SB

37

SFIN

FILE

REPORTED OUT
MAR 2 8 2001
SENATE FINANCE COMMITEE

SENATE FINANCE COMMITTEE REPORT

DATE: 3/14/01

FURTHER:

DATE TURNED IN TO OFFICE: 29 Mar01

Finance Committee considered SENATE BILL NO. 37

PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

"An Act relating to collective negotiation by physicians with health benefit plans; and to health benefit plan contracts with individual competing physicians."

and recommends:

[✓] be **replaced** with ____ **CS** SB 37 (FIN)

[ ] adopt **previous** ____ **CS** CS forthcoming (____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[✓] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
amended fiscal note administration zero				

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
H&SS	1/17/01		✓	#4
DCED	1/19/01	30.1		#2
LAW	1/22/01	357.0		#1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
			✓	
		✓		
			✓	
	✓			
			✓	
	✓			
COCHAIR:			✓	
COCHAIR:	✓			

MAR 2 8 2001
SENATE FINANCE
COMMITEE

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB 37 (FIN)
(S) Publish Date:

Revision Date/Time (Note if correction): 3/28/2001
Dept. Affected: Administration
Title: "An Act relating to collective negotiation by physicians with health benefit...
BRU: Centralized Admin Svcs.
Component: Retirement & Benefits
Sponsor: Senate Finance
Requester: Senate Finance Committee
Component Number: 64

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
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)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

This version of the bill will have no fiscal impact on the State's ability to manage health care costs.

Prepared by: SENATE FINANCE COMMITTEE
Phone: 465-1881

Senator: SENATOR PETE KELLY,CO-CHAIR
SENATOR DAVE DONLEY,CO-CHAIR
Date: 3/28/2001

REPORTED OUT

MAR 2 8 2001

SENATE FINANCE COMMITEE

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 37
(S) Publish Date: 2/22/01

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

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	199.8	199.8	199.8	199.8	199.8	
Travel	5.6	5.6	5.6	5.6	5.6	
Contractual	135.9	135.9	135.9	135.9	135.9	
Supplies	2.7	2.7	2.7	2.7	2.7	
Equipment	13.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**357.0**	**344.0**	**344.0**	**344.0**	**344.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )		344.0	344.0	344.0	344.0	0.0

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF	249.9					
1005 GF/Program Receipts	107.1	344.0	344.0	344.0	344.0	
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**357.0**	**344.0**	**344.0**	**344.0**	**344.0**	**0.0**

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time	2	2	2	2	2	
Part-time						
Temporary						

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

SB 37 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. The bill further contains a sunset provision, repealing the new program on July 1, 2006.

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 very fact intensive determination whether to approve or not approve a proposed negotiated contract

Prepared by: Joan M. Kasson
Phone 465-5370
Division Attorney General's Office
Date/Time 1/22/01 8:59 AM
Approved by: Kathryn Daughhetee for Bruce M. Botelho, Attorney General
Date 1/22/2001
Agency Department of Law

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ANALYSIS CONTINUATION

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 when the health benefit plan has a market share greater than 15 percent in the geographic service area of the negotiating physicians.

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 7,000 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 new 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. $100,000 is included for outside expert costs (500 hours at an estimated average cost of $200/hour).

In-house estimates are based on the department's FY 2002 standard full-time equivalent attorney and paraprofessional schedules, which include clerical support, communications, space, supplies, data processing, and other normal overhead expenses. (FTE attorney: $141,776, 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. In the first year, it will take 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 fees will be set to cover all program costs. The Department of Law estimates, based on Texas' experience, that at least nine months will be required to get regulations in place. Accordingly, funds are split 70/30 general fund and general fund program receipts in FY 2002.

REPORTED OUT

MAR 2 8 2001

SENATE FINANCE COMMITEE

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SB 37
(S) Publish Date: 2/22/01

Revision Date/Time (Note if correction): 1/19/2001 5:25pm
Dept. Affected: DCED
Title: An act relating to collective negotiation by physicians with health benefit plans
BRU: Insurance
Component: Insurance
Sponsor: Senator Pete Kelly
Requester: Senate Judiciary
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	23.6	23.6	24.1	24.6	25.1	25.6
Travel						
Contractual						
Supplies	1.5	1.5	1.5	1.5	1.5	1.5
Equipment	5.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**30.1**	**25.1**	**25.6**	**26.1**	**26.6**	**27.1**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	30.1					
1005 GF/Program Receipts		25.1	25.6	26.1	26.6	27.1
1037 GF/Mental Health						
1156 RSS						
TOTAL	**30.1**	**25.1**	**25.6**	**26.1**	**26.6**	**27.1**

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

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

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

A part-time administrative clerk III position is needed in order to gather and report the health benefit plan market share information required under Sec. 23.50.020 (e)(C), page 4, lines 12&13. 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 employers who do not respond to the survey.

Prepared by: Robert A. Lohr
Phone 907-269-7900
Division: Insurance
Date/Time 1/19/2001 5:25:00pm
Approved by: Commissioner, Deborah B. Sedwick
Date 1/19/2001
Agency: Dept. of Community & Economic Development

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COMMITTEE CC:

REPORTED OUT

MAR 2 8 2001

SENATE FINANCE COMMITEE

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: SB 37
(S) Publish Date: 2/22/01

Revision Date/Time (Note if correction):
Dept. Affected: Health and Social Services
Title: Collective bargaining by physicians
BRU: Medical Assistance
Component: Medicaid Services
Sponsor: Kelly
Requester: Judiciary
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
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 G.						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

The Division of Medical Assistance assumes this bill will not impact the Medicaid and CAMA programs as the definition of health benefit plan in AS 21.54.500 does not include these public programs. Federal rules require Medicaid compensation to be sufficient to enlist enough providers so that services under the plan are available to the same extent as to the general public, however reimbursement rates for all services are also driven by appropriations. The Department of Health and Social Services supports exclusion of public programs from the physician negotiations provisions of this legislation.

Prepared by: Nancy Weller
Phone 465-3355
Division Medical Assistance
Date/Time 1/17/01 12:00 AM
Approved by: Elmer A. Lindstrom, Special Assistant to the Commissioner
Date 1/23/01 3:44 PM
Agency Department of Health & Social Services

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COMMITTEE CC:

amended (+ adopted)

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB(37)(L&C)
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: An Act relating to collective negotiation by physicians with health benefit...
BRU: Centralized Administrative Services
Component: Retirement and Benefits
Sponsor: Senator Pete Kelly
Requester: Senate Finance
Component Number: 64

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	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)						
TOTAL	*	*	*	*	*	*

Estimate of any current year (FY2001) cost: *

POSITIONS

Full-time						
Part-time						
Temporary						

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

~~The bill would compromise the State's ability to manage health care costs. Analyses of similar legislation at the federal level estimate health care increases of 5-13% when this type of legislation is enacted. That represents a potential increase to the State's plan of $3.5 - 9.1 million.~~

~~The State's contribution as an employer is capped by collective bargaining agreements and is in statute for non covered employees. Any increase in cost will be borne by employees. Based upon FY 01 premiums, this could raise each employee's cost $34 to $88 per month.~~

Delete language

Prepared by: Guy Bell, Director
Phone 465-4471
Division Retirement and Benefits
Date/Time March 14, 2001

Approved by: Jim Duncan, Commissioner
Date March 15, 2001
Agency Department of Administration

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SENATE FINANCE
COMMITTEE
Amendment Number: #1 adopted
Bill Number: SB 57
Sponsor: Kelly Date: 3/28/01
Logged In By: Cindy

22-LS0323\B.1
Bannister
3/28/01

AMENDMENT

OFFERED IN THE SENATE Senator Kelly

TO: CSSB 37( ), Draft Version "B"

Page 7, lines 15 – 19:

Delete all material and insert:

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

Amend #2. (adopted)

Sec. 23.50.030. Fee for registration of authorized third parties. (a) The attorney general shall adopt regulations that establish the amount and manner of payment of a registration fee for authorized third parties. The attorney general shall establish the fee level so that the total amount of fees collected from authorized third parties approximately equals the actual regulatory costs for the oversight of joint negotiations between physicians and health benefit plans. The attorney general shall annually review the fee level to determine whether the regulatory costs are approximately equal to fee collections. If the review indicates that the fee collections and regulatory costs are not approximately equal, the attorney general shall calculate fee adjustments and adopt regulations under this subsection to implement the adjustments. In January of each year, the attorney general shall report on the fee level and revisions for the previous year under this subsection to the office of management and budget.

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

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

Sec. 23.50.099. Definitions. In this chapter,

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

(2) "health benefit plan" has the meaning given in AS 21.54.500, but does not include a health benefit plan that is a self-insured health benefit plan.

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

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

~~* 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.~~ delete

Alaska State Senate

Senate Finance Committee

Official Business

Mail Stop 3100
State Capitol
Juneau, Alaska 99801-1182

FAX COVER SHEET

DATE: 28 March 2001 TIME: 6:45 pm

TO: Legal Services

NUMBER OF PAGES, INCLUDING COVER SHEET: 3

FROM: MINDY ROWLAND
SENATE FINANCE COMMITTEE SECRETARY
PHONE: 465-4935
FAX: 465-2187

NOTES: Request for final
SB 34 22-LS0323\B 3/27/01
with 2 amendments attached

Thanks.
Mindy

faxed

CS FOR SENATE BILL NO. 37(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR KELLY

A BILL

FOR AN ACT ENTITLED

"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."

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

*** Section 1.** AS 23 is amended by adding a new chapter to read:

Chapter 50. Collective Negotiation by Physicians.

Sec. 23.50.010. Legislative findings. (a) The legislature finds that permitting competing physicians to engage in collective negotiation of certain terms and conditions of contracts with a health benefit plan will benefit competition, so long as the physicians do not engage in an express or implied threat of retaliatory collective action, including boycotts or strikes.

(b) The legislature finds that permitting physicians to engage in collective negotiations over fee-related terms may, in some circumstances, yield anti-competitive

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

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

Sec. 23.50.020. Collective action by competing physicians. (a) Competing physicians may meet and communicate in order to collectively negotiate with a health benefit plan concerning any of the contract terms and conditions described in this subsection. Competing physicians may not engage in a boycott related to these terms and conditions. Competing physicians may meet and communicate concerning

(1) physician clinical practice guidelines and coverage criteria;

(2) the respective liability of physicians and the health benefit plan for the treatment or lack of treatment of insured or enrolled persons;

(3) administrative procedures, including methods and timing of the payment of services to physicians;

(4) procedures for the resolution of disputes between the health benefit plan and physicians;

(5) patient referral procedures;

(6) the formulation and application of reimbursement methodology;

(7) quality assurance programs;

(8) health service utilization review procedures; and

(9) criteria to be used by health benefit plans for the selection and termination of physicians, including whether to engage in selective contracting.

(b) Except as provided in (d) of this section, competing physicians may not meet and communicate for the purpose of collectively negotiating the following terms and conditions with a health benefit plan:

(1) the fees or prices for services, including fees or prices arrived at by

applying any reimbursement methodology procedures;

(2) the conversion factor in a resource-based relative value scale reimbursement methodology or similar methodologies;

(3) the amount of any discount on the price of services to be rendered by the physicians;

(4) the dollar amount for capitation or fixed payment for each person covered by the health benefit plan for health services rendered by physicians to a health benefit plan's insureds, beneficiaries, or enrollees; or

(5) the inclusion or alteration of terms and conditions to the extent that they are prohibited or required by law; however, this paragraph does not limit physician rights to collectively petition the government for a change in the law.

(c) An authorized third party that intends to negotiate with a health benefit plan the items identified under (a) of this section shall provide the attorney general with written notice of the intended negotiations before the negotiations begin. Negotiation of items identified in (a) of this section shall be conducted separately from, and shall be concluded before, negotiations are begun of the items identified in (b) of this section.

(d) Competing physicians within the service area of a health benefit plan may collectively negotiate with a health benefit plan the items described in (b) of this section if

(1) the health benefit plan has substantial market power;

(2) negotiation of items identified under (a) of this section has concluded;

(3) the physicians and the health benefit plan jointly request the attorney general to authorize them to negotiate the items identified under (b) of this section; and

(4) the attorney general issues a written authorization for the physicians and the health benefit plan to negotiate the items.

(e) The attorney general shall provide the authorization described under (d) of this section if the requirements of (d)(1), (2), and (3) have been met.

(f) A health benefit plan is rebuttably presumed to have substantial market

power. A health benefit plan may rebut the presumption of substantial market power by providing proof satisfactory to the attorney general that the health benefit plan's market share does not exceed 15 percent

(1) as measured by the number of covered lives at the end of the most recently completed calendar year or by the actual number of consumers of prepaid comprehensive health services at the end of the most recently completed calendar quarter divided by the total population of the geographic service area as of the most recent census; or

(2) within a particular geographic service area when its market segments are added together for all types of health insurance insureds, beneficiaries, or enrollees and for Medicare and Medicaid beneficiaries.

(g) In exercising the collective rights granted by (a) and (d) of this section,

(1) physicians may communicate with each other with respect to the contractual terms and conditions to be negotiated with a health benefit plan;

(2) physicians may communicate with an authorized third party regarding the terms and conditions of contracts allowed under this section;

(3) the authorized third party is the sole party authorized to negotiate with a health benefit plan on behalf of a defined group of physicians;

(4) physicians can be bound by the terms and conditions negotiated by the authorized third party that represents their interests;

(5) a health benefit plan communicating or negotiating with the authorized third party may contract with, or offer different contract terms and conditions to, individual competing physicians;

(6) an authorized third party may not represent more than 30 percent of the market of practicing physicians for the provision of services in the geographic service area or proposed geographic service area, if the health benefit plan has less than a five percent market share as determined by the number of covered lives as reported by the director of insurance for the most recently completed calendar year or by the actual number of consumers of prepaid comprehensive health services;

(7) the attorney general may limit the percentage of practicing physicians represented by an authorized third party; however, the limitation may not

be less than 30 percent of the market of practicing physicians in the geographic service area or proposed geographic service area: when determining whether to impose a limitation described under this paragraph, the attorney general shall consider the provisions described under (j), (k), and (l) of this section: this paragraph 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; and

(8) the authorized third party shall comply with the provisions of (h) of this section.

(h) A person acting or proposing to act as an authorized third party under this section shall,

(1) before engaging in collective negotiations with a health benefit plan,

(A) file with the attorney general the information that identifies the authorized third party, the physicians represented by the third party, the authorized third party's plan of operation, and the authorized third party's procedures to ensure compliance with this section;

(B) furnish to the attorney general, for the attorney general's approval, a brief report that identifies the proposed subject matter of the negotiations or discussions with a health benefit plan and that contains an explanation of the efficiencies or benefits that are expected to be achieved through the collective negotiations; the attorney general shall review whether the group of physicians represented by the authorized third party is appropriate to represent the interests involved in the negotiations; the attorney general may not approve the report if the group of physicians is not appropriate to represent the interests involved in the negotiations or if the proposed negotiations exceed the authority granted in this chapter and, if the group is not appropriate or the negotiations exceed the granted authority, shall enter an order prohibiting the collective negotiations from proceeding; the authorized third party shall provide supplemental information to the attorney general as new information becomes available that indicates that the subject matter of negotiations with the health benefit plan has changed or will change;

(2) within 14 days after receiving a health benefit plan's decision to decline to negotiate or to terminate negotiations, or within 14 days after requesting negotiations with a health benefit plan that fails to respond within that time, report to the attorney general that negotiations have ended or have been declined;

(3) before reporting the results of negotiations with a health benefit plan and before giving physicians an evaluation of any offer made by a health benefit plan, provide to the attorney general, for the attorney general's approval, a copy of all communications to be made to physicians related to the negotiations, discussions, and health benefit plan offers.

(i) The attorney general shall either approve or disapprove the contract that was the subject of the collective negotiation within 30 days after receiving the reports required under (h) of this section. If 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. An authorized third party who fails to obtain the attorney general's approval is considered to be acting outside the authority of this section.

(j) The attorney general shall approve a collective negotiation contract if

(1) the competitive and other benefits of the contract terms outweigh any anticompetitive effects; and

(2) the contract terms are consistent with other applicable laws and regulations.

(k) The competitive and other benefits of joint negotiations or negotiated provider contract terms may include

(1) restoration of the competitive balance in the market for health care services;

(2) protections for access to quality patient care;

(3) promotion of health care infrastructure and medical advancement; or

(4) improved communications between health care providers and health care insurers.

(l) When weighing the anticompetitive effects of contract terms, the attorney

general may consider whether the terms

(1) provide for excessive payments; or

(2) contribute to the escalation of the cost of providing health care services.

(m) This section does not authorize 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. The authorized third party shall advise the physicians of the provisions of this subsection and shall warn them of the potential for legal action against those who violate state or federal anti-trust laws by exceeding the authority granted under this section.

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

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

(p) Nothing in this section shall be construed as exempting from the application of the antitrust laws the conduct of providers or negotiations or agreements between providers and a health benefit plan if the purpose or effect of the conduct, negotiations, or agreements would be, directly or indirectly, to exclude, limit the participation or reimbursement of, or otherwise limit the scope of services to be provided by separate or competing classes of providers who practice or seek to practice within the scope of the occupational licenses held by the providers. #1

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

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

(s) In this section,

(1) "covered lives" means the total number of individuals who are entitled to benefits under the health benefit plan;

(2) "geographic service area" means the geographic area of the physicians seeking to jointly negotiate;

(3) "provider" has the meaning given in AS 21.36.090(d);

(4) "substantial market power" means more than 15 percent of the market share.

Sec. 23.50.030. Fee for registration of authorized third parties. (a) The attorney general shall adopt regulations that establish the amount and manner of payment of a registration fee for authorized third parties. The attorney general shall establish the fee level so that the total amount of fees collected from authorized third parties approximately equals the actual regulatory costs for the oversight of joint negotiations between physicians and health benefit plans. The attorney general shall annually review the fee level to determine whether the regulatory costs are approximately equal to fee collections. If the review indicates that the fee collections and regulatory costs are not approximately equal, the attorney general shall calculate fee adjustments and adopt regulations under this subsection to implement the adjustments. In January of each year, the attorney general shall report on the fee level and revisions for the previous year under this subsection to the office of management and budget.

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

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

Sec. 23.50.099. Definitions. In this chapter,

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

(2) "health benefit plan" has the meaning given in AS 21.54.500, but does not include a health benefit plan that is a self-insured health benefit plan.

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

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

#2

adopted

22-LS0323\B
Bannister
3/27/01

CS FOR SENATE BILL NO. 37( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR KELLY

A BILL

FOR AN ACT ENTITLED

"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."

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

*** Section 1.** AS 23 is amended by adding a new chapter to read:

Chapter 50. Collective Negotiation by Physicians.

Sec. 23.50.010. Legislative findings. (a) The legislature finds that permitting competing physicians to engage in collective negotiation of certain terms and conditions of contracts with a health benefit plan will benefit competition, so long as the physicians do not engage in an express or implied threat of retaliatory collective action, including boycotts or strikes.

(b) The legislature finds that permitting physicians to engage in collective negotiations over fee-related terms may, in some circumstances, yield anti-competitive

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

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

Sec. 23.50.020. Collective action by competing physicians. (a) Competing physicians may meet and communicate in order to collectively negotiate with a health benefit plan concerning any of the contract terms and conditions described in this subsection. Competing physicians may not engage in a boycott related to these terms and conditions. Competing physicians may meet and communicate concerning

(1) physician clinical practice guidelines and coverage criteria;

(2) the respective liability of physicians and the health benefit plan for the treatment or lack of treatment of insured or enrolled persons;

(3) administrative procedures, including methods and timing of the payment of services to physicians;

(4) procedures for the resolution of disputes between the health benefit plan and physicians;

(5) patient referral procedures;

(6) the formulation and application of reimbursement methodology;

(7) quality assurance programs;

(8) health service utilization review procedures; and

(9) criteria to be used by health benefit plans for the selection and termination of physicians, including whether to engage in selective contracting

(b) Except as provided in (d) of this section, competing physicians may not meet and communicate for the purpose of collectively negotiating the following terms and conditions with a health benefit plan:

(1) the fees or prices for services, including fees or prices arrived at by

applying any reimbursement methodology procedures;

(2) the conversion factor in a resource-based relative value scale reimbursement methodology or similar methodologies;

(3) the amount of any discount on the price of services to be rendered by the physicians;

(4) the dollar amount for capitation or fixed payment for each person covered by the health benefit plan for health services rendered by physicians to a health benefit plan's insureds, beneficiaries, or enrollees; or

(5) the inclusion or alteration of terms and conditions to the extent that they are prohibited or required by law; however, this paragraph does not limit physician rights to collectively petition the government for a change in the law.

(c) An authorized third party that intends to negotiate with a health benefit plan the items identified under (a) of this section shall provide the attorney general with written notice of the intended negotiations before the negotiations begin. Negotiation of items identified in (a) of this section shall be conducted separately from, and shall be concluded before, negotiations are begun of the items identified in (b) of this section.

(d) Competing physicians within the service area of a health benefit plan may collectively negotiate with a health benefit plan the items described in (b) of this section if

(1) the health benefit plan has substantial market power;

(2) negotiation of items identified under (a) of this section has concluded;

(3) the physicians and the health benefit plan jointly request the attorney general to authorize them to negotiate the items identified under (b) of this section; and

(4) the attorney general issues a written authorization for the physicians and the health benefit plan to negotiate the items.

(e) The attorney general shall provide the authorization described under (d) of this section if the requirements of (d)(1), (2), and (3) have been met.

(f) A health benefit plan is rebuttably presumed to have substantial market

power. A health benefit plan may rebut the presumption of substantial market power by providing proof satisfactory to the attorney general that the health benefit plan's market share does not exceed 15 percent

(1) as measured by the number of covered lives at the end of the most recently completed calendar year or by the actual number of consumers of prepaid comprehensive health services at the end of the most recently completed calendar quarter divided by the total population of the geographic service area as of the most recent census; or

(2) within a particular geographic service area when its market segments are added together for all types of health insurance insureds, beneficiaries, or enrollees and for Medicare and Medicaid beneficiaries.

(g) In exercising the collective rights granted by (a) and (d) of this section,

(1) physicians may communicate with each other with respect to the contractual terms and conditions to be negotiated with a health benefit plan;

(2) physicians may communicate with an authorized third party regarding the terms and conditions of contracts allowed under this section;

(3) the authorized third party is the sole party authorized to negotiate with a health benefit plan on behalf of a defined group of physicians;

(4) physicians can be bound by the terms and conditions negotiated by the authorized third party that represents their interests;

(5) a health benefit plan communicating or negotiating with the authorized third party may contract with, or offer different contract terms and conditions to, individual competing physicians;

(6) an authorized third party may not represent more than 30 percent of the market of practicing physicians for the provision of services in the geographic service area or proposed geographic service area, if the health benefit plan has less than a five percent market share as determined by the number of covered lives as reported by the director of insurance for the most recently completed calendar year or by the actual number of consumers of prepaid comprehensive health services;

(7) the attorney general may limit the percentage of practicing physicians represented by an authorized third party; however, the limitation may not

be less than 30 percent of the market of practicing physicians in the geographic service area or proposed geographic service area; when determining whether to impose a limitation described under this paragraph, the attorney general shall consider the provisions described under (j), (k), and (l) of this section; this paragraph 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; and

(8) the authorized third party shall comply with the provisions of (h) of this section.

(h) A person acting or proposing to act as an authorized third party under this section shall,

(1) before engaging in collective negotiations with a health benefit plan,

(A) file with the attorney general the information that identifies the authorized third party, the physicians represented by the third party, the authorized third party's plan of operation, and the authorized third party's procedures to ensure compliance with this section;

(B) furnish to the attorney general, for the attorney general's approval, a brief report that identifies the proposed subject matter of the negotiations or discussions with a health benefit plan and that contains an explanation of the efficiencies or benefits that are expected to be achieved through the collective negotiations; the attorney general shall review whether the group of physicians represented by the authorized third party is appropriate to represent the interests involved in the negotiations; the attorney general may not approve the report if the group of physicians is not appropriate to represent the interests involved in the negotiations or if the proposed negotiations exceed the authority granted in this chapter and, if the group is not appropriate or the negotiations exceed the granted authority, shall enter an order prohibiting the collective negotiations from proceeding; the authorized third party shall provide supplemental information to the attorney general as new information becomes available that indicates that the subject matter of negotiations with the health benefit plan has changed or will change;

(2) within 14 days after receiving a health benefit plan's decision to decline to negotiate or to terminate negotiations, or within 14 days after requesting negotiations with a health benefit plan that fails to respond within that time, report to the attorney general that negotiations have ended or have been declined;

(3) before reporting the results of negotiations with a health benefit plan and before giving physicians an evaluation of any offer made by a health benefit plan, provide to the attorney general, for the attorney general's approval, a copy of all communications to be made to physicians related to the negotiations, discussions, and health benefit plan offers.

(i) The attorney general shall either approve or disapprove the contract that was the subject of the collective negotiation within 30 days after receiving the reports required under (h) of this section. If 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. An authorized third party who fails to obtain the attorney general's approval is considered to be acting outside the authority of this section.

(j) The attorney general shall approve a collective negotiation contract if

(1) the competitive and other benefits of the contract terms outweigh any anticompetitive effects; and

(2) the contract terms are consistent with other applicable laws and regulations.

(k) The competitive and other benefits of joint negotiations or negotiated provider contract terms may include

(1) restoration of the competitive balance in the market for health care services;

(2) protections for access to quality patient care;

(3) promotion of health care infrastructure and medical advancement; or

(4) improved communications between health care providers and health care insurers.

(l) When weighing the anticompetitive effects of contract terms, the attorney

general may consider whether the terms

(1) provide for excessive payments; or

(2) contribute to the escalation of the cost of providing health care services.

(m) This section does not authorize 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. The authorized third party shall advise the physicians of the provisions of this subsection and shall warn them of the potential for legal action against those who violate state or federal anti-trust laws by exceeding the authority granted under this section.

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

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

(p) Nothing in this section exempts from the application of the antitrust laws an agreement or activity that is not allowed under this chapter and that excludes, limits the participation in, limits the reimbursement of, or limits the scope of services to be provided by providers or groups of providers with respect to the performance of services that are within the scope of the providers' occupational licenses.

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

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

(s) In this section,

(1) "covered lives" means the total number of individuals who are entitled to benefits under the health benefit plan;

(2) "geographic service area" means the geographic area of the physicians seeking to jointly negotiate;

(3) "provider" has the meaning given in AS 21.36.090(d);

(4) "substantial market power" means more than 15 percent of the market share.

Sec. 23.50.030. Fee for registration of authorized third parties. (a) The attorney general shall adopt regulations that establish the amount and manner of payment of a registration fee for authorized third parties. The attorney general shall establish the fee level so that the total amount of fees collected from authorized third parties approximately equals the actual regulatory costs for the oversight of joint negotiations between physicians and health benefit plans. The attorney general shall annually review the fee level to determine whether the regulatory costs are approximately equal to fee collections. If the review indicates that the fee collections and regulatory costs are not approximately equal, the attorney general shall calculate fee adjustments and adopt regulations under this subsection to implement the adjustments. In January of each year, the attorney general shall report on the fee level and revisions for the previous year under this subsection to the office of management and budget.

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

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

Sec. 23.50.099. Definitions. In this chapter,

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

(2) "health benefit plan" has the meaning given in AS 21.54.500, but does not include a health benefit plan that is a self-insured health benefit plan.

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

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

* **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.

CS for Senate Bill 37
Version: 22-LS0323\B
Sectional Analysis

"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 effect of the collective negotiation provisions on health care providers."

***Section 1.** AS 23 is amended by adding a new chapter to read:

Chapter 50. Collective Negotiation by Physicians.

AS 23.50.010

AS 23.50.010 articulates the reasons for the Legislature to set policy to allow joint negotiations between a group of competing physicians and a health insurance company.

AS 23.50.020

AS 23.50.020 (a) enumerates those items which may be the subject of joint negotiations. Those items include clinical practice guidelines and coverage criteria; respective liability of physicians and health care insurers; administrative procedures that include methods and timing of payments to physicians; resolution dispute procedures; patient referral procedures; application of the reimbursement methodologies to be used; quality assurance programs; utilization review procedures; and criteria for the selection and termination of participating physicians. Note that this subsection does not allow for negotiation for that fee or payment related items unless the conditions of AS 21.50.020 (c) are met.

AS 21.050.020 (b) prohibits joint negotiations involving fees or prices for services; the conversion factor in a RBRVS type payment methodology; amounts of discount on the physician services; and dollar amounts for a "captivation" basis of payment. However, it still allows physicians to jointly and collectively petition government for a change in law that provides for payment to doctors under a governmental program (e.g., Medicaid).

AS 21.050.020(c) requires an authorized third party that intends to negotiate with a health benefit plan provide written notification to the Attorney General of when the process is to commence. This section also notes if fees are to be negotiated, medical services must be negotiated first and concluded in (b) of this section.

AS 21.050.020 (d) states that physicians within a service area of a health benefit plan may collectively negotiate if "substantial market power" is present. The Attorney General shall then notify parties of the intent of the negotiations.

The exception is made to allow for joint negotiation for those fee items listed in AS 21.050.020 (d) when a health insurer has "substantial market power." AS 21.050.020 (s)(4) defines a substantial market power when an insurer has more than 15% of the market place as measured by the number of people covered are those covered under Medicaid and Medicare if an insurer provides any claim payment services for the government for those programs. The concept is based in that all "bodies" covered and threats of not contracting with a certain physician are based on the deleterious effect on a physician's practice by removing those patients from his/her practice. Enumerating the persons covered may be difficult for the Division of Insurance. In fact, it is impossible for the Division of Insurance to compel self-insureds to provide it with those data. In one state currently addressing the State Action Doctrine exemption issue (California), it is being considered to just require all health plans to negotiate with physicians without having to prove the "substantial market power" percentage. (Obviously this would allow physicians to still jointly negotiate under active state oversight). The reason for this is that it is clear in California that less than 6 health plans dominate Alaska's marketplace. In (1) of this section, substantial market power is calculated by the numbe· of covered lives per calendar year or number of consumers of prepaid health services divided by the total population of a geographic service area from the most recent census.

AS 21.050 (g) sets out the criteria for those collective rights to be carried out by the physicians jointly negotiating. The core provision is that negotiations are to be conducted through an "authorized third party" that will negotiate on behalf of the physicians who ha· e joined together for that purpose. Conceivably, that person acting as the authorized third party representative could be an IPA, a lawyer, a physician, a specialty medical society, a local medical association, a state medical association, etc. It is presumed a contractual relationship will exist between the represented physicians and the authorized third party that memorializes the obligations and requirements of the parties. This subsection states that the physician who have joined for the purpose of negotiation may communicate with their authorized third party about terms and conditions, which are to be negotiated. The authorized third party is the sole person who is to negotiate on behalf of the doctors. Subsection (5) of this section may provide some confusion in that it would appear to defeat the purpose of the joint negotiations. The intent of subsection (5) is to provide, for example, for different rates of reimbursement to be included for different specialties. (For example, anesthesiologists are typically reimbursed in a different manner than a surgeon and both may be in the same group of physicians engaged in joint negotiations.) Generally, an authorized third party may not represent more than 30% of the physicians. Obviously, the concern would be that physicians represented in great numbers would dictate the terms of a contract to an insurer or health plan. By the same token, for example, it would be unfair for a specialist, who is the only one in a particular area, not be able to join with other physicians to jointly negotiate. This is an area that active state oversight would be necessary so that a fair result for the general public would be the outcome.

AS 21.050.020 (h) sets out what a person desiring to act as an authorized third party needs to do in order to act in that capacity. In short, the authorized third party needs to

register with the Commissioner of Labor and Workforce Development. That registration requires an identification of the authorized third party and how that person intends to operate. It is presumed that this would include a detailed plan of operation along with the contract that it has entered into with the group of physicians to be represented. This must be done for each of the physician service contracts that the authorized third party wishes to jointly negotiate on behalf of the physicians represented. The efficiencies or benefits that are expected to be achieved must be identified. The authorized third party is required to report to the Commissioner of Labor if health care insurer or health plan declines to negotiate or terminates a negotiation within 14 days of receiving that decision. Also, if an insurer or health plan fails to respond within 14 days of a request for negotiation, that fast also needs to be reported to the Commissioner.

AS 21.050.020 (i) requires the Commissioner, with the advice of the Attorney General, to either approve or disapprove a negotiated contract within 30 days of when it was presented. If it is disapproved, the Commissioner must give a written explanation of the deficiencies and how they could be corrected.

AS 21.050.020 (j) explains the Attorney General shall approve a collective negotiation if a competitive aspects outweigh any anti-competitive effects. Also, that the contract terms must be consistent with other applicable laws and regulations.

AS 21.050.020 (k) states the terms of the contracts may include a competitive balance in the market; protections for access to quality patient care; promotion of health care infrastructure and medical advancement; and improved communications between the providers and insurers.

AS 21.050.020 (l) explains the Attorney General may examine possible anti-competitive effects in the terms. Under that consideration the AG examines the possibility of excessive payment; or contributes to the escalation of cost in providing health care services.

AS 21.050.020 (m) prohibits the physicians represented from acting together in response to a report from their authorized third party regarding its discussion or negotiation with a health care insurer or health plan. The authorized third party has a duty to warn the physicians represented of the potential legal action under state and federal anti-trust laws for exceeding the authority granted by this measure.

AS 21.050.020 (n) limits the terms of any contract negotiated to 5 years. It is expected that terms of actual contracts will be for less than 5 years.

AS 21.050.020 (o) keeps all documents relating to joint negotiations, that would come from both physicians and insurers or health plans, confidential and not subject to public inspection.

AS 21.050.020 (p) does not exempt from to exclude the services provided by a provider or group of providers or that limits the participation or scope of services provided within

the scope of certain occupational licenses. This portion of the legislation was amended to meet concerns of the nurse practitioners and midwives. They were concerned their services could be negotiated out of the agreements. This reaffirms AS 21.36.090(d) which prohibits an insurer, HMO, hospital, or medical service-corporation from unfairly discriminating in its benefits between different types of medical care providers.

AS 21.050.020 (s) defines the terms "covered lives", "geographic service area", and "provider", and "substantial market power".

***AS 23.50.030**

AS 23.50.030 creates a fee mechanism to Cover State's cost of providing its active oversight of the joint negotiation authorized by this bill. The fee is to be reflective of the actual costs that the State incurs. The Commissioner sets the fees by regulation and must report on the fees each year to the Office of Management and Budget. At least one other state in dealing with a "State Action Doctrine" exception (California) charges the regulatory costs to health care insurers and health plans on a pro-rata share based on their market share. Theoretically, the cost should be the same without regard to who pays it. If the physicians pay it via their authorized third party, then they will negotiate sufficient payment levels to cover that cost. Conversely, if the insurers and health plans pay it, then they will negotiate sufficient payment levels to cover that cost. The issue is what is the most efficient and fair method of payment to cover the cost. Obviously, the physician community will not be supportive of a fee mechanism that requires a payment up-front only to have an insurer decline to negotiate and not receive any refund.

***AS 23.50.040**

AS 23.50.040 allows the Commissioner of Labor and Workforce Development to adopt regulations to implement this law.

***AS 23.50.099**

AS 23.50.099 is the definition section and contains the definition of the terms "authorized third party", "health benefit plan". The definition of "health benefit plan" in this section excludes those self-insured health benefit plans. These definitions are straightforward and unambiguous.

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

This section is needed to provide for joint negotiation by physicians under the "State Action Doctrine" exemption under Alaska's laws pertaining to competitive practices and regulation of competition.

***Section 3**

This section sets a five year sunset date on the legislation. The law would be repealed July 1, 2006.

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Senator Pete Kelly

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CSSB 37 ( )

Version 22-LS0323\B

"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."

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

In a perfect world, equal bargaining power would exist between the medical care providers and the health insurers. Big hospitals have more equal bargaining power with the health insurers than the typical Alaskan physician in a solo or small group practice. Obviously, a gross inequity in bargaining power exists and there is no conceivable way any health insurer will bargain with an individual doctor regarding individual contract provisions other than on a take it or leave it basis. The resultant effect is physician service contracts heavily weighted in favor of the insurance company. The bottom line is that, in many respects, this adversely affects the care that patients receive. For example, requiring a physician to use lower cost treatment when a higher cost treatment may be medically necessary or preventing a physician from discussing alternative treatments.

Independent, competing physicians are prevented from any collective action by the federal anti-trust laws to which, ironically, the insurers are not subject. This fact plus the market concentration of health insurers causes the imbalance in bargaining power. With insurers having such a high degree of leverage, a balance of interest no longer exists in the market for health care delivery and finance.

Senate Bill 37 can permit independent, competing physicians to collectively negotiate with health insurers in regard to the provisions of physician services contracts to provide quality health care to Alaskans. When the provisions set forth by SB 37 are met, behavior that would otherwise violate the anti-trust laws will be exempt from anti-trust scrutiny. The test for qualifying exemption varies depending on the identity of the party performing the action in question. However, SB 37 will still prohibit a group of independent competing physicians from striking or otherwise engaging in activities that would result in a boycott.

Senate Bill 37
How does it work?

Group of physicians wishing to join..ty 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

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

Non-Fee Related Items

- Notified AG → AG says YES → Plan says YES → Agreement reached → Agreement approved → Corrections approved
- Failed to notify AG **PROCESS ENDS**
- AG says NO **PROCESS ENDS**
- Plan says NO **PROCESS ENDS**
- No agreement reached **PROCESS ENDS**
- Agreement not approved **PROCESS ENDS**
- Agreement not approved **PROCESS ENDS**

Fee Related Items

- Notified AG → AG says YES → Plan says YES → Agreement reached → Agreement approved → Corrections approved
- Failed to notify AG **PROCESS ENDS**
- AG says NO* **PROCESS ENDS**
- Plan says NO **PROCESS ENDS**
- No agreement reached **PROCESS ENDS**
- Agreement not approved **PROCESS ENDS**
- Agreement not approved **PROCESS ENDS**

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

Prepared by Kristopher Knauss, Staff to Senator Kelly

How does SB 37 benefit consumers?

Passage of SB 37 would allow physicians to discuss and agree to definitions and terms used in these service agreements. This bill will give doctors more say when it comes to the specific guidelines of the health plans their patients have to live with. They will have more say about which treatments and medications they can recommend. They will have more say about which specialists they can refer patients to.

Currently patients have no advocate other than their doctors. For example, a patient visits the doctor to have an injured knee examined. The doctor recommends an MRI. Then the doctor must contact the insurance company for approval. If the insurance company does not approve this treatment, but instead recommends physical therapy for 2 weeks, the doctor must relay that to the patient. If doctors could negotiate contractual terms they're confident with, that patient could receive an MRI and a course of treatment could follow based on medical necessity, not cost.

Without the passage of SB 37, we are assured a stagnant market because new insurance carriers find it too expensive and time consuming to attempt to penetrate the Alaskan market without assurances that they can sign up a significant number of doctors from the start. The most effective method is for these new carriers to deal with a representative of a group of doctors, an IPA. If the doctors were allowed to collectively negotiate, new carriers would be much more likely to enter the Alaskan market thereby increasing the competition for patient's health care dollars.

SB 37 will allow patients to choose the right care. Some patients are forced by a plan to accept the least expensive form of treatment even if it is not the care the doctor would recommend. This legislation ensures that health plans do not put profits above patients.

Active state oversight will ensure that insurance premiums are not out of line. The AG will have very specific control over the contract provisions.

SB 37 will allow physicians to negotiate any of the following provisions:

- How to improve preventative care, such as childhood immunizations, prenatal care, and mammograms

Prepared by Kristopher Knauss, Staff to Senator Kelly

- How to better manage chronic diseases, such as diabetes, asthma, and cardiovascular disease
- How to identify, correct, and prevent fraud
- How to promote parental involvement in children's health care
- Resolving disputes between health plans and physicians
- Procedures for referring patients to specialists
- Quality assurance
- Methods and timing of physician reimbursement
- Utilization review
- Physician selection – and "de-selection" criteria

FROM THE TEXAS HANDBOOK:
How will this bill improve patient care?
Contract provisions that impede the ability of physicians to advocate for their patients must be challenged. Unless there is a balance of power between managed care plans and physicians, managed care plans can place profits above patients. Physicians who refuse to cooperate will be driven from the market and patients will lose access to physicians. Diminished access delays care and decreases choice for every patient.

SB37
"State Action Doctrine"

Alaska has never had a great number of health insurance companies competing in the market place. The prospect of even fewer players exists not only here but nationwide. On January 13, 1999, the New York Times reported that since 1994 the leading 18 health insurance companies have combined into 6.

Health insurance plans have increasingly incorporated practices and procedures to manage health care in order to keep costs down. One mechanism used is for a health insurer to contract with different types of providers of health care to provide care for its insureds. Theoretically, the health insurer negotiates discounted fees for health care for the promise of a more guaranteed stream of patients.

In a perfect world, equal bargaining power would exist between the medical care providers and the health insurers. Large group medical practices (none of which exist in Alaska) and big hospitals have more equal bargaining power with the health insurers than the typical Alaskan physician in a solo or small group practice. Obviously, a gross in-equity in bargaining power exists. There is no conceivable way any health insurer will bargain with an individual doctor regarding individual contract provisions. The health insurer will only offer a contract on a take it or leave it basis. The resultant effect is physician service contracts heavily weighted in the favor of the insurance company. The bottom line is that, in many respects, this adversely affects the care that patients receive. For example, requiring a physician to use a lower cost treatment when a higher cost treatment may be medically necessary.

Independent, competing physicians are prevented from any collective action by the federal anti-trust laws to which, ironically, the insurers are not subject. This fact plus the market concentration of health insurers causes the imbalance in bargaining power. With insurers having such a high degree of leverage, a balance of interest no longer exists in the market for health care delivery and finance.

A mechanism, however, is available that can permit independent, competing physicians to collectively negotiate with health insurers in regard to the provisions of physician services contracts. That mechanism is an act of the legislature which would create a "state action doctrine" exception which was first set forth in a 1943 U.S. Supreme Court decision in Parker v. Brown. In general, the state action doctrine states that the anti-trust actions do not apply to actions by a state operating in its sovereign capacity, or to private conduct compelled or approved by the state. In other words, where the requirements of the state action doctrine are met, behavior that would otherwise violate the anti-trust laws will be exempt from antitrust scrutiny. The test for qualifying for exemption varies depending on the identity of the party performing the action in question.

If the party is a state legislature or a state court, the exemption is complete and no further inquiry is required. Where the party is a state agency or local government official, further inquiry is required with respect to whether the action in question followed a "clearly articulated and affirmatively expressed state policy." However, when the party is a private party, the test for

qualifying for the state action exemption is the strictest. In addition to having to comport with the "clearly articulated and affirmatively expressed state policy," the action must also be subject to active state supervision. In other words, the state must, in practice, exercise some degree of independent judgement or control over the activity in question. Passive or theoretical power of a state to review a private action in question is insufficient to meet this standard.

Physicians fall into the category of a private party. Therefore, collective actions taken by physicians would ordinarily be illegal under anti-trust laws. In the instance of independent, competitive physicians engaging in collective negotiations with a health insurer, such actions would only be exempt from anti-trust scrutiny if the requirements above for a private party are met.

The most obvious way for a state to lay out those requirements is through legislation. SB37 is a bill that lays out the "clearly articulated and affirmatively expressed state policy" and provides for active state supervision through oversight by the Attorney General. Important to note is that this bill will still prohibit a group of independent competing physicians from striking or otherwise engaging in activities that would result in a boycott.

Please help level the playing field for Alaska's patients and the physicians who care for them by supporting SB37.

Provided by: ASMA

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

January 22, 2001

Honorable Robin Taylor
Alaska State Legislature
State Senate
Chairman, Senate Judiciary Committee
Room 30
Juneau, Alaska 99801-1182

RE: SB 37—Physician Joint Negotiation with Large Private Health Care Insurers.

Dear Senator Taylor,

The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them. ASMA urges you to support and vote for SB 37. Below, is a short outline of what SB 37 is and is not.

SB 37
WHAT IS IT?

- It allows independent, competing physicians to jointly negotiate terms of physicians services agreements with the insurance companies without violating federal anti-trust laws.
- It can only be created by an Act of the State Legislature that:
    1. Clearly establishes a state policy;
    2. Clearly describes the situation(s) in which it may occur (e.g., dominance in the marketplace by an insurer);
    3. Clearly establishes active state oversight of the process; and
    4. Clearly defines the process and who needs to represent the doctors in such negotiations.
- It creates a more fair and equitable negotiating process between doctors and the large and powerful insurance companies regarding the business relationship between them.
- It is voluntary.
- There are numerous other states considering similar legislation.

SB 37
WHAT IT IS NOT!

- IT IS NOT a union-creating device.
- IT IS NOT Collective Bargaining. (Only employed physicians and residents can collectively bargain with their employer.)
- IT IS NOT MANDATORY for either a doctor or for an insurance company.
- IT IS NOT A MECHANISM THAT WOULD ALLOW A DOCTOR OR DOCTORS TO STRIKE OR ENGAGE IN A BOYCOTT.
- IT IS NOT A MECHANISM THAT IMPACTS THE CONTRACTUAL RELATIONSHIPS BETWEEN AN INSURANCE COMPANY AND AN EMPLOYER OR OTHER HEALTH PLAN SPONSOR; OR THE COVERED PATIENT.

Attached is a more in depth description of the legal doctrine, the "State Action Doctrine", on which this bill is based. ASMA urges you to vote for SB 37.

Sincerely,

Peter Lawrason

BY: Peter Lawrason, MD, President
FOR: Alaska State Medical Association

LP

Alaska Physicians & Surgeons, Inc.
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February 28, 2001

Senator Randy Phillips
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

Dear Senator Phillips,

As one of the supporters of SB37 (The Physician Negotiation Bill), which is up before your committee tomorrow, March 1, 2001, I have been asked by Senator Pete Kelly's office to give you a thumbnail sketch of our perception of the reasons the opponents of the bill have problems with it. The opponents are as follows:

- The Attorney General's Office - In discussions with Mr. Sniffen, the Assistant Attorney General in charge of anti-trust, his primary concern seems to be that the bill is not specific enough in its description of what constitutes adequate state oversight. We feel, that the language in the bill is specific enough, and gives the Attorney General's office broad latitude in writing enabling administrative rules, to clarify the Attorney Generals "active state oversight" function.

- The Unions - Last year both the AFL-CIO, and the Teamsters opposed the bill primarily on the grounds that they would be forced to negotiate with physicians about contract terms for their self insured plans, and that those negotiations would raise medical costs to their union members. A secondary concern was that because their plans are self insured, they should be exempted from negotiating with physicians, because self-insured plans are generally subject to ERISA preemption. We strongly feel that these concerns are misplaced, because the bill clearly states that all negotiations are voluntary not mandatory. Second, if there is a question as to whether or not a union's self insured plan would be exempted under ERISA, the union and/or the physicians can ask the Attorney General's office for a legal opinion prior to negotiations.

- Insurers - Blue Cross Blue Shield and Aetna were the chief insurance opponents of the bill last year were. Their primary argument seemed to be that if physicians were allowed to negotiate as a group, the effect would be to drive up the cost of health care in Alaska, because the bill would give physicians too much bargaining power. From our standpoint, the insurers repeatedly failed to address the bill's requirement that any contract ultimately must be approved by, and is subject to an Attorney General's veto, if financial or non-financial contract terms are deemed not to be in the best interest of the citizens of Alaska.

- The Division of Insurance - My association is still unclear about the issues of concern that the Division of Insurance has and would appreciate if you could have them specify in writing, at the earliest possible time, what their concerns are, and have them include suggested amendments to the bill.

- My association is aware that there are currently 4 separate fiscal notes attached to SB37. As you may recall from last years debate over the bill, a larger fiscal note was attached, which included an assumption that if the bill passed, there would be upward of 1,000 contracts that the Attorney General's office would have to review and approve. Speaking as one who would be negotiating these contracts, that figure was wildly exaggerated. I predict no more than 10 to 20 contracts would need to be reviewed in any given year, and that would not be likely occur until 3 years after the implementation of the bill. We are seeking clarification from the 4 fiscal note authors as to the assumptions that went into their fiscal notes' conclusions. We would appreciate your help in getting that information as soon as possible.

Sincerely,

Michael Haugen, JD, MBA
Executive Director

SENATE COMMITTEE REPORT

DATE: 2/22/01

FURTHER: Finance

DATE TURNED IN TO OFFICE: 3-13-01

Labor and Commerce Committee considered SENATE BILL NO. 37

PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

"An Act relating to collective negotiation by physicians with health benefit plans; and to health benefit plan contracts with individual competing physicians."

and recommends:

Senate Bill:
[ ] same title
[X] new title
House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #____

[X] be **replaced** with ____ **CS** SB37 (L&C)

[ ] adopt **previous** ____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
DOLaw	1/22/01	$		1
DCED	1/19/01	$		2
DOA	1/19/01	*		3
DH&SS	1/23/01		0	4

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
Ben Ellis	✓			
Bettye Davis			✓	
Con A. Keithan	✓			
Torgerson			✓	
CHAIR: Ted L. Ellis			✓	

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/22/01

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: 1/22/01
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: 2-22-01

Judiciary Committee considered SENATE BILL NO. 37

~~"An Act~~ relating to collective negotiation by physicians with health benefit plans; ~~and to health benefit plan contracts with individual competing physicians."~~

and recommends:

[✓] be **replaced** with ____ **CS** SB 37 (JUD)

[ ] adopt **previous** ____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[ ] same title
[✓] new title
House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
DOLaw	1/22/01	$		1
DCED	1/19/01	$		2
ADM	1/22/01	*		3
DH&SS	1/23/01		Ø	4

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
John Cowdery			✓	
[illegible]		✓		
[illegible]		✓		
Dave Herriault			✓	
CHAIR: John Taylor			✓	

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

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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 de ned 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 bar 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* 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).

STATE OF ALASKA

DEPARTMENT OF LAW

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February 5, 2001

Senator Robin Taylor
Chair, Senate Judiciary Committee
Mailstop: 3100, Room 30
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Juneau, AK 99801-1182

Re: SB 37 – Physician Negotiations with Health Benefit Plans

Senator Taylor:

This letter responds to questions raised during the Senate Judiciary Committee hearing held January 22, 2001, at 1:30 p.m. regarding SB 37, "An Act relating to collective negotiation by physicians with health benefit plans . . . ." During the hearing, two specific questions were asked of the Department of Law: (1) How have other states dealt with antitrust issues for this type of legislation? and (2) Are health benefit plans exempt from antitrust laws, and if so, doesn't SB 37 essentially "level the playing field" between physicians and health care plans? We will address each of these questions separately.

1. *How have other states dealt with antitrust issues for this type of legislation?*

On December 15, 1995, the Washington State Attorney General's Office, with the assistance of economic, management, and policy experts, made a report to the Washington State Legislature (the "Washington Report") on the role of antitrust immunity in Washington's health care market. The purpose of the report was to "examine the issue of whether antitrust immunity should be granted to allow certain activities by health care providers and purchasers which might otherwise violate state or federal antitrust laws."[1] According to the report, eighteen states had statutes (at that time)

[1] The report is 89 pages in length, with an additional 100 pages of appendices. The executive summary and selected portions of the report are attached.

that provided for some degree of antitrust immunity for health care providers. These statutes represent a broad range of approaches to providing antitrust immunity in various circumstances. Some statutes, for example, restrict joint activity to rural areas while others apply only to hospitals. None of the statutes reviewed in the Washington Report provide for the kind of collective negotiation among physicians contemplated by SB 37. A summary of the laws in these eighteen states as of 1995 is included with the attached materials.

We have reviewed the state statutes identified in the Washington Report, as well as other state statutes to identify other states that have adopted laws that allow collective negotiation among physicians in a manner similar to SB 37. We could identify only two states with similar legislation – Washington and Texas. One other state, New Jersey, and the District of Columbia have comparable bills pending.

A. Washington State Law.

In 1997, partially as a response to health care reform and the creation of HMO's, Washington enacted legislation that significantly changed its health care laws. Revised Code of Washington ("RCW") 43.72.300 - .310 was amended to recognize that competition among health care providers, facilities, payers, and purchasers could have beneficial consumer impacts, and provides antitrust immunity to certain health care entities who engage in activities authorized under the statute. The statute does not, however, allow any activity that would result in a *per se* violation of state or federal antitrust laws. This essentially forbids agreements among competitors that relate to price or discount terms and forbids strikes and boycotts.

Before collective negotiations can occur in Washington, a health care entity must make a request to the Department of Health to obtain an informal opinion from the Attorney General as to whether the proposed conduct is authorized. The request must contain a comprehensive description of the proposed activity, how it will meet the goals of health care reform, and the nature of the continued supervision and oversight necessary to ensure that benefits from the proposal outweigh the disadvantages. *See* Title 245 Washington Administrative Code ("WAC"), Ch. 245-01 and 245-02.

After it receives an opinion from the Attorney General, the Department of Health may authorize the proposed conduct. If the Attorney General determines the conduct is not authorized, the health care entity can petition the Department of Health for review and approval of such conduct in accordance with a specific set of rules and procedures under Washington's Administrative Procedures Act (RCW 34.05 et seq.) that allow for an adjudicative proceeding. If the Attorney General determines the conduct is

authorized, the opinion must include: (1) a description of the continued oversight the AG believes is necessary to ensure the proposal continues to be authorized, (2) the form of annual (or more frequent) progress reports that will allow continuing evaluation, and (3) the types of data the Attorney General believes are necessary to evaluate continuing conduct.

In summary, Washington's statute and related regulations are strictly construed so that *per se* violations of state and federal antitrust law are not allowed (i.e., negotiations over fees cannot occur) and proposed negotiations among competitors for other (non-fee) terms require approval from the Department of Health and the Attorney General. A petitioner can challenge a rejected request through an adjudicatory process established through the Department of Health.

B. Texas Law.

Chapter 29 of the Texas Insurance Code was added in 1999. This legislation, like SB 37, is patterned after the American Medical Association ("AMA") "model" draft and provides antitrust immunity for joint negotiations by physicians with health care plans. This law is the first of its kind in the country. The "findings and purpose" provision of the statute recognizes that in some cases health plans dominate the market to such a degree that fair negotiations between physicians and health plans are unobtainable absent joint action on behalf of physicians. The Texas legislature found it necessary to authorize joint negotiations where such imbalances exist.

The salient features of the law are as follows:

1. The law applies only to health plans that provide benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, and not for several other types of plans.

2. Competing physicians within the service area of a health plan can meet and discuss several non-fee terms.

3. Competing physicians cannot meet and discuss price terms unless the health plan has substantial market power and the price terms to be negotiated have already affected or threaten to adversely affect the quality and availability of patient care. The Attorney General determines what constitutes substantial market power.

4. Competing physicians can communicate with each other, but not with a health plan except through an authorized representative.

5. Before a representative can negotiate with a health plan, it must provide a report to the Attorney General identifying several items of information. After negotiations, the representative must provide the Attorney General with a copy of the proposed agreement or notify the Attorney General that negotiations have failed.

6. The Attorney General must either approve or disapprove an initial filing or proposed contract within 30 days. If the initial filing or contract is disapproved, the Attorney General must provide a written explanation of any deficiencies and a statement of specified remedial measures that would allow such deficiencies can be corrected.

7. The Attorney General can approve an initial filing or proposed contract only if the ATTORNEY GENERAL determines the benefits of the proposal outweigh the disadvantages from a reduction in competition.

8. Joint negotiations are limited to no more than 10 percent of the physicians in a health plan's geographic service area (with limited exceptions).

9. Physicians are prohibited from any cessation, reduction, or limitation of health care services.

10. Physicians may not negotiate with a plan to exclude, limit, or otherwise restrict non-physician health care providers from participation in a health benefit plan based substantially on the fact that the health care provider is not a licensed physician.

The Texas Attorney General drafted regulations to implement this law that were adopted in May 2000. The regulations are comprehensive and require an application for both fee and non-fee-related negotiations to include over 40 categories of information. The Attorney General is then required to conduct an independent investigation to determine whether the proposed negotiations are appropriate and provide approval or disapproval within 30 days. The Texas regulations are attached.

Since the adoption of the above regulations in May 2000, there have been no applications submitted for joint negotiations. Even though the application fee is set at $4,000, the legislature intended application fees to cover the Attorney General's cost of administering the statute, which is estimated to be $500,000 annually. In addition, there is some speculation that the Texas law will be challenged soon.

2. Summary of Washington and Texas laws compared with SB 37.

Washington's approach to this law was to apply antitrust immunity only to joint negotiations that are not *per se* illegal under state and federal antitrust laws. This removes any fee-related negotiations from the protections of the statute. Even then, Washington has established a fairly comprehensive review procedure that requires active state involvement, including continuing review and investigation of contracts, to determine whether such contracts remain beneficial.

Texas allows fee-related joint negotiations, subject to review and approval by the Attorney General, only when an imbalance in market power is demonstrated. No more than 10 percent of the physicians within the geographic service area of a health plan can be represented in the negotiation. Texas regulations require submission of comprehensive information by an applicant who intends to engage in joint negotiations.

SB 37, unlike Washington's statute, allows fee-related negotiations. Unlike the Texas law, SB 37 allows at *least* 30 percent of the physicians within the geographic service area of a health plan to collectively negotiate whenever a health plan has at least 15 percent of the market share as measured by covered lives, or within a particular service area when all its segments are added together. SB 37 places the burden on the health plan to rebut this statutory presumption, while the Texas law requires physicians to demonstrate that joint activity is necessary.

Finally, SB 37 does not provide for the type of active state supervision and involvement that would satisfy the federal state action immunity doctrine. The level of state oversight and involvement evidenced in Washington's law may be sufficient, but has not been tested. It is doubtful whether the Texas statute and regulations will satisfy the state action requirements.

3. Are health plans exempt from antitrust laws?

The issue of health care insurers' "exemption" from antitrust law is a result of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. There is a widely held misconception that this Act exempts the insurance industry from all forms of antitrust liability. The Act

provides that the Sherman, Clayton, and FTC Acts (the primary sources of federal antitrust law) are only applicable to the "business of insurance" to the extent that such business is not regulated by state law.

The U.S. Supreme Court has articulated various elements that must be met before the exemption will apply. First is the express statutory requirement that the conduct be regulated by the state. Second, the conduct must qualify as the "business of insurance," which has three key subparts: the conduct (1) must be concerned with "spreading and underwriting policyholder risk," (2) must be an integral part of the policy relationship between an insured and its insurer, and (3) must concern entities within the insurance industry itself. Finally, even if the conduct is regulated and constitutes the "business of insurance," it is nonetheless subject to Sherman Act liability it consist of a boycott, coercion, or intimidation. *Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *Union Labor Life Ins. Co. v Pireno*, 458 U.S. 119 (1982); *Hartford Fire Ins. Co. v. California*, 504 U.S. 764 (1993).[2]

From the above, it is impossible to speak of "health plans" in the same sense as we refer to insurance companies, and the two should be distinguished. The term "health benefit plan" as used in SB 37 is defined (by reference to AS 21.54.500) to mean an "employee welfare benefit plan as defined in 29 U.S.C. §1002(1) (ERISA), and includes a "plan, fund, or program" that provides medical care to employees directly or though "insurance, reimbursement, or other method." Accordingly, both insured and self-insured "health plans" are included within this definition. Only those plans that meet the McCarran-Ferguson Act requirements, including the requirement that the plan's conduct is the "business of insurance" will be exempt from antitrust scrutiny. We could find no case law that discussed whether employer health plans (much less self-insured plans) meet the requirements for exemption under the Act.

Examples of conduct that is not exempt from antitrust review can be found in *Pireno, supra* (peer review committee established to review reasonableness of chiropractic treatments not exempt) and *Hartford, supra* (conduct by defendants that forced primary insurance carriers to adopt policy terms favoring commercial liability coverage was a "boycott" not subject to protection). In a 1983 Ninth Circuit case, the court held a regional health care provider that offered prescription drugs to its members at a discount was exempt from antitrust review under the McCarran-Ferguson exemption because the sales (1) were pursuant to health care policies regulated by the state; (2) were

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[2] AS 21.36.080 also forbids a person from entering into an agreement to commit an act of boycott, coercion, or intimidation resulting, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.

part of the broader "spreading of risks" for health care; (3) concerned the relationship between the insurer and insured; and (4) were confined to transactions between the insured and insurer. *Klamath-lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 710 F.2d 1276 (9th Cir. 1983).

Similarly, the McCarran-Ferguson Act was held to shield a Blue Cross organization with respect to assorted practices that had been reviewed and approved by state regulators. *Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island*, 883 F.2d 1101 (1st Cir. 1989). In that case, the plaintiff was a health financing HMO that entered a market where Blue Cross had significant business. Blue Cross responded by countering with a competing HMO tailored to match the plaintiff's service at a reduced price for employers who agreed to use the Blue Cross/HMO combination. The First Circuit held this conduct was exempt from antitrust challenge because Blue Cross met the "business of insurance" test.

Recently, the antitrust division of the Department of Justice challenged contractual provisions imposed on dentists in Rhode Island (*United States v. Delta Dental of Rhode Island*, 943 F. Supp. 172 (D. Rhode Island 1996)) and certain hospitals in the Cleveland, Ohio area (*United States v. Medical Mutual of Ohio, Inc.*, No. 1:98-CV-2172, (N.D. Ohio 2000)).

Except for the limited circumstances outlined in the McCarran-Ferguson Act as narrowly interpreted by the U.S. Supreme Court, the same state and federal antitrust laws that apply to other industries apply to health care insurers. Depending on the specific circumstances of each particular "health care plan," the exemption may or my not apply.

4. Conclusion.

The Department of Law continues to have serious antitrust concerns with SB 37. To comply with the requirements of the state action immunity doctrine, the bill must include provisions that allow for significant and active state oversight. Other states have no history with legislation of this kind. W hington's law does not allow joint negotiations by physicians on price terms, and it ludes provisions for active state

oversight for non-price negotiations. Texas' law requires the state Attorney General to review and approve initial applications and proposed contracts, but its new regulatory structure is untested against the state action doctrine and may not provide the level of active state involvement required for antitrust immunity.

Sincerely,

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CES/sjm
Enclosures

cc: Senate Judiciary Committee Members
Senator Pete Kelly
Mike Abbot, Governor's Legislative Director
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THE ROLE OF ANTITRUST IMMUNITY IN THE WASHINGTON STATE HEALTH CARE MARKET

REPORT TO THE WASHINGTON STATE LEGISLATURE
DECEMBER 15, 1995

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IX. THE NEED FOR AN IMMUNITY STATUTE AND THE STATUS OF IMMUNITY IN OTHER STATES

A. Progress in the Health Care Industry in States With and Without Antitrust Immunity

The Attorney General was also directed to "include a summary of how other states have allowed for greater coordination and consolidation of health care services without such additional immunities."[138]

Pleas for immunity have been premised in part on the argument that antitrust enforcement is impeding the development of health care. As noted above, antitrust proponents argue the opposite: that without the protection of antitrust laws, innovation in this area would have been stifled, preventing the development of the managed care networks we see today.

It is difficult to find baseline statistics to measure the progress of developments in the health care area. States do not routinely keep statistics on what developments have taken place even if they have an immunity statute. Thus, we have no way of measuring progress. Although we generally assumed that the health care industry did not stagnate in the thirty-two states without immunity, we had little comparative data upon which to draw conclusions.

We were unable to find support for the proposition that the antitrust laws have "chilled" progress.[139] As commentator David Burda has noted, "in fact, the overwhelming amount of evidence indicates that hospitals, with a few notable exceptions, have done just about anything they've wanted."[140] Based on American Hospital Association data, Burda notes that nearly 300 hospitals engaged in collaborative ventures, and notes that nearly 200 hospital mergers occurred between 1980 and 1991.[141] Although 44% of CEOs surveyed claimed that antitrust enforcement had slowed their plans, 72% said they were still planning to share services with another hospital and 52% disagreed that antitrust enforcement had a chilling effect.[142] In contrast, only 27 of 229 hospital mergers were investigated by the DOJ and FTC during the

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[138]1995 Wash. Laws Ch. 267, § 9.

[139]We attempted to elicit information concerning hospital mergers from the American Hospital Association, but none was received prior to the publication of this report.

[140]David Burda, Mergers Thrive Despite Wailing About Adversity, Modern Healthcare, October 12, 1992, at 26.

[141]Id. at 26-27. From 1981 to 1991, the FTC and the DOJ reviewed 307 Hart-Scott-Rodino filings for acute care hospital mergers. The agencies did not report how many filings actually resulted in mergers. General Accounting Office, Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry, 8-9 (1994).

[142]David Burda, Mergers Thrive Despite Wailing About Adversity, Modern Healthcare, October 12, 1992, at 26.

1987-91 time period, leading to only 3 actions.[143] Similar statistics for both state and federal enforcement are discussed below.

We also attempted to elicit examples from the Washington State Medical Association, Washington State Hospital Association, and the Office of Rural Health, demonstrating procompetitive transactions which would be prohibited by the antitrust laws. We did not receive any examples, although all of these groups expressed fear of antitrust enforcement as a primary concern.

B. The Status of Immunity in Other States

If the Legislature chooses to maintain a procedure for state action immunity, a wide range of options exists. Our survey revealed that immunity provisions ranged from the extremely limited, such as joint activity for purposes of organ transplantation procedures, to the extremely broad, such as the scheme present here in Washington. Table IX.B. illustrates the variety of immunity statutes.

Eighteen states have statutes providing some degree of antitrust immunity for health care providers.[144] The general legislative purpose of these statutes is to provide the citizens of the states with better health care, generally measured as an improvement in the quality, access, or cost efficiency of health care. The legislatures believe that offering some type of antitrust immunity to health care providers will allow those providers to supply better health care.

Although the eighteen different legislatures passed the antitrust immunity statues with the same general purpose, the statutes represent the approaches of eighteen different legislatures to a complex problem. As a result, the statutes exhibit a great deal of variety. There are several issues that arise commonly among the statutes, but not all of the issues are necessarily addressed in each statute. These general issues are:

1) The identity of the providers offered immunity;
2) the type of activity granted immunity by the statute;
3) the identity of the state agency that grants immunity.

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[143] Id. at 30, citing Charles James, Assistant Attorney General of the DOJ; General Accounting Office, Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry, 8-9 (1994). We realize the AHA numbers and the FTC/DOJ numbers do not correspond precisely. This is part of the problem we encountered in searching for base data on mergers.

[144] The nineteenth state, Florida, repealed its immunity statute as part of the repeal of its health care reform act. Two states, Massachusetts and Michigan, currently have pending antitrust immunity statutes for health care providers. Proposed antitrust immunity statutes failed in Maryland, Missouri, and New Jersey.

There are several excellent articles addressing the antitrust immunity statutes. See James Blumstein, Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation, 79 Cornell L. Rev. 1459 (1994); General Accounting Office, Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry: GAO/HEHS-94-220 (1994); Robert Langer, The Relationship Between the State Action Immunity Doctrine and State Provider Collaboration Statutes, address presented to the National Health Lawyers Association, Washington D.C. (Feb. 16 1995); Sarah Vance, Immunity for State-Sanctioned Provider Collaboration after Ticor, 62 Antitrust L.J. 409 (1994).

4) the role of the state attorney general;
5) the criteria the state agency uses to decide whether to grant immunity;
6) the standard of proof the agency applies to the criteria; and
7) the statement of clear articulation and ongoing supervision required to satisfy the state action immunity doctrine.

The first issue is the identity of the providers to whom antitrust immunity is granted. At a minimum, all eighteen of the statutes provide immunity for some hospital transactions. Oregon is the most restrictive, allowing only certain hospitals to operate a joint venture for performing heart and kidney transplantations.

Ten statutes also include joint activity by other types of health care providers. Generally, these statutes include providers such as physicians, nursing homes, home health care agencies, and ambulatory surgical centers.[145] South Carolina even includes health care purchasers. Washington's statute is very broad, and covers activity proposed by certified health plans, health care facilities, health care providers, or any other person.[146] Two states, Kansas and New York, allow immunity only for providers in rural areas.

The second issue is the type of activity immunized by the statute. Twelve of the statutes provide immunity for joint ventures only. Two provide immunity for joint ventures and mergers. Georgia's statute addresses only mergers. Three states, including Washington, permit other activities such as cooperative agreements. Washington's statute specifically provides potential immunity for "conduct that could tend to lessen competition in the relevant market."[147]

The third issue is the identity of the state agency that grants the immunity. Under all 18 statutes, the hospitals or providers must apply to the proper agency for approval. In many of the states, the approving agency is the Department of Health or an agency with a similar title. However, some go to the public health agency, and some states such as Washington and Colorado have health boards which authorize the activity.[148] Under the Idaho statute, the attorney general authorizes the activity.

The fourth issue is the role of the attorney general. Approximately half of the statutes require that the granting agency consult with the attorney general. The power of the Attorney General to act varies by state. At one extreme, the Idaho Attorney General authorizes the activity and the North Carolina Attorney General can veto the proposed action. At the other extreme, five state statutes provide no specific role for the attorney general. Most statutes limit the attorney general to giving an opinion, as does Washington's.[149]

The fifth issue is the criteria the state agency uses to decide whether to grant immunity.

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[145] See table IX.B.

[146] RCW 43.72.310(2)(a) (1994).

[147] RCW 43.72.310(3) (1994), amended by 1995 Wash. Laws Ch. 267, § 8(3).

[148] RCW 43.72.310 (1994) and 1995 Wash. Laws Ch. 267 refer to the Health Care Commission. However, the Commission has been replaced by the Health Care Policy Board.

[149] RCW 43.72.310(1), amended by 1995 Wash. Laws Ch. 267, § 8(1)

Generally, the granting agency is directed to balance the benefits of the proposed activity against the disadvantages. The statutes for the most part base the definition of benefits on the public health triad of quality, access, and efficiency. The cooperative action must improve the quality of health care, create greater access to health care, or result in greater efficiency in health care and thus lower costs to the citizens. Many statutes list additional benefits, such as the preservation of hospital services in geographic proximity to communities and the avoidance of the duplication of services.

Once the agency determines that these benefits will occur, the benefits must be weighed against the disadvantages of allowing the cooperative activity. Examples of disadvantages are reductions in competition, adverse effects on quality or access, adverse impacts on the ability of health care payers to negotiate competitive contracts with hospitals and providers, and the possibility of arrangements less restrictive of competition.

At one extreme, Georgia's statute does not address any benefits or disadvantages. Conversely, Washington's statute lists as benefits quality, the avoidance of duplication of resources, utilization, and cost efficiency.[150] As to the latter two, it also lists the facilitating of information exchange on performance, the simplification of negotiations, and the reduction of transaction costs.[151] These benefits are to be weighed against the disadvantages of reduced competition, adverse impact on quality, availability, or price of health care services, and the availability of less restrictive arrangements.[152]

The sixth issue is the standard of proof the agency applies to the criteria. At least six states demand that the applicants show by "clear and convincing" evidence that the benefits will outweigh the disadvantages. Many other states ask only that the benefits be "likely" to outweigh the disadvantages. Finally, several states have no provision for the standard of proof. Washington's statute requires a "strong showing" that the conduct is likely to achieve the benefits.[153]

The seventh issue is the statement of clear articulation and degree of active supervision, which must be mandated to meet the requirements of the state action immunity doctrine. Most of the statutes do clearly articulate the state's intent to displace competition.[154] Washington's statute declares an intention to displace competition and to immunize activity approved pursuant to the statute.[155]

It is unlikely, however, that all of the states require sufficient active supervision to meet

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[150]RCW 43.72.310(4) (1994).

[151]Id.

[152]Id.

[153]RCW 43.72.310(2)(a) (1994).

[154]See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (180), supra: pp. 12-13.

[155]RCW 42.73.300 (1994).

the standards of Ticor.[156] Some states make no mention of supervision. Many other statutes provide only that the agency or attorney general may require reports. Washington and a few other states specifically require active supervision.[157] The lack of adequate state supervision could be one of the reasons why health care providers have not used the immunity statutes in most states where they are available.[158]

Our survey demonstrates that a wide variety of options is available for implementing an immunity process if one is deemed necessary. Our present statute could be maintained in its broad form, or it could be narrowed in some fashion. However, care should be taken, as with the present statute, to both clearly articulate an intention to displace competition and provide for meaningful, active supervision of any approved conduct.

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[156] See Federal Trade Commission v. Ticor Title Insurance Co., 112 S. Ct. 2169 (1992), supra, page 13-14.

[157] RCW 43.73.310(6) (1994).

[158] For a strong presentation of this argument, see Robert M. Langer, The Relationship Between the State Immunity Doctrine and State Provider Collaboration Statutes, Address to the National Health Lawyers Association, Washington D.C. (February 16, 1995).

TABLE IX.B.
ANTITRUST IMMUNITY STATUTES

STATE*	ACTIVITIES COVERED	PROVIDERS COVERED	STATUTE(S)	ACTIVITY IF ANY
Colorado	Joint ventures	Hospitals	The Hospital Efficiency and Cooperation Act (1993 Colorado Sess. Laws p. 1888); Colorado Rev. Stat §§ 25.5-1-501 to -516 (1995); (original version at Colorado Rev. Stat. §§ 24-32-2701 to -2715 (1993)).	None
Florida **REPEALED**	Joint ventures	Certified rural hospitals and other certified rural health care providers	Health Reform Act of 1993 (1993 Florida Laws ch. 93-129); Fla. Stat. Ann. § 395.304 (**REPEALED BY** Fl Legis 95-146, s 18 (1995)).	None
Georgia	Mergers	Specified county hospital authorities	The Hospital Authorities Law (1993 Georgia Laws p. 1020); Ga. Code Ann. § 31-7-72.1 (1994).	None
Idaho	Joint ventures	Hospitals, physicians and other health care providers	Session Law Chapter 283 Regarding Idaho Health Care Planning Act (1994 Idaho Sess. Laws ch. 283); Idaho Code §§ 39-4901 to -4903 (1994).	No activity. No funding for implementation authorized.
Kansas	Mergers and joint ventures in rural health networks	Hospital, physicians and other health care providers in rural areas	Health Care Provider Cooperation Act (1994 Kansas Sess. Laws 153); Kan. Stat. Ann. §§ 65-468 to -472 (1993).	None

Maine	Joint ventures	Hospitals	Hospital Cooperation Act of 1992 (1991 Main Laws c. 814, sec. 1); Maine Rev. Stat. Ann. ch. 405-D (West 1993); Me. Rev. Stat. Ann. title 22 §§ 1881-1887 (1994).	One application approved - Joint venture on MRI unit
Minnesota	Mergers and joint ventures	Hospitals, health care providers, and health care purchasers	The Minnesota Integrated Service Network Act (1993 Minnesota Laws ch. 345, art. 6, sec. 14); Minnesota Stat. Ann. §§ 62J.2912 to .2921 (1994).	One application approved - Merger of two hospital systems
Montana	Joint ventures, mergers, and consolidations	Hospitals and physicians	An Act Providing for Universal Health Care Access (1993 Mont. Laws ch 606); Mont. Code Ann. §§ 50-4-601 to -612 (1994); (amended by 1995 Mont. Laws ch 378).	None
Nebraska	Joint ventures	Hospitals and health care providers	The Health Care Facility-Provider Cooperation Act (1994 Nebraska Laws 1223); Neb. Rev. Stat. §§ 71-7701 to -7711 (1994).	None
New York	Joint ventures and integrative arrangements	Hospitals, physicians and other health care providers serving rural areas	Cooperative Programs and Networks in Rural Areas Act (1993 New York Laws ch. 731); N.Y. Pub. Health Law 45 §§ 2950-2958 (McKinney 1993, 1995 Interim Update).	None
North Carolina	Joint ventures	Hospitals (and other persons in a joint venture with a hospital)	Hospital Cooperation Act of 1993 (1993 North Carolina Sess. Laws ch. 529); N.C. Gen. Stat. §§ 131E-192.1 to -192.13 (1994).	None

North Dakota	Joint ventures and mergers	Hospitals, health care providers, and third-party payers	Health Care Provider Cooperative Agreements (1993 North Dakota Laws ch. 263); N.D. Cent. Code § 23-17.5-01 to 17.5-11 (1993); (Amended by 1995 N.D. Laws H.B. 1050).	None
Ohio	Joint ventures	Hospitals	Voluntary Cooperative Actions to Improve Health Care (1992 Ohio Laws 209); Ohio Revised Code Ann. sec. 3727.21 to .24 (Baldwin 1995).	None
Oregon	Joint ventures	Hospitals (for heart and kidney transplantations and related services only)	Cooperative Program on Heart and Kidney Transplants (1993 Oregon Laws ch. 769); Or. Rev. Stats. §§ 442.700 to .760 (1994).	None
South Carolina	Joint ventures and mergers	Hospitals, health care providers, and purchasers	South Carolina Health Care Cooperation Act, §§ 44-7-500 to -590 of the Code of Laws of South Carolina (1994).	None
Tennessee	Joint ventures	Hospitals	Hospital Cooperation Act of 1993 (1993 Tennessee Public Acts ch. 331); Tenn. Code Ann §§ 68-11-1301 to -1309 (1994).	None

Texas	Joint ventures	Hospitals	An Act Relating to Cooperative Agreements Among Hospitals (1993 Texas Sess. Law Serv. ch. 638 (Vernon)); Tex. Health & Safety Code Ann. §§ 313.001 to .008 (1993); Recodified as Tex. Health & Safety Code Ann. §§ 314.001 to 008. by Tx. Legis. Ch. 76, § 17.01(25) (1995).	None
Washington	(1) Cooperative agreements	Rural hospital districts	Act Relating to Cooperative Activities of Local Governments (1992 Washington Laws ch. 161); Wash. Rev. Code §§ 39.34.030 to .060 and Wash. Rev. Code §§ 70.44.450 to .460 (1994).	None
	(2) Cooperative agreements, including joint ventures, acquistions, and mergers	Health plans, health care facilities including hospitals, and health care providers	Washington Health Services Act of 1993 (1993 Washington Laws ch. 492); Wash. Rev. Code § 43.72.310 (1994); (Temporarily suspended by 1995 Washington Laws ch. 267, § 9).	Eleven petitions: 2 approved, 3 pending, 6 withdrawn.

Wisconsin	Joint ventures	Hospitals, physicians, and other health providers	1991 Wisconsin Act 250 Regarding Health Care Cooperative Agreements, September 1992 (1991 Wisconsin Laws Act 250) Wis. Stat. § 150.84 to .92 (1995)	None

* Connecticut and Maryland both have had legislation involving comprehensive hospital review mechanisms for a substantial period of time. Thus, neither state is included in either the chart or the text. The Iowa Health Insurance Purchasing Cooperative Project. 1993 Iowa Acts. Ch. 158; Iowa Code § 96.3.10 has also been excluded.

This is an updated version of the chart presented by Robert M. Langer in The Relationship Between the State Immunity Doctrine and State Provider Collaboration Statutes, Address to the National Health Lawyers Association, Washington D.C. (Feb. 16, 1995).

C. State Enforcement Activity in the Health Care Industry and the Impact of an Antitrust Immunity Statute

We next attempted to discover if the presence of antitrust immunity affected the number of antitrust cases filed by state enforcement agencies. Our approach here was to first gather information concerning the types of enforcement activities that have occurred in both immunity and non-immunity states. We then compared the activity in the non-immunity states with the immunity states to see if there was a significant difference in the level of activity. Finally, we compared the enforcement activity in the immunity versus non-immunity states to see if there was a quantitative or qualitative difference in the enforcement actions taken.[159]

We concluded that the absence or presence of an immunity statute had little effect on the number or types of enforcement actions. The rate of enforcement actions challenging transactions appeared to be no greater in the non-immunity states than in the immunity states. State attorneys general filed only twelve formal state antitrust enforcement actions in the health care field from January 1994 to September 1995. Eight of those were filed in states without an immunity statute in place, and four were filed in states with immunity statutes, but outside of the immunity process. Roughly half as many states have immunity as do not.[160] Therefore, the rate of antitrust filings did not appear to be lower for immunity states.[161]

It is important to remember two things when examining the number of actions taken by state antitrust enforcement officials. First, the number of actions taken as a percentage of total activity that took place in the industry remains quite small. Thus, of the hundreds of transactions that took place during the last two years, only a handful met with scrutiny and of those only a few were challenged. Although we have taken the time below to explain the circumstances of the challenges, far more transactions took place which were unrestrained and likely did not violate state or federal antitrust laws. For example, according to our survey, since January 1994, attorneys general nationwide have closed at least thirty-four investigations without further action. Seventeen of those involved hospital mergers and an additional six involved health systems mergers. Six involved alleged boycotts.[162]

Second, private parties can challenge transactions and are not required to report such challenges to their state antitrust authorities. This prohibits us from being able to report on the number of private actions because many are settled or dismissed without our knowledge.

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[159]The Washington Attorney General based this part of the study in part on a recent survey by the National Association of Attorneys General Health Care Antitrust Task Force. Twenty-three states provided written responses to the survey. The additional state attorneys general, except for Wyoming's, who did not respond to calls, were contacted directly by the Office of the Attorney General.

[160]Eighteen states have immunity statutes; thirty-two do not.

[161]Two of those enforcement actions were brought by the Florida Attorney General. The Florida legislature repealed the Florida immunity statute in 1995. We kept the actions on the immunity statute table because the actions were instigated and mostly resolved before the legislature repealed the statute.

[162]Similarly, we have been apprised of approximately seventeen health care industry investigations currently ongoing, approximately half of which involve hospital mergers.

Although a few have come to our attention, we have not included them in our survey, nor do we have a way of determining if their numbers were affected by the presence of an immunity statute.

1. Enforcement Activity in States Without Immunity Statutes

There are thirty-two states without antitrust immunity statutes for health care providers.[163] Twenty-one of these thirty-two states reported no state enforcement activity in the health care field. Those states are Alabama, Alaska, Arkansas, California, Delaware, Hawaii, Illinois, Indiana, Iowa, Louisiana, Michigan, Mississippi, Nevada, New Jersey, New Mexico, Oklahoma, Rhode Island, South Dakota, Utah, Vermont, and West Virginia.

Seven attorneys general reported eight consent decrees.[164] Two involved hospital mergers (Kentucky/DOJ and New Hampshire/DOJ), two involved health system mergers (both in Pennsylvania), one involved a boycott (Arizona), one involved §§ 1 and 2 violations by a Physician-Hospital Organization (Connecticut and the DOJ), one involved price-fixing and a boycott by a doctor's group (Virginia), and one involved monopolization concerns raised by a physician group acquisition and the physicians' steering of patients to ancillary services owned by those physicians (Missouri).

In addition to the formal action taken, the attorneys general in non-immunity states also took the following informal actions. Four assurances of discontinuance were negotiated by the Massachusetts Attorney General; one involved monopolization concerns arising from a boycott by an insurer and a hospital against another hospital, one involved a hospital merger, one involving a Health Maintenance Organization merger, and one involved exclusivity concerns arising from a "right of first opportunity" clause in a Physician-Hospital Organization contract.

There was also one voluntary compliance on a Physician-Hospital Organization "right of first opportunity" contract clause (Massachusetts), and two out-of-court agreements, one addressing exclusive dealings concerns by physicians (New Hampshire), and one focusing on concerns regarding acquisitions by a health system (Missouri).

The Maryland Attorney General informally issued a business review approval of a home health care joint venture.

Of the sixteen formal and informal actions addressed, all were resolved through negotiation of some form of settlement agreement which permitted the activity to go forward, but with certain constraints. Notably, none of the transactions was subjected to a full trial on the merits.

As the survey indicates, a great number of transactions are taking place throughout the country. Those drawing the attention of enforcement agencies include provider mergers, boycotts and market power issues. Yet even those which have been the subject of action have been allowed to occur under limited conditions. Based on the survey results and apparent outcomes, it is difficult to state that health care industry activity has been stifled by enforcement in states without immunity. In such states, in those rare instances in which they have been problematic,

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[163]Wyoming does not have a statute, but did not respond to our investigation. Florida is now one of the thirty-two, but is included with the immunity states because it brought antitrust actions before it repealed its statute.

[164]See Table IX.C.1., infra.

the problems have been successfully addressed by negotiated settlements between the parties and the antitrust enforcement agencies.

Additionally, virtually every state attorney general has expressed a willingness to informally meet with parties to discuss health care proposals and potential antitrust ramifications, either through a business review procedure or in the normal course of business. We did not report such discussions unless they resulted in some form of action because they were too numerous to track. However, for both states with and without immunity, these informal mechanisms are frequently used.

TABLE IX.C.1
STATE ACTIVITY IN STATES WITHOUT ANTITRUST IMMUNITY STATUTES FOR HEALTH CARE PROVIDERS

	Consent Decrees	Assurance of Discontinuance	Settlement Agreement	Voluntary Compliance	Informal Business Review
Hospital Mergers	2 (Kentucky, New Hampshire)	1 (Massachusetts)			
HMO Mergers		1 (Massachusetts)			
Health System Mergers	2 (Pennsylvania)				
Health System Acquisition of Hospital					
Hospital Chain Merger					
Boycott	1 (Arizona)	1 (Massachusetts)			
Joint Venture by Home Health Providers					1 (Maryland)
§ 2 Exclusive Dealing			1 (New Hampshire)		

	Consent Decrees	Assurance of Discontinuance	Settlement Agreement	Voluntary Compliance	Informal Business Review
§ 2 Acquisitions			1 (Missouri)		
§ 1 Restraint of Trade	1 (Virginia)				
"Right of First Opportunity"		1 (Massachusetts)			
§ 2 Steering Patients to Ancillary Services	1 (Missouri)				
PHO Restraints of Trade	1 (Massachusetts)			1 (Massachusetts)	
Physician Group Merger					

2. Health Care Enforcement in States with Immunity Statutes

a. Health Care Activity Approved Pursuant to an Immunity Process

Three states with antitrust immunity statutes, Maine, Minnesota, and Washington, have approved activity under those statutes. Maine and Minnesota have each granted one approval, both of them in 1993. Maine approved a joint venture for the purchase of an MRI and Minnesota approved the merger of two hospitals. Washington is by far the most active state. The Washington Health Policy Board has received petition for five transactions and has approved two as of this date, with the last three currently under advisement. As noted above, there were eleven petitions filed originally, but six were withdrawn with the transaction still proceeding. The activities approved include a joint venture by the two hospitals in Spokane to support a new Rehabilitation Center and a physician-hospital organization joint ventures. Left to be decided are a hospital/physician merger, a physician-hospital organization joint venture, and a request for collaborative activity by the Washington State Medical Association.

In the other 15 states that have antitrust immunity statutes, there have been no approvals under those statutes. These states are: Colorado, Georgia, Idaho, Kansas, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Tennessee, Texas, and Wisconsin. North Carolina is currently reviewing a hospital merger petition under its immunity statute. Florida repealed its antitrust immunity statute in 1995, and did not grant any approvals before its repeal.

In sum, only three of the eighteen states that have antitrust immunity statutes have granted approvals under those statutes. The reasons for this lack of activity are uncertain. Some commentators, such as Robert Langer, attribute it to the uncertainty of state action immunity protection after Ticor.[165] It could be argued that some of the statutes were passed without sufficiently clear articulation or active supervision to meet Ticor's requirements. Another argument is that the statutes are not necessary because most pro-competitive activity will be acceptable under the antitrust laws even without immunity and thus there is no need to go through the process.[166] For example, in the Maine transaction, the activity would probably have been permitted anyway under the DOJ/FTC Statements.

b. Antitrust Enforcement Activity Outside of an Immunity Process

Although the above states have immunity statutes, it is important to remember that such statutes do not preclude antitrust enforcement entirely, nor do they indicate the level of activity in the industry. We have no data on the transactions which took place without notification to any health care or antitrust authority. Thus, although we have a general impression that realignment in the industry took place at unprecedented high levels, we know only about those activities

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[165]Robert Langer, The Relationship Between the State Action Immunity Doctrine and State Provider Collaboration Statutes, Address to the National Health Lawyers Association, Washington D.C. (Feb. 6 1995).

[166]See, Arthur N. Lerner "Antitrust and Physician Involvement in Managed Care: Is Reform Needed?", Report to the Physician Payment Review Commission, November 29, 1994.

which were filed under an immunity process or were challenged by the local enforcement authority outside of the immunity process.

In fourteen of the eighteen states with antitrust immunity statutes, the attorney general reported that they have had no antitrust activity outside of the statute in the health care field. Those states are Colorado, Georgia, Idaho, Kansas, Maine, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, and Wisconsin.

In four of the eighteen states with antitrust immunity statutes, the attorney general did take either formal or informal action outside of those statutes.[167] As to formal action, the Tennessee Attorney General negotiated one consent decree for a health system acquisition of a hospital. The Texas Attorney General negotiated one consent decree in a hospital merger case. Florida had a state action immunity statute, but repealed it in 1995. However, during the statute's existence, the Attorney General joined two consent decrees, one with the DOJ on a hospital merger, and one with the FTC on the merger of two hospital systems.

State attorneys general in the four states also took the following informal actions. The Florida Attorney General negotiated a settlement agreement on a hospital merger. The Minnesota Attorney General took action under its informal review procedure, informing the inquiring parties that it would not take action against the proposed merger.

In Washington, the Attorney General has taken no formal action outside of the immunity process since January 1994. However, it has investigated without further action the Group Health/Virginia Mason health plan merger, the Lewis-Clark Valley Community Health Organization (physician-hospital organization), the Northwest/Northpointe Orthopedic joint venture, the Spokane Physician Community Hospital Organization, and the Whatcom Integrated Delivery System, and is reviewing the Tri-Cities Cancer Center's proposal for a Regional Breast Cancer Diagnostic Treatment Center.

In summary, the immunity statute in four states did not deter all action by state and federal enforcement agencies. In Washington, at least six proposed transactions have been reviewed and allowed to proceed even though they did not go through the statutory immunity process. It is interesting to note that four of those six transactions originally had filed petitions for immunity, but those petitions were withdrawn before the process was completed. Nevertheless, the transactions still proceeded, ostensibly with the parties taking the calculated risk that their activity is legal and not in need of immunity. It is difficult to tell whether this situation exists in other states with immunity processes. However the low level of enforcement activity in general seems to indicate that most health care activity is receiving little if any scrutiny or question outside of an immunity process.

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[167] See, Table IX.C.2., infra.

TABLE IX.C.2
STATE ACTIVITY IN STATES WITH ANTITRUST IMMUNITY STATUTES
FOR HEALTH CARE PROVIDERS

	Consent Decrees	Assurance of Discontinuance	Settlement Agreement	Voluntary Compliance	Informal Business Review
Hospital Mergers	2 (Texas, Florida)		1 (Florida)		
HMO Mergers					
Health System Mergers					
Health System Acquisition of Hospital	1 (Tennessee)				
Hospital Chain Merger	1 (Florida)				
Boycott					
Joint Venture					
§ 2 Exclusive Dealing					
§ 2 Acquisitions					
§ 1 Restraint of Trade					

	Consent Decrees	Assurance of Discontinuance	Settlement Agreement	Voluntary Compliance	Informal Business Review
"Right of First Opportunity"					
§ 2 Steering Patients into Ancillary Services					
PHO Restraints of Trade					
Physician Group Merger					1 Minnesota

XI. CONCLUSION

The antitrust laws are premised on the assumption that consumers benefit when businesses compete on the basis of price, quality and service. It has been argued that the health care industry presents special circumstances in which the market has failed to work in the traditional manner.

Proponents of immunity cite the need for certainty, the need for a level playing field and the promotion of innovation as reasons for relief from the laws. Opponents of reform state that antitrust laws currently allow procompetitive activity, fear that a "leveling" of the playing field will result in higher prices and note that more guidance has been given about antitrust enforcement in this industry than in any other.

Our empirical study of hospital and physician markets in Washington showed that prices are lower in areas where competition exists. Additionally, purchasers are able to obtain more favorable contract terms with more choices available. Thus, the economics demonstrate that the medical market behaves in Washington just as it does in other industries. Although this may not have been true prior to the 1980s, the development of informed purchasers in the form of managed care plans has changed that result. Real and substantial results were obtained in the price study, with statistical levels of confidence.

Given the economic benefits of competition, substantial benefits of immunity should be found if it is to be granted. Additionally, an immunity process, essentially a regulatory proceeding, will be required to provide ongoing, active supervision if it is to meet legal requirements for state action immunity. These regulatory costs must be included in any assessment of the value of immunity.

Finally, our state and federal survey indicates three things. First, a wide variety of statutory options exists if immunity is to be granted, ranging from the general to the very specific. Second, the fear of antitrust prosecution is based on a perception not supported by the number of enforcement actions filed. Of the total numbers of transactions taking place in the health care industry, only a handful are addressed each year by enforcement agencies. Additionally, the presence of immunity statutes did not appear to have a noticeable affect on the number of enforcement actions taken by states.

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

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March 8, 2001

Senator Randy Phillips
Chair, Senate Labor and Commerce Committee

Re: CSSB 37

Dear Chairman Phillips:

This letter responds to your request made at the March 1, 2001, Labor and Commerce Committee hearing for suggested changes to CSSB 37 that would address the antitrust concerns raised by the Department of Law. The Department's concerns about the current bill were submitted to the Senate Judiciary Committee through two letters, dated January 19, 2001, and February 5, 2001. Those letters have been copied for you and this committee as well.

The thrust of the Department's concern is that this bill violates state and federal antitrust law. To avoid this potential conflict, the bill must satisfy the "state action" doctrine, which requires two things: (1) clear and specific legislative intent to provide antitrust immunity, and (2) active state supervision. "Active state supervision" means the state must "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."

CSSB 37 does not provide for this level of state supervision. The Department does not believe any revision(s) to the bill would change this conclusion. A complete re-write of the bill would be necessary before the state action immunity doctrine could be successfully raised as a defense to an attack under state and federal antitrust laws.

Based on our research and review of other states' approaches to this issue, the Department believes that Washington's statute comes closest to satisfying the elements of the state action immunity doctrine. Before the Washington law was enacted, a comprehensive study of Washington's health care market was undertaken to determine the scope of the issues that should be addressed. Given Alaska's unique geographical limitations and population, a similar study would provide important information about the scope of the issues to be addressed in any bill proposed for Alaska.

Washington's statute is attached; it contains language the Department would consider appropriate to address the antitrust elements of CSSB 37, with some limited modification as proposed below. The key elements of Washington's statute are:

1. The statute does not authorize activities that would constitute *per se* violations of state and federal antitrust laws. This includes price-related terms, and prohibits boycotts, coercion, intimidation, or any other coercive activity;

2. A health carrier can request that the Department of Health obtain an informal opinion from the Attorney General as to whether the conduct is authorized. The Attorney General can request additional information to make this decision. A health care entity can also petition the Department directly, without requesting Attorney General approval;

3. After receiving an opinion from the Attorney General, the Department of Health may authorize the conduct, and adopt rules governing the conduct, including rules on specific contract clauses;

4. If the Attorney Gene . determines the activity is not authorized, the health care entity can petition the Department of Health to approve the request anyway;

5. In authorizing conduct and adopting rules of conduct, the Department of Health, with advice from the Attorney General, must consider the benefits of such conduct in furthering the goals of health care reform. The benefits must outweigh the anti-competitive nature of the conduct, and any adverse impact on the quality, availability, or price of health care;

6. The Department of Health, with the assistance of the Attorney General, must actively supervise the conduct to determine whether it should continue, or whether other alternatives are available. This supervision includes submission of annual (or more frequent) progress reports and continued evaluations.

The Department would request the following additions to this statute:

If CSSB 37 is intended to be a voluntary process, as advocated by its sponsors, then a provision to the effect that "a health benefit plan can unilaterally choose, for any reason or no reason at all, to not negotiate with a physician's representative" should be added. It should be made clear that no boycott, coercion or intimidation of any kind can be taken in response to such a decision.

The Washington law requires the Attorney General to issue an informal opinion within 30 days of receiving a request, or within 30 days after obtaining additional information. This is not enough time to conduct a through review, and the Department believes 90 days would be more realistic.

Regulations adopted by the Washington Department of Health to implement this law are attached. The Department of Law does not agree that the Washington regulations are sufficient. In addition to these regulations, Alaska regulations should include:

1. Submission of more-detailed information by a physician representative which includes descriptions of the geographic and product markets affected by the proposed negotiations; anticipated price increases; and other impacts on health care;

2. A restriction that limits any bargaining group to 20 percent of the providers in either the geographic or product market, i.e., no more than 20 percent of physicians in any given area *or* within any given specialty;

3. At least 90 days to review and approve proposed negotiations;

4. A statement that collective activity by physicians who are contemplating a request for collective negotiations is not authorized;

5. If Washington's terminology is to used, there needs to be some clarification about what a "health carrier" is, and if that term is meant to be different from "health insurers."

The Department of Law has restricted its comments to the antitrust issues raised in this bill, and these suggestions should not be taken as an endorsement of this bill.

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

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

cc: Senate Labor and Commerce Committee Members
Chrystal Smith
Shari Kochman
Senator Pete Kelly
Senator Robin Taylor
Bruce Botelho

CES/sjm

43.72.300. Managed competition—Findings and intent

(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 finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

(2) The legislature therefore intends to exempt from state anti-trust laws, and to provide immunity from federal anti-trust laws through the state action doctrine for 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 by any person or entity created or regulated by chapter 492, Laws of 1993 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 RCW 43.72.310 or under rules adopted pursuant

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to chapter 492, Laws of 1993, 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 health plan based upon the perceived or actual risk of loss in including such resident or group of residents in a health plan or purchasing group.

Enacted by Laws 1993, ch. 492, § 447, eff. July 1, 1993. Amended by Laws 1997, ch. 274, § 6, eff. July 1, 1997.

Historical and Statutory Notes

Effective date—1997 c 274: See note following RCW 41.05.021.

43.72.310. Managed competition—Competitive oversight—Attorney general duties—Anti-trust immunity—Fees

(1) A health carrier, health care facility, health care provider, or other person involved in the development, delivery, or marketing of health care or health plans may request, in writing, that the department of health obtain an informal opinion from the attorney general as to whether particular conduct is authorized by chapter 492, Laws of 1993. Trade secret or proprietary information contained in a request for informal opinion shall be identified as such and shall not be disclosed other than to an authorized employee of the department of health or attorney general without the consent of the party making the request, except that information in summary or aggregate form and market share data may be contained in the informal opinion issued by the attorney general. The attorney general shall issue such opinion within thirty days of receipt of a written request for an opinion or within thirty days of receipt of any additional information requested by the attorney general necessary for rendering an opinion

unless extended by the attorney general for good cause shown. If the attorney general concludes that such conduct is not authorized by chapter 492, Laws of 1993, the person or organization making the request may petition the department of health for review and approval of such conduct in accordance with subsection (3) of this section.

(2) After obtaining the written opinion of the attorney general and consistent with such opinion, the department of health:

(a) May authorize conduct by a health carrier, health care facility, health care provider, or any other person that could tend to lessen competition in the relevant market upon a strong showing that the conduct is likely to achieve the policy goals of chapter 492, Laws of 1993 and a more competitive alternative is impractical;

(b) Shall adopt rules governing conduct among providers, health care facilities, and health carriers including rules governing provider and facility contracts with health carriers, rules governing the use of "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 the terms and conditions of contracts with a health carrier including the ability of providers to meet and communicate for the purposes of these negotiations;

(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

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set forth findings as to benefits and disadvantages and conclusions as to whether the benefits outweigh the disadvantages.

(4) In authorizing conduct and adopting rules of conduct under this section, the department of health with the advice of the attorney general, shall consider the benefits of such conduct in furthering the goals of health care reform including but not limited to:

(a) Enhancement of the quality of health services to consumers;

(b) Gains in cost efficiency of health services;

(c) Improvements in utilization of health services and equipment;

(d) Avoidance of duplication of health services resources; or

(e) And as to (b) and (c) of this subsection: (i) Facilitates the exchange of information relating to performance expectations; (ii) simplifies the negotiation of delivery arrangements and relationships; and (iii) reduces the transactions costs on the part of health carriers and providers in negotiating more cost-effective delivery arrangements.

These benefits must outweigh disadvantages including and not limited to:

(i) Reduced competition among health carriers, health care providers, or health care facilities;

(ii) Adverse impact on quality, availability, or price of health care services to consumers; or

(iii) The availability of arrangements less restrictive to competition that achieve the same benefits.

(5) Conduct authorized by the department of health shall be deemed taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(6) With the assistance of the attorney general's office, the department of health shall actively supervise any conduct authorized under this section to determine whether such conduct or rules permitting certain conduct should be continued and whether a more competitive alternative is practical. The department of health shall periodically review petitioned conduct through, at least, annual progress reports from petitioners, annual or more frequent reviews by the department of health that evaluate whether the conduct is consistent with the petition, and whether the benefits continue to outweigh any disadvantages. If the department of health determines that the likely benefits of any conduct approved through rule, petition, or otherwise by the department of health no longer outweigh the disadvantages attributable to potential reduction in competition, the department of health shall order a modification or discontinuance 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 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 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.

Enacted by Laws 1993, ch. 492, § 448, eff. July 1, 1993. Amended by Laws 1995, ch. 267, § 8, eff. May 8, 1995; Laws 1997, ch. 274, § 7, eff. July 1, 1997.

Historical and Statutory Notes

Effective date—1997 c 274: See note following RCW 41.05.021.

Captions not law—Severability—Effective dates—1995 c 267: See notes following RCW 43.70.052.

Administrative Code References

Antitrust immunity and competitive oversight,
Procedural rules, see WAC 245-02-100 et seq.
Substantive rules, see WAC 245-02-010 et seq.

Title 246 WAC DEPARTMENT OF HEALTH
Chapter 246-25 WAC ANTITRUST IMMUNITY AND COMPETITIVE OVERSIGHT

Chapter 246-25 WAC
ANTITRUST IMMUNITY AND COMPETITIVE OVERSIGHT

(Formerly Chapter 245-02 WAC)

Last Update: 1/28/99

WAC

SUBSTANTIVE RULES

246-25-010	Definitions.
246-25-020	General policy statement--Antitrust immunity and competitive oversight.
246-25-025	Scope and applicability.
246-25-030	Cooperative activities--Policy statement.
246-25-035	Consumer access to local health services in rural areas.
246-25-040	Collective negotiations--Policy statement--Permitted negotiations--Petitions.
246-25-045	"Most favored nations clauses"--Policy statement.
246-25-050	Exclusive dealing clauses--Policy statement.

PROCEDURAL RULES

246-25-100	Purpose.
246-25-110	Form of petition and request for informal opinion.
246-25-115	Contents of requests for informal opinions and written petitions.
246-25-120	Continuing oversight and reporting requirements.
246-25-125	Additional information.
246-25-130	Submission of information.
246-25-131	Public notice and comment.
246-25-135	Commission to provide copy of informal opinion to applicant.
246-25-140	Attorney general to provide informal opinion and advice on petitions to the commission.
246-25-145	Applicant may request an adjudicative proceeding or file a petition.
246-25-150	Decision not to conduct an adjudication.
246-25-155	Adjudicative proceeding--Rules of procedure.
246-25-160	Adjudicative proceedings--Notice of hearing.
246-25-165	Presiding officer.
246-25-170	Commission to retain jurisdiction.
246-25-175	Adjudicative proceedings--Reconsideration.
246-25-180	Notice of modification or withdrawal of authorization.

SUBSTANTIVE RULES

WAC 246-25-010 Definitions.

Unless the context requires otherwise, the definitions contained in this section apply throughout this chapter.

(1) "**Attorney general**" means the antitrust section of the office of the attorney general

(2) "**Applicant**" means a certified health plan, health care facility, health care provider, or other person involved in the development, delivery, or marketing of health services or certified health plans.

(3) "**Parties**" means the natural persons, corporations, or associations involved in the plan or activity which is the subject of the proposal being reviewed.

(4) "**Petition**" means the document that shall be filed with the commission pursuant to RCW 43.72.310 (3) by an applicant in order to request approval of conduct that could tend to lessen competition in the relevant market.

(5) "**Proposal**" means the plan or activity that is being reviewed.

(6) "**Request for informal opinion**" means the document that may be filed with the commission pursuant to RCW 43.72.310(1) by an applicant.

(7) "**Exclusive dealing clause**" means a clause in a contract between a certified health plan and a health care provider or facility by which the provider or facility agree not to provide services to another certified health plan.

(8) "**Health care network**" means a group of providers or facilities controlled by the providers, facilities or intermediary organizations including, but not limited to, physician hospital organizations and independent practice associations.

(9) "**Most favored nations clause**" means terms in a contract between a certified health plan and a health care provider or facility by which the provider or facility agrees they will not charge other plans a lower price than the price charged the plan instituting the clause.

(10) "**Rural area**" means a geographical area outside the boundaries of Metropolitan Statistical Areas (MSAs) or an area within an MSA, but more than thirty minutes average travel time from an urban area of at least ten thousand population.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-010, filed 1/28/99, effective 1/28/99; 95-04-115, § 245-02-010, filed 2/1/95, effective 10/1/95.]

WAC 246-25-020 General policy statement--Antitrust immunity and competitive oversight.

(1) The purpose of WAC 245-02-020 through 245-02-050 is to implement provisions of the act that require the commission to adopt rules governing antitrust immunity, competitive oversight, and conduct of certified health plans, health care providers, and health care facilities. The provisions of these rules shall be strictly construed. Whenever there is doubt as to the meaning of these rules or as to their applicability to particular conduct or circumstances, these rules shall be interpreted in a manner consistent with existing antitrust law principles of this state and of the federal government, including final orders of the Federal Trade Commission and final decisions of the federal courts interpreting the various federal antitrust statutes.

(2) Unless explicitly permitted under this chapter or pursuant to a petition approved in accordance with the provisions of RCW 43.72.310 (3) and (4), nothing in these rules shall be deemed or interpreted to permit activities or to grant immunity for those activities prohibited under RCW 43.72.300(3) or any other activity which would constitute a per se violation of state or federal antitrust laws.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-020, filed 1/28/99, effective 1/28/99; 95-04-115, § 245-02-020, filed 2/1/95, effective 10/1/95.]

WAC 246-25-025 Scope and applicability.

The provisions of WAC 245-02-010 through 245-02-050 shall govern contracts and conduct among health care providers, health care facilities, and certified health plans entered into or renewed on and after October 1, 1995.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-025, filed 1/28/99, effective 1/28/99; 95-04-115, § 245-02-025, filed 2/1/95, effective 10/1/95.]

WAC 246-25-030 Cooperative activities--Policy statement.

The commission recognizes that reforms in the health system will occur through the development of comprehensive, integrated, and cost-effective health services delivery systems. Because the health services market place is evolving in anticipation of changes required by the act, it would not be appropriate to establish with precision specific areas where cooperative activities are entitled to immunity from antitrust laws. Pursuant to RCW 34.05.023, the commission therefore adopts as an interim policy statement the *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust* issued by the U.S. Department of Justice and the Federal Trade Commission on September 27, 1994. These nine policy statements address: (1) Mergers among hospitals; (2) hospital joint ventures involving high-technology or other expensive health care equipment; (3) hospital joint ventures involving specialized clinical or other expensive health care services; (4) providers' collective provision of nonfee-related information to purchasers of health care services; (5) providers' collective provision of fee-related information to purchasers of health care services; (6) provider participation in exchanges of price and cost information; (7) joint purchasing arrangements among health care providers; (8) physician network joint ventures; and (9) analytical principles relating to multiprovider networks.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-030, filed 1/28/99, effective 1/28/99; 95-04-115, § 245-02-030, filed 2/1/95, effective 10/1/95.]

WAC 246-25-035 Consumer access to local health services in rural areas.

An applicant may petition the commission for approval of a managed health care finance and delivery system in a rural area that may violate existing antitrust law principles or provisions of WAC 245-02-040, 245-02-045 or 245-02-050 but is necessary to preserve local access to regular and ongoing health services in a rural area. In addition to the requirements set forth in WAC 245-02-110, et seq., such petitions shall include information demonstrating that the proposed system: (a) Has been developed through a community-based process that takes into consideration the concerns of local residents, health care providers, public and private health care facilities, local community organizations, and appropriate state agency health planning organizations located in or with responsibility for health services in rural areas, (b) will achieve quality improvements and cost efficiencies over present health service capabilities in the rural area, (c) will result in local access to regular and ongoing services required under the uniform benefits package, (d) will combine health care service delivery and financing, and (e) will or will not have special community governance arrangements. Nothing contained in this section shall be deemed to relieve an applicant from meeting the requirements imposed by law for registration and certification of certified health plans.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-035, filed 1/28/99, effective 1/28/99; 95-04-115, § 245-02-035, filed 2/1/95, effective 10/1/95.]

WAC 246-25-040 Collective negotiations--Policy statement--Permitted negotiations--Petitions.

(1) The board finds that collective negotiation by competing health care providers of certain nonfee terms and conditions of contracts with health carriers may result in procompetitive effects in the absence of any express or implied threat of retaliatory collective action by health care providers. However, the board finds few or no procompetitive effects in permitting competing health care providers to collectively negotiate contract terms and conditions that include fees or prices for provider services. The potential anticompetitive harms arising from collective exchanges of fee or price information by competing providers and collective negotiation by competing providers of the fees to be paid providers by health carriers far outweigh any potential gains in simplifying provider and health carrier

negotiations, any reduction in transaction costs, and any potential gains in cost-effective health care delivery systems. To the contrary, the board finds that collective negotiation of fees or other prices for services by competing health care providers creates the potential to thwart the cost containment goals of health care reform by enabling health care providers to resist health carrier and purchaser pressure to reduce or limit the increase in prices for health care services. Except as herein provided, nothing contained in this section shall authorize any person or entity to engage in activities that would constitute violations of state or federal antitrust laws.

(2) Competing health care providers within the service area of a health carrier may meet and communicate for the purposes of collectively negotiating the following terms and conditions of contracts with health carriers:

(a) Respective provider and health carrier liability for the treatment or lack of treatment of health carrier enrollees;

(b) Administrative procedures including methods and timing of provider payment for services

(c) Dispute resolution procedures relating to disputes between health carriers and provider including disputes between providers and health carriers that originate from enrollees;

(d) Patient referral procedures;

(e) Formulation and application of reimbursement methodology, e.g., risk pools, capitation, and capitation between providers and hospitals, except as provided in section 3;

(f) Quality assurance programs;

(g) Health service utilization review procedures; and

(h) Carrier provider selection and termination criteria, or whether to engage in selective contracting. Nothing herein shall be construed to allow a boycott.

(3) Competing health care providers shall not meet and communicate for the purposes o collectively negotiating the following terms and conditions of contracts with health carriers:

(a) The fees or prices for services, including those arrived at by applying any reimbursemen methodology procedures;

(b) The conversion factor in a resource based relative value scale reimbursement methodology or similar methodologies;

(c) The amount of any discount or the price of services to be rendered by providers

(d) The dollar amount of capitation or fixed payment for health services rendered by providers to health carrier enrollees; or

(e) The inclusion or alteration of terms and conditions to the extent they are the subject o government regulation prohibiting or requiring the particular term or condition in question; however, such restriction does not limit provider rights to collectively petition government for a change in such regulation.

(4) Competing health care providers' exercise of collective negotiation rights granted by this section shall conform to the following criteria:

(a) Provid shall communicate or negotiate with health carriers through a third party who is authorized by the providers;

(b) Each competing provider involved in the communication and negotiation with health carriers shall make an independent decision to accept or reject a specific offer from a health carrier;

(c) Health carriers communicating or negotiating with the providers' representative shall remain free to contract with or offer different contract terms and conditions to individual competing providers;

(d) The providers' representative shall not recommend to providers that providers accept or reject the health carrier offer; the representative may only deliver the offer to providers and communicate to providers an evaluation of the positive or negative aspects of the offer;

(e) The providers' representative shall not represent more than 30% of the market of practicing providers for the provision of services of a particular provider type or specialty in the service area or proposed service area of a health carrier with less than 5% of the market, as measured by 1) the number of covered lives as reported by the Insurance Commissioner, or 2) the actual number of consumers of

prepaid comprehensive health services; and

(f) The providers' representative shall comply with the provisions of subsection (5) of this section.

(5) Any person or organization proposing to act or acting as a representative of providers for the purpose of exercising the authority granted under this section shall comply with the following requirements:

(a) Before engaging in any collective negotiation with health carriers on behalf of competing health care providers, the representative shall file with the board information identifying the representative, the representative's plan of operation. and the representative's procedures to ensure compliance with this section;

(b) Before engaging in any collective negotiations with health carriers on behalf of providers, the representative shall furnish for the board's approval, a brief report identifying the proposed subject matter of the negotiations or discussions with health carriers and the efficiencies expected to be achieved thereby.

Approval shall be withheld by the board if the proposed negotiations would exceed the authority granted under this section. The representative shall supplement the report to the board as new information becomes available that indicates that the subject matter of the negotiations with the health carrier has or will change;

(c) Within fourteen days of a health carrier decision declining negotiation, terminating negotiation, or failing to respond to a request for negotiation the representative shall report to the board the end of negotiations;

(d) Before reporting the results of negotiations with a health carrier and before giving providers an evaluation of any offer made by a health carrier, the representative shall furnish for the board's approval prior to dissemination to providers, a copy of all communications to be made to providers related to negotiations, discussions, and health carrier offers.

(6) With the advice of the attorney general, the board shall either approve or disapprove the activity as identified in the report within thirty days of filing. If disapproved, the board shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies could be corrected. A representative who fails to obtain the board's approval is deemed to act outside the authority granted under this section.

(7) Nothing contained in this section is intended to authorize competing providers to act in concert in response to a report issued by the providers' representative related to the representative's discussions or negotiations with health carriers. The representative of the providers shall advise providers of the provisions of this section and shall warn providers of the potential for legal action against providers who violate state or federal antitrust laws by exceeding the authority granted under this section.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-040, filed 1/28/99, effective 1/28/99; 96-11-133, § 245-02-040, filed 5/22/96, effective 6/22/96; 95-04-115, § 245-02-040, filed 2/1/95, effective 10/1/95.]

WAC 246-25-045 "Most favored nations clauses"--Policy statement.

"Most favored nations clauses" may discourage discounting by the affected seller, may facilitate oligopolistic pricing and deter entry by more efficient competitors. "Most favored nations clauses" are often used as a replacement for innovation or efficiency by large competitors and act as a disincentive for creativity by small competitors. The commission finds that the use of "most favored nations clauses" in contracts between a health care provider or facility and a certified health plan create the potential to thwart the cost containment goals of health care reform. For these reasons, the use of "most favored nations clauses" in contracts between a health care provider or facility and a certified health plan is prohibited.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-045, filed 1/28/99, effective 1/28/99; 95-04-115, § 245-02-045, filed 2/1/95, effective 10/1/95.]

WAC 246-25-050 Exclusive dealing clauses--Policy statement.

(1) Exclusive dealing clauses in health care provider and facility contracts with certified health plans may enhance the quality of health services, achieve economic efficiencies, or improve the cost-effective use of health services and equipment. Exclusive dealing clauses may also reduce competition among certified health plans, providers, and facilities when the clauses prevent other competitors from entering the relevant market, thereby increasing the probability of the creation of a monopoly in that market.

(2) A contract between a certified health plan and a health care facility or provider may not contain an exclusive dealing clause if the plan holds more than forty percent of the relevant market.

(3) A contract between a certified health plan and a health care facility or provider may contain an exclusive dealing clause if the plan holds twenty percent or less of the relevant market.

(4) A contract between a certified health plan and a health care facility or provider may contain an exclusive dealing clause if the plan holds between twenty and forty percent of the relevant market and the commission has explicitly permitted its use. To obtain such approval, a plan must request an informal opinion as to use of the clause in the particular circumstances or seek approval by written petition pursuant to the procedures set forth in WAC 245-02-110, et seq.

(5) A contract between a health care network and a health care facility or provider may not contain an exclusive dealing clause if the health care network holds more than forty percent of the relevant market.

(6) A contract between a health care network and a health care facility or provider may contain an exclusive dealing clause if the health care network holds twenty percent or less of the relevant market.

(7) A contract between a health care network and a health care facility or provider may contain an exclusive dealing clause if the network holds between twenty and forty percent of the relevant market and the commission has explicitly permitted its use. To obtain such approval, a network must request an informal opinion as to use of the clause in the particular circumstances or seek approval by written petition pursuant to the procedures set forth in WAC 245-02-110, et seq.

(8) The provisions of this section do not apply to contracts between a staff or group model health maintenance organization and its health care facilities or providers.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-050, filed 1/28/99, effective 1/28/99; 95-04-115, § 245-02-050, filed 2/1/95, effective 10/1/95.]

PROCEDURAL RULES

WAC 246-25-100 Purpose.

The purpose of WAC 245-02-110 through 245-02-175 is to implement RCW 43.72.310 by setting forth the form and procedure for: (1) Requests for informal opinions from the attorney general as to whether particular conduct is authorized by the act, and (2) written petitions to the commission requesting approval of conduct that could tend to lessen competition in a relevant market.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-100, filed 1/28/99, effective 1/28/99. 95-04-112, § 245-02-100, filed 2/1/95, effective 3/4/95.]

WAC 246-25-110 Form of petition and request for informal opinion.

A petition, request for informal opinion, or request for adjudicatory proceeding shall adhere generally to the following form:

(1) At the top of the page shall appear the wording "before the Washington Health Services Commission." On the left side of the page, below the foregoing, the following caption shall be set out "In the Matter of (name of applicant)." Opposite the foregoing caption shall appear the words "petition," or "request for informal opinion," or, "request for adjudicatory proceeding," whichever is applicable.

(2) The materials required by WAC 245-02-115 through 245-02-125 shall be attached to the foregoing.

(3) The petition or request shall be signed and dated by the entity named in the first paragraph, or by its attorney. The original and five copies shall be filed with the commission as described in WAC 245-02-130.

(4) Information required by this chapter may be submitted in hard copy or in machine readable form:

(a) If hard copy, documents shall be submitted and organized by request;

(b) If in machine readable form, the data should comply with specifications acceptable to the commission and attorney general, which will be provided upon request.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-110, filed 1/28/99, effective 1/28/99; 95-04-112, § 245-02-110, filed 2/1/95, effective 3/4/95.]

WAC 246-25-115 Contents of requests for informal opinions and written petitions.

The following information shall accompany any written petition or request for informal opinion submitted to the commission:

(1) **Identification of parties.** Identify all parties to the proposal, and their parent entities, and for each one state:

(a) The name(s) under which it is doing business, or proposes to do business, in Washington

(b) Its business address(es);

(c) Its type of business organization (for example, corporation, sole proprietorship, partnership, or association);

(d) A brief description of the nature or type of business conducted at each of its business locations within the state of Washington; and

(e) The person to whom questions regarding the request or petition should be directed

(2) **Nature and description of proposal.** State or describe:

(a) The nature and type of transaction (for example, joint venture, acquisition, or merger

(b) The business(es) involved or affected;

(c) The products and services involved or affected;

(d) The scheduled timeline, including expected dates of any major events required to consummate the proposed activity;

(e) The geographic area(s) in which business will be conducted;

(f) Whether the same products or services as those listed in (c), above, are currently offered within thirty miles of the geographic area(s) identified in (e), above, and if so, by whom; and

(g) The extent to which the participants share substantial risk including, but not limited to: (1) The extent to which the venture agrees to provide services on a capitated basis, or (2) the extent to which the venture creates significant financial incentives for its participants as a group to achieve specified cost containment goals, such as withholding a substantial amount of compensation due to participants, with distribution of that amount to participants only if the cost containment goals are met.

(h) A general description of any anticipated impact of the proposal on competition, including but not limited to the description of the business(es) involved or affected, the effect upon the parties in their competition with each other, the changes in market share among certified plans, health care providers or health care facilities in the geographic product or service area, the presence and entry of new market participants sufficient to deter or counteract the anti-competitive effects of the proposed activity, and

availability of arrangements less restrictive to competition that would achieve the same or similar benefits to the community in health care delivery.

(i) The exclusive or nonexclusive nature of the proposal including, but not limited to (1) the extent to which viable competing networks or plans with adequate provider participation currently exist in the market, (2) the extent to which providers in the proposed network actually participate in other networks or contract individually with health benefit plans, or other evidence of their willingness and incentives to do so, (3) the extent to which providers in the proposed network will earn substantial revenue outside the network, (4) the absence of any indication of significant deparlicipation from other networks in the market as a result of the proposed venture, and (5) the absence of any indications of coordination among the providers in the network regarding price or other competitively significant terms of participation in other networks or plans.

(3) **Simultaneous review.** Identify any other state or federal agency reviewing the proposal and state the date on which each review was requested.

(4) Identify the name and address of all employee organizations representing the applicant's employees.

(5) **Description of how conduct will meet the goals of health care reform.** Describe in narrative form how the proposal will:

(a) Enhance the quality, access and cost of health services to consumers;

(b) Gain cost efficiency in the provision of health services;

(c) Improve utilization of health services, facilities and equipment;

(d) Avoid duplication of health services resources;

(e) Facilitate the exchange of information relating to performance expectatior

(f) Develop comprehensive, integrated, and cost-effective health services delivery in the geographic, product or service area;

(g) Reduce competition among certified health plans, health care providers, or health care facilities;

(h) Have an impact on the quality, availability, or price of health services to consumers

(i) Reduce the number of people employed or otherwise impact how employees deliver health care services; and

(j) Change or otherwise have an impact on employee to patient ratios and how this will affect the quality of health services available to consumers.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-115, filed 1/28/99, effective 1/28/99; 95-04-112, § 245-02-115, filed 2/1/95, effective 3/4/95.]

WAC 246-25-120 Continuing oversight and reporting requirements.

Written petitions and requests for informal opinions must include, in narrative form, a description of the nature of the continued supervision and oversight the parties' believe would be necessary and appropriate to ensure the proposal continues to be consistent with the petition or request and that its benefits continue to outweigh its disadvantages. The description shall include a recommendation for the form of annual or more frequent progress reports appropriate to the transaction and sufficient to allow the commission and attorney general to evaluate the continuing conduct.

[Statutory Authority: RCW 43.72.310. 99-04-049, recodified as § 246-25-120, filed 1/28/99, effective 1/28/99; 95-04-112, § 245-02-120, filed 2/1/95, effective 3/4/95.]

ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street ·Anchorage, Alaska 99508 ·(907) 562-0304 ·(907) 561-2063 (fax)

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 Alaske 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 ph ician joint negotiation bill. We have already provided you with a great deal of information re g 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 indeterminate 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,

Peter Lawrason

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

c.c. Senate Finance Committee Members.

ERISA Litigation and Physician Autonomy

Peter D. Jacobson, JD, MPH
Scott D. Pomfret, JD

The Employee Retirement Income Security Act (ERISA), enacted in 1974 to regulate pension and health benefit plans, is a complex statute that dominates the managed care environment. Physicians must understand ERISA's role in the relationship between themselves and managed care organizations (MCOs), including how it can influence clinical decision making and physician autonomy.

This article describes ERISA's central provisions and how ERISA influences health care delivery in MCOs. We analyze ERISA litigation trends in 4 areas: professional liability, utilization management, state legislative initiatives, and compensation arrangements. This analysis demonstrates how courts have interpreted ERISA to limit physician autonomy and subordinate clinical decision making to MCOs' cost containment decisions. Physicians should support efforts to amend ERISA, thus allowing greater state regulatory oversight of MCOs and permitting courts to hold MCOs accountable for their role in medical decision making.

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THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) looms like a colossus over the managed care environment. Originally enacted to regulate employer-sponsored pension plans, the statute also covers health care benefits established by self-insured employers (with few exceptions, such as for governmental employees). According to recent Department of Labor estimates, ERISA applies to approximately 125 million US citizens.[1]

ERISA has created a regulatory vacuum by preempting state regulation of managed care organizations (MCOs) and drastically limiting state medical liability lawsuits against MCOs, while providing minimal federal regulation in their place.[2-4] For physicians, ERISA preemption has indirectly caused courts to favor MCOs' cost containment initiatives over traditional notions of physician autonomy.[5] The treatment a physician recommends is vulnerable to a managed care utilization management process largely unconstrained by state regulation or liability law, inevitably resulting in reduced physician autonomy.

The consequences of ERISA preemption lie at the heart of proposed congressional patients' rights legislation that would restore the primacy of the patient-physician relationship and permit state legal challenges to cost containment programs. At issue is control over physicians' clinical decisions and the ability to challenge improperly operated cost containment programs.

Because ERISA plays a vital role in the relationship between physicians and MCOs, it is important for physicians to understand what ERISA is, how it operates, and how it influences clinical decision making and physician autonomy in the managed care era. In this article, we outline ERISA's major provisions, analyze trends in ERISA litigation applicable to physicians, and conclude by discussing the policy implications and significance of these trends for physician autonomy.

AN ERISA PRIMER

Overview

Congress enacted ERISA in 1974 primarily to regulate pension plans, but it also included health benefit plans within its scope.[6] ERISA's goals are to establish uniform national standards, safeguard employee benefits from loss or abuse, and encourage employers to offer those benefits. To achieve these objectives, ERISA imposes strict requirements on pension plan administrators for reporting and disclosure,[7] participation and vesting,[8] funding,[9] and performance of fiduciary obligations.[10] ERISA does not mandate that employers offer benefit plans, but provides a structure for national uniformity of administration once such plans are extended.

Only a few of these requirements apply to health benefit plans, in part because Congress did not pursue the implications of regulating both pension and health benefit plans under 1 statute. Nor could Congress have anticipated the dominance of the managed care model. As a result, ERISA provides almost no federal regulation of health plans. Nevertheless, ERISA has 3 provisions that directly affect physician autonomy: ERISA's preemption clause, its limited remedial scheme, and its fiduciary duty obligation.

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Health Law and Ethics Section Editors: Lawrence O. Gostin, JD, the Georgetown/Johns Hopkins University Program in Law and Public Health, Washington, DC, and Baltimore, Md; Helene M. Cole, MD, Contributing Editor, *JAMA*.

ERISA's Preemption Clause

Traditionally, states are responsible for regulating health care delivery, and litigation against health care providers is resolved under state law. Medical liability lawsuits are rarely heard in federal courts. ERISA alters the traditional approach by preempting state law, which means that state laws purporting to regulate health plans may not be enforced in any court.[11] In this context, state laws include legislation and regulations, such as those mandating particular benefit coverage, and most medical liability actions targeting MCOs.

Courts have interpreted the preemption clause broadly to prevent enforcement of state laws ranging from laws protecting the patient-physician relationship to litigation challenging how cost containment initiatives are implemented. The courts have held that Congress intended such broad preemption of state law to allow a multistate employer to offer a single, nationally consistent plan to all its workers without the cost and inconvenience of complying with contradictory state regulations, legislation, or litigation. National uniformity conforms with congressional intent to keep the costs of administering an employee benefit plan (EBP) low to encourage employers to offer health care coverage.[12]

In assessing whether a particular state law is prohibited, courts look sequentially to each of the 3 parts of the preemption provision. First, courts must decide whether the state law "relates to" an EBP.[13] In doing so, courts consider whether the challenged law burdens the administration of plan benefits or has only a remote impact on them. Courts generally hold that ERISA preempts state laws that bind employers or plan administrators to particular benefit choices or that preclude the uniform administration of an EBP.[14] For example, a state lawsuit challenging a benefit determination, such as an MCO's denial of additional hospital coverage, "relates to" a health plan because that challenge would require the court to interpret the plan's benefits, hence binding the administrator to certain actions. But laws with only a remote or incidental effect on plan administration, such as a surcharge on hospital services, may not "relate to" the EBP.

A law is not preempted merely because it "relates to" a plan. Courts must also interpret 2 qualifying provisions, the *savings* clause and the *deemer* clause. ERISA's savings clause provides that laws regulating the business of insurance, even if they "relate to" a managed care plan, will not be preempted. This allows states to continue to enforce state laws governing the business of insurance by saving state regulation of health insurance, such as solvency requirements, from preemption.

In turn, the deemer clause qualifies the savings clause. The deemer clause prevents states from deeming (or characterizing) an ERISA-covered plan as the business of insurance. States may not characterize a self-funded plan as an insurer to circumvent the effect of the "relates to" clause.

As an example of how these terms interact, consider a state law mandating certain health insurance benefits. That law "relates to" an ERISA plan since it would involve the structure of plan benefits. Even though the legislation would be saved from preemption insofar as it regulates EBPs that purchase traditional insurance policies, it would still be preempted if, for example, a state attempted to apply the statute to a self-funded EBP. Under the deemer clause, a self-funded EBP cannot be an insurer.

ERISA's Limited Remedies

Although much state litigation is preempted, ERISA provides some relief for injuries to health plan participants through its civil enforcement scheme. A plan participant or beneficiary may bring a civil action against an administrator who fails to comply with a request for information about the plan, to recover claimed benefits, to enforce rights under the terms of the plan, or to clarify rights to future benefits.[15] A plan participant may also bring suit against a plan fiduciary who breaches any fiduciary duties and may seek to enjoin practices that violate ERISA or the terms of the plan.

Even if victorious, a plan participant can usually only recover the amount of the benefits that should have been provided, as well as certain incidentals such as attorneys' fees. This is a decidedly more limited remedy than what is usually available under state law, through which the patient might be able to recover damages for any economic losses, noneconomic damages for pain and suffering, and possibly punitive damages (especially in cases alleging bad faith insurance denial).[16]

Take, for example, a challenge to an improperly denied benefit filed in state court. If the MCO successfully invokes preemption, the plaintiff will be forced to sue instead under ERISA's limited civil enforcement scheme. Effectively, this insulates the MCO from exposure to monetary damages, except for what it would have paid (the amount of the denied benefit) in the first place.

Fiduciary Duties

ERISA imposes a fiduciary duty on those who make discretionary decisions on behalf of the EBP. A fiduciary must discharge his/her discretionary functions "solely in the interest of the participants and beneficiaries" of the plan.[17] In many, but not all cases,[18] courts have held that MCOs are subject to this fiduciary duty when making certain decisions, such as reviewing the appropriateness of a physician's treatment recommendations.[19] On the other hand, MCOs and employers are not considered fiduciaries for establishing or changing the terms of the plan. Thus, the fiduciary duty extends only to decisions made once the plan is in place.[20,21] Employers must provide whatever health benefits they promise but need not offer plans at all and can change what they offer after giving plan beneficiaries proper notice.

In exercising the fiduciary duty, an obvious problem is that the clinical needs of one patient may conflict with the MCO's economic interests. Increasingly, disappointed plan participants have sued for breach of fiduciary duty, often challenging the denial of physician-prescribed benefits, especially when there is a potential conflict of interest.[22]

To determine whether an MCO breached its fiduciary duty when denying plan benefits (ie, that the denial is not solely in the interest of the participant), courts use different levels of scrutiny based on the amount of discretion granted to the MCO under the EBP. Generally, courts are very deferential, upholding the plan administrator as long as the decision was not arbitrary and capricious.[23,24] In most cases, courts have equated compliance with the terms of the EBP as, by definition, acting "in the interests" of the plan participant. In this sense, the court limits its review to ensuring that the MCO reasonably comported with the terms of the EBP.[25] As a result, MCOs retain power vis-a-vis physicians by controlling the interpretation of EBP terms (including medical necessity). But in a case from which the plan profits directly from the denial, the potential conflict of interest must be considered a factor in deciding whether there was an abuse of the fiduciary's discretion.[26]

RECENT CASE TRENDS

MCO Malpractice Liability

For many years, courts have monitored quality of care through medical liability lawsuits. Originally, physicians were the targets of such suits, then hospitals were added, and now MCOs have been held liable under state tort law.

When a patient receives care under a health plan not governed by ERISA (as when a person buys his/her own health insurance), MCOs have been held directly liable for their own actions, such as the failure to maintain safe and adequate facilities, select and retain competent physicians, oversee all patient care within the institution, and ensure quality care.[27] Managed care organizations can also be held vicariously (indirectly) liable for malpractice committed by physicians who are independent contractors. The primary factors affecting whether a court will impose vicarious liability include the amount of influence the MCO has over the clinical decision, patients' perceptions of the relationship between the physician and the MCO, and the manner in which the health plan is marketed. Managed care organizations operating in contexts other than ERISA may also be subject to state consumer protection or bad faith insurance laws for improper processing of claims that results in delayed or denied care.[16] In non-ERISA cases, courts are essentially following the pattern of establishing liability that was applied to hospitals beginning in the 1960s.[28]

Managed care organizations covered by ERISA operate under different rules. ERISA preempts many state law claims alleging that the MCO's denial or delay in care caused an adverse medical outcome. Those types of lawsuits may be brought in federal court as actions under ERISA's civil enforcement scheme, but the limited remedies available effectively insulate MCOs from liability and, therefore, accountability for these medical outcomes. Liability may be borne instead entirely by physicians. The practical effect is that MCOs often control resource allocation, but physicians (and patients) bear the costs when resource allocation decisions produce adverse outcomes. In these cases, the patient's only remedy is to sue the physician, regardless of how much influence over the clinical decision the physician actually exercised.

Courts have not been consistent in deciding whether all or merely some state law claims against MCOs will be preempted. Until recently, led by early Supreme Court doctrine, lower federal courts have interpreted the phrase "relates to" very broadly, preempting most state law tort suits challenging health plan innovations and medical decisions. For example, courts generally have held that challenges to delayed or denied care relate to an EBP and are preempted,[29] including litigation alleging that the structure of the EBP was responsible for poor medical outcomes. But in *New York State Conference of Blue Cross and Blue Shield Plans v Travelers Insurance Co*,[30] the Supreme Court permitted New York State to impose a tax on all insurers except Blue Cross and Blue Shield, reasoning that a uniform tax only tangentially relates to ERISA plan administration. This decision signaled a scaling back on the breadth of preemption. After this decision, courts have been less vigorous in finding ERISA preemption.

Narrowing preemption has inspired other related changes. The most important change is that courts have erected a critical distinction between state tort law challenges to the technical quality of care (ie, liability claims for substandard clinical care) and state law challenges to the quantity of care (involving improper plan benefit decisions). The latter must be brought in federal court subject to ERISA's limited remedies; the former would be heard in state court.

In practice, the quantity/quality distinction may signal a nascent trend toward holding MCOs accountable at least in some circumstances, especially, if courts strain to characterize a dispute as involving quality. By way of example, the court in *Bauman v US Healthcare, Inc*[31] recently held that the defendant's policy of discharging a newborn within[24] hours without adequately considering the medical appropriateness in a given case could be challenged in state court as substandard quality of care. As their liability expands, MCOs may begin to reconsider the ways in which they review clinical decisions, as the United Healthcare decision[32] signaled recently by shifting greater clinical authority back to physicians. It is one thing to deny treatment when potential liability rests with the treating physician, but it is another to deny the claim when the organization might also be held responsible.

Consider, for example, state litigation seeking to hold an MCO indirectly liable for the actions of an affiliated physician. Because substandard care is litigation about the quality of care and not the quantity of benefits, the case will probably be heard in state court. And because state courts assess liability based in part on the amount of influence the MCO exerts over clinical decision making, MCOs may seek to avoid liability by loosening their control below the threshold required by state law. The result is increased physician au-

tonomy. While this result is what we anticipate, greater liability exposure could alternatively lead an MCO to protect itself by exerting stricter oversight of clinical decisions. Exactly how MCOs respond will need to be studied.

Preemption is not the only area in which this trend toward judicial reconsideration may be emerging. In recent years, many lawsuits charging MCO misconduct that resulted in adverse outcomes from delayed or denied care have been cast as breaches of fiduciary duty under ERISA.[33] No patient has yet recovered a judgment in such a case[34]; but to the extent such suits are successful, MCOs might be less likely to second-guess clinical decision making. To date, the decisions have been inconsistent and no truly coherent doctrine has yet emerged. Most courts have explicitly refused to be the agents of a major overhaul of ERISA doctrine, preferring to leave such a role in the legislative arena.[5]

Utilization Management

A central aspect of the managed care environment is the emergence of new organizational forms, including utilization management processes, which have mixed clinical and financial functions. Managed care organizations rely heavily on utilization management techniques, such as preauthorization for high-cost medical interventions, to reduce costs. The more courts uphold utilization management decisions, the less control the treating physician has over the clinical encounter.

In state cases for which ERISA does not apply, courts have held generally that physicians and MCOs may share liability for bad outcomes.[35,36] By contrast, ERISA preemption clearly shields MCOs from liability in state courts for utilization management decisions, even when these are arguably medical and not merely administrative in nature. So far, federal courts have uniformly held that utilization management decisions relate to benefit plans and are preempted, regardless of whether medical care recommended by the treating physician is denied. For instance, in *Danca v Private Health Care Systems Inc*,[37] the court supported the prevailing view that a utilization review dispute was preempted by ERISA because it is part of the process used to assess a benefit dispute.[38] And in *Corcoran v United Health Care Inc*,[39] the court concluded that United's utilization management program, whose denial of hospital care resulted in the death of a fetus, made medical decisions in the context of determining benefits. Accordingly, the court preempted Corcoran's lawsuit under ERISA. By holding that the administrative aspect of the utilization management process trumps the medical aspect (ie, that it is more a quantity than a quality decision), the federal courts, through ERISA, provide wide latitude for health care plans to control costs, at the possible expense of both individual access to health care services and the treating physician's clinical autonomy.

State Legislative Initiatives

As part of the backlash against managed care, many state legislatures have tried to safeguard physician autonomy. This legislation has ranged from prohibiting gag clauses to comprehensive reforms designed to limit the primacy of cost containment strategies. In many instances, courts have ruled that these laws are preempted by ERISA, although the decisions are by no means uniform. Such rulings have essentially negated state legislative attempts to restore physician autonomy and have reinforced health plan control over clinical decisions.

The most extensive attempt to regulate MCOs is the Texas statute[40] requiring an external appeals process for health care denials and allowing subscribers to sue the MCO for poor quality of health care. A federal district court recently upheld the right to sue, based on the quality/quantity distinction, yet overturned the external grievance process as preempted by ERISA.[41] Although the case is on appeal, that the court preempted the external review process as a law "relating to" an EBP is an indication of the ERISA-created hurdles facing state laws that try to bolster clinical autonomy.

Just as troublesome, the current uncertainty in ERISA litigation makes it difficult, if not impossible, to predict which state laws will be preempted. As an example, courts have split on whether any willing provider laws are preempted by ERISA.[42,43] Any willing provider laws would require MCOs to contract with any provider willing to meet the MCO's established criteria and are intended to preserve patient choice of physician.

Compensation Arrangements

Another important cost containment mechanism used by MCOs is to provide financial incentives to plan physicians to restrain costs. For instance, salary withholds and bonuses are used as compensation incentives for limiting referrals to specialists and other high-cost procedures. No court has yet ruled that these financial incentives violate public policy, though some non-ERISA cases have permitted challenges to be tried before a jury.[44]

ERISA does not regulate how MCOs create incentive structures to motivate contracting physicians' compliance with cost containment measures. More importantly, ERISA preemption may prevent states from trying to regulate such compensation and incentive arrangements through tort law or legislation. A typical case is *Lancaster v Kaiser Foundation Health Plan of Mid-Atlantic States Inc*,[45] in which the court held that the plaintiff's state law claim alleging negligence in establishing and operating an incentive program that encouraged physicians not to prescribe certain expensive tests and not to refer to specialists, was preempted by ERISA. The plaintiff claimed that this program was a substantial factor in her physicians' failure to diagnose her brain tumor for 5½ years until it had invaded 40% of her brain. The court characterized the establishment and operation of this incentive scheme as an administrative decision affecting the provision of benefits and therefore dismissed the claim as preempted.

Not all courts have agreed.[46] A more recent case perhaps presages a different direction based on breach of ERISA fi-

duciary duties (with, of course, the corresponding limit on remedies under ERISA). In *Herdrich v Pegram*,[47] the court held that a patient could sue for breach of fiduciary duty based on an allegation that the nature of incentive arrangements between the MCO and the physicians caused her to be deprived of proper medical care and that the MCO reaped economic gain from this deprivation. Even though the Herdrich court specifically noted that the existence of economic incentives would not automatically be tantamount to a breach of fiduciary duty, this case is a potentially significant extension of the rationale advanced in non-ERISA cases. If read broadly and followed by other courts, this case could augur an attack on the underlying financial incentives at the core of managed care, perhaps by seeking to enjoin their use.[47] However, Herdrich may represent a legal theory that is viable only in an extreme case in which "a fiduciary jettisons his responsibility to the physical well-being of the beneficiaries in favor of loyalty to his own financial interests,"[46] and the Supreme Court has agreed to review the decision.

COMMENT

ERISA has played an important role in facilitating, and perhaps stimulating, the development of managed care. But this undeniable policy benefit has come at a high cost to some individual plan subscribers and to physicians. From a policy perspective, ERISA has created a regulatory vacuum in which states cannot act and there is no comparable federal regulatory mechanism. From a legal perspective, ERISA has essentially insulated MCOs from liability by blocking state courts from resolving litigation challenging managed care practices. From a clinical perspective, ERISA has facilitated reductions in physician autonomy relative to health plan influence over clinical decisions.

Policy Consequences

This analysis suggests several consequences of importance to physicians. First, the effect of judicial interpretations of ERISA is to subordinate physician autonomy and the patient-physician relationship to managed care cost containment goals. Implicitly, ERISA reinforces the status quo of the health care delivery market and hence managed care's current market domination.

Second, perceiving themselves bound by ERISA, courts do not champion either physician autonomy or the patient-physician relationship. Courts that once protected physician autonomy, are no longer doing so.[49] Judges repeatedly suggest that complaints against managed care should be taken to the legislative branches of government rather than to the courts. Since state legislative initiatives are often barred by ERISA preemption, Congress appears to be physicians' best hope for change or relief. As of this writing, congressional action to amend the preemption provision (so that state legislatures and courts may act with fewer constraints) or to create new federal regulations similar to recent state initiatives appears to be unlikely. During the 1999 session, the House of Representatives enacted a bill that would permit patients to sue MCOs for damages in state courts, but the Senate bill does not contain a right-to-sue provision. Although House and Senate conferees have been meeting to reconcile the 2 bills, the prospects for enactment are slight, in part because the House conferees are largely opposed to the right-to-sue provision.

Regardless, physicians should continue to support attempts to remove ERISA preemption. Even though treating physicians would remain accountable, MCOs should also be held accountable for both financial decisions that affect clinical treatment and for their implicit role in making medical decisions. Physicians should not be left in the untenable position of being entirely responsible for cost containment provisions over which they have almost no control. By exposing MCOs to similar liability considerations, MCOs will not be able to influence medical decisions with impunity, which may enhance physician autonomy.

Short of eliminating ERISA preemption, Congress could also amend ERISA by expanding on the available remedies. Consistent with the goal of maintaining national uniformity, Congress could retain preemption but allow individuals to sue for monetary damages in federal court for an ERISA violation. Congress could also direct the US Department of Labor (as the appropriate regulatory agency) to develop regulations that would more effectively protect the patient-physician relationship. For instance, regulations might address patients' rights to notice of a denial of care and to an external grievance panel.

Physician Autonomy

An assumption animating this article is that deference to physician autonomy is a desirable goal for better patient care. To some, that proposition may not be self-evident. After all, public concern with rising health care costs and perceived harms from overtreatment in the fee-for-service era led directly to managed care's cost containment innovations and concomitant restrictions on physician autonomy as public policy objectives. Indeed, constraints on physician autonomy predate the effects of ERISA litigation.[50]

Thus, one scenario suggests that if Congress removes ERISA preemption and helps restore physician autonomy, managed care's cost containment goals may be difficult to achieve. This outcome seems unlikely given the current policy environment. Another possible scenario is that MCOs might respond to eliminating ERISA preemption by imposing more aggressive utilization management controls, ironically reducing physician autonomy below what it is under current financial incentives. Yet there is no indication that MCOs are eager to accept the additional liability consequences that may result from greater control over clinical decisions.

No matter whether Congress changes ERISA preemption or expands ERISA's limited remedies, the tensions among physicians, MCOs, and patients will not be resolved easily

Even if there are some downsides to physician autonomy, patient care ultimately depends on the treating physician's ability to maintain patient trust while balancing patient demands for high-quality care with the MCO's legitimate cost containment efforts. In truth, these cost containment programs are needed corrections to an unsustainable fee-for-service system, and many physicians have worked effectively to mediate managed care's constraints. Yet, inevitably, some patients will not be well served by this system. Either there will be undue delay in arranging health care, or benefits will be denied that should have been provided. In those situations, holding MCOs legally accountable provides incentives for better health care plan administration. ERISA preemption simply goes too far in removing the liability threat for improper undertreatment.

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