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COMMENTARY

THE HEALTH CARE COOPERATION ACT: PANACEA OR PERIL?

*Natalma M. McKnew**

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I. INTRODUCTION

This is a time of unprecedented change in the health care industry. Pressure from consumers to reduce health care costs, the increasing power of health care insurers and hospitals (and the resulting price squeeze on health care providers), and even President Clinton's failed efforts to address health care issues have fueled the fires of change. In a near panic, physicians are banding together in independent practice associations (IPAs), preferred provider organizations (PPOs), and other alliances.

The federal antitrust laws¹ hang over these efforts like the Sword of Damocles, a potential threat to every combination that could be seen to reduce competition or increase concentration in any segment of the provider market. The recent efforts of the Department of Justice and the Federal Trade Commission to describe "safe harbors" in which such alliances will not attract regulatory attention,² while helpful, do not satisfy the needs of the health care industry—particularly physicians—for predictability.

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1. The Sherman Act, the central federal antitrust statute, declares it unlawful to combine, contract, or conspire "in restraint of trade or commerce" or to "monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce" of the states. 15 U.S.C. §§ 1, 2 (1988).

2. See UNITED STATES DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN THE HEALTH CARE AREA (1993), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,150, revised, Sept. 27, 1994 [hereinafter DOJ/FTC Policy Statements].

Unable to achieve predictability, providers have sought the assistance of state legislatures to escape the ambit of federal antitrust laws.³ These efforts led to enactment of the South Carolina Health Care Cooperation Act in 1994.⁴

The Health Care Cooperation Act attempts to create an exemption from state and federal antitrust statutes for certain cooperative agreements within the health care industry. If (and only if) properly administered, this exemption will remove state-supervised restraints on competition in the health care industry from the reach of a Sherman Act challenge.

The Health Care Cooperation Act will create an effective state action exemption if it is properly written and fully implemented by the state. However, it will not shield the health care providers from liability if the state fails to maintain an active role.⁵ In addition, one provision of the statute clearly will fail to provide immunity from the antitrust laws. Section 44-7-520(B) allegedly shields from antitrust scrutiny "conduct in negotiating and entering into a cooperative agreement."⁶ This provision is not only misleading, it is potentially dangerous. Because the state is not involved in the pre-filing negotiation stage, there can be no state action immunity for activities during that stage. Negotiating activities per se will remain fully exposed to antitrust claims. Health care providers involved in negotiations are well advised to act cautiously, to document discussions, and to involve an attorney to avoid liability problems. Ensuring that inappropriate topics are avoided during these initial stages is crucial.

II. THE STATE ACTION EXEMPTION

The state action exemption originated in a 1943 United States Supreme Court decision, *Parker v. Brown*.⁷ In that case, the Court held that, because of principles of federalism and state sovereignty, a state sponsored market-sharing scheme was immune from antitrust attack.⁸ It reasoned that the purpose of the Sherman Act was to prohibit private restraints on trade, not to prohibit anticompetitive acts prescribed by the states "as an act of govern-

3. At least 21 states have enacted statutes designed to exempt cooperative arrangements in the health care industry from state and federal antitrust laws. See, e.g., ARIZ. REV. STAT. ANN. §§ 20-1051 to -1068 (1990 & Supp. 1995); GA. CODE ANN. § 31-7-72.1 (Supp. 1995); KAN. STAT. ANN. § 65-472 (1992); ME. REV. STAT. ANN. tit. 22 §§ 1881-1888 (West Supp. 1995); WASH. REV. CODE ANN. § 70.44.450 (Supp. 1996); WIS. STAT. ANN. § 150.85 (West Supp. 1995); WYO. ST. § 35-24-101 to -116 (Supp. 1995). See also Sarah S. Vance, *Immunity for State-Sanctioned Provider Collaboration After Tigor*, 62 ANTITRUST L.J. 409 (1994) (comparing recently enacted legislation for provider immunity).

4. S.C. CODE ANN. §§ 44-7-500 to -590 (Law. Co-op. Supp. 1995)

5. See *FTC v. Tigor Title Ins. Co.*, 112 S. Ct. 2169, 2176-77 (1992).

6. S.C. CODE ANN. § 44-7-520(B) (Law. Co-op. Supp. 1995).

7. 317 U.S. 341 (1943).

8. *Id.* at 350-52.

ment.”⁹ Thus, states are lawfully permitted to establish regulatory programs that may adversely affect competition, without exposing the participants to antitrust liability. *Parker* essentially allows a state government artificially to impair competition despite the free competition policies implicit in the federal antitrust statutes.¹⁰

Since enunciating the doctrine, the Court has refined and narrowed the state action exemption. A two-prong test for state action immunity was described in *California Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*¹¹ Before state-sponsored anticompetitive activities are shielded from antitrust liability, according to the Court, two requirements must be fulfilled: (1) the state must articulate a clear and affirmative policy to allow the anticompetitive conduct, and (2) the state must actively supervise the conduct.¹² In other words, the state must clearly express and authorize a policy to displace competition with regulation. Only activities that further state regulatory policies are protected by this doctrine. For this reason, the state must clearly express its intent to depart from the ordinary market principles underlying the Sherman Act.¹³

9. *Id.* at 352. In a later case, the Court held that *Parker* immunity also shields private parties from antitrust liability. *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 61-62 (1985).

10. The courts have long held that freedom from price fixing and cartels is essential to the preservation of a free market system. *See, e.g., United States v. Topco Assocs.*, 405 U.S. 596, 610 (1972) (explaining that the Sherman Act is “as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms”).

11. 445 U.S. 97 (1980).

12. *Id.* at 105.

13. Later cases further refined the *Parker* immunity doctrine. For example, conduct by the state (rather than that delegated to an agency) is not held to as strict a standard under the state exemption doctrine. *See Hoover v. Ronwin*, 466 U.S. 558 (1984) (exempting anticompetitive conduct performed by the state from antitrust liability regardless of the state’s motives). Municipalities are also granted some leniency in the burden of proof because they are considered to be arms of the state and are presumed to act in the public interest. *See Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985) (granting state action immunity to municipal restriction of competition without applying the second prong of *Midcal* when the municipality was implementing a clearly articulated state policy). However, the courts have held nonmunicipal parties to a higher standard and have applied both prongs of the *Midcal* test. *See Southern Motor Carriers Rate Conference, Inc.*, 471 U.S. 48 (requiring collective ratemakers to satisfy both prongs of *Midcal* in order for anticompetitive conduct to be immune from Sherman Act liability). However, “the State’s failure to describe the implementation of its policy in detail will not subject the program to the restraints of the federal antitrust laws,” so long as the state’s intent to establish an anticompetitive regulatory program is clear. *Id.* at 65. *See also 324 Liquor Corp. v. Duffy*, 479 U.S. 335 (1987) (displacing competition among liquor retailers without substituting an adequate system of regulation will not support a state action exemption); *Lancaster Community Hosp. v. Antelope Valley Hosp. Dist.*, 940 F.2d 397, 403 (9th Cir. 1991) (stating that “mere statutory authorization to engage in business will not be so readily viewed as a displacement of

The second prong of *Midcal* was not closely scrutinized until 1988, when the Court more sharply defined the active supervision requirement in *Patrick v. Burget*.¹⁴ The Court in *Patrick* recognized that private parties engage in anticompetitive activity primarily to further their own interests, not those of the state. In order to ensure that anticompetitive acts of a private party actually further state regulatory policies, the Court held that the state must “exercise ultimate control” over the challenged conduct.¹⁵ Only if state officials have the power to review the challenged anticompetitive activity can there be any assurance that the conduct in fact furthers state, rather than private, interests. In order to satisfy the second prong of the *Midcal* test, therefore, the state must have and exercise such power.¹⁶

Prior to its 1992 decision in *Federal Trade Commission v. Tigor Title Insurance Co.*,¹⁷ the Supreme Court had not defined the precise level of state activity required to trigger the exemption. In *Tigor*, the Court finally attempted to describe “how much activity is enough.” The questionable conduct in *Tigor* involved horizontal fee-setting by six title insurance companies.¹⁸ The *Tigor* decision reaffirmed that the active supervision test is not met simply because a state agency is empowered and required to regulate activity pursuant to a declared state policy.¹⁹ Instead, the state must actually play a substantial role in supervising the activity.²⁰ Unfortunately, the Court did not adequately define the meaning of “substantial role.” Some

competition”).

14. 486 U.S. 94 (1988).

15. *Id.* at 101.

16. *See id.* at 102-03 (explaining that a general supervisory power does not constitute active supervision).

17. 112 S. Ct. 2169 (1992). In its decision, the Court assumed that *Parker* immunity applies to the Federal Trade Commission Act in the same way it applies to the Sherman Act. *Id.* at 2177-78.

18. *Id.* at 2172. *See also* Jeffery M. Cross & Patrick J. Ahern, FTC v. Tigor Title Insurance: Supreme Court Puts State Action Immunity Under the Lens, ANTI-TRUST, Fall/Winter 1992, at 24.

19. *Tigor Title Ins. Co.*, 112 S. Ct. at 2176-78. Health care providers should be very concerned about this reaffirmation and its potential effect on activity under the Health Care Cooperation Act. However, it should be noted that the states involved in the *Tigor* decision filed amicus briefs, admitting they had not actively supervised the anticompetitive conduct at issue. *See id.* at 2178. Undoubtedly, these briefs played a significant role in persuading the Court to deny state action immunity to the title companies' conduct.

20. *See id.* at 2177. Lower courts have applied this requirement to private parties only. *See Askew v. DCH Regional Health Care Auth.*, 995 F.2d 1033, 1038 (11th Cir. 1993) (stating that *Tigor* is not applicable to political subdivisions of the state); *Porter Testing Lab. v. Board of Regents*, 993 F.2d 768, 772 (10th Cir. 1993) (stating that “dicta in later Supreme Court cases imply that the active supervision requirement of the *Midcal* test applies only to private parties”); *Bolt v. Halifax Hosp. Medical Ctr.*, 980 F.2d 1381, 1385-87 (11th Cir. 1993) (declaring that political subdivisions need to meet only the *Hallie* requirements and not the second prong of *Midcal*).

scholars have interpreted *Ticor* to mean that a defendant “can claim the *Parker* exemption only by showing that the practice at issue was brought to the attention of the regulatory agency, that the agency considered the practice with the requisite degree of attention, and then approved it.”²¹ Although this may be an accurate reading of *Ticor*, it gives little guidance as to the required level of state attention. States that intend statutorily to create a *Parker* exemption are left to muddle in the dusk.

It would be difficult for any state to establish and implement an assuredly exempt regulatory program based on the current state of the law. Recent opinions focus on what is not active supervision, rather than defining the level of state involvement necessary to establish *Parker* immunity for private parties. In *Patrick*, for instance, the Court found insufficient state supervision to confer immunity in a hospital peer review system with the following powers reserved to the state: general supervisory powers over matters relating to health; a statutory obligation to establish and review procedures; the power to initiate judicial proceedings; and the power to deny, suspend, or revoke hospital license for failure to comply with statutory requirements.²² The Court criticized the state agency’s inability to review program quality, but otherwise was not overly helpful.

Divining the level of state activity that will satisfy the active supervision requirement remains difficult even after *Ticor*. Rather than defining a normative standard, the Court instead preached the importance of active state supervision (without suggesting how a state could meet this standard).²³ Despite this lack of guidance, a few things are relatively clear after *Ticor*.

It is now clear that to satisfy the active supervision requirement, a defendant must show not only the existence of a state regulatory program in which a state agency has the authority to regulate the anticompetitive conduct, but also evidence that such authority has been exercised.²⁴ A state regulatory program that simply rubber-stamps the conduct of a private party is not

21. PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 212.7b, at 220 (Supp. 1995).

22. *Patrick*, 486 U.S. at 102.

23. *Ticor Title Ins. Co.*, 112 S. Ct. at 2176-77.

24. *See, e.g., Yeager’s Fuel, Inc. v. Pennsylvania Power & Light Co.*, 804 F. Supp. 700, 712 (E.D. Pa. 1992) (recognizing state action immunity where the Pennsylvania Public Utility Commission “devised a detailed scheme for the evaluation and supervision of electric utility load management programs[,] . . . is sensitive to potential anticompetitive impacts, [and] is continually refining this scheme to make clearer programs that further the state policy”).

sufficient.²⁵ Under *Ticor*'s concept of the supervision prong, the state itself, rather than the private party, must be the effective decision-maker.²⁶

Ticor clearly disfavors what is known as a negative option scheme.²⁷ Under such a scheme, rates set by private parties are filed with a state agency and become effective unless the agency affirmatively rejects the rates within a certain period of time. The state agency clearly lacks active supervisory power in a negative option scheme. Because the state maintains no involvement in establishing or monitoring the rates, it cannot exercise "ultimate control" over the anticompetitive conduct.²⁸ Furthermore, should the state agency fail to respond within the set time period, the rates become effective, whether an agency official has reviewed the conduct or not. The fact that the state theoretically has the authority to reject a rate plan will not support *Parker* immunity. Clearly, the state must be more deeply involved.

Antitrust jurisprudence embraces the presumption that private parties acting in an anticompetitive manner are doing so out of concern for their own interests.²⁹ Therefore, a state regulatory scheme will not satisfy *Ticor* unless it includes mechanisms by which the state can ensure that a private party's anticompetitive conduct promotes state policy. The Court in *Ticor* thus observed that the purpose of the active supervision requirement is to ensure that "the State has exercised sufficient independent judgment and control" over the anticompetitive conduct and to ensure that such conduct is the "product of deliberate state intervention."³⁰ Under this analysis, courts should not be concerned with whether a state regulation functions efficiently or is the optimal economic choice. Rather, the inquiry should be "whether the anticompetitive scheme is the state's own."³¹

The *Ticor* Court's reliance on *Parker* suggests that the active supervision requirement should be applied to a wide range of anticompetitive behavior. However, the majority also used language that could be read to limit *Ticor*'s application. For example, the Court cautioned that its "decision should be read in light of the gravity of the antitrust offense [price fixing], the involvement of private actors throughout, and the clear absence of state supervision."³² It warned that price fixing is the most "pernicious" antitrust offense,

25. *Ticor Title Ins. Co.*, 112 S. Ct. at 2176-77 (stating that "[a]ctual state involvement, not deference to private price fixing arrangements . . . is the precondition for immunity from federal law").

26. *Id.*

27. *See id.* at 2179.

28. *See Patrick*, 486 U.S. at 100-01.

29. *Town of Hallie*, 471 U.S. at 47 (noting that "[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests").

30. *Ticor Title Ins. Co.*, 112 S. Ct. at 2177.

31. *Id.*

32. *Id.* at 2180.

perhaps suggesting that the required level of state activity might be less with other types of anticompetitive conduct.³³ It would be foolish to assume, however, that the active supervision test could be ignored, regardless of the type of conduct at issue.

The *Ticor* Court's unsurprising failure to establish strict rules regarding the active supervision requirement makes the opinion particularly dangerous to the health care industry in this era of rapid change. As Chief Justice Rehnquist observed, the majority gave no rational guidance to regulated private parties who wish to rely on *Parker* immunity.³⁴ As a result, whether health care industry participants in South Carolina will actually achieve the immunity promised by the Health Care Cooperation Act will remain in question until the statute and regulations are analyzed by state and federal courts. This uncertainty may discourage some health care providers from pursuing cooperative agreements. The more likely result is that industry participants—and their attorneys—will be forced to monitor and even encourage active state participation as a security measure against antitrust liability.³⁵ Ironically, if the Health Care Cooperation Act is to provide immunity, the objects of its regulation must be certain that the state is watching and acting.

III. THE HEALTH CARE COOPERATION ACT

The South Carolina Health Care Cooperation Act is designed to provide immunity from federal and state antitrust laws to health care providers who participate in state-supervised cooperative arrangements.³⁶ Cooperative

33. *See id.*

34. *Id.* at 2182 (Rehnquist, J., dissenting).

35. For a discussion of the impact *Ticor* may have on motions to dismiss and requests for summary judgment, see Cross & Ahern, *supra* note 18.

36. *See* S.C. CODE ANN. § 44-7-520(A) (Law. Co-op. Supp. 1995) (stating that “[i]t is the intent of this article to require the State to provide direction, supervision, regulation, and control over approved cooperative agreements . . . [in order to] provide immunity . . . from civil liability and criminal prosecution under federal or state antitrust laws”). The attempt to create state action immunity resulted from the General Assembly's findings:

(1) that the cost of improved health technology and scientific methods contributes significantly to the increasing cost of health care;

(2) that cooperative agreements among hospitals[,] health care purchasers, and other health care providers would foster improvements in the quality of health care for South Carolinians, moderate cost increases, improve access to needed services in rural areas, and enhance the likelihood that rural hospitals can remain open;

(3) that federal and state antitrust laws may prohibit or discourage cooperative agreements that are beneficial to South Carolinians and that such agreements should be encouraged; and

(4) that competition as currently mandated by federal and state antitrust laws should be supplemented by a regulatory program to permit and encourage cooperative

agreements are defined by the Act as those created for the “sharing, allocation, and referral” of patients, programs, facilities (including support, medical, diagnostic, or laboratory), procedures, and equipment or the acquisition or merger of assets.³⁷ The Act purports to create a mechanism by which certain cooperative activities among competitors in the health care field might achieve immunity from antitrust scrutiny. In order to effectively provide this immunity, however, the Act must meet both prongs of *Midcal*, as modified by the recent *Ticor* decision.

The first prong of the *Midcal* test is clearly satisfied. Section 44-7-505(4) specifically states that health care “competition . . . should be supplanted by a regulatory program” in South Carolina.³⁸ The legislature has thus stated that, in an effort to improve the quality of health care available to South Carolinians, the state will permit certain collaborative arrangements, even though these agreements might otherwise be considered anticompetitive.³⁹ This provision articulates the clear intention of the South Carolina legislature to displace competition with regulation, as required by the first prong of *Midcal*.⁴⁰

The Act’s satisfaction of the second prong of *Midcal* is less clear. *Patrick* and *Ticor* significantly narrowed the definition of active supervision.⁴¹ Although the Act may sufficiently empower state officials, it is not clear whether that power will be exercised consistently with *Ticor* to create *Parker* immunity.

The Act directs the Department of Health and Environmental Control (DHEC) to evaluate and issue Certificates of Public Advantage for qualifying cooperative health care arrangements.⁴² Cooperative arrangements eligible

agreements between [sic] hospitals, health care purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects on competition.

S.C. CODE ANN. § 44-7-505 (Law. Co-op. Supp. 1995).

37. S.C. CODE ANN. § 44-7-510(3) (Law. Co-op. Supp. 1995). These are the same types of activities that are addressed in DOJ/FTC Policy Statements, *supra* note 2.

38. S.C. CODE ANN. § 44-7-505(4) (Law. Co-op. Supp. 1995).

39. S.C. CODE ANN. § 44-7-505(2) (Law. Co-op. Supp. 1995). *See also supra* note 36.

40. *See Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 39-46 (1985) (explaining and applying the first prong of the *Midcal* test); *California Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980) (stating that the first prong of the state action immunity test is that “the challenged restraint must be ‘one clearly articulated and affirmatively expressed as state policy’”).

41. The *Patrick* Court refined the meaning of active state supervision by concluding that “state officials [must] have *and exercise* power to review” anticompetitive activity. *Patrick v. Burget*, 486 U.S. 94, 101 (1988) (emphasis added). Not until *Ticor* did the Court address the sufficiency of a state regulatory program that gave state officials the power to review private party conduct. *See supra* notes 17-21 and accompanying text.

42. S.C. CODE ANN. §§ 44-7-540 to -550 (Law. Co-op. Supp. 1995).

for certification under the Act include IPAs, PPOs, mergers, equipment and facility cooperatives, and other network or joint venture activities.⁴³ The statute directs DHEC to issue a certificate if the likely benefits from the agreement outweigh the likely disadvantages, and if the resulting reduction in competition is reasonably necessary to obtain the likely benefits.⁴⁴

Adequate empowerment becomes questionable only in South Carolina Code section 44-7-550, which establishes a negative option alternative to truly active state supervision. That provision can be read to provide for automatic approval by DHEC if the Attorney General fails to act on an application within thirty days. State action immunity for the negative option, which was specifically disapproved in *Ticor*,⁴⁵ may seriously threaten any immunity supposedly conferred by the Act. Because there are clearly expressed standards for approval and an opportunity for DHEC to act, the theoretical negative option need not be fatal. Evidence of active evaluation, approval, and disapproval by DHEC, together with appropriate regulations and an absence of arrangements that become effective through the negative option, may overcome the statutory taint.⁴⁶ In order for cooperative arrangements to be shielded from antitrust challenge, DHEC must actively approve, disapprove, and monitor the agreements. Ideally, this would include rejecting some requests for certificates.⁴⁷ If the state regulatory mechanism becomes lethargic, however, the risk to health care industry participants increases, and the cloak of immunity may suddenly disappear.

The success of the Act depends largely upon DHEC and the state legislature. Although the precise degree of state activity needed to comply with *Parker* and *Ticor* is unclear, DHEC must maintain an active presence. The South Carolina Legislature has taken the first step to protect the health

43. S.C. CODE ANN. § 44-7-510(3) (Law. Co-op. Supp. 1995). Price fixing and predatory pricing are specifically excluded from eligibility.

44. S.C. CODE ANN. § 44-7-560(1), (2) (Law. Co-op. Supp. 1995). The statute lists nine possible advantages of cooperative agreements that DHEC should consider, including increased cost efficiency, improved access to health care services, enhanced health care services to Medicaid and indigent patients, and the avoidance or reduction of duplicated resources. S.C. CODE ANN. § 44-7-560(1)(a)(i)-(ix) (Law. Co-op. Supp. 1995). The inability of health care purchasers to negotiate optimal payment and service arrangements with health care providers, the reduction in competition, and the adverse impact on patients in the quality and price of services available are among the likely disadvantages DHEC is to consider and weigh. S.C. CODE ANN. § 44-7-560(1)(b)(i)-(v) (Law. Co-op. Supp. 1995).

45. *FTC v. Ticor Title Ins. Co.*, 112 S. Ct. 2169, 2178 (1992).

46. *See id.* at 2177 (stating that the purpose of the active supervision inquiry "is to determine whether the state has exercised sufficient independent judgment and control so that the [anticompetitive conduct has] been established as a product of deliberate state intervention, not simply by agreement among private parties").

47. By rejecting some requests, the regulatory agency demonstrates active control over the anticompetitive conduct, rather than merely rubber-stamping participants' anticompetitive schemes. *See, e.g., Patrick*, 486 U.S. at 101 (noting that "[t]he active supervision prong of the *Midcal* test requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail Absent such a program of supervision, there is no realistic assurance that a private party's anticompetitive conduct promotes state policy").

care field from liability, but only a fully staffed and fully funded program will properly immunize purchasers and providers.

IV. REGULATION 61-31

DHEC approved Regulation 61-31, pertaining to health care cooperative agreements, on December 8, 1994, and the Regulation became effective June 23, 1995.⁴⁸ The Regulations describe an active supervisory role for the state. An application for a Certificate of Public Advantage must be filed with DHEC,⁴⁹ which will review the application to determine whether it is complete.⁵⁰ When DHEC determines that the application is complete, DHEC must forward a copy to the Attorney General's Office.⁵¹ The Attorney General "may advise" DHEC in writing "to approve or deny the application."⁵² Failure of the Attorney General to act within thirty days constitutes a recommendation of approval to DHEC.⁵³

The Attorney General's required review tracks S.C. Code section 44-7-550(A), the only part of the Health Care Cooperation Act where compliance with *Midcal* becomes questionable. The regulation is ambiguous, providing that the Attorney General's failure to act within thirty days "constitutes a recommendation for approval of the request." This could be read as a negative option, resulting in automatic approval without sufficient statutory review.

The statute does not resolve the ambiguity. S.C. Code section 44-7-550(B) requires DHEC to issue an order "approving or denying the application for a Certificate of Public Advantage" upon receipt of the Attorney General's advice or (presumably if the Attorney General fails to act) "at the end of the review period outlined in [s]ection 44-7-540." Whether DHEC makes an independent decision, or is instead required to follow the Attorney General's advice, is dangerously unclear. Were this the final expression of state authority, the negative option would likely taint the entire regulatory system. However, Regulation 61-31, section 305 resolves the ambiguity in favor of active state regulation: "The Attorney General's opinion is advisory and DHEC is responsible for rendering the final decision."

There is no negative option in DHEC's responsibilities under the Regulations. Section 307 of Regulation 61-63 requires DHEC to consider the record before it (including any opinion from the Attorney General), the application, input from affected persons, relevant data, literature, and other

48. Regulation 61-31, drafted by Leon Frishman, was discussed in depth at the Eighth Annual Health Care Law Seminar, sponsored by the South Carolina Bar CLE Division on September 22, 1995. Mr. Frishman's Regulations are well-drafted, but he expressed some of the same concerns that are expressed by the authors of this article.

49. S.C. CODE REGS. 61-31 § 301 (Supp. 1995).

50. S.C. CODE REGS. 61-31 § 302 (Supp. 1995).

51. S.C. CODE REGS. 61-31 § 305 (Supp. 1995).

52. *Id.*

53. *Id.*

information.⁵⁴ The Department's decision must be in writing and must "set forth the basis for the decision." An affected person may undertake an administrative appeal, and DHEC's decision is not final until the appellate process is complete.⁵⁵ Thus, it appears that the Regulations provide DHEC with sufficient authority to supervise actively the process of granting Certificates of Public Advantage.

Initial supervision, however, is not enough. Active state supervision requires some involvement in monitoring the continued favorable status of the arrangement. The Regulations once again direct such supervision. Review is two-fold: first, DHEC is required to "actively monitor" the arrangement and "may request" additional information at will; second, parties to the arrangement must file an activities report with DHEC every two years after a certificate is granted.⁵⁶ In fact, the Regulations do not stop with the mere filing of a biennial report. DHEC is required affirmatively to determine "whether the cooperative agreement continues to comply with the terms of the Certificate of Public Advantage."⁵⁷ DHEC's monitoring activities, however, are not as well-defined as the initial granting activities. Thus, although the Regulations mandate review of the activities report by DHEC at least every two years, there are no requirements of publication, notification of affected persons, or the like, except when a certificate is revoked.⁵⁸ Although this creates some small risk, the risk does not appear significant in light of the extensive review at the initial certificate stage.

Of far more concern to the practical effect of creating a state action exemption are (1) the paucity of data required in initial support of the application, (2) the lack of funding for operation of the program, and (3) the lack of personnel to enforce the regulatory requirements. *Ticor* requires not only that a state agency be authorized to supervise; the agency must also actually supervise. Clearly, the *Ticor* requirements are not fulfilled on paper alone, and a court may look beyond the written word to a state's actual regulatory activities. Any such review of South Carolina's scheme could prove fatal.

S.C. Code section 44-7-560 defines the economic benefits that could result from a cooperative health care arrangement.⁵⁹ Admittedly, these are worthy objectives. However, the data that participants are required to provide to DHEC could not possibly provide a sufficient basis on which to determine whether in fact such benefits are achieved. The Regulations are nonspecific as to the economic market data required and, in fact, anticipate that applicants themselves will perform the economic analysis. The applicant is thus directed to "[d]emonstrate and document that the likely benefits accruing from the

54. *Id.*

55. *Id.*

56. S.C. CODE REGS. 61-31 § 502 (Supp. 1995).

57. *Id.*

58. *See, e.g.*, S.C. CODE REGS. 61-31 §§ 501-503 (Supp. 1995).

59. These include, for instance, "gains in the cost efficiency of . . . services," "avoidance or elimination or reduction of duplication of health care resources," and "preservation of health care providers close to communities." S.C. CODE ANN. § 44-7-560 (Law. Co-op. Supp. 1995).

cooperative agreement outweigh the likely disadvantages.” Rather than DHEC assuming responsibility to determine “how the cooperative agreement will reduce competition, reduce patient choice, or otherwise negatively impact the health care system”⁶⁰ based on economic data collected by the Department, the applicant performs the critical task. Because the applicant defines the problem, describes a solution, and submits only the data that support the solution, there may be no basis on which DHEC could possibly undertake a *de novo* review.⁶¹

The regulatory preference for analysis by confession may be explained by the lack of a budget and personnel to implement the review required by the Health Care Cooperation Act and Regulation 61-31. It is indeed amazing that Leon Frishman was able to produce the high-quality Regulation 61-31. During the Eighth Annual Health Care Law Seminar,⁶² he indicated that DHEC enforcement staff was nonexistent, and that any enforcement will be funded only by filing fees. Although filing fees are significant,⁶³ they cannot fund a nonexistent staff. Unless a DHEC enforcement staff is funded and active, there is little chance that the Health Care Cooperation Act will provide the immunity that the Legislature intended to create.

V. NONREGULATED ACTIVITIES

Even if the legislature were to fund the program and DHEC were to provide sufficient supervision, however, antitrust problems might still arise. Providers and purchasers of health care must remain vigilant during the pre-filing stages. The Act’s language is dangerous. S.C. Code section 44-7-520(B) provides that parties negotiating a cooperative agreement will not be subject to state antitrust laws, but makes no similar claim for the federal antitrust laws.⁶⁴ The section broadly defines the General Assembly’s

60. S.C. CODE REGS. 61-31 § 202 (Supp. 1995).

61. Compare the Application required by S.C. CODE REGS. 61-31 § 202 (Supp. 1995), for instance, to that required by the Department of Justice and the Federal Trade Commission in connection with the Hart-Scott-Rodino Antitrust Improvements Act premerger notification. In the latter, the applicants are required to provide extensive raw data as to sales, markets, and the like. The economic impact analysis is left to the economists at the FTC or the DOJ. By contrast, under the South Carolina scheme, the applicants are asked to function as DHEC’s economists. It seems dangerous indeed to assume that one seeking a Certificate of Public Advantage will undertake a review of the competitive situation designed to protect state interests, rather than the individual’s interests. The admonition of the Court in *Ticor* that the agency must have “exercised sufficient judgment and control” must be recalled. See *FTC v. Ticor Title Ins. Co.*, 112 S. Ct. 2169, 2177 (1992). State agency dependence upon a participant—who is presumed to be acting in her own interests—may not constitute “sufficient judgment and control.” See *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 47 (1985).

62. September 22, 1995.

63. Regulation 61-31 § 509 prescribes initial filing fees of \$3,000 per party (maximum \$15,000 per application) and monitoring fees of \$5,000 or \$7,000 depending on the number of participants. S.C. CODE REGS. 61-31 § 509 (Supp. 1995).

64. Section 44-7-520(B) reads in part: “A health care provider, health provider network, or health care purchaser may negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any state antitrust law.”

intention that the Act immunize “covered activities” from federal antitrust challenge, which may create a mistaken sense of security at the prefiling state.⁶⁵ Early negotiations cannot be shielded from federal antitrust challenge because the state is not actively evaluating, monitoring, and participating in those potentially anticompetitive activities. The active state supervision required by *Ticor* and directed in the Act is not evident in the period prior to filing an application; thus there can be no state action immunity for these activities. In addition, the protection offered against state antitrust laws applies only if the parties actually apply for a Certificate of Public Advantage. If the negotiations fail to result in an application, the parties remain subject to both state and federal antitrust laws.

Meetings and negotiations among competitors are among the riskiest activities under the antitrust laws.⁶⁶ To the extent that the Act appears to shield these activities from antitrust scrutiny, it is particularly misleading. Health care competitors should continue to enter into negotiations or discussions to achieve the benefits cooperation can engender. However, agendas that steer clear of forbidden issues should be rigidly followed, and antitrust counsel should be involved. Health care providers would be wise not to depend at all on the protection ostensibly offered in section 44-7-520(B).

VI. CONCLUSION

If adequately funded and enthusiastically administered, the Health Care Cooperation Act will provide immunity from antitrust statutes. However, health care industry participants can and should undertake measures to minimize potential antitrust danger: (1) During initial negotiations, assume that all antitrust laws apply; consult with and involve antitrust counsel in these activities. (2) Encourage DHEC to exercise affirmatively the authority provided by the Act and Regulations; do not accept or act upon a “negative option” approval. (3) Conduct business cautiously until DHEC has issued a Certificate of Public Advantage, perhaps following “hold separate” conduct until that time. (4) Provide DHEC with complete information to allow it to actively monitor the activities undertaken under the Certificate. (5) Encourage adequate funding by the legislature.

It seems antithetical to encourage state involvement in industry activity. And unless the contemplated activity poses an antitrust risk, the usual efforts to avoid attracting regulatory attention may still be the best approach. However, to escape the potentially lethal embrace of the antitrust laws, the Health Care Cooperation Act must be fully implemented and actively enforced.

In addition, conduct in negotiating and entering into a cooperative agreement for which an application for a Certificate of Public Advantage is filed in good faith is immune from challenge or scrutiny under state antitrust laws” S.C. CODE ANN. § 44-7-520(B) (Law. Co-op. Supp. 1995).

65. “It is the intention of the General Assembly that this article immunizes covered activities” from the federal antitrust laws. S.C. CODE ANN. § 44-7-520(B) (Law. Co-op. Supp. 1995).

66. *See, e.g., United States v. American Airlines*, 743 F.2d 1114, 1122 (5th Cir. 1984) (holding that an agreement in restraint of trade is not necessary for a violation of the federal antitrust laws; mere verbal attempts to monopolize are sufficient).

If this is done, state action immunity can provide some of the predictability providers are seeking in the dynamic, changing health care industry.