SB
37

22-LS0323\U
Bannister
4/18/02

Amended
Adopted 4.24.02

HOUSE CS FOR CS FOR SENATE BILL NO. 37(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR KELLY

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to collective negotiation by competing physicians with health benefit**
2 **plans, to health benefit plan contracts, to the application of antitrust laws to agreements**
3 **involving providers and groups of providers affected by collective negotiations, and to**
4 **the effect of the collective negotiation provisions on health care providers."**

5 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

6 *** Section 1.** AS 23 is amended by adding a new chapter to read:
7 **Chapter 50. Collective Negotiation by Physicians.**
8 **Sec. 23.50.010. Legislative findings.** (a) The legislature finds that permitting
9 competing physicians to engage in collective negotiation of certain terms and
10 conditions of contracts with a health benefit plan will benefit competition, so long as
11 the physicians do not engage in an express or implied threat of retaliatory collective
12 action, including boycotts or strikes.
13 (b) The legislature finds that permitting physicians to engage in collective
14 negotiations over fee-related terms may, in some circumstances, yield anti-competitive

1 effects. There are, however, instances in which a health benefit plan dominates the
2 market to the degree that fair negotiations between physicians and the health benefit
3 plan are not possible in the absence of joint action on behalf of the physicians. In
4 those circumstances, the health benefit plan can virtually dictate the terms of the
5 contracts that it offers to physicians.

6 (c) The legislature finds that it is appropriate and necessary to authorize
7 collective negotiations between competing physicians and health benefit plans on fee-
8 related and other issues when the imbalances in bargaining capacity described in this
9 section exist.

10 **Sec. 23.50.020. Collective action by competing physicians.** (a) Competing
11 physicians may meet and communicate in order to collectively negotiate with a health
12 benefit plan concerning any of the contract terms and conditions described in this
13 subsection, but may not negotiate the exclusion of providers who are ~~not~~ non-physicians
14 from direct reimbursement by a health benefit plan, and may ~~not~~ negotiate the setting
15 in which providers who are ~~not~~ non-physicians deliver services. Competing physicians
16 may not engage in a boycott related to these terms and conditions. Competing
17 physicians may meet and communicate concerning

Concept. Amendment #1 Adopted

18 (1) physician clinical practice guidelines and coverage criteria;
19 (2) the respective liability of physicians and the health benefit plan for
20 the treatment or lack of treatment of insured or enrolled persons;
21 (3) administrative procedures, including methods and timing of the
22 payment of services to physicians;
23 (4) procedures for the resolution of disputes between the health benefit
24 plan and physicians;
25 (5) patient referral procedures;
26 (6) the formulation and application of reimbursement methodology;
27 (7) quality assurance programs;
28 (8) health service utilization review procedures; and
29 (9) criteria to be used by health benefit plans for the selection and
30 termination of physicians, including whether to engage in selective contracting.
31 (b) An authorized third party that intends to negotiate with a health benefit

1 plan the items identified under (a) of this section shall provide the attorney general
2 with written notice of the intended negotiations before the negotiations begin.
3 (c) In exercising the collective rights granted by (a) of this section,
4 (1) physicians may communicate with each other with respect to the
5 contractual terms and conditions to be negotiated with a health benefit plan;
6 (2) physicians may communicate with an authorized third party
7 regarding the terms and conditions of contracts allowed under this section;
8 (3) the authorized third party is the sole party authorized to negotiate
9 with a health benefit plan on behalf of a defined group of physicians;
10 (4) physicians can be bound by the terms and conditions negotiated by
11 the authorized third party that represents their interests;
12 (5) a health benefit plan communicating or negotiating with the
13 authorized third party may contract with, or offer different contract terms and
14 conditions to, individual competing physicians;
15 (6) an authorized third party may not represent more than 30 percent of
16 the market of practicing physicians for the provision of services in the geographic
17 service area or proposed geographic service area, if the health benefit plan has less
18 than a five percent market share as determined by the number of covered lives as
19 reported by the director of insurance for the most recently completed calendar year or
20 by the actual number of consumers of prepaid comprehensive health services; in this
21 paragraph, "covered lives" means the total number of individuals who are entitled to
22 benefits under the health benefit plan;
23 (7) the attorney general may limit the percentage of practicing
24 physicians represented by an authorized third party; however, the limitation may not
25 be less than 30 percent of the market of practicing physicians in the geographic service
26 area or proposed geographic service area; when determining whether to impose a
27 limitation described under this paragraph, the attorney general shall consider the
28 provisions described under (f) - (h) of this section; this paragraph does not apply if the
29 market of practicing physicians in the geographic service area or proposed geographic
30 service area consists of 40 or fewer individuals; and
31 (8) the authorized third party shall comply with the provisions of (d) of

1 this section.
2 (d) A person acting or proposing to act as an authorized third party under this
3 section shall,
4 (1) before engaging in collective negotiations with a health benefit
5 plan,
6 (A) file with the attorney general the information that identifies
7 the authorized third party, the physicians represented by the third party, the
8 authorized third party's plan of operation, and the authorized third party's
9 procedures to ensure compliance with this section;
10 (B) furnish to the attorney general, for the attorney general's
11 approval, a brief report that identifies the proposed subject matter of the
12 negotiations or discussions with a health benefit plan and that contains an
13 explanation of the efficiencies or benefits that are expected to be achieved
14 through the collective negotiations; the attorney general shall review whether
15 the group of physicians represented by the authorized third party is appropriate
16 to represent the interests involved in the negotiations; the attorney general may
17 not approve the report if the group of physicians is not appropriate to represent
18 the interests involved in the negotiations or if the proposed negotiations exceed
19 the authority granted in this chapter and, if the group is not appropriate or the
20 negotiations exceed the granted authority, shall enter an order prohibiting the
21 collective negotiations from proceeding; the authorized third party shall
22 provide supplemental information to the attorney general as new information
23 becomes available that indicates that the subject matter of negotiations with the
24 health benefit plan has changed or will change;
25 (2) within 14 days after receiving a health benefit plan's decision to
26 decline to negotiate or to terminate negotiations, or within 14 days after requesting
27 negotiations with a health benefit plan that fails to respond within that time, report to
28 the attorney general that negotiations have ended or have been declined;
29 (3) during the negotiation process, provide the attorney general upon
30 the attorney general's request with a copy of all written communications that are
31 between physicians and the health benefit plan, that are relevant to the negotiations,

1 and that are in the possession of the authorized third party;
2 (4) before reporting the results of negotiations with a health benefit
3 plan and before giving physicians an evaluation of any offer made by a health benefit
4 plan, provide to the attorney general, for the attorney general's approval, a copy of all
5 communications to be made to physicians related to the negotiations, discussions, and
6 health benefit plan offers.
7 (e) The attorney general shall either approve or disapprove the contract that
8 was the subject of the collective negotiation within 60 days after receiving the reports
9 required under (d) of this section. If the contract is disapproved, the attorney general
10 shall furnish a written explanation of any deficiencies along with a statement of
11 specific remedial measures that would correct any identified deficiencies. An
12 authorized third party who fails to obtain the attorney general's approval is considered
13 to be acting outside the authority of this section.
14 (f) The attorney general shall approve a collective negotiation contract if
15 (1) the competitive and other benefits of the contract terms outweigh
16 any anticompetitive effects; and
17 (2) the contract terms are consistent with other applicable laws and
18 regulations.
19 (g) The competitive and other benefits of joint negotiations or negotiated
20 provider contract terms must include
21 (1) restoration of the competitive balance in the market for health care
22 services;
23 (2) protections for access to quality patient care;
24 (3) promotion of health care infrastructure and medical advancement;
25 or
26 (4) improved communications between health care providers and
27 health care insurers.
28 (h) When weighing the anticompetitive effects of contract terms, the attorney
29 general shall consider whether the terms
30 (1) provide for excessive payments; or
31 (2) contribute to the escalation of the cost of providing health care

1 services.

2 (i) This section does not authorize competing physicians to act in concert in
3 response to a report issued by an authorized third party related to the authorized third
4 party's discussion or negotiations with a health benefit plan. The authorized third
5 party shall advise the physicians of the provisions of this subsection and shall warn
6 them of the potential for legal action against those who violate state or federal anti-
7 trust laws by exceeding the authority granted under this section.

8 (j) A contract allowed under this section may not exceed a term of five years.

9 (k) The documents relating to a collective negotiation described under this
10 section that are in the possession of the Department of Law are confidential and not
11 open to public inspection.

12 (l) Nothing in this section shall be construed as exempting from the
13 application of the antitrust laws the conduct of providers or negotiations or agreements
14 between providers and a health benefit plan if the purpose or effect of the conduct,
15 negotiations, or agreements would be, directly or indirectly, to exclude, limit the
16 participation or reimbursement of, or otherwise limit the scope of services to be
17 provided by separate or competing classes of providers who practice or seek to
18 practice within the scope of the occupational licenses held by the providers.

19 (m) A contract entered into under this section must be consistent with
20 AS 21.36.090(d).

21 (n) Nothing in this section shall be construed to make any conduct by
22 providers unlawful if the conduct was lawful before the effective date of this Act.

23 (o) In this section,

24 (1) "geographic service area" means the geographic area of the
25 physicians seeking to jointly negotiate;

26 (2) "provider" has the meaning given in AS 21.36.090(d).

27 **Sec. 23.50.030. Fee for registration of authorized third parties.** (a) The
28 attorney general shall adopt regulations that establish the amount and manner of
29 payment of a registration fee for authorized third parties. The attorney general shall
30 establish the fee level so that the total amount of fees collected from authorized third
31 parties approximately equals the actual regulatory costs for the oversight of joint

1 negotiations between physicians and health benefit plans. The attorney general shall
2 annually review the fee level to determine whether the regulatory costs are
3 approximately equal to fee collections. If the review indicates that the fee collections
4 and regulatory costs are not approximately equal, the attorney general shall calculate
5 fee adjustments and adopt regulations under this subsection to implement the
6 adjustments. In January of each year, the attorney general shall report on the fee level
7 and revisions for the previous year under this subsection to the office of management
8 and budget.

9 (b) In this section, "regulatory costs" means costs of the Department of Law
10 that are attributable to oversight of joint negotiations between physicians and health
11 benefit plans.

12 **Sec. 23.50.040. Regulations.** The attorney general may adopt regulations
13 necessary to implement this chapter.

14 **Sec. 23.50.099. Definitions.** In this chapter,

15 (1) "authorized third party" means a person authorized by the
16 physicians to negotiate on their behalf with a health benefit plan under this chapter;

17 (2) "health benefit plan" means a health care insurer as defined in
18 AS 21.54.500, but does not include a self-insured health benefit plan.

19 * **Sec. 2.** AS 45.50.572 is amended by adding a new subsection to read:

20 (k) AS 45.50.562 - 45.50.596 do not forbid the existence or operation of
21 organizations of physicians acting in accordance with AS 23.50, or forbid or restrain
22 members of those organizations from lawfully carrying out the legitimate objectives of
23 them; nor are these organizations or members illegal combinations or conspiracies in
24 restraint of trade under the provisions of AS 45.50.562 - 45.50.596.

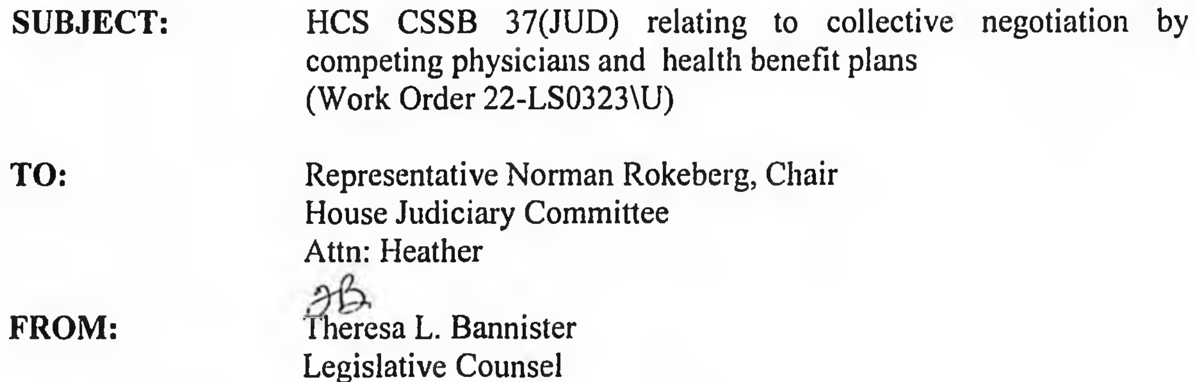
LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 18, 2002



SUBJECT: HCS CSSB 37(JUD) relating to collective negotiation by competing physicians and health benefit plans
(Work Order 22-LS0323\U)

TO: Representative Norman Rokeberg, Chair
House Judiciary Committee
Attn: Heather

FROM: Theresa L. Bannister
Legislative Counsel

This memo accompanies a draft of the bill described above.

1. Misleading definition. The term "health benefit plan" is misleading for the reader because the definition refers to an "insurer," not a "plan" (although the definition of "health care insurer" itself at AS 21.54.500 includes "plans"). A reader does not usually think of a "plan" when reading "insurer." This problem did not originate with this version.

2. ERISA preemption question. Because this bill relates to employee health care plans, there is a preemption issue since the Employee Retirement Income Security Act ("ERISA") addresses the entire field of employee welfare benefit plans. This issue does not originate with the changes made in this draft. I do not know whether preemption is a significant problem for the bill. Even with extensive research, this is a complicated area with few concrete answers.

If I may be of further assistance, please advise.

TLB:med
02-387.med

Enclosure

#2

AMENDMENT TO HOUSE CS FOR CS FOR SENATE BILL NO. 37 (L&C)

ADD NEW SECTION TO READ:

"Sec.3. AS 23.50.010, 23.50.020, 23.50.030, 23.50.040, 23.50.099; and AS 45.50.572(k) are repealed July 1, 2006.

Offered by Berkowitz

B Y
K A
J N
O A
C N
M N
R N

FAILS

From: AK Nurses Assoc.

#3

AMENDMENT TO PROPOSED JUDICIARY DRAFT CS SB37 (L&C)

PAGE 5, LINE 9

"and completing the period for comment and review for interested parties required by this subsection. The review of the contract by the attorney general must allow adequate time for comment and review by interested parties and must include a review whether the contract would harm consumers or providers who are not physicians"

Moved by Berkowitz

B Y
K A
J N
M N
C N
R Y
O A

3-2 Fails

From: AK Nurses Assoc.

#4

AMENDMENT TO HOUSE CS FOR CS FOR SENATE BILL NO. 37 (L&C)

Page 6, Line 20 add new subsection:

"individual physician members covered in the collective negotiations shall accept without qualification Medicare patients."

Re-letter subsections accordingly.

Moved by Berkowitz

B Y
J N
O A
K Y
M N
C N
R N

4-2
fails

Rationale,

The first amendment is a technical amendment replacing not physician with non-physician. (They couldn't read Pat's doctor's handwriting).

The second and third amendments are both from the Senate Labor and Commerce version of the bill. The first amendment places a sunset clause in the bill of 2006.

The second amendment allows for a public comment to the AG's office within the 60 time frame outlined in the bill.

From: AK Nurses Assoc.

Adopted 4.16.02

AMENDMENT #1

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG
TO: HCS CSSB 37 (L & C)

Page 7, Line 15, after "include,"

Delete: "a multiple employer welfare arrangement or"

Tony Knowles, Governor

Department of Community and Economic Development

Division of Insurance

P.O. Box 110805, Juneau, AK 99811-0805
Telephone: (907) 465-2515 • Fax: (907) 465-3422 • Text Telephone: (907) 465-5437
Email: Insurance@dced.state.ak.us • Website: www.dced.state.ak.us/insurance/

April 2, 2002

The Honorable Norman Rokeberg
Alaska House of Representatives
Chairman of the House Judiciary Committee
State Capitol, Room 118
Juneau, AK 99801-1882

Re: Health Care Insurer Definition in HCS CSSB 37(L&C)

Dear Representative Rokeberg:

Thank you for your question regarding the HCS CSSB 37(L&C) definition of a "health benefit plan" and its exclusion of multiple employer welfare arrangements on page 7, lines 14-17 of HCS CSSB 37(L&C). You have asked the division to describe a multiple employer welfare arrangement and comment on why they should (or should not) be included in the definition of a health benefit plan.

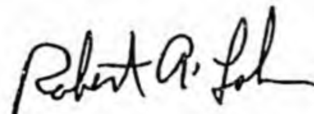
A multiple employer welfare arrangement (MEWA) is defined under ERISA as an employee welfare benefit plan or arrangement established or maintained for the benefit of employees of two or more employers to provide health care or other welfare benefits. MEWAs are often formed by associations of employers in a common industry, but are also formed by associations of unrelated employers. If a plan is established or maintained pursuant to a bona fide collective bargaining agreement it is not a MEWA.

States have clear authority under ERISA to regulate MEWAs. The extent of state authority is limited in the case of a fully insured MEWA to regulation of minimum reserving and contribution standards. However, if a MEWA is not fully insured states have authority to regulate the MEWA as an insurance company. Many MEWAs are not fully insured.

Under current Alaska law, a MEWA is required to obtain a certificate of authority as an insurer in order to offer health benefit plans to its members. The MEWA is subject to all applicable insurance laws including solvency requirements. Many MEWAs have failed across the nation, leaving many employees with unpaid claims and without health insurance, because the MEWAs were not adequately funded. Regulation of MEWAs by the division provides important consumer protections that help ensure that MEWAs have and maintain adequate reserves and surplus to pay claims.

A MEWA operates like any other insurer that provides health insurance coverage to Alaskans. Therefore, the Division can see no reason to subject MEWAs to a different standard than other insurers by excluding them from the definition of a health benefit plan.

Sincerely,



Robert A. Lohr
Director

RAL/KC/go3108
040202a

22-LS0323\W.1
Bannister
4/10/02

Adopted 4.10.02

AMENDMENT #2

OFFERED IN THE HOUSE

TO: HCS CSSB 37(L&C)

1 Page 2, line 13, following "subsection":

2 Insert ", but may not negotiate the exclusion of providers who are not physicians from

3 direct reimbursement by a health benefit plan, and may not negotiate the setting in which

4 providers who are not physicians deliver services"

Alaska State Legislature

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State Capitol
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Fairbanks, AK 99701
Phone: (907) 456-8161
Fax: (907) 456-8163

Senator Pete Kelly
District P

SB 37 Sponsor Statement

"An Act relating to collective negotiation by competing physicians with health benefit plans, to health benefit plan contracts, to the application of antitrust laws to agreements involving providers and groups of providers affected by collective negotiations, and to the effect of the collective negotiation provisions on health care providers."

Senate Bill 37 attempts to level the playing field for Alaska's patients and the physicians who care for them.

Over the past eight years, the health insurance market has continued to consolidate at a rapid pace. There were once 18 national health insurance companies that physicians could choose to contract with. These companies have since merged into 6. It is even more severe for Alaskan physicians who have only 2 choices of insurers in this state. Physicians are given little if any opportunity to advocate for the best care of their patients.

Independent physicians are prevented from collective action by federal antitrust laws and are subject to aggressive antitrust enforcement actions. Large corporations, however, can adopt a "take it or leave it" position without any antitrust ramifications. This plus the market concentration of health insurers causes a damaging imbalance in bargaining power.

This inequity between health insurers and medical care providers dictates physician contracts. The resulting contracts favor the insurance companies over the health care patients receive and can result in such policies where physicians are required to use a low cost treatment when a higher cost treatment may be medically necessary.

Senate Bill 37 will enable independent, competing physicians to become effective advocates for their patients through collective negotiations with health insurers. These negotiations will fall into a narrow scope of topics with regard to the provisions of physician services contracts and will be under the scrutiny of the Attorney General's office. SB 37 will still prohibit a group of independent competing physicians from striking or otherwise engaging in activities that would result in a boycott.

Alaska State Legislature

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Senator Pete Kelly
District P

SB37 Talking Points

"An Act relating to collective negotiation by competing physicians with health benefit plans, to health benefit plan contracts, to the application of anti-trust laws to agreements involving providers and groups of providers affected by collective negotiations, and to the effect of the collective negotiation provisions on health care providers."

- Levels the playing field between Alaska's physicians and the outside insurance companies.
- Does **not** allow for boycotts or strikes.
- Does **not** impact nurses.
- Does **not** create doctor unions.
- Does **not** impact ERISA plans.
- It is **not** mandatory for either doctors or insurance companies to negotiate.
- Will **allow** the Attorney General to stop all negotiations and contracts at ANY time.
- Will **allow** for communication among doctors to improve the delivery of healthcare in Alaska.
- Will **allow** protected contract negotiations for non-cost provisions separate from cost provisions.

Senate Bill 37
How does it work?

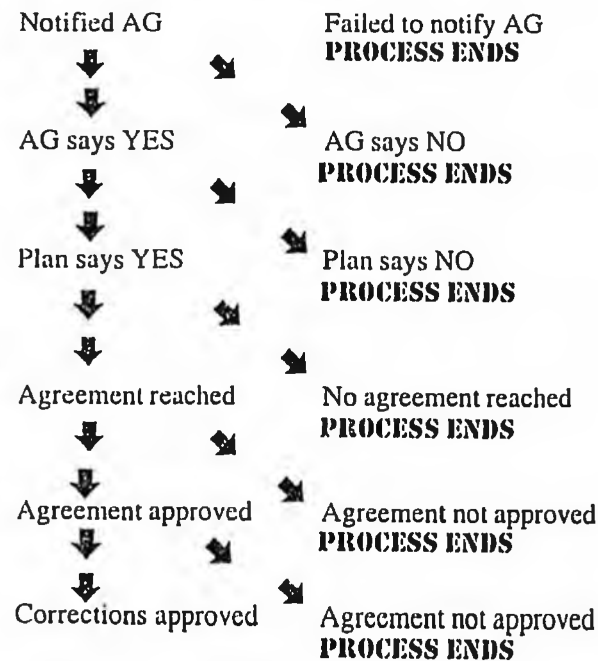
Group of physicians wishing to jointly negotiate

Appoint an exclusive representative

(May not represent more than 30% of doctors in a geographic service area unless the health plan has a market share of more than 5% in that same geographic service area)

Authorized third party

Non-Fee Related Items



1. Notifies the Attorney General and health care plan of desire to negotiate

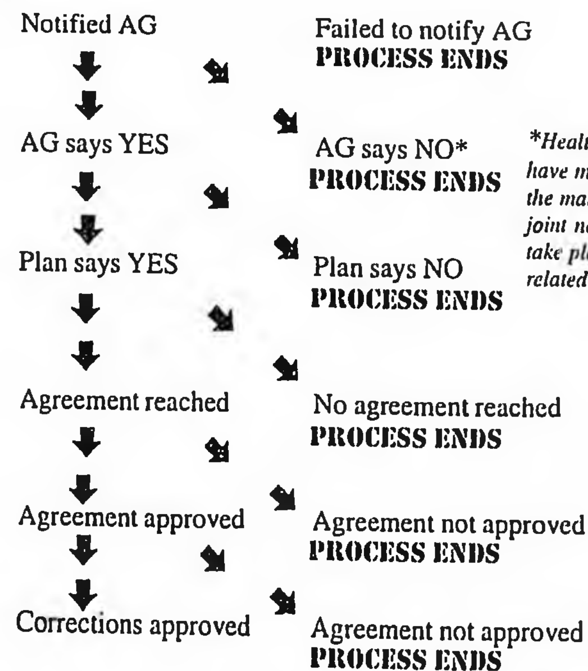
2. Attorney General decides if negotiations may take place

3. Health care plan decides whether to negotiate

4. Agreement between physicians and health plan reached

5. Submit to Attorney General for approval

Fee Related Items



**Health care plan must have more than 15% of the market share for joint negotiations to take place for fee-related items*

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: 6
Bill Version: HCS CSSB 37(L&C)
(H) Publish Date: 3/26/02

Revision Date/Time (Note if correction):
Title "An Act relating to collective negotiation by physicians with health benefits....
Sponsor Senator Pete Kelly
Requester House Labor & Commerce

Dept. Affected: Administration
BRU Centralized Admin Svcs.
Component Retirement & Benefits
Component No. 64

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This version of the bill does not include self-insured plans; it will not apply to the State health plans.

Prepared by: Guy Bell, Director
Division: Retirement & Benefits
Phone 465-4471
Date/Time 3/21/02 4:34 PM

Approved by: Jim Duncan, Commissioner
Agency: Department of Administration
Date 3/21/2002

(Revised 9/2001 OMB)

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: 7
Bill Version: HCS CSSB 37(L&C)
(H) Publish Date: 3/26/02

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: An Act relating to collective negotiation by physicians with health benefits plans
BRU: Insurance Operations (116)
Component: Insurance
Sponsor: Senator Kelly
Requester: House Labor & Commerce
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services	23.7	24.3	25.0	25.7	26.4	27.2
Travel						
Contractual						
Supplies	1.5	1.5	1.5	1.5	1.5	1.5
Equipment	5.0	0.0	0.0	0.0	0.0	0.0
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**30.2**	**25.8**	**26.5**	**27.2**	**27.9**	**28.7**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
1002 Federal Receipts						
1003 GF Match						
1004 GF	30.2					
1005 GF/Program Receipts		25.8	26.5	27.2	27.9	28.7
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**30.2**	**25.8**	**26.5**	**27.2**	**27.9**	**28.7**

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

POSITIONS	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Full-time						
Part-time	1	1	1	1	1	1
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

A part-time administrative position is needed in order to gather and report the health benefit plan market share information required under Sec. 23.50.020(g)(6). This position would be responsible for developing and sending out surveys requesting data from over 18,000 employers in the state and for performing reasonableness checks on the data submitted, entering the data into a spreadsheet, and developing the required market share reports. Since the Division of Insurance does not have regulatory authority over health benefit plans (employers), it is anticipated that employers will be reluctant to respond to the survey (about 30% response rate). Therefore, a significant amount of this employee's time is anticipated to be spent following up with the employers who do not respond to the survey.

Prepared by: Robert A. Lohr, Director
Phone
Division: Insurance
Date/Time: 3/19/02 3:25 PM

Approved by: Deborah B. Sedwick, Commissioner
Date: 3/19/2002
Agency: Department of Community & Economic Development

(Revised 9/2001 OMB)

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: 8
Bill Version: HCS CSSB 37(L&C)
(H) Publish Date: 3/26/02

Revision Date/Time (Note if correction):
Dept. Affected: Law
Title "An Act relating to collective negotiation by competing physicians with health benefit plans, ..."
BRU Civil Division
Component Fair Business Practices
Sponsor Senator Pete Kelly
Requester House Labor and Commerce Committee
Component No. 2206

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services	134.5	134.5	134.5	134.5	134.5	134.5
Travel	5.3	5.3	5.3	5.3	5.3	5.3
Contractual	80.6	80.6	80.6	80.6	80.6	80.6
Supplies	2.3	2.3	2.3	2.3	2.3	2.3
Equipment	13.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**235.7**	**222.7**	**222.7**	**222.7**	**222.7**	**222.7**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	**0.0**	**222.7**	**222.7**	**222.7**	**222.7**	**222.7**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	235.7					
1005 GF/Program Receipts		222.7	222.7	222.7	222.7	222.7
1037 GF/Mental Health						
Other (Specify Type–Do not abbreviate)						
TOTAL	**235.7**	**222.7**	**222.7**	**222.7**	**222.7**	**222.7**

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

Full-time	1	1	1	1	1	1
Part-time	1	1	1	1	1	1
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

CSSB 37 (FIN) provides a method for physicians to collectively negotiate certain terms and conditions of contracts with a health benefit plan. If an authorized third party negotiates with the health benefit plan, the subject matter of the negotiations must be reviewed and approved by the attorney general, who then receives various reports on the progress of the negotiations. Once a negotiated contract proposal is reached, it is to be reviewed and approved by the attorney general, using specific criteria, within thirty days. The bill provides that registration fees for authorized third parties will be established to approximately equal the regulatory costs for the attorney general's oversight of joint negotiations between physicians and health benefit plans.

If enacted, this legislation places substantial responsibilities on the attorney general to approve proposed negotiations, monitor reports of on-going negotiations, and to make a determination whether to approve or not approve a proposed

Prepared by: Joan M. Kasson
Phone (907) 465-5370
Division Attorney General's Office
Date/Time 3/20/02 11:59 AM
Approved by: Kathryn Daughhetee for Bruce M. Botelho, Attorney General
Date 3/20/2002
Agency Department of Law

(Revised 9/2001 OMB)

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

BILL NO. HCS CSSB 37(L&C) - FN#8

ANALYSIS CONTINUATION

negotiated contract within a very short time frame. The economic and patient care detriment or benefit criteria the attorney general is directed to base approval or disapproval on will require significant analysis by expert health care economic assistance, as well as additional legal resources

Under this bill, competing physicians within the service area of a health benefit plan can collectively negotiate certain defined terms and conditions of contracts with the health benefit plan. Negotiations can include fee and price related terms and conditions.

CSSB 37 (FIN) excludes all self-insured plans. It is difficult to predict how many contracts and reports during a given year that the attorney general's office will have to review and approve. There are 2,050 licensed physicians currently in the State of Alaska, and we conservatively estimate more than 5,000 insured health benefit plans will be potentially subject to this bill. Given these numbers, we would anticipate the volume of collective negotiations under the bill to be significant enough that we will need additional resources to complete the required reviews and approvals.

The Department of Law anticipates a minimum of one-half of a full-time equivalent attorney position and one full-time equivalent paraprofessional position will be needed to handle this new workload. Extensive regulation development will be necessary to implement the legislation by defining terms and setting forth the reporting requirements that authorized third parties will be required to submit in order to reduce, or preferably eliminate, investigation time during the 30 day review period. Once regulations are complete, these positions will perform the necessary investigation, review, and antitrust analyses on the collective bargaining reports submitted by the authorized third party, and represent the state when decisions of the attorney general are challenged.

Requests for approval of proposed negotiations and review of negotiated contracts by the attorney general are unlikely to be spread evenly throughout the course of a year. Instead, they may come at any time, and in any volume. Thus, we assume it will be more efficient to hire expert health care economic assistance by contract on an as needed basis. $50,000 is included for outside expert costs (250 hours at an estimated average cost of $200/hour).

In-house estimates are based on the department's FY 2003 standard half-time equivalent attorney and full-time paraprofessional schedules, which include clerical support, communications, space, supplies, data processing, and other normal overhead expenses. (one-half FTE attorney: $70,455, FTE paraprofessional: $92,230). Each position estimate also includes an additional $6,500 for one-time equipment purchases and $5,000 for direct case costs, costs that cannot be included in the rate as overhead.

The bill assumes fees for the registration of authorized third parties will be established to cover the cost of the program upon implementation. It will take at least several months to establish the regulatory framework. During this time, no fees will be generated. General funds are necessary for the first year to implement the program, at which point, the bill envisions that fees will be set to cover all program costs.

STATE HEALTH FACTS *Online* http://statehealthfa

Your source for state he

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999

Guam Puerto Rico U.S. Virgin Islands

- Less than 225
- 225 to 255
- 256 to 282
- More than 282
- No data available/NSD

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999

Sort by: Rank

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999

Rank	State	#
	United States	285
1	District of Columbia	811
2	Massachusetts	454
3	New York	423

4	Maryland	413
5	Connecticut	397
6	Rhode Island	372
7	Vermont	362
8	New Jersey	327
9	Pennsylvania	321
10	Hawaii	306
11	Florida	290
12	Illinois	287
13	Minnesota	282
14	California	280
15	Colorado	274
16	New Hampshire	273
17	Washington	272
18	Louisiana	270
19	Tennessee	269
19	Virginia	269
21	Maine	268
22	Oregon	266
23	Delaware	264
24	North Carolina	262
25	Ohio	261
26	Wisconsin	256
27	Missouri	250
28	Michigan	249
29	Nebraska	247
30	North Dakota	246
31	New Mexico	243
32	Arizona	240
33	West Virginia	239
34	South Carolina	234
35	Kansas	232
35	Kentucky	232
37	Georgia	230
38	Montana	228
39	Utah	225
40	Texas	222
41	Indiana	219
42	Alabama	217
43	Arkansas	214
44	South Dakota	211
45	Iowa	200
46	Nevada	199
47	Wyoming	198
48	Oklahoma	187
49	Alaska	186
50	Mississippi	180
51	Idaho	179
NR	Guam	NA
NR	Puerto Rico	NA
NR	Virgin Islands	NA
NR	Residence Unknown	NA

Notes: Nonfederal physicians are employed in the private sector of the US physician population. They represent 98% of total physicians.
The US total excludes physicians and population in the possessions.

Sources: Physician Characteristics and Distribution in the US, 2001-2002 Edition, American Medical Association, copyright 2001, Table 5.20, p. 348.

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American Medical News
Home

SECTIONS
- Government & Medicine
- Professional Issues
- Business
- Opinion
- Technology
- Health & Science

LISTINGS
By section
By date
By region
By health plan
News briefs
Columns
Letters
Special coverage
Reader opinion
Past years
Search

SERVICES
Mobile edition
E-mail alert
Print subscriptions
Staff directory
Author bios
Advertising
Permissions
AMNews FAQ
Contact us

GOVERNMENT & MEDICINE

N.J. doctors get collective bargaining rights

Physicians can join together, but insurers don't have to negotiate with them. Similar provisions have hurt physician bargaining efforts in other states.

By Amy Snow Landa, *AMNews* staff. Jan. 28, 2002.
Additional information

Washington -- New Jersey has become the third state in the nation to allow independent physicians to bargain collectively with managed care plans over the terms of their contracts.

Legislation signed into law Jan. 8 exempts joint negotiating by physicians and dentists from antitrust laws as long as such activity takes place under close supervision by the state.

"We have been aching for some type of antitrust relief for years," said Angelo S. Agro, MD, president of the Medical Society of New Jersey. "Now it is up to physicians in our state to take advantage of the opportunities we have been fighting for and make them pay off."

Texas and Washington are the other states that give physicians the right to bargain collectively.

The New Jersey law allows doctors in that state to negotiate with health plans on such matters as the definition of medical necessity, utilization management procedures, quality assurance programs, clinical practice guidelines, dispute resolution and credentialing. Physicians also could negotiate payment issues as long as the attorney general found that the plan in question had substantial market power and that terms or conditions of the plan could pose a threat to quality and availability of care.

Doctors are not allowed to strike, nor can they negotiate to exclude nonphysicians from plans.

Write a letter to the edit about this stor

Additional information

Box: Physicians gaining clout

Plans unwilling to play

Like the laws previously enacted in Texas and Washington, the New Jersey act does not require insurers to join doctors at the negotiating table, raising questions about whether self-employed physicians will be able to exert any more leverage in contract talks with health plans than they did before. The experiences of physicians in Texas and Washington seem to provide little basis for optimism.

In June 2000, a group of 11 physicians in Henderson, Texas, applied to the state attorney general's office for permission to band together for contract negotiations with Blue Cross and Blue Shield of Texas -- the area's dominant insurer.

The Henderson group was soon granted permission by Texas Attorney General John Cornyn to bargain collectively. He determined that physicians were locked into contracts with the Blues plan and that their practices couldn't absorb the loss of income they suffered as a result.

The AMA is working on a physician collective bargaining bill it hopes to be introduced in Congress.

Cornyn also stated in his decision that the plan's "dominant position and its terms and conditions for physician compensation threaten to adversely affect the quality and availability of patient care in the Henderson area." He gave the physicians and the insurer a 60-day period to meet to negotiate.

But the Blues plan simply refused to sit down with the physicians, and that was the end of it. Since then, no other group of physicians has decided to pursue an application, said Michael Cushman, director of the Texas Medical Assn.'s health care delivery department.

Like Texas, Washington also did not require insurer cooperation when it enacted its joint negotiation law in 1993.

Physicians' interest in pursuing negotiations with plans appears to have been dampened as a result.

"We can't even get to first base," said Len Edinger, director of public policy and planning for the Washington State Medical Assn.

The WSMA supports a measure that was expected to be introduced in the state Legislature in mid-January that would

amend the 1993 law to explicitly allow negotiations about reimbursement and require insurers to negotiate in good faith with physicians.

Although the New Jersey law does not require insurers to negotiate in good faith, Dr Agro said he hopes the state's doctors will be able to exert enough pressure to bring them to the table anyway.

If one or more groups of physicians apply for and receive permission to engage in joint negotiations with an insurer, and that insurer refuses, it could become a public relations problem for the HMO, he said.

"We think it would be an untenable [position] for the HMOs to stonewall if the state attorney general sees fit to allow negotiations with various groups around the state," he said. "I'm sure it won't help sell policies if it becomes known they're unwilling to negotiate on patient care issues even when the government and physicians say they should."

The New Jersey law also has an advantage over the Texas statute, according to MSNJ. It doesn't cap the percentage of physicians in a market who can negotiate, while the Texas law sets that limit at 10%, society officials said.

The AMA applauds the MSNJ for its success, said Donald J. Palmisano, MD, the Association's secretary-treasurer and a lawyer.

"Too long have insurers used their market concentration and market share to unfairly disadvantage patients and physicians," he said. "If insurers refuse to negotiate, then this will expose the insurers as entities that do not want to listen to reason, but instead want to exercise their monopsony power."

The AMA is working on a new collective bargaining bill that it hopes will be introduced in Congress. An earlier collective bargaining measure passed in the House but died in the Senate in 2000.

Joint negotiation bills have foundered in more than a dozen state legislatures due to concern that physicians would gain too much leverage and that such measures would lead to higher health insurance costs.

That was a complaint the insurance community used in its opposition to the New Jersey law.

"The virtually certain result would be higher costs for patients

and for the health plans that pay for the health care they receive," said the New Jersey Assn. of Health Plans.

Back to top.

ADDITIONAL INFORMATION:

Physicians gaining clout

The New Jersey collective bargaining law:

- Gives physicians the right to bargain collectively, through a representative they select, with insurers on many nonpayment-related subjects, including patient referral standards, drug formularies and clinical practice guidelines.
- Allows doctors to bargain with plans on payment issues as long as the state attorney general has ruled that the carrier has substantial market power and its contract terms and conditions could hurt patient care.
- Requires that physicians submit a collective bargaining petition to the attorney general and pay a filing fee. The results of any collective bargaining agreements are also subject to the attorney general's approval.
- Bars physicians from striking.
- Does not require health plans to join physicians at the bargaining table.

Back to top.

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Tuesday, March 26, 2002, 12:00 a.m. Pacific

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Doctors sue Blue Cross, BlueShield: Late, discounted payments alleged; class-action status sought

By Carol M. Ostrom
Seattle Times staff reporter

Two groups of local doctors have filed twin lawsuits against two of the state's largest health-insurance companies, alleging they systematically deny and delay reimbursing doctors for the services they provide patients.

The civil lawsuits, against Premera Blue Cross and Regence BlueShield and their affiliated organizations, were filed Friday by Franciscan Medical Group and Tacoma Orthopaedic Surgeons Inc. in Pierce County Superior Court.

The lawsuits allege the insurers routinely engage in a process called "bundling," which lumps procedures that should be reimbursed separately into one lesser reimbursement. It also accuses the insurers of "downcoding," in which the insurer refuses to reimburse for the actual medical service billed and instead substitutes a lower reimbursement.

Neither company yesterday would respond directly to the suits, but Regence spokesman Chris Bruzzo said the company was disappointed because it had worked hard to address doctors' concerns about its reimbursement practices.

About 65 doctors and seven midlevel practitioners such as physician assistants joined in the lawsuits. They also are asking the court to certify the lawsuit as a class-action claim, which could involve more than 22,000 health-care providers in the state, said J. Richard Creatura, an attorney for the medical groups.

The suits say the insurers violated laws against criminal profiteering and requiring insurers to pay providers promptly.

Dr. Cliff Robertson, chief medical officer for the Franciscan Medical Group, said the lawsuit grew out of longstanding belief that the insurers were shortchanging doctors. "There's been a growing frustration that even when we do things correctly, we weren't getting paid based on our contractual relationships," he said.

For example, Robertson said, if a parent brought in a child for a routine exam and during that visit asked about removing a wart, the only way for doctors to assure payment for both would be for the doctor to schedule a second appointment for the wart removal.

"The rules don't make sense, and we believe they're not consistent," Cullison said. "We believe legally we should be paid for those services, and we're not."

Premera Blue Cross spokesman Scott Forslund declined to address the lawsuit, saying his company was reviewing it. Regence's spokesman, Bruzzo, also said his company is investigating the

claim.

Regence [illegible] disappointed that the physician concerns had been voiced through a lawsuit, Bruzzo said. "Physicians are incredibly important — integral — to Regence's job of providing health insurance." Regence has gone to some lengths to create processes by which doctors can address their concerns, including funding a physician ombudsman and a physician advisory board. "We have some good, strong systems in place for hearing physicians and working with them on their issues."

The system is complex, Bruzzo noted — based on more than 7,800 Current Procedural Terminology (CPT) codes and a system of assigning "relative values" of time and effort spent on each visit or procedure.

"There are going to be concerns with a system as complicated as this one," Bruzzo said. "We have certainly heard concerns like this. Our goal is to work outside lawsuits to resolve differences that exist."

But Bruzzo noted that similar lawsuits have been filed across the country.

Even within Washington, such complaints appear not to be limited to Regence and Premera. And the doctors who sued last week are also not the only ones complaining.

Stephanie Marquis, spokeswoman for the state Insurance Commissioner's Office, said her office receives many calls and letters from doctors who think insurers have violated the law. The office sends letters to the insurers, she said, but beyond that has little enforcement power.

Dr. Sam Cullison, president of the Washington State Medical Association, said the association has no way of measuring the extent of the problem. "What I have is hearsay evidence that is still quite powerful. As I go around the state, physicians are voicing concerns to me about problems such as this in practically every meeting I go to."

Many doctors think the appeals and arbitration processes set up by insurers are meant to throw expensive and time-consuming roadblocks at their efforts to get fair reimbursement, he said.

Both Cullison and Robertson noted the bankruptcy filings of several Western Washington clinics, evidence that doctors are taking early retirement and leaving the state. Because practices are becoming "so economically fragile," Robertson said, they no longer can afford to ignore such insurer practices.

Carol M. Ostrom can be reached at 206-464-2249 or costrom@seattletimes.com.

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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

COMMISSION AUTHORIZED

Bureau of Competition
Office of Policy Planning

By Facsimile and First Class Mail

January 18, 2002

The Honorable Lisa Murkowski
Chair, House Labor and Commerce Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Re: Alaska Senate Bill 37

Dear Representative Murkowski:

We write in response to your request for comment on Alaska Senate Bill 37, a bill that seeks to authorize competing physicians to engage in collective bargaining with health plans over fees and other terms.[1] As discussed below, the Commission has opposed legislation before the U.S. Congress that would create an antitrust exemption for physician collective bargaining, and the Commission staff has expressed similar concerns about bills before state legislatures. We continue to believe that the behavior authorized by the physician collective bargaining legislation would significantly increase health care costs and harm consumers.

You also specifically solicited our opinion on whether the bill meets the legal test of the state action doctrine. As you know, state economic regulation can immunize private parties from federal antitrust liability, but only where the displacement of competition furthers a clearly articulated policy of, and is actively supervised by, the state government. In the case of Senate Bill 37, the level of government involvement described falls far short of the level of "active supervision" required by the Supreme Court.

I. Physician Collective Bargaining

The Commission's opposition to legislation intended to create an antitrust exemption for physician collective bargaining has historically focused on two fundamental points, both of which are relevant to your consideration of Senate Bill 37:

[1] These comments are views of the staff of the Bureau of Competition and of the Office of Policy Planning of the Federal Trade Commission. They do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize the Bureau of Competition and the Office of Policy Planning to submit these comments.

(1) such legislation would likely harm consumers – an antitrust exemption would authorize price-fixing by physicians, which could be expected to result in increased consumer costs and decreased consumer access to care; and

(2) such legislation would not likely improve the quality of care – an antitrust exemption would not likely improve patient care, and there are other, more effective means of addressing quality of care issues that do not sacrifice the benefits of a competitive marketplace.

A. Consumer Harm

In testimony before Congress regarding a proposed federal antitrust exemption for physician collective bargaining,[2] the Commission detailed the predictable impact on consumers that such legislation would have:

> Without antitrust enforcement to block price fixing and boycotts designed to increase health plan payments to health care professionals, we can expect prices for health care services to rise substantially. Health plans would have few alternatives to accepting the collective demands of health care providers for higher fees. The effect of the bill . . . can be expected to extend to various parties, and in various ways, throughout the health care system:
>
> - Consumers and employers would face higher prices for health insurance coverage.
> - Consumers also would face higher out-of-pocket expenses as copayments and other unreimbursed expenses increased.
> - Consumers might face a reduction in benefits as costs increased.
> - Senior citizens participating in Medicare HMOs would face reduced benefits . . . .
> - The federal government would pay more for health coverage for its employees through the Federal Employees Health Benefits Program and military health programs.
> - State and local governments would incur higher costs to provide health

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[2] Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 22, 1999) ("FTC Testimony on H.R. 1304") at 5-6 *available at* <http://www.ftc.gov/os/1999/ 9906/healthcaretestimony.htm> (Attachment A) (footnotes 3-5 in original).

benefits to their employees.

- State Medicaid programs attempting to use managed care strategies to serve their beneficiaries could have to increase their budgets, cut optional benefits, or reduce the number of beneficiaries covered.

- State and local programs providing care for the uninsured would be further strained, because, by making health insurance coverage more costly, the bill threatens to increase the already sizable portion of the population that is uninsured.

These widespread effects are not simply theoretical possibilities. The record of antitrust law enforcement sets forth the impact of collective 'negotiations' on the public. For example, as described in the Commission's complaints, collective bargaining by anesthesiologists in Rochester, New York, and by obstetricians in Jacksonville, Florida, forced health plans to raise their reimbursement, and the result was increased premiums for the HMOs' subscribers.[3] Other cases have challenged actions by associations of pharmacists who succeeded in forcing state and local governments to raise reimbursement levels paid under their employee prescription drug plans.[4] In one such case, an administrative law judge found that the collective fee demands of pharmacists cost the State of New York an estimated $7 million.[5]

Prior Commission cases illustrate the types of physician conduct that have raised problems. Price-fixing is one type of such conduct, and last year's *Alaska Health Network, Inc.*[6] case is a prime example. In that case, the Commission alleged that competing physicians organized and conspired to fix the prices and other competitively significant terms on which they would deal with health plans in Fairbanks, Alaska. Another type of conduct is price-related group boycotts, such as the one addressed in the *M.D. Physicians of Southwest Louisiana, Inc.*[7] case. There, the Commission charged a group of competing physicians with conspiring not to deal with certain third-party payers, as part of an unlawful enterprise designed to prevent managed care contracts

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[3] Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

[4] See, e.g., Baltimore Metropolitan Pharmaceutical Assoc., Inc. and Maryland Pharmacists Assoc., 117 F.T.C. 95 (1994) (consent order); Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

[5] See Peterson Drug Company, 115 F.T.C. 492, 540 (1992). See also Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

[6] Docket No. C-4007, 2001 WL 443471 (F.T.C. April 25, 2001) (consent order).

[7] Docket No. C-3824, 1998 WL 566834 (F.T.C. August 31, 1998) (consent order).

from taking hold in the Lake Charles, Louisiana region.

There is widespread agreement that horizontal agreements among competitors can raise the most significant competitive concerns. The facilitation of naked horizontal price-fixing is among the most serious of these concerns, as such conduct predictably and consistently results in substantial consumer harm. Departing from the general rules of antitrust in such a competitively sensitive area presents substantial risks that would not be offset by procompetitive gains from physician collective bargaining.

The two arguments that have typically been presented to justify a departure from the general rules of antitrust in this context are that, given health plan concentration, physician collective bargaining would (1) increase patients' quality of care, and (2) allow physicians to bargain on a more "level playing field." The former argument is based on a misunderstanding of both current law and the effects of collective bargaining, as will be discussed in the next section.

The latter argument is more straightforward, but equally problematic. As the Commission explained in its testimony before Congress:

> Arguments that consumers would not be harmed by an antitrust exemption for collective bargaining by independent health care professionals appear to rest on assertions that the [federal] bill would balance the bargaining power between health care professionals and health plans. These assertions, however, are incorrect. The bill would permit doctors to create monopolies. On the health plan side of the ledger, the evidence does not support the suggestion that most (or even many) areas have only one or two health plans.[8]

Furthermore, even if the assumption that physicians confront monopoly health plans were correct, authorizing collusive conduct by physicians would not necessarily serve the interests of consumers. The argument that physician collusion would merely counterbalance hypothetical monopsony power by health plans implicitly assumes that collective bargaining would generate physician fees no larger than the fees that would exist in a competitive market. However, there is little reason to believe that a successful physician cartel would settle for fees at the competitive level. If a health plan possessed actual market power, health care consumers could be doubly harmed by physician collective bargaining, because they could be forced to pay the health care plan's monopoly mark-up on top of the elevated fees charged by the physicians.

B. Quality of Care

Proponents of antitrust exemptions for physicians often suggest that greater physician bargaining power against health plans would result in increased quality of care for patients. This claim fails for two reasons: (1) physician collective bargaining has historically focused on

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[8] FTC Testimony on H.R. 1304, supra note 2, at 6-7.

physician compensation, rather than patient care; and (2) current antitrust law already permits physicians to work collectively on legitimate quality of care issues.

Immunizing collective bargaining imposes costs while providing little assurance that consumers' interest in quality care will be served. As the Commission stated before Congress:

> Collective bargaining rights are designed to raise the incomes and improve the working conditions of union members. The law protects the United Auto Workers' right to bargain for higher wages and better working conditions, but we do not rely on the UAW to bargain for safer cars. Congress addressed those concerns in other ways.[9]

Moreover, discussions between physician groups and health plans are not illegal. Current antitrust law permits doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The Health Care Guidelines – jointly issued by the Federal Trade Commission and the Antitrust Division of the Department of Justice – emphasize physicians' ability under the antitrust laws to organize networks, and other joint arrangements, to deal collectively with health plans and other purchasers.[10] In addition, through their professional societies and other groups, health care professionals can jointly provide information and express opinions to health plans.[11]

As the Commission explained in its congressional testimony:[12]

> [T]he antitrust laws do not prohibit medical societies and other groups from engaging in collective discussions with health plans regarding issues of patient care. Among other things, physicians may collectively explain to a health plan why they think a particular policy or practice is medically unsound, and may present medical or scientific data to support their views . . . .[13]

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[9] FTC Testimony on H.R. 1304, supra note 2, at 10.

[10] See Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (Aug. 1996) ("Health Care Guidelines") *available at* <http://www.ftc.gov/reports/hlth3s.htm>. The Health Care Guidelines discuss "messenger model" arrangements designed to minimize the costs associated with the contracting process.

[11] See, e.g., Schachar v. American Academy of Ophthalmology, 870 F.2d 397 (7th Cir. 1989); Statements 4-5 of Health Care Guidelines, supra note 10.

[12] FTC Testimony on H.R. 1304, supra note 2, at 7-8 (footnotes 13-15 in original).

[13] [The Health Care Guidelines] create an antitrust safety zone for health care providers' collective provision of non-fee-related information to health plans. . . . [See Statement 4 of Health Care Guidelines, supra note 10.]

The Commission has never brought a case based on physicians' collective advocacy with a health plan on an issue involving patient care. Our cases have addressed instances in which physician groups (1) negotiated collectively on fee levels or other price-related issues, or (2) collectively refused to contract with plans, either to gain acceptance of their price-related demands or to prevent or delay market entry by managed care plans generally. In all such cases, the Commission has been very careful to make sure that its orders do not interfere with the legitimate exchange of information and views between health plans and health care practitioners. Indeed, in the Commission's first litigated case involving collective negotiations by physicians - *Michigan State Medical Society* - the opinion emphasized that the antitrust laws do not prohibit health care providers' collective provision of information and views to health plans.[14] Specific language was inserted in that order, and in subsequent orders, to make it clear that bans on anticompetitive agreements among competing providers do not prohibit the provision of information and views to health plans concerning any issue, including reimbursement.[15]

Accordingly, blanket antitrust immunity for physician price-fixing is not necessary to protect patient welfare.

II. The Alaska Bill

Nonetheless, Senate Bill 37, like its federal and state counterparts, seeks to confer antitrust immunity with respect to collective physician conduct. To be sure, Senate Bill 37 also contains a number of provisions designed to protect consumers from the potential harms arising from a physician collective bargaining exemption. In some respects, these provisions resemble protections contained in physician collective bargaining bills introduced in Texas and the District of Columbia, on which the Commission staff also has commented.[16] As with the protections in the Texas and District of Columbia bills, these provisions – addressing a health plan's market power, the size of the physician bargaining group, and potential boycott conduct -- do not alleviate the risk of substantial consumer harm resulting from a collective bargaining exemption.

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[14] 101 F.T.C. [191,] at 302-09 [(1983)].

[15] Id. at 314; see also Southbank IPA, 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

[16] Letter to the Texas Legislature on Senate Bill 1468 (May 13, 1999) *available at* <http://www.ftc.gov/be/v990009.htm> (Attachment B); Letter to the District of Columbia Office of Corporation Counsel on Bill No. 13-333 (Oct. 29, 1999) ("District of Columbia Letter") *available at* <http://www.ftc.gov/be/rigsby.htm> (Attachment C).

A. Minimum Threshold for Health Plan Market Power

Section (d)(1) of Senate Bill 37 states that physicians may "collectively negotiate with a health benefit plan the items described in (b)" – including fees or prices – provided that the health benefit plan has "substantial market power." "Substantial market power" is defined as "more than 15 percent of the market share." *Id.* at § (s)(4). Alternative formulas by which market power may be measured are set forth in Sections (f)(1) and (f)(2).

This market power screen is unlikely to guard against consumer harm.

First, the screen does not apply to all collective bargaining by physicians, or even to all price-related bargaining. Rather, it applies only to certain kinds of price-related matters. For example, the market share screen does not apply to negotiations concerning the formulation and application of reimbursement methodology. *Id.* at § (a)(6). The method a health plan uses to calculate its payments to providers for particular services, however, can have a direct and significant impact on the ultimate price that providers receive for their services, and thus such matters are also "price" terms. Moreover, even collective bargaining over other, more clearly "non-price" issues in a health plan contract can have a substantial effect on the ultimate costs paid by consumers.

Second, there are significant problems with the concept of health plan market power as defined in the bill. As the Commission staff noted in its comment on the District of Columbia bill:

> Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only if based upon a properly defined market. Even if the bill's categories correctly identified relevant markets, a 15% market share . . . is not a level ordinarily assumed to constitute market power.[17]

Although the Alaska bill's definition of "substantial market power" is not entirely clear, one thing is certain: it does not define antitrust markets in a legal or economic sense. For example, it uses as a proxy for a relevant geographic market the health plan's "service are " but this area does not necessarily correspond to a proper relevant antitrust geographic market, and could serve to overstate the market share of the plan.

Furthermore, by setting the market power threshold at a 15 percent market share, the bill would authorize anticompetitive behavior by physicians in many situations in which the health plan would not in fact possess market power. Indeed, 15 to 20 percent is below the level courts

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[17] District of Columbia Letter, supra note 16, at 3-4.

typically require before upholding a finding of market power.[18] Finally, the bill does not take into account that even a plan with a large share of a market might be constrained from exercising market power if new entry by competing plans is easy.

Third, in practice, the market share screen appears unlikely to provide any limitation at all. That is because the bill would create a presumption that a health plan has substantial market power (Section (f)), unless the health plan persuades the Attorney General that it does not meet the 15 percent threshold. It seems unlikely that a health plan would seek to offer such proof, however, because the kind of price-related collective bargaining to which the market share screen applies can occur only if the health plan agrees to engage in such negotiations. *See* Section (d)(3). Thus, it appears that a health plan could simply decline to negotiate with physician collective bargaining groups, without making any showing regarding market share.

In addition, it should be noted that the bill's restrictions on collective fee negotiation to situations where the health plan consents to such negotiations would offer only limited protection to consumers. Such a restriction could limit certain kinds of anticompetitive effects, by preventing groups without health plan consent from engaging in even preliminary bargaining activities (such as physicians entering into agreements on the fee levels to be sought) that could facilitate anticompetitive agreements with respect to physicians' individual dealings with health plans. Nonetheless, a variety of risks remain. First, although participation is voluntary, some health plans may feel compelled to deal with a group if it includes most of the physicians in a particular specialty or many physicians with large numbers of loyal patients. Second, even absent any implicit coercion, in some circumstances a health plan may find it less troublesome to simply accede to price-setting by physicians and then pass the higher costs on to consumers. In either case, such behavior presents a risk not only to the enrollees of the particular plan in question, but also to other consumers, because a group of physicians organized to bargain with one health plan could more easily collude in its dealings with other health plans that eschew collective bargaining.

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[18] Although the federal courts have not identified a precise market share figure that constitutes market power, the guidance they have provided strongly suggests that 15 to 20 percent is not sufficient. In Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984), for example, the Supreme Court rejected the possibility that the defendant hospital had market power in spite of the fact that it serviced roughly 30 percent of the relevant market. Subsequent opinions from lower courts have tended to adhere to this 30 percent "rule of thumb." See, e.g., United States v. Eastman Kodak Co., 63 F.3d 95 (2d Cir. 1995) (30 percent share of U.S. photocopying market too small to give rise to inference of market power); New York v. Anheuser-Busch, Inc., 811 F. Supp. 848 (E.D.N.Y. 1993) (40 percent market share insufficient to show market power in light of low barriers to entry); Manufacturer's Supply Co. v. Minnesota Mining & Manufacturing Co., 688 F. Supp. 303 (W.D. Mich. 1988) (25.8 percent market share insufficient to show market power).

B. Limitations on Size of Physician Negotiating Group

Section (g)(6) of the Senate Bill 37 states that an authorized third party "may not represent more than 30 percent of the market of practicing physicians in the geographic service area or proposed geographic service area if the health benefit plan has less than a five percent market share." In addition, Section (g)(7) authorizes the Attorney General to limit the percentage of practicing physicians represented by an authorized third party. However, the Attorney General may not impose a limit of "less than 30 percent of the market of practicing physicians" and may not impose any limit at all if "the market of practicing physicians . . . consists of 40 or fewer individuals." *Id.*

These limitations on the size of the physician group authorized to collectively bargain are also unlikely to adequately protect consumers. First, the 30 percent limitation applies only in those cases in which the health plan has a very small share of the (potentially ill-defined) market. Furthermore, the 30 percent limit appears to contemplate a percentage of all physicians and, if so, it would not necessarily prevent aggregation of a large portion of the physicians in a given specialty. Given the high level of specialization among physicians, and the fact that different medical specialty services often are not substitutable, the relevant market for antitrust purposes may be a particular specialty or specialties rather than physicians as a whole. And just as individual specialties may constitute different product markets, relevant geographic markets may differ by specialty.

C. Exclusion of Physician Boycott Conduct

Section (m) of the bill states that the antitrust exemption for physician collective bargaining does not extend to boycott conduct. Specifically, Section (m) states that no provision of the bill should be construed as authorizing "competing physicians to act in concert in response to a report issued by an authorized third party related to the authorized third party's discussion or negotiations with a health benefit plan." It further notes that authorized third parties "shall" inform physicians of Section (m) and "warn them of the potential for legal action against those who violate state or federal antitrust laws." *Id.*

Although this provision is likely to prevent Senate Bill 37 from being used as legal cover for explicit boycott threats, it does not protect consumers from all boycott-related concerns arising from physician collective bargaining. As the Commission has previously observed, collective negotiations can by their very nature convey an implicit threat that, if the health plan does not agree to terms acceptable to the physician group as a whole, it will be prevented from successfully negotiating agreements with the members of the group separately.[19] Furthermore, by

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[19] See Alaska Healthcare Network, Inc., Docket No. C-4007, 2001 WL 443471 (F.T.C. Apr. 25, 2001) ("Payors believed that they could not go around [Alaska Healthcare Network] to contract individually with physicians in Fairbanks, and thus that they had no alternative but to reach agreement with AHN or to give up their planned entry into Fairbanks."). See also

immunizing agreements among competing physicians on the fees and other terms they will accept from health plans, the bill facilitates coordinated conduct – such as collusive refusals to deal – that, even though not immune, would be difficult to detect and prosecute.

III. State Action Immunity

Under the judicially-created "state action" doctrine, a state may override the national policy favoring competition only where it expressly decides to govern aspects of its economy by state regulation rather than market forces. A state may not simply authorize private parties to violate the antitrust laws.[20] Instead, it must actually substitute its own active control for the discipline that competition would otherwise provide. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct.[21]

Senate Bill 37 faces severe difficulties under the "active supervision" prong of that test. In order for state supervision to be adequate for state action purposes, state officials must "have and exercise ultimate authority over the challenged anticompetitive conduct."[22] Senate Bill 37 falls far short of providing the "pointed reexamination"[23] of private anticompetitive conduct necessary to confer antitrust immunity.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own."[24] Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state

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Michigan State Medical Society, 101 F.T.C. 191, 296 n.32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations).

[20] See Parker v. Brown, 317 U.S. 341, 351 (1943) ("a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or declaring that their action is lawful").

[21] See California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 92 (1980).

[22] Patrick v. Burget, 486 U.S. 94, 100 (1988).

[23] Midcal, 445 U.S. at 105-06.

[24] Patrick, 486 U.S. at 106.

intervention, not simply by agreement among private parties."[25] In this instance, the bill does not appear to provide the Attorney General with the means to exercise sufficient independent judgment and control.

Lack of Active Supervision

The regulatory scheme established by Senate Bill 37 endeavors to provide state supervision of physician collective bargaining by authorizing the Attorney General to approve or disapprove: (1) the composition of a physician collective bargaining group, (2) a brief report on any proposed collective negotiations, and (3) a contract that was the subject of collective bargaining. The Attorney General's role is limited in significant respects, however, making it unlikely that the regulatory scheme would be found to provide the level of active supervision required to confer antitrust immunity.

1. Review of Composition of Physician Groups

The power to approve or disapprove the composition of a physician collective bargaining group is provided by Section (g)(7). This provision states that the Attorney General may limit the percentage of physicians represented by an authorized third party, but that the limitation "may not be less than 30 percent of the market." Furthermore, the Attorney General "shall" consider the potential competitive benefits and anticompetitive effects described in Sections (k) and (l). The Attorney General has no power to impose such limitations when the market of practicing physicians consists of "40 or fewer individuals."

The Supreme Court has emphasized that active supervision requires that state officials "*have and exercise* power to review *particular anticompetitive acts* of private parties and disapprove those that fail to accord with state policy."[26] The Attorney General's limited review of bargaining groups at the formation stage, under Section (g)(7), would not amount to active supervision of "particular anticompetitive acts." Indeed, in a market of "40 or fewer individuals," the Attorney General has no authority whatsoever to review the composition of physician groups. This loophole may be particularly significant in a state like Alaska which, due to its population and its large geographic area, may have a large number of physician specialty markets consisting of 40 or fewer providers.

2. Review of "Brief Report" on Proposed Negotiations

The power to approve or disapprove a "brief report" on any proposed collective negotiations is provided by Section (h)(1)(B). This provision appears to provide the Attorney General with authority to disapprove proposed negotiations if the physician group is found to be

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[25] Federal Trade Commission v. Ticor Title Insurance Co., 504 U.S. 621, 634-35 (1992).

[26] Id. at 634 (emphases added).

"not appropriate to represent the interests involved in the proposed negotiations."[27] It is unclear, however, what authority this actually would confer, or how the Attorney General could make such an assessment on the basis of the limited information that the third party representative is required to submit. The report would describe the proposed subject matter of the negotiations and a statement of the expected efficiencies or benefits, but it would not supply a wide variety of information that would enable the Attorney General to assess the likely competitive effects of the negotiations. Further, there is no provision for the Attorney General to require submission of additional information, nor any mechanism by which to receive input from other physicians, affected health plans, or patients.

3. Review of Collectively Negotiated Contracts

The power to approve or disapprove a contract that was the subject of collective bargaining is provided by Sections (i) and (j). Section (i) states that the Attorney General "shall" either approve or disapprove a contract "within 30 days after receiving the reports required under (h)." During that brief period of time, the Attorney General is to attempt to ascertain whether "the competitive and other benefits of the contract terms outweigh any anticompetitive effects." Lists of competitive benefits and anticompetitive effects that the Attorney General "may" consider are provided in Sections (k) and (1), respectively.

These provisions have two principal defects that are likely to vitiate the active supervision required by the state action doctrine: (1) the Attorney General is presented with insufficient information, and (2) the Attorney General is given insufficient time. Additionally, a provision requiring a written decision for both contract approvals and disapprovals would help to ensure that adequate information is both sought and reviewed.

(a) Insufficient Information

In order for state action immunity to apply, Supreme Court precedent requires the State to "undertake[] the necessary steps to determine the specifics of the ratesetting scheme."[28] Senate Bill 37 falls far short of providing the information necessary for state officials to make such a determination. Moreover, what little information is provided is all at the initiative of third parties. The bill does not authorize the Attorney General to request or gather specific additional

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[27] The Attorney General may not approve the report if: (1) the group of physicians "is not appropriate to represent the interests involved in the negotiations" (a provision seemingly redundant with Section (g)(7), discussed above), or (2) the proposed negotiations "exceed the authority granted in this chapter." If either of these conditions is satisfied, the Attorney General "shall" enter an order "prohibiting the collective negotiations from proceeding."

[28] Ticor, 504 U.S. at 638.

information of any kind.[29]

The "brief report" would contain the "proposed subject matter" of the negotiations and one party's "explanation of the [expected] efficiencies or benefits." Notably absent from the "brief report" is a wide variety of information that would assist the Attorney General in assessing the likely competitive effects of the negotiations. An Attorney General armed with greater information – including, for example, information concerning product and geographic market definition, current price levels, availability of substitutes, or ease of entry for new competing physicians – would, of course, be better able to make appropriate determinations. An equally troubling omission from the process is any mechanism by which to receive input from other physicians, affected health benefit plans, or patients. Indeed, the process provides no notice to any of these groups, and so no means for them even to be aware of the potential value of their input.

To attempt to ascertain credibly whether "the competitive and other benefits of the contract terms outweigh any anticompetitive effects" – the core stated criterion of the Attorney General's review – without sufficient data, or adequate input from other parties, would be extremely difficult. Making judgments about competitive effects is the Commission's core function. To carry out this function, the Commission employs a large staff of lawyers and economists, who rely on information gathered from the careful review of a complete documentary record and interviews of numerous key witnesses. "Active supervision" need not necessarily entail the same exhaustive examination but, at the very least, it should constitute a pointed and meaningful review.

In addition, Section (h)(3) requires an authorized third party to provide the Attorney General with all communications "to be made to physicians" related to negotiations. This requirement, however, omits at least four additional categories of potentially critical competitive information: (1) communications from physicians to authorized third parties, (2) communications

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[29] Courts have tended to reject claims of state action immunity where state officials lacked sufficient information to conduct a meaningful review of the private conduct. See, e.g., Ticor Title Insurance Co. v. Federal Trade Commission, 998 F.2d 1129, 1140 (3d Cir. 1993) (finding lack of state supervision where Connecticut never obtained necessary information that would have enabled it to assess the appropriateness of filed rates). In contrast, courts have tended to accept such claims where the review included hearings and an opportunity for potentially affected parties to be heard. See, e.g., TEC Cogeneration Inc. v. Florida Power & Light Co., 76 F.3d 1560 (11th Cir.), amended in part, 86 F.3d 1028 (11th Cir. 1996) (rates determined by Public Service Commission rulemaking and subject to extensive agency proceedings); DFW Metro Line Services v. Southwestern Bell Telephone, 988 F.2d 601, 606-07 (5th Cir. 1993) (Public Utility Commission conducted both broad-based ratemaking proceedings and adjudications of specific complaints about the reasonableness of rates); Lease Lights, Inc. v. Public Serv. Co., 849 F.2d 1330, 1334-35 (10th Cir. 1988) (state held public hearings to assess reasonableness of rates).

from authorized third parties to health plans, (3) communications between physicians, and (4) communications between authorized third parties.

It is worth noting that the core conduct at issue here, naked price-fixing among horizontal competitors, is deemed to be *per se* illegal precisely because the law presumes that in almost no circumstances imaginable will the benefits "outweigh any anticompetitive effects."[30] To be able to attempt such a judgment, the Attorney General needs to be able to review the relevant information.

(b) Insufficient Time

The law of active supervision requires that the Attorney General have and exercise "independent judgment and control" sufficient to render the challenged conduct effectively that of the State and not that of private parties. Yet Section (i) allows only 30 days for the Attorney General to review the facts and render a decision about the anticompetitive effects of a given contract. The time period is mandatory ("shall either approve or disapprove . . . within 30 days") and there is no provision for extension.[31] It is by no means clear that the Attorney General could complete the "pointed reexamination" required to immunize the underlying physician conduct in such a short time.

IV. Transparency

Section (i) of Senate Bill 37 provides that "[i]f the contract is disapproved, the attorney general shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures that would correct any identified deficiencies." Notably, the bill contains no complementary provision requiring a written decision to *approve* a proposed contract. A written decision, expressly considering the potentially anticompetitive implications of a proposed contract and attempting to quantify the consumer impact and expected effect on consumer prices, would serve a number of salutary purposes. First, it would inform affected parties of the levels at which prices were being fixed, and so provide an opportunity for comment or challenge as to the appropriateness of those levels. Second, it would help inform the public of the likely impact of the proposed contract on their health care costs.

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[30] See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (holding naked horizontal price-fixing among physicians to be per se illegal).

[31] In addition, the current legislative draft is ambiguous as to when the 30-day clock commences. Section (i) allows 30 days from receipt of "the reports required under section (h)," without specifying which report – the "brief report," the "copy of all communications," or the contract itself.

Under the current draft, an explanation is required only when the Attorney General disapproves a contract. From a consumer perspective, however, disapproval of a contract is the less troubling result. Disapproval indicates that market forces will continue to govern, whereas approval indicates that they will be temporarily suspended, with a potentially adverse impact on price and access. It is the latter situation that more clearly warrants an explanation and is more properly subject to consumer scrutiny.

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In sum, the proposed antitrust exemption for physician collective bargaining is likely to result in increased consumer costs and threatens to reduce access to care. Furthermore, the risk of consumer harm does not appear to be offset by any substantial procompetitive benefits or increased quality of care.

Parties claiming immunity under the state action doctrine bear the burden of establishing their entitlement to such immunity. If the Alaska Legislature were to enact a bill that fails to provide for the level of active supervision required by Supreme Court precedent, physicians relying on the bill's provisions to confer antitrust immunity would risk exposure to potentially significant financial liability for their actions.

Thank you for your inquiry. We hope you find these comments helpful. Should you have any additional questions, please feel free to contact Jeff Brennan at (202) 326-3688.

Sincerely,

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Prepared Statement
of the
Federal Trade Commission

Presented by

Robert Pitofsky, Chairman (1)
Federal Trade Commission

Before The
Committee on the Judiciary
United States House of Representatives

Concerning H.R. 1304
the "Quality Health-Care Coalition Act of 1999"

June 22, 1999

Mr. Chairman, the Federal Trade Commission thanks you and the members of the Committee for inviting us again this year to present the Commission's views on a proposed antitrust exemption to allow physicians and other health care professionals to engage in collective bargaining with health plans. The basic effect of this year's bill is the same as last year's proposal: to grant independent health care practitioners the right to agree on the fees and other terms that they will accept from insurers, employers, and other third party payers, and to boycott payers who refuse to accept their demands. This year's version, however, makes clear that the immunity would apply not just to doctors, but also to pharmacists and others who supply health care products or services. The Commission continues to believe that such an exemption would be bad medicine for consumers. The issues that have been raised regarding patient protection are vitally important, but this proposal is not the way to address them.

H.R. 1304 would create a broad antitrust exemption that would, for example, allow all of the physicians in a particular medical specialty in an area to demand a 20% increase in fees and to refuse to contract with any insurer who refused to pay those rates. The example mentioned above is not a mere hypothetical. The Commission's staff currently has an investigation into just such conduct. Nor is this an isolated case. The Commission has brought numerous actions challenging similar activities.(2)

The bill, while appealing in its apparent simplicity, threatens to cause serious harm to consumers, to employers, and to federal, state, and local governments:

- Doctors and other health care professionals could join together to demand substantially higher fees.
- Pharmacists could insist on higher payments for filling prescriptions. The bill apparently would permit even large chain pharmacies, such as CVS and Rite Aid, to get together and demand higher prices.
- Consumers and employers, including government employers, would face higher insurance premiums.

- Consumers would pay more out-of-pocket and could see their benefits reduced.
- Medicaid programs that provide services through managed care plans could be forced to increase their budgets or reduce services.
- The number of uninsured Americans, and the costs borne by state and local governments in providing for their care, could increase significantly.

Supporters of the bill argue that giving this kind of unrestrained power to private competitors is needed because of concerns about the changes taking place in our nation's health care system. That significant changes are occurring is beyond dispute. Efforts by private employers and government health care programs to address rapidly increasing health care costs have transformed health service markets. Many doctors are concerned about their ability to care for their patients in the way they believe is best. Many patients are dissatisfied with the services they have received from their health plans; others are worried about the availability and quality of services should they become seriously ill. Press reports of apparent abusive practices by some health plans abound. But even though there are serious problems concerning the relationship of HMOs and other health plans to doctors and patients that deserve to be addressed, this proposal is the wrong approach.

What do we mean by this? An across-the-board antitrust exemption would allow all doctors in a community or all members of a particular specialty - for example, specialists already compensated at $150,000 to $200,000 a year, not to mention pharmacists who work for large corporate pharmacies -- to band together and insist that they be paid an additional 10 or 20%. Although H.R. 1304 is presented as an extension of the antitrust immunity granted to labor organizations, the circumstances here are surely very different from the context in which the labor exemption was originally adopted by Congress.

The Commission's opposition to the proposed exemption is not based on any policy preference for HMOs over fee-for-service medicine, or on an assumption that the market, if left alone, will cure all problems. Nor does it reflect a lack of concern about the special characteristics of health care markets, or disregard for the strong sense of responsibility that medical practitioners feel for the welfare of their patients. Rather, our opposition is based on the Commission's experience investigating the impact on consumers of numerous instances of collective bargaining by independent health care practitioners.

The bill's stated purpose is to promote the quality of patient care. Collective bargaining by health care professionals, however, does not ensure better care for patients. Two broad-based commissions recently studied changes in the health care system and recommended numerous measures to protect consumers and promote quality. But neither suggested that antitrust immunity was appropriate or desirable.(3) The Commission believes that measures designed to increase the power of consumer choice will serve patients, and our nation as a whole, far better than giving providers the collective power to dictate what choices -- and, significantly, what prices -- will be available in the marketplace. Government can play an important role in creating the conditions for effective competition in health care markets, and in addressing specific abuses through targeted regulation.

The Bill Would Grant Broad Antitrust Immunity For Price Fixing, Boycotts, And Other Anticompetitive Conduct

H.R. 1304, like the proposal before the Committee last year, would create a broad antitrust

exemption for price fixing and boycotts by physicians, dentists, pharmacists, and other health care professionals. To understand the types of activity that this bill would legalize, one need only refer to the record of antitrust law enforcement over the past two decades. The Commission, the Department of Justice, and state attorneys general have brought numerous actions challenging price fixing and boycotts by health care professionals who sought to obtain higher fees or more favorable reimbursement terms from third party payers. For example, the Commission's early case against the Michigan State Medical Society(4) challenged the Society's formation of a "negotiating committee" that orchestrated boycotts of the state Blue Shield plan and the state Medicaid program in order to promote the reimbursement policies that the Society preferred. Among other things, the Society opposed vision and hearing care benefits plans negotiated by the United Auto Workers union, because these programs provided for different reimbursement levels for participating and nonparticipating providers.(5)

More recently, the Commission issued a consent order settling charges that a group of physicians in Danville, Virginia, agreed on reimbursement rates and other terms of dealing with third-party payers, agreed to boycott payers that did not meet those terms, and thereby succeeded in obstructing the entry of new health care plans into its area.(6) One of the victims of the boycott was a health plan established by Virginia to cover state employees. The Commonwealth of Virginia jointly investigated the case with FTC staff, and collected $170,000 in penalties and damages for the increased costs it had to bear in providing health benefits to its employees.(7)

The Commission's most recent challenge to providers' collective negotiation with health plans involved a group of independent physicians that included between 70 and 80% of the doctors in the Lake Tahoe area. According to the complaint, the doctors negotiated collectively with all health plans in the area, and forced the plans to either accept rates much higher than those paid in other parts of California or Nevada, or abandon plans to contract with doctors in the area. The physicians asked Blue Shield of California to raise its premiums to fund increased payments to doctors, and concertedly terminated their participation agreements with Blue Shield when it did not comply with their demands.(8)

These are just a few examples of actions antitrust enforcers have blocked - actions that meant higher prices for consumers without any guarantee of improved patient care. There are many more.(9) The immediate effect of H.R. 1304 would be to allow such anticompetitive conduct to proceed unchallenged, and it may encourage health care professionals to undertake such actions.

The bill also could permit physicians to collectively demand terms from health plans that would disadvantage allied health care providers or other alternatives to prevailing modes of medical practice. The collective judgment of health care professionals concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace. The Commission has taken enforcement action in cases in which provider groups sought to impede practice by competing alternatives by, for example, denying, delaying, or limiting hospital privileges of non-physician providers(10) or physicians providing services through innovative arrangements, such as the Cleveland Clinic's integrated multi-specialty group practice.(11) Other cases illustrate how groups of professionals have attempted to secure health plan payment policies that disadvantage their

competitors.[12] Although it was suggested at last year's hearing that the legislation would not grant antitrust immunity to agreements between doctors and health plans that disadvantaged competing providers, but would protect only agreements among physicians on what terms they will accept from plans, it is not clear that the courts would interpret the law in that way.[13]

The differences between this year's bill and last year's do nothing to reduce the Commission's concerns about the potential harm to consumers. Indeed, the changes primarily broaden rather than limit the bill's scope. The current version includes an expansive definition of "health care professional" that appears designed to encompass a sweeping array of individuals who provide health care products or services. This year's bill also makes clear that state, as well as federal, antitrust enforcement would be displaced. In addition, although the current bill excludes the "collective cessation of service to patients" from its protections, this limitation takes virtually nothing away from the coercive power the bill grants to providers. The bill continues to permit physicians and others to collectively refuse to deal with a health plan that refuses their demands for higher fees. If a plan failed to accede to those demands, and the group refused to contract, the plan could be forced from the market,[14] or patients would be left to pay their medical bills out of their own pockets.[15] Thus, although providers could not collectively refuse to treat patients, their collective refusal to contract with a plan could impose formidable financial obstacles to patients seeking care.

Although styled as a labor exemption, the antitrust immunity that H.R. 1304 would confer has little to do with established labor law and policy. The labor exemption *already* applies to health care professionals under the same standards that apply in other sectors of the economy; that is, physicians who are employees (for example, of hospitals) are already covered by the labor exemption under current law. The labor exemption, however, is limited to the employer-employee context, and it does not protect combinations of independent business people.[16] H.R. 1304 is designed to override the distinction Congress drew in the labor laws between employees and independent contractors, and to allow some independent contractors -- doctors and other health care professionals operating as independent businesses -- to collectively exert economic pressure on health plans to gain higher fees and other, more favorable, terms of dealing.[17] In addition, it grants the exemption without providing for any oversight of the collective bargaining process by the National Labor Relations Board.

Moreover, this extension of the labor exemption is being offered as a way to remedy matters that collective bargaining was never intended to address. The stated goal of this bill is to promote the quality of patient care. The labor exemption, however, was not created to solve issues regarding the ultimate quality of products or services that consumers receive. Collective bargaining rights are designed to raise the incomes and improve working conditions of union members. The law protects the United Auto Workers' right to bargain for higher wages and better working conditions, but we do not rely on the UAW to bargain for safer cars. Congress addressed those concerns in other ways. The patient care issues raised by supporters of the bill deserve serious attention, but an ill-fitting labor exemption is the wrong approach.

II. The Exemption Would Harm Consumers

It is undisputed that the immediate effect of H.R. 1304 would be to permit all doctors in a community -- indeed, all health care professionals - to bargain collectively with all health plans that contract with independent health practitioners. It would permit those practitioners to demand much higher fees for their services, and to refuse collectively to contract with plans that did not meet those demands. What is disputed is the impact the bill would have on consumers.

At last year's hearing, there was much discussion about hypotheticals and theoretically-possible results. The Commission believes, however, that past experience is a more reliable guide to what is likely to happen when health care practitioners collectively bargain with health plans. That experience suggests that the proposed exemption presents substantial risks of harm to consumers, private and governmental purchasers of health care, and taxpayers who ultimately foot the bill for government-sponsored health care programs.

A. The Exemption Would Raise Costs And Threatens To Reduce Access To Care

Without antitrust enforcement to block price fixing and boycotts designed to increase health plan payments to health care professionals, we can expect prices for health care services to rise substantially. Health plans would have few alternatives to accepting the collective demands of health care providers for higher fees. The effect of the bill, however, would not simply be on the health plans and employers that are forced to pay higher prices to health care practitioners, but can be expected to extend to various parties, and in various ways, throughout the health care system:

- Consumers and employers would face higher prices for health insurance coverage.
- Consumers also would face higher out-of-pocket expenses as copayments and other unreimbursed expenses increased.
- Consumers might face a reduction in benefits as costs increased.
- Senior citizens participating in Medicare HMOs would face reduced benefits, because Medicare pays these HMOs a fixed amount per enrollee. Higher fees for professional services means health plans would have fewer dollars available to pay for prescription drug coverage and other benefits that are not available under traditional Medicare but currently are provided by many Medicare HMOs.
- The federal government would pay more for health coverage for its employees through the Federal Employees Health Benefits Program and military health programs.
- State and local governments would incur higher costs to provide health benefits to their employees.
- State Medicaid programs attempting to use managed care strategies to serve their beneficiaries could have to increase their budgets, cut optional benefits, or reduce the number of beneficiaries covered.
- State and local programs providing care for the uninsured would be further strained, because, by making health insurance coverage more costly, the bill threatens to increase the already sizable portion of the population that is uninsured.

These widespread effects are not simply theoretical possibilities. The record of antitrust law enforcement sets forth the impact of collective "negotiations" on the public. For example, as described in the Commission's complaints, collective bargaining by anesthesiologists in

Rochester, New York, and by obstetricians in Jacksonville, Florida, forced health plans to raise their reimbursement, and the result was increased premiums for the HMOs' subscribers.[18] Other cases have challenged actions by associations of pharmacists who succeeded in forcing state and local governments to raise reimbursement levels paid under their employee prescription drug plans.[19] In one such case, an administrative law judge found that the collective fee demands of pharmacists cost the State of New York an estimated $7 million.[20]

By raising health care costs and making health insurance less affordable, the exemption threatens to increase the number of uninsured and thus reduce access to care. A 1997 report by the General Accounting Office concluded that a major reason for declining private health coverage is the rising cost of health insurance. Higher insurance costs affect employers' decisions whether to offer health benefits and employees' decisions whether to purchase coverage.[21] In a country where 43.4 million people did not have health insurance in 1997 (1.7 million more than in 1996), any development that threatens to increase the proportion of the population that is uninsured is cause for serious concern.

B. There Is No Support For Claims That Consumer Costs Would Not Increase

In last year's hearing there was acknowledgment that passage of the bill could result in higher payments to health professionals. There has been a suggestion that fee increases imposed on health plans might not be passed on to consumers, but could simply reduce health plan profits. Such a result is unlikely. Fees for professional services account for almost one-half of private insurance payments for health services and supplies.[22] If these costs increase significantly, the most logical assumption is that costs to consumers would go up substantially. Relying on an assumption that higher costs will not be passed on to consumers puts consumers at risk of serious harm. Economic theory predicts that a significant industry-wide increase in input costs will ordinarily raise the price of the final product.[23] Moreover, as noted above, our enforcement actions provide numerous examples in which health care professionals' collective demands for higher fees resulted in higher costs to consumers and to government purchasers.

Arguments that consumers would not be harmed by an antitrust exemption for collective bargaining by independent health care professionals appear to rest on assertions that the bill would balance the bargaining power between health care professionals and health plans. These assertions, however, are incorrect. The bill would permit doctors to create monopolies. On the health plan side of the ledger, the evidence does not support the suggestion that most (or even many) areas have only one or two health plans. A November 1998 letter to Chairman Hyde from Chairman Pitofsky discussed in greater length than is possible here the available information on the extent to which health plans have market power in individual geographic areas. That information indicates that health plan markets vary widely, and simply does not support suggestions that most markets have little or no health plan competition. For example, individual HMOs typically face considerable competition from other HMOs.[24] Data on HMO penetration published in June 1998 show that areas in which HMOs as a group have the largest collective market share tend to have a larger number of individual HMOs in operation and more competitive HMO markets.[25] Of course, HMOs also face competition from other types of health plans, such as preferred

provider organizations ("PPOs").[26]

Nor does the recent number of highly publicized mergers among commercial health plans suggest that most markets are likely to have only one or two health plans in the future. The Commission and the Department of Justice review these transactions, and we have investigated those that appeared to raise competitive concerns. The Commission is committed to preserving competition in the market for health plans, as in all markets, and if a proposed transaction appeared likely to create market power, we would challenge it.

Arguments about equalizing bargaining power also rest on unsupported assertions that the McCarran-Ferguson Act gives insurance companies leverage in bargaining with health care professionals. Although McCarran-Ferguson protects certain types of activities by insurers (to the extent that such activity is regulated by state law), the Supreme Court has held an insurance company's agreements with providers on the fees they will be paid are not "the business of insurance" and thus are not covered by the McCarran-Ferguson immunity.[27] It seems clear, therefore, that collusion among insurers on such agreements likewise would not be protected by the Act. In fact, complaints about health plans wielding power over doctors appear to have nothing to do with McCarran-Ferguson or with any statutorily-protected collusion among insurers. We know of no evidence of insurers colluding in setting fees or other terms of dealing with providers, and the Commission does not believe that McCarran would protect such conduct. Rather, the complaints revolve around the size and power of individual insurers relative to individual health professionals.

There is undoubtedly a bargaining imbalance between an individual physician in solo practice and an insurance company. Bargaining imbalances between parties to a commercial transaction are not uncommon in our economy. But the suggestion that this bill would not impose higher costs on consumers and others -- on the ground that the exemption would merely create a countervailing monopoly -- is premised on theoretical arguments about market conditions that do not describe most health care markets. These speculative arguments provide no assurance that the bill's effect would not be a dramatic inflation in health care costs.

C. No Antitrust Exemption Is Needed To Allow Professional Societies And Others To Discuss Their Concerns About Actions By Health Plans

In the debate over this proposed exemption, we frequently hear arguments that the antitrust laws prevent physicians from being effective advocates for their patients. Indeed, it is often suggested that any effort by physicians to talk among themselves or with plans about concerns regarding health plans' practices would violate the antitrust laws. That is simply not the case. Health care professionals can and do engage in collective advocacy, both to promote the interests of their patients and to express their opinions about other issues, such as payment delays, dispute resolution procedures, and other matters. Health care associations have traditionally played an active role in lobbying legislatures and regulatory bodies, such as state insurance commissions, and presenting issues to the media and the public.

Moreover, the antitrust laws do not prohibit medical societies and other groups from engaging in collective discussions with health plans regarding issues of patient care. Among other things, physicians may collectively explain to a health plan why they think a particular policy or practice is medically unsound, and may present medical or scientific data to

support their views.[28] In fact, physician groups have presented their views on a number of issues to payers. For example, the American Medical Association has issued a Model Medical Services Agreement that explains its views on appropriate contract terms and on why other contract terms are inappropriate or harmful. Recent press reports indicate that Aetna U.S. Healthcare has altered some of its contract terms in response to communications from the American Medical Association concerning physician dissatisfaction with the contracts.[29]

The Commission has never brought a case based on physicians' collective advocacy with a health plan on an issue involving patient care. Our cases have addressed instances in which physician groups (1) negotiated collectively on fee levels or other price-related issues, or (2) collectively refused to contract with plans, either to gain acceptance of their price-related demands or to prevent or delay market entry by managed care plans generally. In all such cases, the Commission has been very careful to make sure that its orders do not interfere with the legitimate exchange of information and views between health plans and health care practitioners. Indeed, in the Commission's first litigated case involving collective negotiations by physicians - Michigan State Medical Society - the opinion emphasized that the antitrust laws do not prohibit health care providers' collective provision of information and views to health plans.[30] Specific language was inserted in that order, and in subsequent orders, to make it clear that bans on anticompetitive agreements among competing providers do not prohibit the provision of information and views to health plans concerning any issue, including reimbursement.[31]

III. There Are Better Ways To Protect Consumers

For all the reasons set forth above, the Commission believes the proposed antitrust exemption is the wrong approach to solving concerns about patient care, and that it threatens serious harm to consumers. The Commission recognizes the serious concerns that have been raised regarding the current operation of health care markets. We do not suggest that the market is performing as well as it could, or that the market can or will cure all of the problems that concern this Committee. But recent efforts to examine health care markets, such as the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, have produced a variety of concrete proposals for reform. As antitrust enforcers, we do not seek to endorse any specific proposal. We note, however, that these studies recommend a number of ways to improve quality and protect consumers, and they do not recommend antitrust immunity or collective bargaining rights for providers.

Proposals for reform include:

Increasing Consumers' Ability To Choose Their Health Plan.

A fundamental concern expressed by health policymakers -- and by members of this Committee at last year's hearing -- is that many consumers lack a choice among different types of health plans. Most consumers obtain health care coverage as a benefit of employment, and many employers offer only one plan. Consumers have different views about many aspects of health care service delivery, including the types of settings in which they want to receive health care, the kinds of services and health practitioners to which they want access, how much they are willing to pay for health insurance, and the value they

attach to broader choices among providers.[32] Offering consumers a choice can help make health plans more responsive to consumer preferences. Consumer choice can be increased, for example, by regulatory changes making it easier for small employers to participate in purchasing pools that can offer individuals a choice of health plans.[33]

Increased consumer choice among health plans also would be good for doctors. Patients who can choose among plans are less likely to have to switch doctors when the employer changes the health plan that is offered, with the result that doctors likely would feel less pressure to participate in a large number of plans in order to retain access to their patients.

Improving Consumer Information.

Several proposals would require health plans to disclose various kinds of information, including limits on coverage, use of drug formularies, how procedures and drugs are deemed experimental, and the types and extent of dispute resolution procedures. In addition, work also is underway to develop ways of presenting consumers with comprehensive comparative quality and performance information about health plans, to better inform their decision-making.[34]

The Commission's Bureau of Consumer Protection has been active in efforts to improve the information available to consumers through a federal interagency task force on health care quality (the Quality Interagency Coordinating Task Force). The consumer information committee of this group is working on ways to improve the information that federal health care plans disclose to consumers, and is considering the types of information that should be disclosed, the way the information should be communicated, and development of a common terminology.[36] The Commission's staff is considering other ways that the Commission can help improve the quantity and quality of information about health plans available to consumers.

Regulation of Plan Behavior.

Targeted regulation of certain aspects of health plan behavior may be appropriate in some cases to protect consumers. Numerous bills addressing such things as patients' access to appeal and review mechanisms are under consideration at both the state and federal levels.

The Commission appreciates the desire to avoid detailed federal regulation of health plan behavior and to rely instead on the market. However, the proposed exemption would not let the market work. On the contrary, it would severely limit competition among health professionals and health plans, without any regulatory oversight or other mechanism to protect the public interest.

Conclusion

There are no easy solutions to the problems inherent in the simultaneous pursuit of cost effectiveness, high quality, and wider access to health care services. But allowing doctors and other health care practitioners to fix prices and other contract terms is not the answer. The Commission continues to believe that competition among health care providers and among health plans is an important tool for controlling costs, providing consumer choice,

and promoting innovation and high quality. We counsel strongly against abandonment of competition as a mechanism for promoting a better health care system, and we urge that every effort be made to address concerns about quality and patient care while preserving and strengthening the benefits that competition can provide. The Commission stands ready to help in any way it can.

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1. This written statement represents the views of the Federal Trade Commission. Chairman Pitofsky's oral presentation and responses to questions are his own, and do not necessarily represent the views of the Commission or any other Commissioner.

2. An appendix describing these cases in more detail will be provided under separate cover.

3. *See* President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Quality First: Better Health Care for All Americans (1998); California Managed Health Care Improvement Task Force, Improving Health Care in California (1998).

4. 101 F.T.C. 191 (1983).

5. *Id.* at 234-35.

6. Physicians Group, Inc., 120 F.T.C. 567 (1995) (consent order).

7. *Commonwealth of Virginia v. Physicians Group, Inc.*, 1995-2 Trade Cas. (CCH) ¶ 71,236 (W.D. Va. 1995) (consent decree).

8. North Lake Tahoe Medical Group, Inc., FTC File No. 981-0261, 64 Fed. Reg. 14730 (Mar. 26, 1999) (proposed consent order).

9. *See, e.g.*, Mesa County Physicians Independent Practice Association, Inc., Dkt. No. 9284 (May 4, 1999) (consent order); Asociacion de Farmacias Region de Arecibo, Dkt. No. C-3855 (March 2, 1999) (consent order); Ernesto L. Ramirez Torres, D.M.D., Dkt. No. C-3851 (Feb. 5, 1999) (consent order); M.D. Physicians of Southwest Louisiana, Inc., Dkt. No. C-3824 (Aug. 31, 1998) (consent order); Institutional Pharmacy Network, Dkt. No. C-3822 (Aug. 11, 1998) (consent order); *FTC and Commonwealth of Puerto Rico v. College of Physicians-Surgeons of Puerto Rico*, FTC File No. 971-0011, Civil No. 97-2466-HL (D.P.R. October 2, 1997) (consent decree); Montana Associated Physicians, Inc./Billings Physician Hospital Alliance, Inc., 123 F.T.C. 62 (1997) (consent order); La Asociacion Medica de Puerto Rico, 119 F.T.C. 772 (1995) (consent order); McLean County Chiropractic Association, 117 F.T.C. 396 (1994) (consent order); Baltimore Metropolitan Pharmaceutical Association, Inc. and Maryland Pharmacists Association, 117 F.T.C. 95 (1994) (consent order); Southeast Colorado Pharmacal Association, 116 F.T.C. 51 (1993) (consent order); Peterson Drug Company, 115 F.T.C. 492 (1992); Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order); Patrick S. O'Halloran, M.D., 111 F.T.C. 35 (1988) (consent order); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order); New York State Chiropractic Association, 111 F.T.C. 331 (1988) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order); Preferred Physicians, Inc., 110 F.T.C. 157 (1988) (consent order); Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order).

10. *See, e.g.*, Medical Staff of Memorial Medical Center, 110 F.T.C. 541 (1988) (consent order); North Carolina Orthopaedic Association, 108 F.T.C. 116 (1986) (consent order).

11. *See* Medical Staff of Broward General Medical Center, 114 F.T.C. 542 (1991) (consent order); Medical Staff of Holy Cross Hospital, 114 F.T.C. 555 (1991) (consent order).

12. The Commission challenged an alleged boycott of a health plan by physiatrists (doctors specializing in rehabilitative medicine) that demanded not only higher fees, but also that the plan pay for physical therapy services only if the patient was referred by a physiatrist (rather than a doctor in another specialty). La Asociacion Medica de Puerto Rico, 119 F.T.C. 772 (1995) (consent order). *See also Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (physicians used their control of Blue Shield to impose payment policies that disadvantaged competing clinical psychologists).

The courts have immunized certain agreements arising out of collective bargaining between employers and unions -- the so-called "nonstatutory" or "implicit" labor exemption -- precisely because it was necessary to effectuate the statutory exemption that protects the bargaining and related activities of unions and their members. *See Brown v. Pro Football, Inc.*, 518 U.S. 231, 237 (1996). *See also* P. Areeda and H. Hovenkamp, IA Antitrust Law ¶ 255c at 173 (1997) ("There seems little warrant in labor law or policy for distinguishing most collective bargaining agreements from unilateral union activities to accomplish the same result."). Courts might well find similar logic supports immunizing many agreements arising from the collective bargaining protected by H.R. 1304, including not only agreements about wages, but also agreements that preserve the ability of physicians to work free from competition by nonphysicians.

14. Some types of plans are required as a condition of licensure to maintain a network of providers adequate to provide services to their enrollees; thus, the inability to establish a satisfactory network would force such a plan to leave the market (or prevent it from entering).

15. Enrollees of HMOs would have to pay out of pocket the full cost of services obtained from non-network providers. PPO enrollees who see non-network providers would have to pay any amount by which the providers' billed charges exceeded the plan's payment allowance. In addition, they likely would have to pay the full charge at the time of service, file a claim for payment, and wait to be reimbursed by the plan, instead of simply paying the copayment and relying on the doctor to collect the remainder of the fee directly from the insurance company.

16. *Columbia River Packers Ass'n v. Hinton*, 315 U.S. 143 (1942). *Accord, Los Angeles Meat and Provision Drivers Union v. United States*, 371 U.S. 94 (1962); *United States v. National Ass'n of Real Estate Boards*, 339 U.S. 485 (1950); *United States v. Women's Sportswear Mfg. Ass'n*, 336 U.S. 460 (1949); *American Medical Ass'n v. United States*, 317 U.S. 519, 533-36 (1943) (rejecting assertions that the labor exemption to the antitrust laws applied to joint efforts by independent physicians and their professional associations to boycott an HMO in order to force it to cease operating).

17. This distinction between employees and independent contractors is fundamental to the labor relations scheme established by Congress. NLRA Section 2(3) gives the right to bargain collectively only to "employees." The 1947 Taft-Hartley amendments to the NLRA included a provision expressly stating that the term "employee" does not include "any individual having the status of an independent contractor." 29 U.S.C. § 152(3). The House Report accompanying the amendment stated:

> In the law, there always has been a difference, and a big difference, between "employees" and "independent contractors." "Employees" work for wages or salaries under direct supervision. "Independent contractors" undertake to do a job for a price, decide how the work will be done, usually hire others to do the work, and depend for their income not upon wages, but upon the difference between what they pay for goods, materials, and labor and what they receive for the end result, that is, upon profits.

H.R. Rep. No. 245, 80th Cong., 1st Sess. 18 (1947). Just last month, the NLRB Regional Director in Philadelphia decided, after having held 14 days of hearings, that network doctors of a New Jersey HMO were independent contractors rather than employees within the meaning of the NLRA. AmeriHealth Inc./AmeriHealth HMO and United Food and Commercial Workers Union, Case 4-RC-19260 (NLRB 4th Region, May 24, 1999).

18. Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

19. *See, e.g.*, Baltimore Metropolitan Pharmaceutical Association, Inc. and Maryland Pharmacists Association, 117 F.T.C. 95 (1994) (consent order); Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

20. *See* Peterson Drug Company, 115 F.T.C. 492, 540 (1992). *See also* Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

21. United States General Accounting Office, "Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures" 2-3 (GAO/HEHS-97-122) (July 1997). A more recent study also concluded that the increase in the proportion of workers who are not covered by private health insurance, from 15.1% in 1979 to 23.3% in 1995, was due in large part to per capita health care spending rising much more rapidly than personal income during the period. (Per capita health spending divided by median income rose from 4.5% in 1979 to 7.3% in 1995.) Kronick & Gilmer, "Explaining The Decline in Health Insurance Coverage, 1979-1995," 18:2 Health Affairs 30 (March/April 1999). Another study reported that in 1997, 2.5 million people refused to accept employer-sponsored health insurance coverage for which they were eligible, even though they had no other source of coverage. Sixty-eight percent of these employees reported that the high cost of health insurance was the reason they rejected the coverage. Thorpe & Florence, "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997," 18:2 Health Affairs 213 (March/April 1999). See also Findlay & Miller, "Down a Dangerous Path: The Erosion of Health Insurance Coverage in the United States" (May 1999).

22. In 1997, private insurance paid $109.1 billion for physician services, and an additional $43.2 billion for dental and other professional services. This amounts to about 44 % of total private insurance payments, and about 49% of private insurance payments for health services and supplies. National Health Expenditures 1997, Table 3 (found at *www.hcfa.gov/stats/nhe-oact/tables/t11.htm*).

23. A study published last year concluded that, although health care costs and health insurance premiums did not increase at identical rates on a year-to-year basis in recent years, "over a slightly longer period, the dominant influence on premiums is underlying costs" of health care products and services. Ginsberg & Gabel, "Tracking Health Care Costs: What's New in 1998," 17:5 Health Affairs 141, 145 (Sept./Oct. 1998).

24. Information on HMOs' market shares is most readily available.

25. *See* The InterStudy Competitive Edge, *Regional Market Analysis 8.1* (June 1998).

26. Indeed, in 1997 the percentage of workers in traditional HMOs fell from 33 to 30%, while the percentage enrolled in PPOs and point of service plans rose. *See* "Wall Street Verbatim; Wider Networks Need Not Drive New Cost Explosion," Medicine & Health (June 22, 1998).

27. *Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *see also Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

28. The statements of antitrust enforcement policy issued by the Commission and the Department of Justice create an antitrust safety zone for health care providers' collective provision of non-fee-related information to health plans. *See* Statements of Antitrust Enforcement Policy in Health Care 40, 4 Trade Reg. Rep. (CCH) ¶13,151 (Aug.1996) (available at *www.ftc.gov/reports/hlth3s.htm*).

29. "Aetna's U.S. Healthcare Unit Revamps Doctors' Contracts After AMA Criticism," Wall Street Journal B10 (Oct. 20, 1998).

30. 101 F.T.C. at 302-09.

31. *Id.* at 314; *see also* Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

32. For example, a survey conducted by the Center for Studying Health System Change found large differences in Americans' willingness to trade lower health care costs for limits on choice of providers available in the network, and that many people on both sides of the question had strongly held views. Data Bulletin Number 4 (Fall 1997).

33. Other observers have urged actions to make it possible for much greater numbers of consumers to choose their health plans directly, rather than having their range of choice defined by their employer. The AMA, for example, has proposed moving from an employment-based system of health insurance to a system of individually selected and owned health insurance coverage, in order to permit individuals with varying needs and preferences to choose the plan that suits them best. As the AMA recognizes, such a system depends on competition among various plans on price, plan features, and quality, that will place pressure on plans to operate efficiently and to lower the price of insurance, as well as to be responsive to individual patients' concerns about quality. American Medical Association, "Expanding Access to Insurance Coverage for Health Expenses" (Nov. 1998); American Medical Association, "Rethinking Health Insurance" (Nov. 1998).

34. The Presidential Commission concluded that more active involvement by public and private group purchasers and by consumers in demanding high quality services would increase the industry's ability and willingness to focus on quality improvement. To this end, it recommended development of core sets of quality measures for health plans, institutional providers, and individual practitioners, and making valid, reliable and comprehensive comparative quality information widely available.[35]

35. Report at 3-4.

36. In addition, there are plans to use a government website as a gateway for consumers seeking information on health care quality.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
William J. Baer, Director
Direct Dial
(202) 326-2932

May 13, 1999

The Honorable Rene O. Oliveira
Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Representative Oliveira:

The Bureau of Competition of the Federal Trade Commission is pleased to respond to your request, dated May 5, 1999, for comment on Senate Bill 1468, "An Act Relating to the Regulation of Physician Joint Negotiation" (SB 1468), which currently is being considered by the Texas legislature.[1] The bill would permit competing physicians to jointly negotiate contractual terms with health plans under certain circumstances. Our understanding is that SB 1468 has been adopted by the Texas Senate, and that a vote on a similar measure is expected in the House of Representatives in the very near future. Given the limited time available, we highlight three concerns about the bill, but are not able to provide a complete analysis of all the issues that the bill raises.

The Commission has previously expressed serious concerns about the impact on consumer welfare of a federal proposal to enact an antitrust exemption intended to authorize collective negotiation between health service practitioners and health plans. In testimony before the Committee on the Judiciary of the United States House of Representatives in July 1998, the Commission opposed enactment of H.R. 4277, the "Quality Health-Care Coalition Act of 1998." The Commission stated that the exemption would immunize "a broad range of anticompetitive joint conduct by physicians and other health care professionals that could seriously harm consumers and undermine efforts to promote high-quality, cost-effective health care for consumers." Furthermore, the Commission pointed out, the exemption would impair innovation in health care financing and delivery, and reduce choices among alternative health plans. Finally, the Commission noted that an antitrust exemption is not needed in order to allow physicians collectively to express their concerns about patient care and quality of care issues that may arise from their participation in managed care plans, or to permit them to enter into joint ventures that can offer better alternatives to patients or to health plans. A copy of the Commission's testimony is enclosed for your information.

The bill being considered by the Texas legislature differs from H.R. 4277 in various respects. In contrast to the federal proposal, which would simply provide an antitrust exemption for collective negotiations, SB 1468 requires some oversight of the negotiating process by the Texas Attorney General. In addition, SB 1468 would limit to 10% the proportion of physicians in a geographic area who could negotiate collectively, unless the

Attorney General approved inclusion of a larger number in the group. The bill allows collective negotiation of certain types of fee-related issues only where the Attorney General determines that the health plan has substantial market power.

It is not clear, however, to what extent these differences would reduce the potential for anticompetitive effects otherwise likely to arise from the authorization of collective bargaining among competing physicians. For example, the provision in Section 29.09(b) that no joint negotiation shall represent more than 10% of the licensed physicians in a defined geographic area provides no significant limitation on the aggregation of bargaining power by many types of physician groups. For many medical specialities, a group including *all* the physicians in a particular speciality or subspeciality would constitute less than 10% of all licensed physicians, and their combination in a single bargaining group could give them significant market power over health plans.[2] Although the bill permits the Attorney General to raise or lower the percentage in particular cases, it does not provide any standards to guide the Attorney General's decision. It is unclear, for example, whether the bill's intent is that the Attorney General limit bargaining groups to 10% of a properly defined antitrust market. Without such a limitation, the 10% cap on the size of physician bargaining groups does not protect against the risk of substantial consumer harm.

Second, it is not clear to what extent the bill's use of a health plan market power screen for some types of collective bargaining would limit potential consumer harm. The bill prohibits collective negotiation on certain specified fee-related issues, unless the Attorney General determines that a health plan with which physicians are negotiating possesses "substantial market power." However, the bill provides no standard for determining when substantial market power will be deemed to exist. We are uncertain whether the intent is to have the Attorney General apply established antitrust principles of market power analysis, or whether the reference in the bill's preamble to "imbalances" in bargaining power suggests some other approach that would compare the bargaining power of a plan to that of an individual physician. In addition, the scope of arrangements to which the market power screen applies is limited. For example, negotiating over formulation and application of physician reimbursement methodology is not subject to the requirement that the health plan have substantial market power, though such matters plainly can have a direct and substantial effect on fee levels. Collective negotiation about other "non-price" issues also can have a substantial effect on the cost of services that the plan covers, as well as limiting the options available to plans to meet consumer demand for high-quality and affordable health insurance.

Third, the bill imposes substantial responsibilities on the Attorney General that could be difficult to carry out given the time frames provided in the bill and the fact-intensive nature of the issues. Moreover, we note that the regulatory scheme established by the bill contains no mechanism for members of the public, or others who stand to be affected by the Attorney General's decision, to offer evidence and views pertaining to the costs and benefits of the proposal or any of the underlying issues. In addition, the bill provides little guidance as to how the discretion granted to the Attorney General is to be exercised. For example, section 29.09(b) of the bill directs the Attorney General to approve a request to enter into joint negotiation or a proposed contract if the applicants demonstrate that "the likely benefits resulting from the joint negotiation or proposed contact outweigh the disadvantages attributable to a reduction in competition" that may result, but it provides no criteria to guide the Attorney General in evaluating benefits or disadvantages, or in weighing one against the

other.(3)

We hope you find these comments helpful. Should you have any additional questions concerning this issue, please contact Richard Feinstein at 202-326 3688.

Sincerely yours,

William J. Baer

Enclosure

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1. This letter represents the views of the staff of the Bureau of Competition of the Federal Trade Commission and does not necessarily represent the views of the Commission or any individual Commissioner.

2. Physicians differ as to specialities and these individual specialties may constitute different product markets. Moreover, relevant geographic markets may differ as to specialty.

3. The nature of the oversight actually exercised by the Attorney General is important to the question whether private parties acting pursuant to the statute would be exempt from the federal antitrust laws by virtue of the "state action doctrine." The "state action doctrine" allows a state to override the national policy favoring competition where the state legislature clearly articulates a policy to displace competition with regulation, and state officials actively supervise private anticompetitive conduct. *See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). The active supervision requirement "is designed to ensure that the state action doctrine will shelter only the particular anticompetitive acts of private parties that in the judgment of the State, actually further state regulatory policies." *Patrick v. Burget*, 486 U.S. 94, 100 (1988). The question to be addressed in any individual case, therefore, is "whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S.621, 634-35 (1992). We note in particular that Section 29.09(c) of the bill provides that an approval of the initial filing for authorization to bargain collectively covers all subsequent negotiations between the parties, apparently without regard to whether circumstances have changed such that the subsequent bargaining might no longer qualify for approval.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20589

Bureau of Competition

Richard A. Feinstein
Assistant Director

Direct Dial
(202) 326-3688

October 29, 1999

Robert R. Rigsby
Interim Corporation Counsel
Office of the Corporation Counsel
Government of the District of Columbia
441 Fourth Street, N.W., Tenth Floor North
Washington, D.C. 20001

Re: Physicians Negotiation Act of 1999

Dear Mr. Rigsby:

This letter is a response to your request for comment by Federal Trade Commission staff on the "Physicians Negotiation Act of 1999," Bill No. 13-333 in the District of Columbia Council. This bill is intended to permit competing physicians to engage in collective bargaining with health plans. As is discussed below, the Commission has opposed enactment of a bill currently before Congress, H.R. 1304, that would create an antitrust exemption for collective negotiations between health care providers and health plans. Such an exemption, the Commission stated, will not ensure better care for patients, and threatens to raise health care costs and reduce access to care. In my view, the District of Columbia proposal raises similar concerns.

In addition, it is doubtful that the D.C. bill in its current form would immunize physicians from liability for conduct that violates the federal antitrust laws. State economic regulation can immunize private parties from federal antitrust liability, but only where it satisfies the requirements of the "state action" doctrine. It is unclear whether enactments of the District of Columbia Council would be treated as equivalent to statutes of a state legislature for purposes of the state action doctrine. Moreover, even assuming the Council has the ability to confer state action immunity, the level of governmental involvement called for in the bill falls far short of the "active state supervision" that the Supreme Court has required to displace federal antitrust law.

Background

Antitrust law already allows doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The Federal Trade Commission

and the Department of Justice have issued health care policy statements that emphasize physicians' ability under the antitrust laws to organize networks and other joint arrangements to deal collectively with health plans and other purchasers.(1) In addition, health care professionals can, through their professional societies and other groups, jointly provide information and express opinions to health plans.(2) Legislative proposals to permit collective bargaining by health care professionals, however, such as the one pending in the District of Columbia, seek to authorize conduct that would otherwise constitute unlawful price fixing or other serious antitrust violations.

The Commission's June 1999 testimony on H.R. 1304 before the House Judiciary Committee explains its opposition to creating an antitrust exemption to allow otherwise unlawful collective bargaining by competing health care providers. The Commission's belief that such an exemption could cause serious harm -- to consumers, employers who provide health care coverage for employees, and to federal, state, and local governments -- is based on its experience investigating the effects of numerous instances of collective bargaining by competing health care providers. For example, the Commission, after a joint investigation with the Commonwealth of Virginia, issued a consent order settling charges that a group of physicians in Danville, Virginia, agreed on reimbursement rates and other terms of dealing with health plans, and agreed not to deal with plans that did not meet those terms.(3) The Commonwealth of Virginia collected $170,000 in damages and penalties for the increased costs the state was forced to bear in providing health care benefits to its employees as a result of the physician group's conduct.(4) Likewise, the Commission took enforcement action against collective fee demands by pharmacists in the State of New York that cost the state an estimated $7 million in increased health benefits costs for state employees.(5)

Without antitrust enforcement to block such price fixing, the Commission stated, "we can expect prices for health care services to rise substantially." Raising health care costs and making health insurance less affordable, the testimony observed, threatens to increase the already substantial uninsured population, and thereby reduce access to health care services. In addition, the Commission noted that the exemption could also allow physicians to collectively demand terms from health plans that would make it difficult for consumers to choose to obtain services from allied health care providers, such as nurse-midwives.

The Commission emphasized that immunizing collective bargaining would impose costs without any guarantee that patients' interests in quality care would be served:

> Collective bargaining rights are designed to raise the incomes and improve working conditions of union members. The law protects the United Auto Workers' right to bargain for higher wages and better working conditions, but we do not rely on the UAW to bargain for safer cars. Congress addressed those concerns in other ways.(6)

The Commission's testimony also pointed out that other approaches to improve quality and protect consumers have been proposed that would not sacrifice the benefits of competition by granting collective bargaining rights to health care professionals, and briefly described some of those proposals. A copy of the testimony (Attachment A) is

enclosed for your information.

I am also enclosing a copy of a letter from FTC staff discussing a collective bargaining bill in Texas (Attachment B). The letter notes that the Texas bill, while different in certain respects from the federal proposal, still carries substantial potential for consumer harm.

The District of Columbia Bill

The District of Columbia bill closely follows model state legislation on physician collective negotiations developed by the American Medical Association. In fact, the bill appears to adopt all of the provisions of the AMA model except Section 1, which is a declaration of legislative purpose. I will first discuss a few issues regarding the scope of conduct the bill seeks to authorize, and then analyze the question whether the bill would be effective in creating immunity from federal antitrust law for private parties acting pursuant to its provisions.

The Scope of Permitted Conduct

The collective bargaining permitted by the bill is subject to certain limitations not present in the federal proposal, but these limitations are ambiguous in some important respects. As a result, it is difficult to ascertain the precise scope of conduct that the bill would seek to authorize. In any event, however, the two primary ways that the bill limits collective bargaining -- the market share limitations and the ban on boycotts -- appear to leave consumers at risk of substantial harm.

First, the bill's reach depends in part on market shares of health plans and, to a lesser extent, physician groups. It authorizes collective negotiation with health plans, but negotiation over certain price-related terms is limited to situations in which the health plan has "substantial market power," which, under the bill's terms, exists when a health plan's market share exceeds 15%. In addition, under section 5(f), where a health plan has less than a 5% market share, the physician group may not exceed 30% of physicians (or of a particular physician type or specialty) in the health plan service area.

Although the bill appears to make the concept of market power an important limitation on some forms of collective bargaining, it is unclear how market shares are to be delineated or applied. According to the bill, substantial market power exists if the health plan has a 15% share of any of the following: (1) the number of covered lives as reported by the insurance commissioner; (2) the actual number of consumers of prepaid comprehensive health services; or (3) a particular "market segment," to wit: "Medicare, Medicaid, or commercial, managed care and health maintenance organization." Although category (1) appears straightforward, it is unclear to us what is intended by the other two categories. Moreover, it is not clear what geographic area would be used to calculate market shares, at least with respect to categories (2) and (3), or which payers are to be included in the market share calculations.

Aside from the ambiguity, however, the bill's provisions are not based on accepted concepts of market power in a legal or economic sense. Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only

if based upon a properly defined market. Even if the bill's categories correctly identified relevant markets, a 15% market share (let alone a share above 5%) is not a level ordinarily presumed to constitute market power.(7) In addition, the bill does not take into account ease of entry in assessing market power, as antitrust analysis ordinarily would.

The limitation on the "market share" of physician groups negotiating with small health plans (which sets a higher threshold for physician market power than for health plan market power) also does not reflect market power, and may understate the economic clout of a physician group. The 30% share limitation is based on the portion of physicians "in the health plan service area or proposed service area." There is no reason, however, to expect that a health plan service area would necessarily represent an appropriate geographic market for the physician services in question. Indeed, geographic markets for physician services may vary by specialty. A health plan service area could well be broader that the geographic market for physician services, with the result that the 30% cap would not prevent aggregation of physicians with substantial market power within the service area negotiating with very small health plans.

The other major limitation in the bill, section 2(b), which provides that "Nothing herein shall be construed to allow a boycott," also raises significant questions of interpretation and may not offer significant protection to consumers. First, its wording and placement could be read to suggest that the limitation applies only to the conduct authorized in Section 2, rather than the entire bill. If that were the case, other sections of the bill could permit physicians to engage in boycotts. Second, the term "boycott" has been subject to varying interpretations, in some cases being understood as collective refusals to deal to force a party to accept terms, and in others limited to refusals to deal with third parties to pressure another party with whom the group has a dispute.(8) It is unclear whether the bill is intended to bar agreements not to deal with health plans except on collectively-determined terms, or whether it would only prohibit agreements to withhold services from third parties (patients or others), in order to pressure health plans to accede to the contract terms demanded by the physician group.

The federal collective bargaining bill excludes from its authorization "collective cessation of services to patients" (*i.e.*, boycotts in the narrow sense), and the Commission in its testimony (p.8) observed that "this limitation takes virtually nothing away from the coercive power the bill grants to providers." Furthermore, as the testimony explains, a collective refusal to contract, if it did not force the health plan to capitulate to physician demands for fee increases, could result in patients' having to pay medical bills out of their own pockets, and thus would impose formidable obstacles to patients seeking care.

Even if it were clear that the D.C. bill would not protect physicians' concerted refusals to deal with health plans, however, its authorization of collective bargaining would still present a serious risk of anticompetitive harm. As the Commission has previously observed, collective negotiations by their very nature can convey an implicit threat that if the health plan does not agree to terms acceptable to the physician group, the plan will be unable to obtain agreements with group members.(9) By immunizing, and thereby encouraging, agreements among physicians on the prices and other terms they will accept from health plans, the bill would facilitate coordinated conduct among physicians, such as collusive refusals to deal that, even though not immune, would be difficult to detect and prosecute. I would also note that the analysis that accompanies the AMA model legislation

makes it clear that the bill's purpose is to allow physicians to exert "leverage" over payers in order to obtain more favorable terms. Thus, excluding concerted refusals to contract from the bill's protections would not appear to eliminate the coercive force of collective bargaining, or obviate concerns that the bill would increase the likelihood of concerted refusals to contract.

I would also note that the analysis in the AMA model states that Section 2 allows physicians to discuss managed care contract terms "free from the antitrust risk that normally accompanies such collaborative activity." You may wish to advise Council members that the antitrust laws do not prohibit the mere discussion of issues such as those enumerated in Section 2 unaccompanied by agreements on the terms on which the physicians will deal.

Immunity Issues

Under the judicially-created "state action" doctrine, states may override the national policy favoring competition and provide that aspects of their economies will be governed by state regulation rather than market forces. States, however, may not simply authorize private parties to violate the antitrust laws.(10) Instead, a state must substitute its own control for that of the market. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct. *See California Retail Liquor Dealers Assen v. Midcal Aluminum, Inc.*, 445 U.S. 92 (1980).

A threshold issue is whether the District of Columbia is equivalent to a state for purposes of the state action doctrine, or otherwise has the ability under federal law to create antitrust immunity for private parties. I am not aware of any controlling authority on the question, and I am not in a position to offer an opinion.(11) It is, of course, a key question to be resolved, because if the Council lacks authority to create antitrust immunity through adoption of a regulatory scheme, physicians acting in reliance on the bill would be exposed to significant risk of antitrust liability.

Assuming, however, that the Council has the authority to create state action immunity, the critical question is whether the bill establishes a scheme with sufficiently active state supervision of private conduct to satisfy the second prong of the state action test. The bill's authorization of collective bargaining appears to satisfy the requirement of a state policy to supplant competition. But in order for state supervision to be adequate for state action purposes, state officials must "have and exercise ultimate control over the challenged anticompetitive conduct." *Patrick v. Burget,* 486 U.S. 94, 100 (1988). On this second requirement for immunity, the bill falls far short.

Section 6 of the bill provides that the representative who will negotiate on behalf of physicians must obtain approval from the Mayor to undertake negotiations. The Mayor is to withhold approval if "the proposed negotiations would exceed the authority granted under this act." Section 6(b). The Mayor is to make this determination within 30 days based on information identifying the representative, its plans and procedures, and "a brief report" identifying the proposed subject matter of the negotiations and the expected benefits to be achieved. In addition, the representative must furnish for the Mayor's approval, prior to dissemination, a copy of "all communications to be made to physicians

related to negotiations, discussions, and health plan offers." The bill does not grant the Mayor the power to review and disapprove contract terms or other matters on the ground that they are unreasonable, unjust, or otherwise contrary to the interests of consumers.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own." *Patrick* at 106. It is not met where the reviewing state official does not evaluate the substantive merits of the private action. *Id.* at 102-105. Thus, the Court has held that a state did not actively supervise price arrangements when it did not establish the prices, review the reasonableness of prices, monitor market conditions, or engage in any "pointed reexamination" of the program. *Midcal*, 445 U.S. at 105-106. Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S.621, 634-35 (1992).

The apparently limited nature of the Mayor's authority to review and approve the authorized private conduct alone makes the bill on its face inadequate to establish active supervision. Other aspects of the bill also raise questions as to the adequacy of supervision. For example, the limited nature of information that a physician representative must provide to obtain approval would raise questions as to the extent to which government officials have exercised "sufficient independent judgment and control." Indeed, it is unclear that the Mayor would even have sufficient information to determine whether the group's negotiations complied with the market share limitations of the bill. In addition, the bill's failure to specify a standard against which the Mayor would evaluate proposed collective bargaining activities further suggests that no substantive review is contemplated.

Parties claiming immunity under the state action doctrine bear the burden of establishing that they are entitled to such immunity. Thus, should the Council desire to go forward with a collective bargaining bill, it will be important to ensure that the bill establishes a regulatory scheme that meets the rigorous requirements that the Supreme Court has established. Otherwise, physicians relying on the bill's provisions to provide antitrust immunity would risk exposure to potentially significant financial liability for their actions.

* * *

I hope you find these comments helpful. The views expressed in this letter, of course, do not necessarily represent the views of the Commission or any individual Commissioner. Should you have any additional questions, feel free to contact me at 202-326-3688.

Sincerely,

Richard A. Feinstein
Assistant Director

Attachments

Endnotes

1. *See* Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (August 1996) (available at www.ftc.gov/reports/hlth3s.htm).

2. *See, e.g., Schachar v. American Academy of Ophthalmology*, 870 F.2d 397 (7th Cir. 1989); Statements 4 & 5 of Statements of Antitrust Enforcement Policy in Health Care, *supra* note 1.

3. Physicians Group, Inc., 120 F.T.C. 567 (1995) (consent order).

4. *Commonwealth of Virginia v. Physicians Group, Inc.*, 1995-2 Trade Cas. (CCH) ¶ 71,236 (W.D. Va. 1995) (consent decree).

5. *See* [illegible]terson Drug Company, 115 F.T.C. 492, 540 (1992). *See also* Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

6. Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 21, 1999) at 10.

7. *See. e.g.,* Statement 8 of Statements of Antitrust Enforcement Policy in Health Care, *supra* note 1 (establishing antitrust "safety zone" for physician network joint ventures that constitute 20 percent or less of the physicians in each physician specialty in the relevant geographic market)

8. See *Hartford Fire Insurance Co. v. California*, 509 U.S. 764 (1993). In *Hartford*, which construed the meaning of the term "boycott" for purposes of the McCarran-Ferguson Act, Justice Scalia, writing for the majority, distinguished between boycotts and "concerted agreements to seek particular terms in particular transactions," which he termed "cartelization." *Id.* at 801-802. A boycott, Justice Scalia wrote, is limited to a refusal to deal with a party in order to obtain an objective collateral to the boycotters' relationship with that party. *Id.* at 801. He also pointed to a distinction in labor law between a strike, *i.e.*, a collective refusal to deal with an employer to obtain better contract terms from that employer, and a boycott, involving a work stoppage designed to put pressure on some other employer.

9. *See* Michigan State Medical Society, 101 F.T.C. 191, 296 n.32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); *see also* Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations)..

10. *Parker v. Brown*, 341 U.S. 351 (1943) ("a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or declaring that their action is lawful").

11. In *American Telephone & Telegraph Co. v. Eastern Pay Phones*, Inc.., 767 F. Supp. 1335 (E.D. Va. 1991), the court ruled that a regulatory scheme of the District of Columbia did not provide state action immunity, without discussing whether the District stands on the same footing as states with respect to the state action doctrine. An earlier case (arising prior to Congress' grant to the District of home rule powers) involving the District of Columbia Armory Board, a governmental entity, evaluated antitrust immunity claims with reference the Board's federal enabling legislation. *See Hecht v. Pro-Football, Inc.*, 444 F.2d 931 (D.C. Cir 1971).

Alaska State Medical Association

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February 11, 2002

Honorable Lisa Murkowski
Alaska State House of Representatives
State Capitol, Room 408
Chair, House Labor and Commerce Committee
Juneau, AK 99801-1182

Dear Representative Murkowski:

The Alaska State Medical Association (ASMA's) lobbyist has provided me with a copy of the response (dated 1/18/ 2002) from several staff members from the Federal Trade Commission (FTC). At the risk of stating the obvious, please note that these are the comments of staff members (Messrs. Simons and Cruz) and do not represent the position of the FTC. This is the same situation when another FTC staff person (Richard Feinstein) testified on SB 256 (SB 37 during the last session) on his own behalf and not representing the views of the FTC.

The response from Mr. Simons and Mr. Cruz again reflect similarly the comments made in regard to the "state action doctrine exception" bills in both Texas and the District of Columbia. ASMA has responded to the comments with both written and oral testimony on numerous occasions, including before House Labor and Commerce Committee as well as in your work session this past December. Therefore, I am not going to comment in detail again but will instead make several comments on a broader basis. (By the way, a private attorney representing an undisclosed client in D.C. brought very similar arguments to those of Mr. Simons and Mr. Cruz in opposition to the D.C. bill establishing a state action doctrine exception. Mr. Charles James was the D.C. medical society legal council and he responded to those arguments. I will share some of Mr. James' comments with you as well.)

I will begin by framing the issue that is illustrative of why ASMA has brought forth and supported the concept embodied in SB 37. Alaska is faced with a situation where the private insurers involved in the health insurance are an oligopoly; Alaska has an inadequate number of physicians plus a great number who will be leaving practice soon due to age; and a necessary symbiotic relationship exists between physicians and the third party payors. ASMA is very interested in the physician workforce issues due to concerns over access to care issues. The symbiotic relationship, embodied by the whole concept and practice of assignment of benefits, is necessary due to legitimate public health reasons. (This relationship is required to exist by AS 21.87.140 for a medical service corporation.) Additionally, the contractual arrangements between insurers and physicians have been such that no negotiation takes place, with physicians being offered contracts on a "take it or leave it" basis. This happens because of the monopsony power that is exercised by the few insurers in the marketplace. ASMA finds this to be patently unfair.

Mr. Cruz and Mr. Simons seem to be unaware of the health care environment in Alaska and make the presumption that the health insurers can not look out after their own best interests. ASMA feels that the State is in a better position to determine what is needed to meet the health care needs of the citizens and that the large health insurers can and do vigorously look out for their own interests. (Also, and again, the entire process embodied in SB 37 is voluntary.)

Mr. James was the outside legal council for the medical association in D.C. when it was pursuing its bill embodying the "state action doctrine exception". He now is the head of the U.S. Justice Department's anti-trust enforcement division. The following is a response from Mr. James pertaining to arguments made by a lawyer (Mr. Hartwell) against D.C.'s "state action doctrine exception bill"; which represent an excellent overview:

"...It is true, the proposed legislation does not rely on elaborate pricing mechanisms to fix the outcome of the negotiations. From his letter, it appears that Mr. Hartwell would have the District insinuate itself into every facet of the negotiation process, establishing, among other things, a "framework" for the actual negotiations and a "procedural mechanism for evaluating the fairness of the negotiated terms and conditions." (Ltr. From Ray V. Hartwell, III., Esq. to Linda Crop of 4/24/00 at 6.) But the active supervision requirement does not require the District actually to sit at the bargaining table. Such a narrow interpretation indeed would turn the state action doctrine on its head. The underlying rationale of the doctrine, again, is to free the exercise of District's police powers from federal interference. Mr. Hartwell's understanding of the active supervision requirement would effectively preclude the District from adopting more progressive regulatory policies, like those embodied in the Act, that take advantage of efficiencies inherent in a bargained-for exchange. Rather than trying to impose bureaucratic notions of fairness, the Act relies on the self-interest of the physicians and the health plans to drive the bargaining process toward the most efficient result. At the same time the Mayor retains the ability to fix certain parameters before negotiations commence, (see Bill 13-333 at § 7), and to review the end-result (see id. At §§ 7-8). This structure ensures that the District has the final say on the agreement, while securing the efficiency benefits of a private bargain."

Additionally, I would like to point out that the letter from Mr. Simons and Mr. Cruz point out the need for non-fee related items to be covered in SB 37. On page 7, the last two sentences are as follows:

"...The method a health plan uses to calculate its payments to providers for particular services, however, can have a direct and significant impact on the ultimate price that providers receive for their services, and thus such are also "price" terms. Moreover, even collective bargaining over other, more clearly "non-price" issues in a health plan contract can have a substantial effect on the ultimate costs paid by consumers."

Finally, some of the points made by Mr. Simons and Mr. Cruz in last several pages of this letter pertaining to information provided the AG in the course of the process and the time in which the AG needs to make its final decision have merit. We addressed those issues with Sen. Kelly and have suggested amendments to address those issues.

Please give me a call if you wish to discuss any of the issues involving SB 37.

Sincerely,

James J. Jordan

Cc: Sen. Pete Kelly
John Troxel, MD, ASMA President

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February 5, 2002

Alaska State Legislature
State Capitol (MS 3100)
Representative Lisa Murkowski
Chairman House Labor & Commerce Committee
Juneau, AK 99801-1182

Dear Representative Murkowski:

Our lobbyist has made available to us a copy of the Federal Trade Commission's comments on SB37 the Alaska Physician Negotiation Bill, and I have several comments to make.

First, the tenor and tone of the letter does not surprise me given the FTC's long-standing opposition to exemptions to federal anti-trust law. What does surprise me is that Mr. Simons and Mr. Cruz seem to be out of sink with their boss (President Bush) and his opinion on the merits of this type of legislation, given that while President Bush was Governor of Texas, he signed similar legislation.

The FTC also seems at odds with a Mr. Charles James, the current head of the US Justice Department's anti-trust enforcement division, who while counsel to Washington, DC's medical association, wrote eloquently on the merits of allowing groups of independent physicians to negotiate with third party payors, provided there is active oversight.

The first 5-½ pages of the FTC response, in my mind is nothing more than a recitation of their opposition to a federal bill (The Campbell Bill). The FTC keeps hammering the point that "costs" will rise out of control. What is critical to understand is that our bill contains substantial state oversight and safe guards, which were not included in the Campbell Bill. The discussion of the Campbell Bill was therefore gratuitous and misleading.

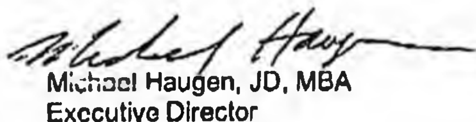
The FTC's criticisms on pages 6 through 9, center around issues of: substantial market power, screens for market share, and limitations on physician negotiation group size. Each of these issues and our reasoning behind the specific bill language have repeatedly been expressed in written and oral testimony by both my group, Alaska Physicians & Surgeons, and the Alaska State Medical Association. In each case the language was chosen to account for the unique nature of Alaska's geographic and demographic challenges.

Finally, the FTC's comments on pages 10 through 14 all revolve around in Mr. Simons' and Mr. Cruz's opinion that the bill, as written does not provide the State Attorney General with enough on-going information, or time, to fulfill the requirements of the active state oversight component of the State Action Doctrine. We think both of these points have merit and have addressed each issue in proposed amendments, which we have given to Senator Kelly.

It has always been the physician's intention that the oversight agency, in this case the Attorney General's office has the authority under the bill, to comply with the requirements of the active state oversight function of the State Action Doctrine. After all, it is the physicians and only the physicians who would be in legal jeopardy, if the federal requirements are not met.

If you would like to discuss any of these issues in more detail, please call me at 561-7705.

Sincerely,



Michael Haugen, JD, MBA
Executive Director

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March 13, 2002

Alaska State Legislature
State Capitol (MS 3100)
Representative Lisa Murkowski
Chairman House Labor & Commerce Committee
Juneau, AK 99801-1182

Dear Representative Murkowski:

It has come to our attention that the Alaska Nurses Association, the Alaska Nurse Practitioners Association, and the nurse midwives still oppose SB37, the Alaska Physician Negotiation Bill in its entirety, and are attempting to generate a letter writing campaign to influence your committee's vote on the bill.

We are in possession of a form letter written at the request of Sandy Perry-Provost, which contains numerous misstatements of fact and a gross misunderstanding of what, and how, SB37 would allow physicians to negotiate with third party payors.

It is important to refute a few of the more outrageous claims made in the form letter, among which are:

- The nurses claim the bill would authorize price fixing by physicians.
    - Fact: price fixing would remain illegal even if the bill were law. Nothing in the bill authorizes price fixing.
- The nurses claim the bill would allow physicians and insurers to discriminatory exclude nurses from contracts.
    - Fact: passage of the bill would in no way protect physicians or insurers from state or federal anti-trust laws if either party conspired to shut out a different provider group from a contract. In addition, at the nurses request, the bill's sponsor Senate Pete Kelly, incorporated specific language in the bill in section; 23.50.020 (p) reiterating the point that the bill does not protect physicians from exclusionary conduct.

- The nurses claim the bill would increase costs and reduce service.
    - Fact: The bill requires final approval of a contract, including the fee schedule, by the Attorney General, who has ultimate veto power. The proposed amendments given to your office should also give the Attorney General all of the authority needed to collect any and all relevant information to make an informed decision about the merits of a final contract. One of the bill's primary purposes is to foster open communication between physicians and payors to address known inefficiencies in the healthcare delivery system, and thus potentially lower the overall cost of healthcare, and increase the level of service.

The physicians in my association feel they have gone out of their way to address the nurses concerns, and have gone so far to offer verbatim use of the language in SB37, if the nurses wish to create their own negotiation bill.

If you have any questions please contact me at 561-7705.

Sincerely,

Michael Haugen, JD, MBA
Executive Director

c: Senator Pete Kelly

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Edward M. Voke, M.D. · Robert J. Hall, M.D. · Cindy M. Lee, D.O.

April 4, 2001

SB37- Physician Negotiation Bill

The Honorable Pete Kelly
CO-Chairman Senate Finance Committee
State Capitol Building
Juneau, Alaska 99508

Dear Senator Kelly:

We would like to encourage you and your colleagues to support Senate Bill 37. We, as are many Alaskan physicians, are very concerned about the current climate that exists between physicians and third party payers. We feel passage of this bill is imperative in allowing physicians to address the many concerns that exist regarding contracts with insurance companies.

At this time, Alaska's physicians are barred from collectively addressing a multitude of issues with third party payers. These issues certainly affect the ability of the physician to work in a free-market environment by establishing their own fee schedule(s). It directly affects patient care by inhibiting the physician from referring patients to other physicians of their choice. These issues, and others, ultimately impede both the patient and physician in making the best, most independent decisions concerning their care.

Passage of SB37 would allow groups of independent physicians to negotiate with health benefit plans, with the active state oversight of this process. All negotiations are voluntary, and any party can withdraw at any time. The Alaska Attorney General has veto power over the final contracts, including the fee schedule. This veto power should alleviate many concerns that this bill would allow physicians to increase the cost of medical care.

In fact, there are similar independent purchasing syndicates with similar values. When small, independent businesses are allowed to negotiate terms collectively, this allows solid competition. Otherwise, these businesses would certainly fail when competing with larger companies, invariably defeating a competitive environment.

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March 28, 2001

Honorable Pete Kelly
State Senate
Co- Chairman Senate Finance Committee
State Capitol, Room 518
Juneau, AK 99801-1182

RE: SB 37

Dear Senator Kelly:

The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them. Thank you for this opportunity to again provide you testimony on this important matter.

ASMA continues to support a strong physician joint negotiation bill. We have already provided you with a great deal of information relating to our support of SB 37. Today, I would like to provide you with a slightly different perspective.

ASMA is pursuing legislation like SB 37 because it views enactment of this and other physician friendly legislation as important in creating an environment that will attract physicians to practice in Alaska. Why is this important? A few numbers will serve to illustrate. It has been reported that there are over 2000 physicians licensed to practice in Alaska. That is correct but not all of those physicians practice and reside in Alaska. ASMA maintains a database of those physicians practicing and residing in Alaska and at December 20, 2000 that number was 1,036 physicians. But this is only part of the story. Below is an extract from physician workforce data compiled by Dr. Sam Cullison, an AMA delegate from Washington.

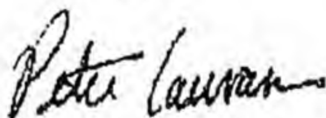
State	Number of Physicians	Per Capita Physicians/100K
Alaska	1,036	171
California	89,153	282
Hawaii	3,399	286
Washington	14,759	271
Oregon	8,333	265
U.S.	-	282

It would appear that Alaska is either "underserved" or the other states are "over served". We suspect the former.

Finally, in an analysis done last year of ASMA's data base, over one-half of the physicians in private practice are over the age of 51. (This was estimated using the year of graduation from medical school and assuming an age of 26 at the time of graduation and anyone with an inderterminate year of graduation was assumed to be under 51.) We are facing a serious recruiting effort in order to replace those leaving practice in Alaska. Idaho is facing a similar situation in that a little over 40% of its physician workforce is over the age of 50. Idaho is seeking 10 more slots per year in the WWAMI program to help meet its future recruitment needs.

Access to timely and appropriate care is already an issue in Alaska for certain specialties. Alaska, in the foreseeable future, will continue to be a "net importer" of physicians. We believe it is critical that an environment is created and maintained that will attract well trained physicians in sufficient numbers to adequately and expediently care for Alaska's patients. Passage of bills like SB 37 help to create that favorable environment. Thank you for your continued support in this endeavor.

Sincerely,



By: Peter Lawrason, MD, President
For: Alaska State Medical Association

c.c. Senate Finance Committee Members.

GRIFFITH C. STEINER, M.D.

OPHTHALMOLOGY

3340 Providence Drive, Suite 565
Anchorage, Alaska 99508
Tel. (907) 561-1167
Fax (907) 561-7051

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99801

RE: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

I am a private practice physician in Anchorage, Alaska. I am writing to ask for you and your Senate colleague's support to pass SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

As you know, without passage of the bill Alaska physicians are currently barred from collectively discussing a host of issues with third party payors, which directly and indirectly affect patient care. SB37 would allow groups of independent physicians to negotiate with health benefit plans so long as there is "active state oversight" of the process. It should be noted that all negotiations are voluntary, and any party can withdraw at any time.

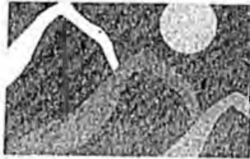
And finally, the Alaska Attorney General has veto power over the final contracts, including the fee schedule. This veto power should go a long way toward ameliorating the concerns of those who claim that passage of this bill will simply allow physicians to ratchet up the cost of medicine.

I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday April 3rd, and again I ask for you and your colleague's support.

Sincerely,

Griffith C. Steiner, MD
Glaucoma, Cornea/External Disease, Cataracts and
Refractive Surgery

GCS:jes


Summit
Family
Practice
1200 Airport Heights Drive, Suite 278
Anchorage, Alaska 99508
Telephone: 907-272-3366

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capital Building
Juneau, AK 99801

Re: SB37-Physician Negotiation Bill

Dear Senator Kelly:

I am a family physician in private practice physician in Anchorage, Alaska. I am writing to ask you and your Senate colleagues to support the passage of SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for our patients when dealing with third party payors over contracting issues.

As you know, without passage of the bill Alaskan physicians are currently barred from collectively discussing a host of issues with third party payors, which directly and indirectly affect patient care. SB37 would allow groups of independent physicians to negotiate with health benefit plans, so long there is "active state oversight" of the process. It should be noted that all negotiations are voluntary, and any party can withdraw at any time.

I understand that the Alaska Attorney General has veto power over the final contracts, which should reassure those who claim that passage of this bill will simply allow physicians to ratchet up the cost of medicine.

I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday, April 3rd, and again ask for you and your colleague's support of the vote.

Sincerely,

S. Lynn Hornbein, MD

S. Lynn Hornbein, M.D.
Jeffrey W. Russell, P.A.-C.

Providence Anchorage Anesthesia Medical Group, P.C.

3300 Providence Drive, Suite 207
Anchorage, AK 99508-4619
(907) 561-0005 • FAX (907) 563-9140

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capital Building
Juneau, AK 99801

Re: SB37-Physician Negotiation bill

Dear Senator Kelly:

I am a private practice physician in Anchorage, Alaska. I am writing to ask for your and your Senate colleagues to support the passage of SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

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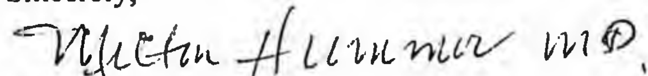
I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday April 3rd, and again ask for you and your colleagues' support of the vote.

Sincerely,



Milton Hummer, M.D.

THE
FOLLOWING
DOCUMENT(S)
ARE
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ORIGINAL
COPIES

Apr 02 01 07:06a Phyllis Ann Finley 9075617704 p.3
03/30/2001 14:57 FAX 002/003

Dale I. Webb, MD
Melissa Corcoran, MD, Ph.D
Dennis Beckworth, MD
Nancy Schmetzer, ANP
Beth Conklin, ANP

Katmai Oncology Group

3260 Providence, Suite 526
Anchorage, Alaska 99508-4627
(907) 562-0321
(907) 562-2683 FAX

March 30, 3001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99801

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

I am a private practice physician in Anchorage, Alaska. I am writing to ask for your and your Senate colleagues support to pass SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

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I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday April 3rd, and again ask for you and your colleague's support of the vote

Sincerely,

Dale Webb, MD

JOHN M. TROXEL, M.D.

DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY

3340 PROVIDENCE DRIVE
SUITE #359
ANCHORAGE, AK 99508

TEL: 907-562-6886
FAX: 907-562-1021
drjohn@gci.net

March 30, 2001

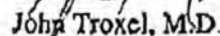
The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99801

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly,

I am a physician in private practice in Anchorage, Alaska. I am writing to ask for your support and that of your colleagues on SB37. Currently physicians barred from discussing a whole host of issues with third party payors, which directly and indirectly affect patient care. Given the oversight and voluntary participation in the negotiations, I don't think that passage of the bill will increase the cost of medicine. Thank you for your consideration.

Sincerely,



John Troxel, M.D.

Alaska Ear Nose & Throat

William R. Fell, MD
Jerome List, DDS, MD
Deborah Kiley, ANP

Tel: (907) 261-3096
Fax: (907) 261-3094
www.alaskaENT.com

March 30, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, Alaska 99801

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

I am a private practice physician in Anchorage, Alaska. I am writing to ask you and your Senate colleagues support to pass SB37 into law. I feel that passage of the Physician Negotiation Bill will allow myself and my colleagues to be more effective advocates for patients, when dealing with third party payors.

As you know, without passage of the bill, Alaska physicians are currently barred from collectively discussing a host of issues with third party payors, which affects patient care both directly and indirectly. SB37 would allow groups of independent physicians to negotiate with health benefit plans, as long as there is "active state oversight" of the process. It should be noted that all negotiations are voluntary, and any party can withdraw at any time.

Finally, the Alaska Attorney General has veto power over the final contracts, including the fee schedule. This veto power should go a long way toward ameliorating the concerns of those who claim the passage of this bill will simply allow physicians to "ratchet up the cost of medicine."

I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday, April 3rd, 2001. Again I respectfully ask for your support of the vote.

Respectfully,

Jerome List, DDS, MD

3340 Providence Drive, Suite 357 • Anchorage, Alaska 99508

[illegible], M.D., FACOG
A Professional Corporation

Obstetrics and Gynecology

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99801

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

I am a private practice physician in Anchorage, Alaska. I am writing to ask for your and your Senate colleagues support to pass SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

As you know, without passage of the bill Alaska physicians are currently barred from collectively discussing a host of issues with third party payors, which directly and indirectly affect patient care. SB37 would allow groups of independent physicians to negotiate with health benefit plans; so long there is "active state oversight" of the process. It should be noted that all negotiations are voluntary, and any party can withdraw at any time.

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I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday April 3rd, and again ask for you and your colleague's support of the vote.

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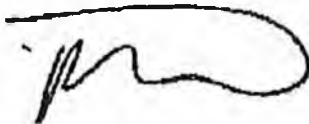


2341 DeBarr Road, Suite 45, Anchorage, Alaska 99508 Phone (907) 336-6375 • FAX (907) 336-7211

Roland E. Gower, M.D.
A PROFESSIONAL CORP.
3841 DE BARR RD #41
ANCHORAGE ALASKA 99508
907-276-5564

PRACTICE LIMITED TO GENERAL SURGERY

BY APPOINTMENT ONLY

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99081

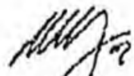
Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

I am a private practicing surgeon in Anchorage. I support SB37 and ask that you and your Senate colleagues pass it on to the House. I feel that passage of the Physician Negotiation Bill will allow physicians to be better advocates for patients when dealing with third party payors over contracting issues.

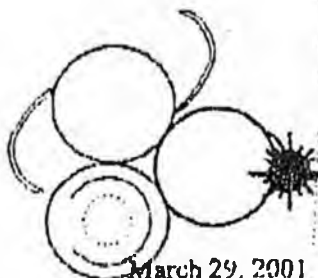
I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday, April 3rd, and again ask for you and your colleague's support of the vote.

Sincerely,



Roland E. Gower, MD

REG/eas



Grendahl Eye Associates

3500 La Touche, Suite 240 · Anchorage, Alaska 99508
907-561-1917 800-478-4502

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99801

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

I am an ophthalmologist in private practice in Anchorage, Alaska. I am writing to ask for your support to pass SB37 into law. The passage of the Physician Negotiation Bill would allow my colleagues and I to become better patient advocates when dealing with third party payors with respect to contracting issues.

As you know, without the bill, Alaska physicians are currently barred from collectively discussing a host of issues with third party payors, which directly and indirectly affect patient care. SB37 would allow groups of independent physicians to negotiate with health benefit plans. All negotiations would be voluntary, and any party could withdraw at any time.

The Alaska Attorney General has veto power over the final contracts, including the fee schedule. This veto power should go a long way toward ameliorating concerns of those who claim that passage of this bill will simply allow physicians to ratchet up the cost of medicine.

I understand that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday April 3rd. Again, I ask for your support as well as your colleague's support of the vote.

Sincerely,

Marvin Grendahl, MD

Geneva Woods Ear, Nose and Throat Associates, Inc.
FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

J. DAVID WILLIAMS, M.D
DONALD R. ENDRES, M.D.

3730 RHONE CIRCLE, SUITE 205
ANCHORAGE, ALASKA 99508
TELEPHONE: (907) 563-3515
FAX: (907) 562-0425

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99801

Re: SB37-Physician Negotiation Bill

Dear Senator Kelly:

I am a private practice physician in Anchorage, Alaska. I am writing to ask for your and your Senate colleagues' support to pass SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

As you know, without passage of the bill Alaska physicians are currently barred from collectively discussing a host of issues with third party payors, which directly and indirectly affect patient care. SB37 would allow groups of independent physicians to negotiate with health benefit plans; so long there is "active state oversight" of the process. It should be noted that all negotiations are voluntary, and any party can withdraw at any time.

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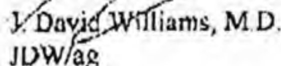

J. David Williams, M.D.
JDW/ag

OPHTHALMIC ASSOCIATES
a PROFESSIONAL CORPORATION

642 WEST SECOND AVENUE
ANCHORAGE, ALASKA 99501-2342
TELEPHONE (907) 276-1617
FAX (907) 278-1705

935 E. WESTPOINT DR., SUITE 307
WASILLA, ALASKA 99654-7143
TELEPHONE (907) 373-0229
FAX (907) 373-7778

CORDOVA (907) 270-1617
KODIAK (907) 486-4766

March 30, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, Alaska 99801

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

A am a private practice physician in Anchorage, Alaska. I am writing to ask for your and your Senate colleagues support to pass SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

As you know, without passage of the bill Alaska physicians are currently barred from collectively discussing a host of issues with third party payors, which directly and indirectly affect patient acre. SB37 would allow groups of independent physicians to negotiate with health benefit plans; so long as there is "active state oversight" of the process. It should be noted that all negotiations are voluntary, and any party can withdraw at any time.

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I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday, April 3rd, and again ask for you and your colleague's support of the vote.

Sincerely,

__________, M.D.

EDWARD E. CROUCH, M.D., F.A.C.S.
GENERAL OPHTHALMOLOGY

ROBERT W. ARNOLD, M.D.

AMANON STERNBERG, O.D., F.A.A.O.
GENERAL EXAMINATIONS

CARL E. ROSEN, M.D.

SCOTT A. LIMSTROM, M.D.
GENERAL OPHTHALMOLOGY

LYNN J. COOK, O.D., F.A.A.O.

WILLIAM C. COMPTON, MD
KENNETH A. MORHAIN, MD
NATALIA SAPRYKINA, MD
HERDI J. HURLIMAN, ANP
JENNIFER BZOWY, ANP
3340 PROVIDENCE DRIVE · SUITE 457
ANCHORAGE ALASKA 99508
Telephone 561 1594 Fax 561-2539

April 2, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
Alaska State Capitol Building
Juneau, Alaska 99801-1182

Re. SB37-Physican Negotiation Bill

Dear Senator Kelly

I am a private practice physician in Anchorage, Alaska. I am writing to request your support and that of your Senate colleagues in order to pass SB37 into law I strongly feel that passage of the Physician Negotiation Bill will allow me, and my colleagues, to be better advocates for patients when dealing with third party payers over contracting issues

SB37 will allow groups of independent physicians to negotiate with health benefit plans as long as there is "active state oversight" of the process. Without passage of the bill Alaska physicians are currently barred from collectively discussing a host of issues with third party payers which affects patient care both directly and indirectly. All negotiations are voluntary, so it should be noted that any party may withdraw at any time.

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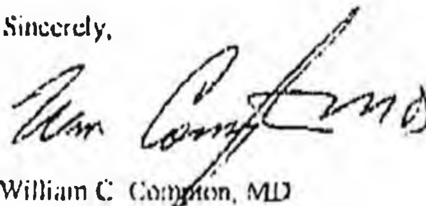
I understand that the bill is up for a Senate floor vote on Monday April 2nd or Tuesday April 3rd, and again I ask for your support and that of your colleagues

Sincerely,



William C Compton, MD

Summit Family Practice
1200 Airport Heights Drive, Suite 278
Anchorage, Alaska 99508
Telephone: 907-272-3366

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capital Building
Juneau, AK 99801

Re: SB37-Physician Negotiation Bill

Dear Senator Kelly:

I am a family physician in private practice physician in Anchorage, Alaska. I am writing to ask you and your Senate colleagues to support the passage of SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for our patients when dealing with third party payors over contracting issues.

As you know, without passage of the bill Alaskan physicians are currently barred from collectively discussing a host of issues with third party payors, which directly and indirectly affect patient care. SB37 would allow groups of independent physicians to negotiate with health benefit plans, so long there is "active state oversight" of the process. It should be noted that all negotiations are voluntary, and any party can withdraw at any time.

I understand that the Alaska Attorney General has veto power over the final contracts, which should reassure those who claim that passage of this bill will simply allow physicians to ratchet up the cost of medicine.

I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday, April 3rd, and again ask for you and your colleague's support of the vote.

Sincerely,

S. Lynn Hornbein, MD

F. LELAND JONES, M.D.
KENNETH S. LAUFER, M.D.
R. MATISON WHITE, JR., M.D.
RICHARD R. TAYLOR JR., M.D.
CHARLES L. AARONS, M.D.
GLENN J. SCHULTES, M.D.
GARY L. CHILD, D.O.
TIMOTHY COALWELL, M.D.
MARIO A. LANZA, M.D.
MICHELE A. CHASE, M.D.
DARREN B. LEWIS, M.D.

2211 EAST NORTHERN LIGHTS BOULEVARD, ANCHORAGE ALASKA 99508

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99801

RE: SB37 - Physician Negotiation Bill

Dear Senator Kelly,

I am a private practice physician in Anchorage, Alaska. I am writing to ask for your support as well as your Senate colleagues support to pass SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

As you know, without passage of the bill Alaska physicians are currently barred from collectively discussing a host of issues with third party payors, which directly and indirectly affect patient care. SB37 would allow groups of independent physicians to negotiate with health benefit plans, so long as there is "active state oversight" of the process. It should be noted that all negotiations are voluntary, and any party can withdraw at any time.

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I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday, April 3rd, and again ask for you and your colleague's support of the vote

Sincerely,

Mario A. Lanza, MD

PHONE (907) 279-8486 • FAX (907) 276-7265 (UPSTAIRS) • FAX (907) 257-6160 (DOWNSTAIRS)

March 30,2001

The Honorable Pete Kelly
Co-Chair Senate Finance Committee
State Capitol Building
Juneau, AK 99801

Re: SB37 Physician Negotiation Bill

Dear Senator Kelly,

Current legislation prevents private physicians, such as myself, from collectively bargaining with insurance companies or other third party payors. SB37 would allow such negotiation. This bill would allow doctors to discuss **benefit plan features** that directly affect patient care. Without this ability to communicate our patient's concerns in an open and *voluntary* format, the insurance companies will continue to dictate unreasonable and often "unhealthy" policy issues.

Opposition concerns regarding an increased cost of health care are unfounded. Protections within the SB37 include completely voluntary participation and active state over site of the process. The State AG will have final veto authority over all final contracts.

I ask that you give consideration to support of SB37 as it makes its way to the floor on April 2nd or 3rd. Thank you.

Sincerely,

Michael D. Manuel, M.D.

Harbir S. Makin, M.D.

3300 PROVIDENCE DR., SUITE 114
ANCHORAGE, ALASKA 99508
TELEPHONE (907) 261-3171

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capitol Building
Juneau, AK 99801

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

I am a private practice physician in Anchorage, Alaska. I am writing to ask for your and your Senate colleagues support to pass SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

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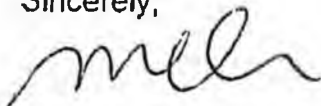

Subject: **[Fwd: SB 37]**
Date: Fri, 06 Apr 2001 12:07:14 -0900
From: Pete Kelly <Senator_Pete_Kelly@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Kristopher Knauss <Kristopher_Knauss@Legis.state.ak.us>

Subject: **SB 37**
Date: Thu, 05 Apr 2001 12:05:31 -0800
From: eichler <eichler@mosquitonet.com>
To: Senator_Pete_Kelly@Legis.state.ak.us

Dear Sen. Kelly:

I applaud you for this courageous bill. I have wondered since entering dental practice how insurance companies can get away with their cutthroat practices but lobbying dollars do indeed talk.

Could you consider adding dentists to the parties included in the bill? We operate under the same disadvantages as physicians and would appreciate this consideration.

Again, thanks for working for us in Juneau.

Dave Eichler

Providence Anchorage Anesthesia Medical Group, P.C.

3300 Providence Drive, Suite 207
Anchorage, AK 99508-4619
(907) 561-0005 • FAX (907) 563-9140

March 29, 2001

The Honorable Pete Kelly
Co-Chairman Senate Finance Committee
State Capital Building
Juneau, AK 99801

Re: SB37-Physician Negotiation bill

Dear Senator Kelly:

I am a private practice physician in Anchorage, Alaska. I am writing to ask for your and your Senate colleagues to support the passage of SB37 into law. I feel that passage of the Physician Negotiation Bill will allow me and my colleagues to be better advocates for patients when dealing with third party payors over contracting issues.

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I've been told that the bill is up for a Senate floor vote on Monday, April 2nd or Tuesday April 3rd, and again ask for you and your colleagues' support of the vote.

Sincerely,

Steven Rosenfield, M.D.

JOHN B. DEKEYSER, M.D., P.C.
Obstetrics & Gynecology

Alaska Medical Plaza
1200 Airport Heights Drive, #280A
Anchorage, Alaska 99508-2955
(907) 264-2317 (800) 818-2229
Fax (907) 264-2320

March 24, 2002

Honorable Mr. Rokeburg,

I encourage you to look favorably on SB37.

**Contrary to information promulgated by some nurse practitioners, we are not trying to exclude them but rather we are trying to address each of their concerns.

**This bill would help level the playing field between large insurance carriers and solo practitioners, like myself.

**Alaska is underserved by physicians. This bill could attract more physicians by creating a more physician friendly environment.

**The Attorney General's concerns are unfounded as the physicians would be assuming the risk in this bill.

Sincerely,

John DeKeyser

Sincerely,

John DeKeyser

MAR-26-2002 10:05 AM YolandaMeza&KateLehn 907 338 1769 P.01

Bearing In Mind Birth Center
4050 LAKE OTIS PARKWAY
SUITES 100A AND 101
ANCHORAGE, ALASKA 99508
Telephone (907) 561-2822
Fax (907) 561-4812

Norman Rokeberg

RE: Senate Bill 37

I am a certified nurse-midwife/advanced nurse practitioner in Alaska. I am writing to voice my opposition to SB 37. ANPs and CNMs are primary care providers with a proven track record of safety, quality, and competence. We want to deliver primary care services in a competitive marketplace that allows Alaskan consumers to choose the health care provider who best meets their needs. Enactment of SB 37 would undermine that competitive marketplace by virtually eliminating competition among independent physicians and minimizing regulation.

The antitrust exemption sought in SB 37 would authorize price-fixing by physicians. It would allow physicians to collude against ANPs, CNMs, CRNAs and other health care professionals. It would remove antitrust protections we need to protect ourselves from discriminatory practices undertaken by physicians and designed to prevent our inclusion as providers in health care delivery systems.

Senate Bill 37 is fundamentally flawed, cannot be fixed, and should be completely abandoned. **VOTE NO ON SENATE BILL 37!**

Thank you!

Yolanda A. Meza CNM, MS

CECONSULTING

3998 DIANE ROAD
JUNEAU, ALASKA 99801
PHONE 907-789-3345 FAX 907-789-5022

FACSIMILE TRANSMITTAL SHEET

TO: NORMAN ROKEBERG, CHAIR, HOUSE JUDICIARY COMMITTEE

FROM: CAROLE S. EDWARDS, RN,BSN

DATE: 4/7/02

FAX NUMBER
907-465-2040

TOTAL NO. OF PAGES INCLUDING COVER:
1

MESSAGE: I strongly oppose Senate Bill 37 which is scheduled to be heard in the House Judiciary Committee April 10, 2002. This bill allows many ways that consumer's costs may increase and access to care may decrease. Senate Bill 37, in any form, is unnecessary. According to the Federal Trade Commission "current antitrust law already permits physicians to work collectively on legitimate quality of care issues." If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place. PLEASE VOTE NO ON SENATE BILL 37!

Carole S. Edwards RN

Norman Rokeberg, Chair, House Judiciary Committee
(Room 118)

Rep. Rokeberg,

I am writing to express my strong opposition to Senate Bill 37 which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00 PM.

The current House Labor & Commerce CS has deleted those sections allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consumers' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a nonphysician professional as their healthcare provider.

Though this bill's proponents from among the ranks of Alaska Physicians and Surgeons (I too am a member, though I dissent on this issue) sincerely attest that they have no motive to exclude or otherwise disenfranchise non-physician health care providers, I think there are many of my colleagues who would seize upon the opportunity presented by this bill to do exactly that.

Senate Bill 37 in any form is unnecessary. According to the January 18, 2002 letter from the Federal Trade Commission to Representative Lisa Murkowski "...current antitrust law already permits physicians to work collectively on legitimate quality of care issues."
I don't dispute the idea that the playing field is not level and that insurance companies are abusing their power at the expense of health care providers (physicians and non-physicians alike). I wish that my colleagues would attack the issue of insurance company malfeasance with the same zeal that they are pushing SB37. I wish that they would look to strengthening current statute language, specifically Chapter 21.07.010, Patient and Health Care Provider Protection (also known as the Alaska Patient's Bill of Rights), in order to meet their goal of allowing balanced negotiations with insurance companies.

The physician's lobby is powerful and the non-physicians health care providers are weak. Doctors make a lot of money and Nurse Practitioners don't. They will not be able to defend their right to practice if this bill goes through. VOTE NO ON SENATE BILL 37! Make my colleagues find a different way to redress the wrongs of the medical insurance industry. Help your colleagues find a way to advance the cause of patients' right to access and choice in health care. Do not waste precious time in the session passing special interest legislation when there are so many important major issues before the legislature.

Bradley K. Cruz, MD
Anchorage
7 Apr 2002

April 8, 2002

The Honorable Norman Rokeberg
Chair, House Judiciary Committee
Alaska State Legislature
State Capitol, Room 118
Juneau, Alaska 99801-1182
Fax: (907) 465-2040

RE: Senate Bill 37

Dear Representative Rokeberg:
I am writing concerning SB 37, which would give broad antitrust immunity to physicians negotiating collectively with insurance companies. I am a member of the Legislative Affairs Committee of the Alaska Nurse Practitioner Association (ANPA).

Nurse practitioners (NPs) provide health care to people all over this state and nation at lower cost than physicians, but of equal quality. A study published in The Journal of the American Medical Association found: "In an ambulatory care situation in which patients were randomly assigned to either nurse practitioners or physicians, and where nurse practitioners had the same authority, responsibilities, productivity and administrative requirements, and patient population as primary care physicians, **patients' outcomes were comparable.**" (JAMA 283 (1), pg 59 - 68; Jan 5, 2000). Needless to say, the American Medical Association did not like the findings of this report. They have made it a priority to limit the scope of practice of NPs and other non-physician practitioners, as evidenced by their efforts to restrict the practice of these other health care providers.

Last week the British Medical Journal, (324, pg 819 - 823; April 6, 2002) published the results of a systematic review of randomized controlled trials and prospective observational studies comparing nurse practitioners and doctors providing care as first point of contact for patients with undifferentiated health problems in a primary care setting. Eleven trials and 23 observational studies found that patients were more satisfied with care by a nurse practitioner. No differences in health status were found. Nurse practitioners had longer consultations and made more investigations than did doctors. No differences were found in prescriptions, return consultations, or referrals. Quality of care was in some ways found to be better for nurse practitioner consultations. **The study's conclusion was that increasing availability of nurse practitioners in primary care is likely to lead to high levels of patient satisfaction and high quality of care.**

Nurse practitioners focus on wellness and illness prevention, which ultimately lowers health care costs. We provide a vital service in this state, where many rural clinics are staffed ONLY by non-physician providers. NPs provide cost effective care. As an example, I have worked at a nurse practitioner owned and operated clinic in West Anchorage. The fee for an average visit is almost **HALF the cost** of the same visit at the physician owned urgent care center located around the corner. In addition, the physician owned urgent care center declines to serve Medicare patients....they refer those patients around the corner to **the nurse practitioner clinic, who DOES SERVE the Medicare patients.**

Instead of limiting NPs and other non-physician practitioners from providing services to Alaskans, the state legislature should be focusing on how to unencumber them. The Harvard Business Review (Sept/Oct 2000, pgs 102 -112) article "Will disruptive innovations cure health care?" speaks to these very issues of **cost-effective, accessible, quality health care provided by nurse practitioners.**

There is no acceptable way of amending this bad legislation. It must be summarily discarded. This opinion is held not just by non-physician provider groups whose practices will be impacted, such as the Alaska Nurses Association (AaNA), Alaska Nurse Practitioner Association (ANPA), Alaska Chapter of the American College of Nurse-Midwives (AK-ACNM), and Alaska Nurse Anesthetists. Consumer groups, insurance companies, and legal experts are also opposed to this legislation. Please do not allow SB 37 to proceed in any form.

Thank you for your attention to this matter. I appreciate your service to Alaska as you work in the Legislature.

Respectfully,

Cathy Giessel, MSN, RN, FNP-CS
12701 Ridgewood
Anchorage, AK 99516-2934
cgiessel@mac.com

Commissioner, Municipality of Anchorage, Health and Human Services Commission
lifelong Alaskan and "super" voter

cc: Scott Ogan fax: (907) 465-3265
Ethan Berkowitz fax: (907) 465-2137
John Coghill, Jr fax: (907) 465-3258
Jeannette James fax: (907) 465-2381
Kevin Meyer fax: (907) 465-3476
Albert Kookesh fax: (907) 465-2827

FROM: Deidre Strother
Psychiatric Nurse Practitioner
ph# 907-688-0186

I am writing to express my strong opposition to Senate Bill 37 which is scheduled to be heard in the House Judiciary committee on Wednesday April 10, 2002 at 1 p.m. S.B. 37 in Any form is unnecessary. If enacted S.B. 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place.

Vote No on S.B. 37

Thank you
Deidre Strother
4/8/02

RE: Senate Bill 37

Representative Norm Rokeberg,

As a long time Alaskan, Nurse Practitioner and business owner (my husband Harry McDonald and I are owners of Carlile Tranportation) I am writing to express my strong opposition to Senate Bill 37 that is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00 PM.

The current House Labor & Commerce CS has deleted those sections allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consumers' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a non-physician professional as their healthcare provider.

Senate Bill 37 in any form is unnecessary. According to the January 18, 2002 letter from the Federal Trade Commission to Representative Lisa Murkowski "...current antitrust law already permits physicians to work collectively on legitimate quality of care issues." Physicians could look to strengthening current statute language, specifically Chapter 21.07.010, Patient and Health Care Provider Protection (also known as the Alaska Patient's Bill of Rights),in order to meet their goal of allowing balanced negotiations with insurance companies.

If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place.

PLEASE VOTE NO ON SENATE BILL 37!

Thank you for your consideration in this matter as I feel that this bill may be detrimental both to the health care options available to all Alaskans as well as possibly restricting or eliminating all together my ability to provide healthcare as a Nurse Practitioner. Please feel free to call or email me if you wish to discuss the potential impact of the bill.

Pat McDonald MS, FNP
346-2556 pmcd6640@yahoo.com

To: Norm Rokeberg, Chair, House Judiciary Com
Room 118 907-465-2040

From: Martha Linden, CNM., ANP

RE: Senate Bill 37

I am writing to express my strong opposition to Senate Bill 37 which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00 PM.

The current House Labor & Commerce CS has deleted those sections allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consumers' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a nonphysician professional as their healthcare provider.

Senate Bill 37 in any form is unnecessary. According to the January 18, 2002 letter from the Federal Trade Commission to Representative Lisa Murkowski "...current antitrust law already permits physicians to work collectively on legitimate quality of care issues." Physicians could look to strengthening current statute language, specifically Chapter 21.07.010, Patient and Health Care Provider Protection (also known as the Alaska Patient's Bill of Rights), in order to meet their goal of allowing balanced negotiations with insurance companies.

If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place.
VOTE NO ON SENATE BILL 37!

Thank you!

Martha Linden CNM

t/ 907-274-0827
f/ 907-272-0292

2207 East Tudor Rd. Suite 34
Anchorage, AK 99507-1069
www.aknurse.org
aknurse@aknurse.org

April 8, 2002

The Honorable Norman Rokeberg
Chair, House Judiciary Committee
Alaska State Legislature
State Capitol (MS 3100) Room 118
Juneau, Alaska 99801-1182

RE: Senate Bill 37

Dear Mr. Chairman:

We—the presidents of the Alaska Nurses Association (AaNA), the Alaska Nurse Practitioner Association (ANPA), the Alaska Chapter of the American College of Nurse-Midwives (AK-ACNM), and the Alaska Association of Nurse Anesthetists (AkANA)—are writing this letter to express our continued opposition to SB 37, "An Act relating to collective negotiation by competing physicians with health benefit plans...."

Healthcare in Alaska is provided by a diverse group of professionals, including advanced nurse practitioners, clinical nurse specialists, certified nurse-midwives, certified direct-entry midwives, certified registered nurse anesthetists, psychologists, social workers, optometrists, podiatrists, physical therapists, chiropractors, and naturopaths, to name a few. These practitioners provide many thousands of Alaskans with a broad spectrum of affordable, accessible, high-quality health services delivered with care and compassion.

The nursing community in Alaska has been opposed to SB 37 since its introduction, and the current CS for SB 37 does not address the serious and continued concerns of the organizations we represent. Amendments offered and adopted in the House Labor and Commerce Committee's CS for SB 37 on March 22nd would eliminate the ability for physicians to collectively negotiate pric^ of care. While removing the negotiation of price-related items is a step in the right direction, the current bill could still cause increased healthcare costs, and reduce Alaskans' access to a variety of health care providers. Despite the fact that non-physician providers usually provide lower cost services, the current bill could limit the ability of non-physician providers to compete with physicians for insured patients.

A recent national survey, found at www.tarrance.com/battleground/default.asp, showed that one of American's top concerns about the economy is the rising cost of healthcare (11-13 % last year). A recent article in the March 11, 2002 *Time* magazine features an

article about the increasing problem of healthcare accessibility and affordability to the average citizen, "Health Care Has a Relapse."

SB 37 would reduce health care options available to people by reducing competition, and so would increase healthcare costs by limiting access to diverse and often less expensive healthcare options. The American Medical Association has made it a priority to limit the scope of practice of advanced nurse practitioners and other non-physician professionals. Their members have repeatedly sought to restrain the trade of these healthcare providers. Their statements and behavior to this effect are a matter of public record. We refer you to www.ama-assn.org/sci-pubs/amnews/pick_01/prsb0101.htm.

If SB 37 is enacted, physicians potentially could negotiate contracts wherein nurse-midwife and advanced nurse practitioner services are provided and paid by the insurer only when the nurse-midwife or advanced nurse practitioner is a directly supervised employee of the physician. Such a negotiated provision could eliminate the ability of independent-practice nurse-midwives and advanced nurse practitioners to compete for insured patients and would effectively put them out of business.

Physicians also could negotiate "quality" or "safety" clauses into a contract, such as one stating that all covered births must take place in a hospital. This could put licensed birth centers, owned and operated by certified nurse-midwives, and certified direct-entry midwives, out of business by eliminating their ability to compete for insured patients. As hospitals are more costly than birthing centers, such a limitation would increase healthcare costs for birthing parents.

Advanced nurse practitioners, certified nurse midwives and other non-physician professionals provide a broad spectrum of affordable, accessible, high-quality healthcare services to many thousands of Alaskans who want to choose the provider that best meets their needs. Passage of SB 37 is a step towards eliminating the ability of insured Alaskans to make such healthcare decisions for themselves. In addition, legislators should be concerned about the potential for the State to be subjected to increased costs for Medicaid programs if less expensive healthcare options are threatened during this time of budget shortfall.

Finally, it appears that SB 37 is unnecessary. Physicians interested in negotiating quality-of-care issues already may do so under current antitrust law, as noted in the January 18, 2002 letter from the Federal Trade Commission to Representative Lisa Murkowski. Physicians also could look to strengthening current statute language, specifically Chapter 21.07.010, Patient and Health Care Provider Protection (also known as the Alaska Patient's Bill of Rights), in order to meet their goal of allowing balanced negotiations with insurance companies. If enacted, SB 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that already can take place.

The organizations we represent continue to have serious concerns about the ability to modify this bill sufficiently to eliminate our concerns about its negative impact on healthcare in Alaska. Amendments that would have afforded advanced nurse

practitioners and other non-physician health care professionals minimal protections against maximal competitive harm and physician misconduct were offered and adopted in the Senate Labor and Commerce Committee's CS for SB 37 in March 2001. These minimal protections, however, were deleted along with the sunset clause in the Senate Finance Committee, which is co-chaired by the bill's sponsor. Interestingly, these protections were deleted at a hastily scheduled 6:00 PM meeting on Wednesday, March 28, 2001, at which the bill's sponsor, as committee co-chair, took no testimony, despite the presence of parties with opposing views wishing to be heard.

Thank you for your time and consideration of our concerns. Please let us know if you have any questions. You may contact: Laura Sarcone, CNM, at 907-272-4047, Patricia Senner, ANP, at 907-243-8044, or Sandy Perry-Provost at 321-2446.

Sincerely,

Patricia Senner, MS, RN, ANP
President, AaNA

Mary Kutney, RN, ANP
President, ANPA

Yolanda Meza, MS, CNM
President, AK-ACNM

Kathy Madej, CRNA
President AkANA

cc: Scott Ogan
John Coghill
Jeannette James
Kevin Meyer
Ethan Berkowitz
Albert Kookesh

Primary care

Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors

Sue Horrocks, Elizabeth Anderson, Chris Salisbury

Abstract

Objective To determine whether nurse practitioners can provide care at first point of contact equivalent to doctors in a primary care setting.
Design Systematic review of randomised controlled trials and prospective observational studies.
Data sources Cochrane controlled trials register, specialist register of trials maintained by Cochrane Effective Practice and Organisation of Care Group, Medline, Embase, CINAHL, science citation index, database of abstracts of reviews of effectiveness, national research register, hand searches, and published bibliographies.
Included studies Randomised controlled trials and prospective observational studies comparing nurse practitioners and doctors providing care at first point of contact for patients with undifferentiated health problems in a primary care setting and providing data on one or more of the following outcomes: patient satisfaction, health status, costs, and process of care.
Results 11 trials and 23 observational studies met all the inclusion criteria. Patients were more satisfied with care by a nurse practitioner (standardised mean difference 0.27, 95% confidence interval 0.07 to 0.47). No differences in health status were found. Nurse practitioners had longer consultations (weighted mean difference 3.67 minutes, 2.05 to 5.29) and made more investigations (odds ratio 1.22, 1.02 to 1.46) than did doctors. No differences were found in prescriptions, return consultations, or referrals. Quality of care was in some ways better for nurse practitioner consultations.
Conclusion Increasing availability of nurse practitioners in primary care is likely to lead to high levels of patient satisfaction and high quality care.

Introduction

Recent policy developments in the National Health Service, including NHS walk-in centres, NHS Direct, and nurse led personal medical services schemes, have been based on nurses rather than doctors acting as first point of contact with the health service.[1 2] Several factors have led to this expansion in the role of nurses, including issues of cost, the need to increase provision of care to improve access, the availability of doctors, and the skills and expertise of nurses.

Particular interest has been shown in the concept of nurse practitioners providing front line care in general practice and in emergency departments. In this way they may potentially substitute for doctors, particularly in the management of patients with acute illness. Nurse practitioners have undergone further training, often at graduate level, to work autonomously, making independent diagnoses and treatment decisions.[3] It is important to consider whether the evidence supports the notion that nurse practitioners can substitute for doctors by providing safe, effective, and economical front line management of patients.

Nurse practitioners have been established in North America for several decades, and studies of their role have been reviewed previously.[4 5] But these reviews are dated and of limited applicability to the United Kingdom. After the expansion of nurse practitioners in the NHS during the 1990s, several relevant randomised controlled trials have been published that directly compare nurse practitioners and doctors. We aimed to systematically review research that assesses the process, costs, or outcomes of care provided by nurse practitioners compared with doctors, working in primary care as a first point of contact for any patient with undifferentiated health problems.

Methods

Selection of studies for review

We included randomised controlled trials and observational studies with a prospective experimental design comparing nurse practitioners and doctors working in a similar way as concurrent controls. Because of inconsistency in the use of the term "nurse practitioner," we developed criteria to determine whether papers should be included. We included studies where nurses provided first point of contact, made an initial assessment, and managed patients autonomously, whether or not they were described as nurse practitioners. We used sensitivity analysis to examine the effect on our results of including or excluding "ambiguous" studies where inclusion was debatable.

We also included studies if the nurse provided care at first point of contact for unselected patients in primary care including general practice, out of hours centres, walk-in centres, and emergency departments. The main focus of our review was previously undiagnosed patients with undifferentiated health problems. We limited our review to studies from devel-

Division of Primary Health Care, University of Bristol, Bristol BS8 6JL
Sue Horrocks *research associate*
Chris Salisbury *consultant senior lecturer*

Faculty of Health and Social Care, University of West of England, Bristol BS16 1DD
Elizabeth Anderson *senior lecturer*

Correspondence to: C Salisbury c.salisbury@bristol.ac.uk

BMJ 2002;324:819–23

Additional tables and references appear on bmj.com

APR- 8-02 MON 1:54 PM ALASKA NURSES ASSOC. FAX NO. 907 272 0292 P. 6

oped countries (Europe, North America, Australasia, Israel, South Africa, and Japan) to increase its relevance for the UK system. Some studies concerned care provided at a single consultation, others concerned care over a period of time. We included both types of study, but we used sensitivity analysis to compare the results from these different types. Finally, we only included studies if they provided data about one or more of the following outcomes: patient satisfaction, health status, health service costs, or process of care measures (consultation length, number of prescriptions, investigations, referrals, admissions, return consultations, patient adherence, or measures of quality of care).

Identification of studies

We identified studies from searches of electronic databases and hand searches of recent editions of relevant journals, bibliographies, and reference lists of other reviews and papers.[7] We scrutinised the following databases with no language restrictions: Medline (1966-2001), Embase (1980-2001), CINAHL (1982-2001), science citation index, database of abstracts of reviews of effectiveness, national research register, Cochrane controlled trials register and the specialist register of trials maintained by the Cochrane Effective Practice and Organisation of Care Group. We used the Cochrane optimal search strategy for randomised controlled trials, with advice from university librarians. All educational centres offering training for nurse practitioners in the United Kingdom and nurse practitioner organisations in the United States, South Africa, and Australia were approached for any unpublished studies. We contacted authors of included studies for additional research and for missing data. Data were extracted by one reviewer (SH) and one of two other reviewers (EA or CS) working independently. Disagreements were resolved by discussion with the third reviewer.

Assessment of study quality

We assessed methodological quality on the basis of the criteria of the review group of the Cochrane Effective Practice and Organisation of Care Group. We did not calculate a composite score for study quality in view of the current debate about the validity of such scores.[8 9]

Data analysis

We conducted our analyses with Meta-View Rev-Man software version 4.1. We calculated odds ratios for dichotomous outcomes and standardised mean differences for continuous outcomes. We used random effects methods in the analysis because of the degree of heterogeneity of the studies. If standard deviations were not available we used the average standard deviation reported by other studies for that outcome. We used meta-analytic techniques to combine data from the randomised controlled trials where at least two studies provided data on a particular outcome. For the observational studies we compared the findings qualitatively. These studies were carried out in a variety of settings; many were small and had other methodological shortcomings, making quantitative synthesis inappropriate. We analysed studies set in emergency departments or minor injury units together and separately from those based in general practice owing to the degree of heterogeneity between these different settings.

We investigated heterogeneity by examining the results from studies conducted in differing settings, studies of individual consultations or care over time, and studies of nurse practitioners with different levels of qualification. We carried out sensitivity analysis to explore the impact of including or excluding studies where there was ambiguity regarding inclusion.

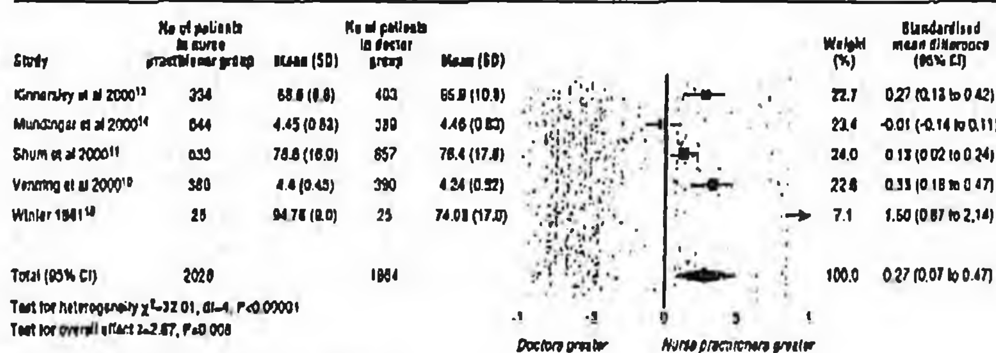
Results

Searches identified 119 potentially relevant papers, of which 35 reporting 34 studies fulfilled the inclusion and exclusion criteria. These papers comprised 11 randomised controlled trials (table A on bmj.com) and 23 observational studies (table B on bmj.com). Tables C and D on bmj.com show the quality assessment of the included studies.

The results for the observational studies may be obtained from the authors. The findings of the observational studies replicated those of the randomised controlled trials for all outcomes except costs and investigations, despite shortcomings in their design.

Patient satisfaction

Nine randomised trials reported patient satisfaction (one of these was unpublished).[10-19] One paper could not be included in a meta-analysis owing to a lack of detail in the reporting of results.[13] Five trials reported continuous data on patient satisfaction (figure). These



Studies reporting continuous data on patient satisfaction

Process measures

	No of studies	No in intervention group	No in control group	Odds ratio or weighted mean difference (95% CI)	Heterogeneity		Overall effect	
					χ^2	P value	Z value	P value
Consultation length	5	2277; mean 14.89 min	2266; mean 11.14 min	3.67 (2.05 to 5.29)*	61.87 df=4	<0.00001	4.44	0.00001
Prescriptions	4	1665/2503	1944/2861	1.02 (0.90 to 1.15)	3.26 df=3	0.35	0.32	0.8
Investigations	5	932/2573	1015/2898	1.22 (1.02 to 1.46)	6.31 df=4	0.18	2.18	0.03
Return consultations	6	836/2819	919/3247	1.08 (0.87 to 1.28)	12.08 df=5	0.034	0.54	0.6
Referrals	2	40/1293	33/1367	0.71 (0.60 to 1.70)	4.07 df=1	0.044	0.76	0.4

*Weighted mean difference. Only one study reported admissions and none reported patient adherence.

were all in general practice settings, three in the United Kingdom and two in the United States.[10-12 14 18]

The figure presents the summary statistics for studies using continuous data. These suggest that patients were more satisfied with consultations with nurse practitioners than those with doctors. The results showed considerable heterogeneity, which was explored by comparing studies of individual consultations with care over time and by comparing studies based on nurse practitioners with different levels of training. Although there remained considerable heterogeneity between the studies, all analyses suggested that patients were more satisfied with consultations with nurse practitioners. Three randomised controlled trials reported results with dichotomous data.[15-17] Two of them were set in emergency units.[16 17] No significant difference was found in patient satisfaction for patients attending either provider with these studies (all studies (n=3), odds ratio 1.56, 0.56 to 4.34; overall effect z=0.85, P=0.4; and all studies of emergency units (n=2), 3.27, 0.41 to 25.98; z=1.12, P=0.3).

Health status

Any measure used by the authors to determine either health status or quality of life and its validity for this purpose were recorded. Seven randomised controlled trials reported on these outcomes.[10-12 14 15 16 18] These results were not analysed with meta-analysis because of the heterogeneity between measures and episode of care length, but a comparison of the results showed no significant differences in patient health outcomes (table E on bmj.com).

Process measures

The results for process outcomes for which there were sufficient data for meta-analysis showed that nurse practitioners undertook significantly more investigations and had longer consultations than doctors (table).

Quality of care

Quality of care measures may include communication skills, accurate diagnosis, investigations appropriately carried out, and appropriate advice on self management or medication.[21] Six randomised controlled trials reported quality of care outcomes (see table F on bmj.com).[11-13 15 17] Heterogeneity of measures used meant that analysis was restricted to qualitative review only. Nurse practitioners seemed to identify physical abnormalities more often.[17] In one study nurse practitioners gave more information to patients.[11] Interestingly this study also reported no apparent difference in patients' intention to self treat next time. Nurse practitioners made more complete records and scored better on communication than did doctors.[16 17] They also offered more advice on self care and management.[11 12] Two studies set in emergency departments tested the appropriateness of investigations and ability to interpret x ray films.[16 17] The results suggested that nurse practitioners were as accurate as doctors at ordering and interpreting x ray films, with small in-study variations depending on the relative experience of both providers.

Discussion

Nurse practitioners can provide care that leads to increased patient satisfaction and similar health outcomes when compared with care from a doctor. Nurse practitioners seemed to provide a quality of care that is at least as good, and in some ways better, than doctors.

Although all of the randomised trials found no significant differences between doctors and nurse practitioners in health outcomes, the research has important limitations. The studies used many different outcome measures, reflecting the difficulty in measuring changes in health outcomes after single consultations predominantly about minor illnesses. None of the studies in our review was adequately powered to detect rare but serious adverse outcomes. Since one important function of primary care is to detect potentially serious illness at an early stage, a large study with adequate length of follow up is now justified.

Limitations of the review

Ambiguity exists over the use of the term "nurse practitioner," with much debate about this role.[22 23] The overlap between nursing roles in the United Kingdom and the introduction of another advanced practice nursing title, nurse consultant, adds to the difficulty in understanding the role definitions in nursing.[1 24] Although specific training for nurse practitioners is available, the content of this varies.[25] Because of this ambiguity, the definition used in our review was purposefully inclusive.

Our review was limited by the quality of the available studies. There were few recent randomised trials, and the larger number of observational studies were generally of poor quality. Because of these problems we based our conclusions primarily on the randomised trials, the more recent of which were of

APR- 8-02 MON 1:55 PM ALASKA. NURSES. ASSOC. FAX NO. 907 272 0292 P. 8

generally high quality, although only one study used patients new to both providers.[14]

Noticeable heterogeneity was observed between the studies on almost all outcomes. Although differences between studies in terms of setting, level of nurse training, and the period of time studied were anticipated and explored in our review, much heterogeneity remained after allowing for these factors. This probably reflects the diverse ways in which nurse practitioners currently work. Despite these differences, the direction of the effect for the main findings was consistent between different studies and also between the randomised controlled trials and the observational studies.

It was not possible to conduct a robust economic analysis of the costs of care from nurse practitioners compared with doctors. Only five studies provided data about costs.[16 17 18 19 26] These used different approaches to the valuing of resources and were inadequately powered for economic analysis. The lack of good evidence about the economic impact of substituting nurse practitioners for doctors needs to be addressed in future research, otherwise changes may be introduced that are thought to be efficient when they may not be so.[27]

Policy implications

Our review lends support to an increased involvement of nurse practitioners in primary care. However, most recent research has been based on nurse practitioners providing care for patients requesting same day appointments predominantly for acute minor illness and working in a team supported by doctors. It cannot be assumed that similar results would be obtained by nurse practitioners working in different settings or with different groups of patients, nor that they could substitute entirely for general practitioners.

Unresolved issues

Future research should address several unresolved issues. Firstly, if patients are more satisfied with care provided by nurse practitioners than the factors that lead to this effect should be elucidated. Satisfaction with care could be related to differences in the training and consultation skills of nurses, patients' expectations, or the extra length of time that nurse practitioners spend in consultations.

Secondly, nurse practitioners and doctors did not necessarily work under similar circumstances or with similar pressures on their time, even in the controlled trials. It is necessary to determine whether the differences between nurse practitioners and doctors in patient satisfaction and quality of care remain if they work under identical circumstances, particularly with the same rates of booked consultations.

Thirdly, research on nurse practitioners needs to be broadened to encompass a wider range of patient groups, including those with complex psychosocial problems or chronic diseases. Research is also necessary that extends beyond the scope of comparing individual nurses with doctors and evaluates different models of organisation, such as several nurse practitioners providing care at first point of contact supported by a smaller number of general practitioners providing second line advice.

Finally, the role of a nurse practitioner is not clearly defined in the United Kingdom and includes nurses from a wide range of educational backgrounds. In addition, nurses are increasingly involved in assessing and advising patients with minor illness in settings such as NHS Direct and NHS walk-in centres without a recognised qualification for this role. It is important to study the training, skills, and experience that nurses need in order to offer the benefits to patients shown by our review.

What is already known on this topic

Nurse practitioners have existed in North America for many years

An increasing number of such nurses are being employed in the United Kingdom in general practice, emergency departments, and other primary care settings

Reviews suggest that nurse practitioners are equivalent to doctors on most variables studied, but the relevance of this in the context of the NHS is unclear

What this study adds

Patients are more satisfied with care from a nurse practitioner than from a doctor, with no difference in health outcomes

Nurse practitioners provide longer consultations and carry out more investigations than doctors

Most recent research has related to patients requesting same day appointments for minor illness, which is only a limited part of a doctor's role

Conclusion

Patients are at least as satisfied with care at the point of first contact with nurse practitioners as they are with that from doctors. Although assessments of the quality of care and short term health outcomes seem to be equivalent to that of doctors, further research is needed to confirm that nurse practitioner care is safe in terms of detecting rare but important health problems.

We thank Kate Baxter, Knut Schroeder, Alan Montgomery, and Tom Fahey (Division of Primary Health Care); Karen Rees and Margaret Burke (Department of Social Medicine); Cherry Cullen; and those authors who responded to our call for further research in this field.

Contributors: CS had the idea, devised the protocol, obtained funding, and contributed to data extraction. SH conducted searches, obtained and extracted data, carried out the analysis, and managed the project. EA contributed to the protocol, extracted data, and contributed to the analysis. All authors contributed to the paper. CS will act as guarantor for the paper.

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Competing interests: None declared.

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(Accepted 11 March 2002)

A memorable patient

Bridging medicine

In the early 1990s, as a registrar at J J Hospitals in Mumbai (Bombay), I had the experience of a lifetime. J J Hospitals was situated in a Muslim area of the city, and most of its catchment population were Muslim community whereas most of the doctors were Hindu. With trust between patients and doctors paramount, the different religious beliefs had never vitiated the congenial atmosphere at the hospital.

Then, on 6 December 1992, some Hindu radicals demolished the Babari mosque at Ayodhya, igniting widespread riots. Fundamentalists in both communities set on each other, destroying shops, burning vehicles, and attacking individuals of the opposite faith. Hundreds were killed and thousands injured. The normally busy, vibrant city of Bombay, an epitome of religious harmony, was transformed into a virtual war zone, with seething hatred and distrust. Faced with the stupendous task of managing the countless casualties pouring in, every resident was working relentlessly.

In the casualty department I saw a young Muslim teenager brought by his elder brother. His three fingers were partially cut, but when I rushed to offer first aid I was suddenly rebuffed by the patient's brother, who held me back vehemently with an angry and suspicious stare. Clearly he wasn't prepared to risk his brother being treated by a Hindu doctor. A lot of persuasion was in vain. Ultimately, I had to request one of my Muslim colleagues to take the patient to the operation theatre for further management and tried to forget this as an unpleasant event.

Six hours later, the elder brother himself was wheeled into casualty bleeding profusely from a stab in the groin. Without immediate surgical intervention, he would bleed to death. He looked very angry as I approached and obviously still didn't trust me but realised that his life was at stake. Taking his silence as tacit approval, I rushed him to the operating theatre, controlled the bleeding, and cleaned and sutured the wound. Luckily, no major neurovascular structures were injured. Assuming him to be another religious fanatic, I ignored him once he was settled postoperatively. I had the next patient to look after, and the next, and the next.

Two days later, the atmosphere was still tense. I was working in my own ward when I saw my reluctant patient walking towards me holding a plastic bag with something suspicious within. I also noticed his brother with the injured fingers standing at the end of the ward guarding the door. The ward was a cul-de-sac with no place to run or hide. Panicked, I looked around for a security guard, but none was there. As the man came closer, I knew my life was in danger. Not knowing what was ahead of me, I shut my eyes tightly preparing for any eventuality. He lifted my hand and placed the plastic bag on it, then hugged me tightly and whispered in my ear, "Shukria Bhaijan" ("Thank you, big brother").

I can't remember how long we stood like this, but I could feel tears running down his cheeks. The plastic bag contained a present—chicken biryani his mother had prepared specially for us, the Hindu doctors. I was completely overwhelmed by his gesture, and tears ran down my cheeks. The whole ward was at a standstill, in a state of a shock, watching a Hindu and a Muslim hugging each other in the midst of a city burning in Hindu-Muslim riots.

Until then, I had considered medicine as merely a science used to heal human bodies. But that day I realised medicine can also touch hearts, unite minds, bridge religious divides, and provide memories to cherish life long.

Kishor Choudhari *consultant neurosurgeon, Royal Victoria Hospital, Belfast*

We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.

TO:

Norman Rokeberg, Chair, House Judiciary Committee (Room 118)
1-800-773-4968 (Tel)
1-907-465-2040 (Fax)

Scott Ogan, Vice Chair, House Judiciary Committee (Room 108)
1-800-862-3878 (Tel)
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John Coghill (Room 102)
1-877-465-3719 (Tel)
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Kevin Meyer (Room 110)
1-866-465-4945 (Tel)
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Albert Kookesh (Room 114)
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Jeannette James (Room 214)
1-800-565-3743 (Tel)
1-907-465-2381 (Fax)

Ethan Berkowitz (Room 404)
1-888-465-4919 (Tel)
1-907-465-2137 (Fax)

RE: Senate Bill 37

I am writing to express my strong opposition to Senate Bill 37 which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00 PM.

The current House Labor & Commerce CS has deleted those sections allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consumers' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a nonphysician professional as their healthcare provider.

Senate Bill 37 in any form is unnecessary. According to the January 18, 2002 letter from the Federal Trade Commission to Representative Lisa Murkowski "...current antitrust law already permits physicians to work collectively on legitimate quality of care issues." Physicians could look to strengthening current statute language, specifically Chapter 21.07.010, Patient and Health Care Provider Protection (also known as the Alaska Patient's Bill of Rights), in order to meet their goal of allowing balanced negotiations with insurance comapnies.

If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place. **VOTE NO ON SENATE BILL 37!**

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VOTE NO ON SENATE BILL 37!

Mary Anne Wilson, ANP

337-1005

1982 Waldron Drive
Anchorage, Alaska 99507

April 9, 2002

To:
Norman Rokeberg, Chair, House Judiciary Committee
1-907-465-2040

Scott Ogen, Vice Chair, House Judiciary Committee
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Ethan Berkowitz
1-907-465-2137

Albert Kookesh
1-907-465-2827

Re: Senate Bill 37

As a Family Nurse Practitioner, I am writing to express my strong opposition to Senate Bill 37, which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00 P.M.

The current House Labor & Commerce CS has deleted those sections of the Bill allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consumers' costs may increase and access to health care and health care providers may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers' ability to choose a non-physician professional, such as a nurse practitioner or nurse midwife, as their health care provider.

Senate Bill 37 in any form is unnecessary. Physicians could look to strengthening current statute language, specifically Chapter 21.07.010, Patient and Health Care Provider Protection (also known as the Alaska Patient's Bill of Rights), in order to meet their goal of allowing balanced negotiations with insurance companies. In addition, if enacted, Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place.

I urge you to VOTE NO ON SENATE BILL 37

Candace C. Norris, RN, MS, FNP
Family Nurse Practitioner

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-5903
PHONE: (907)269-5100
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April 5, 2002

The Honorable Norman Rokeberg, Chair
and Members
House Judiciary Committee

Re: SB 37

Dear Representative Rokeberg:

The Department of Law ("department") has provided written comments on SB 37 on numerous occasions to various Senate Committees and the House Labor and Commerce Committee. *See* attached letters. The department opposed the bill in its initial form for several reasons that are discussed in detail in the attached letters. The crux of the department's concern was the following:

- SB 37 will result in anti-competitive conduct that will harm consumers by leading to higher health care costs and a reduction in access to health care.

- SB 37 does not satisfy the United States Supreme Court's requirements under the "state action doctrine" because it does not provide for the appropriate level of state supervision and control over the bargaining process.

The Federal Trade Commission ("FTC") confirmed this analysis in a letter to the House Labor and Commerce Committee dated January 31, 2002. At a recent hearing before the House Labor and Commerce Committee, the Director of the FTC's Office of Policy Planning Ted Cruze testified that this bill would create the potential for serious anti-competitive harm.

In response to some of these concerns, SB 37 was amended to remove reference to any price terms. In its current form, competing physicians can meet with each other and communicate concerning nine areas specified in the bill. The removal of price terms from this legislation greatly reduced the potential for anti-competitive harm. Both the department and the FTC testified, however, that with the removal of price terms, this bill is not needed. Physicians can already meet and confer on issues involving quality of care without fear of violating antitrust laws. Accordingly, this legislation has no utility in its current form.

The Department remains concerned that this bill will create unnecessary government oversight where none is needed. Sponsors of SB 37 claim that providing a mechanism to allow negotiations over quality of care issues will shield negotiating physicians from potential antitrust investigations. SB 37 will not provide that protection. In its current form, SB 37 does not satisfy

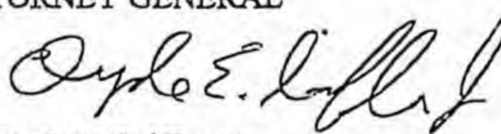
the state action doctrine. That doctrine is discussed in detail in the attached letters. Thus, even if the procedures of SB 37 were followed, negotiating physicians could still be subject to antitrust liability if such negotiations were otherwise illegal, i.e., price or price related terms were discussed.

In addition, proponents of the bill have yet to demonstrate a need for this kind of legislation in Alaska, where there are no HMO's. Representations made by the Alaska State Medical Association concerning the lack of physicians in Alaska and the quality of health care are not supported. In a letter from the department to the House Labor and Commerce Committee dated March 19, the department explains in more detail the lack of any evidence to support these statements.

Please contact me if you have questions or would like to discuss these issues in greater detail.

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: 
Clyde E. Sniffen, Jr.
Assistant Attorney General

cc: Senator Pete Kelly
House Judiciary Committee Members
Mike Abbott
Deborah Behr
Chrystal Smith

CES/sjm/lb

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

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March 19, 2002

Honorable Lisa Murkowski
Chairperson, House Labor and Commerce Committee
State Capitol, Room 408
Juneau, AK 99801-1182

Re: SB 37; Physician Negotiations with Health Care Insurers

Dear Representative Murkowski:

The Department of Law ("department") is pleased to offer these comments on SB 37 (version 22-LSO323\R) following recent developments on this legislation. Specifically, the Department agrees with the comments made by the Federal Trade Commission ("FTC") in its letter to you dated January 31, 2002. The FTC's comments are consistent with comments made by the department last year on this legislation. Those comments can be summarized as follows:

- SB 37 will result in anti-competitive conduct that will harm consumers in the form of higher health care costs and a reduction in access to health care.

- SB 37 does not satisfy the United States Supreme Court's requirements under the "state action doctrine" because it does not provide for the appropriate level of state supervision and control over the bargaining process.

In addition, proponents of the bill have yet to demonstrate a need for this kind of legislation in Alaska, where there are no HMO's. The FTC opposed a similar bill proposed by Washington State that would allow joint price negotiations by competing providers. *See* Washington House Bill 2360, attached. For many of the same reasons SB 37 was opposed, the FTC criticized the Washington bill because it would authorize illegal price fixing, and was not needed to permit competing providers to exchange

information under certain circumstances. *See* FTC's February 8, 2002 letter attached. In response to this and other criticisms, including an opposition to the bill by Washington's Attorney General, the bill was amended to a "study bill" establishing a joint select committee on collective negotiations to study the need for collective negotiations. *See* attached letter from Washington Attorney General Christine O. Gregoire, and Substitute House Bill 2360.

Interestingly, General Gregoire noted a strong disagreement on the need for the legislation because of dramatically different opinions and statistics on whether there was a shortage of physicians in Washington – a position taken by the Washington State Medical Association. The Alaska State Medical Association ("ASMA") makes these same claims with respect to SB 37. There is no evidence that Alaska has experienced a shortage of health care providers, or that the current physician/insurer environment has been the cause of any physicians leaving the state.

In a letter from Jim Jordan of the ASMA dated February 11, the ASMA claims "Alaska has an inadequate number of physicians . . . ." I strongly urge this committee to question that statement, and gather reliable statistics to determine whether Alaska suffers from a lack of physicians. The ASMA further claims that a "great number" of physicians will be leaving practice because of age or retirement. This phenomena is not new to the practice of medicine, and occurs in every occupation without incident. There is no evidence to suggest that the rate of retiring physicians in Alaska is unusual or that it has caused a physician shortage.

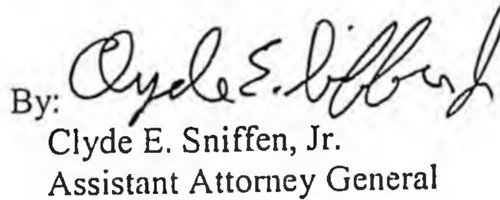
Mr. Jordan also states that a "symbiotic relationship exists between physicians and third party payors" which is "necessary due to legitimate public health reasons." These relationships are formed between physicians and insurers in a competitive environment, and there is no evidence of a public health concern. The ASMA's primary concern, that insurers only offer physician contracts on a "take it or leave it" basis, has not been shown to cause any public health crisis, either in terms of access to health care, quality of health care, or a shortage of physicians.

Finally, the department disagrees with the AMA's characterization of the FTC's letter as representing the views of only two FTC staff members. The letter represents the views of the entire staff of the FTC Bureau of Competition and the FTC Office of Policy Planning. *See* footnote 1 of the letter. Further, The Commission voted 5-0 to authorize the submission of the letter to this committee. The views in the letter are clearly those of the entire commission.

Please contact me if you have questions or would like to discuss these issues in greater detail.

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: 
Clyde E. Sniffen, Jr.
Assistant Attorney General

cc: Senator Pete Kelly
House L&C Committee Members
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Deborah Behr
Chrystal Smith

CES/sjm

Christine O. Gregoire
ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE • PO Box 40100 • Olympia WA 98504-0100

February 4, 2002

The Honorable Margarita Prentice
Washington State Senate
P.O. Box 40482
Olympia, WA 98504-0482

The Honorable Eileen Cody
Washington State House of Representatives
Legislative Building
P.O. Box 40600
Olympia, WA 98504-0600

Re: SB 6642/HB 2360- regulation of negotiations between health providers and health carriers

Dear Senator Prentice and Representative Cody:

Thank you for the opportunity to comment regarding HB 2360/SB 6642. The bill expands current law by allowing joint price negotiations by providers and requiring state oversight of those negotiations.[1] For the reasons explained below, the Attorney General's Office opposes this particular legislation as currently drafted.

Initially, I would like to point out that my staff and I met with representatives of the Washington State Medical Association, Spokane County Medical Society, Regence, Premera and Group Health, to discuss this proposal. Not surprisingly, viewpoints drastically differed on the need for the legislation and the assumptions upon which the legislation is premised. However, three points became apparent to me. First, the parties disagree on the need for the legislation because they offer diametrically different opinions and statistics on whether there is in fact a shortage of physicians or any other health providers in the state. While the physicians offered accounts of doctors having difficulties with carriers and leaving the state, the carriers presented statistics showing that the number of health providers in every category, except LPNs, has increased in greater proportion than the increase in the Washington state population. I am in no position to determine whose statistics are correct.

[1] Current law allows collective discussions of nonprice issues concerning quality and service.

February 4, 2002
Page 2

Second, all parties agreed that Washington state providers and carriers are greatly hampered by the extremely low reimbursement rates paid by the federal government for Medicare patients. These low federal reimbursement rates create challenging business environments for physicians and also result in low benchmark rates used by the carriers for their reimbursement rates. As a result, providers feel pressured to obtain higher rates from commercial insurers to help address this inadequacy. I agree strongly with both groups that federal reimbursement rates should be raised for providers in Washington state and am taking separate steps to try to help address that issue.

Third, it appears that communications between the physicians and carriers have broken down. Physicians stated that one of their main goals of the proposed legislation is to create a dialogue with carriers, because they currently feel they must "take it or leave it" with no questions asked. They feel reimbursement levels have not been adequate and they can make no headway without some dialogue. In response, carriers insist that they have mechanisms currently in place which create an ongoing dialogue, including conversations concerning price. They also point to increased payments to providers over the years as indications that they are being reasonable in those discussions. These differing viewpoints describing the degree of communication themselves indicate that something should be done to improve the dialogue between the parties. To use an old adage, the providers and the carriers were not unlike "ships passing in the night" on these issues.

The three points above help in understanding the context in which this legislation has been proposed. Unfortunately the current draft is contrary to competition policy as articulated by our long established antitrust laws. It does not clearly identify what pricing activity is to be "authorized" or "supervised" and it creates an additional significant fiscal impact on both the Department of Health and my office.

As the chief law enforcement of the state, like my colleagues, I have generally opposed exemptions from the antitrust laws, including exemptions for airlines and major league baseball. It is my strong belief that consumers benefit most when the marketplace r ains free and open, requiring competitors to compete on the basis of price, quality and service. The proposed legislation allows collective behavior that to date has been viewed by the courts as so pernicious it is per se illegal. The courts have ruled this way because collective price-setting by competitors generally results in higher costs to consumers, without any corresponding benefit. This is true even when price-fixing is done in response to a dominant market power, including when those claims are made in health care markets.[2]

As noted above, there is not a consensus on the definition of the problem. At a minimum, care should be taken to determine the scope of the problem and limit the exemption to those particular areas. For example, the assumption that there is a shortage of health care providers may be true for some categories of providers but not others. Any shortage may vary depending

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[2] Michigan State Medical Society, 101 F.T.C. 191 (1983); *United States v. Alston*, 974 F. 2d 1206 (9th Cir. 1992).

on the geographic region of the state, and also may vary by specialty. I believe it would be problematic not to find a less anticompetitive alternative designed to focus on the specific problem identified.

It is important to recognize that this legislation is unprecedented. Attempts at federal legislation allowing for joint price negotiations have been rejected. Only two states to date have passed legislation allowing joint price negotiations and in each state it is allowed only in extremely limited circumstances. In Texas, the law recognizes the possibility of providers gaining undue bargaining power and caps the number of participants at 10% of the physicians in a market. In New Jersey, payment issues can be discussed only after a finding that a carrier in a particular area has substantial market power, with the caveat that the carriers do not have to participate. In contrast, this legislation applies to *all* providers in any market, regardless of a finding that there is any form of market power in existence and regardless of the size of the negotiating group. It simply allows unfettered joint action, placing an enormous burden upon DOH and the AGO to try to review and regulate the activity.

The proposal is also vague as to the standards my office and DOH should use when reviewing the joint negotiations. As currently structured, the legislation contemplates a scheme in which the DOH would seek "legal"[3] opinions from the AGO concerning all proposals to collectively bargain. There are no clear guidelines as to what is to be "authorized". While such standards may be workable in reviews of nonprice activities, as are currently reviewed, without clear direction from the legislature, the DOH and AGO will have no guidance concerning what the legislature contemplates as being "authorized" pricing behavior. Because collective price negotiations are generally viewed as always harming consumers, it will be difficult to contemplate a situation in which price-fixing should be "authorized" as a policy matter. Therefore, we need the legislature to specify what types of prices, or price increases, it feels are appropriate for a level of service so that the DOH and my office can carry out that directive.

Finally, the fiscal impact on both the AGO and DOH may be significant. For immunity to attach, there must be "active supervision" by the state, not simply a passive form of regulation.[4]. As noted above, price negotiations create a new form of regulation by the state. DOH and the AGO will have to establish a regulatory infrastructure to handle these petitions and provide ongoing oversight.[5] Theoretically every health provider in the state could petition for immunity as part of some group, or several groups.

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[3] It is not clear why the word "legal" was inserted into the bill, but it does create confusion due to the existence of formal AGO Opinions. It is also not clear whether the word "legal" is meant to bind the DOH to the AGO opinion.

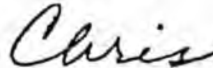
[4] *Federal Trade Commission v. Ticor Title Insurance Company*, 504 U.S. 621 (1992).

[5] WSMA takes the position that ongoing oversight after a price discussion takes place is not necessary. However, this theory is untested and the Attorney General is concerned that without continuing oversight the sought for immunity will not attach.

The current proposal is not clear on other important points. For example, Section 2(8) limits the review fee to paying the Attorney General's "costs" of issuing the opinion. It is unclear if this includes allowance for payment of staff time to research and respond to the opinion request. Absent that inclusion my office simply does not have the staff to absorb this responsibility. Also, when does the review fee get paid? Is it one fee for every contract including all subsequent renewals? If so, $25,000 is clearly an insufficient fee amount.

In summary, it is apparent that our providers and carriers are suffering from a lack of communication and low reimbursement rates. There also may very well be a shortage of certain types of providers in certain areas of the state. Perhaps a legislative study that probes the specific problems encountered by both carriers and providers may be an appropriate means to develop a viable solution to these difficulties. In suggesting this to them I found they both seemed receptive.

Sincerely,



CHRISTINE O. GREGOIRE
Attorney General

COG/nc
cc: The Honorable Tom Campbell
The Honorable Shay Schaul-Berke

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Office of Policy Planning
Northwest Region

February 8, 2002

By Facsimile and First Class Mail

The Honorable Brad Benson
Ranking Minority Member
Financial Institutions & Insurance Committee
State of Washington House of Representatives
412 John L. O'Brien Building
Olympia, WA 98504-0600

Re: Washington House Bill 2360

Dear Representative Benson:

We are pleased to provide comments on House Bill 2360 and the four specific issues you raised.[1] As you note, House Bill 2360 seeks to allow physicians and other health care providers to engage in collective bargaining with health plans over a variety of contract terms and conditions, including the fees they would receive for their services.

The Federal Trade Commission has opposed a federal antitrust exemption for collective bargaining between providers and health plans.[2] The Commission concluded that an exemption would not ensure better care for patients, and that permitting doctors to join together and exert their collective market power threatens to increase fees, raise insurance premiums, and diminish access to health care. The FTC staff has expressed similar concerns in commenting on collective bargaining bills introduced in Alaska, the District of Columbia, and Texas.[3]

In seeking to immunize provider collective bargaining over fees, House Bill 2360 similarly poses risks of substantial consumer harm. Although the legislative findings suggest that the Bill does not contemplate conduct that would otherwise constitute a *per se* violation of the antitrust

[1] This letter expresses the views of the Bureau of Competition, the Office of Policy Planning, and the Northwest Region of the Federal Trade Commission. The letter does not necessarily represent the views of the Commission or any individual Commissioner. The Commission has, however, voted to authorize the Bureau of Competition, the Office of Policy Planning, and the Northwest Region to submit these comments.

[2] See Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 22, 1999) *available at* <http://www.ftc.gov/os/1999/9906/healthcaretestimony.htm>.

[3] See Letter to the Alaska House of Representatives on Senate Bill 37 (Jan. 18, 2002) *available at* <http://www.ftc.gov/be/v020003.htm>; Letter to the District of Columbia Office of Corporation Counsel on Bill No. 13-333 (Oct. 29, 1999) *available at* <http://www.ftc.gov/be/rigsby.htm>; Letter to the Texas Legislature on Senate Bill 1468 (May 13, 1999) *available at* <http://www.ftc.gov/be/v990009.htm>.

laws – such as agreements between competing physicians "to fix the price of their services" – that is, in fact, precisely the sort of conduct that it expressly authorizes.[4] Moreover, measured against the proposed federal legislation and other bills, House Bill 2360 appears to increase the risk of consumer injury significantly because it *requires* health plans to bargain with providers. This requirement would make it more difficult for plans to resist provider pressures for higher fees. Furthermore, the Bill would expose health plans, but not providers, to severe punishments for a failure to bargain in good faith. Health plans alone could lose their licences, be enjoined from doing business in the state, and incur substantial fines. The Bill asserts that the "requirement of good faith negotiations is a . . . proven process for inducing parties . . . to resolve their differences with accommodations resulting in their mutual benefit."[5] While the process the Bill envisions may work to the "mutual benefit" of the bargaining parties, that process is likely to substantially harm consumers. Accommodations made by health plans to benefit providers are likely to significantly increase health care costs to consumers.

The specific issues you asked us to address raise additional questions about House Bill 2360. As we explain below:

- House Bill 2360 seeks to immunize conduct that the federal antitrust laws regard as illegal price fixing. Such conduct raises the most significant competitive concerns.

- The Bill is not needed to allow providers to exchange information among themselves in circumstances where the exchange is unlikely to harm consumers. Such conduct is competitively neutral or beneficial, and is not illegal under the antitrust laws.

- The Bill – despite its intended effect – may not confer federal antitrust immunity because fee agreements between health insurers and providers are not entitled to immunity under the McCarran-Ferguson Act, the federal statute that immunizes, under certain circumstances, the "business of insurance."

- Finally, House Bill 2360 cannot be said to be likely to provide federal antitrust immunity under the "state action" doctrine because it may not provide sufficient "active supervision" of the anticompetitive conduct at issue.

I. Physician Collective Bargaining Will Likely Harm Consumers

The Commission's testimony before Congress regarding a proposed federal antitrust exemption for physician collective bargaining details the predictable dangers such bargaining

[4] For example, RCW 43.72.310(2)(c) provides that the Department of Health "[s]hall adopt rules permitting health care providers within the service area of a plan to collectively negotiate *all* terms and conditions of contracts, *including reimbursement for provider services*, with a health carrier" (emphasis added).

[5] RCW 43.72.300(1).

would create for consumers:[6]

> Without antitrust enforcement to block price fixing and boycotts designed to increase health plan payments to health care professionals, we can expect prices for health care services to rise substantially. Health plans would have few alternatives to accepting the collective demands of health care providers for higher fees. The effect of the bill . . . can be expected to extend to various parties, and in various ways, throughout the health care system:
>
> - Consumers and employers would face higher prices for health insurance coverage.
> - Consumers also would face higher out-of-pocket expenses as copayments and other unreimbursed expenses increased.
> - Consumers might face a reduction in benefits as costs increased . . .
> - State and local governments would incur higher costs to provide health benefits to their employees.
> - State Medicaid programs attempting to use managed care strategies to serve their beneficiaries could have to increase their budgets, cut optional benefits, or reduce the number of beneficiaries covered.
> - State and local programs providing care for the uninsured would be further strained, because, by making health insurance coverage more costly, the bill threatens to increase the already sizable portion of the population that is uninsured.

These widespread effects are not simply theoretical possibilities. The record of antitrust law enforcement sets forth the impact of collective "negotiations" on the public. For example, as described in the Commission's complaints, collective bargaining by anesthesiologists in Rochester, New York, and by obstetricians in Jacksonville, Florida, forced health plans to raise their reimbursement, and the result was increased premiums for the HMOs' subscribers.[7] Other cases have challenged actions by associations of pharmacists who succeeded in forcing state and local governments to raise reimbursement levels paid under their employee prescription

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[6] FTC Testimony on H.R. 1304, supra note 2, at 5 (footnotes 7-9 in original).

[7] Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

drug plans.[8] In one such case, an administrative law judge found that the collective fee demands of pharmacists cost the State of New York an estimated $7 million.[9]

The Commission's testimony also examined two arguments frequently advanced to justify physician collective bargaining – that it would: (1) increase patients' quality of care, and (2) allow physicians to negotiate on a more "level playing field." The Commission pointed out that physicians do not need to engage in joint fee negotiation to improve quality of care; they can work to improve care directly.[10] Furthermore, providers can communicate the results of their efforts to health plans without violating existing law:

> [T]he antitrust laws do not prohibit medical societies and other groups from engaging in collective discussions with health plans regarding issues of patient care. Among other things, physicians may collectively explain to a health plan why they think a particular policy or practice is medically unsound, and may present medical or scientific data to support their views . . . . The Commission has never brought a case based on physicians' collective advocacy with a health plan on an issue involving patient care.[11]

The Commission also noted that a collective bargaining exemption would not level the playing field, but would instead favor physicians to the detriment of consumers:

> Arguments that consumers would not be harmed by an antitrust exemption for collective bargaining by independent health care professionals appear to rest on assertions that the [federal] bill would balance the bargaining power between health care professionals and health plans. These assertions, however, are incorrect. The bill would permit doctors to create monopolies. On the health plan side of the ledger, the evidence does not support the suggestion that most (or even many) areas have only one or two health plans.[12]

II. Responses to Specific Questions Regarding HB 2360

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[8] See, e.g., Baltimore Metropolitan Pharmaceutical Assoc., Inc., and Maryland Pharmacists Assoc., 117 F.T.C. 95 (1994) (consent order); Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

[9] See Peterson Drug Company, 115 F.T.C. 492, 540 (1992). See also Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

[10] As the Commission and others have noted, there are a variety of ways of improving quality of care (e.g., through evaluation of existing procedures, dissemination of best practices, and development of quality ratings for providers and health plans).

[11] FTC Testimony on H.R. 1304, supra note 2, at 7.

[12] Id. at 6.

Our responses to the specific issues you raised identify additional questions about House Bill 2360. In particular, our response to your "state action" question indicates that the Bill is insufficient either to establish this exemption or to protect consumers from the dangers of provider collective bargaining described above.

1. Would the Bill authorize conduct that is considered to be illegal price fixing under the federal antitrust laws?

Yes. Since the Bill would allow competing providers to agree on the prices they would accept for their services, it would authorize *per se* illegal price fixing. The Health Care Guidelines issued by the Federal Trade Commission and the U.S. Department of Justice address this issue directly.[13] In Example 3 of Statement 8, competing physicians form a hypothetical independent practice association ("IPA") to "combat the power" of managed care plans by negotiating with them collectively rather than individually. The IPA involves no integration that is likely to result in significant efficiencies (*i.e.*, no financial risk-sharing among the members; no indicia of clinical integration, such as joint development of protocols for improving care; *etc.*). This combination – collective negotiation over price and no significant efficiency-enhancing integration – means that "the physicians' agreement to bargain through the joint venture will be treated as *per se* illegal price fixing."[14] In short, collective bargaining over prices amounts to *per se* illegal price fixing.[15]

2. Do the current antitrust laws, as interpreted by the Federal Trade Commission, prohibit the exchange of information among competing health care providers in situations where such exchange of information is unlikely to harm consumers?

No. The antitrust laws do not prohibit information exchanges that are unlikely to harm consumers. The Supreme Court has determined that information exchanges among competitors must be evaluated on a case-by-case basis to determine whether their benefits outweigh any potential anticompetitive effects.[16] In an assessment of the net effect of a particular exchange, the decisive issue is the impact on consumer welfare.[17] Thus, if a plaintiff cannot show that an

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[13] See Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (Aug. 1996) ("Health Care Guidelines") *available at* <http://www.ftc.gov/ reports/ hlth3:.htm>.

[14] Example 3, Statement 8, Health Care Guidelines, supra note 13.

[15] Federal Trade Commission v. Superior Court Trial Lawyers Association, 493 U.S. 411, 422 (1990).

[16] See United States v. United States Gypsum Co., 438 U.S. 422 (1978).

[17] See Reiter v. Sonotone Corp., 442 U.S. 330, 343 (1979) ("Congress designed the Sherman Act as a 'consumer welfare prescription'"); General Leaseways, Inc. v. National Truck Leasing Assn., 744 F.2d 588, 596 (7th Cir. 1984) (rule of reason inquiry ultimately "proceeds to the question whether the challenged practice was likely – with due consideration for any justificatory evidence presented by the defendant – to

information exchange among competing providers is likely to injure consumers, the practice would not be held unlawful.

The Health Care Guidelines illustrate the law's approach to information exchanges. Statement 6 of the Guidelines notes that information exchanges among competing providers "can have significant benefits for health care consumers."[18] In general, therefore, the agencies will evaluate information exchanges by considering their benefits as well as their potential for anticompetitive effects. The Guidelines even identify circumstances in which an information exchange is so unlikely to harm consumers that it falls within an "antitrust safety zone."[19] Accordingly, passage of House Bill 2360 is not necessary to insulate from antitrust liability information exchanges that are unlikely to harm consumers.

3. Are agreements between health carriers and health care providers regarding the provision of services to subscribers of the health carriers within the "business of insurance" as defined in the McCarran-Ferguson Act (codified at 15 U.S.C. §§ 1011-1015)?

Although McCarran-Ferguson protects certain types of activities by insurers (to the extent such activity is regulated by state law), the Supreme Court has held that an insurance company's agreements with providers on the fees they will be paid are not "the business of insurance" and thus are not covered by the McCarran-Ferguson immunity.[20] This conclusion would not be altered by House Bill 2360's determination to "regulat[e] the procedures under which health carriers negotiate the terms and conditions of contracts for health care provider services."[21] State regulation of insurer-provider contracts would satisfy the second element of the McCarran-Ferguson exemption, the "regulated by state law" element. But it would not change the result under the first element – "the business of insurance" – which depends on specific business or

help rather than hurt competition, viewed not as rivalry as such but as the allocation of resources that maximizes consumer welfare").

[18] Statement 6, Health Care Guidelines, supra note 13.

[19] Specifically, the Health Care Guidelines state that, absent extraordinary circumstances, the antitrust enforcement agencies will not challenge provider participation in written surveys of prices for healthcare services or salaries of healthcare personnel if: (1) the survey is managed by a third party; (2) the information provided by participants is based on data more than three months old; and (3) at least five providers report data on each statistic, with no provider's data representing more than 25%, and all data are disseminated in aggregated form. Id.

[20] FTC Testimony on H.R. 1304, supra note 2, at 6 (citing Group Life & Health Insurance Co. v. Royal Drug, 440 U.S. 205 (1979)). See also Ratino v. Medical Serv., 718 F.2d 1260 (4th Cir. 1983) (Blue Shield's "usual, customary and reasonable" insurance plan involving provider agreements is not the business of insurance).

[21] RCW 43.72.300(2).

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[21] RCW 43.72.300(2).

economic characteristics, not the presence or absence of state regulation.[22]

4. Is the Bill likely to be effective in creating immunity from the federal antitrust laws, under the "state action doctrine," for collective bargaining by competing health care providers (*e.g.*, does this bill provide for "active supervision" by the State that is sufficient to satisfy the requirements of the state action doctrine as set forth by the United States Supreme Court)?

Under the judicially-created "state action" doctrine, a state may override the national policy favoring competition only where it expressly decides to govern aspects of its economy by state regulation rather than market forces. A state may not simply authorize private parties to violate the antitrust laws.[23] Instead, it must actually substitute its own active control for the discipline that competition would otherwise provide. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct.[24] The critical question here is whether the collective bargaining over fees authorized by the Bill will be subject to sufficient state supervision.

In order for state supervision to be adequate for state action purposes, state officials must "exercise ultimate control over the challenged anticompetitive conduct."[25] The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State effectively has made [the challenged] conduct its own."[26] Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties."[27]

Given the indeterminate nature of the supervisory regime created by House Bill 2360, it is

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[22] See ABA Section of Antitrust Law, Antitrust Law Developments 1295-96 (4th ed. 1997) ("business of insurance" determined by three criteria: "(1) whether the practice has the effect of spreading or transferring a policyholder's risk, (2) whether the practice is an integral part of the policy relationship between insurer and the insured, and (3) whether the practice is limited to entities within the insurance industry").

[23] See Parker v. Brown, 317 U.S. 341, 351 (1943) ("a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful").

[24] See California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 92 (1980).

[25] Patrick v. Burget, 486 U.S. 94, 101 (1988).

[26] Id. at 106.

[27] Federal Trade Commission v. Ticor Title Insurance Co., 504 U.S. 621, 634-35 (1992).

not at all clear that it would satisfy the Supreme Court's rigorous standard. In particular, there is no provision in the Bill to ensure that the relevant state agencies receive sufficient information to be able to exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention."[28]

For example, both the Office of the Attorney General ("OAG") and the Department of Health ("DOH") are expected to determine if specific provider conduct is authorized by the Bill. OAG makes this assessment based on a request for informal opinion,[29] while DOH reviews a petition for approval of conduct.[30] Both are written documents prepared unilaterally by providers. But the Bill provides no guidance regarding the types of information that either document is required to contain. The annual progress reports to be filed by successful petitioners suffer from a similar defect.[31] To be sure, the Bill does not suggest that the OAG and DOH will lack authority to require the submission of a full factual record through regulatory provisions (as they have done in other contexts),[32] but neither does the Bill purport to provide guidance as to what the contours of those regulations should be. Thus, the Bill fails to specify any independent basis upon which the state would "effectively . . . ma[k]e [the challenged] conduct its own."

In some regulatory contexts, state agencies might be able to rely on interested non-parties, such as advocacy groups and consumers, to supply any missing information. House Bill 2360, however, does not necessarily provide an opportunity for notice and comment by the public, leaving it instead to OAG and DOH to decide whether to allow such input.

Even if the agencies were ultimately provided with adequate information, the lack of statutory guidance regarding the manner in which OAG and DOH should exercise their supervisory authority potentially creates another active supervision problem. For example, the Bill merely provides that OAG shall issue a legal opinion within 30 days of receipt of a request.[33] As OAG itself has noted, the Bill does not provide sufficient guidance regarding the factors that OAG can, or should, consider when determining whether to approve particular provider conduct.[34] The manner in which DOH should exercise its statutory authority is similarly

[28] Id. at 634.

[29] RCW 43.72.310(1).

[30] RCW 43.72.310(3).

[31] RCW 43.72.310(6).

[32] Cf. WAC 246-25-110 - 131, issued under RCW 43.72.

[33] RCW 43.72.310(1).

[34] See Letter of Hon. Christine O. Gregoire to Washington Legislature on SB 6642/HB 2360 (Feb. 4, 2002) at 3. For example, if a group of providers were to negotiate a 20% fee increase after the legislation was passed, how much would the providers have to increase their services or improve their quality of care

indefinite,[35] as are the "annual or more frequent reviews" DOH is expected to provide with OAG's "assistance."[36]

Even if the reviewing agencies are able to overcome these informational obstacles, it is unclear whether House Bill 2360 would survive court scrutiny. In order to constitute active supervision, state agencies must "have *and exercise* power to review" the challenged anticompetitive conduct.[37] Thus, the scope of actual agency conduct under the bill would be highly relevant to the state action inquiry. Currently, the DOH appears to have no formal program for overseeing collective provider conduct and no budget for such a function. Under the existing state antitrust immunity statute,[38] the OAG has conducted several investigations of proposed provider alliances and similar conduct in order to advise DOH. But as presently structured and funded, neither DOH nor OAG may be able to actively supervise the broad range of collective activity the Bill would authorize. And if the state regulatory scheme does not satisfy the requirements of the state action defense, private parties who engage in collective negotiation of fees will run the risk of potentially significant financial liability for their actions.

House Bill 2360 also raises a broader policy issue: how much costly regulatory oversight is the state willing to undertake to ensure that consumers are not harmed by the price fixing the Bill would permit? Regulations issued under the existing immunity statute do not allow providers to engage in collective negotiation of prices.[39] If Washington reversed that determination and authorized provider price fixing, but still wished to protect consumers from the predictable consequences of such price fixing, it would have to engage in price regulation. Yet as the experience of public utility commissions indicates, price regulation can be a complex, time-consuming, and expensive effort, requiring attention to numerous cost, risk, quality, and service issues with no assurance of achieving the correct result. If the state decides to replace the market with collective determination of prices, protecting consumers and the public interest may require such costly and uncertain regulation.

* * *

to justify the higher fees? The Bill does not say. It lists several general factors the agencies must consider in evaluating a price increase, but it does not explain how much weight to give them.

[35] Rather than setting forth clear standards, the Bill simply provides that such standards will be articulated through subsequent DOH rulemaking. See RCW 43.72.310(2)(b)-(c).

[36] RCW 43.72.310(6).

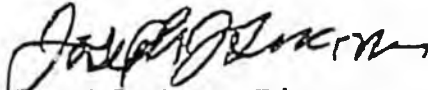
[37] Patrick, 486 U.S. at 101 (emphasis added).

[38] RCW 43.72.

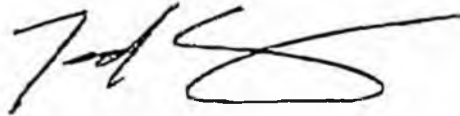
[39] WAC § 246-25-040 (finding that the costs of collective fee negotiations far outweigh any possible benefits).

We hope you find these comments helpful. If you have additional questions, please contact Jeff Brennan at (202) 326-3688 or John Kirkwood at (206) 220-4484. Our view, in short, is that House Bill 2360 poses substantial risks for residents of the State of Washington. The Bill would authorize provider price fixing and thus threatens consumers with higher prices and restricted access to health care – without compensating benefits. In addition, if the state did not engage in sufficient supervision to exercise genuinely independent control over collectively bargained fees, the Bill would fail to confer "state action" immunity and would expose providers who engage in collective bargaining to a significant risk of liability and damages.

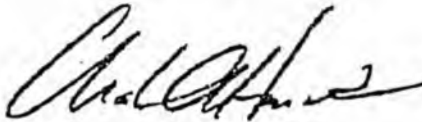
Sincerely,



Joseph J. Simons, Director
Jeffrey W. Brennan, Assistant Director
Bureau of Competition



R. Ted Cruz, Director
John T. Delacourt, Attorney
Office of Policy Planning



Charles A. Harwood, Director
John B. Kirkwood, Attorney
K. Shane Woods, Attorney
Northwest Region

H-4217.1

SUBSTITUTE HOUSE BILL 2360

State of Washington 57th Legislature 2002 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Conway, Campbell, Cody, Edwards, Wood and Schual-Berke)

Read first time 02/08/2002. Referred to Committee on .

1 AN ACT Relating to the regulation of negotiations between health
2 care providers and health carriers; and creating a new section.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. Sec. 1. (1) There is hereby established a joint
5 select committee on collective negotiations to study the regulation of
6 collective negotiations between health care providers and health
7 insurance carriers authorized under chapter 43.72 RCW. The committee
8 shall be composed of (a) two members of the house of representatives,
9 one from each political caucus to be appointed by the speaker; (b) two
10 members of the senate, one from each political caucus appointed by the
11 president of the senate; and (c) ex officio representatives of the
12 office of the attorney general, the office of the insurance
13 commissioner, and the department of health respectively. The chair of
14 the committee shall be selected by legislative members. In its
15 deliberations, the committee shall consult with health care provider
16 professional associations, health carriers, and other state agencies
17 directly affected by the activities of collective negotiations.
18 (2) The committee shall review (a) the appropriateness of
19 collective negotiations on the terms and conditions of contracts

1 between health care providers and health carriers, including
2 reimbursement for provider services; (b) the benefits of voluntary
3 mediation and arbitration in case of impasse for furthering dispute
4 resolution; (c) the appropriateness of requiring health carriers and
5 health care providers to enter into collective negotiations in good
6 faith; (d) the impact of collective negotiations on the access of the
7 public to health care providers, on the costs of health care services,
8 and on state and federal antitrust laws; and (e) such other matters
9 related to the purposes of this study.
10 (3) The committee may use the staffing and support resources of the
11 office of program research of the house of representatives and the
12 office of senate committee services within available funds.
13 (4) The committee shall report to the legislature by the first day
14 of the regular legislative session commencing in January 2003 on its
15 findings and recommendations, together with any legislative proposals
16 implementing them. The authority of the committee expires at such
17 time.

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H-2875.9

HOUSE BILL 2360

State of Washington 57th Legislature 2002 Regular Session

By Representatives Conway, Campbell, Cody, Edwards, Wood and Schual-Berke

Read first time 01/16/2002. Referred to Committee on Health Care.

AN ACT Relating to the regulation of negotiations between health providers and health carriers; amending RCW 43.72.300 and 43.72.310; adding a new section to chapter 43.72 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 43.72.300 and 1997 c 274 s 6 are each amended to read as follows:

(1) The legislature recognizes that competition among health care providers, facilities, payers, and purchasers will yield the best allocation of health care resources, the lowest prices for health care services, and the highest quality of health care when there exists a large number of buyers and sellers, easily comparable health plans and services, minimal barriers to entry and exit into the health care market, and adequate information for buyers and sellers to base purchasing and production decisions. ((~~However~~)) The legislature further recognizes, however, that managed competition may be adversely affecting the supply of health care providers in this state. The provision of health services by health care providers in participating provider agreements with health carriers, while resulting in health cost containment, is leading to a flight of these providers to other

1 areas of the country where bureaucratic demands on practices are less
2 cumbersome and reimbursement levels are noticeably higher, causing a
3 serious drain on the supply of health care providers available for
4 serving patients and otherwise threatening public access to health care
5 services in the state. As the marketplace of health carriers tends to
6 be more concentrated than the market for health care providers, there
7 is often a disparity of bargaining power between them, resulting in a
8 dramatic disadvantage of health care providers in their efforts to
9 negotiate the terms and conditions of their contracts with health
10 carriers. This inequality of bargaining power is exacerbated by the
11 absence of a health carrier's obligation to bargain in good faith. The
12 prohibition under current law to negotiate appropriate reimbursement
13 levels forces health care providers to either accept the contract
14 proposals offered by health carriers or seek more acceptable terms
15 available in other states. The requirement of good faith negotiations
16 is a recognized and proven process for inducing parties in dispute to
17 resolve their differences professionally with accommodations resulting
18 in their mutual benefit. In addition, the legislature finds that
19 purchasers of health care services and health care coverage do not have
20 adequate information upon which to base purchasing decisions; that
21 health care facilities and providers of health care services face legal
22 and market disincentives to develop economies of scale or to provide
23 the most cost-efficient and efficacious service; that health insurers,
24 contractors, and health maintenance organizations face market
25 disincentives in providing health care coverage to those Washington
26 residents with the most need for health care coverage; and that
27 potential competitors in the provision of health care coverage bear
28 unequal burdens in entering the market for health care coverage.
29 (2) The legislature further finds that the regulation of health
30 insurance by whatever means authorized by state law is within the
31 sovereign and constitutional powers of state government to further its
32 interests in protecting the health, safety, and welfare of the people
33 of the state, and includes regulating the procedures under which health
34 carriers negotiate the terms and conditions of contracts for health
35 care provider services, including reimbursement for these services.
36 The legislature therefore intends to exempt from state anti-trust laws,
37 and to provide immunity from federal anti-trust laws through the state
38 action doctrine for collective negotiations by health care providers
39 with health carriers, including customary communications between health

care providers with those negotiating for them to inform and advance the negotiations with other activities approved under this chapter that might otherwise be constrained by such laws and intends to displace competition in the health care market: To contain the aggregate cost of health care services; to promote the development of comprehensive, integrated, and cost-effective health care delivery systems through cooperative activities among health care providers and facilities; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure universal access to a publicly determined, uniform package of health care benefits; and to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care services, providers of health care services, health care facilities, and Washington residents. To these ends, any lawful action taken pursuant to ((~~chapter 492, Laws of 1993~~)) this section and RCW 43.72.310 by any person or entity created or regulated ((~~by chapter 492, Laws of 1993~~)) under these sections are declared to be taken pursuant to state statute and in furtherance of the public purposes of the state of Washington.

(3) The legislature does not intend and, unless explicitly permitted in accordance with this section and RCW 43.72.310 or under rules adopted ((~~pursuant to chapter 492, Laws of 1993~~)) under these sections, does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal anti-trust laws including but not limited to conspiracies or agreements:

(a) Among competing health care providers not to grant discounts, not to provide services, or to fix the price of their services;

(b) Among health carriers as to the price or level of reimbursement for health care services;

(c) Among health carriers to boycott a group or class of health care service providers;

(d) Among purchasers of health plan coverage to boycott a particular plan or class of plans;

(e) Among health carriers to divide the market for health care coverage; or

(f) Among health carriers and purchasers to attract or discourage enrollment of any Washington resident or groups of residents in a

1 health plan based upon the perceived or actual risk of loss in
2 including such resident or group of residents in a health plan or
3 purchasing group.

4 Sec. 2. RCW 43.72.310 and 1997 c 274 s 7 are each amended to read
5 as follows:
6 (1) A health carrier, health care facility, health care provider,
7 or other person involved in the development, delivery, or marketing of
8 health care or health plans may request, in writing, that the
9 department of health obtain an informal legal opinion from the attorney
10 general as to whether particular conduct is authorized by ((~~chapter~~
11 ~~492, Laws of 1993~~)) this section and RCW 43.72.300. Trade secret or
12 proprietary information contained in a request for informal opinion
13 shall be identified as such and shall not be disclosed other than to an
14 authorized employee of the department of health or attorney general
15 without the consent of the party making the request, except that
16 information in summary or aggregate form and market share data may be
17 contained in the informal opinion issued by the attorney general. The
18 attorney general shall issue such opinion within thirty days of receipt
19 of a written request for an opinion or within thirty days of receipt of
20 any additional information requested by the attorney general necessary
21 for rendering ((~~an~~)) a legal opinion unless extended by the attorney
22 general for good cause shown. If the attorney general concludes that
23 such conduct is not authorized by ((~~chapter 492, Laws of 1993~~)) this
24 section and RCW 43.72.300, the person or organization making the
25 request may petition the department of health for review and approval
26 of such conduct in accordance with subsection (3) of this section.
27 (2) After obtaining the written legal opinion of the attorney
28 general and consistent with such opinion, the department of health:
29 (a) May authorize conduct by a health carrier, health care
30 facility, health care provider, or any other person that could tend to
31 lessen competition in the relevant market upon a strong showing that
32 the conduct is likely to achieve the policy goals of ((~~chapter 492,~~
33 ~~Laws of 1993~~)) this section and RCW 43.72.300 and a more competitive
34 alternative is impractical;
35 (b) Shall adopt rules governing conduct among providers, health
36 care facilities, and health carriers including rules governing provider
37 and facility contracts with health carriers, rules governing the use of
38 "most favored nation" clauses and exclusive dealing clauses in such

contracts, and rules providing that health carriers in rural areas contract with a sufficient number and type of health care providers and facilities to ensure consumer access to local health care services;

(c) Shall adopt rules permitting health care providers within the service area of a plan to collectively negotiate all the terms and conditions of contracts, including reimbursement for provider services, with a health carrier ((~~including~~)). The rules must include the ability of providers to meet and communicate for the purposes of these negotiations, a requirement for representatives of health care providers and health carriers to negotiate in good faith, and options for voluntary mediation or arbitration in case of impasse. The rules must provide for the exclusion of agencies and subdivisions of the state of Washington from the requirements of this subsection. For the purpose of collective negotiation under this act, health care providers include those health care practitioners regulated under Title 18 RCW by the department of health to practice health or health-related services or otherwise practicing health care services in this state consistent with state law;

(d) Shall adopt rules governing cooperative activities among health care facilities and providers; and

(e) Effective July 1, 1997, in addition to the rule-making authority granted to the department under this section, the department shall have the authority to enforce and administer rules previously adopted by the health services commission and the health care policy board pursuant to RCW 43.72.310.

(3) A health carrier, health care facility, health care provider, or any other person involved in the development, delivery, and marketing of health care services or health plans may file a written petition with the department of health requesting approval of conduct that could tend to lessen competition in the relevant market. Such petition shall be filed in a form and manner prescribed by rule of the department of health.

The department of health shall issue a written decision approving or denying a petition filed under this section within ninety days of receipt of a properly completed written petition unless extended by the department of health for good cause shown. The decision shall set forth findings as to benefits and disadvantages and conclusions as to whether the benefits outweigh the disadvantages.

1 (4) In authorizing conduct and adopting rules of conduct under this
2 section, the department of health with the advice of the attorney
3 general, shall consider the benefits of such conduct in furthering the
4 goals of health care reform including but not limited to:
5 (a) Enhancement of the quality of health services to consumers;
6 (b) Gains in cost efficiency of health services;
7 (c) Improvements in utilization of health services and equipment;
8 (d) Avoidance of duplication of health services resources; or
9 (e) And as to (b) and (c) of this subsection: (i) Facilitates the
10 exchange of information relating to performance expectations; (ii)
11 simplifies the negotiation of delivery arrangements and relationships;
12 and (iii) reduces the transactions costs on the part of health carriers
13 and providers in negotiating more cost-effective delivery arrangements.
14 These benefits must outweigh disadvantages including and not
15 limited to:
16 (i) Reduced competition among health carriers, health care
17 providers, or health care facilities;
18 (ii) Adverse impact on quality, availability, or price of health
19 care services to consumers; or
20 (iii) The availability of arrangements less restrictive to
21 competition that achieve the same benefits.
22 (5) Conduct authorized by the department of health shall be deemed
23 taken pursuant to state statute and in the furtherance of the public
24 purposes of the state of Washington.
25 (6) With the assistance of the attorney general's office, the
26 department of health shall actively supervise any conduct authorized
27 under this section to determine whether such conduct or rules
28 permitting certain conduct should be continued and whether a more
29 competitive alternative is practical. The department of health shall
30 periodically review petitioned conduct through, at least, annual
31 progress reports from petitioners, annual or more frequent reviews by
32 the department of health that evaluate whether the conduct is
33 consistent with the petition, and whether the benefits continue to
34 outweigh any disadvantages. If the department of health determines
35 that the likely benefits of any conduct approved through rule,
36 petition, or otherwise by the department of health no longer outweigh
37 the disadvantages attributable to potential reduction in competition,
38 the department of health shall order a modification or discontinuance
39 of such conduct. Conduct ordered discontinued by the department of

health shall no longer be deemed to be taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(7) Nothing contained in chapter 492, Laws of 1993 is intended to in any way limit the ability of rural hospital districts to enter into cooperative agreements and contracts pursuant to RCW 70.44.450 and chapter 39.34 RCW.

(8) The secretary of health shall from time to time establish fees to accompany the filing of a petition or a written request to the department to obtain ((~~an~~)) <u>a legal</u> opinion from the attorney general under this section and for the active supervision of conduct approved under this section. Such fees may vary according to the size of the transaction proposed in the petition or under active supervision. In setting such fees, the secretary shall consider that consumers and the public benefit when activities meeting the standards of this section are permitted to proceed; the importance of assuring that persons sponsoring beneficial activities are not foreclosed from filing a petition under this section because of the fee; and the necessity to avoid a conflict, or the appearance of a conflict, between the interests of the department and the public. The total fee for a petition under this section, a written request to the department to obtain ((~~an~~)) <u>a legal</u> opinion from the attorney general, or a combination of both regarding the same conduct shall not exceed the level that will defray the reasonable costs the department and attorney general incur in considering a petition and in no event shall be greater than twenty-five thousand dollars. The fee for review of approved conduct shall not exceed the level that will defray the reasonable costs the department and attorney general incur in conducting such a review and in no event shall be greater than ten thousand dollars per annum. The fees shall be fixed by rule adopted in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW, and shall be deposited in the health professions account established in accordance with RCW 43.70.320.

<u>NEW SECTION.</u> Sec. 3. A new section is added to chapter 43.72 RCW to read as follows:

The insurance commissioner may, subject to a hearing if one is demanded, revoke, suspend, or refuse to accept or renew registration from any health carrier, issue a cease and desist order, or bring an

1 action in any court of competent jurisdiction to enjoin a health
2 carrier from doing any further business in this state, if the health
3 carrier violates the provisions of RCW 43.72.310(2)(c) or any rules
4 promulgated under that subsection. After hearing or upon stipulation
5 by the registrant and in addition to or in lieu of the suspension,
6 revocation, or refusal to renew any registration of a health carrier,
7 the commissioner may levy a fine against the party involved for each
8 offense in an amount not less than ten thousand dollars. The order
9 levying the fine shall specify the period within which the fine shall
10 be fully paid. The period shall not be less than thirty days from the
11 date of the order. Upon failure to pay any fine when due, the
12 insurance commissioner shall revoke the registration of the health
13 carrier and the fine shall be recovered in a civil action brought in
14 behalf of the commissioner by the attorney general. Any fine collected
15 shall be paid by the commissioner to the state treasurer for deposit in
16 the general fund.

17 NEW SECTION. Sec. 4. This act is remedial in nature and shall be
18 construed to effect the purposes expressed in section 1 of this act.

--- END ---

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Office of Policy Planning

By Facsimile and First Class Mail January 18, 2002

The Honorable Lisa Murkowski
Chair, House Labor and Commerce Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Re: Alaska Senate Bill 37

Dear Representative Murkowski:

We write in response to your request for comment on Alaska Senate Bill 37, a bill that seeks to authorize competing physicians to engage in collective bargaining with health plans over fees and other terms.[1] As discussed below, the Commission has opposed legislation before the U.S. Congress that would create an antitrust exemption for physician collective bargaining, and the Commission staff has expressed similar concerns about bills before state legislatures. We continue to believe that the behavior authorized by the physician collective bargaining legislation would significantly increase health care costs and harm consumers.

You also specifically solicited our opinion on whether the bill meets the legal test of the state action doctrine. As you know, state economic regulation can immunize private parties from federal antitrust liability, but only where the displacement of competition furthers a clearly articulated policy of, and is actively supervised by, the state government. In the case of Senate Bill 37, the level of government involvement described falls far short of the level of "active supervision" required by the Supreme Court.

I. Physician Collective Bargaining

The Commission's opposition to legislation intended to create an antitrust exemption for physician

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[1] These comments are views of the staff of the Bureau of Competition and of the Office of Policy Planning of the Federal Trade Commission. They do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize the Bureau of Competition and the Office of Policy Planning to submit these comments.

collective bargaining has historically focused on two fundamental points, both of which are relevant to your consideration of Senate Bill 37:

(1) such legislation would likely harm consumers – an antitrust exemption would authorize price-fixing by physicians, which could be expected to result in increased consumer costs and decreased consumer access to care; and

(2) such legislation would not likely improve the quality of care – an antitrust exemption would not likely improve patient care, and there are other, more effective means of addressing quality of care issues that do not sacrifice the benefits of a competitive marketplace.

A. Consumer Harm

In testimony before Congress regarding a proposed federal antitrust exemption for physician collective bargaining,[2] the Commission detailed the predictable impact on consumers that such legislation would have:

> Without antitrust enforcement to block price fixing and boycotts designed to increase health plan payments to health care professionals, we can expect prices for health care services to rise substantially. Health plans would have few alternatives to accepting the collective demands of health care providers for higher fees. The effect of the bill . . . can be expected to extend to various parties, and in various ways, throughout the health care system:
>
> - Consumers and employers would face higher prices for health insurance coverage.
> - Consumers also would face higher out-of-pocket expenses as copayments and other unreimbursed expenses increased.
> - Consumers might face a reduction in benefits as costs increased.
> - Senior citizens participating in Medicare HMOs would face reduced benefits . . . .
> - The federal government would pay more for health coverage for its employees through the Federal Employees Health Benefits Program and military health

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[2] Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 22, 1999) ("FTC Testimony on H.R. 1304") at 5-6 *available at* <http://www.ftc.gov/os/1999/ 9906/healthcaretestimony.htm> (Attachment A) (footnotes 3-5 in original).

programs.

- State and local governments would incur higher costs to provide health benefits to their employees.

- State Medicaid programs attempting to use managed care strategies to serve their beneficiaries could have to increase their budgets, cut optional benefits, or reduce the number of beneficiaries covered.

- State and local programs providing care for the uninsured would be further strained, because, by making health insurance coverage more costly, the bill threatens to increase the already sizable portion of the population that is uninsured.

These widespread effects are not simply theoretical possibilities. The record of antitrust law enforcement sets forth the impact of collective 'negotiations' on the public. For example, as described in the Commission's complaints, collective bargaining by anesthesiologists in Rochester, New York, and by obstetricians in Jacksonville, Florida, forced health plans to raise their reimbursement, and the result was increased premiums for the HMOs' subscribers.[3] Other cases have challenged actions by associations of pharmacists who succeeded in forcing state and local governments to raise reimbursement levels paid under their employee prescription drug plans.[4] In one such case, an administrative law judge found that the collective fee demands of pharmacists cost the State of New York an estimated $7 million.[5]

Prior Commission cases illustrate the types of physician conduct that have raised problems. Price-fixing is one type of such conduct, and last year's *Alaska Health Network, Inc.*[6] case is a prime example. In that case, the Commission alleged that competing physicians organized and conspired to fix the prices and other competitively significant terms on which they would deal with health plans in

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[3] Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

[4] See, e.g., Baltimore Metropolitan Pharmaceutical Assoc., Inc. and Maryland Pharmacists Assoc., 117 F.T.C. 95 (1994) (consent order); Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

[5] See Peterson Drug Company, 115 F.T.C. 492, 540 (1992). See also Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

[6] Docket No. C-4007, 2001 WL 443471 (F.T.C. April 25, 2001) (consent order).

Fairbanks, Alaska. Another type of conduct is price-related group boycotts, such as the one addressed in the *M.D. Physicians of Southwest Louisiana, Inc.*[7] case. There, the Commission charged a group of competing physicians with conspiring not to deal with certain third-party payers, as part of an unlawful enterprise designed to prevent managed care contracts from taking hold in the Lake Charles, Louisiana region.

There is widespread agreement that horizontal agreements among competitors can raise the most significant competitive concerns. The facilitation of naked horizontal price-fixing is among the most serious of these concerns, as such conduct predictably and consistently results in substantial consumer harm. Departing from the general rules of antitrust in such a competitively sensitive area presents substantial risks that would not be offset by procompetitive gains from physician collective bargaining.

The two arguments that have typically been presented to justify a departure from the general rules of antitrust in this context are that, given health plan concentration, physician collective bargaining would (1) increase patients' quality of care, and (2) allow physicians to bargain on a more "level playing field." The former argument is based on a misunderstanding of both current law and the effects of collective bargaining, as will be discussed in the next section.

The latter argument is more straightforward, but equally problematic. As the Commission explained in its testimony before Congress:

> Arguments that consumers would not be harmed by an antitrust exemption for collective bargaining by independent health care professionals appear to rest on assertions that the [federal] bill would balance the bargaining power between health care professionals and health plans. These assertions, however, are incorrect. The bill would permit doctors to create monopolies. On the health plan side of the ledger, the evidence does not support the suggestion that most (or even many) areas have only one or two health plans.[8]

Furthermore, even if the assumption that physicians confront monopoly health plans were correct, authorizing collusive conduct by physicians would not necessarily serve the interests of consumers. The argument that physician collusion would merely counterbalance hypothetical monopsony power by health plans implicitly assumes that collective bargaining would generate physician fees no larger than the fees that would exist in a competitive market. However, there is little reason to believe that a successful physician cartel would settle for fees at the competitive level. If a health plan possessed actual market power, health care consumers could be doubly harmed by physician collective bargaining, because they could be forced to pay the health care plan's monopoly mark-up on top of the elevated fees charged by the physicians.

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[7] Docket No. C-3824, 1998 WL 566834 (F.T.C. August 31, 1998) (consent order).

[8] FTC Testimony on H.R. 1304, supra note 2, at 6-7.

B. Quality of Care

Proponents of antitrust exemptions for physicians often suggest that greater physician bargaining power against health plans would result in increased quality of care for patients. This claim fails for two reasons: (1) physician collective bargaining has historically focused on physician compensation, rather than patient care; and (2) current antitrust law already permits physicians to work collectively on legitimate quality of care issues.

Immunizing collective bargaining imposes costs while providing little assurance that consumers' interest in quality care will be served. As the Commission stated before Congress:

> Collective bargaining rights are designed to raise the incomes and improve the working conditions of union members. The law protects the United Auto Workers' right to bargain for higher wages and better working conditions, but we do not rely on the UAW to bargain for safer cars. Congress addressed those concerns in other ways.[9]

Moreover, discussions between physician groups and health plans are not illegal. Current antitrust law permits doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The Health Care Guidelines – jointly issued by the Federal Trade Commission and the Antitrust Division of the Department of Justice – emphasize physicians' ability under the antitrust laws to organize networks, and other joint arrangements, to deal collectively with health plans and other purchasers.[10] In addition, through their professional societies and other groups, health care professionals can jointly provide information and express opinions to health plans.[11]

As the Commission explained in its congressional testimony:[12]

> [T]he antitrust laws do not prohibit medical societies and other groups from engaging in collective discussions with health plans regarding issues of patient care. Among other

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[9] FTC Testimony on H.R. 1304, supra note 2, at 10.

[10] See Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (Aug. 1996) ("Health Care Guidelines") *available at* <http://www.ftc.gov/reports/hlth3s.htm>. The Health Care Guidelines discuss "messenger model" arrangements designed to minimize the costs associated with the contracting process.

[11] See, e.g., Schachar v. American Academy of Ophthalmology, 870 F.2d 397 (7th Cir. 1989); Statements 4-5 of Health Care Guidelines, supra note 10.

[12] FTC Testimony on H.R. 1304, supra note 2, at 7-8 (footnotes 13-15 in original).

things physicians may collectively explain to a health plan why they think a particular policy or practice is medically unsound, and may present medical or scientific data to support their views . . . .[13]

The Commission has never brought a case based on physicians' collective advocacy with a health plan on an issue involving patient care. Our cases have addressed instances in which physician groups (1) negotiated collectively on fee levels or other price-related issues, or (2) collectively refused to contract with plans, either to gain acceptance of their price-related demands or to prevent or delay market entry by managed care plans generally. In all such cases, the Commission has been very careful to make sure that its orders do not interfere with the legitimate exchange of information and views between health plans and health care practitioners. Indeed, in the Commission's first litigated case involving collective negotiations by physicians - *Michigan State Medical Society* - the opinion emphasized that the antitrust laws do not prohibit health care providers' collective provision of information and views to health plans.[14] Specific language was inserted in that order, and in subsequent orders, to make it clear that bans on anticompetitive agreements among competing providers do not prohibit the provision of information and views to health plans concerning any issue, including reimbursement.[15]

Accordingly, blanket antitrust immunity for physician price-fixing is not necessary to protect patient welfare.

II. The Alaska Bill

Nonetheless, Senate Bill 37, like its federal and state counterparts, seeks to confer antitrust immunity with respect to collective physician conduct. To be sure, Senate Bill 37 also contains a number of provisions designed to protect consumers from the potential harms arising from a physician collective bargaining exemption. In some respects, these provisions resemble protections contained in physician collective bargaining bills introduced in Texas and the District of Columbia, on which the

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[13] [The Health Care Guidelines] create an antitrust safety zone for health care providers' collective provision of non-fee-related information to health plans. . . . [See Statement 4 of Health Care Guidelines, supra note 10.]

[14] 101 F.T.C. [191,] at 302-09 [(1983)].

[15] Id. at 314; see also Southbank IPA, 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

Commission staff also has commented.[16] As with the protections in the Texas and District of Columbia bills, these provisions – addressing a health plan's market power, the size of the physician bargaining group, and potential boycott conduct – do not alleviate the risk of substantial consumer harm resulting from a collective bargaining exemption.

A. Minimum Threshold for Health Plan Market Power

Section (d)(1) of Senate Bill 37 states that physicians may "collectively negotiate with a health benefit plan the items described in (b)" – including fees or prices – provided that the health benefit plan has "substantial market power." "Substantial market power" is defined as "more than 15 percent of the market share." *Id.* at § (s)(4). Alternative formulas by which market power may be measured are set forth in Sections (f)(1) and (f)(2).

This market power screen is unlikely to guard against consumer harm.

First, the screen does not apply to all collective bargaining by physicians, or even to all price-related bargaining. Rather, it applies only to certain kinds of price-related matters. For example, the market share screen does not apply to negotiations concerning the formulation and application of reimbursement methodology. *Id.* at § (a)(6). The method a health plan uses to calculate its payments to providers for particular services, however, can have a direct and significant impact on the ultimate price that providers receive for their services, and thus such matters are also "price" terms. Moreover, even collective bargaining over other, more clearly "non-price" issues in a health plan contract can have a substantial effect on the ultimate costs paid by consumers.

Second, there are significant problems with the concept of health plan market power as defined in the bill. As the Commission staff noted in its comment on the District of Columbia bill:

> Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only if based upon a properly defined market. Even if the bill's categories correctly identified relevant markets, a 15% market share . . . is not a level ordinarily assumed to constitute market power.[17]

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[16] Letter to the Texas Legislature on Senate Bill 1468 (May 13, 1999) *available at* <http://www.ftc.gov/be/v990009.htm> (Attachment B); Letter to the District of Columbia Office of Corporation Counsel on Bill No. 13-333 (Oct. 29, 1999) ("District of Columbia Letter") *available at* <http://www.ftc.gov/be/rigsby.htm> (Attachment C).

[17] District of Columbia Letter, supra note 16, at 3-4.

Although the Alaska bill's definition of "substantial market power" is not entirely clear, one thing is certain: it does not define antitrust markets in a legal or economic sense. For example, it uses as a proxy for a relevant geographic market the health plan's "service area," but this area does not necessarily correspond to a proper relevant antitrust geographic market, and could serve to overstate the market share of the plan.

Furthermore, by setting the market power threshold at a 15 percent market share, the bill would authorize anticompetitive behavior by physicians in many situations in which the health plan would not in fact possess market power. Indeed, 15 to 20 percent is below the level courts typically require before upholding a finding of market power.[18] Finally, the bill does not take into account that even a plan with a large share of a market might be constrained from exercising market power if new entry by competing plans is easy.

Third, in practice, the market share screen appears unlikely to provide any limitation at all. That is because the bill would create a presumption that a health plan has substantial market power (Section (f)), unless the health plan persuades the Attorney General that it does not meet the 15 percent threshold. It seems unlikely that a health plan would seek to offer such proof, however, because the kind of price-related collective bargaining to which the market share screen applies can occur only if the health plan agrees to engage in such negotiations. *See* Section (d)(3). Thus, it appears that a health plan could simply decline to negotiate with physician collective bargaining groups, without making any showing regarding market share.

In addition, it should be noted that the bill's restrictions on collective fee negotiation to situations where the health plan consents to such negotiations would offer only limited protection to consumers. Such a restriction could limit certain kinds of anticompetitive effects, by preventing groups without health plan consent from engaging in even preliminary bargaining activities (such as physicians entering into agreements on the fee levels to be sought) that could facilitate anticompetitive agreements with respect to physicians' individual dealings with health plans. Nonetheless, a variety of risks remain. First, although participation is voluntary, some health plans may feel compelled to deal with a group if it

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[18] Although the federal courts have not identified a precise market share figure that constitutes market power, the guidance they have provided strongly suggests that 15 to 20 percent is not sufficient. In Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984), for example, the Supreme Court rejected the possibility that the defendant hospital had market power in spite of the fact that it serviced roughly 30 percent of the relevant market. Subsequent opinions from lower courts have tended to adhere to this 30 percent "rule of thumb." See, e.g., United States v. Eastman Kodak Co., 63 F.3d 95 (2d Cir. 1995) (30 percent share of U.S. photocopying market too small to give rise to inference of market power); New York v. Anheuser-Busch, Inc., 811 F. Supp. 848 (E.D.N.Y. 1993) (40 percent market share insufficient to show market power in light of low barriers to entry); Manufacturer's Supply Co. v. Minnesota Mining & Manufacturing Co., 688 F. Supp. 303 (W.D. Mich. 1988) (25.8 percent market share insufficient to show market power).

includes most of the physicians in a particular specialty or many physicians with large numbers of loyal patients. Second, even absent any implicit coercion, in some circumstances a health plan may find it less troublesome to simply accede to price-setting by physicians and then pass the higher costs on to consumers. In either case, such behavior presents a risk not only to the enrollees of the particular plan in question, but also to other consumers, because a group of physicians organized to bargain with one health plan could more easily collude in its dealings with other health plans that eschew collective bargaining.

B. Limitations on Size of Physician Negotiating Group

Section (g)(6) of the Senate Bill 37 states that an authorized third party "may not represent more than 30 percent of the market of practicing physicians in the geographic service area or proposed geographic service area if the health benefit plan has less than a five percent market share." In addition, Section (g)(7) authorizes the Attorney General to limit the percentage of practicing physicians represented by an authorized third party. However, the Attorney General may not impose a limit of "less than 30 percent of the market of practicing physicians" and may not impose any limit at all if "the market of practicing physicians . . . consists of 40 or fewer individuals." *Id.*

These limitations on the size of the physician group authorized to collectively bargain are also unlikely to adequately protect consumers. First, the 30 percent limitation applies only in those cases in which the health plan has a very small share of the (potentially ill-defined) market. Furthermore, the 30 percent limit appears to contemplate a percentage of all physicians and, if so, it would not necessarily prevent aggregation of a large portion of the physicians in a given specialty. Given the high level of specialization among physicians, and the fact that different medical specialty services often are not substitutable, the relevant market for antitrust purposes may be a particular specialty or specialties rather than physicians as a whole. And just as individual specialties may constitute different product markets, relevant geographic markets may differ by specialty.

C. Exclusion of Physician Boycott Conduct

Section (m) of the bill states that the antitrust exemption for physician collective bargaining does not extend to boycott conduct. Specifically, Section (m) states that no provision of the bill should be construed as authorizing "competing physicians to act in concert in response to a report issued by an authorized third party related to the authorized third party's discussion or negotiations with a health benefit plan." It further notes that authorized third parties "shall" inform physicians of Section (m) and "warn them of the potential for legal action against those who violate state or federal antitrust laws." *Id.*

Although this provision is likely to prevent Senate Bill 37 from being used as legal cover for explicit boycott threats, it does not protect consumers from all boycott-related concerns arising from physician collective bargaining. As the Commission has previously observed, collective negotiations

can by their very nature convey an implicit threat that, if the health plan does not agree to terms acceptable to the physician group as a whole, it will be prevented from successfully negotiating agreements with the members of the group separately.[19] Furthermore, by immunizing agreements among competing physicians on the fees and other terms they will accept from health plans, the bill facilitates coordinated conduct – such as collusive refusals to deal – that, even though not immune, would be difficult to detect and prosecute.

III. State Action Immunity

Under the judicially-created "state action" doctrine, a state may override the national policy favoring competition only where it expressly decides to govern aspects of its economy by state regulation rather than market forces. A state may not simply authorize private parties to violate the antitrust laws.[20] Instead, it must actually substitute its own active control for the discipline that competition would otherwise provide. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct.[21]

Senate Bill 37 faces severe difficulties under the "active supervision" prong of that test. In order for state supervision to be adequate for state action purposes, state officials must "have and exercise ultimate authority over the challenged anticompetitive conduct."[22] Senate Bill 37 falls far short of providing the "pointed reexamination"[23] of private anticompetitive conduct necessary to confer antitrust immunity.

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[19] See Alaska Healthcare Network, Inc., Docket No. C-4007, 2001 WL 443471 (F.T.C. Apr. 25, 2001) ("Payors believed that they could not go around [Alaska Healthcare Network] to contract individually with physicians in Fairbanks, and thus that they had no alternative but to reach agreement with AHN or to give up their planned entry into Fairbanks."). See also Michigan State Medical Society, 101 F.T.C. 191, 296 n.32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations).

[20] See Parker v. Brown, 317 U.S. 341, 351 (1943) ("a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or declaring that their action is lawful").

[21] See California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 92 (1980).

[22] Patrick v. Burget, 486 U.S. 94, 100 (1988).

[23] Midcal, 445 U.S. at 105-06.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own."[24] Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties."[25] In this instance, the bill does not appear to provide the Attorney General with the means to exercise sufficient independent judgment and control.

Lack of Active Supervision

The regulatory scheme established by Senate Bill 37 endeavors to provide state supervision of physician collective bargaining by authorizing the Attorney General to approve or disapprove: (1) the composition of a physician collective bargaining group, (2) a brief report on any proposed collective negotiations, and (3) a contract that was the subject of collective bargaining. The Attorney General's role is limited in significant respects, however, making it unlikely that the regulatory scheme would be found to provide the level of active supervision required to confer antitrust immunity.

1. Review of Composition of Physician Groups

The power to approve or disapprove the composition of a physician collective bargaining group is provided by Section (g)(7). This provision states that the Attorney General may limit the percentage of physicians represented by an authorized third party, but that the limitation "may not be less than 30 percent of the market." Furthermore, the Attorney General "shall" consider the potential competitive benefits and anticompetitive effects described in Sections (k) and (l). The Attorney General has no power to impose such limitations when the market of practicing physicians consists of "40 or fewer individuals."

The Supreme Court has emphasized that active supervision requires that state officials "*have and exercise* power to review *particular anticompetitive acts* of private parties and disapprove those that fail to accord with state policy."[26] The Attorney General's limited review of bargaining groups at the formation stage, under Section (g)(7), would not amount to active supervision of "particular anticompetitive acts." Indeed, in a market of "40 or fewer individuals," the Attorney General has no authority whatsoever to review the composition of physician groups. This loophole may be particularly significant in a state like Alaska which, due to its population and its large geographic area, may have a large number of physician specialty markets consisting of 40 or fewer providers.

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[24] Patrick, 486 U.S. at 106.

[25] Federal Trade Commission v. Ticor Title Insurance Co., 504 U.S. 621, 634-35 (1992).

[26] Id. at 634 (emphases added).

2. Review of "Brief Report" on Proposed Negotiations

The power to approve or disapprove a "brief report" on any proposed collective negotiations is provided by Section (h)(1)(B). This provision appears to provide the Attorney General with authority to disapprove proposed negotiations if the physician group is found to be "not appropriate to represent the interests involved in the proposed negotiations."[27] It is unclear, however, what authority this actually would confer, or how the Attorney General could make such an assessment on the basis of the limited information that the third party representative is required to submit. The report would describe the proposed subject matter of the negotiations and a statement of the expected efficiencies or benefits, but it would not supply a wide variety of information that would enable the Attorney General to assess the likely competitive effects of the negotiations. Further, there is no provision for the Attorney General to require submission of additional information, nor any mechanism by which to receive input from other physicians, affected health plans, or patients.

3. Review of Collectively Negotiated Contracts

The power to approve or disapprove a contract that was the subject of collective bargaining is provided by Sections (i) and (j). Section (i) states that the Attorney General "shall" either approve or disapprove a contract "within 30 days after receiving the reports required under (h)." During that brief period of time, the Attorney General is to attempt to ascertain whether "the competitive and other benefits of the contract terms outweigh any anticompetitive effects." Lists of competitive benefits and anticompetitive effects that the Attorney General "may" consider are provided in Sections (k) and (1), respectively.

These provisions have two principal defects that are likely to vitiate the active supervision required by the state action doctrine: (1) the Attorney General is presented with insufficient information, and (2) the Attorney General is given insufficient time. Additionally, a provision requiring a written decision for both contract approvals and disapprovals would help to ensure that adequate information is both sought and reviewed.

(a) Insufficient Information

In order for state action immunity to apply, Supreme Court precedent requires the State to

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[27] The Attorney General may not approve the report if: (1) the group of physicians "is not appropriate to represent the interests involved in the negotiations" (a provision seemingly redundant with Section (g)(7), discussed above), or (2) the proposed negotiations "exceed the authority granted in this chapter." If either of these conditions is satisfied, the Attorney General "shall" enter an order "prohibiting the collective negotiations from proceeding."

"undertake[] the necessary steps to determine the specifics of the ratesetting scheme."[28] Senate Bill 37 falls far short of providing the information necessary for state officials to make such a determination. Moreover, what little information is provided is all at the initiative of third parties. The bill does not authorize the Attorney General to request or gather specific additional information of any kind.[29]

The "brief report" would contain the "proposed subject matter" of the negotiations and one party's "explanation of the [expected] efficiencies or benefits." Notably absent from the "brief report" is a wide variety of information that would assist the Attorney General in assessing the likely competitive effects of the negotiations. An Attorney General armed with greater information – including, for example, information concerning product and geographic market definition, current price levels, availability of substitutes, or ease of entry for new competing physicians – would, of course, be better able to make appropriate determinations. An equally troubling omission from the process is any mechanism by which to receive input from other physicians, affected health benefit plans, or patients. Indeed, the process provides no notice to any of these groups, and so no means for them even to be aware of the potential value of their input.

To attempt to ascertain credibly whether "the competitive and other benefits of the contract terms outweigh any anticompetitive effects" – the core stated criterion of the Attorney General's review – without sufficient data, or adequate input from other parties, would be extremely difficult. Making judgments about competitive effects is the Commission's core function. To carry out this function, the Commission employs a large staff of lawyers and economists, who rely on information gathered from the careful review of a complete documentary record and interviews of numerous key witnesses. "Active supervision" need not necessarily entail the same exhaustive examination but, at the very least, it should constitute a pointed and meaningful review.

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[28] Ticor, 504 U.S. at 638.

[29] Courts have tended to reject claims of state action immunity where state officials lacked sufficient information to conduct a meaningful review of the private conduct. See, e.g., Ticor Title Insurance Co. v. Federal Trade Commission, 998 F.2d 1129, 1140 (3d Cir. 1993) (finding lack of state supervision where Connecticut never obtained necessary information that would have enabled it to assess the appropriateness of filed rates). In contrast, courts have tended to accept such claims where the review included hearings and an opportunity for potentially affected parties to be heard. See, e.g., TEC Cogeneration Inc. v. Florida Power & Light Co., 76 F.3d 1560 (11th Cir.), amended in part, 86 F.3d 1028 (11th Cir. 1996) (rates determined by Public Service Commission rulemaking and subject to extensive agency proceedings); DFW Metro Line Services v. Southwestern Bell Telephone, 988 F.2d 601, 606-07 (5th Cir. 1993) (Public Utility Commission conducted both broad-based ratemaking proceedings and adjudications of specific complaints about the reasonableness of rates); Lease Lights, Inc. v. Public Serv. Co., 849 F.2d 1330, 1334-35 (10th Cir. 1988) (state held public hearings to assess reasonableness of rates).

In addition, Section (h)(3) requires an authorized third party to provide the Attorney General with all communications "to be made to physicians" related to negotiations. This requirement, however, omits at least four additional categories of potentially critical competitive information: (1) communications from physicians to authorized third parties, (2) communications from authorized third parties to health plans, (3) communications between physicians, and (4) communications between authorized third parties.

It is worth noting that the core conduct at issue here, naked price-fixing among horizontal competitors, is deemed to be *per se* illegal precisely because the law presumes that in almost no circumstances imaginable will the benefits "outweigh any anticompetitive effects."[30] To be able to attempt such a judgment, the Attorney General needs to be able to review the relevant information.

(b) Insufficient Time

The law of active supervision requires that the Attorney General have and exercise "independent judgment and control" sufficient to render the challenged conduct effectively that of the State and not that of private parties. Yet Section (i) allows only 30 days for the Attorney General to review the facts and render a decision about the anticompetitive effects of a given contract. The time period is mandatory ("shall either approve or disapprove . . . within 30 days") and there is no provision for extension.[31] It is by no means clear that the Attorney General could complete the "pointed reexamination" required to immunize the underlying physician conduct in such a short time.

IV. Transparency

Section (i) of Senate Bill 37 provides that "[i]f the contract is disapproved, the attorney general shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures that would correct any identified deficiencies." Notably, the bill contains no complementary provision requiring a written decision to *approve* a proposed contract. A written decision, expressly considering the potentially anticompetitive implications of a proposed contract and attempting to quantify the consumer impact and expected effect on consumer prices, would serve a number of salutary purposes. First, it would inform affected parties of the levels at which prices were being fixed, and so provide an opportunity for comment or challenge as to the appropriateness of those levels. Second, it would help inform the public of the likely impact of the proposed contract on their health

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[30] See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (holding naked horizontal price-fixing among physicians to be per se illegal).

[31] In addition, the current legislative draft is ambiguous as to when the 30-day clock commences. Section (i) allows 30 days from receipt of "the reports required under section (h)," without specifying which report – the "brief report," the "copy of all communications," or the contract itself.

care costs.

Under the current draft, an explanation is required only when the Attorney General disapproves a contract. From a consumer perspective, however, disapproval of a contract is the less troubling result. Disapproval indicates that market forces will continue to govern, whereas approval indicates that they will be temporarily suspended, with a potentially adverse impact on price and access. It is the latter situation that more clearly warrants an explanation and is more properly subject to consumer scrutiny.

* * *

In sum, the proposed antitrust exemption for physician collective bargaining is likely to result in increased consumer costs and threatens to reduce access to care. Furthermore, the risk of consumer harm does not appear to be offset by any substantial procompetitive benefits or increased quality of care.

Parties claiming immunity under the state action doctrine bear the burden of establishing their entitlement to such immunity. If the Alaska Legislature were to enact a bill that fails to provide for the level of active supervision required by Supreme Court precedent, physicians relying on the bill's provisions to confer antitrust immunity would risk exposure to potentially significant financial liability for their actions.

Thank you for your inquiry. We hope you find these comments helpful. Should you have any additional questions, please feel free to contact Jeff Brennan at (202) 326-[illegible]688.

Sincerely,

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For Release: January 31, 2002

Related Documents:

Alaska Senate Bill 37, V020003 [PDF 39KB] (January 18, 2002)

FTC Staff Opposes Alaska Proposal to Allow Physician Collective Bargaining

Proposed Legislation Would Significantly Increase Consumer Health Care Costs

A bill pending before the Alaska legislature that seeks to authorize competing physicians to engage in collective bargaining with health plans over fees and other terms would significantly increase health care costs and harm consumers, according to the staff of the Federal Trade Commission. The Commission has opposed similar legislation at the federal level, and Commission staff have expressed concerns about similar bills before state legislatures on a number of occasions.

In response to a request for comment on Alaska Senate Bill 37 from Representative Lisa Murkowski, Chair of the Labor and Commerce Committee of the Alaska House of Representatives, staff of the Bureau of Competition and the Office of Policy Planning note that the bill would authorize horizontal price fixing by physicians, as well as collusive refusals to deal with health plans.

According to the FTC staff opinion, such anticompetitive physician conduct is likely to result in substantial consumer harm. Consumers and employers would face higher prices for health insurance coverage. Consumers would also face a reduction in access to care, as increasing costs would likely result in a reduction in health care benefit options. State Medicaid programs using managed care strategies would be forced to increase their budgets, cut optional benefits, or reduce the number of covered beneficiaries. And state and local programs providing care for the uninsured would be adversely affected as well, as an increase in health care costs would likely add additional consumers to the ranks of the uninsured.

In addition, FTC staff conclude that the proposed regulatory structure to be established by the Alaska bill does not satisfy the Supreme Court's requirements under the "state action" doctrine, which allows a state to override the national policy favoring competition only where it expressly decides to govern aspects of its economy by state regulation rather than market forces. Under that doctrine, a state may not simply authorize private parties to violate the antitrust laws; instead, it must actually substitute its own active control for the discipline that competition would otherwise provide. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct.

As the FTC staff opinion further explains, Senate Bill 37 falls far short of the "active supervision" required by Supreme Court case law. The opinion notes that the Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has

effectively made [the challenged] conduct its own." The Court has also held that active supervision requires a state to exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." In this instance, the bill does not provide the Attorney General with the means to exercise sufficient independent judgment and control, according to the FTC staff opinion. As a result, anticompetitive conduct undertaken in conformity with the bill would not be immunized, and could subject physicians to antitrust liability.

"In sum," the letter concludes, "the proposed antitrust exemption for physician collective bargaining is likely to result in increased consumer costs and threatens to reduce access to care. Furthermore, the risk of consumer harm does not appear to be offset by any substantial procompetitive benefits or increased quality of care."

The letter represents the views of the FTC's Bureau of Competition and Office of Policy Planning. Although it does not necessarily represent the views of the Commission or any individual Commissioner, the Commission authorized submission of the letter by a vote of 5-0.

Copies of the staff opinion letter are available from the FTC's Web site at http://www.ftc.gov and also from the FTC's Consumer Response Center, Room 130, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580. The FTC's Bureau of Competition seeks to prevent business practices that restrain competition. The Bureau carries out its mission by investigating alleged law violations and, when appropriate, recommending that the Commission take formal enforcement action. To notify the Bureau concerning particular business practices, call or write the Office of Policy and Evaluation, Room 394, Bureau of Competition, Federal Trade Commission, 600 Pennsylvania Ave, N.W., Washington, D.C. 20580, Electronic Mail: antitrust@ftc.gov; Telephone (202) 326-3300. For more information on the laws that the Bureau enforces, the Commission has published "Promoting Competition, Protecting Consumers: A Plain English Guide to Antitrust Laws," which can be accessed at http://www.ftc.gov/bc/compguide/index.htm.

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(FTC Matter No.: V020003)

(http://www.ftc.gov/opa/2002/01/alaskaphysicians.htm)

STATE OF ALASKA

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January 19, 2001

Senator Robin Taylor
Chair, Senate Judiciary Committee
State Capitol Building
Juneau, Alaska 99801-1182

Re: SB 37 – Physician Negotiations with Health Benefit Plans.

Dear Senator Taylor:

The State of Alaska, Department of Law submits the following written comments regarding SB 37. "An Act relating to collective negotiation by physicians with health benefit plans; and to [allow] health benefit plan contracts with individual competing physicians." This bill is essentially identical to CS for Senate Bill 256 (Fin) introduced by Senator Kelly during the Twenty-First Legislature in 2000. The following comments, therefore, are essentially the same comments provided by the department to Senator Tim Kelly last year, with minor modifications.

In general, the department has serious legal and policy concerns regarding the collective negotiation aspects of this bill. We believe the bill, if passed, may result in substantial harm to consumers in the form of increased health care costs and reduced health care options. Further, the level of state involvement provided in the bill may not be sufficient under the state action doctrine to immunize physicians from federal anti-trust enforcement.

I. Purpose of Senate Bill 37.

Collective negotiations of price and price related terms by physicians is considered "per se" illegal price fixing in violation of state and federal antitrust laws. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). SB 37 attempts to displace free market competition and allow competing physicians to collectively negotiate with health plans on non-price and price terms of a contract under certain circumstances. The bill also attempts to provide the physicians immunity from prosecution under federal antitrust laws, through the state action doctrine, by establishing a review process of the negotiations and contracts through the Office of the Attorney General.

II. Issues relating to SB 37.

A. Harm to Consumers.

The Department of Law agrees with the concerns relating to collective negotiations by physicians raised by Federal Trade Commission (FTC) representative, Richard Feinstein, in the oral testimony given before the Finance Committee on February 25, 2000, and in the letters submitted to the Committee dated May 13, 1999, and October 29, 1999, relating to collective negotiation legislation in Texas and Washington, D.C. Those letters are attached. Since that time, Texas legislation has been enacted, but not implemented because of serious issues related to the drafting of regulations.

Specifically, according to the FTC, allowing physicians to collectively negotiate on price terms will not ensure better care for patients, and may result in substantial harm to consumers. For instance, likely increased rates negotiated by physicians under negotiated contracts threatens to raise health care costs for individuals, employers, and state and federal governments, and may reduce access to care and increase the number of uninsured. The FTC's conclusions are based on prior investigations and enforcement actions where similar results occurred when physicians collectively negotiated price terms. *See* October 29, 1999 letter from FTC to Robert R. Rigsby, Office of Corporate Counsel, Washington, D.C., pg. 2.

Further, as discussed by Robert Lohr, Director, Alaska Department of Community and Economic Development, Division of Insurance, in his March 30, 2000, letter submitted to the Senate Finance Committee, a recent study conducted by Charles Rivers Associates, Inc., estimates that private health insurance premiums would rise by approximately 5 to 13 percent under the pending federal legislation (H.R. 1304) permitting health care professionals to negotiate collectively with health care plans. Based on this study, and Mr. Lohr's discussions, it can be assumed that Alaska will experience similar increased health care costs as a result of collective negotiations by physicians, absent adequate limits on the collective bargaining.

B. Limits on collective bargaining are not sufficient to protect consumers from substantial harm.

1. Market share limits.

SB 37 provides that health plans must have substantial market power, defined as 15% of the market share, before they will be subject to ***price*** negotiations by physicians. Where a health plan has less than 5% market share, the physician group may not exceed 30% of the market in the physician's geographic service area. ***Non-price terms*** can be negotiated regardless of market share.

Although the bill appears to make the concept of market power an important limitation on physician's ability to collectively negotiate price terms, these provisions are not based on accepted concepts of market power in a legal or economic sense. See FTC letter dated October

29, 1999. Specifically, a 15% market share is not ordinarily presumed to constitute market power. Accordingly, even though a health plan may meet the presumption of market power under the bill, it may not, in fact, have the market power which gives them the ability to reduce prices below competitive levels. Absent a showing that *actual market power* is held by a health plan, there is no justification for collective negotiations.

Further, the bill's limits on physician group size do not reflect the potential market power (ability to raise prices) of physician groups. Currently, SB 37 lacks a cap on the market share of a physician group when negotiating *price terms* with a health plan that has greater than 5% of the market share. This may result in a disproportionately large physician group (up to 100% of the market share in a geographic market) negotiating with a small health plan (as small as 5% market share), resulting in substantial market power by the physicians. The limit on the market share of physicians groups and the corresponding market share limit placed on health plans does not necessarily reflect *actual market power*, and may underestimate the economic clout of a physician group which is dealing with a small health plan.

The bill attempts to cure the above problems by giving the Attorney General the authority to limit the percentage of practicing physicians represented by an authorized third party. The limitation provides, however, that the number of physicians, under any circumstance, cannot be less than 30% of the market of practicing physicians in the geographic service area. This does nothing to cure the problem, and the bill still provides the potential for a physician group to be formed with significant economic clout. There is an exception in the bill which states the limit does not apply if the market of practicing physicians in the geographic service area or proposed geographic service area consists of 40 or fewer individuals. This leaves smaller towns such as Barrow, Sitka, or Ketchikan vulnerable to physician groups that could exercise market power.

2. Prohibition on boycotts/concerted action.

Another limitation in SB 37 relates to the prohibitions on boycotts and concerted action by physicians. The two sections in the bill that address these provisions raise significant questions of interpretation and may not offer adequate protections to consumers.

Section 23.50.020 (a) prohibits competing physicians from engaging in boycotts relating to the non-price terms and conditions listed in that subsection. A similar prohibition is conspicuously absent from the price and price related terms and conditions listed in subsection (c). It is not clear whether this omission was purposeful. The effect is significant, however, in that the prohibition on boycotts is absent for price and price related terms.

Subsection (k) of the bill, relating to concerted action by physicians, does not fully correct the problem. Subsection (k) provides that new section 23.50.020 does not authorize competing physicians to act in concert in response to a report issued by an authorized third party related to the third party's discussions or negotiations with a health benefit plan. First, this section does not clearly prohibit concerted action, such as boycotts. It only states that it is not authorized by the section. Subsection (k) needs to be amended to provide that concerted action

is clearly prohibited, as it is in subsection (a). Second, the only conduct that is affected under subsection (k) is concerted action ***in response to*** third party discussions/negotiations with health plans. Concerted conduct by physicians ***prior to, or during*** negotiations, is not affected by this section. Therefore, for instance, a boycott or strike by physicians in response to a health plan's refusal to collectively negotiate with a physician group on price terms would not be prohibited by this subsection.

Another issue, which must be clarified, relates to the definition of boycott. As the FTC points out in its letter to the Washington D.C. Corporate Counsel, dated October 29, 1999, it is unclear whether the boycott prohibition is intended to bar agreements not to deal with health plans except on collectively-determined terms, or whether it would only prohibit agreements to withhold services from third parties, in order to pressure health plans to accede to the contract terms demanded by the physician group. *Id* at pg. 4. The bill needs to be clarified to indicate which type of boycott is prohibited by this section, the former being the much more coercive type of boycott which should not be allowed.

Even if the bill was amended, as suggested above, so that it was clear that all types of boycotts and concerted action are prohibited, SB 37's authorization of collective bargaining would still present a serious risk of anticompetitive harm. The FTC has previously observed that collective negotiations by nature convey an implied threat that if the health plan does not agree to the terms presented by the physician group the plan will be unable to obtain agreements with individual group members. *Id.* By immunizing agreements among physicians on the prices and other terms they will accept from a health plan, SB 37 facilitates coordinated conduct among physicians, such as collusive refusals to deal that, even though not authorized by the bill, would be difficult to detect and prosecute. Because the purpose of the bill is to allow physicians to exert leverage over health plans in order to get more favorable terms, prohibiting concerted action by physicians would likely not eliminate the coercive force of collective bargaining, or obviate concerns that the bill would increase the likelihood of concerted refusals to contract with health plans. *Id.*

C. Immunity Issues – State Action Doctrine

In order for collective private activity, such as proposed in this bill, to be shielde from the antitrust laws, the bill must satisfy the "state action doctrine" as set out in *California Retail Liquor Dealers Assn. V. Mid Cal Aluminum, Inc.* 445 U.S. 97 (1980); *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48 (1985) and *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621 (1992). Under this doctrine, antitrust liability is avoided only if (1) the challenged action is the result of a clearly articulated and affirmatively expressed state policy to supplant competition, and (2) the action is "actively supervised" by the state. Actual state involvement, not deference to private price fixing arrangements under the general auspices of state law, is the precondition for immunity from federal law. *Ticor*, 504 U.S. at 621, 112 S. Ct. 2169, 2176 – 77.

Active supervision, for the purpose of obtaining immunity under federal antitrust law means the regulatory agency must "have and exercise ultimate control over the challenged

conduct." *Patrick v. Burget*, 486 U.S. 94, 100 (1988). In this context the issue is whether "the state has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among the parties." *Ticor*, 112 S. Ct. at 2177. The Court has held that a state did not actively supervise price arrangements when it did not establish the prices, review the reasonableness of the prices, monitor market conditions, or engage in any pointed reexamination of the program. *Midcal*, 445 U.S. 92, 105-106 (1980).

Several aspects of the provisions of SB 37 raise questions as to the adequacy of state supervision authorized by the bill, thereby reducing the likelihood that the legislation meets the requirements of the state action doctrine immunizing physicians from prosecution under federal antitrust laws. First, the limited nature of information that a third party representative must provide to the Attorney General to obtain approval to negotiate raises the question as to the extent the Attorney General can exercise sufficient independent judgment and control to make the determinations required under the bill. For example, the Attorney General must determine whether the third party has complied with the physician market share limits under the bill in order to decide whether the proposed negotiations exceed the authority granted under the chapter. The third party, however, is not required to provide any information necessary to make such a determination, such as information relating the physicians they represent, their specialty areas, market shares, etc.

Second, the bill imposes substantial responsibilities on the Attorney General to approve or not approve a proposed negotiated contract, utilizing specific criteria, but provides only a very short time frame (30 days) within which to make that fact intensive determination, and does not require that the parties provide any information to the Attorney General to make such a determination. Moreover, the regulatory scheme established by the bill contains no mechanism for members of the public, or others affected by the decision, to offer evidence and argument relating to the costs or benefits of the proposed contracts. All of these factors suggest that no substantive review is contemplated by the legislation, nor would the Attorney General be in a position to exercise independent judgment and control in determining the reasonableness of negotiated terms of the contract.

Finally, rather than putting the burden on the proponents of a contract to demonstrate that the proposed contract complies with the articulated standards, SB 37 puts the burden on the Attorney General to make that determination without any information to assist in the review. This is contrary to established legal principles that the party requesting a change from the status quo has the burden of proving that the requested action is justified. The proponents of a negotiated contract are the entities with the information and knowledge necessary to establish that the criteria have been met. SB 37's failure to place the burden on the proponents of the contract to demonstrate that the standards for approval have been met is further indicia that a substantive review of the contract terms is not contemplated by the legislation.

For these reasons, it may be found that the level of state involvement provided in SB 37 may not be sufficient "active state supervision" under the state action doctrine to immunize physicians from federal antitrust enforcement.

D. Issues relating to Geographic Service Area

1. AS 23.50.020(d) refers to geographic service area, which is defined to mean the "geographic area of the physicians seeking to jointly negotiate." This definition raises a couple of issues that need to be addressed. First, it is unclear what standards are to be used to determine the geographic area of a physician under the definition. This will need to be clarified before an accurate and consistent market share analysis can be performed under the bill. Second, a health plan's market share is calculated based on the physician group's geographic service area. It will need to be confirmed that information can, in fact, be obtained about a health plan's market share within a particular physician group's geographic service area. If it cannot, then the market share analysis contemplated in the bill will not be able to be performed.

2. AS 23.50.020(h) – (j) provides standards for approval by the Attorney General of a collective negotiation. A number of the standards, however, appear vague, making it impossible to determine what factors are contemplated under the standard and whether the factors are appropriate for the Attorney General's consideration. For instance, it is not clear what sort of factors or terms would fall under the category "promotion of health care infrastructure and medical advancement" found in subsection (i)(3). Also, to provide a balanced consideration of factors, the standards should be amended under subsection (j) to allow the Attorney General to consider whether the proposed contract terms impose impediments or decrease access to quality patient care, when weighing the anticompetitive effects of the contract terms.

III. ERISA Preemption Issues.

The collective negotiation provisions of this bill apply to "health benefit plans" instead of "health care insurers." We understand that this wording was intended to include self-funded health plans within the scope of the bill in addition to fully insured plans. This change, however, raises a federal preemption issue under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA preempts all state laws that relate to an employee benefit plan, which by definition includes a "health benefit plan." ERISA regulates the administration of employee health care benefits as well as the structure of the plans. While there is case law that may seem to narrow the breadth of the broad ERISA preemption, this bill is still a high risk of preemption to the extent that the bill will affects the benefits and administration of a health benefit plan. This risk can be avoided by restricting the application of the bill to entities traditionally regulated under Alaska's insurance laws, which was the approach used by Texas in similar legislation passed in 1999.

IV. Miscellaneous Issues.

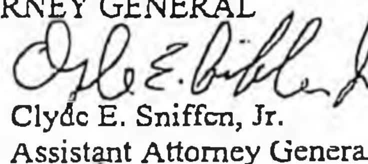
Written testimony submitted to various committees last year, and proposed AS 23.50.020(f)(2) indicate that negotiation with an authorized third party is not mandatory for health benefit plans. However, the language in proposed AS 23.50.020(c) and (d) imply that all health benefit plans are required to negotiate with an authorized third party unless it can prove that it does not have substantial market power. The bill needs to clarify whether such negotiations are voluntary or not.

By using the term "health benefit plan" in the bill, insurance companies are not subject to the bill's requirements as may have been intended. If this is not the legislature's intent, then the bill should be amended to clarify that insurers are subject to this bill.

If you have any questions regarding these written comments, please let us know.

Very truly yours,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: 
Clyde E. Sniffen, Jr.
Assistant Attorney General

cc: Members, Senate Judiciary Committee
Senator Pete Kelly
Mike Abbot, Office of the Governor
Robert Lohr, Division of Insurance
Deborah Behr, Department of Law
Chrystal Smith, Department of Law

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
William J. Baer, Director
Direct Dial
(202) 326-2932

May 13, 1999

The Honorable Rene O. Oliveira
Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Representative Oliveira:

The Bureau of Competition of the Federal Trade Commission is pleased to respond to your request, dated May 5, 1999, for comment on Senate Bill 1468, "An Act Relating to the Regulation of Physician Joint Negotiation" (SB 1468), which currently is being considered by the Texas legislature.[1] The bill would permit competing physicians to jointly negotiate contractual terms with health plans under certain circumstances. Our understanding is that SB 1468 has been adopted by the Texas Senate, and that a vote on a similar measure is expected in the House of Representatives in the very near future. Given the limited time available, we highlight three concerns about the bill, but are not able to provide a complete analysis of all the issues that the bill raises.

The Commission has previously expressed serious concerns about the impact on consumer welfare of a federal proposal to enact an antitrust exemption intended to authorize collective negotiation between health service practitioners and health plans. In testimony before the Committee on the Judiciary of the United States House of Representatives in July 1998, the Commission opposed enactment of H.R. 4277, the "Quality Health-Care Coalition Act of 1998." The Commission stated that the exemption would immunize "a broad range of anticompetitive joint conduct by physicians and other health care professionals that could seriously harm consumers and undermine efforts to promote high-quality, cost-effective health care for consumers." Furthermore, the Commission pointed out, the exemption would impair innovation in health care financing and delivery, and reduce choices among alternative health plans. Finally, the Commission noted that an antitrust exemption is not needed in order to allow physicians collectively to express their concerns about patient care and quality of care issues that may arise from their participation in managed care plans, or to permit them to enter into joint ventures that can offer better alternatives to patients or to health plans. A copy of the Commission's testimony is enclosed for your information.

The bill being considered by the Texas legislature differs from H.R. 4277 in various respects. In contrast to the federal proposal, which would simply provide an antitrust exemption for collective negotiations, SB 1468 requires some oversight of the negotiating process by the Texas Attorney General. In addition, SB 1468 would limit to 10% the proportion of physicians in a geographic area who could negotiate collectively, unless the Attorney General approved inclusion of a larger number in the group. The bill allows collective negotiation of certain types of fee-related issues only where the Attorney General determines that the health plan has substantial market power.

It is not clear, however, to what extent these differences would reduce the potential for anticompetitive effects otherwise likely to arise from the authorization of collective bargaining among competing physicians. For example, the provision in Section 29.09(b) that no joint negotiation shall represent more than 10% of the licensed physicians in a defined geographic area provides no significant limitation on the aggregation of bargaining power by many types of physician groups. For many medical specialities, a group including *all* the physicians in a particular speciality or subspeciality would constitute less than 10% of all licensed physicians, and their combination in a single bargaining group could give them significant market power over health plans.[2] Although the bill permits the Attorney General to raise or lower the percentage in particular cases, it does not provide any standards to guide the Attorney General's decision. It is unclear, for example, whether the bill's intent is that the Attorney General limit bargaining groups to 10% of a properly defined antitrust market. Without such a limitation, the 10% cap on the size of physician bargaining groups does not protect against the risk of substantial consumer harm.

Second, it is not clear to what extent the bill's use of a health plan market power screen for some types of collective bargaining would limit potential consumer harm. The bill prohibits collective negotiation on certain specified fee-related issues, unless the Attorney General determines that a health plan with which physicians are negotiating possesses "substantial market power." However, the bill provides no standard for determining when substantial market power will be deemed to exist. We are uncertain whether the intent is to have the Attorney General apply established antitrust principles of market power analysis, or whether the reference in the bill's preamble to "imbalances" in bargaining power suggests some other approach that would compare the bargaining power of a plan to that of an individual physician. In addition, the scope of arrangements to which the market power screen applies is limited. For example, negotiating over formulation and application of physician reimbursement methodology is not subject to the requirement that the health plan have substantial market power, though such matters plainly can have a direct and substantial effect on fee levels. Collective negotiation about other "non-price" issues also can have a substantial effect on the cost of services that the plan covers, as well as limiting the options available to plans to meet consumer demand for high-quality and affordable health insurance.

Third, the bill imposes substantial responsibilities on the Attorney General that could be difficult to carry out given the time frames provided in the bill and the fact-intensive nature of the issues. Moreover, we note that the regulatory scheme established by the bill contains no mechanism for members of the public, or others who stand to be affected by the Attorney General's decision, to offer evidence and views pertaining to the costs and benefits of the proposal or any of the underlying issues. In addition, the bill provides little guidance as to how the discretion granted to the Attorney General is to be exercised. For example, section 29.09(b) of the bill directs the Attorney General to approve a request to enter into joint negotiation or a proposed contract if the applicants demonstrate that "the likely benefits resulting from the joint negotiation or proposed contact outweigh the disadvantages attributable to a reduction in competition" that may result, but it provides no criteria to guide the Attorney General in evaluating benefits or disadvantages, or in weighing one against the other.[3]

We hope you find these comments helpful. Should you have any additional questions concerning this issue, please contact Richard Feinstein at 202-326 3688.

Sincerely yours,

William J. Baer

Enclosure

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1. This letter represents the views of the staff of the Bureau of Competition of the Federal Trade Commission and does not necessarily represent the views of the Commission or any individual Commissioner.

2. Physicians differ as to specialities and these individual specialties may constitute different product markets. Moreover, relevant geographic markets may differ as to specialty.

3. The nature of the oversight actually exercised by the Attorney General is important to the question whether private parties acting pursuant to the statute would be exempt from the federal antitrust laws by virtue of the "state action doctrine." The "state action doctrine" allows a state to override the national policy favoring competition where the state legislature clearly articulates a policy to displace competition with regulation, and state officials actively supervise private anticompetitive conduct. *See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). The active supervision requirement "is designed to ensure that the state action doctrine will shelter only the particular anticompetitive acts of private parties that in the judgment of the State, actually further state regulatory policies." *Patrick v. Burget*, 486 U.S. 94, 100 (1988). The question to be addressed in any individual case, therefore, is "whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S.621, 634-35 (1992). We note in particular that Section 29.09(c) of the bill provides that an approval of the initial filing for authorization to bargain collectively covers all subsequent negotiations between the parties, apparently without regard to whether circumstances have changed such that the subsequent bargaining might no longer qualify for approval.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition

Richard A. Feinstein
Assistant Director

Direct Dial
(202) 326-3688

October 29, 1999

Robert R. Rigsby
Interim Corporation Counsel
Office of the Corporation Counsel
Government of the District of Columbia
441 Fourth Street, N.W., Tenth Floor North
Washington, D.C. 20001

Re: Physicians Negotiation Act of 1999

Dear Mr. Rigsby:

This letter is a response to your request for comment by Federal Trade Commission staff on the "Physicians Negotiation Act of 1999," Bill No. 13-333 in the District of Columbia Council. This bill is intended to permit competing physicians to engage in collective bargaining with health plans. As is discussed below, the Commission has opposed enactment of a bill currently before Congress, H.R. 1304, that would create an antitrust exemption for collective negotiations between health care providers and health plans. Such an exemption, the Commission stated, will not ensure better care for patients, and threatens to raise health care costs and reduce access to care. In my view, the District of Columbia proposal raises similar concerns.

In addition, it is doubtful that the D.C. bill in its current form would immunize physicians from liability for conduct that violates the federal antitrust laws. State economic regulation can immunize private parties from federal antitrust liability, but only where it satisfies the requirements of the "state action" doctrine. It is unclear whether enactments of the District of Columbia Council would be treated as equivalent to statutes of a state legislature for purposes of the state action doctrine. Moreover, even assuming the Council has the ability to confer state action immunity, the level of governmental involvement called for in the bill falls far short of the "active state supervision" that the Supreme Court has required to displace federal antitrust law.

Background

Antitrust law already allows doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The Federal Trade Commission and the Department of Justice have issued health care policy statements that emphasize physicians' ability under the antitrust laws to organize networks and other joint arrangements to deal collectively with health plans and other purchasers.[1] In addition, health care professionals can, through their professional societies and other groups, jointly

provide information and express opinions to health plans.(2) Legislative proposals to permit collective bargaining by health care professionals, however, such as the one pending in the District of Columbia, seek to authorize conduct that would otherwise constitute unlawful price fixing or other serious antitrust violations.

The Commission's June 1999 testimony on H.R. 1304 before the House Judiciary Committee explains its opposition to creating an antitrust exemption to allow otherwise unlawful collective bargaining by competing health care providers. The Commission's belief that such an exemption could cause serious harm -- to consumers, employers who provide health care coverage for employees, and to federal, state, and local governments -- is based on its experience investigating the effects of numerous instances of collective bargaining by competing health care providers. For example, the Commission, after a joint investigation with the Commonwealth of Virginia, issued a consent order settling charges that a group of physicians in Danville, Virginia, agreed on reimbursement rates and other terms of dealing with health plans, and agreed not to deal with plans that did not meet those terms.(3) The Commonwealth of Virginia collected $170,000 in damages and penalties for the increased costs the state was forced to bear in providing health care benefits to its employees as a result of the physician group's conduct.(4) Likewise, the Commission took enforcement action against collective fee demands by pharmacists in the State of New York that cost the state an estimated $7 million in increased health benefits costs for state employees.(5)

Without antitrust enforcement to block such price fixing, the Commission stated, "we can expect prices for health care services to rise substantially." Raising health care costs and making health insurance less affordable, the testimony observed, threatens to increase the already substantial uninsured population, and thereby reduce access to health care services. In addition, the Commission noted that the exemption could also allow physicians to collectively demand terms from health plans that would make it difficult for consumers to choose to obtain services from allied health care providers, such as nurse-midwives.

The Commission emphasized that immunizing collective bargaining would impose costs without any guarantee that patients' interests in quality care would be served:

> Collective bargaining rights are designed to raise the incomes and improve working conditions of union members. The law protects the United Auto Workers' right to bargain for higher wages and better working conditions, but we do not rely on the UAW to bargain for safer cars. Congress addressed those concerns in other ways.(6)

The Commission's testimony also pointed out that other approaches to improve quality and protect consumers have been proposed that would not sacrifice the benefits of competition by granting collective bargaining rights to health care professionals, and briefly described some of those proposals. A copy of the testimony (Attachment A) is enclosed for your information.

I am also enclosing a copy of a letter from FTC staff discussing a collective bargaining bill in Texas (Attachment B). The letter notes that the Texas bill, while different in certain respects from the federal proposal, still carries substantial potential for consumer harm.

The District of Columbia Bill

The District of Columbia bill closely follows model state legislation on physician collective negotiations developed by the American Medical Association. In fact, the bill appears to adopt all of the provisions of the AMA model except Section 1, which is a declaration of legislative purpose. I will first discuss a few issues regarding the scope of conduct the bill seeks to authorize, and then analyze the question whether the bill would be effective in creating immunity from federal antitrust law for private parties acting pursuant to its provisions.

The Scope of Permitted Conduct

The collective bargaining permitted by the bill is subject to certain limitations not present in the federal proposal, but these limitations are ambiguous in some important respects. As a result, it is difficult to ascertain the precise scope of conduct that the bill would seek to authorize. In any event, however, the two primary ways that the bill limits collective bargaining -- the market share limitations and the ban on boycotts -- appear to leave consumers at risk of substantial harm.

First, the bill's reach depends in part on market shares of health plans and, to a lesser extent, physician groups. It authorizes collective negotiation with health plans, but negotiation over certain price-related terms is limited to situations in which the health plan has "substantial market power," which, under the bill's terms, exists when a health plan's market share exceeds 15%. In addition, under section 5(f), where a health plan has less than a 5% market share, the physician group may not exceed 30% of physicians (or of a particular physician type or specialty) in the health plan service area.

Although the bill appears to make the concept of market power an important limitation on some forms of collective bargaining, it is unclear how market shares are to be delineated or applied. According to the bill, substantial market power exists if the health plan has a 15% share of any of the following: (1) the number of covered lives as reported by the insurance commissioner; (2) the actual number of consumers of prepaid comprehensive health services; or (3) a particular "market segment," to wit: "Medicare, Medicaid, or commercial, managed care and health maintenance organization." Although category (1) appears straightforward, it is unclear to us what is intended by the other two categories. Moreover, it is not clear what geographic area would be used to calculate market shares, at least with respect to categories (2) and (3), or which payers are to be included in the market share calculations.

Aside from the ambiguity, however, the bill's provisions are not based on accepted concepts of market power in a legal or economic sense. Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only if based upon a properly defined market. Even if the bill's categories correctly identified relevant markets, a 15% market share (let alone a share above 5%) is not a level ordinarily presumed to constitute market power.(7) In addition, the bill does not take into account ease of entry in assessing market power, as antitrust analysis ordinarily would.

The limitation on the "market share" of physician groups negotiating with small health plans (which sets a higher threshold for physician market power than for health plan market power) also does not reflect market power, and may understate the economic clout of a physician group. The 30% share limitation is based on the portion of physicians "in

the health plan service area or proposed service area." There is no reason, however, to expect that a health plan service area would necessarily represent an appropriate geographic market for the physician services in question. Indeed, geographic markets for physician services may vary by specialty. A health plan service area could well be broader that the geographic market for physician services, with the result that the 30% cap would not prevent aggregation of physicians with substantial market power within the service area negotiating with very small health plans.

The other major limitation in the bill, section 2(b), which provides that "Nothing herein shall be construed to allow a boycott," also raises significant questions of interpretation and may not offer significant protection to consumers. First, its wording and placement could be read to suggest that the limitation applies only to the conduct authorized in Section 2, rather than the entire bill. If that were the case, other sections of the bill could permit physicians to engage in boycotts. Second, the term "boycott" has been subject to varying interpretations, in some cases being understood as collective refusals to deal to force a party to accept terms, and in others limited to refusals to deal with third parties to pressure another party with whom the group has a dispute.[8] It is unclear whether the bill is intended to bar agreements not to deal with health plans except on collectively-determined terms, or whether it would only prohibit agreements to withhold services from third parties (patients or others), in order to pressure health plans to accede to the contract terms demanded by the physician group.

The federal collective bargaining bill excludes from its authorization "collective cessation of services to patients" (*i.e.*, boycotts in the narrow sense), and the Commission in its testimony (p.8) observed that "this limitation takes virtually nothing away from the coercive power the bill grants to providers." Furthermore, as the testimony explains, a collective refusal to contract, if it did not force the health plan to capitulate to physician demands for fee increases, could result in patients' having to pay medical bills out of their own pockets, and thus would impose formidable obstacles to patients seeking care.

Even if it were clear that the D.C. bill would not protect physicians' concerted refusals to deal with health plans, however, its authorization of collective bargaining would still present a serious risk of anticompetitive harm. As the Commission has previously observed, collective negotiations by their very nature can convey an implicit threat that if the health plan does not agree to terms acceptable to the physician group, the plan will be unable to obtain agreements with group members.[9] By immunizing, and thereby encouraging, agreements among physicians on the prices and other terms they will accept from health plans, the bill would facilitate coordinated conduct among physicians, such as collusive refusals to deal that, even though not immune, would be difficult to detect and prosecute. I would also note that the analysis that accompanies the AMA model legislation makes it clear that the bill's purpose is to allow physicians to exert "leverage" over payers in order to obtain more favorable terms. Thus, excluding concerted refusals to contract from the bill's protections would not appear to eliminate the coercive force of collective bargaining, or obviate concerns that the bill would increase the likelihood of concerted refusals to contract.

I would also note that the analysis in the AMA model states that Section 2 allows physicians to discuss managed care contract terms "free from the antitrust risk that normally accompanies such collaborative activity." You may wish to advise Council members that the antitrust laws do not prohibit the mere discussion of issues such as those enumerated in Section 2 unaccompanied by agreements on the terms on which the

physicians will deal.

Immunity Issues

Under the judicially-created "state action" doctrine, states may override the national policy favoring competition and provide that aspects of their economies will be governed by state regulation rather than market forces. States, however, may not simply authorize private parties to violate the antitrust laws.[(10)] Instead, a state must substitute its own control for that of the market. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct. *See California Retail Liquor Dealers Assen v. Midcal Aluminum, Inc.*, 445 U.S. 92 (1980).

A threshold issue is whether the District of Columbia is equivalent to a state for purposes of the state action doctrine, or otherwise has the ability under federal law to create antitrust immunity for private parties. I am not aware of any controlling authority on the question, and I am not in a position to offer an opinion.[(11)] It is, of course, a key question to be resolved, because if the Council lacks authority to create antitrust immunity through adoption of a regulatory scheme, physicians acting in reliance on the bill would be exposed to significant risk of antitrust liability.

Assuming, however, that the Council has the authority to create state action immunity, the critical question is whether the bill establishes a scheme with sufficiently active state supervision of private conduct to satisfy the second prong of the state action test. The bill's authorization of collective bargaining appears to satisfy the requirement of a state policy to supplant competition. But in order for state supervision to be adequate for state action purposes, state officials must "have and exercise ultimate control over the challenged anticompetitive conduct." *Patrick v. Burget*, 486 U.S. 94, 100 (1988). On this second requirement for immunity, the bill falls far short.

Section 6 of the bill provides that the representative who will negotiate on behalf of physicians must obtain approval from the Mayor to undertake negotiations. The Mayor is to withhold approval if "the proposed negotiations would exceed the authority granted under this act." Section 6(b). The Mayor is to make this determination within 30 days based on information identifying the representative, its plans and procedures, and "a brief report" identifying the proposed subject matter of the negotiations and the expected benefits to be achie ed. In addition, the representative must furnish for the Mayor's approval, prior to dissemination, a copy of "all communications to be made to physicians related to negotiations, discussions, and health plan offers." The bill does not grant the Mayor the power to review and disapprove contract terms or other matters on the ground that they are unreasonable, unjust, or otherwise contrary to the interests of consumers.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own." *Patrick* at 106. It is not met where the reviewing state official does not evaluate the substantive merits of the private action. *Id.* at 102-105. Thus, the Court has held that a state did not actively supervise price arrangements when it did not establish the prices, review the reasonableness of prices, monitor market conditions, or engage in any "pointed reexamination" of the program. *Midcal*, 445 U.S. at 105-106. Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of

the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S.621, 634-35 (1992).

The apparently limited nature of the Mayor's authority to review and approve the authorized private conduct alone makes the bill on its face inadequate to establish active supervision. Other aspects of the bill also raise questions as to the adequacy of supervision. For example, the limited nature of information that a physician representative must provide to obtain approval would raise questions as to the extent to which government officials have exercised "sufficient independent judgment and control." Indeed, it is unclear that the Mayor would even have sufficient information to determine whether the group's negotiations complied with the market share limitations of the bill. In addition, the bill's failure to specify a standard against which the Mayor would evaluate proposed collective bargaining activities further suggests that no substantive review is contemplated.

Parties claiming immunity under the state action doctrine bear the burden of establishing that they are entitled to such immunity. Thus, should the Council desire to go forward with a collective bargaining bill, it will be important to ensure that the bill establishes a regulatory scheme that meets the rigorous requirements that the Supreme Court has established. Otherwise, physicians relying on the bill's provisions to provide antitrust immunity would risk exposure to potentially significant financial liability for their actions.

* * *

I hope you find these comments helpful. The views expressed in this letter, of course, do not necessarily represent the views of the Commission or any individual Commissioner. Should you have any additional questions, feel free to contact me at 202-326-3688.

Sincerely,

Richard A. Feinstein
Assistant Director

Attachments

Endnotes

1. *See* Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (August 1996) (available at www.ftc.gov/reports/hlth3s.htm).

2. *See, e.g., Schachar v. American Academy of Ophthalmology*, 870 F.2d 397 (7th Cir. 1989); Statements 4 & 5 of Statements of Antitrust Enforcement Policy in Health Care, *supra* note 1.

3. Physicians Group, Inc., 120 F.T.C. 567 (1995) (consent order).

4. *Commonwealth of Virginia v. Physicians Group, Inc.*, 1995-2 Trade Cas. (CCH) ¶ 71,236 (W.D. Va. 1995) (consent decree).

5. *See* Peterson Drug Company, 115 F.T.C. 492, 540 (1992). *See also* Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

6. Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 21, 1999) at 10.

7. *See, e.g.*, Statement 8 of Statements of Antitrust Enforcement Policy in Health Care, *supra* note 1 (establishing antitrust "safety zone" for physician network joint ventures that constitute 20 percent or less of the physicians in each physician specialty in the relevant geographic market)

8. See *Hartford Fire Insurance Co. v. California*, 509 U.S. 764 (1993). In *Hartford*, which construed the meaning of the term "boycott" for purposes of the McCarran-Ferguson Act, Justice Scalia, writing for the majority, distinguished between boycotts and "concerted agreements to seek particular terms in particular transactions," which he termed "cartelization." *Id.* at 801-802. A boycott, Justice Scalia wrote, is limited to a refusal to deal with a party in order to obtain an objective collateral to the boycotters' relationship with that party. *Id.* at 801. He also pointed to a distinction in labor law between a strike, *i.e.*, a collective refusal to deal with an employer to obtain better contract terms from that employer, and a boycott, involving a work stoppage designed to put pressure on some other employer.

9. *See* Michigan State Medical Society, 101 F.T.C. 191, 296 n.32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); *see also* Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations)..

10. *Parker v. Brown*, 341 U.S. 351 (1943) ("a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or declaring that their action is lawful").

11. In *American Telephone & Telegraph Co. v. Eastern Pay Phones*, Inc.., 767 F. Supp. 1335 (E.D. Va. 1991), the court ruled that a regulatory scheme of the District of Columbia did not provide state action immunity, without discussing whether the District stands on the same footing as states with respect to the state action doctrine. An earlier case (arising prior to Congress' grant to the District of home rule powers) involving the District of Columbia Armory Board, a governmental entity, evaluated antitrust immunity claims with reference the Board's federal enabling legislation. *See Hecht v. Pro-Football, Inc.*, 444 F.2d 931 (D.C. Cir 1971).

DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE

TABLE OF CONTENTS

Introduction

Statement 1 - Mergers Among Hospitals

Statement 2 - Hospital Joint Ventures Involving High Technology Or Other Expensive Health Care Equipment

Statement 3 - Hospital Joint Ventures Involving Specialized Clinical Or Other Expensive Health Care Services

Statement 4 - Providers' Collective Provision Of Non-Fee-Related Information To Purchasers Of Health Care Services

Statement 5 - Providers' Collective Provision Of Fee-Related Information To Purchasers Of Health Care Services

Statement 6 - Provider Participation In Exchanges Of Price And Cost Information

Statement 7 - Joint Purchasing Arrangements Among Health Care Providers

* **Statement 8** - Physician Network Joint Ventures

Statement 9 - Multiprovider Networks

Separate Statement of Commissioner Christine A. Varney On the Revised Health Care Guidelines

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DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE

INTRODUCTION

In September 1993, the Department of Justice and the Federal Trade Commission (the "Agencies"), issued six statements of their antitrust enforcement policies regarding mergers and various joint activities in the health care area. The six policy statements addressed: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) health care providers' joint purchasing arrangements; and (6) physician network joint ventures. The Agencies also committed to issuing expedited Department of Justice business reviews and Federal Trade Commission advisory opinions in response to requests for antitrust guidance on specific proposed conduct involving the health care industry.

The 1993 policy statements and expedited specific Agency guidance were designed to advise the health

care community in a time of tremendous change, and to address, as completely as possible, the problem of uncertainty concerning the Agencies' enforcement policy that some had said might deter mergers, joint ventures, or other activities that could lower health care costs. Sound antitrust enforcement, of course, continued to protect consumers against anticompetitive activities.

When the Agencies issued the 1993 health care antitrust enforcement policy statements, they recognized that additional guidance might be desirable in the areas covered by those statements as well as in other health care areas, and committed to issuing revised and additional policy statements as warranted. In light of the comments the Agencies received on the 1993 statements and the Agencies' own experience, the Agencies revised and expanded the health care antitrust enforcement policy statements in September 1994. The 1994 statements, which superseded the 1993 statements, added new statements addressing hospital joint ventures involving specialized clinical or other expensive health care services, providers' collective provision of fee-related information to purchasers of health care services, and analytical principles relating to a broad range of health care provider networks (termed "multiprovider networks"), and expanded the antitrust "safety zones" for several other statements.

Since issuance of the 1994 statements, health care markets have continued to evolve in response to consumer demand and competition in the marketplace. New arrangements and variations on existing arrangements involving joint activity by health care providers continue to emerge to meet consumers', purchasers', and payers' desire for more efficient delivery of high quality health care services. During this period, the Agencies have gained additional experience with arrangements involving joint provider activity. As a result of these developments, the Agencies have decided to amplify the enforcement policy statement on physician network joint ventures and the more general statement on multiprovider networks.

In these revised statements, the Agencies continue to analyze all types of health care provider networks under general antitrust principles. These principles are sufficiently flexible to take into account the particular characteristics of health care markets and the rapid changes that are occurring in those markets. The Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, their goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition.

The revisions to the statements on physician network joint ventures and multiprovider networks are summarized below. In addition to these revisions, various changes have been made to the language of both statements to improve their clarity. No revisions have been made to any of the other statements.

Physician Network Joint Ventures

The revised statement on physician network joint ventures provides an expanded discussion of the antitrust principles that apply to such ventures. The revisions focus on the analysis of networks that fall outside the safety zones contained in the existing statement, particularly those networks that do not involve the sharing of substantial financial risk by their physician participants. The revised statement explains that where physicians' integration through the network is likely to produce significant efficiencies, any agreements on price reasonably necessary to accomplish the venture's procompetitive benefits will be analyzed under the rule of reason.

The revised statement adds three hypothetical examples to further illustrate the application of these principles: (1) a physician network joint venture that does not involve the sharing of substantial financial

risk, but receives rule of reason treatment due to the extensive integration among its physician participants; (2) a network that involves both risk-sharing and non-risk-sharing activities, and receives rule of reason treatment; and (3) a network that involves little or no integration among its physician participants, and is per se illegal.

The safety zones for physician network joint ventures remain unchanged, but the revised statement identifies additional types of financial risk-sharing arrangements that can qualify a network for the safety zones. It also further emphasizes two points previously made in the 1994 statements. First, the enumeration in the statements of particular examples of substantial financial risk sharing does not foreclose consideration of other arrangements through which physicians may share substantial financial risk. Second, a physician network that falls outside the safety zones is not necessarily anticompetitive.

Multiprovider Networks

In 1994, the Agencies issued a new statement on multiprovider health care networks that described the general antitrust analysis of such networks. The revised statement on multiprovider networks emphasizes that it is intended to articulate general principles relating to a wide range of health care provider networks. Many of the revisions to this statement reflect changes made to the revised statement on physician network joint ventures. In addition, four hypothetical examples involving PHOs ("physician-hospital organizations"), including one involving "messenger model" arrangements, have been added.

Safety Zones and Hypothetical Examples

Most of the nine statements give health care providers guidance in the form of antitrust safety zones, which describe conduct that the Agencies will not challenge under the antitrust laws, absent extraordinary circumstances. The Agencies are aware that some parties have interpreted the safety zones as defining the limits of joint conduct that is permissible under the antitrust laws. This view is incorrect. The inclusion of certain conduct within the antitrust safety zones does not imply that conduct falling outside the safety zones is likely to be challenged by the Agencies. Antitrust analysis is inherently fact-intensive. The safety zones are designed to require consideration of only a few factors that are relatively easy to apply, and to provide the Agencies with a high degree of confidence that arrangements falling within them are unlikely to raise substantial competitive concerns. Thus, the safety zones encompass only a subset of provider arrangements that the Agencies are unlikely to challenge under the antitrust laws. The statements outline the analysis the Agencies will use to review conduct that falls outside the safety zones.

Likewise, the statements' hypothetical examples concluding that the Agencies would not challenge the particular arrangement do not mean that conduct varying from the examples is likely to be challenged by the Agencies. The hypothetical examples are designed to illustrate how the statements' general principles apply to specific situations. Interested parties should examine the business review letters issued by the Department of Justice and the advisory opinions issued by the Federal Trade Commission and its staff for additional guidance on the application and interpretation of these statements. Copies of those letters and opinions and summaries of the letters and opinions are available from the Agencies at the mailing and Internet addresses listed at the end of the statements.

The statements also set forth the Department of Justice's business review procedure and the Federal Trade Commission's advisory opinion procedure under which the health care community can obtain the Agencies' antitrust enforcement intentions regarding specific proposed conduct on an expedited basis. The statements continue the commitment of the Agencies to respond to requests for business reviews or advisory opinions from the health care community no later than 90 days after all necessary information is received regarding any matter addressed in the statements, except requests relating to hospital mergers

outside the antitrust safety zone and multiprovider networks. The Agencies also will respond to business review or advisory opinion requests regarding multiprovider networks or other non-merger health care matters within 120 days after all necessary information is received. The Agencies intend to work closely with persons making requests to clarify what information is necessary and to provide guidance throughout the process. The Agencies continue this commitment to expedited review in an effort to reduce antitrust uncertainty for the health care industry in what the Agencies recognize is a time of fundamental change.

The Agencies recognize the importance of antitrust guidance in evolving health care contexts. Consequently, the Agencies continue their commitment to issue additional guidance as warranted.

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1. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON MERGERS AMONG HOSPITALS

Introduction

Most hospital mergers and acquisitions ("mergers") do not present competitive concerns. While careful analysis may be necessary to determine the likely competitive effect of a particular hospital merger, the competitive effect of many hospital mergers is relatively easy to assess. This statement sets forth an antitrust safety zone for certain mergers in light of the Agencies' extensive experience analyzing hospital mergers. Mergers that fall within the antitrust safety zone will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.[(1)] This policy statement also briefly describes the Agencies' antitrust analysis of hospital mergers that fall outside the antitrust safety zone.

A. *Antitrust Safety Zone:* Mergers Of Hospitals That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge any merger between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years, absent extraordinary circumstances. This antitrust safety zone will not apply if that hospital is less than 5 years old.

The Agencies recognize that in some cases a general acute care hospital with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients will be the only hospital in a relevant market. As such, the hospital does not compete in any significant way with other hospitals. Accordingly, mergers involving such hospitals are unlikely to reduce competition substantially.

The Agencies also recognize that many general acute care hospitals, especially rural hospitals, with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients are unlikely to achieve the efficiencies that larger hospitals enjoy. Some of those cost-saving efficiencies may be realized, however, through a merger with another hospital.

B. The Agencies' Analysis Of Hospital Mergers That Fall Outside The Antitrust Safety Zone

Hospital mergers that fall outside the antitrust safety zone are not necessarily anticompetitive, and may be procompetitive. The Agencies' analysis of hospital mergers follows the five steps set forth in the Department of Justice/ Federal Trade Commission *1992 Horizontal Merger Guidelines*.

are likely to be national or at least regional in scope. Thus, while County and SMC might well account for more than 35 percent of the total sales of many hospital supplies in Smalltown or Rural County, they and the other hospitals in Big City that will participate in the arrangement together would likely not account for significant percentages of sales in the actual relevant markets. Thus, the first criterion for inclusion in the safety zone is likely to be satisfied.

The Agencies would then inquire whether the supplies to be purchased jointly account for less than 20 percent of the total revenues from all products and services sold by each of the competing hospitals that participate in the arrangement. In this case, County and SMC are competing hospitals, but this second criterion for inclusion in the safety zone is also likely to be satisfied, and the Agencies would not challenge the joint purchasing arrangement.

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Hospitals or other health care providers that are considering joint purchasing arrangements and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of health care providers considering a joint purchasing arrangement within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

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8. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PHYSICIAN NETWORK JOINT VENTURES

Introduction

In recent years, health plans and other purchasers of health care services have developed a variety of managed care programs that seek to reduce the costs and assure the quality of health care services. Many physicians and physician groups have organized physician network joint ventures, such as individual practice associations ("IPAs"), preferred provider organizations ("PPOs"), and other arrangements to market their services to these plans.[21] Typically, such networks contract with the plans to provide physician services to plan subscribers at predetermined prices, and the physician participants in the networks agree to controls aimed at containing costs and assuring the appropriate and efficient provision of high quality physician services. By developing and implementing mechanisms that encourage physicians to collaborate in practicing efficiently as part of the network, many physician network joint ventures promise significant procompetitive benefits for consumers of health care services.

As used in this statement, a physician network joint venture is a physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services.[22] Other types of health care network joint ventures are not directly addressed by this statement.[23]

This statement of enforcement policy describes the Agencies' antitrust analysis of physician network joint ventures, and presents several examples of its application to specific hypothetical physician network joint ventures. Before describing the general antitrust analysis, the statement sets forth antitrust safety zones that describe physician network joint ventures that are highly unlikely to raise substantial competitive concerns,

and therefore will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.

The Agencies emphasize that merely because a physician network joint venture does not come within a safety zone in no way indicates that it is unlawful under the antitrust laws. On the contrary, such arrangements may be procompetitive and lawful, and many such arrangements have received favorable business review letters or advisory opinions from the Agencies.[(24)] The safety zones use a few factors that are relatively easy to apply, to define a category of ventures for which the Agencies presume no anticompetitive harm, without examining competitive conditions in the particular case. A determination about the lawfulness of physician network joint ventures that fall outside the safety zones must be made on a case-by-case basis according to general antitrust principles and the more specific analysis described in this statement.

A. *Antitrust Safety Zones*

This section describes those physician network joint ventures that will fall within the antitrust safety zones designated by the Agencies. The antitrust safety zones differ for "exclusive" and "non-exclusive" physician network joint ventures. In an "exclusive" venture, the network's physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans. In a "non-exclusive" venture, on the other hand, the physician participants in fact do, or are available to, affiliate with other networks or contract individually with health plans. This section explains how the Agencies will determine whether a physician network joint venture is exclusive or non-exclusive. It also illustrates types of arrangements that can involve the sharing of substantial financial risk among a network's physician participants, which is necessary for a network to come within the safety zones.

1. Exclusive Physician Network Joint Ventures That The Agencies Will Not Challenge, Absent Extraordinary Circumstances

The Agencies will not challenge, absent extraordinary circumstances, an exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 20 percent or less of the physicians[(25)] in each physician specialty with active hospital staff privileges who practice in the relevant geographic market.[(26)] In relevant markets with fewer than five physicians in a particular specialty, an exclusive physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty, on a non-exclusive basis, even though the inclusion of that physician results in the venture consisting of more than 20 percent of the physicians in that specialty.

2. Non-Exclusive Physician Network Joint Ventures That The Agencies Will Not Challenge, Absent Extraordinary Circumstances

The Agencies will not challenge, absent extraordinary circumstances, a non-exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 30 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market. In relevant markets with fewer than four physicians in a particular specialty, a non-exclusive physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty, even though the inclusion of that physician results in the venture consisting of more than 30 percent of the physicians in that specialty.

3. Indicia Of Non-Exclusivity

Because of the different market share thresholds for the safety zones for exclusive and non-exclusive physician network joint ventures, the Agencies caution physician participants in a non-exclusive physician network joint venture to be sure that the network is non-exclusive in fact and not just in name. The Agencies will determine whether a physician network joint venture is exclusive or non-exclusive by its physician participants' activities, and not simply by the terms of the contractual relationship. In making that determination, the Agencies will examine the following indicia of non-exclusivity, among others:

(1) that viable competing networks or managed care plans with adequate physician participation currently exist in the market;

(2) that physicians in the network actually individually participate in, or contract with, other networks or managed care plans, or there is other evidence of their willingness and incentive to do so;

(3) that physicians in the network earn substantial revenue from other networks or through individual contracts with managed care plans;

(4) the absence of any indications of significant de-participation from other networks or managed care plans in the market; and (5) the absence of any indications of coordination among the physicians in the network regarding price or other competitively significant terms of participation in other networks or managed care plans.

Networks also may limit or condition physician participants' freedom to contract outside the network in ways that fall short of a commitment of full exclusivity. If those provisions significantly restrict the ability or willingness of a network's physicians to join other networks or contract individually with managed care plans, the network will be considered exclusive for purposes of the safety zones.

4. Sharing Of Substantial Financial Risk By Physicians In A Physician Network Joint Venture

To qualify for either antitrust safety zone, the participants in a physician network joint venture must share substantial financial risk in providing all the services that are jointly priced through the network.(27)

The safety zones are limited to networks involving substantial financial risk sharing not because such risk sharing is a desired end in itself, but because it normally is a clear and reliable indicator that a physician network involves sufficient integration by its physician participants to achieve significant efficiencies.(28) Risk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians.

The following are examples of some types of arrangements through which participants in a physician network joint venture can share substantial financial risk:(29)

(1) agreement by the venture to provide services to a health plan at a "capitated" rate;(30)

(2) agreement by the venture to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;(31)

(3) use by the venture of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:

(a) withholding from all physician participants in the network a substantial amount of the compensation

due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole; or

(b) establishing overall cost or utilization targets for the network as a whole, with the network's physician participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and

(4) agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialities offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors.[32]

The Agencies recognize that new types of risk-sharing arrangements may develop. The preceding examples do not foreclose consideration of other arrangements through which the participants in a physician network joint venture may share substantial financial risk in the provision of medical services through the network.[33] Organizers of physician networks who are uncertain whether their proposed arrangements constitute substantial financial risk sharing for purposes of this policy statement are encouraged to take advantage of the Agencies' expedited business review and advisory opinion procedures.

B. The Agencies' Analysis Of Physician Network Joint Ventures That Fall Outside The Antitrust Safety Zones

Physician network joint ventures that fall outside the antitrust safety zones also may have the potential to create significant efficiencies, and do not necessarily raise substantial antitrust concerns. For example, physician network joint ventures in which the physician participants share substantial financial risk, but which involve a higher percentage of physicians in a relevant market than specified in the safety zones, may be lawful if they are not anticompetitive on balance.[34] Likewise, physician network joint ventures that do not involve the sharing of substantial financial risk also may be lawful if the physicians' integration through the joint venture creates significant efficiencies and the venture, on balance, is not anticompetitive.

The Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, their goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition.

1. Determining When Agreements Among Physicians In A Physician Network Joint Venture Are Analyzed Under The Rule Of Reason

Antitrust law treats naked agreements among competitors that fix prices or allocate markets as per se illegal. Where competitors economically integrate in a joint venture, however, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason.[35] In accord with general antitrust principles, physician network joint ventures will be analyzed under the rule of reason, and will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies.[36]

Where the participants in a physician network joint venture have agreed to share substantial financial risk as defined in Section A.4. of this policy statement, their risk-sharing arrangement generally establishes both an overall efficiency goal for the venture and the incentives for the physicians to meet that goal. The setting of price is integral to the venture's use of such an arrangement and therefore warrants evaluation under the rule of reason.

Physician network joint ventures that do not involve the sharing of substantial financial risk may also involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies. Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

The foregoing are not, however, the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis, and the Agencies will consider other arrangements that also may evidence such integration. However, in all cases, the Agencies' analysis will focus on substance, rather than form, in assessing a network's likelihood of producing significant efficiencies. To the extent that agreements on prices to be charged for the integrated provision of services are reasonably necessary to the venture's achievement of efficiencies, they will be evaluated under the rule of reason.

In contrast to integrated physician network joint ventures, such as these discussed above, there have been arrangements among physicians that have taken the form of networks, but which in purpose or effect were little more than efforts by their participants to prevent or impede competitive forces from operating in the market. These arrangements are not likely to produce significant procompetitive efficiencies. Such arrangements have been, and will continue to be, treated as unlawful conspiracies or cartels, whose price agreements are per se illegal.

Determining that an arrangement is merely a vehicle to fix prices or engage in naked anticompetitive conduct is a factual inquiry that must be done on a case-by-case basis to determine the arrangement's true nature and likely competitive effects. However, a variety of factors may tend to corroborate a network's anticompetitive nature, including: statements evidencing anticompetitive purpose; a recent history of anticompetitive behavior or collusion in the market, including efforts to obstruct or undermine the development of managed care; obvious anticompetitive structure of the network (*e.g.*, a network comprising a very high percentage of local area physicians, whose participation in the network is exclusive, without any plausible business or efficiency justification); the absence of any mechanisms with the potential for generating significant efficiencies or otherwise increasing competition through the network; the presence of anticompetitive collateral agreements; and the absence of mechanisms to prevent the network's operation from having anticompetitive spillover effects outside the network.

2. Applying The Rule Of Reason

A rule of reason analysis determines whether the formation and operation of the joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the joint venture. The rule of reason analysis takes into account characteristics of the particular physician network joint venture, and the competitive environment in which it operates, that bear on the venture's likely effect on competition.

A determination about the lawfulness of a network's activity under the rule of reason sometimes can be reached without an extensive inquiry under each step of the analysis. For example, a physician network joint venture that involves substantial clinical integration may include a relatively small percentage of the physicians in the relevant markets on a non-exclusive basis. In that case, the Agencies may be able to conclude expeditiously that the network is unlikely to be anticompetitive, based on the competitive environment in which it operates. In assessing the competitive environment, the Agencies would consider such market factors as the number, types, and size of managed care plans operating in the area, the extent of physician participation in those plans, and the economic importance of the managed care plans to area physicians. *See infra* Example 1. Alternatively, for example, if a restraint that facially appears to be of a kind that would always or almost always tend to reduce output or increase prices, but has not been considered per se unlawful, is not reasonably necessary to the creation of efficiencies, the Agencies will likely challenge the restraint without an elaborate analysis of market definition and market power.[37]

The steps ordinarily involved in a rule of reason analysis of physician network joint ventures are set forth below.

Step one: Define the relevant market. The Agencies evaluate the competitive effects of a physician network joint venture in each relevant market in which it operates or has substantial impact. In defining the relevant product and geographic markets, the Agencies look to what substitutes, as a practical matter, are reasonably available to consumers for the services in question.[38] The Agencies will first identify the relevant services that the physician network joint venture provides. Although all services provided by each physician specialty might be a separate relevant service market, there may be instances in which significant overlap of services provided by different physician specialties, or in some circumstances, certain nonphysician health care providers, justifies including services from more than one physician specialty or category of providers in the same market. For each relevant service market, the relevant geographic market will include all physicians (or other providers) who are good substitutes for the physician participants in the joint venture.

Step two: Evaluate the competitive effects of the physician joint venture. The Agencies examine the structure and activities of the physician network joint venture and the nature of competition in the relevant market to determine whether the formation or operation of the venture is likely to have an anticompetitive effect. Two key areas of competitive concern are whether a physician network joint venture could raise the prices for physician services charged to health plans above competitive levels, or could prevent or impede the formation or operation of other networks or plans.

In assessing whether a particular network arrangement could raise prices or exclude competition, the Agencies will examine whether the network physicians collectively have the ability and incentive to engage in such conduct. The Agencies will consider not only the proportion of the physicians in any relevant market who are in the network, but also the incentives faced by physicians in the network, and whether different groups of physicians in a network may have significantly different incentives that would reduce the likelihood of anticompetitive conduct. The Department of Justice has entered into final judgments that permit a network to include a relatively large proportion of physicians in a relevant market where the percentage of physicians with an ownership interest in the network is strictly limited, and the network subcontracts with additional physicians under terms that create a sufficient divergence of economic interest between the subcontracting physicians and the owner physicians so that the owner physicians have an incentive to control the costs to the network of the subcontracting physicians.[39] Evaluating the incentives faced by network physicians requires an examination of the facts and circumstances of each particular case. The Agencies will assess whether different groups of physicians in the network actually have significantly divergent incentives that would override any shared interest, such

as the incentive to profit from higher fees for their medical services. The Agencies will also consider whether the behavior of network physicians or other market evidence indicates that the differing incentives among groups of physicians will not prevent anticompetitive conduct.

If, in the relevant market, there are many other networks or many physicians who would be available to form competing networks or to contract directly with health plans, it is unlikely that the joint venture would raise significant competitive concerns. The Agencies will analyze the availability of suitable physicians to form competing networks, including the exclusive or non-exclusive nature of the physician network joint venture.

The Agencies recognize that the competitive impact of exclusive arrangements or other limitations on the ability of a network's physician participants to contract outside the network can vary greatly. For example, in some circumstances exclusivity may help a network serve its subscribers and increase its physician participants' incentives to further the interests of the network. In other situations, however, the anticompetitive risks posed by such exclusivity may outweigh its procompetitive benefits. Accordingly, the Agencies will evaluate the actual or likely effects of particular limitations on contracting in the market situation in which they occur.

An additional area of possible anticompetitive concern involves the risk of "spillover" effects from the venture. For example, a joint venture may involve the exchange of competitively sensitive information among competing physicians and thereby become a vehicle for the network's physician participants to coordinate their activities outside the venture. Ventures that are structured to reduce the likelihood of such spillover are less likely to result in anticompetitive effects. For example, a network that uses an outside agent to collect and analyze fee data from physicians for use in developing the network's fee schedule, and avoids the sharing of such sensitive information among the network's physician participants, may reduce concerns that the information could be used by the network's physician participants to set prices for services they provide outside the network.

Step three: Evaluate the impact of procompetitive efficiencies.[(40)] This step requires an examination of the joint venture's likely procompetitive efficiencies, and the balancing of these efficiencies against any likely anticompetitive effects. The greater the venture's likely anticompetitive effects, the greater must be the venture's likely efficiencies. In assessing efficiency claims, the Agencies focus on net efficiencies that will be derived from the operation of the network and that result in lower prices or higher quality to consumers. The Agencies will not accept claims of efficiencies if the parties reasonably can achieve equivalent or comparable savings through significantly less anticompetitive means. Inmaking this assessment, however, the Agencies will not search for a theoretically least restrictive alternative that is not practical given business realities.

Experience indicates that, in general, more significant efficiencies are likely to result from a physician network joint venture's substantial financial risk sharing or substantial clinical integration. However, the Agencies will consider a broad range of possible cost savings, including improved cost controls, case management and quality assurance, economies of scale, and reduced administrative or transaction costs.

In assessing the likelihood that efficiencies will be realized, the Agencies recognize that competition is one of the strongest motivations for firms to lower prices, reduce costs, and provide higher quality. Thus, the greater the competition facing the network, the more likely it is that the network will actually realize potential efficiencies that would benefit consumers.

Step four: Evaluation of collateral agreements. This step examines whether the physician network joint venture includes collateral agreements or conditions that unreasonably restrict competition and are unlikely

to contribute significantly to the legitimate purposes of the physician network joint venture. The Agencies will examine whether the collateral agreements are reasonably necessary to achieve the efficiencies sought by the joint venture. For example, if the physician participants in a physician network joint venture agree on the prices they will charge patients who are not covered by the health plans with which their network contracts, such an agreement plainly is not reasonably necessary to the success of the joint venture and is an antitrust violation.(41) Similarly, attempts by a physician network joint venture to exclude competitors or classes of competitors of the network's physician participants from the market could have anticompetitive effects, without advancing any legitimate, procompetitive goal of the network. This could happen, for example, if the network facilitated agreements among the physicians to refuse to deal with such competitors outside the network, or to pressure other market participants to refuse to deal with such competitors or deny them necessary access to key facilities.

C. Examples Of Physician Network Joint Ventures

The following are examples of how the Agencies would apply the principles set forth in this statement to specific physician network joint ventures. The first three are new examples: 1) a network involving substantial clinical integration, that is unlikely to raise significant competitive concerns under the rule of reason; 2) a network involving both substantial financial risk-sharing and non-risk-sharing arrangements, which would be analyzed under the rule of reason; and 3) a network involving neither substantial financial risk-sharing nor substantial clinical integration, and whose price agreements likely would be challenged as per se unlawful. The last four examples involve networks that operate in a variety of market settings and with different levels of physician participants; three are networks that involve substantial financial risk-sharing and one is a network in which the physician participants do not jointly agree on, or negotiate, price.

1. Physician Network Joint Venture Involving Clinical Integration

Charlestown is a relatively isolated, medium-sized city. For the purposes of this example, the services provided by primary care physicians and those provided by the different physician specialties each constitute a relevant product market; and the relevant geographic market for each of them is Charlestown.

Several HMOs and other significant managed care plans operate in Charlestown. A substantial proportion of insured individuals are enrolled in these plans, and enrollment in managed care is expected to increase. Many physicians in each of the specialties participate in more than one of these plans. There is no significant overlap among the participants on the physician panels of many of these plans.

A group of Charlestown physicians establishes an IPA to assume greater responsibility for managing the cost and quality of care rendered to Charlestown residents who are members of health plans. They hope to reduce costs while maintaining or improving the quality of care, and thus to attract more managed care patients to their practices.

The IPA will implement systems to establish goals relating to quality and appropriate utilization of services by IPA participants, regularly evaluate both individual participants' and the network's aggregate performance with respect to those goals, and modify individual participants' actual practices, where necessary, based on those evaluations. The IPA will engage in case management, preauthorization of some services, and concurrent and retrospective review of inpatient stays. In addition, the IPA is developing practice standards and protocols to govern treatment and utilization of services, and it will actively review the care rendered by each doctor in light of these standards and protocols.

There is a significant investment of capital to purchase the information systems necessary to gather

aggregate and individual data on the cost, quantity, and nature of services provided or ordered by the IPA physicians; to measure performance of the group and the individual doctors against cost and quality benchmarks; and to monitor patient satisfaction. The IPA will provide payers with detailed reports on the cost and quantity of services provided, and on the network's success in meeting its goals.

The IPA will hire a medical director and a support staff to perform the above functions and to coordinate patient care in specific cases. The doctors also have invested appreciable time in developing the practice standards and protocols, and will continue actively to monitor care provided through the IPA. Network participants who fail to adhere to the network's standards and protocols will be subject to remedial action, including the possibility of expulsion from the network.

The IPA physicians will be paid by health plans on a fee-for-service basis; the physicians will not share substantial financial risk for the cost of services rendered to covered individuals through the network. The IPA will retain an agent to develop a fee schedule, negotiate fees, and contract with payers on behalf of the venture. Information about what participating doctors charge non-network patients will not be disseminated to participants in the IPA, and the doctors will not agree on the prices they will charge patients not covered by IPA contracts.

The IPA is built around three geographically dispersed primary care group practices that together account for 25 percent of the primary care doctors in Charlestown. A number of specialists to whom the primary care doctors most often refer their patients also are invited to participate in the IPA. These specialists are selected based on their established referral relationships with the primary care doctors, the quality of care provided by the doctors, their willingness to cooperate with the goals of the IPA, and the need to provide convenient referral services to patients of the primary care doctors. Specialist services that are needed less frequently will be provided by doctors who are not IPA participants. Participating specialists constitute from 20 to 35 percent of the specialists in each relevant market, depending on the specialty. Physician participation in the IPA is non-exclusive. Many IPA participants already do and are expected to continue to participate in other managed care plans and earn substantial income from those plans.

Competitive Analysis

Although the IPA does not fall within the antitrust safety zone because the physicians do not share substantial financial risk, the Agencies would analyze the IPA under the rule of reason because it offers the potential for creating significant efficiencies and the price agreement is reasonably necessary to realize those efficiencies. Prior to contracting on behalf of competing doctors, the IPA will develop and invest in mechanisms to provide cost-effective quality care, including standards and protocols to govern treatment and utilization of services, information systems to measure and monitor individual physician and aggregate network performance, and procedures to modify physician behavior and assure adherence to network standards and protocols. The network is structured to achieve its efficiencies through a high degree of interdependence and cooperation among its physician participants. The price agreement, under these circumstances, is subordinate to and reasonably necessary to achieve these objectives.(42)

Furthermore, the Agencies would not challenge under the rule of reason the doctors' agreement to establish and operate the IPA. In conducting the rule of reason analysis, the Agencies would evaluate the likely competitive effects of the venture in each relevant market. In this case, the IPA does not appear likely to limit competition in any relevant market either by hampering the ability of health plans to contract individually with area physicians or with other physician network joint ventures, or by enabling the physicians to raise prices above competitive levels. The IPA does not appear to be overinclusive: many primary care physicians and specialists are available to other plans, and the doctors in the IPA have been selected to achieve the network's procompetitive potential. Many IPA participants also participate in other

managed care plans and are expected to continue to do so in the future. Moreover, several significant managed care plans are not dependent on the IPA participants to offer their products to consumers. Finally, the venture is structured so that physician participants do not share competitively sensitive information, thus reducing the likelihood of anticompetitive spillover effects outside the network where the physicians still compete, and the venture avoids any anticompetitive collateral agreements.

Since the venture is not likely to be anticompetitive, there is no need for further detailed evaluation of the venture's potential for generating procompetitive efficiencies. For these reasons, the Agencies would not challenge the joint venture. However, they would reexamine this conclusion and do a more complete analysis of the procompetitive efficiencies if evidence of actual anticompetitive effects were to develop.

2. Physician Network Joint Venture Involving Risk-Sharing And Non-Risk-Sharing Contracts

An IPA has capitation contracts with three insurer-developed HMOs. Under its contracts with the HMOs, the IPA receives a set fee per member per month for all covered services required by enrollees in a particular health plan. Physician participants in the IPA are paid on a fee-for-service basis, pursuant to a fee schedule developed by the IPA. Physicians participate in the IPA on a non-exclusive basis. Many of the IPA's physicians participate in managed care plans outside the IPA, and earn substantial income from those plans.

The IPA uses a variety of mechanisms to assure appropriate use of services under its capitation contracts so that it can provide contract services within its capitation budgets. In part because the IPA has managed the provision of care effectively, enrollment in the HMOs has grown to the point where HMO patients are a significant share of the IPA doctors' patients.

The three insurers that offer the HMOs also offer PPO options in response to the request of employers who want to give their employees greater choice of plans. Although the capitation contracts are a substantial majority of the IPA's business, it also contracts with the insurers to provide services to the PPO programs on a fee-for-service basis. The physicians are paid according to the same fee schedule used to pay them under the IPA's capitated contracts. The IPA uses the same panel of providers and the same utilization management mechanisms that are involved in the HMO contracts. The IPA has tracked utilization for HMO and PPO patients, which shows similar utilization patterns for both types of patients.

Competitive Analysis

Because the IPA negotiates and enters into both capitated and fee-for-service contracts on behalf on its physicians, the venture is not within a safety zone. However, the IPA's HMO contracts are analyzed under the rule of reason because they involve substantial financial risk-sharing. The PPO contracts also are analyzed under the rule of reason because there are significant efficiencies from the capitated arrangements that carry over to the fee-for-service business. The IPA's procedures for managing the provision of care under its capitation contracts and its related fee schedules produce significant efficiencies; and since those same procedures and fees are used for the PPO contracts and result in similar utilization patterns, they will likely result in significant efficiencies for the PPO arrangements as well.

3. Physician Network That Is Per Se Unlawful

A group of physicians in Clarksville forms an IPA to contract with managed care plans. There is some limited managed care presence in the area, and new plans have announced their interest in entering. The physicians agree that the only way they can effectively combat the power of the plans and protect themselves from low fees and intrusive utilization review is to organize and negotiate with the plans

collectively through the IPA, rather than individually.

Membership in the IPA is open to any licensed physician in Clarksville. Members contribute $2,000 each to fund the legal fees associated with incorporating the IPA and its operating expenses, including the salary of an executive director who will negotiate contracts on behalf of the IPA. The IPA will enter only into fee-for-service contracts. The doctors will not share substantial financial risk under the contracts. The Contracting Committee, in consultation with the executive director, develops a fee schedule.

The IPA establishes a Quality Assurance and Utilization Review Committee. Upon recommendation of this committee, the members vote to have the IPA adopt two basic utilization review parameters: strict limits on documentation to be provided by physicians to the payers, and arbitration of disputes regarding plan utilization review decisions by a committee of the local medical society. The IPA refuses to contract with plans that do not accept these utilization review parameters. The IPA claims to have its own utilization review/quality assurance programs in development, but has taken very few steps to create such a program. It decides to rely instead on the hospital's established peer review mechanisms.

Although there is no formal exclusivity agreement, IPA physicians who are approached by managed care plans seeking contracts refer the plans to the IPA. Except for some contracts predating the formation of the IPA, the physicians do not contract individually with managed care plans on terms other than those set by the IPA.

Competitive Analysis

This IPA is merely a vehicle for collective decisions by its physicians on price and other significant terms of dealing. The physicians' purpose in forming the IPA is to increase their bargaining power with payers. The IPA makes no effort to selectively choose physicians who are likely to further the network's achievement of efficiencies, and the IPA involves no significant integration, financial or otherwise. IPA physicians' participation in the hospital's general peer review procedures does not evidence integration by those physicians that is likely to result in significant efficiencies in the provision of services through the IPA. The IPA does not manage the provision of care or offer any substantial potential for significant procompetitive efficiencies. The physicians are merely collectively agreeing on prices they will receive for services rendered under IPA contracts and not to accept certain aspects of utilization review that they do not like.

The physicians' contribution of capital to form the IPA does not make it a legitimate joint venture. In some circumstances, capital contributions by an IPA's participants can indicate that the participants have made a significant commitment to the creation of an efficiency-producing competitive entity in the market.[43] Capital contributions, however, can also be used to fund a cartel. The key inquiry is whether the contributed capital is being used to further the network's capability to achieve substantial efficiencies. In this case, the funds are being used primarily to support the joint negotiation, and not to achieve substantial procompetitive efficiencies. Thus, the physicians' agreement to bargain through the joint venture will be treated as per se illegal price fixing.

4. Exclusive Physician Network Joint Venture With Financial Risk-Sharing And Comprising More Than Twenty Percent Of Physicians With Active Admitting Privileges At A Hospital

County Seat is a relatively isolated, medium-sized community of about 350,000 residents. The closest town is 50 miles away. County Seat has five general acute care hospitals that offer a mix of basic primary, secondary, and tertiary care services.

Five hundred physicians have medical practices based in County Seat, and all maintain active admitting privileges at one or more of County Seat's hospitals. No physician from outside County Seat has any type of admitting privileges at a County Seat hospital. The physicians represent 10 different specialties and are distributed evenly among the specialties, with 50 doctors practicing each specialty.

One hundred physicians (also distributed evenly among specialties) maintain active admitting privileges at County Seat Medical Center. County Seat's other 400 physicians maintain active admitting privileges at other County Seat hospitals.

Half of County Seat Medical Center's 100 active admitting physicians propose to form an IPA to market their services to purchasers of health care services. The physicians are divided evenly among the specialties. Under the proposed arrangement, the physicians in the network joint venture would agree to meaningful cost containment and quality goals, including utilization review, quality assurance, and other measures designed to reduce the provision of unnecessary care to the plan's subscribers, and a substantial amount (in this example 20 percent) of the compensation due to the network's physician participants would be withheld and distributed only if these measures are successfully met. This physician network joint venture would be exclusive: Its physician participants would not be free to contract individually with health plans or to join other physician joint ventures.

A number of health plans that contract selectively with hospitals and physicians already operate in County Seat. These plans and local employers agree that other County Seat physicians, and the hospitals to which they admit, are good substitutes for the active admitting physicians and the inpatient services provided at County Seat Medical Center. Physicians with medical practices based outside County Seat, however, are not good substitutes for area physicians, because such physicians would find it inconvenient to practice at County Seat hospitals due to the distance between their practice locations and County Seat.

Competitive Analysis

A key issue is whether a physician network joint venture, such as this IPA, comprising 50 percent of the physicians in each specialty with active privileges at one of five comparable hospitals in County Seat would fall within the antitrust safety zone. The physicians within the joint venture represent less than 20 percent of all the physicians in each specialty in County Seat.

County Seat is the relevant geographic market for purposes of analyzing the competitive effects of this proposed physician joint venture. Within each specialty, physicians with admitting privileges at area hospitals are good substitutes for one another. However, physicians with practices based elsewhere are not considered good substitutes.

For purposes of analyzing the effects of the venture, all of the physicians in County Seat should be considered market participants. Purchasers of health care services consider all physicians within each specialty, and the hospitals at which they have admitting privileges, to be relatively interchangeable. Thus, in this example, any attempt by the joint venture's physician participants collectively to increase the price of physician services above competitive levels would likely lead third-party purchasers to recruit non-network physicians at County Seat Medical Center or other area hospitals.

Because physician network joint venture participants constitute less than 20 percent of each group of specialists in County Seat and agree to share substantial financial risk, this proposed joint venture would fall within the antitrust safety zone.

5. Physician Network Joint Venture With Financial Risk-Sharing And A Large Percentage Of

Physicians In A Relatively Small Community

Smalltown has a population of 25,000, a single hospital, and 50 physicians, most of whom are family practitioners. All of the physicians practice exclusively in Smalltown and have active admitting privileges at the Smalltown hospital. The closest urban area, Big City, is located some 35 miles away and has a population of 500,000. A little more than half of Smalltown's working adults commute to work in Big City. Some of the health plans used by employers in Big City are interested in extending their network of providers to Smalltown to provide coverage for subscribers who live in Smalltown, but commute to work in Big City (coverage is to include the families of commuting subscribers). However, the number of commuting Smalltown subscribers is a small fraction of the Big City employers' total workforce.

Responding to these employers' needs, a few health plans have asked physicians in Smalltown to organize a non-exclusive IPA large enough to provide a reasonable choice to subscribers who reside in Smalltown, but commute to work in Big City. Because of the relatively small number of potential enrollees in Smalltown, the plans prefer to contract with such a physician network joint venture, rather than engage in what may prove to be a time-consuming series of negotiations with individual Smalltown physicians to establish a panel of physician providers there.

A number of Smalltown physicians have agreed to form a physician network joint venture. The joint venture will contract with health plans to provide physician services to subscribers of the plans in exchange for a monthly capitation fee paid for each of the plans' subscribers. The physicians forming this joint venture would constitute about half of the total number of physicians in Smalltown. They would represent about 35 percent of the town's family practitioners, but higher percentages of the town's general surgeons (50 percent), pediatricians (50 percent), and obstetricians (67 percent). The health plans that serve Big City employers say that the IPA must have a large percentage of Smalltown physicians to provide adequate coverage for employees and their families in Smalltown and in a few scattered rural communities in the immediate area and to allow the doctors to provide coverage for each other.

In this example, other health plans already have entered Smalltown, and contracted with individual physicians. They have made substantial inroads with Smalltown employers, signing up a large number of enrollees. None of these plans has had any difficulty contracting with individual physicians, including many who would participate in the proposed joint venture.

Finally, the evidence indicates that Smalltown is the relevant geographic market for all physician services. Physicians in Big City are not good substitutes for a significant number of Smalltown residents.

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would comprise over 30 percent of the physicians in a number of relevant specialties in the geographic market. However, the Agencies would not challenge the joint venture because a rule of reason analysis indicates that its formation would not likely hamper the ability of health plans to contract individually with area physicians or with other physician network joint ventures, or enable the physicians to raise prices above competitive levels. In addition, the joint venture's agreement to accept capitated fees creates incentives for its physicians to achieve cost savings.

That health plans have requested formation of this venture also is significant, for it suggests that the joint venture would offer additional efficiencies. In this instance, it appears to be a low-cost method for plans to enter an area without investing in costly negotiations to identify and contract with individual physicians.

Moreover, in small markets such as Smalltown, it may be necessary for purchasers of health care services to contract with a relatively large number of physicians to provide adequate coverage and choice for enrollees. For instance, if there were only three obstetricians in Smalltown, it would not be possible for a physician network joint venture offering obstetrical services to have less than 33 percent of the obstetricians in the relevant area. Furthermore, it may be impractical to have less than 67 percent in the plan, because two obstetricians may be needed in the venture to provide coverage for each other.

Although the joint venture has a relatively large percentage of some specialties, it appears unlikely to present competitive concerns under the rule of reason because of three factors: (1) the demonstrated ability of health plans to contract with physicians individually; (2) the possibility that other physician network joint ventures could be formed; and (3) the potential benefits from the coverage to be provided by this physician network joint venture. Therefore, the Agencies would not challenge the joint venture.

6. Physician Network Joint Venture With Financial Risk Sharing And A Large Percentage Of Physicians In A Small, Rural County

Rural County has a population of 15,000, a small primary care hospital, and ten physicians, including seven general and family practitioners, an obstetrician, a pediatrician, and a general surgeon. All of the physicians are solo practitioners. The nearest urban area is about 60 miles away in Big City, which has a population of 300,000, and three major hospitals to which patients from Rural County are referred or transferred for higher levels of hospital care. However, Big City is too far away for most residents of Rural County routinely to use its physicians for services available in Rural County.

Insurance Company, which operates throughout the state, is attempting to offer managed care programs in all areas of the state, and has asked the local physicians in Rural County to form an IPA to provide services under the program to covered persons living in the County. No other managed care plan has attempted to enter the County previously.

Initially, two of the general practitioners and two of the specialists express interest in forming a network, but Insurance Company says that it intends to market its plan to the larger local employers, who need broader geographic and specialty coverage for their employees. Consequently, Insurance Company needs more of the local general practitioners and the one remaining specialist in the IPA to provide adequate geographic, specialty, and backup coverage to subscribers in Rural County. Eventually, four of the seven general practitioners and the one remaining specialist join the IPA and agree to provide services to Insurance Company's subscribers, under contracts providing for capitation. While the physicians' participation in the IPA is structured to be non-exclusive, no other managed care plan has yet entered the local market or approached any of the physicians about joining a different provider panel. In discussing the formation of the IPA with Insurance Company, a number of the physicians have made clear their intention to continue to practice outside the IPA and have indicated they would be interested in contracting individually with other managed care plans when those plans expand into Rural County.

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would comprise over 30 percent of the general practitioners in the geographic market. Under the circumstances, a rule of reason analysis indicates that the Agencies would not challenge the formation of the joint venture, for the reasons discussed below.

For purposes of this analysis, Rural County is considered the relevant geographic market. Generally, the Agencies will closely examine joint ventures that comprise a large percentage of physicians in the relevant

market. However, in this case, the establishment of the IPA and its inclusion of more than half of the general practitioners and all of the specialists in the network is the result of the payer's expressed need to have more of the local physicians in its network to sell its product in the market. Thus, the level of physician participation in the network does not appear to be overinclusive, but rather appears to be the minimum necessary to meet the employers' needs.

Although the IPA has more than half of the general practitioners and all of the specialists in it, under the particular circumstances this does not, by itself, raise sufficient concerns of possible foreclosure of entry by other managed care plans, or of the collective ability to raise prices above competitive levels, to warrant antitrust challenge to the joint venture by the Agencies. Because it is the first such joint venture in the county, there is no way absolutely to verify at the outset that the joint venture in fact will be non-exclusive. However, the physicians' participation in the IPA is formally non-exclusive, and they have expressed a willingness to consider joining other managed care programs if they begin operating in the area. Moreover, the three general practitioners who are not members of the IPA are available to contract with other managed care plans. The IPA also was established with participation by the local area physicians at the request of Insurance Company, indicating that this structure was not undertaken as a means for the physicians to increase prices or prevent entry of managed care plans.

Finally, the joint venture can benefit consumers in Rural County through the creation of efficiencies. The physicians have jointly put themselves at financial risk to control the use and cost of health care services through capitation. To make the capitation arrangement financially viable, the physicians will have to control the use and cost of health care services they provide under Insurance Company's program. Through the physicians' network joint venture, Rural County residents will be offered a beneficial product, while competition among the physicians outside the network will continue.

Given these facts, the Agencies would not challenge the joint venture. If, however, it later became apparent that the physicians' participation in the joint venture in fact was exclusive, and consequently other managed care plans that wanted to enter the market and contract with some or all of the physicians at competitive terms were unable to do so, the Agencies would re-examine the joint venture's legality. The joint venture also would raise antitrust concerns if it appeared that participation by most of the local physicians in the joint venture resulted in anticompetitive effects in markets outside the joint venture, such as uniformity of fees charged by the physicians in their solo medical practices.

7. Physician Network Joint Venture With No Price Agreement And Involving All Of The Physicians In A Small, Rural County

Rural County has a population of 10,000, a small primary care hospital, and six physicians, consisting of a group practice of three family practitioners, a general practitioner, an obstetrician, and a general surgeon. The nearest urban area is about 75 miles away in Big City, which has a population of 200,000, and two major hospitals to which patients from Rural County are referred or transferred for higher levels of hospital care. Big City is too far away, however, for most residents of Rural County to use for services available in Rural County.

HealthCare, a managed care plan headquartered in another state, is thinking of marketing a plan to the larger employers in Rural County. However, it finds that the cost of contracting individually with providers, administering the system, and overseeing the quality of care in Rural County is too high on a per capita basis to allow it to convince employers to switch from indemnity plans to its plan. HealthCare believes its plan would be more successful if it offered higher quality and better access to care by opening a clinic in the northern part of the county where no physicians currently practice.

All of the local physicians approach HealthCare about contracting with their recently-formed, non-exclusive, IPA. The physicians are willing to agree through their IPA to provide services at the new clinic that HealthCare will establish in the northern part of the county and to implement the utilization review procedures that HealthCare has adopted in other parts of the state.

HealthCare wants to negotiate with the new IPA. It believes that the local physicians collectively can operate the new clinic more efficiently than it can from its distant headquarters, but HealthCare also believes that collectively negotiating with all of the physicians will result in it having to pay higher fees or capitation rates. Thus, it encourages the IPA to appoint an agent to negotiate the non-fee related aspects of the contracts and to facilitate fee negotiations with the group practice and the individual doctors. The group practice and the individual physicians each will sign and negotiate their own individual contracts regarding fees and will unilaterally determine whether to contract with HealthCare, but will agree through the IPA to provide physician, administrative, and utilization review services. The agent will facilitate these individual fee negotiations by discussing separately and confidentially with each physician the physician's fee demands and presenting the information to HealthCare. No fee information will be shared among the physicians.

Competitive Analysis

For purposes of this analysis, Rural County is considered the relevant geographic market. Generally, the Agencies are concerned with joint ventures that comprise all or a large percentage of the physicians in the relevant market. In this case, however, the joint venture appears on balance to be procompetitive. The potential for competitive harm from the venture is not great and is outweighed by the efficiencies likely to be generated by the arrangement.

The physicians are not jointly negotiating fees or engaging in other activities that would be viewed as per se antitrust violations. Therefore, the IPA would be evaluated under the rule of reason. Any possible competitive harm would be balanced against any likely efficiencies to be realized by the venture to see whether, on balance, the IPA is anticompetitive or procompetitive.

Because the IPA is non-exclusive, the potential for competitive harm from foreclosure of competition is reduced. Its physicians are free to contract with other managed care plans or individually with HealthCare if they desire. In addition, potential concerns over anticompetitive pricing are minimized because physicians will continue to negotiate prices individually. Although the physicians are jointly negotiating non-price terms of the contract, agreement on these terms appears to be necessary to the successful operation of the joint venture. The small risk of anticompetitive harm from this venture is outweighed by the substantial procompetitive benefits of improved quality of care and access to physician services that the venture will engender. The new clinic in the northern part of the county will make it easier for residents of that area to receive the care they need. Given these facts, the Agencies would not challenge the joint venture.

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Physicians who are considering forming physician network joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of physicians who are considering forming a network joint venture within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance about the information that

should be submitted.

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9. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON MULTIPROVIDER NETWORKS

Introduction

The health care industry is changing rapidly as it looks for innovative ways to control costs and efficiently provide quality services. Health care providers are forming a wide range of new relationships and affiliations, including networks among otherwise competing providers, as well as networks of providers offering complementary or unrelated services.[44] These affiliations, referred to herein as multiprovider networks, can offer significant procompetitive benefits to consumers. They also can present antitrust questions, particularly if the network includes otherwise competing providers.

As used in this statement, multiprovider networks are ventures among providers that jointly market their health care services to health plans and other purchasers. Such ventures may contract to provide services to subscribers at jointly determined prices and agree to controls aimed at containing costs and assuring quality. Multiprovider networks vary greatly regarding the providers they include, the contractual relationships among those providers, and the efficiencies likely to be realized by the networks. Competitive conditions in the markets in which such networks operate also may vary greatly.

In this statement, the Agencies describe the antitrust principles that they apply in evaluating multiprovider networks, address some issues commonly raised in connection with the formation and operation of such networks, and present examples of the application of antitrust principles to hypothetical multiprovider networks. Because multiprovider networks involve a large variety of structures and relationships among many different types of health care providers, and new arrangements are continually developing, the Agencies are unable to establish a meaningful safety zone for these entities.

A. Determining When Agreements Among Providers In A Multiprovider Network Are Analyzed Under The Rule Of Reason

Antitrust law condemns as per se illegal naked agreements among competitors that fix prices or allocate markets. Where competitors economically integrate in a joint venture, however, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason.[45] In accord with general antitrust principles, multiprovider networks will be evaluated under the rule of reason, and will not be viewed as per se illegal, if the providers' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network providers are reasonably necessary to realize those efficiencies.[46]

In some multiprovider networks, significant efficiencies may be achieved through agreement by the competing providers to share substantial financial risk for the services provided through the network.[47] In such cases, the setting of price would be integral to the network's use of such an arrangement and, therefore, would warrant evaluation under the rule of reason.

The following are examples of some types of arrangements through which substantial financial risk can be

Health Insurance Association of America

April 9, 2002

The Honorable Norm Rokeberg
Chair, House Judiciary Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Re: Senate Bill 37

Dear Representative Rokeberg:

This letter pertains to CSSB 37, concerning antitrust waivers for physicians, on behalf of the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. We represent many of the health insurance companies which would be subject to this legislation.

HIAA respectfully recommends the committee defeat this legislation since it is unnecessary and does not improve competition or, more importantly, benefit the citizens of Alaska. Health benefit plans are not prohibited from negotiating with independent physician groups under existing law and currently negotiate with large physician groups through an independent practice association, among others. In fact, without a physician antitrust waiver, physicians have *increasingly* joined these large groups to reduce administrative costs in negotiating contracts with managed care companies, risk sharing and the need to purchase expensive equipment. As recently as February 22, 2002, the Federal Trade Commission (FTC) permitted a multi-specialty physician practice association in Denver, Colorado to proceed to improve quality.[1] Approximately 60 percent of physicians nationally belong to groups with three or more physicians and the figures are expected to dramatically increase in the next few years[2]. Competition among health insurers in Alaska is impacted primarily by the small population base in the state, and the high costs of medical care, not due to the cost of negotiating contracts with physicians and other medical service providers.

Since the contract negotiation process does not influence competition, HIAA would respectfully request the legislature amend the legislative finding in Section 23.50.010(a) which alleges competition would be increased through a physician antitrust waiver. As the trade association that represents most of the carriers affected by this legislation and the carriers

[1] Federal Trade Commission letter authored by Jeffrey Brennan, Assistant Director, to John Miles of Ober, Kaler, Grimes & Shriver, dated February 19, 2002
[2] Wall Street Comes to Washington: Analysts' Perspectives on Health System Change." Issue Brief, Center for Studying Health System Change, No. 17, December 1998

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considering conducting business in Alaska, HIAA contends that competition would be diminished, and not improved, with the enactment of CSSB 37

The impact of the proposed CSSB 37 on small businesses could be devastating. When similar legislation was introduced at the federal level, Charles River Associates calculated that total annual personal health care spending would increase between 2.5 and 8.3 percent and that private health insurance premiums would annually increase by 4.7 to 13.2 percent as a result of this granting an antitrust waiver to physicians[3]. A premium increase at the conservative level of 4.7 percent, discounting any other factors which may increase premiums, could significantly decrease the ability of small employers to offer coverage to their employees because of the increased cost.

HIAA has significant specific concerns with CSSB 37. We support the comments in the FTC letter dated January 18, 2002 outlining the strong antitrust implications of the bill regardless of whether the issues negotiated on are fee or non-fee related, as well as their testimony before the House Labor and Commerce Committee (3/22/02). In addition, HIAA concurs with concerns raised by the Office of Attorney General (the entity charged with oversight of the proceedings under CSSB 37) as they have testified before the Senate Judiciary Committee (1/23/01) and the Senate Commerce and Labor Committee (3/8/01) that the legislation contains insufficient state supervision and would ultimately violate state and federal antitrust law[4]. Even if the legislature amended the bill to address the concerns of the Attorney General's Office and the FTC, we would respectfully recommend a thorough study of the issue before proceeding in order to examine the effects on Alaskans.

In addition, under Section 23.50.020(c), providers are permitted to negotiate with health plans over terms of fees and price if the plan exhibits substantial market power, presumably measured as 15 percent of the market under Section 23.50.020(f). This threshold appears extremely low to gauge substantial market power. HIAA would respectfully recommend, at a minimum, adhering to 30 percent of the market as recommended by FTC guidelines[5]. Increasing the substantial market threshold to 30 percent would also compare to the provisions in Section 23.50.020 (e)(6) and 23.50.020 (e)(7) which prohibits the Attorney General from limiting the representation of providers to less than 30 percent of the practicing physicians in the geographic service area. Further, why include a rebuttable presumption that a carrier has substantial market power and force the carrier to prove they do not meet the 15 percent threshold? The burden should be to prove the carrier possesses greater than the 15 percent of the market. Since few health insurers will possess the necessary market power to permit negotiations on fee-related issues, HIAA would respectfully suggest the legislature attempt to minimize the unnecessary administrative burden to all parties and amend this section

In Section 23.50.020 (e)(f)(2), health insurers must prove they possess lower than the 15 percent substantial market power as measured by covered lives, including Medicaid and

[3] The National Costs of Physician Antitrust Waivers. Charles River Associates Inc., March 2000, p. 21

[4] see also March 8, 2001 letter to Senate Commerce and Labor Chairman Randy Phillips, and February 5, 2001 letter to Senate Judiciary Chairman Robin Taylor, both from Attorney General Bruce Botelho

[5] Statements of Antitrust Enforcement Policy in Health Care, Issued by the U.S. Department of Justice and the Federal Trade Commission, page 65, August 1996

Medicare beneficiaries within a defined geographic area. HIAA respectfully requests both of these groups be removed from the definition of a covered life. The inclusion of the Medicare and Medicaid beneficiaries in this section may be interpreted as applying the entire legislation to these programs, which obviously is illegal in the case of Medicare, and may falsely illustrate a market power that is inapplicable to the negotiation process. CSSB 37 is aimed at the private market and inclusion of Medicaid and Medicare confuses the process.

In Section 23.50 020 (e)(f), an authorized third party may not represent more than 30 percent of the physicians unless the carrier possesses more than 5 percent of the market. HIAA would respectfully suggest amending this section to provide consistency with Section 23.50.020 (e)(f) where a carrier is deemed to have substantial market power if they enjoy 15 percent of the market. This section permits a third party representative to provide representation to all of the physicians in a designated market if a carrier has 5.01 percent of the market yet is not deemed to possess substantial market power. A carrier with 5.01 percent of the market has minimal effect on the market and should not provide all physicians with the ability to collectively negotiate as a single group. Neither of these thresholds meets the standards provided by the FTC. However, HIAA would respectfully request some equity and consistency in these provisions.

These issues raised are a few of the concerns of the insurance industry and amongst the challenges confronting the legislature with CSSB 37. HIAA respectfully believes the amendments to this bill neglect to address the concerns raised by the FTC or the Attorney General's Office and caution the committee members in their consideration. Thank you very much for considering our concerns. If you have any questions concerning our viewpoint, please contact me at 202.824.1708 or at jtindall@hiaa.org.

Sincerely,

Jeffrey E. Tindall
Legislative Director

cc: Reed Stoops

Testimony on HCS for Senate Bill 37
Mike Wiggins,
Aetna

Chairman Rokeberg and members of the House Judiciary Committee, my name is Mike Wiggins and I am the head of national accounts for the State of Alaska. In various capacities I have been involved in the health care insurance market in Alaska for the past 15.years, and have worked with Blue Cross, New York Life and more recently Aetna.

Aetna has opposed Senate Bill 37 and remains opposed to the latest draft of the bill. While the bill has been significantly narrowed from its original version, we still feel that it will neither benefit consumers nor competition in the Alaska health insurance market.

The major impact of the bill is to allow collective negotiations by physicians with health insurers on broad contractual items, which are listed on page 2 of the bill. Aetna and the Health Insurance Association of America which represents most of the other health insurers in the Alaska market agree with the Federal Trade Commission that bargaining on contractual issues will likely have a significant impact on the cost of health care and therefore is likely to increase the cost of insurance in Alaska. Since the bill only applies to the privately insured market (mainly individuals and small groups), it will have an adverse effect on the part of the market that already has the highest costs and in the market where the insured members are least able to afford increases. As you are aware there are two other bills pending before the legislature this year, which seek to find less expensive ways to provide health insurance in this sector of the market.

Two years ago, during the legislative session, Aetna participated extensively in the House Judiciary Committee proceedings on the Alaska " Patient Protection Act" which ultimately passed the Legislature . The main focus of that bill was to address the same contractual issues for which the physicians are now seeking the right of collective bargaining. That bill today provides safeguards in Alaska law and prohibits many of the practices such as "anti gag clauses" that physicians have testified, should be dealt with through the mechanism of SB 37.

Further, the FTC has testified that physician's groups are now permitted to bargain on "quality of care" issues within the federal constraints on antitrust. Passing a state law will not change the FTC's ultimate authority for evaluating and prosecuting. By adopting differing state and federal standards for antitrust actions, the situation will become more confusing, not less

Except for Blue Cross in a relatively small part of the total insurance market, we don't believe that any health insurer can be reasonably considered to have market power using the normal definition of that term. If HB 37 is intended to regulate Blue Cross in some fashion, as a nonprofit corporation they are subject to a different section of the insurance

statutes than the for profit insurers. Any concerns in the individual and small group market could be addressed under their unique part of Alaska's insurance statutes.

To address previous testimony by physicians on their inability to appeal claims that have been denied for "Medical Necessity", I have provided summary of State of Alaska - Aetna information to the committee illustrating the small number of these type appeals and their disposition. Ultimately, within the Aetna organization it is an independent physician and not a non-physician that decides the merits of these appeals.

Thank you for the opportunity to testify. I'll be glad to answer any questions from the committee.

STATE OF ALASKA 2001

APPEALS AND GRIEVANCES

- TOTAL CLAIMS PROCESSED- 1,105,956
- TOTAL APPEAL AND GRIEVANCES- 110
  - Actives- 46
  - Retiree-64
- Total overturned- 21 or 19%

2001 GRIEVANCES BY CATEGORY

- 22 PROGRAM COMPLAINTS
  - 9 SLOW CLAIMS PROCESSING
  - 4 EXCLUSIONS
  - 3 CLAIM PROCESSING ERROR
  - 2 MEMBER COPAY
  - 2 CLAIM PROCESSING ERROR
  - 1 MEMBER MATERIALS
  - 2 BALANCE BILLS
  - 1 ? MEDICAL CARE

STATE OF ALASKA - APPEALS

2001 APPEAL REASONS BY CATEGORY

- 17 DENTAL
- 16 NON COVERED BENEFITS
- 14 TRAVEL
- 10 UCR
- 3 VISION
- 2 RX/DME
- 2 DIAGNOSTIC SERVICES/SURGEY

Kimberly Ann Ressler, RN, MSN, FNP
PO Box 84471
Fairbanks, AK 99708

April 9, 2002

Dear Representative Norman Rokeberg, Chair, House Judiciary Committee

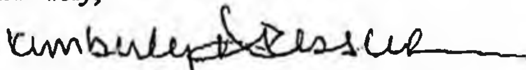
I am writing to express my strong opposition to Senate Bill 37 which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002.

I am concerned that negotiated contracts might contain language that would limit my patient's ability to choose a nonphysician professional as their healthcare provider. As an advanced practice nurse, I am able to deliver quality health care to the people of the Fairbanks community. I practice in an urgent care setting with a physician available for telephone consultation. Throughout the state of Alaska, nurse practitioners and physician assistants assess, diagnose, and treat both acute and chronic illness in all age groups. They are a critical link in providing cost-effective health care for many people where access is limited.

I view Senate Bill 37 as an attempt to limit the scope of practice for nonphysician professionals as negotiated contracts may contain wording that specifies that care may only be given by a physician. Let the patients chose their own healthcare provider. Senate Bill 37 only adds to the bureaucracy of health care legislation to regulate a process that already can take place. Thank you for your time and consideration.

VOTE NO ON SENATE BILL 37!!

Sincerely,



Kimberly A. Ressler, RN, MSN, FNP
home phone 907-458-7118 e-mail: kimressler@gci.net

DEPARTMENT OF VETERANS AFFAIRS
ALASKA VA HEALTHCARE SYSTEM AND REGIONAL OFFICE
2925 DEBARR RD
ANCHORAGE AK 99508

PRIMARY CARE CLINIC

FAX TRANSMISSION

DATE: 4/9/02

FROM: MARY KUTNEY & YVONNE STEVENSON

TELEPHONE NUMBER: 907-257-4950 **FAX NO.:** 907-257-7454

You should receive _____ page(s) including the cover sheet.
If you do not receive all the pages, please call (907) 257-4954.

MESSAGE TO: NORMAN Rokeberg

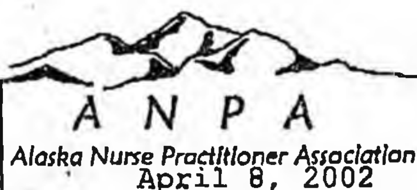
LOCATION: Judiciary Committee Chair

FAX NO. (907) 465-2040

COMMENTS:

VOTE NO SB 37

This transmission is intended only for the use of the person or office to whom it is addressed, and may contain information that is privileged, confidential, or provided by law. All others are hereby notified that receipt of this message does not waive any applicable privilege or exemption from disclosure and that any dissemination, distribution, or copying of this communication is prohibited. If you have received this communication in error, please notify us immediately at the telephone number shown.



ANPA
Alaska Nurse Practitioner Association

2207 East Tudor Road. Suite #34
Anchorage. Alaska 99507
907-222-6847

April 8, 2002

Mr Norman Rokeberg, Chair, House Judiciary Committee:

As the President of the Alaska Nurse Practitioner Association I am writing to express our strong opposition to Senate Bill 37 which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00 PM.

The current House Labor & Commerce CS has deleted those sections allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consume' ' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a nonphysician professional as their healthcare provider.

Senate Bill 37 in any form is unnecessary. According to the January 18, 2002 letter from the Federal Trade Commission to Representative Lisa Murkowski "...current antitrust law already permits physicians to work collectively on legitimate quality of care issues. "Physicians could look to strengthening current statute language, specifically Chapter 21.07.010, Patient and Health Care Provider Protection (also known as the Alaska Patient's Bill of Rights), in order to meet their goal of allowing balanced negotiations with insurance companies.

If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place.

Thank you for your time to review this issue

PLEASE VOTE NO ON SENATE BILL 37!

Sincerely,

Mary M Kutney MSN RN FNP

Mary M. Kutney MSN, RN, FNP
President Alaska Nurse Practitioner Association

April 8, 2002

Norman Rokeberg (Room 118)
Chair
House Judiciary Committee

Dear Sir:

I am writing to express my strong opposition to Senate Bill 37 which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00pm.

The current House Labor & Commerce CS has deleted those sections allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consumers' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a non-physician professional as their healthcare provider.

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If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place.

VOTE NO ON SENATE BILL 37!

Yvonne Stevenson, RNC, MSN, FNP
Family Nurse Practitioner

April 9th 2002

Girdwood Clinic
P.O. Box 1130
Girdwood, Alaska 99587

To:
Norman Rokeberg, Scott Ogan John Coghill, Jeannette James, Kevin Meyer, Ethan Berkowitz, Albert Kookesh.

RE: Senate Bill 37

Please vote NO on Senate bill 37. This bill could allow provisions excluding non-physician providers such as Nurse Practitioners from providing needed care to consumer in their communities. This would have a devastating effect on may small communities. Here in Girdwood the only clinic providing urgent care and family practice is by a Nurse Practitioner. I am writing to express my strong opposition to Senate Bill 37, which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00 PM.

The current House Labor & Commerce CS has deleted those sections allowing physiciar to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consumers' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a nonphysician professional as their healthcare provider.

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If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place. VOTE NO ON SENATE BILL 37!

Sincerely,

Kerry Dorius FNP

Kerry Dorius FNP

April 9, 2002

Representative Norman Rokeberg
State Capitol, Room 118
Juneau AK 99801-1182

Dear Representative Rokeberg:

RE: Senate Bill 37

I am writing to express m·· strong opposition to Senate Bill 37, which is scheduled to be heard in the House Judici / Committee on Wednesday, April 10, 2002 at 1:00 PM.

I am gravely concerned about the effect of this bill on access to healthcare and the costs of healthcare. I believe it will limit access by allowing only certain providers with the negotiating powers provided in this bill to obtain lucrative contracts, and block their "competitors" from an equal share of the market of healthcare consumers. In practical terms, I could lose the provider I choose because she or he is not a part of the negotiated contract. I find this unfair from a consumer viewpoint.

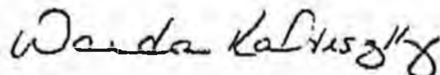
The current House Labor & Commerce CS has deleted those sections allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remains, however, many ways that consumers' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a nonphysician professional as their healthcare provider.

Senate Bill 37 in any form is unnecessary. According to the January 18, 2002 letter from the Federal Trade Commission to Representative Lisa Murkowski "...current antitrust law already permits physicians to work collectively on legitimate quality of care issues." Physicians could look to strengthening current statute language, specifically Chapter 21.07.010, Patient and Health Care Provider Protection (also known as the Alaska Patient's Bill of Rights), in order to meet their goal of allowing balanced negotiations with insurance companies.

If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place.

THIS BILL IS BAD PUBLIC POLICY! VOTE NO ON SENATE BILL 37!

Sincerely,



Wanda Katinszky, RN, BSN, MS
MSW Graduate Student
University of Alaska Anchorage
2931 Legacy Drive
Anchorage AK 99516

5654 Chilkoot Ct
Anchorage AK 99504
April 10, 2002

Representative Norman Rokeberg
Chair, House Judiciary Committee

I am writing to express my strong opposition to Senate Bill 37 which is scheduled to be heard in the House Judiciary Committee on Wednesday, April 10, 2002 at 1:00 PM.

The current House Labor & Commerce CS has deleted those sections allowing physicians to negotiate prices, eliminating only the most blatant attempts at price-fixing. There remain, however, many ways that consumers' costs may increase and access may decrease. Negotiated contracts could contain "quality" or "safety" provisions that might limit or eliminate consumers ability to choose a non-physician professional as their healthcare provider.

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If enacted Senate Bill 37 would create an unnecessary layer of expensive bureaucracy to regulate an activity that can already take place.

I urge you to vote NO on Senate Bill 37!

Sincerely,

Patricia Hong, RN

Subject: SB 37
Date: Wed, 10 Apr 2002 19:32:25 -0800
From: "nancy felton" <endrd@alaska.net>
To: <Heather_Nobrega@Legis.State.Ak.Us>

Dear Representative Roberg,
I am writing to you in regards to Senate Bill 37. I request that you oppose the bill. Nurse Practitioners provide care to many underserved populations as well as providing a choice for individuals' health care needs. It will be detrimental to Nurse Practitioners in this state if this bill is passed. The current antitrust law already provides physicans the ability to work collectively. Please share this with the House Judiciary Committee. - Nancy Felton,ANP

Subject: [Fwd: Oppose SB 37]
Date: Wed, 10 Apr 2002 08:46:34 -0800
From: Representative Norman Rokeberg <Representative_Norman_Rokeberg@legis.state.ak.us>
Organization: Alaska State Legislature
To: Heather_Nobrega@legis.state.ak.us

Subject: Oppose SB 37
Date: Wed, 10 Apr 2002 01:26:45 -0800
From: Lisa Howe Kocur <lisah@acsalaska.net>
To: Representative_Norman_Rokeberg@legis.state.ak.us

SB 37 should be opposed! Beides being unneccesary, it is unreasonable.
Very often the Nurse Practitioners, Nurse Anesthetists, and Physicians
Assistants have skills and experience equal to or greater than a
physician, and at a much more reasonable cost.
As a self employed (and uninsured) Alaskan, I shudder to think of the
rise in medical costs that would be associated with this bill.
Please put this one to rest for good!

Lisa H. Kocur

4/9/02

House Judiciary committee
Norm RoKeberg, Chair

As a long time Nurse Midwife/Advanced Nurse Practitioner, I have enjoyed the autonomy of private practice in Alaska. I feel SB 37 is bad legislation and will effect consumers ability to choose a non-physician as their health care provider and therefore preventing me from a livelihood that I have depended on for the past 12 years. I've read the Federal Trade Commission's report and their findings and recommendations are compelling and wish that you would VOTE NO ON SB 37.

Yolanda A. Meza, CNM, ANP
1/907 338-2380

4/9/02

House Judiciary committee

As a long time Nurse Midwife/Advanced Nurse Practitioner, I have enjoyed the autonomy of private practice in Alaska. I feel SB 37 is bad legislation and will effect consumers ability to choose a non-physician as their health care provider and therefore preventing me from a livelihood that I have depended on for the past 12 years. I've read the Federal Trade Commission's report and their findings and recommendations are compelling and wish that you would VOTE NO ON SB 37.

Yolanda A. Meza, CNM, ANP

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HCS CS SB 37 (L&C)
() Publish Date:

Revision Date/Time (Note if correction):
Title: Physician Negotiations with Health Insurance
Sponsor: Senator Kelly
Requester: House Judiciary

Dept. Affected: DCED
BRU: Insurance (116)
Component: Insurance Operations
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill requires the director of insurance to determine the number of individuals covered under health benefit plans in Alaska. A health benefit plan is now defined as a health care insurer instead of an employee welfare benefit plan. The division already collects covered lives data from health care insurers for purposes of reporting under AS 21.06.110. Therefore, any cost to modify the survey form, compile and report this data would be absorbed within existing division resources.

Prepared by: Robert A. Lohr, Director
Division: Insurance
Phone: 907-269-7900
Date/Time: 4/10/02 11:46 AM

Approved by: Deborah B. Sedwick, Commissioner
Agency: Department of Community & Economic Development
Date: 4/10/2002

(Revised 9/2001 OMB)

Principal Life
Insurance Company

VIA FACSIMILE & REGULAR MAIL

April 10, 2002

The Honorable Norm Rokeberg
Chair, House Judiciary Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

RE Opposition to Collective Negotiation by Physicians, S.B. 37

Dear Representative Rokeberg:

I am writing on behalf of the Principal Financial Group to urge you and your committee members to oppose S.B. 37, a bill that permits collective negotiation by competing physicians with health benefits plans. The Principal is a leader in offering businesses, individuals and institutional clients products and services, including life and health insurance, retirement and investment services, and mortgage banking through its diverse family of financial service companies. We provide medical, dental, or vision insurance to over 10,000 Alaskans through Principal Life Insurance Company.

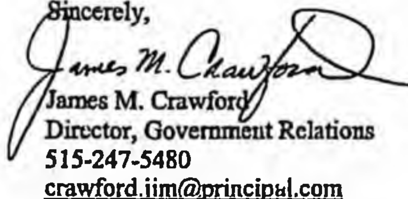
The Principal opposes this legislation because it will be very detrimental for consumers in your state. Competition is essential in order to provide quality health services on a cost-effective basis. Existing antitrust laws provide adequate flexibility for physicians, hospitals and health professionals to work together to organize networks and other provider delivery systems and distinguish themselves in ways that will benefit customers. However, S.B. 37 will ultimately cause health care costs to increase, while doing very little, if any, to improve the quality of health care for Alaskans.

Vigorous enforcement of federal and state antitrust laws is also essential if health plans are to enter new communities and continue to expand their presence by developing innovative, cost effective health care programs. Health care plans must be able to contract with quality providers without facing boycotts, price-fixing, artificial ethical restraints on the ability of doctors to enter into contracts, or local provider monopolies.

We strongly believe that enactment of S.B. 37 will diminish competition. In addition, any weakening of current antitrust laws will hamper efforts to control health care costs as health plans seek to contract with high-quality providers and reward care that is delivered both effectively and efficiently.

I hope you will consider our views and oppose this legislation. If you have any questions please call me or Martha Crist at 1-800-325-2532. Thank you.

Sincerely,



James M. Crawford
Director, Government Relations
515-247-5480
crawford.jim@principal.com

JMC:klp

cc Judiciary Committee — Jeff Tindall
Merle Pederson — Martha Crist

Div of Insurance

April 10, 2002

Summary
Talking Points HCS CSSB 37(L&C)

Introduction

The primary mission of the Alaska Division of Insurance is protect Alaskan insurance consumers. We oppose this legislation because:

1. The bill is simply unnecessary since the Patients Bill of Rights already addresses the issues raised by the physicians regarding quality of care.
2. It will increase the cost of health insurance and thereby the number of uninsured Alaskans.
3. It will discourage insurers from entering or remaining in the Alaska market.
4. Specific problems regarding health insurance benefits should be addressed by the legislature, not health care providers for the protection of insured Alaskans.

Who the bill applies to:

- Less than 20% or about 115,000 Alaskans are covered under insured health plans in Alaska. This means that the remaining 80% or about 500,000 people are either uninsured or covered under a health plan that is not subject to SB 37.
- This bill also does not apply to the federal employee program, State of Alaska, Medicaid, Medicare, Indian Health Service or other government payors as well as the largest private employer plans in the state, which are self-funded.
- This bill would harm those Alaskans that are most vulnerable, small Alaskan employers and individual families that purchase insurance through a health care insurer.

Stated Need for this bill is Quality of Care

1. Quality of care issues were addressed in the Patients Bill of Rights that became effective July 1, 2001.
2. Under the Patients Bill of Rights the provider contract must protect the ability of the provider to communicate openly regarding treatment options. There is strong and clear language that would prohibit insurers from imposing "gag orders" or discouraging a provider from discussing all appropriate options including higher cost options.
3. Why do insurers contract with providers? Primarily to get lower cost health care services for their insureds and to protect their insureds by assuring that a provider they contract with is properly licensed, has the proper credentials and maintains medical malpractice insurance.
4. Alaska has no HMOs and limited managed care. Health insurers in Alaska do not provide care. They are payors, not health care providers and they do not make medical decisions. What they decide is what services will be covered under an insurance contract with an Alaskan insured?

April 10, 2002

Stated Need for bill related to FTC Action against Alaska Healthcare Network (AHN) in Fairbanks

- Settlement agreement issued April 28, 2001
- AHN's actions:
  1. resulted in a wide range of payors unable to secure physician contracts and thus unable to do business in the Fairbanks area.
  2. restrained price and other competition among physicians in the Fairbanks area and thereby harmed consumers by increasing prices for physician services
  3. limited competition among health plans.
- This bill appears to try to use the State Action Doctrine to accomplish what the FTC found harmful to insurers and consumers.

Physicians want to define medical necessity

- An extremely small number of claims are denied on the basis of medical necessity During the first quarter of 2002 Blue Cross estimated that the percentage of claims denied due to medical necessity was roughly .02%. Aetna's number is also very low.
- The Alaska Patients Bill of Rights requires internal appeal and external appeal processes and sets forth timeframes for the reviews to provide protections to Alaskans specifically in regard to medical necessity decisions.
- As the chair is aware the definition of medical necessity was a contentious issue when the Patient's Bill of Rights was being drafted. The parties could not agree on a definition and there is no reason to believe that this bill would change that. The process in the Patient's Bill of Rights to allow these decisions to be made in a fair and objective manner by a third party through external review is the most appropriate way to handle this contentious issue for the benefit of insured Alaskans.

Physicians assert that Insurers have Market Power and it is Increasing

- In the last eight years the market share of the top three insurers in the group health market has not increased They were Blue Cross, Aetna and Principal Life.
- In fact it has declined by 5% during that period.

Therefore, IN ALASKA there has not been a significant change in the insurance market and insurers market power has not been increasing. This may be the case in the lower 48 particularly with HMOs but it is not the case in Alaska. **If there is a problem in the Alaska market the solution should be tailored to Alaska's market, not using some national model that doesn't even make sense for Alaska.**

Physicians assert that the bill will attract new insurers to Alaska

- Alaska has a small remote population which results in a small base over which to spread administrative costs making it difficult to be competitive and make money, this is the reason why insurers are not attracted to Alaska's market
- To put Alaska's market in perspective, Alaska's health insurance market represents less than .2% of the indemnity market in the U.S.
- The two insurers that pulled out of the individual and small group markets in 2000 left because their Alaska business was not profitable

- Insurers that the division has talked with about the bill have stated that allowing physicians to collectively negotiate with insurers would actually be a deterrent to entering and staying in the Alaska insurance market

Physicians assert that insurers only allow referrals to contracted providers

- The Patients Bill of Rights requires adequate referrals including referrals to providers not under contract with the insurer in order to receive medically necessary or specialty care
- The division reviews health insurance contracts to make sure that provisions for adequate referrals are made. If no contracted provider is available (reasonable distance from the insured) then the insurer must pay benefits to an available provider that is not under contract, as if the provider, were under contract.
- The division considers it a violation of the unfair trade practice to reimburse a provider not under contract at a lower rate if a provider under contract is not available. In fact the Division imposed a significant fine on an insurer that was reimbursing insureds at out-of-network rates when a network provider was not available in the service area of the insured.

Physicians assert that insurers have a take it or leave it attitude

- According the Kaiser Family Foundation comparison of physicians per 100,000 population Alaska ranks 49th at 186. The U.S. average is 285, Washington is 272, Oregon is 266. This fact indicates that there is relatively little competition between providers in Alaska with the result that insureds and insurance companies pay higher costs for health care services in Alaska and that providers have little incentive to contract with insurers to reduce their charges.
- In fact Health care costs in Alaska are approximately 30% higher than in Washington.
- Insurers in Alaska base their reimbursement on a usual, customary and reasonable (UCR) charge basis in compliance with Alaska regulations. If there are few providers providing a particular health care service, those providers essentially set the reimbursement rate for the health care service under a UCR system.
- In a non-competitive health provider market like Alaska, providers clearly do not need to contract in order maintain viable businesses. As the only provider in some cases they get patients regardless of whether they contract with an insurer.
- **Alaska is not a competitive market for health care providers and they are not at a disadvantage in negotiating contracts with health plans.**

Exclusion of MEWAs

The H L&C amendment to remove MEWAs from the definition was suggested the Alaska State Medical Association who is working with the Alaska Physicians and Surgeons on this bill. It is interesting to observe that the physicians that so stongly support this legislation do not want to be subject to its provisions.

Conclusion

The Division of Insurance whose primary mission is protect Alaskan consumers is opposed to this legislation since

April 10, 2002

1. The bill is simply unnecessary since the Patients Bill of Rights already addresses the issues raised by the physicians regarding quality of care
2. It will increase the cost of health insurance and thereby the number of uninsured Alaskans.
3. The bill will discourage insurers from entering or staying in the Alaska market.
4. pecific problems regarding health insurance benefits should be addressed by the legislature, not health care providers for the protection of insured Alaskans.

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HCS SB 37 (L&C)
() Publish Date:

Revision Date/Time (Note if correction):
Title "An Act relating to collective negotiation by physicians with health benefit plans....
Sponsor Senator Kelly
Requester House Judiciary

Dept. Affected: Administration
BRU Centralized Admin Svcs.
Component Retirement & Benefits
Component No. 64

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This version of the bill does not include self-insured plans; it will not apply to the State plans. It will have no fiscal impact on the State.

Prepared by: Guy Bell, Director
Division: Retirement & Benefits
Phone: 465-4471
Date/Time: 4/10/02 1:40 PM

Approved by: Jim Duncan, Commissioner
Agency: Department of Administration
Date: 4/10/2002

(Revised 9/2001 OMB)

Principal Life
Insurance Company

VIA FACSIMILE & REGULAR MAIL

April 10, 2002

The Honorable Norm Rokeberg
Chair, House Judiciary Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

RE Opposition to Collective Negotiation by Physicians, S.B. 37

Dear Representative Rokeberg:

I am writing on behalf of the Principal Financial Group to urge you and your committee members to oppose S.B. 37, a bill that permits collective negotiation by competing physicians with health benefits plans. The Principal is a leader in offering businesses, individuals and institutional clients products and services, including life and health insurance, retirement and investment services, and mortgage banking through its diverse family of financial service companies. We provide medical, dental, or vision insurance to over 10,000 Alaskans through Principal Life Insurance Company.

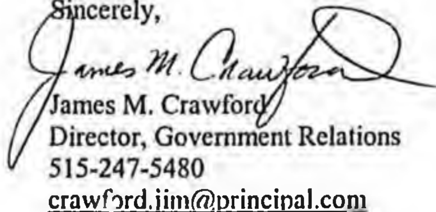
The Principal opposes this legislation because it will be very detrimental for consumers in your state. Competition is essential in order to provide quality health services on a cost-effective basis. Existing antitrust laws provide adequate flexibility for physicians, hospitals and health professionals to work together to organize networks and other provider delivery systems and distinguish themselves in ways that will benefit customers. However, S.B. 37 will ultimately cause health care costs to increase, while doing very little, if any, to improve the quality of health care for Alaskans.

Vigorous enforcement of federal and state antitrust laws is also essential if health plans are to enter new communities and continue to expand their presence by developing innovative, cost effective health care programs. Health care plans must be able to contract with quality providers without facing boycotts, price-fixing, artificial ethical restraints on the ability of doctors to enter into contracts, or local provider monopolies.

We strongly believe that enactment of S.B. 37 will diminish competition. In addition, any weakening of current antitrust laws will hamper efforts to control health care costs as health plans seek to contract with high-quality providers and reward care that is delivered both effectively and efficiently.

I hope you will consider our views and oppose this legislation. If you have any questions please call me or Martha Crist at 1-800-325-2532. Thank you.

Sincerely,



James M. Crawford
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JMC:klp

cc Judiciary Committee
Merle Pederson
Jeff Tindall
Martha Crist

Michael D. Wiggins

Vice President
National Accounts

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Aetna U.S. Healthcare

600 University, Suite 1400
Seattle. WA 98101

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To start the appeals process (formerly referred to as grievance), the member or provider/representative acting on behalf of the member submits an oral or written request asking for a change in the initial determination decision regarding:

- Certification of health care services; (e.g., pre-certification, concurrent review, emergency services)
- Claim payment
- Plan interpretation
- Benefit determinations
- Eligibility

The member, or provider/representative on behalf of the member, has 180 days after receipt of a coverage decision to file an appeal, unless otherwise required by law.

Within five business days of receipt of a written appeal, an acknowledgment letter is sent. This letter states that the member, provider, and facility will receive a response no later than 30 days from receipt of the appeal.

For all types of appeals, if the member, provider, or facility submitted information, a comprehensive review letter explaining the reason for the appeal determination is sent no later than 30 days from receipt of the information. If no information was submitted, a comprehensive review letter explaining the reason for the denial is sent no later than 30 days from receipt of the appeal.

Expedited appeal determinations are made within 72 hours.

The customer resolution team reviews non-clinical denial appeals with assistance, if needed, from their supervisor. For cases involving denials of coverage based on medical necessity, the customer resolution team forwards the case to the appropriate clinical business unit for review. The specific steps in our decision-making process may include a review of the following:

- Applicable policy or contract language
- Claims and utilization management guidelines and policies

- Relevant medical and dental records

The following may be involved in the appeals process:

- Attending provider, if willing to cooperate
- Benefit, risk policy, and claim personnel
- Customer service professionals
- Legal/compliance
- Our medical or dental policy personnel
- Ou· technology assessment and policy staff about investigational or other status
- Providers in the same or similar specialty as the attending provider
- Others, as appropriate to the issues raised by the appeal

If an appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, medical and dental information reviews, and any other applicable appeal procedures that may be available.

The member, or provider/representative on behalf of the member, has 180 days after receipt of a decision to request a Level II appeal.

If the member or provider/representative on behalf of the member is not satisfied with the outcome of the Level I appeal decision they may submit a written request for further appeal review. For clinical appeals the second level review is performed by a practitioner who typically treats the condition, performs the procedure, or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal. The practitioner must hold a current unrestricted license to practice medicine and be board certified by a specialty board of Medical Specialties.

If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, medical and dental information reviews, and any other applicable appeal procedures that may be available.

Every business unit has procedures for documenting

the review process for each appeal.

Each regional customer resolution team records and tracks all appeal activity. Quarterly activity on appeals is monitored at the regional or local market level. These reports include: number of Level I and II appeals, member identifier (ID number), member state of residence, type of appeal, dates of receipt of appeal and other communications, levels of review for each appeal, timeframes of responses, final decision and providers involved, and turnaround time in days.

When the customer is claim fiduciary, we are not responsible for the appeal or final claim determination. Upon receipt of an appeal, we will review the appeal and any additional information that has not previously been reviewed to determine whether the denial decision should be changed. If an obvious error in the initial claim determination is discovered, or if the additional information justifies payment of the claim, the initial denial is reversed and the claim is processed for payment. If this is not the case, a letter is sent to the member informing him/her that the appeal must be sent to the customer/claim fiduciary for final determination. We provide to the customer/claim fiduciary, via a copy of the denial letter, the rationale for the decision. We are also responsible for supplying to the claim fiduciary, upon request, any additional information and all documentation (including medical reviews, whether by our own medical directors or outside consultants) relating to the decision.

In the event new information is received after the appeal has been sent to the customer, the information will be reviewed again by the person who made the initial denial determination, and by the appropriate medical director. The medical director's opinion would then be provided to the customer.

We also offer an external review program that may be elected as an additional service.

We have developed a process that gives members the option of requesting an objective and timely external review of certain coverage denials. Once our internal grievance resolution process is exhausted, members may appeal the decision if the coverage denial is based on our determination that the requested service or treatment is not medically necessary or is experimental or investigational, and the cost of the service or treatment at issue the member is financially responsible exceeds $500. A member or physician, on the member's behalf, may request an external review within 60 days after the internal process has been exhausted.

An external review organization refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. After all necessary information is submitted, the external reviewer decides within 30 days of the request. Expedited

reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. Once the review is complete, we abide by the decision of the external reviewer.

We have access to the following two external review organizations: HAYES Plus, Inc. and Maximus (formerly The Center for Health Dispute Resolution, a.k.a. CHDR). Both external review organizations use board-certified physician reviewers and take an evidence-based approach to reviewing coverage decisions.