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INTERFACE

1985: A Turning Point

Toward the end of 1984, I was honored to be asked to speak to the National Association of State EMS Directors. As dinner speaker, my assignment, according to Paul Anderson (Idaho), was to talk about something so controversial that everyone would stay awake—full bellies notwithstanding.

I told the group that Rocco Morando and Alan Jameson were developing a National Registry test for state EMS directors. That woke them up. After admitting my little joke, I got serious. I told them that the most important and most controversial issue ahead would be the development and enforcement of state standards governing the conduct by local governments of competitive procurements of ambulance services.

Antitrust and You

Whether you're working in the private sector or for a government-operated paramedic service, the complex law of antitrust will surely affect your world. Long ago, Congress passed laws that made it illegal to engage in anti-competitive activities, except under certain special circumstances. Should those laws apply to the prehospital care industry in the same way they are applied to hardware stores and cable TV? What should happen when the patient's right to a chance of survival collides with a businessman's "right" to pursue a profit?

Is a 9-1-1 system an "essential facility" under the doctrine of antitrust? Can "cream skimmers" who are willing to meet clinical standards be prevented from raking off the most lucrative business, leaving the rest to others? Is it fair for a city to conduct a competitive bid, and then award the contract to its own fire department?

When a city decides to change its prehospital system in a way that displaces local firms, what are the rights of the owners? How can competitive bids work to combine less desirable ambulance service markets (e.g. poor or rural areas) with more desirable and more lucrative markets, so that both can be served adequately? Will states with "certificate of need" laws already on the books continue to award certificates non-competitively? Will some states continue to award exclusive market rights without regulating rates? Where rates are controlled by the state, will local governments be allowed to adjust the rate/subsidy balance in their respective communities? When a city divides itself into ambulance districts, giving each provider exclusive rights within a district, are the resulting mini-monopolies any less objectionable, under antitrust, than one big monopoly?

These are the questions that will decide the future of the private ambulance industry and its impact upon government provider organizations. 1985 may well be the year these issues will be decided, and if you're a private provider, what you think you wish would happen may actually be fatal to your own business objectives.

The law of antitrust is quite complex. But one very important aspect has to do with the so-called "state action exemption." In general, states are exempt from federal antitrust laws, and states can pass that exemption onto the cities and counties, *provided state law exists to demonstrate that the state legislature intended to give such power to local government*. In addition, passing on the exemption to local government means that the state must "actively supervise" the activities of local government as regards the allowed anti-competitive activity.

To those of us who aren't attorneys, this all seems pretty clear-cut. It isn't. Expensive and complex litigation is prevalent, and the issues generally have to do with how specific a state statute is, and whether the required "state supervision" is present. Even where everyone admits that required state laws don't exist, there are arguments over whether a 9-1-1 system is an "essential facility" (an argument in favor of deadly call rotation or franchising by district), or whether a competitively awarded exclusive franchise is actually "pro-competitive" (i.e. promotes more effective competition).

How to Socialize the Industry

If you wanted to guarantee the eventual socialization of the entire paramedic industry, you couldn't do better than to force local governments to choose between a system of regulated multiple providers competing at the retail level vs. socialized paramedic service. Retail competition in the ambulance industry has never produced reliable response times, good clinical capability, and financially stable service delivery. Retail competition is the reason half the paramedic industry is already socialized.

For standard microeconomic forces to work effectively the "consumer" must have reason and opportunity to quality/price shop for service. But in our industry, the "consumer" may be pinned under a car, sprawled over his desk in full cardiac arrest, or just home alone and terrified by unfamiliar symptoms. Poor "shoppers," these folks.

Even among so called routine transfer patients, many are old and too senile to "shop," and in many cases, the selection of the provider is made by a nursing home staff member, the doctor's secretary or a family member. Oh, there are many effective ways to compete in a multiple provider system, but they have little to do with providing better service at lower prices, and the winners of retail competition in this industry are rarely those who furnish the best quality of care, with the most reliable response time performance, to both rich and poor neighborhoods, at the lowest possible costs. If that were the case, superb multiple provider systems would exist throughout the U.S., for retail competition has had its chance in nearly every community. We needn't argue about the value of retail competition in the prehospital industry. It has been thoroughly tested and the result is socialized paramedic service.

Too many people think that the only alternative to retail competition is no competition. But there's a third

choice that is fairer and more effective than either. In a multiple provider system with retail competition, the opportunity for competition theoretically takes place each time a "consumer" needs ambulance services.

But if all of these potential consumers, acting collectively through their city or county governments, pool their purchasing power in one big competitive bid process every few years, quality/price shopping on an enormously effective scale can be achieved. More companies of higher quality will compete than ever before. In legal terms, the result is a sort of "term agreement for requirements," with local government acting as "purchasing agent" for potential "buyers."

The solution to the failure of retail competition in the prehospital care industry doesn't have to be socialization, or non-competitive monopolization by an exclusive private provider. When it comes to wives, husbands and ambulance services, it's okay to have several, but one at a time.

Trouble Brewing in the Private Sector

The American and California Ambulance Associations have recently filed a "friend-of-the-court brief" in a case before the U.S. Supreme Court regarding these issues. The issues are complex, but in simple terms, the associations are hoping that the court will rule to require much more specific state legislative authorization than has been required in the past to permit local government immunity from antitrust requirements.

By itself, the associations' position makes sense. I can support it myself, though probably for different reasons than those which have motivated the submission of the brief. By restricting local governmental immunity to more defined circumstances, a very uncertain situation will become much less uncertain. Cities and counties without governmental immunity will know it. At the same time, the question of 9-1-1 systems as an "essential facility" will become crucial. And cities and counties across the country will demand the required state legislation, and most will get it. Therein lies the real danger.

Do we really want local governments to be able to eliminate retail competition in our industry without replacing it with another, more effective, form of competition at the "wholesale" level? I prefer to limit the power of local governments to *competitive* awarding of exclusive rights to ambulance markets. The associations' current position will encourage the proliferation of state laws offering the needed exemption, but will do nothing to limit the delegation of that power to local governments willing to restructure—but not eliminate—competition.

The problem within the associations is that there are two kinds of companies which make up the memberships—those which make their living as primary providers of paramedic services and those which make their living primarily by selling BLS transportation services. The self-interests of these two types of companies are not the same and may even be in conflict.

Their interests may conflict because companies having the responsibility of being primary providers of paramedic services often rely heavily upon the authority of

the local governments they serve to protect their own markets against cream-skimming operations that could destroy the financial viability of the markets they serve. At the same time, the cream skimmers are counting upon the Supreme Court to stop local governments from offering that very protection. And in the meantime, some local governments are using their uncertain powers to establish and protect socialized paramedic services. Government providers, private paramedic providers, and BLS cream skimmers. . . each group jockeying for position. When you understand that, you understand a lot.

At least two states (California and Arkansas) have passed the kind of state statute that makes real sense. (California's new law becomes effective in January of 1985.) In both cases, the state grants antitrust immunity to local governments, *but only if a competitive award of market rights takes place*. These laws provide a means of replacing retail competition without eliminating competition and without socializing the industry. Just as importantly, they imply the absence of antitrust immunity in localities where competition has not taken place, a fact which promises to open the doors to private paramedic providers throughout California.

Of course, the advantages inherent in these new state laws could be realized nationwide, and without state legislation, if the Supreme Court would determine that the *restructuring of competition*, from an ineffective form to a more effective form, is not per se a violation of the intent of federal antitrust law, but may instead be considered *pro-competitive* under certain circumstances involving public safety issues. If that were the case, local government wouldn't need to be immune from antitrust law, if a fair and competitive market allocation process was used.

What's Next?

Hopefully more states will pass laws like those of Arkansas and California. And hopefully the states will learn quickly to provide the necessary "state supervision." In any case, the action will move to the state level, as local governments demand antitrust exemption, and as private providers demand fair competition in the award of market rights. The opportunity for real progress will be tremendous. But the opportunity for bureaucratic bungling will be equally available. Cream-skimming companies will prefer socialized emergency providers, since government providers rarely intrude into the more profitable transfer business. And the fate of the real private paramedic industry will depend upon the ability of state regulatory agencies to referee (i.e. "supervise") effectively. Some will. Some won't. But in either case, the focus of this industry will be upon the supervising state agencies as referees of the competition to come, except in states where antitrust immunity is granted without the requirement to competitively award market rights. In those states, government providers and cream skimmers will rule the industry. □

Editor's note: *Mr. Stout's company, The Fourth Party, is sponsoring in February a workshop for government officials and private providers, entitled "Managing Ambulance Service Procurements: a Skill Building Workshop."*