Collaboration Among Competing Managed Care Organizations for Quality Improvement

Molla S. Donaldson, Editor; The National Roundtable on Health Care Quality, Institute of Medicine

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Collaboration Among Competing Managed Care Organizations for Quality Improvement

Summary of a Conference
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The National Roundtable on Health Care Quality
Division of Health Care Services
Institute Of Medicine

Molla S. Donaldson, *Editor*

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The serpent has been a symbol of long life, healing and knowledge among almost all cultures and religions since the beginning of recorded history. The serpent adopted as a logotype by the Institute of Medicine is a relief carving from ancient Greece, now held by theca Staatliche Museen in Berlin.

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PREFACE AND ACKNOWLEDGMENTS

The National Roundtable on Health Care Quality was established in 1995 by the Institute of Medicine (IOM). The Roundtable consists of experts, formally appointed through procedures of the National Research Council who represent both public and private-sector perspectives and substantive expertise, not organizations. The Roundtable was supported by funds from the National Research Council's Endowment, the Commonwealth Fund, the Agency for Health Care Policy and Research (Public Health Service, U.S. Department of Health and Human Services), the U.S. Department of Defense, and Pfizer Inc. In 1996, the Roundtable asked a group of individuals to advise it on aspects of quality in managed care. Because it is often believed that competition is the primary lever for improving quality, the group was interested in exploring the limits of competition and the possible value of collaboration among health plans to improve quality. Accordingly, a Steering Committee composed of Robert A. Berenson, M.D., Clark Havighurst, J.D., John Iglehart, Mark Pauly, Ph.D., Lee Newcomer, M.D., and Stephen C. Schoenbaum, M.D., planned a workshop which was held on November 13, 1997.

The conference explored potential areas for collaboration to improve quality among competing health plans within the constraints established by the antitrust laws and other legal requirements. The conference was convened to clarify what is meant by "collaboration for quality," to clarify the limits of such potential activities, and to explore ways to stimulate collaboration. Robert A. Berenson, M.D. introduced the subject, and Clark Havighurst, J.D prepared and presented a commissioned paper on antitrust concerns in collaboration. His paper is included in this summary. Charles C. Eads, Ph.D. provided an overview view of collaboration in other industries, particularly, the automotive industry. The summary describes speaker and reactor comments about antitrust and other legal barriers, and examples of collaboration in health care as well as other industries.

The conference had three sessions. The first session addressed conceptual issues. The second session was a reactor panel discussion among parties with different perspectives. The third session included real-world examples of collaborative efforts. Finally, the conference participants were invited to discuss their views and conclusions about the plausibility of collaborative efforts in health care and ways to encourage such efforts.

This summary has been reviewed according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine. The purpose of this independent review is to provide candid and critical comments to assist the authors and the National Academy of Sciences in making the published summary as sound as possible and to ensure that the summary meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The content of the review comments and the draft manuscript remain confidential to protect the integrity of the deliberative process. The Institute of Medicine would like to thank the following individuals for their participation in the review of this document: Catherine Borbas, Ph.D.; Peter Barton Hutt, L.L.M.; George Isham, M.D.; David Nerenz, Ph.D.; and Leif I. Solberg, M.D. While the individuals listed above provided many constructive comments and suggestions, responsibility for the final content of the summary rests solely with the authoring group and the National Academy of Sciences.

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SUMMARY

In November, 1997, The Institute of Medicine convened a one-day conference to explore areas for potential collaboration to improve quality among competing health plans consistent with antitrust and other legal requirements. The conference was convened to clarify the limits of such potential activities and to explore ways to stimulate collaboration; in short, to explore permissible and promising areas for collaboration for competing health plans.

Competition has existed at the provider level in the pre-managed care era and continues among physicians, physician groups and hospitals today. What is new is the extent of competition at the managed care organization level in individual regional markets. As large numbers of individuals are enrolled in health plans, the potential for new forms of cooperation for improving quality of care becomes possible. Along with these new possibilities, however, come questions about whether they bring the potential for antitrust violation.

Why Do Organizations Collaborate?

Collaboration is a way to capture either positive or negative externalities. When a single firm is dominant, the dominant firm believes it is likely to capture the benefit of its work without collaboration. When industries are fragmented, no one company can capture all the externalities such as the establishment of standards. In such circumstances, collaboration is more possible. Even without antitrust concerns, however, there are barriers to collaboration.

One reason an organization might refuse to collaborate with competitors is a perception that it could lose market share by foregoing product differentiation opportunities. Despite such reluctance and the cost and difficulty in doing so,

however, successful collaborations have improved entire industries. Examples are the automotive and electronics industry.

In the electronics industry, as in any fast-changing industry, most of what is proprietary is old, not current or future. Manufacturers whose products are in competition at the retail level collaborate on a next generation of technology, and for this reason sharing proprietary information and technologies is not a competitive threat.

What would induce determined competitive health plans to collaborate, even on quality improvement? There is, at present, little reward in the market for investing in quality. In part this is because they do not perceive that it will bring increased market share, and in part it is because investment in quality by one plan is likely to result in a "flee-rider problem" where all plans benefit. Further, the market imperative for plans to engage most of the physicians in an area of nonexclusive relationships creates networks that are too large and too broad to efficiently address improvement efforts, even if plans were willing to accept the free-rider burden.

Collaboration is a strategy that plans might use to achieve economies of scale and avoid the free-rider problem. Purchasers are likely to be an important stimulus to bringing competing plans to the table to encourage specific quality improvement initiatives that they would not likely undertake on their own and to achieve. Potential areas for collaboration include:

- the identification of substandard practitioners, in part through carrying out the objectives of the Health Care Quality Improvement Act of 1986;
- joint practitioner educational efforts;
- joint public education efforts; and
- joint development of guidelines for the use of effective therapies.

Antitrust Issues

Although one can make a plausible case for collaboration, there are barriers. One barrier is the perceived threat of antitrust scrutiny, though the perception is likely to be worse than the reality. Nevertheless, better guidance is needed about what forms of collaboration concerning quality that the antitrust laws clearly permit, what activities represent *per se* violations, and where there is uncertainty.

The market paradigm is embodied in the antitrust laws. These laws would welcome, not oppose, many forms of collaboration among competing health plans where the collaboration has the potentia for improving the quality of care. Although antitrust law takes a dim view of concerted action that is antithetical to competition, it is clearly not intended to discourage all competitor collaboration, much of which is clearly procompetitive. Only if the likely anticompetitive effects outweigh the procompetitive ones will a particular collaboration be deemed a restraint of trade.

Although antitrust law prohibits naked agreements by competitors on the nature and quality of the services that they plan to sell as the use of coercive measures to enforce a particular standard or definition of quality, the law should pose no obstacle to cooperation for the purpose of producing new information for the use of market participants or to collaboration that improves the market's functioning in some other way.

The federal antitrust statutes have also been construed so that they do not apply to collective efforts to influence governmental action. As a result, there is significant room for private collaboration that aims at getting state and local governments to improve the quality of health care, even if the methods adopted by government might be deemed anticompetitive and illegal if employed by private interests.

The acceptability of particular collaborative activities cannot be answered definitively in advance as much will depend on the specific factual situation and the evidence. In general, however, market participants should not be deterred by antitrust fears from collaborating to improve the quality of care in ways that do not interfere with the freedom of buyers and sellers to decide for themselves how and with whom to do business.

Collaborators should definitely avoid certain kinds of concerted action that would fall under any of the so-called per se rules. Under these rules certain kinds of horizontal agreements among competitors are conclusively presumed to have a prohibited effect on competition and are thus treated as illegal "*per se*." Conduct outside the reach of the "*per se rule*," will be analyzed more fully under the so-called *rule of reason*. In such cases, there must be inquiry into the actual or probable effects on competition.

It would be unwise for competitors designing collective action to rely on being able to defend anticompetitive actions by pointing to good intentions, some alleged market failure, or arguable improvements in the quality of health care. Even if a given market were seriously imperfect, antitrust law provides no clear and reliable reason for competitor groups to substitute their own judgments for those of the market.

Standard Setting

One collaborative quality assurance strategy that may be lawfully pursued by competing health plans involves the production and dissemination of information and opinion intended to better inform purchasing and other decisions. Clinical practice guidelines are an example of standards that might be privately developed (or adapted from published studies) and promulgated by a coalition of local health plans.

The legal system has not arrived at a clear consensus on how private standard setting and accrediting should be viewed for antitrust purposes. However, it is unlikely that programs for collecting and disseminating information or opinion

related to the quality of care will be viewed as *per se* violations of the antitrust laws. Well-run, fairly administered programs can be expected to survive scrutiny under the *rule of reason*.

Information Collection and Exchange

Quality assurance programs that focus on collecting and disseminating data should create no serious antitrust problems as long as they are voluntary and operate within the market paradigm rather than outside it. That is, collaborators must avoid *coercing* participation to collect and disseminate information. Any such strategy should leave each actor free to make its own decisions about how to improve the quality of those decisions and produce better market outcomes. Concerns would arise if the data exchange were designed to trigger uniform, noncompetitive responses, serving as a signal for concerted action.

Selecting High-Quality Providers

A possible strategy for improving the quality of care would be to encourage provider groups to specialize in providing particular services. Unfortunately, collective efforts by health plans to favor one or a few providers with their business *would* raise antitrust problems. For example, an agreement to use only a designated provider could be characterized as a boycott of other providers. A collaborative strategy of promoting quality by encouraging local providers to become "centers of excellence" would avoid antitrust problems only if the collaborators confined their effort to collecting information on comparative performance.

Lobbying and Working with Government

Under the so-called *Noerr-Pennington doctrine*, collective lobbying for anticompetitive legislation is not subject to antitrust challenge—even if some misrepresentation is involved. Under the Noerr doctrine, private interests could seek governmental action to maintain quality of care. Thus, for example, it would be permissible to agree to report particular practitioner to a public authority for possible sanctioning.

State legislatures can confer so-called *state-action* immunity on anticompetitive activities; however, plaits must exercise special care in relying for immunity on the actions of local government. If such a governmental entity does not possess clear delegated authority from state legislature to act in anticompetitive ways, it is not capable of conferring antitrust protection.

Conclusion

Antitrust violations are unlikely to be found if collaborating health plans seeking to raise the quality of health care can successfully confine their commercial (as opposed to their political) activities to developing and disseminating information that makes the competitive market (which depends fundamentally upon independent decision making by competing entities), work better and give greater weight to quality considerations in purchasing. Even though the law will continue to be vigilant against concerted action that interferes with the competitive process, there are many opportunities for useful collaboration by competing health plans. Although antitrust law has often been invoked by competitors injured by the circulation of information, modern courts are increasingly inclined to recognize that the Sherman Act was intended by Congress to protect "competition, not competitors."

A number of imperfections in the health care market could be addressed by collaborative action. Cooperation makes sense in several areas: when the science is compelling; when plans are common customers of a supplier as well as being competitors; and when adverse outcomes occur rarely, and competitors want to use scientific methods to help guide improvement.

The social purpose of health care may justify special treatment under antitrust laws. That is, it should be possible for competitors to cooperate where the common good justifies it. For example, appeals by multiple managed care organizations to office-based practices to implement commonly accepted standards of infection control can be simplified by collaboratively developed standards with which compliance is required.

Other opportunities for collaboration exist to promote public health and research. On the public health side, common immunization registries for public health and improved immunization status of health plan populations should be encouraged. From a research perspective the opportunity to collect the data on rare conditions or experimental treatment would serve the larger public good in addition to the individual needs of health plans.

SESSION 1:

CONCEPTUAL ISSUES IN COLLABORATION

INTRODUCTION TO COLLABORATION[1]

Robert A. Berenson, M.D.

Collaboration among competing health plans need not fundamentally challenge the current competition model in health care, which features vigorous price competition. Health care is not such a unique activity that it is necessary to abandon notions of competition. The question is, within a competitive environment, what are permissible and promising areas for collaboration among competing health plans?

Value purchasing, not just purchasing on the basis of price, is to some extent occurring—although purchasing currently focuses primarily on price and choice of provider. Employers, who are the main purchasers of health care, make purchasing decisions that reflect employees' desires for access to a particular physician rather than for objective or even subjective measures of quality.

Despite the best efforts of many groups to emphasize the importance of quality information including external accreditation groups, such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and despite the emphasis placed on the reporting of quality performance measures, such as the NCQA's Health Employer Data and Information Set, it is hard to find organizational rewards for investing in quality.[2] Those organizations that do invest in high-quality services either are looking toward the future when quality might become a basis for competition or investing as a public service based on their own corporate mission.

Currently, many health plans feel market pressure for a broad panel of providers. This breadth may be provided within the plan through a point-of-service

[1] This presentation was revised and published in: Berenson, R.A. Bringing Collaboration Into the Market Paradigm. *Health Affairs* November/December 17:128–137, 1998

[2] Lipson, D.J. and De Sa, J.M. Impact of Purchasing Strategies on Local Health Care Systems. *Health Affairs*. 15:62–76, 1996.

option or by contracting directly with many or most providers in a community. As a result of this inclusiveness, plans have less ability to select carefully from among the larger pool of physicians those who provide higher quality care in their particular fields. It also prevents plans from creating a small group of practitioners who could easily work together on mutually agreed upon goals.

As pressure to increase the size of networks increases, the ability of each plan to affect practice decreases. For example, if a given health plan provides only 10 percent of a physician's business, no single plan has enough data, influence, or incentive to work with those physicians to improve quality. For one thing, they lose economies of scale. For example, obtaining data about the performance of 1,000 physicians for whom the health plan provides 10 percent of their patients is much more costly and less useful than obtaining data from 100 physicians for whom the plan provides 100 percent of their patients.

In addition, when plans deal with physicians and hospitals that are also in most other plans, there is a "free-rider" concern. In such an open-panel model, any serious investment in improving quality in one plan also benefits all of the plan's competitors. For example, sending a primary care physician to a course on dermatology so that she is better able to identify and treat skin lesions benefits not only the patients in that plan but those of its competitors as well.

In short, the market imperative for plans to engage most of the physicians in an area of nonexclusive relationships creates networks that are too large and too broad to address improvement efforts efficiently, even if plans are willing to accept the free-rider burden. One way out of this dilemma would be for physicians to organize themselves into manageable units, to assume financial risk, and to be accountable for the quality of the services that they provide. Collaboration is another strategy that plans might use to achieve economies of scale and avoid free-rider problems.

Potential Areas for Collaboration

Within the reasonable constraints of antitrust laws, how might plans collaborate on clinical initiatives that could lead to greater quality and efficiency? One possibility would be to carry out the objectives of the Health Care Quality Improvement Act of 1986. Currently, when plans identify possibly serious quality deficiencies in the care provided by contract physicians, they find that it is easier to terminate those physicians "without cause" than to follow the requirements of the Health Care Quality Improvement Act. These requirements include a due process hearing to identify grossly substandard care provided by the physician and the reporting of quality deficiencies to the National Practitioner Data Bank.

Similarly, many physicians identified as providing substandard care would prefer being terminated without cause and foregoing due process to avoid being reported to the Data Bank. By not reporting a physician, the plan can protect its own patients and the integrity of its own operations, but that does not help the

public at large, because the terminated physician is able to continue contracting with other plans. This represents an opportunity for sharing data about physician performance, however. By pooling data, each plan would have a more useful database with which to identify incompetence, to profile comparative performance, and to initiate quality improvement programs. Antitrust laws prevent competing plans from making joint decisions not to contract with a particular physician but should tolerate information sharing among plans.

Another example of an opportunity for collaboration is joint educational efforts. The following is an example of the kind of poor quality that health plans might improve through collaboration. In a recent article, Hartert et al[3] reported on a study of in-hospital admissions for patients with asthma. The average number of admissions per patient was 2.5 per year, meaning that these patients had moderate to severe asthma. This study showed that fewer than half of the patients studied had been prescribed inhalation steroid therapy, which has become the mainstay of asthma treatment. Of those patients who were told by a health care professional to use a metered-dose inhalant, only 11 percent could actually use the inhaler correctly. Only 28 percent of patients had been given by their physicians an action plan to follow in the event of an acute asthma attack.

Here, the challenges are to educate physicians and their staffs about modern asthma therapy and to help them educate and wain their asthmatic patients about self-management. A major educational program might be too expensive for any individual plan to undertake alone. Similarly, a practice guideline might well be ignored by physicians practicing in multiple plans. In addition, identifying preventable hospitalizations for asthma to target educational efforts is difficult because of the lack of statistical power that any plan would face if it relied only on its own data.

By acting jointly, the plans could all contribute to education, perhaps through jointly issued and prominently disseminated practice guidelines. By pooling data, plans could also identify patterns of hospital admissions associated with particular physicians or other providers.

Another clinical example in which collaboration might be beneficial is that of thrombolytic therapy. A vigorous policy debate among physicians, ethicists, and policy analysts has centered on the use of streptokinase as the preferred thrombolytic agent or whether the much higher cost of tPA is justified by its marginal benefit. (In meta-analyses, the benefit in terms of decreased mortality seems to be on the order of 1 per 1,000 patients.)

Yet many patients do not get thrombolytic therapy at all, and the benefits of any thrombolytic therapy, whether it is streptokinase or tPA, are on the order of a 25 to 50 percent reduction in mortality. That is where mortality might be re-

[3] Hartert TV, Windom HH, Peebles RS Jr., et al. Inadequate Outpatient Medical Therapy for Patients with Asthma Admitted to Two Urban Hospitals. *American Journal of Medicine* 100:381–382, 1996.

duced and where attention should be focused.[4] Plans might collaborate, for example, to establish a guideline regarding the use of streptokinase. In exchange for cost savings in drug use, they could then jointly fund public education programs targeted to patients at high risk of a heart attack. Collaboration might serve a useful public health function, if such programs emphasize the need for patients to go to an emergency room quickly if they are having chest pain or other worrisome symptoms. At the very least, medical directors of competing plans could together work with hospitals to improve emergency room performance in initiating thrombolytic therapy.

Issues for the Conference

Although one can make a plausible case for this type of collaboration, there are major barriers. One is the perceived threat of antitrust scrutiny, though the perception is likely to be worse than the reality. Nevertheless, we need to provide better guidance about what forms of collaboration concerning quality the antitrust laws clearly permit, what activities represent *per se* violations, and where there is uncertainty.

More fundamentally, we need to understand what would induce determined competitors to collaborate, even on quality improvement. Here, the purchasers would be an important stimulus to bringing competing plans to the table to encourage specific quality improvement initiatives that they would not likely undertake on their own. We would also like to know what market characteristics might be important in determining the likelihood of collaboration. Perhaps there are important lessons—from both successes and failures—to be learned from other industries. Finally, what do we know about past successes and failures in health care delivery in the area of collaboration? The IOM conference was convened to begin a discussion of these issues.

LEGAL ISSUES IN COLLABORATION

Clark C. Havighurst, J.D.

Time was when health care was generally viewed as a collaborative enterprise and private interests, always professing primary concern for the quality of care, routinely cooperated to define and enforce the standards that governed it. Broad-based private organizations, mostly controlled by organized medicine,

[4] Dracup K, Alonzo AA, Atkins JM, et al. The Physician's Role in Minimizing Prehospital Delay in Patients at High Risk for Acute Myocardial Infarcation: Recommendations from the National Heart Attack Alert Program. *Annals of Internal Medicine* 126:645–651, 1997.

routinely prescribed ethical canons to guide the behavior of professionals, set educational and training standards for health care personnel, and established and applied accrediting standards for institutional providers. Not only did professional groups set standards and certify compliance with them, but they were also in a position, as an ostensibly benign monopoly, to enforce their standards and ethical values by collective action of a coercive nature. With boycotts and similar sanctions available to deter any actor who might be tempted to take a disapproved initiative, health care in the United States was very much a regulated industry. The power to prescribe rules and coerce adherence to them was exercised, however, not by public officials accountable in some measure to the electorate but by the industry itself, through interlocking, cooperating organizations representing mostly the interests of physicians. Under the paradigm of medical care that prevailed in public policy until the mid-1970s (and that still lingers in many minds today), professional self-regulation and centralized control of industry developments by ostensibly well-meaning professional interests were deemed to serve the public better than any government-controlled or market-driven system. The role of government was limited largely to enacting rules that reflected the dominant paradigm and reinforced the mechanisms of professional self-regulation.

In recent years, of course, the health care industry has changed dramatically. Indeed, since the late 1970s, health care providers have been viewed increasingly as economic competitors, and collaboration among them has been subject to scrutiny under federal and state antitrust laws. The most important effect of introducing antitrust constraints on collective action in the health care field was to deprive professional interests of the power to impose direct, coercive sanctions to discourage developments that they did not like. As the medical profession lost control of its economic environment, crucial decisions affecting the quality and cost of health care were increasingly taken in response to the concerns not of professional interests but of consumers and their agents, including cost-conscious employers purchasing health coverage or health services for their employees. Particularly in the 1990s, purchasers' demands for cost control, the emergence of selective contracting and price competition, and the spread of managed care techniques for countering the effects of moral hazard have put severe pressure on such previously inviolate elements of American health care as physician autonomy and the doctor-patient relationship. For better or for worse, outright entrepreneurship, unconstrained by enforced respect for professional or other norms or by any need to cooperate with organized professional interests or community overseers, has come to American health care. It is arguable that active enforcement of the antitrust laws against health professionals is the most important public policy event that the health care industry has ever seen, because it brought health care out from under the old professional paradigm and exposed the industry to scrutiny under the market paradigm that governs most other economic activity in the United States.

In many respects, these developments have clearly been for the better. In particular, significant amelioration in the rate of health care cost increases can be attributed to the market forces and innovations that were unleashed by antitrust enforcement. But these developments are increasingly perceived as having a potential downside. Thus, as pressures to control costs have increased in an environment with weakened behavioral norms and reduced self-regulatory oversight, there has arisen at least a perception that the quality of care is in unprecedented jeopardy. To be sure, it is hard to document the claim that managed care organizations are sacrificing truly valuable increments of quality or are performing any worse than the fee-for-service system performed under professional stewardship.[5] Nevertheless, it is altogether natural for people to be concerned that the cost of health care, because it is both very high and more easily measured than uncertain marginal benefits, is getting more attention than the other side of the quality-cost trade-off. Although quality and cost do not always move in the same direction (improved quality often leads to lower, not higher, costs), the inability of consumers and others to recognize and assess technical quality in medical care may well create opportunities for inappropriate economizing. Without good accountability when quality slips,[6] opportunistic payers and ethically challenged at-risk providers may be in a position to sacrifice increments of quality that, if all were known and choices were well presented, consumers would choose to pay for. Because of the large transaction costs associated with enforcing the implied contractual obligation to provide at least an efficient level of quality, inappropriate compromises of quality are at least a worrisome possibility.

The object of the conference summarized here was to encourage new kinds of cooperation and collaboration that can foster improved quality of care in local markets within the context of the new paradigm of medical care. The principal purpose of this paper is to show that the market paradigm, as embodied in the anti-trust laws, would welcome, not oppose, many forms of collaboration by competing health plans that have the potential for improving the quality of care. To be sure, antitrust law prohibits naked agreements by competitors on the nature and quality of the services that they plan to sell as well as the use of coercive measures to enforce a particular standard or definition of quality. *Nevertheless, the law should pose no obstacle to cooperation for the purpose of producing new information for the use of market participants or to collaboration that improves the market's functioning in some other way*. The federal antitrust statutes have also been construed so that they do not apply to collective efforts to influence governmental action. As a result, there is significant room for private collaboration that alms at getting state

[5] See Miller RH and Luff HS. Does Managed Care Lead to Better or Worse Quality of Care? *Health Affairs* 16:7, 1997.

[6] Cf. Havighurst CC. Making Health Plans Accountable for the Quality of Care. *Georgia Law Review* 31:587, 1997 (arguing for so-called enterprise liability to ensure that health plans are accountable for the quality as well as the cost of health care provided under their auspices).

and local governments to act in a manner that improves the quality of health care, even though the methods that governments adopt might be deemed anticompetitive and illegal if employed by private interests.

Unfortunately, many legal questions raised by particular collaborative activities cannot be answered definitively in a summary like this one. Moreover, much will depend on the specific factual situation and the evidence that might turn up in a given case—for example, the proverbial "smoking gun" or "hot document." Finally, even if the collaborators have obtained excellent legal advice on the substantive requirements of antitrust law, even scrupulous following of such advice would provide no guarantee that a costly-to-defend antitrust suit would not be filed by some competitor who is adversely affected by lawful collaborative action. In general, however, it is reasonable to expect quick dismissal of invalid claims in nearly all cases, and the law is clear enough that market participants should not be deterred by antitrust fears from collaborating to improve the quality of care in ways that do not interfere with the freedom of buyers and sellers ultimately to decide for themselves how and with whom to do business. Although private groups should not substitute their judgments for those of the marketplace, there are many things they could do to improve the chances that the interactions of independent buyers and sellers in a competitive market will reflect and give effect to consumers' true preferences with respect to the quality as well as the cost of care.

Some Rudiments of Antitrust Law

Most of the antitrust issues raised by collaboration to improve the quality of health care would arise under section I of the Sherman Act, which prohibits "every contract, combination..., or conspiracy in restraint of trade...."[7] The first element of a violation—concerted action by multiple actors—is easily satisfied when independent professionals or other independent entities (such as competing health plans) cooperate for any purpose. The principal question in applying the statute is therefore whether there is in fact a "restraint of trade." Thus, the concerted conduct in question must be scrutinized to determine whether it is compatible with the maintenance of competition as a guarantor of consumer welfare. For these purposes, competition should be thought of as a dynamic process featuring voluntary transactions between and independent decisions by mutually accountable buyers and sellers. If a collaboration does not impair this process, it should not offend the antitrust laws.

Certain kinds of horizontal agreements among competitors are conclusively presumed to have the prohibited effect on competition and are thus treated as illegal "*per se*." Thus, conduct that can be labeled "price fixing," "market allocation," or a "group boycott" will, if proved, be condemned without any further demonstration of the harm to competition, and the defendants will not be permit-

[7] 15 U.S.C. §1 (1994).

ted to show that their purposes were worthy or that they lacked the market power needed to harm consumers. Conduct outside the reach of "*per se* rules," on the other hand, will be analyzed more fully under the so-called Rule of Reason. In such cases, there must be inquiry—sometimes it can be done quickly and easily—into the conduct's actual or probable effects on competition, which may be evidenced by the parties' professed or apparent purposes and the market power they seem capable of exercising.

It is necessary to underscore that any assessment of concerted action under the Sherman Act and the Rule of Reason is concerned only with its effect on the competitive process. It is therefore irrelevant for antitrust analysis that a particular collaboration may enhance consumer welfare in some way other than by enhancing competition itself or that it has arguable virtues of another kind when viewed from the standpoint of general public policy. Standing alone, therefore, claims that concerted action will enhance the quality of health care should carry little weight, as such, in an antitrust court. This judicial response results because Congress is deemed to have created in the Sherman Act a conclusive presumption that consumers will benefit from maintaining competition and its attendant incentives, checks, and balances. Because the competitive process is generally presumed to be capable of addressing quality issues while also taking into account costs and other features of the overall transaction, any collective actions that competitors take to enhance the quality of goods and services must be designed to make that process work better, not to interfere with it. A former head of the Antitrust Division of the U.S. Department of Justice has argued that quality concerns in the health care field do not require special antitrust rules but can be adequately accommodated in traditional analysis focusing on competitive effects.[8]

One Supreme Court decision in particular illustrates the paramountcy of competition as the touchstone of antitrust analysis and the unavailability of defenses based solely on the quality of professional services. In that case, members of the National Society of Professional Engineers agreed to an ethical code under which they refrained from competitive bidding for engineering jobs.[9] In court, they offered to defend their practice under the Sherman Act by showing that price competition would encourage corner-cutting in engineering work and imperil public safety. The Supreme Court, however, refused to allow the engineers

[8] Kauper TE. The Role of Quality of Health Care Considerations in Antitrust Analysis. *Law & Contemporary Problems* 51(Spring):273, 340, 1988: "Conduct that promotes efficiency, ameliorates the effects of market failures or imperfections, or increases quality rivalry among providers is, to this extent, pro-competitive and may improve quality of care by enhancing the competitive process. Any further accommodation of quality-of-care concerns is a direct challenge to the central role of the market in the determination of quality, and therefore to the relevance of antitrust itself." See also Greaney, Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation. *Connecticut Law Review* 21:605, 1989.

[9] *National Society of Professional Engineers v. United States*, 435 U.S. 679, (1978).

even to present evidence in support of their premise that competition, if allowed to operate, would serve the public badly.[10] In so doing, the Court cited a famous case (decided 100 years ago) in which then Judge William Howard Taft opined that to permit true restraints of trade to be upheld under public policy defenses would be "to set sail on a sea of doubt" and to rely upon "the vague and varying opinion of judges as to how much, on principles of political economy, men ought to be allowed to restrain competition.[11]

To be sure, it is not always easy for courts to adhere to Judge Taft's advice to avoid balancing competition against other values in antitrust cases. Indeed, for some reason, the courts have never treated as *per se* offenses all so-called naked restraints of trade—that is, all agreements whose purpose, possibly benign in itself, is achievable only by reducing the vigor of competition in an economic market.[12] On the other hand, neither have they indicated with any clarity what might save an agreement that, while falling outside the *per se* categories, still contemplates some attenuation of competition. Perhaps the most logical possibility is that courts might regard a naked restraint favorably if the particular market had major imperfections and the collaborators' action was likely to produce results closer to those that competition would normally be counted upon to yield. In other words, despite the presumption favoring competition for better or for worse, there may be room for a "market failure" defense under which the law would tolerate some attenuation of rivalry when rivalry can be shown not to serve the public well.[13]

[10] See note 8, section 695 (stating that the society's attempt to justify its restraint on price competition "on the basis of the potential threat that competition poses to the public safety and the ethics of its profession is nothing less than a frontal assault on the basic policy of the Sherman Act").

[11] *United States v. Addyston Pipe & Steel Co*., 85 F. 271,283–284 (6th Cir. 1898). See also *United States v. Socony Vacuum Oil Co*., 310 U.S. 150 (1940) (condemning virtually all agreements aimed at affecting prices, "the central nervous system of the economy"); *United States v. Trenton Potteries*, 273 U.S. 392 (1927) (condemning price fixing as a *per se* restraint without regard to the reasonableness of the prices fixed).

[12] Judge Taft's *Addyston Pipe* opinion first identified the distinction between naked and so-called ancillary restraints. Although a restraint of the latter kind affects competition between the parties to it, it does so only in aid of a larger procompetitive purpose and is therefore not premised on an ability or purpose to subvert competition in the market as a whole. Unfortunately for the clarity of antitrust analysis, courts and antitrust agencies do not routinely employ this distinction and often treat ancillary restraints to which one of the *per se* labels applies as unlawful unless they survive just the kind of balancing test that Judge Taft advised against. See, for example, Havighurst CC. Are the Antitrust Agencies Overregulating Physician Networks? *Loyola Consumer Law Reporter* 8:78 (protesting against use of *per se* labels to condemn conduct—joint marketing efforts by subsets of physicians in a markets—that is not anticompetitive under all circumstances).

[13] See generally 7 Areeda PE, *Antitrust Law: An Analysis of Antitrust Principles and Their Application*. New York: Aspen Law and Business Press. ¶1504, 382–383, 1978

Obviously, if a defense of this kind is available at all, it would have the greatest appeal in markets for professional services, where information problems loom especially large and where the collaborators may be able to claim that, as ethical professionals or concerned health plans, they are looking out for their clients' interests rather than their own.[14] Interestingly, the *Professional Engineers* case itself can be read to support a modest market-failure defense. In that case, the Supreme Court stated, as a reason why the engineers' ethical canon against competitive bidding could not be upheld, that the restraint applied "with equal force to both complicated and simple projects and to both inexperienced and sophisticated customers."[15] This language certainly implies that a ban that applied only to "complicated" projects and affected only "inexperienced" consumers might stand on a different legal footing. Although it still remains hard in theory and under the language of the statute to justify letting private interests make rules that govern competitive practices, it may be desirable as a matter of practical politics for antitrust law and enforcement agencies not to seem too mindlessly or ideologically committed to the proposition that the "free market" always serves consumers well or to the view that professional groups can never be trusted to act in the public interest.[16]

In any event, even though a persuasive case might be made for permitting occasional market-correcting restraints of trade, it would be unwise for competitors designing collective action in local markets to rely on this arguable legal nuance and to count on being able to defend anticompetitive actions by pointing simply to good intentions, some alleged market failure, or arguable improvements in the quality of health care. Even if a particular market were seriously imperfect (because consumers lacked good information on quality, for example), antitrust law still provides no clear and reliable warrant for competitor groups to substitute their own judgments for those of the market. Although it is unlikely that public antitrust enforcers would challenge actions that seemed to have only

(discussing possible market-failure rationale for upholding an otherwise naked restraint that "arguably moves market performance closer to the competitive result").

[14] See generally Clark C. Havighurst, *Health Care Law and Policy: Readings, Notes, and Questions*. Westbury, N.Y.: Foundation Press, 325-339, 1988 (examining antitrust status of canons of professional ethics, which, even if viewed as naked agreements limiting the forms that competition may take, for example, deceptive advertising, would be good candidates for sympathetic treatment under a market-failure defense).

[15] 435 U.S. at 692.

[16] See generally Havighurst CC. Antitrust Issues in the Joint Purchasing of Health Care. *Utah Law Review* 409:446, 1995. ("Indeed, if the law seemed too hidebound in this regard, demands by industry groups for legislative exemptions from or exceptions to antitrust requirements would gain plausibility, with a probable ultimate net loss of competition in the economy as a whole.") Keeping some kind of market-failure defense available in antitrust doctrine would not mean that agencies or courts would often be persuaded that competitors, with a clear conflict of interests are trustworthy guardians of consumer welfare.

benign effects, local providers and others who were injured by the restraint in question could be counted on to raise the issue. Even if expert witnesses were available to show that competition serves consumers badly in the market in question and that concerted action interfering with it would serve consumers better (however it affected the plaintiff), there would still be a good chance that a court would rely upon the statutory presumption favoring untrammeled competition. The best justification for rejecting such defenses remains the one recognized by Judge Taft: the inappropriateness of letting private interests and enforcement agencies or courts, rather than the appropriate legislative body, decide as a policy matter whether competition should be displaced in one part of the economy.

Although antitrust law takes a dim view of concerted action that is antithetical to competition, it is clearly not intended to discourage all competitor collaboration, much of which is clearly procompetitive. For example, antitrust law would not stand in the way if a subset of market participants lacking market power combined their efforts through a synergistic, efficiency-enhancing merger or joint venture. Although such a collaboration would eliminate competition among the participants themselves, that restraint would clearly be ancillary to their larger competitive initiative and should therefore be condemned only if they possess undue market power and if the anti competitive effects of their combination would outweigh efficiencies they could not otherwise obtain. Similarly, no antitrust objection would be raised if a group of competitors takes collective action that makes competition itself more efficient, such as the formation of an auction market (with ancillary rules limiting some forms of competitive endeavor) or the creation, collection, or dissemination of information beneficial to market participants. In general, antitrust authorities and courts in antitrust cases are charged with deciding whether a particular collaboration enhances efficiency without unduly reducing the vigor of competition in the overall market. Only if the likely anti competitive effects outweigh the procompetitive ones will a particular collaboration be deemed a restraint of trade.

Specific Pitfalls to Be Avoided

Before considering the specific kinds of local collaboration that might improve the quality of health care without incurring antitrust penalties, it may be helpful to identify certain kinds of concerted action that collaborators should definitely avoid. Most obviously, health plans and others cooperating to advance quality-of-care objectives in local markets must be careful to avoid conduct that falls under any of the so-called *per se* rules. Thus, in addition to avoiding agreements related to prices, they must not divide markets by agreeing not to compete in providing particular services, in serving particular customers, or in purchasing from particular suppliers. (Later discussion will address the possibility that government or some quasi-public planning apparatus might immunize agreements of

this sort between providers if undertaken in an effort to raise quality through specialization in the provision of services of a particular type.) It should not be difficult for competitors concerned only about improving the quality of care to avoid transgressing these relatively clear legal rules.

Group Boycotts.

It may be harder for competitors collaborating in pursuit of quality goals to avoid conduct falling under the heading of group boycotts or concerted refusals to deal, another category of *per se* violations. Indeed, in any serious quality assurance program, there would be a strong temptation for the collaborators to engage in a concerted refusal to deal with particular providers or suppliers, perhaps because their services or products are deemed substandard. To avoid trouble on this front, however, it may not be enough for the parties simply to avoid making explicit agreements to boycott, since a private party claiming to be the victim of such a conspiracy may be able to prove the requisite agreement or tacit meeting of the minds by circumstantial rather than direct evidence. Although unanimity in rejecting the plaintiff's overtures alone would not be enough to establish a boycott, so-called conscious parallelism in business conduct is suggestive of a conspiracy, which may be confirmed by other evidence pointing in the same direction.[17]

Boycotts were at one time the medical profession's most effective sanction for enforcing its preferences against those who might be inclined to step out of line. Under the antitrust laws, however, any agreement by competitors on a common policy toward some supplier or customer would properly be treated as unlawful *per se*.[18] Thus, the practice, if proved, will be condemned without any demonstration of actual harm to competition and without any opportunity for the defendants to show that they lacked either anticompetitive intent or the market power necessary to harm consumers. Although boycotts are often objected to because they permit powerful private groups to injure a competitor, the harm to competition that should concern antitrust enforcers and the courts lies not in the competitor's injury but in the displacement of independent decisionmaking that occurs when the agreement to boycott is reached. In any event, boycott law is a powerful deterrent to private groups that might be tempted to act, in the name of quality or some other value, as an extragovernmental agency,[19] coercing others to follow a prescribed line of conduct.

[17] So-called conscious parallelism alone is not sufficient to warrant a finding of concerted action. See, for example, *Theater Enterprises v. Paramount Film Distrib. Co*., 346 U.S. 537 (1954) (parallel refusals to offer first-run films for exhibition in plaintiffs theater held not enough when evidence suggested that the defendants had independent reasons for refusal). Nevertheless, an industry-wide policy of acting for mutual rather than individual advantage, such as in refusing to take advantage of potentially profitable market opportunities in an apparent reliance on competitors to act similarly, could be evidence of an unlawful conspiracy.

[18] See, for example, *Klor's, Inc. v. Broadway-Hale Stores, Inc*., 359 U.S. 207 (1959).

[19] *Fashion Originators' Guild v. FTC*, 312 U.S. 457, 465 (1941).

Other Naked Restraints.

In general, competitors must eschew collaboration that short-circuits competition itself, which previous discussion has identified as the ultimate object of the law's protection. Recall that if the stated or obvious purpose of a collaboration is such that it can only be achieved by suppressing the general vigor of competition in the market as a whole, it is a naked restraint and thus a poor candidate to survive antitrust scrutiny. Thus, for example, an agreement among competing health plans not to offer purchasers low-cost options—on the ground that making such options available induces consumers to make unwitting sacrifices of quality—would be classed as a naked restraint because it explicitly substitutes the collective judgment of competitors for the independent judgments of purchasers. Even though such an agreement might yield some real social benefits by overcoming an arguable market failure (specifically, the inability of consumers to recognize and evaluate quality differences), it would almost certainly be illegal because it diminishes competition.

The crucial reason why antitrust law would bar agreements on benefit packages, on business policies, or on competitive strategies is that such agreements represent a surrender by each competitor of its freedom of action. As the Supreme Court has stated, an anticompetitive agreement among competitors "deprives the marketplace of the independent centers of decision making that competition assumes and demands."[20] This suggests a good rule of thumb: In carrying out collaborative activities, each competitor must retain its independence with respect to managing its own business. Agreements surrendering that independence to a group, when not required to achieve an objective compatible with competition, will very likely fail to pass Sherman Act muster.

Standard Setting

As can be sensed from the foregoing discussion, one collaborative quality assurance strategy that may be lawfully pursued by health care providers or competing health plans at the local level involves the production and dissemination of information and opinion that better inform purchasing and other decisions at various levels. The classic example of a lawful informational program is private standard setting, which is often accompanied by a formal program for applying the agreed standards in certifying products, accrediting institutions, or credentialing technical personnel. Programs of this kind are common in the economy as a whole and are ubiquitous in the health care industry, mostly at the national level. One can imagine local programs, however, that adopt and/or apply standards to local health care providers or health plans. Clinical practice guidelines are a specific example of standards that might be privately developed (or adapted from published studies)and promulgated by a coalition of local health plans.

[20] *Copperweld Corp. v. Independent Tube Corp.*, 467 U.S. 752, 768–769 (1984).

The legal system has not arrived at a clear consensus on how private standard setting and accrediting (as used here, *accrediting* includes certification and credentialing) should be viewed for antitrust purposes.[21] One court, for example, saw no restraint of trade at all in the publication by a competitor-controlled body of its authoritative, but debatable, opinion on a controversial topic (radial keratotomy, then an emerging medical technology) even if competitors were adversely affected:

> [W]hen a trade association provides information ... but does not constrain others to follow its recommendations, it does not violate the antitrust laws. An organization's towering reputation does not reduce its freedom to speak out.... The Academy's declaration affected only the demand side of the market, and then only by appealing to consumers' (and third-party payers') better judgment. If such statements should be false or misleading or incomplete or just plain mistaken, the remedy is not antitrust litigation but more speech—the marketplace of ideas.[22]

Other courts that have been called upon to examine accrediting programs under the antitrust laws have been more willing to view competitor-sponsored accrediting as a restraint subject to a reasonableness test.[23] Such an approach to applying the Sherman Act to accrediting appears most clearly in a 1983 study of product standards and certification by the staff of the Federal Trade Commission's (FTC's) Bureau of Consumer Protection: "The standard is the product of joint action and restrains trade by diverting business from one competitor to another.... Standards activities by their nature restrain trade...."[24] Although

[21] See generally Havighurst CC and Brody PM. Accrediting and the Sherman Act *Law & Contemporary Problems*, 57(4):199, 1994. Among other things, standard setting and accrediting involve the expression of opinions, thus raising the question whether antitrust law can provide any oversight of the activity at all without violating constitutional free-speech guarantees. Some oversight is probably permissible under the doctrine permitting some regulation of so-called commercial speech. See also page 220 of Havighurst and Brody.

[22] *Schachar v. American Academy of Ophthalmology*, 879 F.2d 397, 399 (7th Cir. 1989). See Havighurst CC. Applying Antitrust Law to Collaboration in the Production of Information: The Case of Medical Technology Assessment, *Law & Contemporary Problems* 51(2):341, 1988. Other courts have also noted the value and the effectiveness of the marketplace as a forum for resolving trade-offs of the kind that standard setters and accreditors encounter. See, for example, *Consolidated Metal Products v. American Petroleum Inst*., 846 F.2d 284, 296 (5th Cir. 1988) (standard-setting case).

[23] For example, *Paralegal Institute, Inc. v. American Bar Association* , 475 F. Suppl. 1123 (1979) (court assumed, without addressing, the applicability of the antitrust laws to the accreditation of paralegal training programs).

[24] FTC Bureau Of Consumer Protection, Standards and Certification. Final Staff Report. Washington D.C.: Federal Trade Commission, pp. 275–276, 1983; see also page 247 ("Evidence on the rulemaking record ... points out the restraint on market forces that standards can cause due to reliance by buyers, government regulatory agencies, and

this formulation is questionable, many courts have analyzed competitor-sponsored accrediting under a comparable assumption. Such courts are likely to find accrediting's procompetitive aspect in the perceived value and validity of the specific information or opinion provided rather than in the simple fact that an honest, authoritative opinion or new information of at least some arguable value is being added to the "marketplace of ideas." In other words, despite Judge Taft's warning, such courts would be inclined to assess accrediting programs subjectively, looking for evidence of worthy social objectives promoted (e.g., higher quality in products or services).[25] In any event, however the matter is framed, it is probable that programs for collecting and disseminating information or opinion related to the quality of care will not be viewed as *per se* violations of the antitrust laws and that well-run, fairly administered programs can be expected to survive scrutiny under the Rule of Reason, however it is applied.[26]

Standard setting by a competitor group can also give rise to another difficult conceptual problem. Although the standards produced may serve as procompetitive benchmarks useful to independent decisionmakers, they may also be viewed as embodying the sponsors' agreement to abide by the standards in their own competitive endeavors. In theory at least, an agreement merely to publish standards (or to employ them in an accrediting program) is distinguishable from a naked agreement by industry members not to compete by producing nonstandard goods or services. This distinction is highly conceptual, however, and may not seem very helpful in deciding actual cases in the real world. Indeed, it is hard to ignore the reality that, when industry-wide standards are agreed upon, there is probably also some implicit understanding or expectation that they will be followed in practice. Thus, the Supreme Court observed, in the 1988 *Allied Tube* case, that "agreement on a product standard is, after all, implicitly an agreement not to manufacture, distribute, or purchase certain types of products."[27]

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others"). The bureau that prepared this report is not, it should be noted, the commission's antitrust arm.

[25] Enhancing the quality of services has often been identified as a potential procompetitive benefit of concerted action in the market for health and educational services. See, for example, *Kreuzer v. American Acad. of Periodontologists*, 735 F.2d 1479, (D.C. Cir. 1984) (recognizing claim of "patient care motive" and "improved quality of care of periodontal patients" as possible justifications for accrediting standard); *Paralegal Institute, Inc. v. ABA*, 475 F. Supp. 1123, 1130,-31 (E.D.N.Y. 1979) (accreditation scheme approved in part because of its value in improving training of paralegals). Yet quality is generally regarded, not as an end in itself, bat as one of the welcome by-products of competition. See note 4 supra.

[26] Because some courts will view standard setting and accrediting as restraints of trade, the parties should respect the less-restrictive-alternative requirement by adopting fair procedures and by being careful the their processes are not misused.

[27] *Allied Tube & Conduit Corp. v. Indian Head*, 486 U.S. 492, 500 (1988); see also page 507 ("any agreement to exclude polyvinyl chloride conduit from the Code is in part an implicit agreement not to wade in that type of electrical conduit").

Nevertheless, despite the seeming fineness of the distinction between collectively publishing standards of practice guidelines (or verifying compliance with them) and agreeing to follow those standards or guidelines, collaborators in a quality assurance program should try to observe it in their activities. One element of the antitrust Rule of Reason is the requirement that competitors collaborating for a procompetitive purpose must arrange their undertaking so as to pose no unreasonable or unnecessary hazards to competition.[28] Under this "less-restrictive-alternative" requirement, collaborators in standard setting or accrediting should be expected to retain as much independence as possible in deciding what products or services (standard or nonstandard, accredited or unaccredited) to offer, what suppliers to patronize, and what customers to serve. Because any express agreement to abide by the agreed-upon standards or to boycott others who fail to abide by them cannot be defended as being ancillary to the larger accrediting program, all such agreements should probably be unlawful. (Thus, an agreement by local health plans to limit their coverage of, say, mammograms for women below the age of 50 would be risky even if accompanied by an outreach program to older women.) On the other hand, a standard-setting or accrediting program unaccompanied by an actual agreement to abide by the agreed standards has a different appearance. Indeed, the Supreme Court's dictum in the *Allied Tube* case makes doctrinal sense only if read as an appreciation that some degree of common understanding with respect to compliance is inherent in the act of setting standards and cannot, without more, violate the Sherman Act.

Thus, although an overt agreement to honor or enforce a privately agreed-upon standard would be illegal, standard setting itself is not. Indeed, as long as collaborators in standard setting and/or accrediting honor the less-restrictive-alternative requirement by avoiding explicit anticompetitive agreements and by disclaiming any intention to curb independent action, any remaining hazard to competition should be viewed, under the *Allied Tube* dicta, as a lawful ancillary restraint. To be sure, the agreement on standards may limit competition between the parties to some degree. However, if it does so, only in pursuit of a larger, procompetitive objective, there should be no antitrust problem.

Most national accrediting bodies do in fact limit their role to developing standards and to granting and withholding accreditation and do not appear to broker anticompetitive agreements or to enforce their standards in improper ways. Local competitor groups, however, may be at somewhat greater risk of falling into an unlawful conspiracy. Careful attention, however, to the aforemen-

[28] See generally P. AREEDA, *Antitrust Law* § 1505 (1986). See also *Kreuzer v. American Acad. of Periodontology*, 735 F.2d 1479, 1494–1495 (D.C. Cir. 1984). In general, a demonstration that the parties could have achieved their legitimate objectives in a manner less hazardous to competition may establish either that the parties' true purposes were not what they claim or that their conduct was unreasonably restrictive and therefore unlawful. A danger is that courts or law enforcers may be unreasonably demanding in their exercise of hindsight, using small deviations from an ideal arrangement to penalize desirable conduct.

tioned distinction—between setting standards and agreeing to enforce them by explicit boycotts or to be bound by them in their own competitive endeavors—should prevent problems from arising, especially if the parties could demonstrate affirmatively that they preserved and occasionally exercised their competitive independence. Once again, the possibility that parallel action will be interpreted as collusion must be taken into account. On the other hand, if the health plans were accused only of agreeing to limit coverage, no obvious plaintiff who claims an injury to his or her "business or property" would be likely to appear.[29] Thus, serious financial repercussions are unlikely even if a violation were established (say, in the unlikely event that an action was initiated by public prosecutors).[30]

Information Collection and Exchange

Quality assurance programs that focus on collecting and disseminating data should create no serious antitrust problems as long as they are voluntary and operate within the market paradigm rather than outside of it. Indeed, the virtue of information strategies from an antitrust point of view is that they not only leave each actor free to make its own decisions but also improve the quality of those decisions, thus producing better market outcomes. Concerns would arise, however, if the data exchange were designed to trigger uniform, noncompetitive responses, serving as a signal for concerted action. Thus, trade associations that provide data on costs and prices have been found guilty of circulating information that facilitates the making of uniform pricing decisions rather than simply making members more aware of market conditions. If quality-related information were circulated to trigger a boycott of certain providers, a similar problem could arise.[31] On the other hand, uniform responses to objective information do not in themselves constitute a boycott.

[29] An agreement among health plans to cover only streptokinase rather than the more costly tPA would injure no local provider. Conceivably, a supplier of tPA might bring suit, however, seeking treble damages for the profit on lost sales.

[30] In theory, although one might imagine a claim for ordinary (nontreble) damages for personal injuries resulting from a violation of the Sherman Act, no successful claim of this kind has ever been reported.

[31] If there is no overt concerted refusal to deal, it is necessary to ask whether an unlawful conspiracy to boycott can fairly be inferred from the evidence of knowingly similar conduct by the competitors (so-called conscious, parallelism) coupled with other suspicious circumstances. In a 1914 case in which some retail lumber dealers' associations published a list of wholesalers who also traded at retail in competition with the associations' members, the Supreme Court said, "When, in this case, by concerted action the names of wholesalers who were reported as having made sales to consumers were periodically reported to the other members of the associations, the conspiracy to accomplish that which was the natural consequence of such action [i.e., refusals to deal] may be readily inferred." *Eastern States Retail Lumber Dealers' Ass'n v. United States*, 234 U.S.

As noted above, however, a boycott or other conspiracy can be proved without direct evidence of an actual agreement in restraint of trade, and plaintiffs who find themselves cut off or otherwise adversely affected by the collaborators' unanimous actions could be expected to claim that their injuries resulted from at least a tacit conspiracy to act in parallel fashion and not independently.[32] Thus, when collaborators circulate information unfavorable to a provider and the all collaborators thereafter cease to deal with that provider, a question of fact arises as to whether they acted in concert not only in circulating the information but also in deciding what action to take on the basis of it. If the information is such that independent decisionmakers would all be likely to respond to it in the same way, then no inference of conspiracy could be drawn. On the other hand, if each competitor's reaction makes sense (in terms of self-interest) only if others react in the same fashion, then the finder of fact might be justified in finding collusion.

In local health care markets, a publication of unfavorable information concerning a particular provider could easily trigger a uniform response by competing purchasers of that provider's services. Such responses might be attributable to fear of criticism or possible malpractice suits. On the other hand, a boycott claim might be based on the theory that no single competitor would forego the patients that provider could refer unless it was assured that others would do so as well. Among the safeguards that should be adopted to minimize the risk of a successful conspiracy charge is the couching of information in the form of objective facts, not of recommendations for action of a particular kind. Collaboration in the collection and dissemination of information, while justified by the efficiencies achievable from pooling information and in processing and publishing it, must at all points create no greater danger to competition than is reasonably necessary to achieve those efficiencies. Some protections against unfair actions harmful to individual providers, while not strictly required by law, would be highly desirable as a way of demonstrating good faith and reassuring courts that quality assurance was the sole consideration in the actions taken.[33]

Collaborators must also avoid coercing participation in any quality assurance program for collecting and disseminating information they might wish to launch. Thus, participation in a joint information program must be voluntary, not enforced by threats to boycott nonparticipants. Likewise, the collaborators should avoid brokering anticompetitive actions by others, such as by inducing local employers, hospitals, or health plans to act in concert in refusing to deal

600, 612 (1914). A conspiracy to boycott could not be inferred from an exchange of information and opinion, however, if that exchange had value other than as a signal for concerted action. Quality-related information can be viewed as having such value.

[32] In general, antitrust plaintiffs, to establish a conspiracy, "must present evidence that tends to exclude the possibility that the alleged conspirators acted independently." *Matsushita Elec. Industrial Co. v. Zenith Radio Corp*., 475 U. S. 574, 588 (1986) (stating test for summary judgment in conspiracy cases), quoting *Monsanto Co. v. Spray-Rite Service Corp*., 465 U.S. 752, 764 (1984).

[33] Cf. *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963).

with a discredited provider or with a nonparticipant in some group-sponsored program. As a general rule, each market participant should be left free to make its own judgments about participating in joint activities and about the implications of objective information. On the other hand, it may be possible to take actions that make it distinctly more attractive for independent actors, acting in their own competitive self-interest, to decide one way rather than another. In general, a community-wide information system engaged in profiling providers should not purport to make decisions on individual providers' eligibility to participate in individual health plans. Such decisions should be made independently by the plans themselves, using information not only from the joint undertaking but from other sources as well.

One purpose of the Health Care Quality Improvement Act of 1986[34] was to reduce the legal risks of quality assurance efforts by individual hospitals, other health care entities (including health plans), and local medical societies. Its principal effect is to provide protection against private suits for money damages (including antitrust suits seeking treble damages) where "a professional review action [is taken] in the reasonable belief that the action was in furtherance of the quality of care." Although the act provides a modicum of protection for entities that follow its detailed specifications,[35] it would not be available to protect *collaborative* activities of managed care plans, health insurers, or employer coalitions. To be sure, the act reflects a congressional policy favorable to some forms of quality-enhancing joint action (by professional societies, medical staffs, and the like) and might be cited as a sign that Congress does not trust either the competitive market or antitrust courts, left to their own devices, to give appropriate weight to quality considerations. Nevertheless, antitrust law would almost certainly still bar concerted refusals to deal even if motivated by quality concerns and would apply in the normal fashion to other kinds of quality assurance efforts undertaken by multiple entities (rather than by one of the entities defined by the act). It would seem that the only way that collaborating health plans could take advantage of the limited protections in the 1986 act would be by organizing a formal "professional society" dedicated to admitting only high-quality physicians and other professionals as members. Although each health plan would still have to decide for itself whether to include nonmembers of this "society" in their panels, this visible sign of special competence might alert consumers and others

[34] 42 U. S. C. § § 11111–11115 (1995).

[35] A health plan might not find it worthwhile to follow the act's requirements for several reasons: (1) Meeting those requirements is costly. (2) The act merely restates, possibly restating but not dramatically altering, the plaintiff's burden of proof. (3) The main relief provided by the act (a shifting of the defendant's legal costs to the plaintiff who brings a frivolous claim) is not automatic. (4) It should not be hard for a health plan to avoid opening itself to costly litigation by not doing anything that even arguably violates the law, which permits health plans to terminate physicians and other providers at will or in accordance with their contracts.

to quality differences among providers, Obviously, however, physician-sponsored organizations might have agendas of their own.

Selecting High-Quality Providers

A possible strategy for improving the quality of care would be to encourage providers to specialize in providing particular services. It is widely believed, on the basis of some evidence, that the proficiency of providers in doing particular procedures increases with the number of procedures they do.[36] Collaborating health plans might therefore be tempted to agree to direct their business to particular providers that have demonstrated superior proficiency or that can be expected to achieve it.

Unfortunately, collective efforts by health plans to favor one or a few providers with their business would raise antitrust problems. For example, an agreement to use only a designated provider could be characterized as a boycott of other providers. Although joint purchasing of a particular service might be defended on the ground of efficiencies gained in searching the market and negotiating contracts, any arrangement in which more than a subset of the purchasers in the market participated might be objected to on the ground that it enables the collaborators to exercise monopsony power over the providers seeking contracts. Finally, if the collaborators proceeded by inducing the providers themselves—local hospitals, for example—to agree to specialize in different fields, those agreements would fall within the *per se* rule against market division arrangements.[37] Although the discussion below suggests some ways in which govern-

[36] For example, Chassin MR. Assessing Strategies for Quality Improvement. *Health Affairs* 16:151,154–155, 1997 (observing correlation between improved cardiac surgery survival rates and New York regulations limiting number of hospitals permitted to perform cardiac procedures); Grumbach K, Anderson GM, Luft HS, Roos LL, Brook R. Regionalization of Cardiac Surgery in the United States and Canada: Geographic Access, Choice and Outcomes. *JAMA* 274:1282, 1995.

[37] Many communities have had past experience with so-called comprehensive health planning. In the late 1970s, the question arose whether a local planning agency could broker agreements between hospitals under which each competitor would specialize in different services. Even though both state and federal health planning legislation appeared to ratify the then-prevalent notion that competition was not a reliable force in the health care sector, the antitrust agencies and most courts took the position that market division agreements were unlawful *per se*. See, for example, *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 393 (1981) (federal health planning legislation held not to create "a 'pervasive' repeal of the antitrust laws as applied to every action taken in response to the health-care planning process"); Havighurst CC. Health Planning and Antitrust Law: The Implied Amendment Doctrine of the *Rex Hospital* Case. *North Carolina Central Law Journal* 14:45, 1983. But see Bolze RS and Pennak MW. Reconciliation of the Sherman Act with Federal Health-Planning Legislation: Implied Antitrust Immunity in the Health Care Field. *Antitrust Bulletin*

mental involvement might immunize such arrangements, it is not easily within the power of private competitors alone to eliminate competition even in the name of quality.

In general, it appears that without special legislation sheltering anticompetitive agreements, a collaborative strategy of promoting quality by encouraging local providers to become "centers of excellence" would succeed in avoiding antitrust problems only if the collaborators confined their effort to collecting information on comparative performance. Each health plan and others in the community could then decide independently what action to take on the basis of the evidence provided. To be sure, if the high-quality provider charged higher prices, some competing health plans might not include it at all or might require the patient to pay the difference over a lower-cost service. If the quality advantage was substantial, however, it might enable the provider to charge a lower price, reflecting economies of scale and the lower cost (including lower liability costs) that can accompany better outcomes. In any event, a provider that achieved a local monopoly by means of offering a better product (and not by engaging in exclusionary practices) should not have to worry about being charged with monopolization under section 2 of the Sherman Act.

Lobbying and Working with Government

The Sherman Act has been authoritatively limited in its application to political activity. Under the so-called *Noerr-Pennington* doctrine, collective lobbying for anticompetitive legislation is not subject to antitrust challenge—even if some misrepresentation is involved.[38] Although this principle may seem to derive from the free speech guarantees of the first amendment, it is more accurately viewed as a narrow construction of the Sherman Act that attributes to Congress an intention to regulate only behavior in the marketplace, not political activity. To be sure, one might (under so-called public choice theory) question the ability of political and legal processes to protect consumers against anticompetitive legislation or official action promoted by special interests. Nevertheless, it would be hard to maintain that antitrust law was intended by Congress to limit the political power of well-positioned interest groups.[39] Limitations on the *Noerr* principle

29:225 (1984) (concluding that usual antitrust tests should be relaxed in the presence of publicly authorized health planning). Especially in view of the repeal of the federal health planning act in 1986, health plans competing in local markets should not rely upon local planning agencies (or their modem equivalent) to immunize agreements that offend antitrust principles.

[38] See generally Elhauge E. Making Sense of Antitrust Petitioning Immunity. *California Law Review* 80:1177, 1992.

[39] See *Eastern R.R. Presidents Conf. v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961) (rejecting antitrust claim by trucking firms that railroads waged a publicity campaign "designed to foster the adoption and retention of laws ... destructive of the truck

include the so-called sham exception, which prevents competitors from casting their activities as calls for political action when their true purpose is to inspire a boycott or other direct collective action.[40]

Under the *Noerr* doctrine, therefore, private interests could freely combine to seek governmental action favorable to the maintenance of quality. Thus, for example, an agreement to report a particular provider to a public authority for possible sanctioning would be permissible, if it did not fall within the "sham" exception as a signal also to boycott that provider prior to action being taken. The resulting state or local legislation or regulation, even if highly anticompetitive, would not itself be invalidated or overridden by the federal antitrust laws as long as certain conditions were met. The general rule is that federal antitrust law will defer to state law only if (1) "the state itself," through its legislature or supreme court, has "clearly articulated" a policy at odds with the federal policy of maintaining competition and (2) the state has supplied appropriate oversight ("active supervision") of any private groups that it has authorized to act anti-competitively.[41]

State legislatures are routinely lobbied, of course, by interest groups without fear of antitrust action, and many state laws that could be characterized as restraints of trade are on the books without question as to their validity under federal law. Indeed, in recent years, some 19 states have enacted so-called provider cooperation laws for the purpose of sheltering collaborative activities of certain health care providers, particularly hospitals, from the strictures of federal antitrust law.[42] Although these laws have not been tested for compatibility with federal law, the most carefully drafted ones will probably pass muster. The best example of a well-drafted law is the North Carolina Hospital Cooperation Act of 1993. This statute includes a finding that "cooperative agreements among hospitals and between hospitals and others for the provision of health care services may foster improvements in the quality of health care" and provides as follows:

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ing business"); *Missouri v. National Organization for Women*, 620 F.2d 1301 (8th Cir.), cert. denied 449 U.S. 842 (1980) (Sherman Act construed not to apply to National Organization for Women's boycott of the state's convention facilities; the boycott was aimed at getting the state legislature to ratify the Equal Rights Amendment).

[40] *See Noerr,* 365 U.S. at 144; *Federal Prescription Service, Inc. v. American Pharmaceutical Ass'n*, 663 F.2d 25 3 (D.C. Cir. 1981) (campaign against mail-order sales of prescription drugs, although disingenuous in its professed concern for the pharmacist-patient-physician relationship, was held to have injured plaintiff only as a result of governmental action and thus not to violate the Sherman Act).

[41] *California Retail Liquor Dealers' Ass'n v. Midcal Aluminum, Inc* ., 445 U.S. 97 (1980).

[42] See generally Blumstein JF. Assessing Hospital Cooperation Laws. *Loyola Consumer Law Reports* 8:98, 1995–1996; Blumstein JF. Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation, *Cornell Law Review* 79:1459, 1994; Vance MA. Immunity for State-Sanctioned Provider Collaboration After Ticor. *Antitrust Law Journal* 62:409, 1994.

> A hospital and any person who is a party W a cooperative agreement with a hospital 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 if a certificate of public advantage is issued for the cooperative agreement, or in the case of activities to negotiate or enter into a cooperative agreement, if an application for a certificate of public advantage is filed in good faith. It is the intention of the General Assembly that immunity from federal antitrust laws shall also be conferred by this statute and the State regulatory program that it establishes.[43]

Assuming that the North Carolina act's numerous requirements were met, it would probably be possible for employer coalitions or coalitions of health plans to broker otherwise unlawful arrangements between hospitals that permit the division of markets and the specialization that can thereby be achieved. In states lacking such legislation, such arrangements would be highly problematic. Moreover, most of the state laws are aimed at immunizing hospital agreements, not agreements between competing health plans or competitors of other kinds. Thus, they lack utility for immunizing arrangements to which a hospital is not a party.

Although state legislatures can confer so-called state-action immunity on anticompetitive activities, providers must exercise special care in relying for immunity on the actions of municipalities and other subdivisions of state government. If such a governmental entity does not possess clear delegated authority from the state legislature to act in anticompetitive ways, it is not capable of conferring antitrust protection. In federal eyes, governmental subdivisions cannot exercise the same sovereign power as "the state itself." Thus, it is important for private collaborators relying on the state-action exemption to satisfy themselves that the state has effectively immunized any anticompetitive conduct in which they propose to engage.

Conclusion

The lesson here is that antitrust violations are unlikely to be found if collaborating health plans seeking to raise the quality of health care can successfully confine their commercial (as opposed to their political) activities to developing and disseminating information that makes the competitive market, which de-

[43] N. C. Gen. Stat. § § 131 E-192.3 (1996). A "certificate of public advantage" is to be issued by the North Carolina Department of Human Resources if "it determines that an applicant has demonstrated by clear and convincing evidence that the benefits likely to result from the agreement outweigh the disadvantages likely to result from a reduction of competition." N. C. Gen. Slat. § 192.4. However, the statute gives the Attorney General a veto over the issuance of any certificate. In addition, it requires periodic reports from the parties and permits revocation of certificates either for noncompliance with "conditions" contained therein or after a reassessment of the "benefits and disadvantages" that are to be weighed in approving the agreement.

pends fundamentally upon independent decision making by competing entities, work better and give greater weight to quality considerations in purchasing. Even through the law will continue to be vigilant against concerted action that interferes with the competitive process, there would seem to be many opportunities for useful collaboration by competing health plans. To be sure, there can be no assurance that private parties, particularly providers whose competitive opportunities are reduced by the circulation of information concerning them, will not initiate antitrust suits that are costly to defend. Nevertheless, conscientious efforts to improve the quality of care should survive antitrust scrutiny in nearly every case, and most actions stand a good chance of being dismissed at an early stage. Although antitrust law has often been invoked by competitors injured by the circulation of information, modern courts are increasingly inclined to recognize that the Sherman Act was intended by Congress to protect "competition, not competitors."[44] Thus, if a private injury results only from competition itself, the complainant should soon be out of court. Although losers in the competitive race will always look for scapegoats and significant costs can be incurred in establishing that the competitive process was not interfered with in some way, collaboration in pursuit of quality goals should not be deterred by fears about antitrust consequences.

COLLABORATION FOR QUALITY IMPROVEMENT AMONG MANAGED HEALTH CARE ORGANIZATIONS: WHAT CAN BE LEARNED FROM THE EXPERIENCE OF OTHER INDUSTRIES?

George C. Eads, Ph.D.

Frequently, when organizations discuss collaboration, their lawyers will tell them it might be illegal, and that is the end of the discussion. This often prevents organizations from engaging in some very interesting and important opportunities.

Why Do Organizations Collaborate?

Economists refer to externalities. What this means is that something that one group does generates a benefit or a cost that does not completely return to that group. A positive externality, for example, is basic research, where the research is financed by one group and it benefits others. An example of a negative externality is pollution. In that case, one group pollutes, but the cost is borne by others.

[44] *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc*., 429 U.S. 477, 488 (1977). Despite this dictum, it is not always easy to recall that the antitrust laws are primarily concerned not with helping weaker competitors or with the unfairness of "ganging up" on a victim but with the impairment of competition itself, the process of independent decisionmaking.

Collaboration is one way to internalize or to capture either positive or negative externalities. This is an important issue, particularly when parts of the industry are fragmented, as health care is. When a single firm dominates the industry like Bell Laboratories was in telecommunications, the dominant firm believes that it is likely to capture the benefit of its work without collaboration. For example, Bell Laboratories could afford to do basic physics and math research because they would be able to use their findings in telecommunications. The fact that they could not capture all of the benefits was unimportant. Similarly, in the 1940s through the 1960s, General Motors supported basic research on automobiles because it knew it could make use of whatever came out of the research. Today, in the automobile industry, the Partnership for a New Generation of Vehicles is a collaborative effort of all U.S. automobile manufacturers, and in telecommunications, the Semiconductor Consortium has been formed.

These efforts reflect the fact that the industries have become much more fragmented and no one organization can capture externalities. Examples of these externalities include the establishment of standards, a common way of doing things. An example is the size and shape of electrical plugs in this country. There is a cost to standards, however, and that cost is flexibility. If an organization now believed that it could improve the shape of the electrical plug, it would be nearly impossible to implement that improvement.

Why Do Organizations Refuse to Collaborate?

One reason an organization might refuse to collaborate is the perception that it could lose market share by not being the first to produce something; that is, there may be a reluctance to forego product differentiation opportunities. In industry, the classic case of this is from Japan, in particular, the joint work to develop the 64 kilobyte random access memory (RAM). In the 1970s and 1980s, the 64-kilobyte RAM project was initiated by the Japanese government. Participation in the project was not particularly voluntary, and was not always enthusiastic. Certain firms did not send their best people or walled off parts of their activities to prevent ideas from "leaking out."

The RAM project collaboration worked to some degree because it managed to raise the majority of the Japanese electronics industry to a common level very quickly and enabled a common approach to research. However, it created a myth about collaboration and how it works that has served the Japanese badly in other areas.

Since a change in the antitrust law in 1988, 15 research consortia have been established by domestic automobile makers. In most of these cases, however, the motivating factor has been social or political pressure, not the market. For example, the Advanced Battery Consortium and the Low Emission Paint Consortium are activities that the government has encouraged because it is trying to

reach an objective that does not engender much support from the business community.

Another collaborative effort by the automotive industry is the Development of Advanced Technologies and Systems for Controlling Dimensional Variation in Automobile Body Manufacturing. It is also known as the "two-millimeter project." The objective is to have equivalent dimensional pieces in vehicles to be on average within two millimeters of variation. The "body in white," the basic structure of the car is manufactured from large sheets of steel. It is important, but very difficult, to manufacture the various critical dimensions of the body in white within plus or minus two millimeters in all of the critical intersection points at a rate of production of about 60 bodies per hour.

No one firm and no one part of the industry could do this. Making bodies that fit together involved not just the automobile manufacturers but the entire industry that supplied the various parts of the assembly process, most of which are relatively small firms. One thing that collaboration does is provide a way of bringing together very diverse skills and organizations. The two-millimeter project began in September 1992 and ended in 1996. By December 1995, the five assembly plants had reached or exceeded the standards.

The project involved joint funding: About $5 million came from the Advanced Technology Program of the federal government and about $9 million came from the joint venture partners. Universities were also involved. Obstacles to the project were as much institutional and cultural as they were technical. The serious technical problems that had to be overcome involved people working together in different ways. Assembly plant engineers and line operators were not eager to change what they were doing, and all saw such changes as involving risk. In addition, if it is possible to identify and improve suppliers, they could have leverage over the organization that they supply. Small to medium-sized companies generally have small or no research and development budgets. Yet, just as in this example, the various elements were critical to making the collaboration work.

How Are These Examples Relevant to Health Care?

Health care is a service industry. Unlike automobiles and products that are more tangible, exactly what is produced and how it is produced are much more difficult to define. One risk in collaboration is that an organization may forego the possible benefits of differentiation. Others are the complex activities and relationships required to collaborate. The two-millimeter project was simple compared with the health care system and the large number of entities involved in generating health care.

Finally, collaboration does not happen automatically. The federal government and certain large groups of employers may need to be involved. In collaborative efforts with a variety of contributors, the interests of the different parties

must be balanced, but the desired outcomes of collaborative efforts are not always easily agreed upon.

In sum, collaboration can be useful, especially if the industry is fragmented, but it is difficult to achieve. Organizations need to understand that collaborative activities can be costly, but they can also present potential advantages.

SESSION 2:

PANEL PRESENTATIONS

LESSONS FROM THE ELECTRONICS INDUSTRY

Bruce A. Mueller

Collaboration raises questions about benefits and challenges in health care as in any high-tech industry in which change occurs frequently. Health care is no different from business or industry in the need for collaboration. In health care, however, change is not occurring as fast as it is in the manufacturing segment of the electronics industry.

Collaboration began in the electronics industry more than two decades ago because it was necessary to make substantial improvements in technology. Today, manufacturers whose products are in competition on the shelves of retail stores are collaborating on a next generation, fourth generation, or fifth generation of technology. In the electronics industry, as in any fast-changing industry, most of what is proprietary is old technology, not current or future technology, so that sharing proprietary information and technologies is not a competitive threat.

There have been many failures in the pursuit of quality. Motorola had three different programs to try to improve quality. We learned that it was not until customers were brought in and asked about quality that things began to change. There is still an arrogance that permeates health care, however. Often those in the health care industry believe that they know what consumers want without listening to them. As a result of this misperception, few discussions of quality improvement include consumers when services are designed.

In addition to including consumers in quality improvement efforts, Motorola began to share data with other companies. Dramatically higher quality and lower costs were the result. The lower the costs dropped, the more value Motorola was able to incorporate into the instrument or end product, the more value the consumer received, and the more the consumer trusted the product. This cycle of improvement and increased value and customer loyalty by consumers is an important lesson that health care organizations could emulate.

ANTITRUST REGULATION

Robert F. Leibenluft, J.D.

George Eads commented that organizations should not hide behind the antitrust laws as an excuse for not collaborating to improve quality. This is good advice; and as Clark Havighurst, who gave an excellent summary of the applicable antitrust laws, indicated, collaboration efforts generally can be carried out in a manner consistent with the antitrust laws. Organizations should make sure, however, that they are complying with the antitrust laws in substance and not just in form.

A number of imperfections in the health care market could be addressed by collaborative efforts, including initiatives aimed at measuring quality and collecting data. In regions where providers contract with many plans, such efforts may be particularly worthwhile. It is important, however, to draw the distinction between collaboration that attempts to deal with market failures so as to make the market work better and joint efforts that attempt to supplant market competition. The latter course can be done lawfully under the antitrust laws only by federal or state governments or by private entities under active government supervision pursuant to a clear government policy to supplant competition. Of course, it is also permissible for organizations to lobby and petition the government to take certain actions (including actions that might limit competition).

When examining the actions of private parties, the antitrust enforcement agencies consider whether the collaborative efforts likely will have the effect of creating efficiencies and promoting competition or, whether they will likely have the effect of stifling competition and working to the detriment of consumers. Collaborative activities among competitors, including information sharing and standard setting, are common in many industries and do not raise serious antitrust concerns. For example, efforts to gather and interpret physician data, jointly perform outcomes studies, and develop practice guidelines, all can be procompetitive, and indeed the federal antitrust enforcement agencies have explicitly provided guidance on these issues in their *Statements of Antitrust Enforcement Policy in Health Care*.[45] Actions to exclude providers from plans to achieve better quality or more cost-effective care are also generally acceptable, provided that they are unilateral efforts. However, agreements among competitors to adhere to standards, for example, with respect to what types of medical services are covered or which providers should be included in a network, can raise significant antitrust issues since such joint action limits consumer choice and is less likely to be necessary to achieve efficiencies. Thus, plans should make such decisions independently, without agreement with other competing entities. Also problem-

[45] Department of Justice and Federal Trade Commission. 1993 Statements of Antitrust Enforcement Policy in Health Care. Online. (URL:http://www.ftc.gov/reports/hlth3s.htm). Accessed, June 10, 1998.

atic is the sharing of information on competitive issues, such as the prices to be charged or the services to be offered in a market.

Aside from the legal issues, there are sound policy grounds for avoiding agreements among firms related to quality of care. There is much to be learned about how to measure and achieve health care quality. Procompetitive collaboration and information sharing can serve to increase such knowledge and help make the market for quality health care work better. In addition, vigorous competition among health plans can provide strong incentives to improve quality. On the other hand, agreements across plans can result in the dulling of incentives to develop new ways to measure or improve quality.

THE LIMITS OF COMPETITION

Paul B. Batalden, M.D.

If cooperation for the improvement of quality among competing managed care organizations is to be seriously advanced as a worthy idea, it is likely to require perseverance because giving voice to the importance of cooperation among competitors in the current U.S. health care situation can seem naive to many and even self-defeating. Thomas Gilovich[46] as described several reasons for the persistence of self-fulfilling prophecies like, "cooperation doesn't make sense in a competitive health care system:" First, negative prophecies, such as "we cannot cooperate," are more readily confirmed; second, for prophecies that have a kernel of truth, such as "it is hard to cooperate and compete," that kernel tends to be exaggerated; third, prophecies that seem to be self-fulfilled, such as "because it is so hard for competitors to cooperate, very little meaningful cooperation can be identified," can have the effect of discouraging future actions.

Nevertheless, cooperation in several areas seem to make sense. First, cooperative efforts seem to make sense when the science is compelling. For example, when providers agree on a treatment choice, there are no antitrust constraints. Such a process simply identifies the conditions under which an action ought to occur.

Second, cooperative efforts make sense when competitors realize that they are common customers of a supplier, as well as competitors. As Bruce Mueller said, one of the things that health care organizations must learn is how to be more mature competitors, and they must understand the importance of recognizing that at any one time organizations are competitors, suppliers, and customers. The health care industry has not typically thought of health care providers as suppliers. Health care is an indirect activity in which the competing suppliers of care must realize that

[46] Gilovich, T. *How We Know What Isn't So: The Fallibility of Human Reason in Everyday Life*. New York: The Free Press, 1991.

they need to work in a common environment and should take action to help make that a better environment by offering choices to consumers.

A third opportunity for cooperative efforts makes sense when adverse outcomes occur rarely and competitors want to use scientific methods to help guide improvement. Good examples are conditions for which the mortality rates are less than five percent. It is difficult to conduct studies of these rare conditions in most health care organizations in a statistically varied way. Organizations could work cooperatively to do research and change the ways in which they care for such patients. For example, collaborative research on persistent left ventricular failure after coronary artery bypass grafting is an activity that could benefit competing organizations and the community.

Cooperative efforts may make sense when there is only one delivery system, as is the case in many rural areas. Such circumstances pose considerable costs in setting up alternative systems and pose a risk that newly developed alternatives will take resources out of a community. Government invitations to cooperate may be essential to encouraging cooperative activities in these areas.

THE MEDICAL DIRECTOR'S PERSPECTIVE

George J. Isham, M.D.

Clark Havighurst's reassurance that market paradigms as embodied in antitrust laws would condone, not oppose, many forms of collaboration among competing health plans is reassuring.

Competition in health care is not new. It has existed at the provider level in the pre-managed care era and continues among physicians, physician groups and hospitals to this day. What is new is the extent of competition at the managed care organization level in individual regional markets. As individuals are enrolled in health plans in large numbers the potential for new forms of cooperation in improving quality of care is made possible. With these new possibilities come new questions about whether these possibilities bring the potential of antitrust violation. The Havighurst discussion is a helpful guide in sorting out these questions.

In the Twin Cities metropolitan area, three companies divide approximately 75 percent of the health plan market. Whenever these companies meet they must be careful not to discuss issues that would violate antitrust laws. They therefore often consult with legal experts to assure themselves that this requirement is met.

One troubling conclusion from the Havighurst analysis permits group agreement among competitors to set standards but not to follow them. In health care, the common good or public health can be improved, if effective interventions are implemented universally, even by competitors. As Havighurst points out, however, this is not an acceptable defense under current law. Pediatric immunization is an example. The agreement not only to set, but also to follow

common standards, may help us better performance on key public health measures and better treatment for common chronic conditions, such as hypertension and diabetes mellitus. Redundant requests to physicians and other providers of care by managed care organizations to implement commonly accepted standards such as appropriate infection control procedures in private physician offices, can and should be simplified by common programs that promote the accepted standard and require compliance with it. I believe there is a difference between social purpose of health care and other forms of commerce that may justify some changes in antitrust laws for health care. We must make sure legal mechanisms are available to competitors to cooperate in such areas where the common good justifies it.

There are new opportunities for promoting both new forms of competition and new forms of collaboration in health care. Competition on price, and quality as documented by standardized survey and measurement tools, is being encouraged at the level of provider care systems in Minnesota and New York. Organized, risk bearing, provider care systems are emerging from a cottage industry of individual entrepreneurial health care professionals.

Opportunities for collaboration exist in furthering public health and in conducting research. On the public health side, a common immunization registry would fulfill the need to monitor the immunization status of a population as well as assist competing health plans to monitor and improve the immunization status of the populations they enroll. From a research perspective, collaboration offers the opportunity to increase the effectiveness of care for patients with rare conditions undergoing experimental therapy.

SESSION 3:

EXAMPLES OF COLLABORATION

HEALTH CARE EDUCATION RESEARCH FOUNDATION

Catherine Borbas, Ph.D.

The Health Care Education Research Foundation (HERF) is a nonprofit organization founded in 1982 as part of a hospital association. It became independent in 1986. The board comprises hospital administrators, physicians, health plans, purchasers, health department representatives, and other community organizations. It has projects that involve a considerable proportion of Minnesota's health plans, hospital systems, and provider organizations. Business coalitions and the health department also participate. The HERF mission continues to be to try to raise the quality of health care for the community. Although today's customers are increasingly clinics, clinic systems, hospitals, businesses, and health plans, the focus continues to be on the community, patients, and enrollees.

HERF has developed the Minnesota Clinical Comparison and Assessment Program (MCCAP). The products and services of MCCAP are based on community- and condition-specific evaluations. Since 1987 these projects have been focused on cholecystectomy, hip replacement, management of labor and delivery by Cesarean section, treatment of breast cancer, and acute myocardial infarction. The study involves large numbers of patients at a number of sites. All the data can be sorted by health plan, by clinic, and by physician.

MCCAP is not involved in the routine monitoring of care. The organization becomes involved when members of the Minnesota health care community agree that they have a common problem and would like to modify clinical practice or when the community would like comparative information to evaluate and compare the care provided by medical sites. Using practice guidelines as a blueprint for measurement and collaboration, HERF gathers data from sites using standardized data collection methods and makes the information widely available. The evaluated groups then have the opportunity to evaluate the results and any recommendations that have been offered. HERF then collects another round of data to see if there has been any change in clinical behavior and patient care.

This is difficult, despite the level of practice consolidation in collecting standardized data in Minnesota, because medical records do not reflect that consolidation.

Early on, HERF recognized that hospitals and the health plans were good at making physicians and providers aware of changes. However, HERF found that health care organizations and health plans had a great deal of trouble with the *implementation* of change across systems. For example, there is considerable acceptance of guidelines for the treatment of acute myocardial infarction by cardiologists, but there are many problems with fully integrating these guidelines into practice.

To overcome these problems, HERF identified opinion leaders in given areas by surveying physicians about to whom they turn with questions on the study topics. These physicians are recruited for participation in "spreading the word." HERF's opinion leaders are topic and site specific. Additionally, HERF recruits informal and formal administrative champions because system and process delays cause many difficulties in implementing change.

Many gaps between knowledge and practice can be explained by clinicians' previous negative experiences or personal attitudes and judgments. For example, in explaining why -blockers may not be used as widely as is indicated, one cardiologist said that "in giving [a -blocker] a physician cannot say he has saved a life, but if the patient has a stroke [as a result] he can say he caused it." It is very difficult for a group at a health plan level or even at a hospital department level to deal with these underlying attitudes and fears that can influence some clinical priorities on a day-to-day basis.

The value of HERF has been providing a neutral forum for community collaboration and economies of scale. If plans and providers choose to collaborated through a consortium like HERF, they will have access to the comparative standardized data increasingly requested by purchasers of care, some shared funding, and increased fund-raising capabilities. If they do not choose to engage in this type of activity and stay independent in quality measurement efforts, they will have more control and perceive that they will have a competitive advantage.

THE EMPLOYERS' MANAGED HEALTH CARE ASSOCIATION

Donald M. Steinwachs, Ph.D.

The Employers' Managed Health Care Association (MHCA) comprises Fortune 250 companies and their personnel benefits staffs. After hearing Dr. Paul Ellwood speak about outcomes management at a conference in 1989 or 1990, several members became intrigued by the idea of trying to capture the patient's experience in terms of outcomes and trying to look at health status as an indicator of quality of care.

This subgroup, initially comprising 15 members of MHCA, came together internally to form an outcomes consortium. They recognized that to accomplish anything meaningful they would need to bring their managed care contractors into the effort. About 18 managed care partners joined the consortium. Over time, a few of these managed care organizations have merged with others, such that the consortium now has representation from many of the key actors in managed care in the country. Whenever they meet they are cautious about any potential for antitrust activity.

Although in the late 1980s, employers had focused on ways to cut their costs and to shift costs to employees, in 1991, the MHCA Outcomes Consortium began to examine ways to improve the health of its employees and to improve the quality of care provided by health plans through which they purchase care.

They saw this drive as a feasibility experiment to examine (1) whether it is possible to use the patient's experience (as captured through surveys and other instruments, such as health status measurement) to look at quality, and (2) if it is feasible, whether it is useful. Can health plans use this information to change care? Can the information be translated into clinical indicators of outcome as well as health status and functional status indicators? The initial feasibility test included coronary angiography and adult asthma and sought ways to capture changes in functional status from a baseline and follow-up assessment.

This partnership existed only because the employers brought the managed care organizations to the table and the plans participated to satisfy them. This project resulted in benefits for both the employers and the plans. The plans gained economies of scale in instrument development and in the pooling of data and basic analysis and had the opportunity to measure their progress against the progress of other plans. This provided a way to hold the managed care plans accountable for quality. The employers were able to direct plan attention toward the outcomes that most concerned them. Assessments always included measures such as numbers of work days lost, missed activities, and other measures that represent employer concerns.

Such pooling of data, even when employers did not have much control or input into how the information was used by plans, has been a useful process. It kept the plans' attention on quality. For the plans, this effort was useful in helping them build quality improvement activities. At least one plan in this effort uses the MHCA process to satisfy some NCQA accreditation requirements.

PACIFIC BUSINESS GROUP ON HEALTH

Thomas J Davies, J.D., M.P.A.

Several collaborative efforts on the West Coast offer examples of strategies, philosophies, and approaches that make them successful, as well as some of the pitfalls and barriers to be avoided. The primary example is the California Coop-

erative Healthcare Reporting Initiative (CCHRI), which among other activities provides an annual Health Employer Data and Information Set (HEDIS) report card. CCHRI is designed to collect, verify and report HEDIS data. This collaboration, initiated by the Pacific Business Group on Health (PBGH) has been very successful despite its size, complexity and $2 million annual cost.

In California, there is a high degree of overlap of practitioners in more than 20 health maintenance organization (HMO) networks. This overlap reaches 70 to 80 percent in some cases. This poses a practical problem because each HMO would need to send its own reviewer into each practice site to examine medical charts unless the data can be generated by the HMO's administrative systems, which few of them can do. This avoids the chaos and disruption that would be caused by having so many reviewers descend on so many practices at about the same time.

PBGH initiated the collaborative with 22 HMOs and a broad range of provider organizations. Its purpose was to devise a methodology for independently collecting and verifying HEDIS data on an annual basis on behalf of all participating HMOs and reporting to PBGH's 35 member companies and the public. Without the coalition, it is unlikely that the HMOs would not have launched this collaborative.

There have been numerous difficulties in the technical details, timing, and timeliness of the data. What makes this collaborative successful, however, is (1) the perceived value of the product to the HMOs and physicians; (2) the economies and efficiencies derived from the collaborative effort, such as a single independent party doing the chart reviews; (3) the explicit agreement by everyone about the common goals; and (4) a purchaser-driven component, which is probably the most important ingredient. The purchasers in this coalition are not the entire market, but they are very influential participants in the market and they are trying to drive the market in a direction that emphasizes quality of care.

The philosophical and strategic elements that go into making a collaboration successful are the following: First, collaborate to establish objectives, standards, measures, metrics, approaches, and goals. These are the critically important activities, and they are concentrated at the beginning of the project. Second, each party remains responsible for cooperating in implementation, according to the standards and the plan developed with the support and assistance of the vendor doing the on-site chart review. Although considerable work must be done by the organizations individually, there is a need for cooperation within this framework. Finally, these efforts are meant to support marketplace competition that is based on quality. So, the PBGH approach is to collaborate on the planning, cooperate on the implementation, and compete on the basis of quality and performance. PBGH is committed to making quality count in the process of purchasing health care and to driving a quality agenda in the marketplace.

The major pitfall or barrier to the success of this project that has yet to be overcome is the tendency for the managed care plans to have deep-seated competitive instincts. Some are inclined to function independently, using data in a

proprietary fashion, that does not serve the interest of employers, purchasers, consumers, or physicians.

THE FOUNDATION FOR HEALTHY COMMUNITIES

Rachel M. Rowe, R.N., M.S.

The Foundation for Healthy Communities was founded by the New Hampshire Hospital Association in 1996. The reason it has been successful is that it offers an opportunity for employers, consumers, plans, and hospitals to come together to focus on the care of patients. The foundation is a statewide effort including the seven health plans that do business in New Hampshire. None of these health plans owns hospitals. The New Hampshire legislature recently outlawed exclusive contracts, so provider networks are established primarily on a contractual basis, and the networks overlap.

The New Hampshire Hospital Association established the foundation because the association recognized that there was an opportunity to improve care. However, it was clear that it would be difficult to do this as a trade association. The effort needed to extend beyond hospitals, and the foundation was created as a neutral space where there would be more diverse participation and all parties could come together with an equal voice and influence.

Fortunately, the hospitals have had a long track record of collaborating with one another on a number of quality improvement initiatives. The health care plans also had some experience. In 1991, three of the state's major health plans had initiated and carried out plans to finance the cost of immunizations for children, regardless of their insurance coverage.

With the assistance of Paul Cleary and his colleagues at the Picker Institute, the foundation developed a statewide (now New England-wide) survey process using diagnosis-specific patient feedback and functional status measures to be used across the continuum of care. These measures focused first on two categories of patients: those with myocardial infarction and postsurgical patients. It used a three step survey process to look at aspects of care from the time of hospitalization on. Another component was added to each of these surveys to measure functional status. In the last year, maternal and newborn care have been added. Every hospital in New Hampshire, along with several in Maine, Vermont, and Massachusetts, participated in this effort. During 1997, 16,000 mothers are expected to report on their experiences with prenatal, childbirth, and postpartum care.

Because of the scope of this work, six of seven plans being studied not only agreed to help finance the project, they also agreed to be active in the foundation's work. They were interested in participating and being able to share jointly developed information because of concern about the care and coverage of maternal and newborn care expressed in the political and media arenas. The foundation afforded them an opportunity, as well as the credibility, to participate in a

study of the care of these patients. The results of the initial studies have shown that mothers in managed care plans and mothers throughout the state show no significant differences in their perceptions of the quality of the care they receive. The problems identified appear to be everywhere.

Over the last year, these projects led plans and providers to collaborate on numerous other ventures. Providers were concerned most with who received the generated information and how it might be used internally for quality improvement efforts. With the assistance of Paul Batalden and his colleagues, the foundation is working now to give physicians clinically focused feedback about patients' experiences of care so they can tailor their processes of care. The foundation is midway through this process.

The foundation has been successful with these efforts because of its caution in identifying and avoiding potential barriers. External competition, as well as internal competition, was a concern when the foundation initially looked for funding from the plans. External competition among plans and internal competition for improvement and research funds means that any effort must compete for limited resources. When the foundation asked for funding from the plans, it faced resistance from the administrations because of external competition and from the providers because of internal competition.

Like competition, ownership also presents two potential barriers. First, some of the participating health plans have corporate offices outside of New Hampshire, and they have their own agendas regarding quality improvement. Currently, they are more interested in a national focus than in working with New Hampshire efforts alone. Second, changes in the ownership of plans can make the continuity of these efforts very difficult.

THE NATIONAL RURAL HEALTH ASSOCIATION

Tim Size, M.B.A.

The Wisconsin Rural Zones of Collaboration Initiative grew out of a series of open-ended discussions among HMOs and rural providers in the central and southern parts of the state initiated by the Rural Wisconsin Health Cooperative (RWHC) and the Community Physicians Network. The context was (1) the already high market share held by HMOs in rural counties, (2) the fact that rural providers typically contract with multiple HMOs, and (3) a desire by RWHC that rural health not become primarily defined by competition among regional HMOs.

These exploratory talks led to the development of a shared vision: that rural communities have a strong interest in cooperation among HMOs and other payers on issues directly affecting local care and public health and that some agreement among regional plans with rural providers will reduce duplicative and fragmented interventions within and among rural communities.

Desirable outcomes were identified in three issue clusters: (1) inefficiencies related to multiple HMOs working with the same rural providers, (2) public health, and (3) education and research. Fortunately, just as funding was being sought to initiate activities in the first area of HMO-provider relations, the Health Services Resource Administration's Rural Network Development grant program was announced. RWHC along with the Wisconsin Rural Zones participants wrote and successfully competed for a three-year grant at full funding ($200,000 per year). The focus of the grant is as follows:

1. Increase the effectiveness and utilization of RWHC's regional credentialing service for multiple practitioners, hospitals, health plans, and direct purchasers and more effectively coordinate with neighboring regional credentialing services.
2. Develop and implement a model for providers, plans, and direct purchasers to collaborate on data collection, site visits, and other administrative audits required of practitioners in a rural network.
3. As a rural network, centralize health plan customer satisfaction surveys to achieve a rural database that will be large enough to provide meaningful information for improvements in local areas,
4. As a network, create a common clinical practice guideline review and adoption process and demonstrate rural practitioners' ability to attain the desired clinical practice outcomes.
5. Identify and implement clinical quality management projects in which multiple practitioners, hospitals, health plans, and direct purchasers share a common interest at the local level and develop uniform performance objectives and outcomes measures to improve the health status of the populations served by multiple health plans. (The RWHC Quality Indicators Program is a newly accepted performance measurement system for the Joint Commission on Accreditation of Healthcare Organizations' ORYX Initiative.)

The RWHC has found that some of the following principles enhance the likelihood of successful collaborative behavior:

1. Respect the need to affect one's own future. The preference for autonomy needs to be respected through the promotion of collaborative solutions that enhance the local delivery of health care and the health of the community.
2. Involve the community in the planning process. The planning is interactive, with the plan for the joint enterprise being the result of and feeding into the plans of local and regional participants.
3. Assure all participants know they are needed. All participants must know that they are needed for the success of the joint enterprise.
4. Share the big picture. Participants need to know where the joint enterprise is headed.

5. Agree on methods of accountability up front. Participants must always know up front what the rules and what is expected of them.
6. Ensure a fair system of arbitration is available. A clear, nonthreatening arbitration mechanism in case of contractual or other disputes should be agreed to before disputes arise.
7. Design approach where participation makes sense. Organizations may start participating in a group to explore a group's potential; they remain in a group only if they perceive that they are receiving a good return on their investment of time and money.
8. Make yourself a partner who can be trusted. Develop a relationship based primarily on mutual trust so that the collaborative effort is not limited to the minimum performance inherent in written agreements.

A number of factors are expected to be helpful:

- Perceived win/win/win for insurers/providers/public regarding the:

— demonstration of quality possible in rural areas;
— increased efficiency in the flow and use of data; and
— reduction of provider and plan "hassles."

- Cooperation is not new in Wisconsin.
- The public preference for balance between cooperation and competition.
- The initiative builds on existing relationships and efforts.
- Rural providers are needed by expanding HMOs.
- Rural providers have a "home court" advantage.
- Rural providers provide a neutral forum.

Still other factors might be problematic:

- The complexity of multiple relationships.
- The inherent difficulty of the quality related goals.
- The participants may be unable to "leave their guns at door."
- Rural providers may become or remain fragmented.

Barriers to Collaboration

As of May 1, 1998, RWHC had had six months of very positive experience with implementing the grant-funded goals stated above. Several barriers have been identified and are noted below, along with strategies for addressing them.

- Lack of consensus regarding delegation of tasks relevant to NCQA among health plans. Currently, plans are not willing to commit to full-scale delegation for their involvement with rural practitioners.

Strategy: Collaboration can be viewed at different levels, with increasing benefit accruing to rural practitioners as the collaboration increases.

- The vertical structures of large organizations make communications difficult and diffuse responsibility for effective decisionmaking. Middle managers are reluctant to give firm responses, and frontline staff do not receive the history or the actual documents related to a project.

  Strategy: Use detailed agendas and meeting minutes, and disperse them widely; include staff members from multiple levels within the organization whenever possible; publicize significant accomplishments.
- Frequent turnover of participants.

  Strategy: Prepare a plan for orientation of new participants. Determine the information needed to bring new staff up to date on projects. To the extent that systems and procedures are in place and documented, personnel changes should be less disruptive.
- Different forces drive each organization to begin using clinical guidelines and outcomes such as the requirements of NCQA and JCAHO and bottom-line finances.

  Strategy: Use pilot programs to demonstrate how one project can be used to satisfy various needs.
- The existence of different levels of knowledge regarding clinical guidelines and outcomes research.

  Strategy: Provide educational opportunities for participants as well as encourage participants to learn from one another.
- Statistics: sample size and ceiling effects.

  Strategy: Projects must be carefully selected to ensure adequate sample sizes for analysis of characteristically smaller rural data sets. Projects must be carefully selected by taking into account the possible influences of ceiling effects. For example, as an outcome measure, "smoking cessation" may be a poor choice if most of those who will stop smoking have already done so.

BIOGRAPHIES OF SPEAKERS

Robert A. Berenson, M.D., was at the time of the conference a vice president at The Lewin Group, a privately held health care corporation, and a board-certified internist who practiced in Washington, D.C., for 12 years. Dr. Berenson is a graduate of the Mount Sinai School of Medicine and a former member of the Carter White House Domestic Policy staff, initially as a Robert Wood Johnson Foundation Clinical Scholar. In July 1987, Dr. Berenson helped found National Capital PPO and is a member of its board of directors. He has served as co-medical director since its inception. Dr. Berenson became national program director of the Improving Malpractice Prevention and Compensation systems program in 1994. Currently, Dr. Berenson is the Director of the Center for Health Plans and Providers at the Health Care Financing Administration.

Clark C. Havighurst, J.D., is the William Neal Reynolds Professor of Law at Duke University. He teaches in the fields of antitrust law and health care law and policy. He is a member of the IOM and recently completed his term on its Board on Health Care Services. Professor Havighurst is also an adjunct scholar of the American Enterprise Institute for Public Policy Research. Professor Havighurst's work includes articles on regulation in the health services industry, medical malpractice, and a wide range of antitrust issues arising in the health care field.

George C. Eads, Ph.D., is an internationally known academic economist and senior-level business executive. He is the director of the Charles River Associates, Washington, DC office. From 1986 to 1995, he was vice president and chief economist of the General Motors Corporation (GM). During that time he directed several different GM staffs, including the economic staff, the World-

wide Economic and Market Analysis staff, and the Product Planning and Economic staff. He has also had a distinguished academic career, holding faculty appointments at Harvard University, Princeton University, the George Washington University, and the University of Maryland, College Park. He was also a member of President Carter's Council of Economic Advisers.

Bruce A. Mueller is corporate vice president and director of Human Resources, Infrastructure, and Technology for Motorola, Inc. He is responsible for benefits plans and other human resources issues at Motorola. He also serves as Senior Professor of Human Resources at the Keller Graduate School of Management. He is a Pew Fellow from Boston University and a board member of the Gottlieb Memorial Hospital. He is past president of Harper College's Foundation Board and an industry board member at Little City. He was the chair of the National Association of Manufacturers, Health Systems Reform Committee and a member of the Business Roundtable, the Conference Board, and the Illinois State Chamber of Commerce Health Care Committee.

Robert F. Leibenluft, J.D., was at the time of the conference, assistant director of health care of the Federal Trade Commission's Bureau of Competition. He earned a B.A. and graduated magna cum laude from Yale University in 1973 and is a 1980 graduate of the School of Law at the University of California. In 1981 he was in the firm of Hogan and Hartson, where his practice was devoted to law matters, including Medicare, Medicaid, alternative delivery systems, and antitrust and health care. He has written extensively and has been published in both law and medical journals.

Paul B. Batalden, M.D., is director of Health Care Improvement Leadership Development in the Center for the Evaluative Clinical Sciences at Dartmouth Medical School. In this capacity, he leads the creation and delivery of educational opportunities for physicians and other health professionals from professional school through mid-career. Dr. Batalden has been a student of continual improvement of the quality of health care for 25 years. During the past seventeen years he has applied the work of W. Edwards Deming and others to the improvement of health care. He is currently chair of the Board of the Institute for Health Care Improvement and chair of the Department of Health Care Quality at the Henry Ford Health Sciences Center.

Prior to his current position at Dartmouth, Dr. Batalden was the Vice President for Medical Care and Head of the Quality Resource Group for the Hospital Corporation of America (HCA) in Nashville, Tennessee. Dr. Batalden is a member of the Institute of Medicine and several philanthropic organizations.

George J. Isham, M.D., is medical director and chief health officer of HealthPartners, a large health care plan that enrolls about 800,000 members in Minnesota. HealthPartners also provides direct patient care at its group practice

of over 550 physicians and at Regions Hospitals in St. Paul. Dr. Isham has been involved with quality levels. He currently cochairs NCQA's Committee on Performance Measurement, which guides the evolution of HEDIS measurement standards, and he is a member of the board of directors of the American Association of Health Plans.

Catherine Borbas, Ph.D., M.P.H., is the executive director of the Health Care Education Research Foundation (HERF), an independent, nonprofit applied research organization in St. Paul, Minnesota. Since 1989, HERF has developed clinical guidelines, undertaken outcomes research, and disseminated comparative information to Minnesota health care providers and health plans. Dr. Borbas has been responsible for building two health care quality of care consortiums, the Pediatric Cardiac Care Consortium, including 31 hospitals, and the Minnesota Clinical Comparison and Assessment Program, involving 53 hospitals, three health plans, and three purchaser group.

Donald M. Steinwachs, Ph.D., is chair and professor of the Department of Health Policy and Management at Johns Hopkins University. He is also director of the Health Services Research and Development Center. Dr. Steinwachs's current research areas include medical effectiveness and patient outcomes for a number of medical conditions, studies of managed care and other organizational financial arrangements on quality costs, and case mix adjustment issues. He is a past president of the Association of Health Services Research.

Thomas J. Davies, J.D., M.P.A., is manager of Managed Care for GTE, serving GTE's various businesses and their 79,000 employees, retirees, and dependents throughout the western United States. In this capacity, Mr. Davies is responsible for implementing GTE's value-driven purchasing, managed competition strategy. His responsibilities include selection, evaluation, problem resolution, and performance monitoring of 32 competing HMOs and specialized managed care vendors offered under GTE's benefits program. Mr. Davies serves on the board of directors of the Pacific Business Group on Health, and is the Chairman of its Committee on Quality. He is a member of the Executive Committee of the California Cooperative HEDIS Reporting Initiative and a collaborative project of employers, HMOs, and physician organizations.

Rachel M. Rowe, R.N., M.S., is the executive vice president of the Foundation for Healthy Communities. Ms. Rowe is a diplomate of the American College of Health Care Executives and has worked for a long time in the field of quality improvement. She is a registered nurse with a master's degree in health policy from Harvard University and was a former director of Quality Risk Management at Boston's Beth-Israel Hospital.

Tim Size, M.B.A., received a B.S.E. from Duke and an M.B.A. from the University of Chicago, having interned at Children's Hospital in Chicago and Saint Thomas' Hospital in London. He has worked with the rural Wisconsin Health Cooperative since its incorporation in 1979. Mr. Size helped to establish one of the country's first rural area-based managed care plans now merged into Unity Health Plans. He is currently president of the National Rural Health Association based in Kansas City and Washington, D.C. It is owned and operated by 24 diversified rural general medical surgical hospitals and one urban hospital: the cooperative's emphasis on developing an integrated network among free standing entities is its distinguishing feature.

CONFERENCE AGENDA

Institute of Medicine
National Academy of Sciences
Washington, DC 20418
Collaboration Among Managed Care Organizations for Quality Improvement
November 13, 1997

9:00 a.m.–9:30 a.m.
Introduction to Collaboration
Robert A. Berenson, M.D.
The Lewin Group and Chair, Steering Committee for the Conference

9:30 a.m.–10:30 a.m.
Conceptual Papers
• Legal Issues in Collaboration
Clark Havighurst, J.D.
William Neal Reynolds Professor of Law, Duke University
• Collaboration in Other Industries
George C. Fads, Ph.D.
Charles River Associates, Washington, D.C.

10:30 a.m.–10:50 a.m.
Welcome
Kenneth L Shine
President, Institute of Medicine

10:50 a.m.–11:00 a.m. Break

11:00 a.m.–12:15 p.m.
Panel and group discussion of the papers

- What are the limits to proprietary interests in quality improvement?
- When do we compete; when do or might we collaborate to improve quality?

- What are the concerns, e.g., public goods, the free rider problem, adverse selection?

Panel:

Antitrust

Robert Leibenluft, J.D.

Assistant Director, Health Care, Bureau of Competition, FTC

The Limits of Competition

Paul B. Batalden, M.D.

Director, Health Care Improvement Leadership Development Center for the Evaluative Clinical Sciences, Dartmouth

The Medical Director's Perspective

George J. Isham, M.D.

Medical Director and Chief Health Officer, HealthPartners

Lessons from the Electronics Industry

Bruce Mueller

Corporate Vice President and Director of Human Resources, Infrastructure, and Technology, Motorola, Inc.

12:15 p.m.–1:15 p.m. Lunch

1:15 p.m.–2:45 p.m.

Examples of Collaboration (panel and general discussion)

Panel:

Catherine A. Borbas, Ph.D., M.P.H.

Executive Director, Healthcare Education and Research Foundation St. Paul, MN

Thomas Davies, J.D., M.P.A.

Manager of Managed Care, GTE Services Corporation

Rachel Rowe, R.N.

Executive Vice President, Foundation for Health Communities

Tim Size, M.B.A.

Executive Director, Rural Wisconsin Health Cooperative, and President Elect, National Rural Health Care Coalition

Donald M. Steinwachs, Ph.D.,
Professor and Chair, Department of Health Policy and Management,
School of Public Hygiene and Public Health, John Hopkins University
2:45 p.m.–3:00 p.m. Break
3:00 p.m.–4:30 p.m.
Working session (all invited participants)

- What are the problems?
- Which areas are conducive to collaboration?
- Which areas present serious impediments to collaboration?

4:30 p.m.–5:30 p.m.
Findings and conclusions

- Criteria for collaboration
- Feasible areas for collaboration
- Elements for evaluation of successful collaboration
- Identification of the structures that are needed to promote collaboration
- The role of government?

5:30 p.m. Adjourn