

10-1-1983

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Recommended Citation

Colton, Douglas J. (1983) "Hospital Involvement in Health Care Coalitions," *North Carolina Central Law Review*: Vol. 14 : No. 1 , Article 5.

Available at: <https://archives.law.nccu.edu/ncclr/vol14/iss1/5>

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HOSPITAL INVOLVEMENT IN HEALTH CARE COALITIONS

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The cost of health care has become a national dilemma. Approximately ten per cent of our gross national product is now directed to the health care sector, and the rate of increase of costs in that sector has regularly outstripped even the high general rate of inflation in recent years. A few moments of reflection may suggest some of the roots of this problem.

The resources devoted to healing arts have to a substantial degree increased in proportion to their ability to deliver results. When medical care consisted of cutting off injured or infected limbs, bleeding patients of evident but uncertain malady, and administering opiates to alleviate the symptoms but not the causes of pain, presumably the public as a whole did not clamor for the opportunity to see doctors or enter hospitals. Whatever proportion of national wealth was being dedicated to health care as of the middle of the nineteenth century, it was certainly much less than ten per cent.

Such developments as smallpox vaccinations, rabies vaccine, and the Pasteur process for avoiding milk-carried infections brought both respectability and results to the provision of health care. Herbal nostrums were not necessarily displaced in the pharmacy, but a more scientific and methodical approach to treating illness began to emerge by the mid to late 1800's. Perhaps more than anything else, widespread acceptance of the notion of sepsis may have served to make hospitals acceptable, because the development of antiseptic techniques and products served to minimize the fear that one was more likely to die of the cure in a hospital than from the problem that put one there in the first place. The development of anesthesia in turn permitted the development of surgery as a respectable health care tool rather than a hideous last resort.

By the turn of the century, the medical profession in this country was being accorded higher status, and it in turn organized and manipulated the health care system to further enhance its new-found status and power. That organization influenced the subsequent evolution of the hospital structure to something close to its current form and elevation

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of the general idea of health care as both preventative and curative, thus justifying devotion of more resources to the sector. Thereafter, development of "wonder drugs" such as penicillin and the sulfa compounds, recognition of the causes of disease and means to cure or even prevent them, and development of surgical techniques created a snowballing effect in which health care became the province of learned professionals instead of charletons and barbers.

Beginning during the Depression, a number of forces converged to provide an economic support system capable of delivering medical services to the general public. In the years immediately before World War II, Blue Cross and Blue Shield plans were developed in the Midwest, with sponsorship of unions, hospitals and physicians, as a means of assuring that the providers of health care services would be paid for what they were selling, but also, whether intentionally or not, as a means of spreading the cost of health care out over the healthy as well as the sick. At an early stage in the automotive industry and thereafter in other Mid-western smokestack industries as well, health care plans—whether viewed as "insurance" or as "service benefit plans" or under some other names—proliferated and established the notion that an employee could and should be compensated for his services through provision of health care benefits as well as through cold cash. After the war, this notion spread rapidly through industry, to the point that today virtually all large-scale employers and even a large proportion of the tiniest entrepreneurs view protection against health care costs as a necessary part of any compensation system.

As our public awareness of the needs of the elderly, unemployed, and otherwise deprived in our society expanded in the 1960's, government at the federal and state level began providing health care services on an organized basis that previously had been donated on an ad hoc basis by religious orders, other not-for-profit institutions, and individuals. Access to health care was politically and socially transformed from a privilege to be purchased by those who could afford it into a right or, in current jargon, an entitlement. In a number of recent labor negotiations between unions and troubled industries such as steel and auto making, workers have demonstrated a willingness to surrender wages rather than health care benefits. This attitude prevailed because even the healthiest workers live in fear of the extraordinary costs that can be attendant on even relatively minor health care problems.

At the same time that health care evolved from a haphazard concern to virtually an unstated constitutional right, health care technology delivered more and more of something that had appeared desirable. Major breakthroughs, such as polio vaccine, vastly enhanced the welfare of the entire society by reducing the incidence of disease at a relatively

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small cost. However, medical technology has also followed the availability of funds. We have developed procedures such as renal dialysis that can keep alive those who previously would have had severely limited life spans. Heroic measures can now be used to keep the terminally ill alive for a few more hours or days or months. Physicians, nurses, and capital equipment are thrown into the fray with relatively little thought about whether these resources should be devoted to the particular problem or patient at hand. No one wishes to be responsible for social triage, which is the battlefield doctor's responsibility for deciding who has a chance to live and should be helped, and who has no chance and should not. Until very recently, we have done little to allocate resources in health care; we have simply decided that everything that can be done for every patient should be done, and that "somehow" the associated costs will be paid.

The piper must now be paid. The federal health care funding systems are threatened with bankruptcy, and most state systems are faced with similar prospects. Insurers, who are in fact only conduits in the health care financing chain, have been demanding astronomical increases in premium costs that reflect their rising costs. Employers whose products are not selling well in domestic or international markets are discovering, as have those in the automotive industry, that health care premiums can constitute up to forty per cent of their labor costs. A kind of social consensus has been reached that we simply cannot afford all of the health care we want, without directing attention to the questions of what health care should be provided, to whom, and at what costs, to be borne by what payors.

The choice of many nations, simply to incorporate the health care system into the bundle of goods and services provided by government to all citizens, is not likely to occur in this country for a variety of political and social reasons. Even where that choice has been made, as in Great Britain, the problems of who is to get what health care and at what price, are not solved but merely shifted to different shoulders, since it is hard to refuse to use a new technology or procedure or drug that may in fact help someone remain alive or healthy. Presently, it appears to be our political choice to leave the health care system basically in private hands, but subject to ever more extensive regulation of charges for the goods and services demanded.

The federal and state funding programs have chosen a relatively simple temporary expedient for holding down health care costs. They limit eligibility for services, and inform providers, especially hospitals, that they will pay only so much for health care services and no more. The providers of those services are given the choice of accepting no patients whose services are paid for by the government, and who com-

prise a substantial portion of the population, or of accepting those patients even if government programs pay less than the costs of the services. Acceptance of the publicly funded patients may require shifting any losses incurred by keeping the wards full of private payors, such as insurance companies or the employers whom they represent. This latter choice is the prevalent one: virtually all hospitals participate in the Federal Medicare and state Medicaid programs and, if they are to be believed (the evidence supports them), they lose money on every patient treated although not as much money as would be lost if all of those patients were turned away from the hospital.

Nonetheless, the hospitals do believe that they lose money in treating these patients and that they must recover those losses elsewhere in order to keep their doors open. They thus create the phenomenon known in the industry as "cost shifting," which is no more than segregating purchasers according to their ability to pay. Those who have private health coverage are deemed able to pay more and are charged more than are patients whose coverage comes through a government-sponsored system. The effect of the cost-shift phenomenon is that the health care treatment at the same facility may cost hundreds of dollars per day more if rendered to a privately insured (or personally wealthy) patient than to one whose care is governmentally financed.

Of course, hospitals have been the primary focus because of the cost shift problem and of efforts to hold down health care costs. Perhaps physicians are more politically powerful, perhaps it is administratively more difficult to control physician health care costs, and perhaps there are other reasons as well, but the primary reason for focusing upon hospitals in order to save money in the health care system is that institutional health care providers including hospitals and nursing homes account for considerably more than half of all money spent on health care in this country, concentrated into an administratively manageable number of units. It is believed that there is more waste and inefficiency to be eliminated from institutional providers than can feasibly be accomplished by affecting the prices and the behavior of physicians or drug companies or medical equipment manufacturers. I do not care to comment on the propriety of that attitude, and only observe that the great bulk of hospitals in this country are not-for-profit institutions and are not making much, if any, profit. Nonetheless, they are viewed as the place to look if money is to be saved in our health care system.

All of this brings us to the notion of "health care coalitions," and the antitrust significance of them. My bias is fairly evident: I represent hospitals, and I view coalitions with suspicion, because coalitions are by definition aggregations of purchasers who band together to hold down health care costs in their communities.

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That certainly does not sound evil and in fact would appear to be an admirable goal, since no one is in favor of escalation of health care costs and all the problems that such inflation can bring. However, if one is the administrator or chairman of the board of a hospital, and has just been told that a coalition of all of the largest employers in town has been formed to restrain health care costs, then it is fairly easy to figure out whose revenues are going to be suppressed if the coalition succeeds. The members of the coalition want to spend less for health care. If they spend less, then those who sell health care services will receive less. If the sellers' costs of providing services do not drop as rapidly as their revenues, then a reduction of revenues will lead to losses. Stated more simply, if you have an expensive mortgage to pay on your hospital, and a coalition succeeds in cutting the use of your hospital in half or your prices by half, then you may abstractly applaud the savings enjoyed by society; but you are going to wonder how to pay your mortgage with only half the money you had expected when you borrowed in the first place.

The coalition movement is fairly new, and last year occasioned the formation of an American Hospital Association special Antitrust Task Force on which I served, to examine the antitrust risks created by hospital involvement with coalitions. We started out by trying to define coalitions, and came to a kind of lowest common denominator formulation. Coalitions are groups comprised of purchasers of health care, sometimes also including sellers of health care services, organized around their common desire to see that good health care services are available, but more importantly to see that the costs of those services are kept at a minimum.

Typically, the organizing force behind coalitions is employers or insurers. Insurers do not like to have to pass on higher premiums to their insureds or the employers of their insureds, and may wish to enhance their profits by holding down the costs of paying claims. Ultimately, however, the pressure for the coalition movement comes from employers who provide health care benefits. One could argue that in back of the employers are the employees who have some awareness that a dollar spent for health insurance premiums is a dollar that cannot be taken out in wages. So far, however, it is the equivalent of the vice president for personnel or the "benefits manager" of a corporation, rather than a union representative or a group of employees, who is likely to suggest the desirability of getting together with his or her peers to see what can be done about health care costs.

Once the meeting is called, and a chairman has been elected, how is a coalition to go about having an impact on health care costs? It is my premise that the effectiveness of a coalition in restraining health care

costs will in most circumstances be in direct proportion to the willingness of the participants of the coalition to engage in antitrust violations. There are so far no cases that I am aware of involving health care coalitions, which are a very recent phenomenon, and I do not even know of any pending litigation about them. It may be that politics will make it unlikely for hospitals ever to sue coalitions or their members. Nonetheless, it appears reasonably likely that the *effective* coalitions will be those that are willing to flex their economic muscle as purchasers to compel the economic results that they want. I suggest that doing so raises grave antitrust problems that apparently few if any coalitions wish to think about.

Obviously, one way of holding down the overall cost of health care would be simply to buy less of it. To that end, either persuading citizens not to run to the doctor or hospital with every minor problem, or persuading the physicians who admit patients to hospitals not to do so quite so freely, will reduce the overall consumption level. Similarly, promotion of "wellness" programs that help keep people healthy in the first place would reduce the need for them to consume health care services later. If we lump both of these concepts together under the label of "educational activities," as an antitrust attorney I have little problem with them and cannot imagine an antitrust challenge to them succeeding. In many respects, in fact, educational efforts are likely to be the exercise of First Amendment rights, advising the public of consequences of their action and suggesting means by which the general public welfare may be improved. Let us then assume that newspaper ads regarding the desirability of cutting down health care utilization, and sponsorship of public health and wellness programs, are going to be unobjectionable. In the greater scheme of things, I also tend to believe that they are not likely to be economically significant.

In the end, if employer groups are to be successful in holding down health care costs, they have two primary means of seeking to do so: they can attempt to create a system that will result in lower consumption of health care services, or they can attempt to force the sellers of health care services to do so at lower prices. Each of these possibilities raises substantial, and interesting, antitrust problems.

As a starting point in antitrust analysis, some attempt should be made to characterize the economic relationships of the coalition members. Setting aside the hospitals, who will themselves presumably be viewed as competitors of each other, the initial reaction may be that coalition members are not "competitors" because in a single community they may well not be in the same line of business. On that assumption, an aggregation of their economic power would not appear to be what is called a horizontal relationship under antitrust law, meaning

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one between competitors, that may run a substantial risk of violating the law. This analysis is incorrect because it looks to the goods or services *sold* by these employers, rather than the goods or services purchased by them. They may make automobiles, steel, computers, or fried chicken, and not compete for the same customers in those sales, but they are competitors with regard to the *purchase* of various things.

Hypothetically, if all of the automobile manufacturers in the United States banded together and said that they would pay only so many dollars per ton for steel, and enforced that agreement against sellers of steel, there is little doubt that this would constitute an instance of *purchaser* price fixing. This phenomenon has rarely been noted in anti-trust law, since most price fixing conspiracies that are the subject of reported cases look to restraint of competition in sales and for a variety of reasons purchaser conspiracies are probably much more difficult to assemble or maintain.

Nonetheless, economic theory dictates, and the holding of *Mandeville Island Farms*¹ at least suggests, that purchasers are as much constrained from fixing prices as are sellers. In that case, the purchasers were sugar manufacturers, who agreed on the terms for buying sugar beets from farmers. The issue confronting the Supreme Court in that old case was whether the transactions involved had a sufficient connection with interstate commerce for there to be federal jurisdiction, but the Court endorsed, virtually without discussion, the idea that a conspiracy between purchasers to fix the price they would be willing to pay for a certain product would be an illegal restraint of trade.

A health care coalition that consists of employers in the same community poses the same issue. Those employers compete with each other for the purchase of labor generally and for the purchase of health care services through their health benefit systems. Even if payment for those services is accomplished through a conduit such as an insurance company, there can be little doubt that each of the employers has a motivation to hold down the price of local health care services, since ultimately those costs will be passed on to the employer in the form of insurance premiums or even in the form of direct billing from the sellers of health care services.

A typical, and perhaps not unrealistic, scenario might be a relatively small city having four or five major employers who decide to form a coalition to look into the costs of providing health care services at local hospitals. Imagine that there are five hospitals in town, and that their charges for a day of hospital services vary between \$300 and \$500, with an average of \$400. Coalition members, attempting to be fair, might

1. *Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219, *reh'g denied*, 334 U.S. 835 (1948).

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merely announce that they all agree that \$400 a day is a reasonable price, and that they will not pay the hospital bills for their employees in excess of that amount. We will here assume that the employee benefit or insurance plans can be adjusted to accomplish this goal, probably by shifting any charge amounts over the announced maximum that the employers are willing to pay onto the employees themselves. The employees therefore will have an enormous incentive to use only those institutions that are willing to accept the specified price.

In this scenario, hospitals that can survive at \$400 a day per patient will presumably do all right, but those that must recover more money per patient, for whatever reasons, will be in trouble. If they do not adjust their prices, they will lose the patients whose health care coverage comes from the major employers in town. If those employers provide the health care benefits for a substantial proportion of the population, the hospitals may have little choice but to conform to the announced standard set by the coalition. The virtually inevitable consequence of this action will be a stabilizing of prices in the community. Remember that those hospitals that can afford to charge less than \$400 a day will know that they are safe charging up to that amount, and their prices may float upward. Other hospitals, in order not to lose patients, may have to push their rates downwards and hope to recover costs somewhere else. In the jargon of antitrust prosecutions, the conduct of the coalition will have "tended to fix or stabilize" local hospital price levels.

For those of you who view price fixing that pushes prices down as somehow less contrary to the spirit of antitrust law than upward price fixing, let me assure you that the Supreme Court has announced in clear terms that price fixing is illegal regardless of whether it is "upward" or "downward."² The hospitals in this scenario are victims of a price fixing conspiracy, and one that I think the antitrust laws would easily find illegal.

An alternate scenario is one in which the employers participating in the coalition do not announce a specific price at which they are willing to purchase health care services, but rather perform a study of local health care costs and determine which hospitals are the high cost, and which providers are the "efficient" or "low cost," providers. In this instance, instead of announcing an *amount* that they are willing to pay, the employers may announce *to whom* they are willing to pay health care benefits, meaning that their employees who go to high price hospitals will not receive reimbursement, or perhaps will receive reimbursement only at some reduced level. This arrangement could again be

2. See *U.S. v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940), *Arizona v. Maricopa County Medical Soc'y*, 102 S. Ct. 2466 (1982).

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characterized as price fixing, since it will tend to force prices to the level of the so-called efficient producers, and it will also constitute a group boycott, another major sin under antitrust law, to the extent that the collective purchasing power of the employers is being directed away from certain disfavored sellers in order to coerce them into changing their economic conduct. However socially desirable the goals of these employers, this is conduct that is not permissible under antitrust law, and would probably compel boycotted hospitals that were losing patients and going out of business to bring suit, and quite likely to win.

I want to emphasize that antitrust law does not prohibit hard bargaining and does not restrict the right of any particular purchaser to attempt to get the best price possible for whatever it may be buying. One major employer in town may be able to deal directly or indirectly with hospitals, and set the level of its employee health benefits, either to limit payments to \$400 per day, or to steer employees to a particular hospital or group of hospitals, without a major risk of running afoul of antitrust law. It is only when two or more of the employers in the same community seek to accomplish the same ends collectively, instead of independently, that substantial dangers are created under antitrust law.

In its most basic form, antitrust law assumes that competition between numerous buyers and numerous sellers will eventually force the market price of goods and services to reach an appropriate level and that any aggregation of buyers or sellers using their power to effect that equilibrium price creates a distortion that should not be permitted at law. This is economic theory, not necessarily reality, but it is also the thrust of a large body of case law that attempts to push parties into unilateral economic decisions. That case law has developed out of commercial transactions that are very different from the typical purchase and sale of health care services, and at least respectable arguments can be made that the theory does not fit too well in the health care context, so that different kinds of behavior should be permitted here than elsewhere in the economy. However meritorious those arguments may be, they have substantially been suppressed by the Supreme Court in *Maricopa*, and whether they like it or not the purchasers who are banding together in health care coalitions must behave with as much circumspection regarding health care providers as they do at their own industry trade association meetings—where they are told again and again by their attorneys that they must not discuss the prices at which they are willing to sell their own goods and services.

In dealing with health care coalitions, the antitrust issues are in fact a lot more difficult than in the hypotheticals just discussed. It is unlikely that employers will display a naked exercise of economic power such as that described, but they may do other things that end them up in the

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same place. Interesting dilemmas are raised: What if the coalition employer members do a survey of local hospitals, determine which are the most efficient and low-cost, and then take out newspaper ads strongly "urging" employees to use only the less expensive facilities? Is this a simple First Amendment exercise? Arguably, it is, even though the effect of such publicity may be as harmful to the less efficient, high-cost hospitals as an agreed-upon boycott. At some point between mere announcement of what employers believe to be good social policy, and agreement by them as to whom they will pay for services, there is a vast grey area of conduct into which I suspect many health care coalitions are going to stumble.

It is not only the employers who will face these dilemmas. Hospitals will be under substantial pressure to cooperate with coalitions because failure to do so will suggest a lack of concern for the underlying dilemma of high health care costs. However, once a hospital has begun to participate in or with a health care coalition, it may itself become a violator of antitrust law as much because of the conduct of others as because of its own conduct. For example, the low-cost hospitals in the examples will presumably be the beneficiaries of any revisions in the local health care system that come about as a consequence of coalition activity. If employers succeed in steering their employees away from expensive facilities to more efficient facilities, the efficient facilities will increase their volume, their revenues, and presumably their profits. If those efficient facilities have not only agreed to open their doors to the increased patient flow, but also have provided data to the coalition, or even more have conferred and bargained with the employer members of the coalition, then those hospitals may have become co-conspirators with the employers in the "boycott" of the high-cost hospitals.

The hospital community may find that it becomes fragmented and turns upon itself, hospitals not only competing with each other but suing each other for conspiring to fix prices or eliminate competition. Those of us who deal regularly with hospitals may at first find the notion of one hospital invoking antitrust law against another to be far fetched, but if the alternative is bankruptcy and the end of the institution, even the most passive board of trustees of a not-for-profit institution may seek recourse in court.

Thus, to a certain extent a hospital can find itself at risk merely by cooperating with a coalition and, for instance, providing it with information that the hospital knows is going to be used by employer members to obtain bargaining leverage. Some interesting, and not easily solvable, issues are raised that may depend upon the state of mind and the state of knowledge of a hospital that provides information to a coalition knowing that it is likely to be the beneficiary of anticompetitive

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conduct committed by others. Under traditional antitrust analysis, liability can attach in this situation, but courts may choose to exercise leniency if they find no motive to suppress competition on the part of hospitals themselves. Still, this may be a question of evidence, to be decided by a jury, which is certainly an unpredictable and even more certainly expensive way for hospitals to learn what they may or may not do.

My comments so far have been addressed to steps that coalitions may take directly to affect the cost of services purchased from hospitals. However, as noted previously, the other mechanism through which coalitions may seek to hold down costs may be in reducing consumption of the services themselves. This very idea has interesting implications in antitrust law, since an underlying premise of the whole body of antitrust law and economics is that increased production and consumption of whatever good or service is being discussed is a social good. Indeed, the first tenet of antitrust law is that antitrust law helps preserve competition, which in turn helps assure the greatest variety and quantity of goods and services at the lowest cost for the greatest number of consumers. Antitrust law favors consumption and thus increases in productive capacity, since it assumes that the greater the capacity to produce the lower the cost per unit is likely to be. Health care economics has in recent years taken a different turn, using such things as certificate of need laws to try to reduce capacity and otherwise to try to diminish rather than increase both supply of and demand for health care services. This contradiction between antitrust and health care goals has scarcely been addressed, much less resolved, by courts handling these cases.

Coalitions may attempt to reduce health care demand through a variety of mechanisms. The most likely to be effective is to reduce the amount of service that will be paid for by the employer, thus compelling employees to decide how much health care they can afford to buy. The trend until recently in health insurance has been towards "first dollar" coverage, meaning that all services from the first doctor visit of the year through the most drastic of surgery should be covered. This provides patients and their physicians no incentive to cut back on consumption and to decide to forego treatment for relatively minor problems. Coalitions can become the focal point for individual employer efforts to reduce consumption by agreeing that employees should not have first-dollar coverage, or should have to share with the insurance plan ten percent or twenty percent of every health care dollar spent.

A collective redefinition in a given community of the "going rate" for health care benefits is not very different from an agreement among em-

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ployers as to how much they will pay in wages. Employers who collectively agree as to the appropriate scope of health care coverage are fixing the terms of health care coverage in a way that may create anti-trust injury, and standing, *both* to employees, who find that they no longer can shop among employers to get better health care coverage along with their jobs, and as well to hospitals or physicians who discover that their volume of business has been reduced since patients cannot any longer afford as much of it. There is enough precedent to suggest that both the employers and the health care providers would be able to bring and maintain antitrust suits alleging that this kind of collective activity constitutes a violation.

I do not mean here to attempt to describe the entire gamut of health care coalition activity or the antitrust risks that might be attendant on any particular form of conduct. What I do wish to emphasize is that coalitions whose stated purpose is holding down health care costs cannot simply be viewed as shepherds to lead us out of the wilderness of our health care financing problems. The issues are terribly complex, and most means of "holding down" costs will result in diminishing the revenues that someone receives. When that "someone" is a not-for-profit hospital that is attempting to provide its community a wide variety of services, some of which are money-losing but are still considered necessary, then substantial questions are raised as to whether a simply stated social goal such as "lower health care costs" should be accomplished through a mechanism such as a coalition. We have to remember that almost 100 years of antitrust law have evolved a stern disapproval of similar uses of economic power—disapproval that remains even when the stated purpose for the use of that power appears admirable.

I do not recommend that hospitals, or employers, or insurers, throw up their hands and decide that coalitions are too much of a risk to be tried. What I do suggest is that we all should remember that it took a long time and a lot of converging factors to create the health care financing problems that we have today, and to heed the common wisdom: for every problem there is a simple, direct, and obvious solution—and that solution is usually wrong.