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SELECTED LEGAL ISSUES AFFECTING A STATE'S MOVEMENT TOWARDS HEALTH CARE REFORM

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I. SOCIAL AND HISTORICAL PERSPECTIVES ON HEALTH CARE REFORM IN AMERICA

On November 3, 1992, the issue of health care reform moved to the top of America's political agenda. On that day, a plurality of people voting in the Presidential election chose Bill Clinton, the candidate who campaigned strongly on the premise that our nation's health care system is no longer serving our needs as it should.

In exit interviews, voters made it clear Mr. Clinton's stand on health care had been an important factor in their decisions—a point the electorate continues to make. Polls taken by political and news organizations since that time have shown the proportion of people who believe health care reform is necessary remains fairly constant at about ninety percent.

When the public speaks with such a clear voice, elected officials listen, although they do not always hear the same thing. A year and a half after Election Day 1992, the shape of the new health care system that will emerge from the political debate still cannot be entirely foreseen. As this publication goes to press, at least thirty proposals based on several different concepts of national health care reform have been presented to the United States Senate and House of Representatives. These include the President's own plan, the American Health Security Act; an official Republican "response" plan; a proposal for a single-payer system similar to Canada's; and several other partisan or bipartisan alternatives. In addition, some states have enacted major reforms of their own systems; and others are seriously studying the issue and considering action. In Iowa, two different proposals for comprehensive reform, one from Governor Branstad and one from a consortium of Democrats, were presented to the Legislature at the 1994 session. Portions of the Governor's proposal were enacted, but no comprehensive reform measures were passed.

Although the President has made it clear he wants national health care reform to be enacted quickly, there is no assurance Congress will comply; and it is apparent that few portions of his proposed legislation will go unchallenged. Any comprehensive bill that succeeds at the national level is likely to be a compromise that tempers President and Hillary Rodham Clinton's ideas and ideals with the imperatives of many competing points of view.

Similarly, it is difficult to predict how reforms at the state level will fit in with the national system. Will the final national legislation allow states to retain their own reforms or will it require them to adhere to the national model? What new regulatory mechanisms will be created at the national level and how will these mesh with the states' traditional regulatory role?

Despite many such questions, there is reason to hope that, at long last, America will soon join the rest of the industrialized world in providing its people with universal health care benefits in a rational system of delivery and financing. For many in the health insurance industry, that prospect is both exhilarating and frightening. Over the past five decades, health insurance

coverage has become a key component in financing our nation's medical care—making it accessible to the vast majority of Americans, not just to the very wealthy. By the same token, system-wide health care reform will certainly mean broad changes in the market, the products, and possibly even the very concept of health insurance.

Although the specifics of national and state health care reform are still unclear, it is possible to discern some elements that have sufficient broad based support to be included, in some form, in the final legislative package. Trends that have evolved in the health insurance marketplace over the past decade likewise can provide some interesting clues to the future of the industry. Based on these insights, one can begin to see the outlines of what health insurance might look like in a reformed health care environment:

- More people will be covered by integrated managed care plans, such as Health Maintenance Organizations (HMOs) or Organized Delivery Systems (ODSs). Managed care plans have become increasingly popular because they are perceived as being more effective at controlling utilization and, therefore, the costs of benefits. Nationally, growth in HMO membership increased from 6 million enrollees in 1976 to nearly 38 million enrollees in a total of 550 HMOs in 1991.[1]
- Managed care plans will be based on innovative arrangements that encourage more cost effective and higher quality health care by sharing incentives and risk among physicians, hospitals, and insurers. Insurance companies like Blue Cross and Blue Shield are facilitating the formation of such networks and helping manage the administration and the financial risk of the new programs.
- Voluntary purchasing coalitions are forming in many locations, even before any laws are passed. These coalitions are intended to increase the buying power of groups and individual policyholders by creating large customer pools that negotiate and contract directly with individual providers and integrated health plans.
- Health plans will increasingly emphasize quality, service and other factors that influence consumer satisfaction. There is a strong trend toward consumer report cards, which compare services provided by competing health plans according to industry norms and customers' perceptions of service and quality; there is also a trend toward accreditation of HMOs and other integrated delivery systems.
- Only the larger, stronger insurers will be able to survive in a managed care marketplace. In order to be competitive, health plans will need to have sufficient capital to afford to offer comprehensive services and large enough enrollments to provide these services cost effectively.
- There will be a greater emphasis on preventive care, health education, and medical consumerism.

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1. HEALTH INSURANCE ASSOCIATION OF AMERICA, 1992 SOURCE BOOK OF HEALTH INSURANCE DATA 9 (1992).

• Market reforms will expand access to coverage by limiting exclusions or waiting periods and mandating coverage that is portable from job to job. Most reform proposals also call for some form of community rating.

Many insurance leaders see health care reform as an opportunity to go back to the basics of the insurance industry. While insurers now try to remain competitive by limiting risk, if they were able to return to more inclusive market practices—with appropriate safeguards—they would once again be able to serve the people who most need insurance products and to compete on the basis of quality and service. Instead of looking over physicians' shoulders in the name of cost containment, insurers could work together with physicians to develop integrated systems that would give physicians the freedom to make decisions and the financial incentive to provide high-quality care. Instead of working at what all too often seems like cross purposes to serve their own sovereign needs,[2] insurers, doctors, hospitals, and patients could once again concentrate fully on what should be the insurance industry's primary concern: making the patient well.

For health care reform to come about, however, the insurance industry, doctors, hospitals, and hundreds of other interests, must have the vision—and the courage—to look past the frightening prospect of change and to concentrate on the rewards that lie beyond. So far, this has never happened in America.[3]

Since the Industrial Revolution, several national initiatives have attempted to legislate various kinds of universal coverage that would protect workers and members of the middle class from the devastating financial effects of illness. Every attempt has been fiercely opposed by special interests who succeeded in defeating or gutting much of the proposed legislation and stalling the rest until something else distracted the nation.

In 1915, insurance companies, doctors, drug companies, business and, ironically, labor, lined up to defeat a movement to provide "sickness benefits" to workers to cover lost wages.[4] Insurance companies offered the strongest resistance because they feared a national plan would compete with the "industrial" policies they were then selling to millions of Americans for a dime or a quarter each week.[5] Some labor unions also wanted to offer their own wage protection benefits.[6] Putting out the word that compulsory health insurance was, among other things, a creation of the "evil German empire,"

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2. See Thomas Boyd, *Cost Containment and the Physician's Fiduciary Duty to the Patient,* 39 DePaul L. Rev. 131, 158 (1989) (noting that what is profitable for physicians is often resisted by insurers).

3. *See generally*, PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 235-419 (1982).

4. *See id.* at 240-57.

5. *See id.* at 252.

6. *See id.* at 249.

these allied interest groups were able to fight off health care reform until World War I finally halted the debate.[7]

The same scene, with a slightly different cast, was played out in the 1930s when New Deal legislators dusted off the idea of compulsory health insurance and expanded it to cover the rising costs of medical treatment.[8] The American Medical Association led the opposition to this idea, certain that it would infringe on doctors' professional autonomy.[9] Proponents of other New Deal programs also opposed a national health insurance plan as unwanted competition for federal dollars.[10] Once again, war made the issue moot.

During the Cold War, medical associations, the drug industry, and other opponents of health care reform had an irresistible weapon in the national "anti-Red" hysteria.[11] Their successful efforts to brand national health insurance as "socialized medicine" effectively beat back reform efforts endorsed by the Truman administration.[12] The same taint of communism later colored the Great Society debates that produced the Medicare insurance program for Americans over sixty-five and Medicaid for the poor under the Social Security Act of 1965.[13]

Hospitals carried the battle flag when cost containment became a leading issue in health care reform during the 1970s. They had particular problems with Nixon administration efforts to promote the development of HMOs in a policy that also included national health insurance.[14] Nevertheless, at least some portions of the Nixon program were on the verge of succeeding until they were swept away, along with President Nixon himself, in the tide of Watergate.[15]

Hospitals also led the charge, closely followed by the American Medical Association, against President Carter's efforts to put a limit on the growth of hospitals in the late 1970s.[16] Backed with an impressive lobbying war chest, they also succeeded in halting Senator Edward Kennedy's efforts to promote national health insurance.[17]

Today, of course, one can look back and clearly see that even the partial reform efforts that did succeed, such as the Medicare and Medicaid programs, produced enormous windfalls for the very interests that had originally opposed them most strongly. If these groups had been able to foresee the

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7. *See id.* at 253.
8. *See id.* at 266-80.
9. *See id.* at 270-75.
10. *See id.* at 266-70.
11. *See id.* at 280-86.
12. *See id.* at 280.
13. *See id.* at 367-74.
14. *See id.* at 393-404.
15. *See id.* at 404-05.
16. *See id.* at 411-17.
17. *Id.*

degree to which these programs would benefit their own interests—as well as those of the public—surely they would not have resisted as long and hard as they did. Their failure to recognize such evident self-interests should remind today's proponents to create a consensus for the broad principles of health care reform before beginning debate on specific issues.

Interest groups will be more likely (although by no means certain) to see the advantages to themselves when they are able to participate as co-authors, rather than as adversaries, in reform efforts. The lead author of this Article, Robert Ray, has personally been involved in several of these broad-based roundtables. He now serves as cochairperson of the nonpartisan National Leadership Coalition on Health Care Reform (NLC), a successor to the National Leadership Commission, which was formed in 1986 by a group of concerned citizens from the communities of health care, business, law, economics, politics, ethics, and labor. The Iowa Leadership Consortium on Health Care (ILC), which we convened in 1989, included representatives from the insurance industry, large and small business, labor, doctors, nurses, hospitals, state government, and consumers. In Iowa, the consensus building approach continued in state reform efforts under the auspices of the Iowa Health Reform Council, funded by a two-year grant from the Robert Wood Johnson Foundation.

In both the NLC and the ILC, the various interests learned to hear the concerns of others and to value mutual accommodation. Most chose to work toward proposals all could live with rather than ones that would serve the needs of only a few. Almost all participants acknowledged that serving the greater good in addressing the nation's pressing health care problems would, in the long run, benefit their own interests as well.

Now that the debate on health care reform has moved from voluntary conference tables to the floors of the United States Capitol and Statehouses nationwide, many of the interest groups that have historically opposed health care reform are, today, choosing to support at least its concept. These include many key sectors in the health care system itself, including the American Medical Association, the American Hospital Association, and countless other trade and professional organizations as well as many individual insurance companies.

Most of these groups climbed on the bandwagon in the months following President Clinton's election because it appeared that health care reform was inevitable, supported as it was by nine out of ten Americans. While endorsing the general idea of reform, each interest also made it a point to promote a version favorable to its own economic traditions. Once the Clinton Plan began to show significant vulnerabilities, however, all sides have become more aggressive, engaging in the kind of negative campaigns that, once again, threaten to torpedo any prospects for meaningful reform by diminishing public and legislative support for its various elements.

One example of this is the running battle between the Health Insurance Association of America (HIAA) and backers of the Clinton Plan. After HIAA

began a series of broadcast and print advertisements critical of the Plan, Hillary Rodham Clinton responded by characterizing the health insurance industry as "a center of greed 'that has brought us to the brink of bankruptcy'".[18] The war of words has escalated from there, at great cost to the credibility of our industry and of health care reform.

Similarly, some interests, such as business, which initially supported reform as a cost-cutting tool, are now starting to question what value they would really receive from the plans currently on the table. Politicians, both Republicans and Democrats, have lately felt emboldened to question the need for comprehensive reform at all, publicly declaring that there is no health care crisis. That is a dangerous position.

Regardless of the ebb and flow of the political debate, the health care crisis remains real and destructive. The United States Department of Commerce estimates that America's health care spending will reach $1.06 trillion in 1994, accounting for a record 15% of our nation's output of goods and services.[19] This represents a growth rate of 12.5%, the biggest rise in more than a decade and several times the rate of overall inflation.[20] The Commerce Department report predicts that, without reform, health care expenditures will rise by an average annual rate of 13.5% over the next 5 years, and will account for 18% of the gross domestic product by the year 2000.[21]

This burden rests heavily on business, which provides more than 80% of the private insurance in America and also bears more than one-third of the nation's total health care costs. Results released in February 1994 of a survey of employers by the benefits-consulting firm A. Foster Higgins & Co. revealed that companies paid an average of $3781 in medical costs per employee in 1993, a rise of eight percent from the previous year.[22] While this was a smaller increase than in the five previous years, it was still more than twice the overall rate of inflation.

Much of this expense finds its way into higher price tags on American-made products. Edgar S. Wollard, Chief Executive Officer of DuPont, said the rising costs of benefits amount to a surcharge that has "a direct impact on the competitiveness of many companies in the United States, including DuPont."[23] He added, "There was a time when increased health care costs could be made up through increases in the prices of our products. . . . This is now impossible."[24]

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18. *First Lady Takes on Health Insurers*, DES MOINES REG., Nov. 2, 1993, at A1.

19. United States Department of Commerce, *Health and Medical Services*, U.S. INDUSTRIAL OUTLOOK, Jan. 1994, at 42-7.

20. *Id.*

21. *Id.* at 42-8.

22. A. Foster Higgins & Co., The National Survey of Employer Sponsored Health Plans (Apr. 1994).

23. John Holushu, *Dupont Sets a Charge of $5 Billion*, N.Y. TIMES, Jan. 5, 1993, at D4.

24. *Id.*

Within the vast health care marketplace, one might expect to see everyone happily getting rich, but that is not the case. Insurance companies, caught in a widening gap between rising charges and customer demands for lower costs, find themselves increasingly playing the low-profit roles of third party administrators to self-insured plans and purchasing coalitions. Insurers also pay a substantial portion of the cost of treating the more than 39 million Americans—mostly the working poor and their dependents—who have neither government nor private health insurance.

Hospitals, too, bear the costs of caring for the uninsured. During 1992, the cost to Iowa hospitals for bad debts and charity care grew by $23 million, according to the Iowa Hospital Association (IHA).[25] Hospitals also struggle to finance the widening unpaid balance between actual costs and reimbursements from government programs such as Medicare and Medicaid. According to a February 1993 statement by Stephen Brenton, president of the IHA, hospitals in Iowa were expected to lose an average of more than $500 each time a Medicare patient was admitted in 1993.[26] While this burden is ultimately assumed by private payers through the practice of cost shifting, hospitals also feel the squeeze. A growing number of hospitals in urban or suburban areas have been taken over by for-profit hospital chains; many rural and small town hospitals have had to close their doors.

Physicians, who for decades fended off health care reform as a threat to their professional independence, now find themselves working in growing numbers as salaried employees of large health care conglomerates. They also struggle to maintain some semblance of the art and science of medicine as cost containment measures such as utilization review intrude on the doctor-patient relationship.

Health care reform will certainly not put a dramatic and total stop to problems of soaring costs. The reasons for those costs are deeply rooted in the values, expectations, and changing demographics of American society. Nor will health care reform allow a return to the days when—if they existed at all—one could do business completely free of the constraints of cost containment. Business must continue to be done in ways structured to conserve dollars. The difference is that the constraints would, presumably, be more fairly applied and access to health care fairly shared among all Americans.

High costs, of course, are not the only problem that health care reformers must consider. Costs are intertwined, however, with virtually all of the other issues—many of which have been bundled together as access, or more precisely lack of access, to health insurance coverage—that now frustrate American health care consumers.

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25. *A Profile of Service to the People, IOWA* HOSPS. (Iowa Hosp. Ass'n, Des Moines, Iowa), Jan. 1994, at 24.

26. News Release from the Iowa Hospital Association, Des Moines, Iowa, Iowa Hospital Charges Low Despite Growing Government Shortfalls, Feb. 2, 1993 (on file with authors).

As politicians have discovered and must remember, these consumers are also voters. In recent years, these consumers have expressed a strong desire for a health care system that provides every American with the necessities of health care, including preventive programs, such as immunizations. Consumers are calling, loudly and clearly, for insurance that is affordable, portable from job to job, and guaranteed to all, regardless of pre-existing conditions. A reformed system must, of course, provide these services in a cost effective way, without compromising the third necessary component of a rational health care system: excellent quality of care.

To gain support from a public made increasingly cynical by the negative advertising and publicity surrounding the legislative debate, a proposal for health care reform must find ways to accommodate some of our traditional national values, including the American dream—for most people, now more of a fantasy—of a close one-on-one relationship with a family doctor. Some traditional prerogatives, such as free access to specialists or diagnostic tests, may have to yield to managed care and the goal of cost containment. Other issues, such as access to abortions, the "right to die," and the rationing of health care may be caught up in long debates among Americans with conflicting personal values and spiritual beliefs.

It was as a result of the Great Depression that health insurance became an important part of America's system of financing health care. Today's health insurance evolved from a mutual effort by hospitals, and later, doctors, to make it possible for working people to afford care for themselves and their families by prepaying the costs of that care. A good working system to provide health care to Americans in the next century would do well to acknowledge the historic mission of the health insurance industry as well as to build on the strengths of those who deliver and finance health services today.

Policymakers at the state and local levels still have the opportunity to make partners, rather than adversaries, of the doctors, hospitals, insurers, business, government, consumers, and others who comprise our nation's health care system. Since November 1992, all of these interests have expressed willingness to support at least the principles of health care reform. For many, this marks a historic new direction. It is incumbent upon those of us who are fully committed to the health of our health care system to extend our hands and encourage them to stay for the journey.

II. ORGANIZED DELIVERY SYSTEMS: AN OPTION FOR STATE OR NATIONAL HEALTH CARE

One system that has received a great deal of attention from national reformers and from the ILC is the ODS. The ILC proposal defined an ODS as "a group of rural and/or urban doctors, hospital(s), allied health professionals and other providers affiliated to deliver a comprehensive package of health care services to an enrolled population at a prepaid capitated rate, that is, at

a fixed payment annually per enrollee."[27] The ODS model appears under different names in other reform plans. In the Jackson Hole plan, popular with Clinton administration policymakers, it is called an Accountable Health Plan; elsewhere, it has also been referred to as a Community Care Network.

As a vertically integrated system of health care, the ODS is comparable in structure to an HMO.[28] One major difference is physicians and other health care providers would have an ownership stake in the ODS, perhaps in partnership with a private insurer.

In most proposals, separate ODS groups within a community would compete on the basis of price and quality to provide comprehensive health services to large groups of employees. The current system of providers accepting patients from various health insurance plans would be discouraged; however, exceptions could be made for rural providers on the fringes of different ODSs.[29] Smaller companies would band together in purchasing cooperatives to increase their bargaining power with the ODS.

Proponents of the ODS approach believe this combination of vertical integration and "managed competition" would provide significant cost savings over other systems of delivering health care. During their slow rise to popularity since the early 1970s, HMOs have demonstrated their ability to contain costs; growth in costs for HMOs have consistently been slower than for other treatment models.

As financial partners, and therefore risk-sharers in an ODS, physicians additionally would have a substantial incentive to provide only those services that are medically necessary. Services would also be of high quality, and measured by advanced treatment and outcomes data analysis. In this way, an ODS would "manage care," but the management process would be more

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27. THE IOWA LEADERSHIP CONSORTIUM ON HEALTH CARE, HEALTH CARE REFORM: A PROPOSAL FOR DISCUSSION BY IOWANS 40 (Apr. 1992) (on file with authors) [hereinafter HEALTH CARE REFORM]. Accordingly, an ODS is close in theory to a staff made HMO in which providers employed by the HMO only have patients who are members of the HMO. *See* U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE ("THE PEPPER COMMISSION"), 101ST CONG., 2D SESS., A CALL FOR ACTION: SUPPLEMENT TO THE FINAL REPORT 38-40 (1990) [hereinafter A CALL FOR ACTION].

28. A CALL FOR ACTION, *supra* note 27, at 38-40.

29. *Id.* at 27-28. This is markedly different from other managed care options currently popular, such as preferred provider organizations (PPOs) and HMOs. A PPO is

> [a] health care delivery system composed of physician and/or hospital providers which represents an alternative to the restrictions of the HMO system and the selectivity of traditional indemnity programs. PPOs are based on discounted payments on a fee-for-service basis to preferred providers. Beneficiaries are offered financial incentives to purchase health care services from PPO providers while retaining the option of purchasing such services from providers outside the PPO at a higher out-of-pocket cost.

JAMES H. SNEED & DAVID MARX, JR., ANTITRUST: CHALLENGE OF THE HEALTH CARE FIELD 218 (1990). An HMO can be defined as an "[o]rganized health care system[], combining health care insurance with delivery of services. In exchange for a fixed premium, the HMO provides members with health care services through contracted providers." *Id.* at 217.

collegial and presumably much more professionally palatable than existing "third party" approaches, such as utilization review.[30]

Employers would also share in the financial rewards of lower costs and higher quality care from an ODS, as well as the planning advantages of having fixed "per employee" costs.[31] An additional cost-containment feature now under debate is the setting of mandatory spending limits, or suggested targets, by state or national boards, either separately or together.

The actual legal structure of an ODS could take several different forms.[32] The keys to all varieties are joint planning, shared services, and financial agreements between the providers in the ODS.[33] The more structured forms would have outside representatives on the governing board.[34]

III. FEDERAL LAWS TO BE ADDRESSED IN THE CREATION AND FINANCING OF ORGANIZED DELIVERY SYSTEMS

The failure to prepare a thoughtful business plan or have an adeqate level of economic integration among providers when creating and operating an ODS could adversely impact its ability to operate effectively under current law.[35] In addition, the method of financing the ODS could alter the benefits it offers, thereby preventing the ODS from achieving significant cost savings.[36]

In creating an ODS, either as part of an overall program of health care reform or as an alternative to other managed care options without reform, certain federal laws will affect the structure and operations of the entity. In the context of implementing an overall state reform program, these laws should be given due consideration or perhaps even modified so the promise the reform measures hold for reducing skyrocketing health care costs can be fulfilled. For purposes of this Article, the focus will be on federal antitrust laws and the Employee Retirement Income Security Act (ERISA).

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30. *See* SNEED & MARX, *supra* note 29, at 217.

31. *See generally* Tom Carney, *Health Care of the Future?*, DES MOINES REG., Feb. 21, 1993, at G1 (reporting an employer's satisfaction with its financial arrangement with United Health Care of Wisconsin, an ODS).

32. Stephen M. Shortell, Address at the Iowa Leadership Consortium on Health Care Meeting (Aug. 20, 1992) (manuscript on file with authors). Professor Shortell's speech included a detailed discussion of several different models for an ODS. For purposes of this Article, the actual structure assumed by an ODS is not important. All structures will, by design, cause the exclusion of some providers from the ODS, prevent competition between providers within the ODS, and require examination of the current prohibition against the employment of physicians by a corporation for the purpose of practicing medicine.

33. *Id.*

34. The representation of employers or other members of the ODS on the governing board along with the creation of a state commission to establish a global budget for health care could prove to be an effective substitute for the German system that uses regional sickness fund associations that negotiate fees with provider associations.

35. *See infra* text accompanying notes 58-70.

36. *See infra* text accompanying note 162.

A. *Antitrust*

The federal antitrust statutes most applicable to the health care industry are the Sherman Act[37] and the Clayton Act.[38] The purpose of these laws is "to promote competition and to protect consumers from the inappropriate exercise of market power."[39] Traditionally, health care was a local concern. Health care was not, therefore, subject to federal antitrust laws because theory held to the proposition that there were no effects on interstate commerce.[40] Further, the practice of medicine was believed not to be commerce, but rather a learned profession that fell outside the scope of federal antitrust jurisdiction.[41]

In *Goldfarb v. Virginia State Bar*,[42] the United States Supreme Court limited the learned profession exclusion to a great degree.[43] This change in the law had no real impact on federal antitrust law as it applied to health care, however, because the industry was still considered largely local in nature and therefore outside the scope of those laws. That jurisdictional issue was resolved against the health care industry in *Hospital Building Co. v. Trustees of Rex Hospital*,[44] when the Court found that even though the hospital operated almost entirely locally, a Sherman Act Section 1[45] claim could be supported by looking at various out-of-state purchases, payments, and disbursements that affected interstate commerce.[46]

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37. 15 U.S.C. §§ 1-7 (1988).

38. *Id.* §§ 12-27. Because the Clayton Act is most applicable to merger activity, it will not be addressed in this Article.

39. *See* SNEED & MARX, *supra* note 29, at 2.

40. *See* Phillip A. Proger, *Application of the Sherman Act to Health Care: New Developments and New Directions*, 59 ANTITRUST L.J. 173, 174 (1990).

41. *Id.*

42. Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

43. *Id.* at 786-88; Proger, *supra* note 40, at 174. However, in Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982), the Court suggested in dicta that price-fixing arrangements by professionals that ordinarily would be considered to be per se illegal might be given special consideration if the public service aspects of the profession justified the arrangement. *Id.* at 348-49 (citing National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 696 (1978)). This point should not be lost on state decision-makers as they craft legislation to allow for the creation of ODSs as part of a health care reform program. The legislative history needs to set forth explicitly the critical public policy reasons that require the implementation of what might otherwise seem to be drastically anticompetitive measures.

44. Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738 (1976).

45. 15 U.S.C. § 1 (1988).

46. Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. at 741; Proger, *supra* note 40, at 175. The Court was careful to point out, however, the overall business activities of the defendant were not the focal point of this analysis. *See* Robert Enders, *Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges*, 17 LOY. U. CHI. L.J. 331, 333-34 (1986). Rather, the "restraint in question" is judged to see if it adversely affects commerce. *See* Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. at 743.

The final nail in the coffin for the health care industry's exemption from the federal antitrust laws came in 1982 in *Arizona v. Maricopa County Medical Society*,[47] when the Supreme Court refused to find the health care industry was entitled to any special considerations in determining jurisdiction under the federal antitrust laws.[48] With the jurisdictional hurdles removed, an explosion of federal antitrust lawsuits in the 1980s challenged various activities in the health care industry.[49] Most of the lawsuits were, and continue to be, brought under sections 1 and 2 of the Sherman Act.[50]

Despite the broad language of the statutes, the Supreme Court has interpreted the Sherman Act to prohibit only unreasonable restraints of trade.[51] A restraint of trade is unreasonable if it is within the category of activities considered per se unreasonable under the Sherman Act or is found to be unreasonable under the "rule of reason" analysis.[52] Under section 1, four particular types of conduct have been determined to be per se illegal: price-fixing among competitors, division of markets among competitors, certain concerted refusals to deal among competitors, and certain tying

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47. Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982).

48. *Id.* at 349; Proger, *supra* note 40, at 176. The Court was asked to determine whether an agreement by physicians setting maximum fees to charge for their services was a violation of § 1 of the Sherman Act. Arizona v. Maricopa County Medical Soc'y, 457 U.S. at 349. The physicians argued for special consideration, pointing out the arrangement was meant to hold down costs. *Id.* Nonetheless, the Court declined to accord any special treatment to the physicians' arrangement and declared the price-fixing arrangement was a per se violation of § 1. *Id.* at 351-54.

49. Proger, *supra* note 40, at 173.

50. 15 U.S.C. §§ 1, 2 (Supp. IV 1992); *see* Enders, *supra* note 46, at 332-33 n.1. Section 1 of the Sherman Act provides:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

15 U.S.C. § 1 (Supp. IV 1992).

Section 2 of the Sherman Act provides:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Id. § 2.

51. *See* Arizona v. Maricopa County Medical Soc'y, 457 U.S. at 342-43 (footnotes omitted).

52. *See* FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 458 (1986) (citing Board of Trade of Chicago v. United States, 246 U.S. 231, 238 (1918)).

arrangements.[53] The rule of reason analysis, on the other hand, is a balancing test to determine whether the efficiencies to be gained from the proposed conduct outweigh the anticompetitive effects.[54]

In an analysis on behalf of an ODS, the critical issue is to determine what its market is, whether there are competitors in that market, who the competitors are, and whether a particular form of conduct with those competitors could be construed as an agreement or conspiracy in restraint of trade.[55] Although the federal antitrust statutes seem somewhat simplistic in their wording, the case law and commentaries point out this is one of the most complicated areas of the law today.[56]

Although a full-blown analysis of antitrust issues that could be asserted against an ODS is probably better left to the scholars, a brief discussion of some critical issues for an ODS is justified before examining the exemption from federal antitrust laws available under a health care reform initiative.[57]

First, if no competitors are engaged in the conduct with the ODS, there can be no violation of section 1 of the Sherman Act because it does not prohibit conduct that is wholly unilateral.[58] Operationally, however, the ODS is subject to the antitrust prohibitions against per se unreasonable conduct.[59] Therefore, business plans need to be reviewed periodically with this in mind. Second, at least at the outset, it is doubtful the ODS would have enough market share to warrant a Section 2 claim being brought against it. Periodic review of this element needs to be conducted as the ODS's market share grows. Third, the creation of the ODS itself could possibly be challenged as an agreement among competitors to fix prices.[60] In the event this challenge is made, the degree of economic integration and risk sharing by the providers within the ODS is critical.[61] Further, proof of the parties' motive to restrain

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53. SNEED & MARX, *supra* note 29, at 23-28.

54. *Id.* at 218-19. The rule of reason analysis is performed by defining the relevant market and then evaluating the anticompetitive effects of the proposal. *Department of Justice and Federal Trade Commission Antitrust Enforcement Policy Statements in the Health Care Area,* [July-Dec.] Antitrust & Trade Reg. Rep. (BNA) No. 1631, at S-3 to S-5 (Sept. 15, 1993) [hereinafter *DOJ Policy Statements*]. Any ancillary policies or agreements are also reviewed for any antitrust violations. *Id.* If the proposal passes through these hurdles it does not violate the federal antitrust laws.

55. *See generally* SNEED & MARX, *supra* note 29, at 23-28.

56. *See* Proger, *supra* note 40, at 179-90.

57. *See infra* text accompanying notes 71-88. The antitrust issues facing an ODS are almost identical to those facing HMOs, PPOs, and other managed care programs.

58. *See* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984) (citing Albrecht v. Herald Co., 390 U.S. 145, 149 (1968)).

59. *See supra* text accompanying note 51 .

60. *Cf.* Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982).

61. *See* SNEED & MARX, *supra* note 29, at 10-14. Generally speaking, an ODS should make sure it contains the following four elements to avoid a finding its efforts to set prices are not found to be per se unreasonable:

> [1.] The providers [should] pool a significant amount of capital and share the risk of adverse financial results for the [ODS] as a whole;

trade must be shown to satisfy the requirement that there be an agreement or conspiracy in restraint of trade.[62]

As with existing managed care programs, other critical antitrust issues for an ODS are both over-inclusion and under-inclusion of providers. If an ODS includes too many providers in its organization, it runs the risk of being challenged by other managed care programs or the federal government as a combination in restraint of trade.[63] On the other hand, if the ODS is under-inclusive, it runs the risk of challenge on the basis it has engaged in a group boycott or entered into an agreement among competitors in restraint of trade.[64] This is perhaps the greatest antitrust risk facing an ODS that must exclude certain providers to run efficiently. The ODS may prevail in the face of such challenges if it is able to show its good-faith reasons for the over-inclusion or under-inclusion of providers.[65]

Finally, if the ODS does not engage in any activities that are per se unreasonable, it may also be challenged using the rule of reason analysis.[66] The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have said that in the case of physician network joint ventures the relevant market is determined according to the services provided.[67] Thus, it is logical to conclude that the relevant market for an ODS will initially compare the ODS with all other providers in the relevant geographic area by the types of services provided. If the geographic area is large enough and the concept of

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> [2.] The [ODS should be] marketed as a single entity to payors;
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> [3.] The [ODS should] engage[] in joint billing, utilization management, utilization review and/or peer review activities;
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> [4.] The [ODS should] provide[] benefits to payors (*e.g.* more efficient negotiations, lower transaction costs, discounted fees or charges) that were not previously available from the individual providers.

Id. at 87.

One of the few cases discussing the level of economic integration and risk sharing on the part of providers in an unreasonable activity is Hassan v. Independent Practice Assocs., 698 F. Supp. 679 (E.D. Mich. 1988). In *Hassan*, physicians formed an independent practice association (IPA) to contract with an HMO to provide services to its enrollees. *Id.* at 681. In addition to the physicians' integration of their practices, the IPA shared losses with the HMO up to 15% of the rates to be paid to the IPA by the HMO. *Id.* at 682.

62. SNEED & MARX, *supra* note 29, at 12.

63. *Id.* at 89-91. The authors also quoted from the Department of Justice's policy on this issue, which focuses both on the percent of total providers included in the relevant market and the exclusivity of the arrangement. *Id.* at 90 (quoting Remarks of Charles Rule, Assistant Attorney General, Antitrust Division, United States Department of Justice 16-17 (Mar. 11, 1988)).

64. *Id.*

65. *Id.* Examples of such justifications include concerns over quality care, the provider's willingness to provide the most cost-effective forms of treatment, and so forth. *See* Hassan v. Independent Practice Assocs., 698 F. Supp. at 694.

66. *See supra* notes 54 and accompanying text.

67. *DOJ Policy Statements*, *supra* note 54, at S-15.

ODSs gains popularity, the relevant market may focus on all ODSs in the area.

In assessing the balance of the anticompetive aspects of an ODS against the potential efficiencies to be gained there are strong arguments to be made that ODS could pass the rule of reason test. Each individual sitation, however, will rest on its own merits. The DOJ and the FTC have instigated an expedited business review procedure for certain joint ventures that promises an advisory opinion within ninety days.[68] This should provide some additional guidance to those traveling this largely uncharted course. However, the advisory opinions do not protect the requesting ODSs from anything other than enforcement actions and even this protection is tenuous.[69] In addition, it is not necessarily the threat of a successful legal challenge as much as the threat of litigation that would produce a chilling effect on those who are otherwise inclined to seek the advantages of the efficiencies to be gained by integrating into an ODS. Thus, reform of the health care delivery system needs to be "jump started" with the assistance of state legislatures if not the federal government.

These are but a few of the possible federal antitrust challenges that could affect the creation and operation of an ODS. The laws also need to be analyzed in light of the operating plan of the ODS to make sure the ODS is not engaging in activity that violates the antitrust laws. This is not a task to be taken lightly given the treble damage provision under the federal antitrust laws.[70] The principal source of increased antitrust risk facing an ODS could be the very state health care reform proposals creating them. These proposals will, most likely, call for fee setting, exclusion of providers, limitations on budgets for technology, and so forth. The prospect of federal antitrust relief for these entities without a comprehensive national health care reform carries with it a lot of baggage making this prospect slight. The proposals under consideration by Congress take too much time to come to fruition. Thus, the ODS must be created and operated pursuant to a state legislated health care reform initiative carefully drafted to except the ODS from antitrust scrutiny under the state action doctrine.

1. *State Action Doctrine*

As the Supreme Court began to stretch the reach of the commerce clause,[71] laws that were previously thought only to affect intrastate commerce were suddenly pulled into the mire of federal antitrust law. This was the case

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68. *DOJ Policy Statements*, *supra* note 54, at S-19; *see also* 16 C.F.R. §§ 1.1-1.4 (1993).

69. *DOJ Policy Statements*, *supra* note 54, at S-19.

70. *See* 15 U.S.C. § 15(a) (1988).

71. U.S. CONST. art. I, § 8; *see, e.g.*, Dean Milk Co. v. City of Madison, Wis., 340 U.S. 349, 354-56 (1951); Baldwin v. G.A.F. Seelig, Inc., 294 U.S. 511, 521-26 (1935).

in *Parker v. Brown*,[72] in which the Court was asked to review a California raisin prorate program.[73] The program's intent was to restrain competition among growers through an elaborate state regulatory scheme in order to maintain stable raisin prices.[74] The Court noted the program would have violated the Sherman Act if it had been organized and operated solely by virtue of a contract between private persons, but held such an agreement was not present.[75] The state statute did not allow any sort of individual agreement or combination.[76]

Further, the Court could not find any language in the Sherman Act or its legislative history that precluded a state's officers or agents from carrying out the mandates of its legislature.[77] The Court held the state "made no contract or agreement and entered into no conspiracy in restraint of trade or to establish a monopoly but, *as sovereign*, imposed the restraint as an act of government which the Sherman Act did not undertake to prohibit."[78] Thus, alleged anticompetitive activities otherwise subject to Sherman Act prohibitions were now immune if undertaken by the state pursuant to its sovereign powers.

One problem with the *Parker* state action doctrine was not its creation, but how to determine when a state was acting as sovereign[79] and when it had merely created a statutory scheme that "prompted" private actors to engage in anticompetitive conduct.[80] Therefore, in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*,[81] the Supreme Court established a two-prong test to determine when antitrust immunity is warranted.[82]

The first prong of the *Midcal* test determines whether the state considered the anticompetitive consequences of the legislation when it enacted the statute from which the restraint is said to emanate.[83] The purpose of the second prong of the test is to ensure the state is an active participant in the

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72. Parker v. Brown, 317 U.S. 341 (1943).
73. *Id.* at 344.
74. *Id.* at 346.
75. *Id.* at 350.
76. *Id.*
77. *Id.* at 350-51. The Court noted the sponsor of the bill that created the Sherman Act stated it only prevented "'business combinations.'" *Id.* (quoting 21 CONG. REC. 2457 (Mar. 22, 1890)).
78. *Id.* at 352 (emphasis added) (citing Olsen v. Smith, 195 U.S. 332, 344-45 (1904)).
79. *See* Bates v. State Bar, 433 U.S. 350, 359-62 (1977).
80. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 790-92 (1975); Cantor v. Detroit Edison Co., 428 U.S. 579, 592-98 (1976).
81. California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980).
82. "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the State itself." *Id.* at 105 (quoting City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978)).
83. *See* William H. Page, *State Action and "Active Supervision": An Antitrust Anomaly*, 35 ANTITRUST BULL. 745, 749 (Fall 1990).

oversight of the conduct and has ultimate decision-making authority over the private interests.[84]

If the anticompetitive restraint passes muster under the *Midcal* test, even the conduct of private parties acting pursuant to the state action is immune from antitrust liability.[85] This same immunity has not been extended to subdivisions of state governments, such as counties and municipalities, unless a clearly articulated state policy is shown that evidences an intention to replace competition with regulation.[86] "Local government" units are, however, immune from damage suits under the federal antitrust laws by virtue of the Local Government Antitrust Act of 1984.[87] Therefore, in order for an ODS created or operating under a state health care reform initiative to be immune from antitrust attack, it must meet the *Midcal* test (or its derivation announced by *Town of Hallie* if the ODS is a local government entity[88]) or fall within the purview of the Local Government Antitrust Act.

2. *Application to an ODS*

In drafting legislation for health care reform which seeks to use all of the advantages of ODS structures, some conduct that is anticompetitive in nature may be included.[89] In order to avail themselves of the state action doctrine, it is particularly important that the drafters of the ODS create the appropriate legislative history to establish the first prong of the *Midcal* test. Legislative history must specifically refer to and acknowledge that certain anticompetitive activity will occur under the legislative scheme being considered. Further, the legislation needs to provide for regulation consistent with the second prong of the *Midcal* test.

Although one commentator argues this second prong of the test only allows "conventional command-and-control" regulation,[90] this is not entirely consistent with *Southern Motor Carriers Rate Conference, Inc. v. United*

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84. California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. at 105-06.

85. *See* Southern Motor Carriers Rate Conference v. United States, 471 U.S. 48, 56 (1985).

86. *See* Town of Hallie v. City of Eau Claire, 471 U.S. 34, 43 (1985); *see also* SNEED & MARX, *supra* note 29, at 17. The Court in *Hallie* also held the second prong of the *Midcal* test was inapplicable to municipalities. Town of Hallie v. City of Eau Claire, 471 U.S. at 40-47.

87. 15 U.S.C. §§ 34-36 (1988). For purposes of this discussion, the definition of local government includes the usual subdivisions of state government but also adds "any other general function governmental unit established by State law, [and] . . . any other special function governmental unit established by State law in one or more States . . . ." *Id.* § 34(1). Congress enacted this law to ease the burden on local governmental units posed by the treble damage provisions of antitrust law.

88. *See supra* text accompanying note 86.

89. *See supra* text accompanying notes 63-65.

90. *See* Page, *supra* note 83, at 749.

States.[91] The regulatory structure will sufficiently shield the ODS so long as the state actually exercises oversight and retains ultimate decision-making.[92] In order for an ODS to make a claim it is exempt under the state action doctrine, it is imperative the state legislation not leave these decisions entirely in the hands of the private interests benefiting from the anticompetitive restraints.

Several cases have interpreted whether state action immunity and immunity from antitrust damage suits as a local governmental unit are applicable to hospitals and other providers.[93] These decisions are helpful in determining when a locally chartered ODS would be considered immune from antitrust actions. These cases extend full state action immunity to locally chartered hospitals under the holding of *Town of Hallie.*[94]

State action immunity is of more benefit to an ODS than immunity under the Local Government Antitrust Act. State action results in total immunity from antitrust attack, whereas the Local Government Antitrust Act only bars damage suits.[95] Particularly important is *Sandcrest Outpatient Services v. Cumberland County Hospital System,*[96] because it extends immunity under the Local Government Antitrust Act to private parties acting in their official capacities for local government units.[97] No case has extended

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91. Southern Motor Carriers Rate Conference v. United States, 471 U.S. 48, 62 n.23 (1985) (holding the second prong satisfied when the state demonstrates its commitment to a program through its exercise of regulatory oversight).

92. *See* Patrick v. Burget, 486 U.S. 94, 101 (1988) ("The 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 to accord with state policy."). For example, the state should exercise some oversight for fee structures and perhaps even capital expenditure levels. In addition, the state must actually "exercise" its power and may even need some sort of mechanism for an ongoing review of organized delivery systems following the Supreme Court's decision in FTC v. Ticor Insurance Co., 112 S. Ct. 2169 (1992). *Ticor* makes it more difficult for participants in an ODS to claim state action immunity; however, such ongoing reviews of these contractual relationships would most likely be subject to a lower level of scrutiny than if the state used command and control regulation.

93. *See* Patrick v. Burget, 486 U.S. at 101 (denying physicians state action immunity for hospital peer review committee activities); Todorov v. DCH Healthcare Auth., 921 F.2d 1438, 1461 (11th Cir. 1991) (holding a hospital created pursuant to local chartering laws was a local governmental unit immune from antitrust liability under doctrine of *Town of Hallie*); Lancaster Community Hosp. v. Antelope Valley Hosp. Dist., 940 F.2d 397, 402 (9th Cir. 1991) (holding a hospital not shielded from antitrust activity when evidence showed state did not intend to replace competition with regulation), *cert. denied*, 112 S. Ct. 1168 (1992); Sandcrest Outpatient Servs. v. Cumberland County Hosp. Sys., 853 F.2d 1139, 1143-45 (4th Cir. 1988) (holding county hospital was immune from suit for damages brought under federal antitrust laws because it was a local governmental unit).

94. *See supra* note 86.

95. *See supra* note 87.

96. Sandcrest Outpatient Servs. v. Cumberland County Hosp. Sys., 853 F.2d 1139 (4th Cir. 1988).

97. *Id.* at 1147-48.

full state action immunity to private persons acting in their official capacities for a local governmental unit.

It is critical for the drafters of health care plans to consider the *Midcal* test and make the appropriate legislative history to insulate the anticompetitive behavior necessary to accomplish meaningful health care reform.[98] If the ODS will operate pursuant to local government authority, the modification of the *Midcal* test announced in *Town of Hallie* provides guidance as to the legislative history that is necessary to ensure some immunity for the ODS. Further, the private parties within the ODS may obtain some protection from damage suits based on the holding of *Sandcrest,* if the ODS meets the definition of a local government unit.[99] Without attention to these details, the threat of antitrust attack could stifle the ODS's ability to properly integrate providers, to set fees at an appropriate level, and to limit the amount of money spent on capital items. Behind the shield of antitrust immunity, however, ODSs will be able to operate in a manner that enables them to achieve cost savings while providing quality care.

B. *ERISA*[100]

ERISA[101] was created to promote a comprehensive federal regulatory scheme for employee pension and welfare plans.[102] A welfare plan is an employee benefit plan that provides employees with "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, [or] disability."[103] These benefits may be offered to employees through the purchase of insurance or some other financing arrangement such as self-insurance by the employer.[104]

Although ERISA imposes strict standards on welfare plans related to reporting, disclosure, and fiduciary responsibility, it does not mandate that

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98. An option to the construction of an appropriate legislative history is to seek a special legislative exemption from the antitrust laws specifically for anticompetitive activity that arises out of state health care reform measures. Such a step would not be without precedent. Congress insulated local governments from antitrust damage suits by passing the Local Governmental Antitrust Act of 1984 because of a large increase in the number of damage suits being brought against cities. *Id.* at 1142.

99. *See supra* note 87.

100. The American Health Security Act (AHSA) includes amendments to ERISA that, if passed, make the analysis of this section moot. However, it is likely that numerous states will have health care reform measures in place before any comprehensive federal scheme is in place. Thus, it may be worthwhile for these states to seek redress similar to what is outlined below either for the interim or in the event ERISA remains unscathed by Congress.

101. Employee Retirement Income Security Act, 29 U.S.C. § 1001 (1988).

102. *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985).

103. 29 U.S.C. § 1002 (1988).

104. *Id.* Welfare benefits may be furnished to employees through other entities, such as labor unions. *Id.* For purposes of brevity, however, this Article will focus only on employer-provided welfare plans in the context of ERISA.

plans offer certain benefits to their beneficiaries.[105] If the welfare plan chooses to finance through the purchase of insurance, however, the plan becomes indirectly subject to state regulation by virtue of the state's authority to regulate the business of insurance.[106] Thus, the method of plan funding chosen can have a significant impact on the benefit structure of the plan.

Assuming, arguendo, the creation of an ODS can be accomplished under current state law,[107] no specific ERISA concerns are raised by the employer contracting with an ODS to provide services to a plan's beneficiaries. In that context, an ODS is just another managed care arrangement competing with PPOs and HMOs for business from welfare plans.

The possible pitfall for some current state health care reform proposals lies in the necessity of state lawmaking that could affect welfare plans. For example, the ILC proposal calls for requiring an employer to either provide employees with certain minimum benefits coverage or pay into a state fund.[108] Once the state passes laws imposing requirements on the type of benefits a welfare plan must offer, the types of providers who must be represented, or any sort of provider rate structure that arguably forces plans to fund the fees others are either unwilling or unable to pay, ERISA, as currently drafted, may preempt enforcement of these laws to the extent they relate to welfare plans.

1. *ERISA Preemption Doctrine*

ERISA contains three provisions that form the basis for the ERISA preemption doctrine.[109] First, there is the preemption clause that contains very broad, sweeping language.[110] Second, if a state law falls within the bounds of the preemption clause, the state law may still be "saved" from ERISA preemption by the savings clause.[111] Third, even if it appears that the state law can survive via the savings clause, the state law may still be preempted because self-insured plans will not be deemed to be an insurance company and therefore subject to state regulation.[112] The touchstone of ERISA pre-

105. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. at 732 (construing 29 U.S.C. §§ 101-111, 401-414, 1021-1031, 1101, 1114 and citing Shaw v. Delta Air Lines, 463 U.S. 85, 91 (1983)).

106. *See id.*; *see also infra* text accompanying notes 127-43.

107. An analysis of the issue of creating an ODS under current Iowa law is beyond the scope of this Article.

108. HEALTH CARE REFORM, *supra* note 27, at 30.

109. *See* FMC Corp. v. Holliday, 498 U.S. 52, 57 (1990).

110. 29 U.S.C. § 1144(a) (1988). "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." *Id.*

111. *Id.* § 1144(b)(2)(A). "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Id.*

112. *Id.* § 1144(b)(2)(B).

emption analysis is, however, whether the welfare plan is funded through a fully insured product or is self-funded (self-insured).[113]

Employee benefit plans may choose to avail themselves of the ERISA preemption argument to challenge a variety of state laws.[114] The first part of the argument focuses on whether the state law relates to the employee benefit plan.[115] The Supreme Court defined when a state law "relates to" an employee benefit plan in *Shaw v. Delta Air Lines*.[116] Under the standard delineated in *Shaw*, a state law relates to an employee benefit plan if it has "a connection with or reference to such a plan."[117] Congress intended for the preemption clause to have a broad reach and not just to preempt only those laws that affect employee benefit plans.[118] Thus, included within the reach of the preemption clause are state laws that are consistent with the substantive requirements of ERISA.[119] The preemption clause, therefore, is to be given a scope "as broad as its language."[120]

Despite the broad reach of the preemption clause, the Court has made it quite clear if the relationship between the challenged state law and the plan is too tenuous, the state law will not be subject to ERISA preemption.[121] In *Ingersoll-Rand Co. v. McClendon*,[122] the Court also noted "a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan" does not relate to the plan.[123] In *Mackay v. Lanier Collection Agency & Service*,[124] the Court provided some insight into whether there are any limits to the reach of the ERISA preemption clause when it held a Georgia garnishment statute was not subject to ERISA preemption.[125] Therefore, there are limits to the reach of the preemption clause.

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113. *See infra* text accompanying notes 144-56.

114. *See* FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) (holding Pennsylvania antisubrogation statute preempted by ERISA); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 734 (1985) (holding Massachusetts minimum mental health benefit required in insurance policies saved from ERISA preemption as regulation of insurance business); Shaw v. Delta Air Lines, 463 U.S. 85, 99 (1983) (holding New York law mandating pregnancy benefits preempted by ERISA); *see also* Blue Cross & Blue Shield v. Bell, 798 F.2d 1331, 1334 n.2 (10th Cir. 1986) (holding Kansas mandated provider statute saved from ERISA preemption); Standard Oil Co. v. Agsalud, 442 F. Supp. 695, 697-98 (N.D. Cal. 1977) (holding Hawaii's Prepaid Health Care Act preempted by ERISA), *aff'd*, 633 F.2d 760 (9th Cir. 1980).

115. 29 U.S.C. § 1144(a) (1988).

116. Shaw v. Delta Air Lines, 463 U.S. 85 (1983).

117. *Id.* at 96-97 (footnote omitted).

118. *Id.* at 98; *see also* FMC Corp. v. Holliday, 498 U.S. at 59.

119. Shaw v. Delta Air Lines, 463 U.S. at 98-99.

120. *Id.* More recent attempts to limit the reach of *Shaw* have failed. *See* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990).

121. Shaw v. Delta Air Lines, 463 U.S. 85, 100 n.21 (1983).

122. Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990).

123. *Id.* at 139.

124. Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825 (1988).

125. *Id.* at 841. The Georgia statute was generally applicable to all residents whenever any sort of garnishment was necessary. *Id.* at 831. The fact the law sometimes created an

ERISA will, however, preempt the vast majority of state laws that in some way affect or relate to employee benefit plans unless saved by the savings clause.[126]

The Supreme Court issued its definitive opinion on the scope of the savings clause in *Metropolitan Life Insurance Co. v. Massachusetts*.[127] In *Metropolitan*, the Court was called upon to determine whether a Massachusetts law requiring certain health insurance policies to provide minimum mental health benefits was preempted by ERISA.[128] The law applied to any Massachusetts residents covered by a health insurance policy issued to an employee health care plan.[129] The Court first found, under the standard enunciated in *Shaw*,[130] that the state statute related to an employee benefit plan and was therefore within the grasp of the preemption clause.[131] The Court then turned to the question whether the state law was saved within the meaning of the savings clause. The Court held the Massachusetts mandated benefit law was saved from preemption.[132] The Court observed that the McCarran-Ferguson Act[133] contained language almost identical to the savings clause.[134] Therefore, it reasoned, cases interpreting the McCarran-Ferguson Act provided guidance in establishing the parameters of the ERISA savings clause.[135]

The focus of McCarran-Ferguson Act cases is the definition of the "business of insurance."[136] The Court has developed a three prong test—the McCarran-Ferguson Act test—to guide the inquiry into whether a state law falls within the scope of the McCarran-Ferguson Act's definition of the "business of insurance." Those three prongs are: "'[f]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the

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administrative burden on plans when they were the subject of a garnishment was felt to be too remote a connection to the plans to justify preemption. *Id.* at 831-32.

126. *See* 29 U.S.C. § 1144(b)(2)(A), (B) (1988).

127. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

128. *Id.* at 727.

129. *Id.* at 731-32.

130. Shaw v. Delta Air Lines, 463 U.S. 85, 96-97 (1983).

131. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. at 739.

132. *Id.* at 741.

133. 15 U.S.C. §§ 1011-1015 (1988).

134. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 742-43 (1985). "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . ." 15 U.S.C. § 1012(b) (1988).

135. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. at 742; *see* Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

136. Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. at 210.

insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.'"[137]

In using the McCarran-Ferguson Act test, the *Metropolitan* Court found the Massachusetts mandated benefit law constituted state regulation of the business of insurance.[138] The first prong of the test was satisfied because evidence existed that the legislation was passed in order to spread the risk of the cost of mental health care among those Massachusetts residents covered by group health policies.[139] The second prong of the test was met because the Massachusetts statute purported to limit the type of insurance policy an insurer could sell covering Massachusetts residents.[140] The third prong was satisfied because the statute was aimed solely at insurers.[141]

The primary focus of the cases interpreting the scope of the business of insurance is on the first prong—whether the practice transfers or spreads a policyholder's risk.[142] All three prongs must be met, however, for the state law to be saved from ERISA preemption.[143]

Although a state law may regulate the business of insurance, the state statute may not apply to a self-funded plan by virtue of the deemer clause.[144] In *FMC Corp. v. Holliday*,[145] the Court was first presented with the question of the applicability of a state statute purporting to regulate the business of insurance to a self-funded employee health benefit plan.[146] The Pennsylvania statute in question barred subrogation in any action arising under Pennsylvania's motor vehicle financial responsibility law.[147]

The Court first reaffirmed *Shaw* and found, under the standard enunciated there, the Pennsylvania statute was subject to ERISA preemption.[148] The Court found the requisite nexus between Pennsylvania's antisubrogation

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137. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. at 743 (quoting Union Labor Life Ins. Co. v. Pireno, 458 U.S. at 129).

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*; *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 48 (1987) (stating the third element of the test is met when state law not only has an effect on insurance companies but is directly aimed at them).

142. This is essentially the textbook definition of insurance. ROBERT E. KEETON, BASIC TEXT ON INSURANCE LAW § 1.2 (1988).

143. *See, e.g.*, Baxter v. Lynn, 886 F.2d 182, 185-86 (8th Cir. 1989) (stating a Missouri common-law prohibition against subrogation under health insurance policy was preempted and not saved because common-law antisubrogation rule was not aimed solely at insurance companies).

144. 29 U.S.C. § 1144(b)(2)(B) (1988).

145. FMC Corp. v. Holliday, 498 U.S. 52 (1990).

146. *Id.* at 52.

147. *Id.* at 55 (quoting 75 PA. CONS. STAT. § 1720 (1987)) ("In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . paid or payable under section 1719.'").

148. *Id.*

statute and the plan because the effect of the statute was to bar the plan from enforcing the subrogation provision in the plan document.[149] Before turning to the issue of the application of the deemer clause, the Court noted the Pennsylvania statute clearly fell within the scope of the savings clause.[150] Therefore, the state law would be saved from preemption unless the deemer clause operated to throw the law back into the realm of the preemption clause.[151]

The Court determined the deemer clause operated to "exempt self-funded plans from state laws that 'regulat[e] insurance' within the meaning of the savings clause."[152] Respondent, attempting to argue for a narrow interpretation of the deemer clause, argued the clause would only exempt from the savings clause those state insurance laws that infringe on core ERISA concerns.[153] The Court stated this reasoning was inconsistent with ERISA's congressional history, which supported a much broader reach of the deemer clause.[154] The Court further stated, "[I]f the plan is uninsured, the State may not regulate it."[155]

By giving the deemer clause the full reach of its broad language, the Court has unequivocally given self-funded plans the right to enforce the terms of their plan documents in the face of contrary state laws relating to the plans.[156] Unless the broad preemption language in ERISA is changed, the ERISA preemption analysis may adversely affect health care reform measures in several ways.

2. *Application to Laws Related to Health Care Reform*

Health care reform could create conflict with ERISA if the state passes laws that require employers to provide minimum benefits to their employees, provide certain types of benefits, allow coverage for certain providers, disallow the use of preexisting condition limitations and waiting periods, or provide for fee structures that include components of "uncompensated care."[157]

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149. *Id.* at 60.
150. *Id.*
151. *Id.* at 61.
152. *Id.*
153. *Id.* at 63.
154. *Id.* at 63-64. The legislative history also suggests a broadly construed deemer clause is necessary to prevent the imposition of inconsistent state regulation to benefit plans that operate in more than one state. *See* Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987).
155. FMC Corp. v. Holliday, 498 U.S. 52, 64 (1990).
156. The terms of the plan document must still comply with other constitutional and statutory requirements that are not too tenuously connected to the plan. *See* Shaw v. Delta Air Lines, 463 U.S. 85, 100 n.21 (1983).
157. Uncompensated care is generally care provided to indigent patients, especially pursuant to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1988), the bad debt exposure of providers, or the amount a provider's actual costs exceeds their reimbursements from programs such as Medicare and Medicaid.

State laws mandating benefits and mandating providers have been the primary subjects of challenge.[158]

As seen in *Metropolitan*, mandated benefit laws will be upheld as they apply to insurance policies and therefore indirectly to employee benefit plans.[159] The *Metropolitan* reasoning can also be applied to state laws requiring plans to provide minimum benefits.[160] Based on *FMC Corp.*, however, such laws may not be applied to self-funded plans.[161] Such plans may continue to define for themselves the type or level of benefits they will offer to beneficiaries under their plans.

In a health care reform program, this presents particular conflicts for an ODS, which might be placed in the position of having to provide certain benefits to plan beneficiaries even though they are not consistent with state law.[162] Similarly, the ODS, by virtue of its state charter, may be forced to provide state mandated care but may not be able to recover the costs from a self-funded welfare plan.

The plan can argue that state law, by virtue of the deemer clause, is preempted, which will entitle the plan to enforce the terms of its plan document that may not cover the benefits in question. Under this scenario, the ODS must also administer multiple sets of benefits—one set for fully insured plans and other sets for self-funded arrangements choosing not to offer the same benefits. This would make it difficult to achieve administrative cost-savings that could otherwise be achieved through administering a uniform set of minimum benefits with add-ons available depending on the capacity of the ODS.

There is a split in authority over whether mandatory provider laws are preempted by ERISA. One line of cases has held such laws fall within the regulation of the business of insurance.[163] The other line of cases focuses on the failure of mandatory provider laws to meet the first prong of the McCarran-Ferguson Act test,[164] which would occur when the law does not affect the transferring or spreading of a policyholder's risk.[165]

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158. *See infra* notes 159-68 and accompanying text; *see also* Robert S. McDonough, Note, *ERISA Pre-emption of State Mandated Provider Laws*, 1985 DUKE L.J. 1194. Examples of mandated benefits also include vision care, child care, and so forth. *Id.* at 1202 n.51. Mandatory provider laws generally require that services of certain providers be covered to the same extent the services would be covered by medical doctors. *See generally id.* at 1194 & n.8 to 1197.

159. *See supra* text accompanying note 131.

160. *See supra* text accompanying notes 140-42.

161. *See supra* text accompanying notes 145-55.

162. *See supra* text accompanying notes 138-40.

163. *See, e.g.*, Blue Cross & Blue Shield v. Bell, 798 F.2d 1331, 1336 (10th Cir. 1986). The court found the insured's choice of provider was implicit in the coverage of loss under the policy. *Id.* at 1335.

164. *See supra* text accompanying note 137.

165. *See, e.g.*, Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476, 483-84 (4th Cir. 1980). The court held Blue Shield's billing practice of reimbursing psychologists only when their services were billed through a physician was more akin to the pharmacy agree-

In light of more recent developments in health care delivery such as PPOs and HMOs after the decision in *Blue Cross & Blue Shield v. Bell*,[166] the rationale of *Virginia Academy of Clinical Psychologists v. Blue Shield*[167] seems to be more reasonable than that of *Bell*. Unlike mandated benefit statutes, mandatory provider laws do not expand the coverage of the insured or transfer risks in any meaningful way.[168] Given the conflicting case law, however, the creators of an ODS would do well to make sure all mandatory providers are represented in the venture. This ensures compliance with state law regardless of any preemption ERISA may offer.

Arguably, a self-funded welfare plan's freedom to choose the type of providers it covers under its plan does not affect the ability of the state or local entity to craft basic health care programs for the relevant population. This depends on how one defines "basic" health care, however. Without remedying the ERISA preemption language, the state loses its power to make this determination on behalf of its residents. In addition, this freedom of choice for self-funded welfare plans could prevent the ODS from making its own determinations regarding the most cost-effective means of providing quality care to the extent the ODS derives this authority pursuant to state law.

Most significant to the issue of health care reform is the recent case, *Travelers Insurance Co. v. Cuomo*,[169] in which ERISA preemption analysis was used to bar enforcement of state laws regarding hospital rates in New York.[170] The law in question established hospital rates using diagnostically related groups (DRGs) for certain services.[171] In *Travelers*, the district court found the New York statute was preempted.[172] Because the parties before the court included insurance companies,[173] the court had occasion to reach the issue of whether the hospital rate law was a regulation of the business of insurance and therefore saved from ERISA preemption.[174] The court found although the first prong of the test was met, the second and third prongs were not.[175] Therefore, the law was preempted.[176]

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ments at issue in Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979), than the business of insurance. Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d at 483.

166. Blue Cross & Blue Shield v. Bell, 798 F.2d 1331 (10th Cir. 1986).

167. Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476 (4th Cir. 1980).

168. McDonough, *supra* note 158, at 1210; *see also id.* at 1212 n.109 (criticizing the lower court's decision in *Bell*).

169. Travelers Ins. Co. v. Cuomo, 813 F. Supp. 996 (S.D.N.Y. 1993), *modified*, 14 F.3d 708 (2d Cir. 1994).

170. *Id.* at 999.

171. *Id.*

172. *Id.* at 1006.

173. In fact, the surcharges in New York were discriminatory among insurers. *Id.* at 999.

174. Travelers Ins. Co. v. Cuomo, 813 F. Supp. 996, 1006 (S.D.N.Y. 1993), *modified*, 14 F.3d 708 (2d Cir. 1994).

175. *Id.* at 1007-08; *see also* text accompanying note 137.

A similar result was reached in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*[177] in which the district court held ERISA preempted the New Jersey law as it applied to self-funded plans.[178] The court noted the New Jersey law forced self-funded plans to provide benefits for individuals who were not plan beneficiaries.[179] The court held this in itself violated ERISA.[180]

The Third Circuit reversed *United Wire*, in part, on appeal.[181] In its *Travelers* appellate opinion, the Second Circuit called into question the reasoning of the Third Circuit.[182] Indeed, it does appear that the Third Circuit largely understated the effect of the New Jersey rate-setting scheme on self-funded plans in its analysis. The court relied heavily on what it believed was the general applicability of the statute in holding that the law did not relate to the health benefit plan as required by 29 U.S.C. § 1144(a).[183] The Third Circuit equated the purchase of hospital services by plans to the purchase of public utility services or any other cost of doing business.[184] However, it was not an ordinary cost of doing business of every payor of hospital benefits in New Jersey.[185] It was a charge attributable to the care of nonplan beneficiaries specifically aimed at self-funded ERISA plans.[186] Thus, it was precisely the type of state law to which Congress intended the preemption clause to apply.

Because the Supreme Court refused to hear the appeal in *United Wire*, we are left with diametrically opposing viewpoints by the Second and Third Circuits. The practical effect of this discrepancy may never be known because

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176. Travelers Ins. Co. v. Cuomo, 813 F. Supp. at 1007-08.

177. United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 793 F. Supp. 524 (D.N.J. 1992), *modified*, 995 F.2d 1179 (3d Cir. 1993). In *Travelers* and *United Wire*, the district courts focused on the amount each state required hospitals to charge to self-funded plans for uncompensated care (the amount of costs a hospital is unable to recover from charity cases, bad debts, and the difference between the hospital's actual costs and its reimbursement from programs such as Medicaid and Medicare) through the setting of the hospital's DRG. In the New Jersey scheme, some payors were granted a discount, such as plans with open enrollment and Blue Cross and Blue Shield Plans. N.J. STAT. ANN. § 26:2J-18(b) (West 1987). Under the New York scheme, the DRG is formulated for hospitals first. Then surcharges are added for certain payors above the DRG rate. N.Y. PUBLIC HEALTH LAW § 2807-C(1) (McKinney 1993).

178. United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 793 F. Supp. at 537.

179. *Id.* at 535.

180. *Id.*

181. *See* United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179, *cert. denied*, 114 S. Ct. 382 (1993).

182. Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 721 n.3 (2d Cir. 1994).

183. United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d at 1192.

184. *Id.* at 1195.

185. *Id.* at 1202 (Nygaard, J., dissenting).

186. *Id.* (Nygaard, J., dissenting).

in response to the initial litigation, New Jersey repealed its rate-setting scheme and adopted a new approach.[187]

United Wire and *Travelers* show how futile true reform measures on the state level may be absent meaningful change in ERISA preemption legislation. The cases point out significant hurdles raised in the path of a state's ability to set fees and limit the terms of coverage that must be made available to its residents. Congress should carve out state health care reform proposals from the ERISA preemption clause in much the same manner as the savings clause has for insurance regulation.

If there is concern a state may abuse this power, then Congress should implement national guidelines that would establish the criteria for justifying protection of the program under the savings clause.[188] In addition, the deemer clause should not provide a means of circumventing the state's program. For true health care reform to occur, all players must meet on an equal playing field.

IV. CONCLUSION

Policymakers can create state health care reform proposals that positively alter the current health care delivery and finance systems. Certain federal laws will greatly impact the ability of such programs to succeed. Included in this category are federal antitrust laws and ERISA.

State lawmakers considering health care reform measures must make sure the measures will conform to the requirements of these laws. If appropriate steps are taken by legislators, the ODSs, or other reform entities created pursuant to these programs, may avail themselves of certain immunities from antitrust attack. In addition, private parties acting in their official capacities may be able to shield themselves from antitrust damage suits.

In some situations, the federal laws themselves should be modified. For example, the reasons supporting a statutory extension of antitrust immunity to state health care reform programs are analogous to those that prompted the enactment of the Local Government Antitrust Act. Therefore, Congress should consider codifying the *Midcal* test to create statutory antitrust immunity for certain health care reform proposals. This would enable ODSs to operate without threat of antitrust suit by other parties with standing to assert an antitrust claim against them.

More importantly, federal action is critical to cut down the virtually insurmountable hurdles to state health care reform efforts created by ERISA

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187. *See id.* at 1201-03 (Nygaard, J., dissenting).

188. Simultaneous with such modifications, Congress may have to draft minimum standards to qualify for savings clause treatment. Hopefully this would address the concerns of labor and large firms operating in many states that the occurrence of inconsistent regulation among the states would be kept to a minimal level.

preemption. Congress should save for state regulation health care programs meeting certain minimum criteria. Such an action would not jeopardize Congress' stated goal of not subjecting welfare plans that operate in more than one state to inconsistent state regulations.

Further, self-funded plans should not be able to take advantage of the deemer clause to circumvent the provisions of the state health care reform program. This should be limited, however, to situations in which there is clear and convincing evidence the state statute was enacted to further the goals of the state's health care reform program and not merely to benefit certain private interests.

These steps may create some additional burdens on certain parties affected by modifications of these federal laws. Such burdens must be weighed, however, against the promise state health care reform holds for lowering health care costs, improving the quality of health care, and making access to quality care a reality for more Americans.