corp., Chevron Corp., the Federal Reserve Bank of San Francisco, Fireman's Fund Insurance Co., McKesson Corp., Mervyn's, Pacific Telesis Group, Safeway, Inc., Union Bank, and Wells Fargo Bank. Actual contracts are between health plans and individual employers. Regional Health Alliances Emerging in California on Voluntary Basis, supra note 48.
55 Barnum, supra note 44.
56 Id.; Justice Said Not to Object to Group Purchasing for Health Care, Health Care Pol'y Rep. (BNA) 9, 35 (Feb. 28, 1994) (reporting Justice Department's acceptance of the BBGH plan).
57 The HMOs also agreed to caps on rate increases and to partial refunds if they fail to meet certain performance standards in customer service, quality of care, and data collec-
sector California effort launched without government stimulus, and it is already highly successful.\textsuperscript{58}

C. Purchasing Alliance Activity: Other States

Many other states have followed California's lead by enacting legislation either creating\textsuperscript{59} or encouraging\textsuperscript{60} the formation of health insurance purchasing alliances. These statutory schemes focus on helping small employers to procure affordable health insurance coverage for their workers.\textsuperscript{61} All of these legislatively encouraged affiliations are voluntary, and all facilitate buyer information sharing and group purchasing. They vary from purely state programs;\textsuperscript{62} to state-chartered, nonprofit corporations;\textsuperscript{63} to nonprofit, independent corporations, organizations, and cooperatives.\textsuperscript{64}

While some states have enacted statutes promoting alliance creation, in other jurisdictions private businesses have, as in California's Bay Area, proceeded to form purchasing alliances without the benefit of legislation.\textsuperscript{65} For example, the Massachusetts Healthcare Purchasing Group, a voluntary coalition of corporations and state agencies, plans to challenge all major HMOs not to raise their premiums this year.\textsuperscript{66} The Group includes such large corporations as Gillette, Polaroid, and General Electric, as well as the state's Medicaid program.\textsuperscript{67} The alliance was established in 1993, and held member premium in-

\textsuperscript{58} Barnum, supra note 44.


\textsuperscript{65} Examples of private sector employer alliances arising in the absence of protective legislation can be found both in Massachusetts, Stein, supra note 11, and in Wisconsin, Small, Large Businesses in Wisconsin Set Up Health Purchasing Coalitions, supra note 24. In Iowa the insurance industry has initiated a purchasing alliance. Agent-Backed HIPC Takes Off in Iowa, Nat'l Underwriter, May 2, 1994, at 29.

\textsuperscript{66} Stein, supra note 11.

\textsuperscript{67} Id. at 83. The Group represents over one million people statewide.
creases to 3.2 percent in 1994—handsomely surpassing its goal of containing them to no more than 6.4 percent.68

II
ANTITRUST ANALYSIS OF COLLABORATIVE PURCHASER ACTIVITY

The Supreme Court originally viewed collaboration among buyers as inherently anticompetitive and historically found purchasers who act collectively to be guilty of violating both section one and section two of the Sherman Act.69 Its hostility to joint purchaser behavior has, however, lessened over the years. The Court's current posture is more receptive to considerations of allocative efficiency and therefore more attuned to the economies that buyer cooperation can achieve.70 Among these are the fact that consolidated purchasing permits larger volume purchases, which in turn facilitate such efficiencies as promotion and transportation economies, utilization of excess capacity, warehousing and inventory savings, and economies of scale. Buyer cooperation also saves transactions costs and can counterbalance market power on the part of sellers.71 Nonetheless, recent cases upholding cooperative buying schemes against antitrust challenge often concentrate more on the fact that the collaborating buyers lacked market power than on the economic benefits of aggregated purchasing.72

68 HMOs in Massachusetts Exceed Goal for Slowing Increases Set By Employers, 2 Health Care Pol'y Rep. (BNA) 13 (Mar. 28, 1994).
69 See, e.g., Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U.S. 219 (1948) (sugar refiners' agreement on price paid to beetgrowers violated § 1 and § 2); United States v. Griffith, 334 U.S. 100 (1948) (theater owners' use of common agent to negotiate with film distributors was abuse of monopoly power in towns with no competing theater and violated § 1 and § 2); American Tobacco Co. v. United States, 328 U.S. 781 (1946) (conspiracy to fix prices and exclude competing tobacco buyers violated § 2 only); United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940) (conspiracy to raise or stabilize price by buying gasoline on the spot market violated § 1 only); United States v. Patten, 226 U.S. 525 (1913) (conspiracy to corner cotton market by purchasing for future delivery and withholding from present sale violated § 1 only); Swift & Co. v. United States, 196 U.S. 375 (1905) (bidding agreements among livestock dealers constituted an illegal combination).
71 See generally Jacobson & Dorman, supra note 35 (arguing that joint purchasing counters monopoly power by raising the level of output and lowering prices).
A. Joint Information Gathering and Analysis

Health care markets have long been considered notoriously non-competitive, in large part because reliable product and service information has been either hard to acquire, difficult to understand, or altogether unavailable. Generally speaking, therefore, programs solely focused on gathering and exchanging information among health care purchasers are considered procompetitive; they improve both the quality and the extent of industry knowledge, thereby helping to redress market failure and enhance competition. Furthermore, the positive externalities which may be captured through the joint collection and dissemination of information lends a powerful social welfare justification which, absent editorial exhortations to act collectively upon it, should easily outweigh anticompetitive fears. Even competitor-sponsored credentialing or standard-setting programs designed to influence consumer choice have passed antitrust muster, because “private standards can have significant procompetitive [informational] advantages.”

Antitrust problems arise only when information exchanges are used as a front for unfair methods of competition such as price signalling, or for spillover collusion, particularly on purchase price. Such exchanges are more suspect if they facilitate collusive pricing among buyers who are also rivals in downstream product or service markets. Health insurance purchaser coalitions are only coinciden-


77 Cf. ABA Section of Antitrust Law, INFORMATION SHARING AMONG HEALTH CARE PROVIDERS: AN ANTITRUST ANALYSIS AND PRACTICAL GUIDE 12 (1994) [hereinafter INFORMATION SHARING] (“Anticompetitive use of price or cost information can range from overt price-fixing agreements, to exchanges that facilitate the stabilization of prices, to invitations to collude.”).

78 However, mere parallel conduct or other circumstantial evidence (among upstream collaborators) is not enough to establish (downstream) conspiracy within the meaning of § 1 of the Sherman Act. Matsushita Elec. Indus. v. Zenith Radio Corp., 475 U.S. 574 (1986); Monsanto v. Spray-Rite Serv. Corp., 465 U.S. 752 (1984).
tally likely to be composed of downstream competitors, however. The
employer-participants usually compete not as sellers of goods and serv-
ices but only as purchasers of insurance and, usually to a lesser extent,
labor. They cooperate in data collection and dissemination primarily
to become more savvy buyers of health insurance and medical service
products, for which sellers have usually held a marked informational
advantage. Their collaboration thus tends to correct existing impedi-
ments to a competitive market structure.

The risk that insurance purchaser alliances will engender down-
stream anticompetitive effects is therefore presumably very small.
Whatever bargaining advantages accrue from the joint efforts of alli-
ance members will presumably be passed on to consumers, for whose
favor these buyers will be competing with nonmember sellers in ent-
tirely different markets. Indeed, some commentators suggest that the
antitrust risk can be virtually eliminated so long as the collaborators
limit themselves to information collection and pursue no common
agenda for subsequently dictating purchase price or eliminating high-
cost providers. The collected data should not single out individual
providers and should be distributed devoid of recommendations in a
way that promotes individual, rather than joint, insurance purchaser
response. In such a case, the alliance should be completely home free
from an antitrust point of view, unless its members constitute an over-
whelming majority of the health insurance purchasers in the relevant
market.

B. Joint Lobbying Efforts

An alliance of insurance purchasers may venture beyond mere
information collection and dissemination and attempt to influence
government, insurer, or provider action, either directly or indirectly.
In that case the antitrust analysis shifts, but antitrust risks need not
intensify. The First Amendment protects cooperative purchaser be-
havior if it constitutes a good-faith attempt to lobby for legislative
change, to secure administrative action, or to obtain a favorable
adjudicatory pronouncement. It matters not one whit that the joint
petitioners may otherwise compete as health insurance purchasers, or
even as sellers in downstream markets. That their objective may be
purely to persuade government to fix input prices in their favor is also
immaterial, as would be the fact that the input price they seek to have

79 H. Robert Halper & John J. Miles, Antitrust Guide for Health Care Coali-
80 Information Sharing, supra note 77, at 12-17.
(1961).
fixed might constitute a large percentage of their common product or service cost. In the final analysis, the First Amendment trumps the Sherman Act for the Constitution will always trump legislation. So long as the parties do not engage in sham petitioning of government, their collaborative activity enjoys constitutional protection.  

If the alliance attempts to affect insurer or provider behavior, rather than that of government, its antitrust posture is somewhat more delicate. If an implied or explicit threat of boycott accompanies coordinated advocacy, the alliance may run afoul of the antitrust laws. The mere assertion of a common position, however, does not necessarily constitute such a threat. Rather, the Supreme Court has declared that some "plus factor" sufficient to evidence a "conscious commitment to a common scheme" is required before parallel action rises to the level of collusion within the meaning of section one. If parallel retaliatory conduct in fact occurs and additional evidence suggesting a coordinated response exists, the per se rule against boycotts should apply to the collaborators' behavior, so long as they possess market power. The Supreme Court has held that without market power or exclusive control over an element required for effective competition, the per se offense of boycott is incomplete. If the lobbying collective lacks that degree of dominance, and controls no ingredient critical to completion, its allegedly retaliatory behavior is subject to ordinary rule of reason analysis.

84 Id. See also Professional Real Estate Investors, Inc. v. Columbia Pictures Indus., 113 S. Ct. 1920 (1993) (holding that objectively reasonable litigation efforts cannot constitute "sham," regardless of plaintiff's subjective intent). Cf. Wilk v. American Medical Ass'n, 895 F.2d 352 (7th Cir. 1990) (holding that immunity from antitrust liability is withheld when petition activity, ostensibly directed toward influencing government action, is a mere sham to cover anticompetitive activity). Some would also find the rationale for Noerr implicit in the scope of the Sherman Act itself. Senator Sherman himself said that the act "does not interfere in the slightest degree with voluntary associations made to affect the public opinion to advance the interests of a particular trade or occupation." 21 CONG. REC. 2562 (1890).

85 See F.T.C. v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411 (1990) (boycott by group of lawyers aimed at forcing an increase in compensation was not excepted from antitrust liability).


89 See discussion of market power infra part III. Although health insurance purchasers generally do compete as buyers (rather than sellers), it is difficult to conceive of a lobbying alliance as controlling an element required for effective competition. Even if an alliance were composed of all insurance buyers in the region, and expelled a member for whatever
C. Joint Purchasing

Section one of the Sherman Act outlaws anticompetitive collusion by horizontal competitors and employers do compete horizontally in health insurance markets to buy their workers’ health insurance coverage. Any naked agreement among employers regarding insurance purchase price thus courts per se condemnation. Legitimate insurance buyer agreements need not raise naked price-fixing concerns, however, because efficiency justifications for joint purchasing abound. If the buyers can show a colorable efficiency rationale for their collaborative behavior, their agreement will usually be evaluated under the rule of reason rather than suffer per se treatment. So long as the procompetitive efficiencies stemming from the purchasing agreement outweigh any allocative inefficiencies, the arrangement should pass antitrust muster.

The Justice Department’s “35/20 rules” for identifying potential market power, which guide the government’s approach to joint hospital purchases and mergers, provide a convenient framework for determining when a joint buying arrangement will be likely to attract the attention of federal enforcement agencies. Under this standard, market power is presumed lacking if the cooperating buyers’ purchases do not exceed thirty-five percent of the relevant market. If the buyers also operate downstream as competing sellers, and their joint input purchases represent less than twenty percent of their final product price, then the end-product market is also deemed to be un-
harmed by any anticompetitive effects of their joint purchasing arrangement.

For those agreements falling outside this safe harbor, antitrust risks can be reduced by implementing three safeguards suggested by the DOJ and the FTC, two of which are specifically designed to guard against spillover collusion. As previously noted, downstream spillover collusion is unlikely among cooperating health insurance purchasers because they will compete as sellers in product or service markets only coincidentally. Spillover collusion is possible upstream, however, where members of an alliance are rivals for employees in tight labor markets. Participants should therefore be alert to the dangers presented by, for example, discussing "appropriate" wages to accompany the health insurance employee fringe benefit they collaborate to purchase. Federal antitrust concerns also may be alleviated when the cooperating members do not pledge to use the purchasing arrangement exclusively, but remain free to strike other bargains for obtaining health insurance.

Applying the safe harbor criteria to health insurance buyer collaboration immediately highlights one salient point. Unlike most joint purchasing arrangements, where the participants seek to obtain lower prices for inputs to a relatively homogeneous final commodity, alliance members rarely compete as sellers in the same product or service markets. They may compete as buyers in the same labor pool for employees, but their end products are likely to be as widely disparate as potato chips and microchips. Thus the twenty percent prong of the 35/20 rule simply does not apply, and no successive monopoly dangers therefore exist. With regard to the thirty-five percent prong, only nonmetropolitan areas currently hold the potential for exceeding the protective cutoff point for the kind of voluntary health insurance purchasing alliances currently springing up over the country.

Although the enforcement agencies' 35/20 standard does not specifically apply to health insurance joint purchases, and certainly does not purport to bar private plaintiffs from pursuing their own antitrust claims, it nonetheless functions as a useful proxy for determin-

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94 See Statement No. 5, supra note 35.
95 Id. at S-13. Antitrust risk is reduced if an independent employee or agent conducts negotiations on behalf of the joint purchasers. Antitrust concern is also lessened when communications between the purchasing group and each individual participant are kept confidential and not discussed with or disseminated to the other members.
96 Id. at 30. See National Collegiate Athletic Ass'n v. Board of Regents of Univ. of Okla., 468 U.S. 85, 114 n.54 (1984); Joseph Brodley, Joint Ventures and Antitrust Policy, 95 Harv. L. Rev. 1523, 1555-60 (1982).
97 Cf. Richard Kronick et al., The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition, 328 New Eng. J. Med. 148 (Jan. 14, 1993) (study found that only medium sized and large metropolitan areas could support three independent plans).
ing when collective activity among alliance members might offend the antitrust laws. Separate alliances operating in the same insurance markets which escape scrutiny under the 35/20 rules individually might nonetheless still court antitrust problems should they jointly exceed the threshold by behaving collectively in an anticompetitive manner.

Under the administration’s reform proposal the situation would have been quite different, for the mandatory regional alliances could—and in many cases probably would—have been statewide. Exclusionary practices would not have been an antitrust issue because state-established alliances would have been required to serve all employers in the region not electing to form a corporate alliance. Fewer than 1000 businesses in the country employ the 5000 employees which the Task Force’s plan would have required before an employer could elect to form its own corporate alliance, however. Thus, there would have been little, if any, competition among alliances within states for insurer contracts under the administration proposal. There would, however, presumably have been intense rivalry among insurers for the favor of these very large purchaser groups. The threat of monopsony pricing would thus not have been merely theoretical.

III

ANTITRUST ANALYSIS OF MONOPSONISTIC PURCHASER ACTIVITY

Section two of the Sherman Act condemns the willful acquisition of monopoly—the power to limit output and raise price unilaterally—on the part of sellers. The Supreme Court has also construed section two to outlaw monopsonization, which is the structural flip side to monopoly. The monopsonistic buyer or purchasing coalition has unilateral power to depress input price by restricting purchases and can wield it to take predatory advantage of an upward-sloping supply curve. Social welfare losses occur when the monopsonist flexes its pricing muscle by restricting purchases artificially.

98 See generally HSA, supra note 1, Title I, Subtitle D (1993) (outlining structure and functions of alliances).
99 Of the nonelderly population, 85-90% would thus presumably have received health insurance through regional alliances. Patricelli, supra note 6.
103 Mandeville Island Farms, 334 U.S. at 219. For general overviews of monopsony theory, see Blair & Harrison, Monopsony, supra note 33; CHARLES E. FERGUSON & CHARLES S. MAURICE, ECONOMIC ANALYSIS 459-508 (3d ed. 1978); JOHN P. GOULD & CHARLES E. FERGUSON, MICROECONOMIC THEORY 392 (1980).
When both prices paid and purchases of inputs are cut back, fewer resources are employed than would be the case in a competitive market.

The exercise of monopsony power does not, however, inevitably reduce social welfare. The larger scale purchasing made possible by monopsony can achieve efficiencies for both buyers and sellers, including such salutary economic effects as lowered transaction costs and more reliable long-range planning. Moreover, monopsony power can be utilized beneficially to compensate for previously existing market defects—such as the information inequality which has long plagued the health sector—that previously worked to the advantage of sellers. Rule of reason analysis, therefore, is now generally employed by antitrust courts when deciding section two claims.

Those opposed to the Administration’s proposed purchasing alliances alleged that they constituted either monopsonies themselves or facilitated collusive monopsony among their members. The Clinton Task Force’s proposed legislation was not entirely clear about whether alliances would have been required to purchase insurance plans for employers, their workers, or both, although the Congressional Budget Office’s official summary of the plan seemed to assume that they would. Even if the plan’s mandatory alliances would instead have simply negotiated with insurers to channel purchaser choice, they still would have had undeniable economic leverage to extract price and other concessions either directly or indirectly from insurers, and consequently from providers. Indeed, health service price reduction was the main point of the exercise, notwithstanding certain quality assurance functions that alliances were also expected to perform. Many regional alliances, and perhaps even some corporate ones, would thus have fit squarely into the traditional monopsony mold. That being the case, could their conduct have amounted to illegal monopsonization within the meaning of the Sherman Act?

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105 See Kenneth Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941 (1963) (discussing the special economic problems of medical care); Stanley J. Reiser, Consumer Competence and the Reform of American Health Care, 267 JAMA 1511 (1972) (physicians and managers make most health care decisions).

106 See Jacobson & Dorman, supra note 35. But see Blair & Harrison, Cooperative Buying, supra note 33, at 333-42 (analyzing the procompetitive and anticompetitive aspects of monopsony power and concluding that rule of reason should only rarely be employed).

107 HSA, supra note 1, Title I, Subtitle D, § 1345 implies that they could have done the actual purchasing.

108 According to the summary, regional alliances would contract with health plans; collect funds from employers, households, and governments; and make payments to plans chosen by participants. Analysis of Clinton Health Care Reform Plan, 2 Health Care Pol’y Rep. (BNA), (Special Supp., Feb. 14, 1994).

109 HSA, supra note 1, Title I, Subtitle D, § 1321.
Health sector horizontal and vertical restructuring into much larger provider and integrated provider-insurer entities was well under way for many reasons before the fall of 1993, when the Task Force proposed that mandatory alliances take a leading role in health sector reform.\textsuperscript{1} These networks were already assuming a more aggressive stance toward cost containment, on the theory that waste abounded in health service delivery, and providers had become accustomed to delivering too much care of dubious necessity.\textsuperscript{111} That on-going structural transformation of the industry had already begun to alter power relationships among primary care physicians, specialists, hospitals, and insurers, making it painfully clear that, while primary and outpatient care are assuming more importance, the role of specialists and hospitals is on the decline. Indeed, a recent highly publicized study predicts a surplus of 200,000 medical specialists by the year 2020.\textsuperscript{112}

This excess health sector supply has been fostered historically by an uncritical cost-pass-through payment system for medical services. Flawed understanding of, and information about, the nature of disease and what actually works to prevent, ameliorate, or cure it also contributed significantly to unneeded health industry expansion.\textsuperscript{113} Because of the preexisting health sector surplus and the cost-driven restructuring it has recently spawned, monopsonistic alliance purchasing cannot legitimately be blamed for any present "underemployment" of inputs to the health care final product.\textsuperscript{114} Any current provider dislocations represent in at least significant part a market correction for past overinvestment in hospital and specialist physician capital. They do not constitute examples of provider flight from the market in the face of monopsony pricing at or below marginal cost.

With regard to the market power issue critical to monopsony analysis, the more dominance players eventually achieve on the buyer side of health insurance transactions, the more the traditional anti-


\textsuperscript{111} See \textit{Gaming the Health Care System}, General Accounting Office Report released by the Senate Select Committee on Aging, Aug. 1994 (health care fraud costs private insurers and the federal Medicare & Medicaid programs approximately $100 billion per year, or 10% of United States health care expenditures); Matthew P. Schwartz, \textit{Senate Report Details Rampant Health Care Fraud}, National Underwriter, Aug. 1, 1994, at 46.

\textsuperscript{112} David Kroll, \textit{The Numerology of Graduate Medical Education Reform}, 271 JAMA 1369 (1994).

\textsuperscript{113} See \textit{LYNN PAYER, THE DISEASE MONGERS} 1-100 (1992) (how the American culture "creates" disease); \textit{LYNN PAYER, MEDICINE AND CULTURE} (1988) (describing the way differing cultures take differing approaches toward what constitutes disease and how to treat it).

\textsuperscript{114} Only government itself, through its power over the Medicare and Medicaid programs, could presently be construed as a monopsonistic purchaser of health services.
trust calculus changes on the seller side, which affects both the insurer and the subsidiary provider levels.115 Moreover, recent aggregations of purchasing power in health insurance markets have been matched by an almost symmetrical consolidation of seller power on the other side. The highly visible trend toward hospital mergers, physician-hospital organizations and insurer-provider network arrangements reflects substantial horizontal and vertical restructuring of the entire health sector. This restructuring has created new configurations and constellations of market strength among all the players.116

Market power is a constantly fluctuating factual issue on both sides of any sales transaction, and antitrust evaluation of the dangers posed by purchaser (not seller) power should fluctuate along with it.117 Moreover, the Supreme Court's 1992 Eastman Kodak Co. v. Image Technical Services118 opinion, involving a summary judgment in an alleged tying and monopolization context, deals a new wild card into traditional market power analysis. The decision emphasizes fact based rather than theoretical determinations of market strength. The opinion highlights the kind of market defects that can undermine the cross elasticity of demand in situations where interbrand competition would ordinarily exist but does not because of these defects, thereby creating derivative market power in players with relatively small primary market shares.

In Kodak the Supreme Court refused to hold that the defendant-manufacturer's mere fractional share of all photocopier equipment sales absolutely precluded its ability to force purchases in servicing aftermarkets. The case involved a photocopier seller who conditioned the sale of unique replacement parts, for which it was the dominant supplier, on purchases of its own servicing contracts. The defendant's allegedly anticompetitive behavior effectively forced the plaintiff's independent servicing organizations out of business.

The Supreme Court's opinion broke new ground by focusing its analysis on the anticompetitive impact of certain market imperfections, rather than relying on the assumption that small market share precluded the presence of market power.119 The Court specifically

115 See, e.g., United States v. A. Lanoy Alston, D.M.D. P.C., 974 F.2d 1206, 1214 (9th Cir. 1992) (Health care providers "face an unusual situation that may legitimize certain collective actions" in dealing with payers who "use the clout of their consumer base to drive down health care service fees.").
116 See generally Hall, supra note 30, at 1; Hitchner et al., supra note 110, at 273.
119 In order for the per se tying offense, with which Kodak was charged in the Sherman Act § 1 claim, to be complete the defendant must possess market power in the tying product. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984).
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identified photocopier market information gaps and switching costs—both of which are also endemic to the health sector\(^1\)—as impediments to interbrand competition. It found that defendant-Kodak could indeed possess market power in photocopier aftermarkets, notwithstanding a minuscule primary market share.\(^2\) Kodak would therefore be in a position to exploit that power anticompetitively.

Purchasing alliances are positioned on the buyer side of health insurance sales transactions, and the insurance purchase is the only exchange contemplated between the parties.\(^2\) By way of contrast, the Kodak analysis is directed toward multiple-transaction seller activity and, if read narrowly, would not apply to alliance activity at all. The Supreme Court's reasoning in Kodak may nonetheless be relevant in any antitrust case—such as one involving allegedly monopsonistic health insurance purchasing—where market power becomes an issue and procompetitive justifications for the challenged behavior prove illusory. Thus even an alliance whose contracts constituted only a small percentage of total purchases in the relevant health insurance market might be accused of monopsonization, if information gaps and switching costs were considered significant impediments to the ability of insurers and providers to market their products elsewhere.

IV

SPECIAL ANTITRUST CONSIDERATIONS RELATED TO GOVERNMENT INVOLVEMENT WITH PURCHASING

Government involvement with private action can significantly affect the antitrust analysis of what might otherwise be considered illegal anticompetitive behavior. Although government-initiated group purchasing was a prominent feature of several reform proposals originating in the 103rd Congress,\(^3\) as previously noted the mandatory aspect of collaborative purchasing schemes quickly fell by the wayside.\(^4\) Active government involvement with alliances, which

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\(^1\) According to one knowledgeable antitrust commentator, "It is difficult to imagine an industry in which market imperfections are more self-evident than hospital care." Warren S. Grimes, Antitrust Tie-In Analysis After Kodak: Understanding the Role of Market Imperfections, 62 Antitrust L.J. 263, 305 (1994).


\(^4\) See discussion supra part I.
could have insulated joint purchasing efforts from antitrust exposure under either the implied immunity\textsuperscript{125} or the state action\textsuperscript{126} doctrine, was thus virtually eliminated from federal reform proposals. The state action exemption may still be a factor, however, in those states which have legislated on their own regarding purchaser alliances.

A. Implied Immunity

When the provisions of two federal regulatory statutes are irreconcilable, courts must resolve the conflict. Judges have reasoned that the most recent Congressional expression of intent should prevail over earlier ones and have fashioned the implied immunity doctrine to break the impasse.\textsuperscript{127} Courts are reluctant to create immunity judicially, however, on the theory that Congress could always have expressly immunized affected parties had it chosen to do so.\textsuperscript{128} For example, Congress specifically exempted the insurance industry from antitrust liability when it passed the McCarran-Ferguson Act in 1945.\textsuperscript{129} Thus, judges confer implied immunity from antitrust scrutiny sparingly, and only when Congress enacts a regulatory statute so at odds with the provisions of the Sherman Act that affected parties must be protected from the former law's strictures in order to make the subsequent law work.\textsuperscript{130}

The Task Force's proposed legislation made no attempt to confer express immunity on purchasing alliance activity,\textsuperscript{131} but a respectable argument could be made that at least some antitrust immunity would have been impliedly necessary for federally mandated alliances if they


\textsuperscript{128} Cf. National Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross, 452 U.S. 378 (1981) (participants in health planning process are immune from antitrust scrutiny only to extent Congress specifically mandated anticompetitive conduct).


\textsuperscript{130} Implied repeals are "strongly disfavored, and have only been found in cases of plain repugnancy between the antitrust and regulatory provisions." United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 350-51 (1963).

\textsuperscript{131} However, the Health Security Act did make a convoluted attempt to protect providers by attempting to piggyback on the state action exemption. See supra note 22.
had been required to perform purchasing functions. Thus, despite alliances' monopsony power or their employer members' apparent collusion on price through the vehicle of the alliance, they would not for these reasons alone have been deemed to have violated either section one or section two. Since we are unlikely to see federally mandated health insurance purchasing alliances in the near future, however, the implied immunity issue is for all intents and purposes irrelevant. A more pertinent government-alliance interplay issue concerns the state action exemption from antitrust liability.

B. State Action Exemption

If health insurance purchasing functions are carried out directly by an independent state agency or by an agency of the state itself—as they could have been under the Task Force proposal—the judicially created state action exemption would presumably have insulated them from antitrust exposure. The state action exemption was fashioned by the Supreme Court in the landmark case *Parker v. Brown*, and the doctrine respects state sovereignty concerning economic regulation within state borders. The Supreme Court reasoned in *Parker* that it could not lightly infer Congressional intent under federal antitrust legislation to restrain states from engaging in their own legislatively directed economic regulation. Principles of federalism thus lie at the heart of the *Parker* doctrine.

A state cannot confer federal antitrust immunity on private actors by fiat, but if purchasing alliance functions are carried out by private entities pursuant to express legislative direction and active state supervision, they can enjoy *Parker* protection. The Supreme Court held in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.* that if the two-pronged test of clear state articulation and active state supervision set forth therein is met, private actors involved in economic regulation will be protected from federal antitrust liability.

A number of Supreme Court opinions have fleshed out the contours of *Parker*, and several of them analyze the protection afforded to private actors claiming the shield of "state" action. The most important of these for immediate purposes are *Southern Motor Carriers Rate Conference, Inc. v. United States* and *F.T.C. v. Ticor Title Insurance*

132 HSA, supra note 1, Title I, Subtitle D, § 1301.
133 317 U.S. 341 (1949).
Southern Motor Carriers arguably weakened Midcal's "clear articulation" requirement for granting Parker exemption to private actors because it expressly approved permissive rather than mandatory state regulatory policies. Moreover, even in the absence of state legislation expressly permitting the challenged conduct, the test can be satisfied so long as the state "has articulated clearly its intent to displace price competition [in a particular field] with a regulatory structure." 

Ticor, on the other hand, gave sharp teeth to the active supervision prong of the Southern Motor Carriers test. In fact, Mr. Justice Kennedy expressly reiterated in Ticor that application of the state action exemption is disfavored. Although he also cautioned that the court's decision "should be read in light of the gravity of the [price-fixing] antitrust offense involved," the opinion makes clear that the state must have "played a substantial role in determining the specifics of that economic policy" before immunity will follow.

Only two states—Florida and North Carolina—have thus far enacted legislation explicitly professing to offer antitrust protection for statutorily sanctioned voluntary alliance activity. These provisions purport to require such active state supervision over alliance operations that the operations themselves constitute state action and thus qualify for Parker exemption from antitrust scrutiny. These enactments may not have achieved their objective, however. For example, the Florida statute reads as follows:

In addition to the duties described in § 408.704, the agency shall actively supervise the community health purchasing alliances to ensure that actions that affect market competition are not for private interests . . . so as to provide state and federal antitrust protection of alliances and their board members.

State legislation generally exhorting an agency to supervise alliance activity sufficiently to qualify for antitrust exemption does not necessarily confer protection from federal liability, although it should provide immunity under state law. Clearly the Florida legislature intended to convey antitrust protection, and with respect to state antitrust sanctions this statute will suffice. State legislatures, however, have no inherent power to create exemptions from federal antitrust culpability: In order to provide Parker cover from potential federal

138 Southern Motor Carriers, 471 U.S. at 60.
139 Id. at 65.
140 Ticor, 112 S. Ct. at 2178.
141 Id. at 2180.
142 Id. at 2179.
antitrust liability, a state statutory scheme must mandate agency supervision which is more than merely pro forma. Thus each case of challenged private behavior requires individualized factual scrutiny for the required degree of state involvement before protection will be assured.

To that end, the North Carolina statute adds a state board monitoring requirement “to ensure that the legislative intent . . . to ensure the competitiveness of the small employer health coverage market is not impeded.”\footnote{N.C. Gen. Stat. §§ 148-634 (1993).} This provision helps because it adds specific state monitoring requirements. Nevertheless, an antitrust court could still find that the board’s actions pursuant to its monitoring duties did not rise to the level of active state supervision required by the Supreme Court’s recent pronouncements in \textit{Ticor}.\footnote{1994 N.M. Laws 75, §§ 6(7), (11), (12); Vt. Stat. Ann. tit. 18, § 9413(d) (Supp. 1993).} Other states have imposed annual review, evaluation, and/or reporting requirements in their alliance legislation, without specifying that these provisions are intended to confer antitrust immunity.\footnote{146} These latter provisions, however, may not in fact compel the degree of active state supervision required by \textit{Ticor} for federal antitrust protection. Even if they do purport to compel it, case-by-case factual investigation is nevertheless still needed to determine whether the requisite degree of state involvement in fact occurred.

**Conclusion**

The purchaser alliances on which this article focuses are formed by employers, primarily to achieve savings on an expensive factor in the cost of labor: health insurance. These cooperating employers may still compete with one another as purchasers in labor markets, but they rarely compete as sellers in aftermarkets, and even then only coincidentally. Thus any potential for spillover collusion in downstream product or service markets is minimal. The White House Task Force would have imposed gigantic purchasing alliances with undeniable market power designed to force health service efficiency on employers. That economic model for health sector reform is, however, no longer politically viable. Instead, purchasers are now voluntarily organizing into a variety of smaller alliance forms—often encouraged by state legislation—which compete with one another for insurer and provider contracts to deliver health services. So long as managed competition remains the foundation of health care delivery in this country, these competing alliances probably offer a more effective mechanism for stimulating provider efficiency than would the monopsonistic health insurance purchaser entities the Task Force envi-
sioned. Moreover, these smaller coalitions minimize the potential for monopsonization abuse because they are less likely to enjoy market power over insurance purchases and must compete for insurer contracts. Furthermore, any successive monopoly problem is unlikely to exist because no further insurance-related transactions are contemplated and the participants generally do not compete thereafter as sellers.

As the health sector continues restructuring into ever larger provider and insurer-provider networks, the effects of increasingly concentrated power on the health insurance buying side in any event become diluted. The situation could eventually approach one of bilateral monopoly, but in that case consolidated seller power will tend to check expanded buyer power, and the economic impact of collective purchaser activity cannot be characterized as inevitably inefficient. Moreover, the risk of double markup is absent, because employers who negotiate for health insurance collectively will almost never enjoy joint market power in downstream product or service markets. As a result, whatever bargaining leverage they exert as purchasers will more than likely redound to the ultimate benefit of their employee-subscribers. Generally speaking, therefore, the economic consequences of collective health insurance purchaser activity should be procompetitive, even though they can only be accurately described in advance as indeterminate. Antitrust analysis of alliance behavior should thus continue its journey down the well-trod rule of reason path.