SB

37

Alaska State Legislature

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Senator Pete Kelly

District P

Senate Bill 37

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

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.

Sponsor
Statement/Sectional

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

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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. Burgel*, 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.

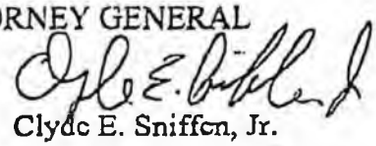
Written testimony submitted to various committees last year, and proposed AS 23.50.020(f)(2) indicate that negotiation with an authorized third party is not mandatory for health benefit plans. However, the language in proposed AS 23.50.020(c) and (d) imply that all health benefit plans are required to 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
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May 13, 1999

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

Dear Representative Oliveira:

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

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

The bill being considered by the Texas legislature differs from H.R. 4277 in various respects. In contrast to the federal proposal, which would simply provide an antitrust exemption for collective negotiations, SB 1468 requires some oversight of the negotiating process by the Texas Attorney General. In addition, SB 1468 would limit to 10% the proportion of physicians in a geographic area who could negotiate collectively, unless the Attorney General approved inclusion of a larger number in the group. The bill allows collective negotiation of certain types of fee-related issues only where the Attorney General determines that the health plan has substantial market power.

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

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

Third, the bill imposes substantial responsibilities on the Attorney General that could be difficult to carry out given the time frames provided in the bill and the fact-intensive nature of the issues. Moreover, we note that the regulatory scheme established by the bill contains no mechanism for members of the public, or others who stand to be affected by the Attorney General's decision, to offer evidence and views pertaining to the costs and benefits of the proposal or any of the underlying issues. In addition, the bill provides little guidance as to how the discretion granted to the Attorney General is to be exercised. For example, section 29.09(b) of the bill directs the Attorney General to approve a request to enter into joint negotiation or a proposed contract if the applicants demonstrate that "the likely benefits resulting from the joint negotiation or proposed contact outweigh the disadvantages attributable to a reduction in competition" that may result, but it provides no criteria to guide the Attorney General in evaluating benefits or disadvantages, or in weighing one against the other.[3]

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

Sincerely yours,

William J. Baer

Enclosure

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

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

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

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

Bureau of Competition

Richard A. Feinstein
Assistant Director

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October 29, 1999

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

Re: Physicians Negotiation Act of 1999

Dear Mr. Rigsby:

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

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

Background

Antitrust law already allows doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The Federal Trade Commission and the Department of Justice have issued health care policy statements that emphasize physicians' ability under the antitrust laws to organize networks and other joint arrangements to deal collectively with health plans and other purchasers.[1] In addition, health care professionals can, through their professional societies and other groups, jointly

provide information and express opinions to health plans.[2] Legislative proposals to permit collective bargaining by health care professionals, however, such as the one pending in the District of Columbia, seek to authorize conduct that would otherwise constitute unlawful price fixing or other serious antitrust violations.

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

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

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

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

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

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

The District of Columbia Bill

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

The Scope of Permitted Conduct

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

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

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

Aside from the ambiguity, however, the bill's provisions are not based on accepted concepts of market power in a legal or economic sense. Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only if based upon a properly defined market. Even if the bill's categories correctly identified relevant markets, a 15% market share (let alone a share above 5%) is not a level ordinarily presumed to constitute market power.[7] In addition, the bill does not take into account ease of entry in assessing market power, as antitrust analysis ordinarily would.

The limitation on the "market share" of physician groups negotiating with small health plans (which sets a higher threshold for physician market power than for health plan market power) also does not reflect market power, and may understate the economic clout of a physician group. The 30% share limitation is based on the portion of physicians "in

the health plan service area or proposed service area." There is no reason, however, to expect that a health plan service area would necessarily represent an appropriate geographic market for the physician services in question. Indeed, geographic markets for physician services may vary by specialty. A health plan service area could well be broader that the geographic market for physician services, with the result that the 30% cap would not prevent aggregation of physicians with substantial market power within the service area negotiating with very small health plans.

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

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

Even if it were clear that the D.C. bill would not protect physicians' concerted refusals to deal with health plans, however, its authorization of collective bargaining would still present a serious risk of anticompetitive harm. As the Commission has previously observed, collective negotiations by their very nature can convey an implicit threat that if the health plan does not agree to terms acceptable to the physician group, the plan will be unable to obtain agreements with group members.[9] By immunizing, and thereby encouraging, agreements among physicians on the prices and other terms they will accept from health plans, the bill would facilitate coordinated conduct among physicians, such as collusive refusals to deal that, even though not immune, would be difficult to detect and prosecute. I would also note that the analysis that accompanies the AMA model legislation makes it clear that the bill's purpose is to allow physicians to exert "leverage" over payers in order to obtain more favorable terms. Thus, excluding concerted refusals to contract from the bill's protections would not appear to eliminate the coercive force of collective bargaining, or obviate concerns that the bill would increase the likelihood of concerted refusals to contract.

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

physicians will deal.

Immunity Issues

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

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

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

Section 6 of the bill provides that the representative who will negotiate on behalf of physicians must obtain approval from the Mayor to undertake negotiations. The Mayor is to withhold approval if "the proposed negotiations would exceed the authority granted under this act." Section 6(b). The Mayor is to make this determination within 30 days based on information identifying the representative, its plans and procedures, and "a brief report" identifying the proposed subject matter of the negotiations and the expected benefits to be achieved. In addition, the representative must furnish for the Mayor's approval, prior to dissemination, a copy of "all communications to be made to physicians related to negotiations, discussions, and health plan offers." The bill does not grant the Mayor the power to review and disapprove contract terms or other matters on the ground that they are unreasonable, unjust, or otherwise contrary to the interests of consumers.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own." *Patrick* at 106. It is not met where the reviewing state official does not evaluate the substantive merits of the private action. *Id.* at 102-105. Thus, the Court has held that a state did not actively supervise price arrangements when it did not establish the prices, review the reasonableness of prices, monitor market conditions, or engage in any "pointed reexamination" of the program. *Midcal*, 445 U.S. at 105-106. Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of

the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S.621, 634-35 (1992).

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

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

* * *

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

Sincerely,

Richard A. Feinstein
Assistant Director

Attachments

Endnotes

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

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

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

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

5. *See* 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).

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

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.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 37
() Publish Date:

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.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 37
() Publish Date:

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)(6), 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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STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

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February 5, 2001

Senator Robin Taylor
Chair, Senate Judiciary Committee
Mailstop: 3100, Room 30
State Capitol
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 provision that allow for significant and active state oversight. Other states have no history v legislation of this kind. Washington's law does not allow joint negotiations by physicians on price terms, and it includes 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,

BRUCE M. BOTELHO
ATTORNEY GENERAL

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

CES/sjm
Enclosures

cc: Senate Judiciary Committee Members
Senator Pete Kelly
Mike Abbot, Governor's Legislative Director
Chrystal Smith, Legislative Liaison, Department of Law

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THE ROLE OF ANTITRUST IMMUNITY IN THE WASHINGTON STATE [illegible]

REPORT TO THE WASHINGTON STATE LEGISLATURE
DECEMBER 15, 1995

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THE ROLE OF ANTITRUST IMMUNITY IN THE WASHINGTON STATE HEALTH CARE MARKET

I. EXECUTIVE SUMMARY

The Legislature directed the Attorney General 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. This report presents the arguments for and against immunity and provides empirical evidence of the role competition has played in the health care service market in Washington.

Representatives of the various segments of the health care industry were invited to provide input and submitted information in support of their claims for immunity. Several strong arguments were made in favor of immunity. Providers fear antitrust prosecution and claim such fear freezes their ability to move forward in the development of managed care programs. They claim that the antitrust laws prevent the development of seamless delivery systems which would result in better patient care. The need for a "level playing field" between providers, or providers and third party payers, was also cited as an argument for immunity. Finally, it was noted that many rural areas simply do not have the population base to support competition and thus it is argued that immunity should be granted for rural activities.

Opponents of immunity fear that it will result in higher prices and a decrease in quality and services. Competition is seen as a critical ingredient in the cost-conscious health care industry, with or without managed care. Immunity opponents also note that a regulatory scheme would be necessary to replace antitrust enforcement, to prevent marketplace abuses. Such a regulatory scheme would be costly and creates inflexibility in the system.

Empirical data and the economic study of Washington markets demonstrate significant beneficial effects from the presence of competition in Washington, for both the hospital and physician markets. Purchase data has been analyzed, along with anecdotal information. Based on the data provided, economics do not seem to support an argument for immunity.

Similarly, a review of the case law and enforcement guidelines in this area demonstrates that the perception of the threat of antitrust enforcement is much greater than would seem warranted by the actions taken. Many of the activities for which immunity is requested are already permissible under current antitrust law and enforcement guidelines.

The grant of antitrust immunity, especially in cases involving price-fixing and monopolization, could have a very significant impact on the competitiveness of managed care programs. Therefore, the benefits to be derived from immunity should be real, measurable and substantial. We were not presented with a single example by those in favor of immunity to support the existence of clear and measurable benefits to consumers that would result from activities permitted only if immunity is granted.

If the legislature deems that immunity is necessary, a wide variety of options exists. We have provided a comprehensive review of the immunity statutes passed by other states, as well as a survey of what state and federal enforcement action has been taken. The variety of approaches highlights the complexity of addressing this issue for the health care industry.

immunity.

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.

Robin Taylor, Chair Judiciary Committee
Alaska State Legislature
State Capitol (MS 3100)
Juneau, AK 99801-1182

Marta Poore
P.O. Box 9396
Ketchikan, AK 99901

February 8, 2001

Dear Senator Taylor,

I am writing in opposition to Senate Bill 37. This bill gives broad antitrust immunity to negotiations between individual competing physicians and health benefit plans. I am most concerned that this will allow physicians to obstruct opportunities for Advanced Nurse Practitioners to participate as providers in health benefit plans.

I am a Certified Nurse-Midwife with a private homebirth practice. I already have difficulty being recognized by health benefit plans as a preferred provider and get reimbursed at a lower rate than physicians despite the more intensive time spent preparing the woman for her homebirth. Studies have documented that nurse-midwives spend more time with the client, improve outcomes, lower costs, and increase satisfaction rates. In 1998, 16.7% of all Alaskan mothers chose a certified nurse-midwife to attend their births. I have had women who would have chosen homebirth with a midwife but their health benefit plan limited their options.

Health benefit plans do not need negotiation with Advanced Nurse Practitioners the way they do with physicians. There will be no incentive for them to make similar collective negotiations. It will just be bottlenecked even more that Advanced Nurse Practitioners must be practicing with a physician to obtain adequate benefit coverage and reimbursement. This will limit Alaskan women's choices.

Advanced Nurse Practitioners need the antitrust laws' protection. Please vote no on SB 37.

Sincerely,

Marta Poore

Marta Poore, CNM, MSN

Feb. 3, 2001

to: Senator Robin Taylor
RE: SB 37 pertaining to Nurse Practitioners

I was recently advised by my physician of 20 yrs. That he is opting out of Medicare because of low pay for his services and too much paperwork required.

This notice from my physician leaves me without medical care.

As a senior on a fixed income, the alternative I and other seniors have chosen is care from a Nurse Practitioner.

SB 37 threatens the careers and livelihood of Nurse Practitioners in Alaska.

NPs, skilled and caring medical providers that they are, also need adequate pay just the same as physicians do and NPs must be paid by insurance companies for their services.

SB 37 is not in the best interests of Alaskans and I urge you to defeat SB 37.

Sincerely,

Gerald "Jerry" Bohms
P.O. Box 80155
Fairbanks, Alaska 99708
(907) 479-6970

(I came to this great State in 1948)

Letter of Opposition

ALASKA STATE MEDICAL ASSOCIATION

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

February 5, 2001

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

RE: SB37- Physician Joint Negotiations

Dear Senator Taylor:

Thank you for the opportunity to provide testimony at the January 22, 2001 Senate Judiciary Committee hearing on SB37. The testimony provided by various people suggests that further commentary is necessary. Additionally, you asked me a specific question pertaining to the comments made by Ms. Sarcone in regards to advanced nurse practitioners.

In regard to the question you asked me regarding Ms. Sarcone's comments, in responding I overlooked another protection already in Alaska insurance law. AS21.36.090 (d) prohibits an insurer, HMO, or hospital or medical service corporation from un-fairly discriminating in its benefits between different types of medical care providers. In essence, so long as the service provided by the practitioner falls within that practioner's licensed scope of practice, they cannot be discriminated against in the benefit plan. Advanced nurse practitioners and nurse midwives are both specifically listed in AS21.36.090(d).

Ms. Katie Cambell of the State Division of Insurance commented that three studies indicated that anti-trust relief would result in increased costs in the health care system. Several clarifying comments need to be made. First, all three studies were of H.R.1304 (the "Campbell Bill") which provided for no oversight of the process as provided for in SB37. Next, the authors of the various studies (primarily the Rivers Study and the Pennsylvania State University study) disagree as to the validity of each other's assumptions. The Penn State Study also reviewed the potential benefits and came up with an estimate of benefits that exceeded the costs which it arrived at. The bottom line is no one knows what the cost or benefits will ultimately be. That is why SB37 contains a "sunset provision" of five years.

You also need to keep in mind that the big "cost drivers" in health care are new technology and the aging population. Also, expenditures for physician services are estimated to be in the 16% to 20% range of total health expenditures.

Ms. Campbell stated that fees for a service are not negotiated. That is true because of the current anti-trust situation. Additionally, ASMA is not aware of any physician services agreement being

offered on other than a "take it or leave it" basis. Attached is a copy of a Blue Cross of Washington and Alaska's (BCWA) "Participating Physician Agreement" as well as a comparison of that contract with the American Medical Association's model agreement. BCWA's agreement states it pays the "BCWA allowable amount" for a covered service. However, no definition of the allowable amount is contained in the contract nor were any "allowable amounts" appended to the contract. It is also interesting to note that in the BCWA contract in II.C that the physician even bears the risk of insolvency on behalf of BCWA. Such contracts are what precipitated the inclusion of provisions in Alaska's Patient Bill of Rights (HB211), enacted last year, that call for these types of contracts to include provisions that specify that the physician is to be paid for the service rendered (AS21.07.010 (a)).

Ms. Campbell also made a curious statement that indicated the she felt that SB37 would help to discourage new players from entering the Alaska marketplace. Managed care runs an entire continuum ranging from an indemnity type plan with a hospital pre-authorization requirement to a full "bricks and mortar" HMO that occupies buildings and has physician employees. One aspect of many managed care type plans is to have a panel of preferred providers that covered people are incentivized to see (e.g., through lower deductibles, higher co-pays, etc.). One difficulty facing a health insurer entering the Alaska marketplace with such a product is the ability to cost effectively enroll a panel of participating physicians. It would seem that it would be more cost effective if an insurer in this position could negotiate with a defined group of physicians as opposed to individual doctors. I suppose such an insurer could mail a contract to each physician on a "take it or leave it" basis but I would guess such an approach would not work. I am curious what the Division of Insurance is doing and/or plans to do to attract new health insurers to the Alaska market.

Mr. Sniffen, Assistant Attorney General, made a number of comments that elicit follow up commentary or clarification. First, it was my recollection and understanding that, in the Senate Finance Hearing on SB256 of 2/25/2000, Richard Feinstein testified on his own behalf and not as a representive of the Federal Trade Commission (FTC).

Mr. Sniffen is correct in that a key element is that actual state supervision must take place for the State Action Doctrine to be function. However, what constitutes the appropriate state oversight is based on the interpretation of a number of seminal cases, which Mr. Sniffen cites. However, not all learned attorneys hold the same interpretation. It appeared for example, that at least an inference was made that a "public utility" style price setting mechanism would have to be in place for the active state oversight condition to be met. I believe Mr. Sniffen was referring to the Ticor case. His is one interpretation. Others have arrived at a different interpretation. It is my understanding that the Ticor case involved title insurance companies in 4 states, which were alleged by the FTC to have engaged in illegal price fixing in setting fees for title searches and examination. A state licensed rating bureau established uniform rates for title searches and examinations, which was permitted under state statutes. The Ticor case, in part, dealt with a state "negative option" approach to reviewing the rates. In other words, the rates were allowed when the state did not either explicitly accept or reject a rate filing. (This is a "deemer" approval scheme used by many state insurance regulatory agencies). The court found this "negative option" approach did not constitute an appropriate level of active state oversight. However, its my understanding that the Ticor case is quite ambiguous and like the others are very fact specific; and does not give a clear indication of what in a more universal since would

provide oversight that meets the test. Apparently, some filings were never reviewed and others only checked for arithmetic accuracy. We feel that SB37 provides the framework for appropriate active oversight to take place and gives the authority to the Attorney General to "fine tune" that framework by the promulgation of regulations. Mr. Sniffen also alluded to other mechanisms currently available to physicians that assumedly would eliminate the need for a bill like SB37. I assume he was referring to the mechanisms of the "messenger model" and the "fully integrated practice model." First, the messenger model has not effectively worked anywhere. In effect, this allows an authorized representative to represent a number of physicians in a negotiation. However, the negotiation must be done on each physician's behalf, individually, with the offer/ acceptance/ negotiation cycle done separately.

The "fully integrated practice model" requires that a group of physicians, in essence, cease separate practices and fully financially and clinically integrate their practices into a single entity. Individual clinical and financial autonomy must be relinquished by each individual physician. Ironically, it would seem such an aggregation runs counter to a more competitive market place. Also, a study sponsored by the American Medical Association, American Academy of Dermatology, American Academy of Pediatrics, American College of Radiology, American Society of Plastic and Reconstructive Surgeons, Michigan State Medical Society, and the South Carolina Medical Association indicates that merging physician practices is costly at the outset and results in an increased overhead for future operations. (Case Study Analysis of Physician Practice Mergers, 1998) Again, an irony in a suggestion of a mechanism that would add to the cost which is a stated outcome trying to be avoided.

As mentioned earlier, determination of what will be make this State Action Doctrine work is situational and fact driven. A big determining factor is the state of the marketplace and all of its facets. As you may be aware a Fairbanks IPA has been involved in a dispute with the FTC which has resulted in a proposed consent decree. The comments made by FTC Commissioners Swindle and Leary, as well as the comments from the AMA and ASMA are illustrative of that situation. I thought those may be of interest to you and have included copies for you. (I've not included all of the various documents involved in the case due to their length. However, you can find those documents at www.ftc.gov for actions on September 20, 2000 for FTC v. Alaska Healthcare Network.)

I hope the foregoing provides you with meaningful information. Let me know if I can provide any further information.

Sincerely,

James J. Jordan
Executive Director

cc: Senator Pete Kelly

sarcone

sarconecnm@yahoo.com

1444 hillcrest drive
anchorage, alaska 99503

telephone 907-272-4047
fax (call first)

January 24, 2001

RECEIVED
JAN 26 2001
Ans'd.....

Senator Robin Taylor
Alaska State Legislature
Juneau, Alaska 99801

Dear Senator Taylor:

Thank you very much for the opportunity to testify regarding SB 37 at the January 22nd meeting of the Senate Judiciary Committee. I appreciate your careful listening and thoughtful questions. I am enclosing a copy of my testimony for your information and review.

Please feel free to contact me if I can answer any questions or be of assistance in any way.

Sincerely,

Laura Sarcone

Laura L. Sarcone, CNM, MS

PS Please excuse my left-handed signature. My right arm is in a cast.

I AM TESTIFYING TODAY IN OPPOSITION TO SENATE BILL 37, WHICH WOULD GIVE BROAD ANTITRUST IMMUNITY TO NEGOTIATIONS BETWEEN INDIVIDUAL COMPETING PHYSICIANS AND HEALTH BENEFIT PLANS. THIS BILL WOULD PROTECT PRICE FIXING, DRIVE UP HEALTH CARE COSTS, AND LET PHYSICIANS OBSTRUCT OPPORTUNITIES FOR ADVANCED NURSE PRACTITIONERS TO PARTICIPATE AS PROVIDERS IN HEALTH BENEFIT PLANS.

ADVANCED NURSE PRACTITIONERS ARE HEALTH CARE PROVIDERS WHO INCREASE ACCESS, IMPROVE OUTCOMES, LOWER COSTS, AND INCREASE SATISFACTION RATES. THEIR SCOPE OF PRACTICE UNDER ALASKA LAW RECOGNIZES THE VALUE OF THE SERVICES THEY PROVIDE TO THE CITIZENS OF OUR VAST AND DIVERSE STATE.

SENATE BILL 37 GIVES PHYSICIANS LEVERAGE TO LEGALLY ESTABLISH SOME OF THE MORE ONEROUS ANTICOMPETITIVE PRACTICES, SUCH AS PRICE FIXING, WHILE AT THE SAME TIME ELIMINATING OPTIONS FOR THE PUBLIC OR INDIVIDUAL PROVIDERS TO CHALLENGE SUCH CONDUCT AND PRACTICE. CONSUMERS, EMPLOYERS, AND THE STATE AND FEDERAL GOVERNMENT, AS PURCHASERS OF HEALTH CARE, WOULD BE STRIPPED OF ANY REMEDY FOR HIGHER PRICES. STATE AND FEDERAL ANTITRUST LAW ENFORCEMENT WOULD BE BARRED.

PHYSICIANS CAN ALREADY FORM PHYSICIAN-ONLY INDIVIDUAL PRACTICE ASSOCIATIONS, OR "IPAs," AND NEGOTIATE AS A GROUP WITH HEALTH BENEFIT PLANS. SB 37 WILL ALLOW PHYSICIANS TO FORM CARTELS AND NEGOTIATE WITH HEALTH BENEFIT PLANS. THE SPECIAL ANTITRUST PROTECTIONS AFFORDED PHYSICIANS BY SB 37 ARE NOT AVAILABLE TO ANY OTHER SELF-EMPLOYED PROFESSIONALS.

THE IMMUNITY PROPOSED IN SB 37 IS UNNECESSARY. ANTITRUST LAW ALREADY PROVIDES A REMEDY AGAINST ANTICOMPETITIVE ABUSES BY

HEALTH BENEFIT PLANS IN THEIR DEALINGS WITH HEALTH CARE PROVIDERS. STATE AND FEDERAL LAWS AND INITIATIVES CAN ADDRESS THE PRACTICES OF HEALTH BENEFIT PLANS. PERMITTING PROVIDER CARTELS WILL NOT SOLVE PROBLEMS, IT WILL ONLY CREATE NEW ONES. THIS BILL WOULD BE PARTICULARLY HARMFUL TO ADVANCED NURSE PRACTITIONERS AND CERTIFIED NURSE-MIDWIVES, WHOSE EXPANDED ROLE IN HEALTH CARE HAS OFTEN BEEN OPPOSED BY PHYSICIANS.

ADVANCED NURSE PRACTITIONERS AND CERTIFIED NURSE-MIDWIVES ARE HEALTH CARE PROVIDERS WHO INCREASE ACCESS, IMPROVE OUTCOMES, LOWER COSTS, AND INCREASE SATISFACTION RATES. IN 1998 OVER 1400 ALASKAN MOTHERS CHOSE A CERTIFIED NURSE-MIDWIFE TO ATTEND THE BIRTH OF THEIR BABY. THAT REPRESENTS 16.7% OF ALL VAGINAL BIRTHS THAT OCCURRED IN THE STATE THAT YEAR.

IT HAS BEEN SAID THAT THIS BILL DOES NOT AND CANNOT IMPACT OTHER CONTRACTUAL RELATIONSHIPS, SUCH AS ONE BETWEEN AN ADVANCED NURSE PRACTITIONER AND A HEALTH BENEFIT PLAN. LET ME OUTLINE FOR YOU WHAT COULD HAPPEN.

- AFTER NEGOTIATING A "BEHIND CLOSED DOORS" CONTRACT WITH A GROUP OF PHYSICIANS, A HEALTH BENEFIT PLAN ELECTS NOT TO RENEW, OR ENTER INTO, A CONTRACT WITH AN ADVANCED NURSE PRACTITIONER
- THE A.N.P. BELIEVES THAT SOME ASPECT OF THE PHYSICIAN CONTRACT HAS INFLUENCED THIS DECISION, EFFECTIVELY SERVING AS A RESTRAINT OF TRADE
- UNDER SB 37 THE A.N.P. HAS NO RECOURSE. ALASKANS INSURED BY THAT HEALTH PLAN HAVE LOST THE OPTION TO CHOOSE NURSE PRACTITIONER OR NURSE-MIDWIFERY CARE

SB 37 LEGISLATES AWAY IMPORTANT TRADE AND PRACTICE PROTECTIONS THAT ADVANCED NURSE PRACTITIONERS AND OTHER NON-PHYSICIAN PROVIDERS CURRENTLY ENJOY.

SOME HAVE SUGGESTED THAT ADVANCED NURSE PRACTITIONERS COULD CREATE THEIR OWN BILL, ALLOWING THEM TO ALSO NEGOTIATE COLLECTIVELY WITH HEALTH BENEFIT PLANS. THE REALITY OF THE HEALTH CARE MARKET PLACE IS THAT HEALTH BENEFIT PLANS MUST NEGOTIATE WITH PHYSICIANS. THEY NEED PHYSICIANS IN ORDER TO CONDUCT THEIR BUSINESS AND OFFER A FULL RANGE OF MEDICAL SERVICES. THEY DO NOT NEED ADVANCED NURSE PRACTITIONERS IN THE SAME WAY. ADVANCED NURSE PRACTITIONERS WILL NEVER HAVE THE MARKET SHARE OR BARGAINING POWER OF PHYSICIANS. ADVANCED NURSE PRACTITIONERS WANT TO CARE FOR PATIENTS AND DO BUSINESS IN THE MARKET PLACE WITH THE ANTITRUST LAWS' PROTECTION. WE DO NOT NEED OR WANT TO BE PROTECTED FROM THE ANTITRUST LAWS.

IN CONCLUSION, ADVANCED NURSE PRACTITIONERS AND CERTIFIED NURSE-MIDWIVES ARE HEALTH CARE PROVIDERS WHO INCREASE ACCESS, IMPROVE OUTCOMES, LOWER COSTS, AND INCREASE SATISFACTION RATES. CONSUMERS IN ALASKA WANT TO CHOOSE THE HEALTH CARE PROVIDER WHO BEST MEETS THEIR NEEDS. SENATE BILL 37 WILL BOTH LIMIT CHOICE AND INCREASE COSTS. ALASKANS DESERVE BETTER.

Separate Statement of Commissioners Orson Swindle and Thomas B. Leary

In *Alaska Healthcare Network, Inc.*, File No. 991 0103

Although we have voted to accept the consent agreement in this matter because we believe the conduct remedy is justified, we also believe that one component of the relief prescribed by the proposed order -- namely, the inclusion of a form of "structural" remedy to help cure the effects of respondent AHN's allegedly unlawful conduct -- is inappropriate in this particular case.

If AHN elects to function as a negotiator or merely as a "messenger," then Paragraph III of the proposed order will for five years impose, respectively, either a 30 percent or a 50 percent "cap" on the number of Fairbanks physicians in each of five "relevant physician markets" who may participate in AHN. Although we believe that limits on a physician group's "market shares" in particular specialties can be appropriate fencing-in relief for the type of conduct involved in this case, we are not persuaded that this provision will operate in a rational and predictable way in a market as small as Fairbanks. This concern is exacerbated by the first proviso to Paragraph III, which allows respondent to "grandfather" in "any one pre-existing practice group" -- no matter how large -- and thus to perpetuate a structure inconsistent with the goals of that paragraph.

The imposition of such structural relief in a setting like Fairbanks results in anomalies that would not arise in a larger urban area. For example, one of the five "relevant physician markets" affected by the order (pediatrics) has only seven practitioners, and five are in a grandfathered group; another "market" (ob/gyn) has only ten practitioners, six of whom are in a grandfathered group. We can certainly understand the desire to refrain from forcing the breakup of a presumably efficient practice group, but this proviso makes the percentage caps ineffective for those specialties. On the other hand, the order itself potentially inhibits the formation of similarly efficient practice groups in the specialties where the caps are effective.

Some form of structural relief might well be warranted in future cases in which the efficacy of a purely "conduct" (*i.e.*, "cease-and-desist") order is in doubt. A formerly collusive group's compliance with the dictates of a conduct order (through the cessation of overtly conspiratorial behavior) does not necessarily spell the end of tacit coordination in the future. In a market with different characteristics from those involved in this case, some type of percentage cap on network membership could go a long way to bolster competition through the creation of one or more competing networks. In this market, however, we question whether the remedy makes sense.

We hope that the public comment period on this consent agreement will yield some illuminating advice from the bar, the medical community, and the public at large, both with respect to the general appropriateness of structural measures in "conduct" cases and with regard to whether such measures make sense in a thinly populated market such as Fairbanks.

American Medical Association
Physicians dedicated to the health of America

E. Ratcliffe Anderson, Jr., MD
Executive Vice President, CEO

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

October 20, 2000

Mr. Donald Clark, Esq.
Office of the Secretary
Federal Trade Commission
600 Pennslyvania Avenue, N.W.
Washington, D.C. 20580

Re: Comments of the American Medical Association to the Consent Agreement and Order Entered In *In Re Alaska Health Network, Inc.*, File No. 991-0103

Dear Mr. Clark:

On September 20, 2000, the Federal Trade Commission (FTC) entered its proposed Consent Agreement and Order (Consent Agreement) in *In re Alaska Healthcare Network, Inc.*, File No. 991-0103. The American Medical Association (AMA) files these Comments in response to the terms of the proposed Consent Agreement.

I. INTRODUCTION

In addition to penalties aimed at AHN's conduct, the Consent Agreement contains penalties intended to restructure AHN. The Consent Agreement permits Alaska Health Network, Inc. (AHN) to, *inter alia*, act as a messenger to qualified financial or clinically integrated "joint arrangements", provided the participating physicians in AHN constitute no more than 30% of physicians in the relevant physician market. AHN may be messenger to "any other arrangement", provided the participating physicians in AHN constitute no more than 50% of the relevant physician market. Further, the proposed decree includes a "grandfathering" provision, which permits AHN to exceed the market share limits set by the FTC, in order to accommodate any single physician, or any one pre-existing practice group.

Two dissenting commissioners note the anomalies created by the structural element of the proposed settlement. In light of the sparse physician population in Fairbanks, the grandfathering provision allows AHN to exceed the 30% and 50% caps set by the Consent Agreement, rendering those caps, and any presumed procompetetive benefits emanating from the caps, meaningless. Conversely, the grandfathering provision may discourage

nascent competition among certain medical specialties in Fairbanks, by allowing potential competitors to AHN to join AHN, instead. In sum, the dissenters contend, while the structural component of the settlement may be appropriate in some areas of the country, the small physician population pools typically found in thinly populated areas like Fairbanks make such schemes impractical for all but urban locations.

The AMA agrees with the dissenting commissioners that a structural settlement should not be used. The AMA believes that the use of a structural settlement is unnecessary, because settlement terms aimed at adjusting conduct can better achieve the FTC's goal of restoring true balance to the marketplace. The AMA also believes that the presumptions underpinning structural settlements demonstrate a misunderstanding of the economic power wielded by physicians in the marketplace. Structural settlements are inappropriate for any physician joint venture that attempts to contract with managed care organizations (MCOs), and particularly inappropriate for joint ventures located in lightly populated communities.

II. THE FTC SHOULD NOT IMPOSE STRUCTURAL REMEDIES ON PHYSICIAN JOINT VENTURES ATTEMPTING TO CONTRACT WITH MANAGED CARE ORGANIZATIONS.

A. Structural Settlements for Physician Joint Ventures Undermine the Aims of the FTC

The AMA finds the structural element of a consent decree, as applied to a physician joint venture that attempts to contract with MCOs, unnecessary and antithetical to the stated goals of restoring balance to the health care market place. In 1996, the FTC issued its Statements of Antitrust Enforcement Policy in Health Care (Statements). The Statements identify conduct by physician joint ventures that the FTC finds violative of antitrust laws. The Statements indicate that, while the government notes the portion of the physician market place held by a physician joint venture, the FTC places greater emphasis on whether, on balance, joint ventures exhibit other anti-competitive behavior:

> "For example, physician network joint ventures in which the physician participants share substantial financial risk, but which involve a higher percentage of physicians in a relevant market than specified in the safety zones, may be lawful if they are not anti-competitive on balance. Likewise, physician network joint ventures that do not involve the sharing of substantial financial risk also may be lawful if the physicians' integration through the joint venture creates significant efficiencies and the venture, on balance, is not anti-competitive."

Further, in a 1998 address, "Antitrust Issues Raised By Rural Healthcare Networks"[1] then-FTC counsel Robert Liebenluft stated that the FTC "focus[es] not on the form that networks

[1] Presented at a meeting of the Network Development Grantees sponsored by the Federal Office of Rural Health Policy, U.S. Dept. of Health and Human Services, Washington, D.C., February 20, 1998.

take, but on their potential for providing real efficiencies in the particular marketing context in which they operate, and on the relationship of any price agreement among competing providers to the production of those efficiencies." In the absence of evidence of market restraint, according to the FTC, the presence of presumptively anti-competitive practices or forms are not *a fortiori* unlawful.

In *In Re AHN*, the FTC has proposed settlement terms directed to AHN's allegedly anti-competitive conduct. Pursuant to the settlement, AHN cannot enter into any agreement with physicians to: negotiate on behalf of any physicians; deal with payors or providers; or restrict the ability of any physician to deal with a payor or provider. The agreement also curtails activity by AHN as a "messenger" between physicians and payors. This behavioral correction goes to the heart of restoring the balance the FTC seeks to return to the market place. By these measures, the FTC will achieve the goal that it has previously stated is of paramount importance to the FTC, namely, achieving pro-competitive harmony in the market. Thus, the additional structural measures imposed on specialist participation in *AHN* are entirely unnecessary.

Additionally, the limit set on the number of physicians allowed to participate in AHN is remarkably similar to the caps on physician participation set forth in the 1996 Statements' "safety zones". While the FTC has cautioned that the safety zones are merely a starting place for antitrust analysis, and that they do not, alone, establish the parameters of competitive conduct, the use of the same numbers in this case belie the FTC's promises of flexibility in its scrutiny of physician joint ventures. Whether it is merely convenient to apply a formula already used as an example by the FTC, or whether the FTC truly intends to use the safety zones as absolute limits of lawful conduct, the fact remains that the FTC, by incorporating these limits into a consent decree, is using supposedly illustrative and voluntary safety zones in a mandatory fashion.

B. Health Plans Pose A Greater Threat to Consumer Choice Than Physician Joint Ventures

The application of a structural element in the AHN proposed settlement also indicates a continuing misapprehension by the FTC of the power physician joint ventures can wield in the marketplace. The focus on physician joint ventures is unwarranted and unfair, when compared to the consolidation of, and resources available to, the managed care entities with which they must contract. As the AMA has previously observed, the federal government has failed to adequately scrutinize the obviously anti-competitive practices embraced by the managed care industry. See, e.g., Testimony in Support of H.R.1304, the Quality Health Care Coalition Act of 1999, presented by E. Ratcliffe Anderson, Jr., M.D., to the House Judiciary Committee, June 22, 1999; American Medical Association Discussion Paper on Aetna/U.S. HealthCare Acquisition of Prudential Health Care, January, 1999. One of these practices is consolidation among managed care providers. Since 1994, the 18 largest health plans in the country have, through mergers and acquisitions, thinned down to just six – Aetna, Cigna, United HealthCare, Foundation Health Systems, Pacificare and Wellpoint

Health Networks. A review of market shares of health plans in 25 states found that the largest five insurers have more than 50% of the covered lives in 23 states, and in 16 of those states, more than 70%.[2]

As a consequence of this unchecked consolidation, physicians and managed care entities do not play on a level field. By allowing these health plans to so thoroughly dominate the market, the FTC robs physicians of real bargaining power with the health plans. Consequently, physicians are subjected to "take it or leave it" contracts that dictate reimbursement and coverage terms to the physicians. These same contracts frequently contain non-negotiable "gag" and all product clauses, and fee schedules subject to unilateral change by the health plan. These contracts are the product of coercion, not genuine bargaining. They unreasonably constrict the physicians' choices and, inevitably, threaten the quality of patient care and the physicians' livelihood.

Similarly, the vast majority of physician groups lack the resources, expertise and legal sophistication to negotiate effectively with MCOs and other health plans. A mere 200 of the group practices nationwide exceed 100 doctors. As noted by Professor Clark Havighurst of the Duke University School of Law, most physicians in solo or small group practices face "severe practical difficulties... in marketing their services to numerous large buyers." Havighurst, *Are the Antitrust Agencies Overregulating Physician Networks?* at 5 (Draft Paper, forwarded to FTC, November 16, 1995). Thus, in part because of the current antitrust laws, these entities have little power compared to the monolithic health plans:

> "[T]here are many markets in which doctors can no longer reasonably hope to forestall unwanted developments by banding together. Too many large purchasers...now have the incentives, the tools, the bargaining power, and the independence they need to prevent doctors from exercising market power. Selective contracting and discounting of physician fees in return for assured patient load are now common practices. In addition, integrated health care systems, combining in various ways the functions of financing and delivery, are being constructed by many players and are now significant factors in most local markets. Although there remain some places where the doctors' old strategies may still be capable of heading off unwanted change, the market forces that have been unleashed in most communities cannot easily be reversed by counter-revolutionary professional action. In most circumstances, antitrust enforcers should no longer presume that physician collaboration that is not certifiably innocuous is intended to restrain trade rather than to achieve efficiencies or to offer purchasers a fuller range of health care options.' Suspicions that were well justified when physicians possessed the means of controlling their economic environment are not generally justified today." *Id.*

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[2] MCO consolidation in Alaska is even worse. According to ASMA, "[t]he dominant participants in the [Alaska] market are Aetna and Premera Blue Cross represent well over 50% of the entire Alaska health plan market."

Physicians also generally lack the ability to participate in development of MCOs or other health plans that could compete with the highly consolidated commercial managed care players. High barriers to entry include, for example, the fact that states often require HMOs to demonstrate a net worth of one to two million dollars and to deposit with the state cash or securities amounting to several hundred thousand dollars.

Despite the obstacles to meaningful physician bargaining power in the market place, the FTC has left health plans virtually untouched, while aggressively targeting physician groups for alleged antitrust violations. An insistence on enforcing a structural settlement, where the parties have already agreed to correct the supposedly unlawful conduct, would be one more example of this misplaced enforcement attention.

III. STRUCTURAL SETTLEMENTS ARE INAPPROPRIATE FOR THE SMALL TOWN AND RURAL MARKETPLACE

Even if the FTC concludes that structural settlements serve, as a general proposition, a valuable purpose in the enforcement of antitrust laws against physician joint ventures, such structural settlements should not be employed in sparsely populated areas. The enforcement of a structural settlement in Fairbanks is contrary to opinions previously expressed by the FTC about appropriate responses to anti-competitive behavior in rural areas. It is also a method that the FTC has not used in locations with similar demographics.

A. Structural Settlements Are Contrary To The FTC's Goals For A Market With A Small Population

In his speech "Antitrust Issues Raised by Rural Healthcare Networks", Mr. Liebenluft expressed concern about the "participation of a substantial proportion of providers in a network:"

> "One [concern] is that the joining together of most or all providers in a market, as a practical matter, may make formation of other networks unlikely, in a situation where operation of competing networks might be feasible and beneficial to consumers. This can occur because cooperation of competitors in even a legitimate joint undertaking may dull the incentives of the participants to continue to compete vigorously with one another outside the joint venture. Another concern flows from the possibility that the venture may result in the exchange of competitively sensitive information that facilitates implicit collusion among the participants to limit competition outside the venture. The higher the proportion of available competitors represented in the joint venture, the greater is the potential impact of these effects on the market as a whole."

The FTC's decision in this case seems squarely at odds with the concerns expressed in the preceding paragraph. As noted by the dissenting commissioners, the grandfathering provision of the structural element would allow the vast majority of physicians in certain specialties to join a single joint venture. In the words of the FTC, the grandfathering provision will inhibit the growth of other networks, or facilitate collusion among network participants. This result, in turn, will inhibit the growth of potential competitors, and thereby jeopardize the goals sought to be achieved by the conduct-altering settlement terms.

Even in the absence of the grandfathering option, the cap on physician participation is ill-conceived. As explained in the prior section of these Comments, the structural element is a superfluous addition to the conduct-oriented terms of the Consent Agreement. Additionally, the comments submitted by the Alaska State Medical Society (ASMA) on October 17, 2000, demonstrate that a structural settlement will do more than just encourage a non-competitive health care environment. The structural element could exact a personal toll on physicians and patients in the Fairbanks area. As ASMA explains, the number of physicians practicing in Alaska is comparatively low. Thus, any impediments to practice that discourage needed specialists from relocating to Alaska can quickly lead to burn-out of physicians already in the state. Poorly performing physicians can, in turn, pose a danger to the public health.

B. Prior FTC Settlements In Rural And Small Markets Did Not Employ Structural Settlements

Further, the majority's assurances that structural settlements have been employed before are unpersuasive. The two prior consent agreements on which the majority relies are readily distinguishable from the present facts. In *In re Home Oxygen & Medical Equipment Co.*, 118 F.T.C. 661 (1995), 60% of the pulmonologists in Alameda County, California, owned an interest in Home Oxygen and Medical Equipment Company (Home Oxygen), a company that supplied oxygen delivery systems to patients in need of supplemental oxygen. Alameda County includes the City of Oakland, California. The FTC alleged that Home Oxygen created a barrier to entry in the market and inhibited free and open competition. In pertinent part, the consent agreement in *Home Oxygen* decision prescribed a 10 year prohibition on granting or acquiring an ownership interest in any entity that sold, leased or treated oxygen delivery systems, if more than 25% of the pulmonologists in the relevant area were affiliated with the entity.

In the present matter, the relevant market is a town of 30,000, with a "metropolitan" region of only 80,000. The nearest city of any notable size is over 300 miles away. Further, as the FTC admits, of the few physicians practicing in the market, not all are year-round residents. Presumably, therefore, at certain times of the year, the physician population is even smaller than the numbers described in the Consent Agreement. Thus, the structural element of the proposed settlement in this case will have a much greater impact on the relevant provider population in Fairbanks than in a large urban market like Oakland, California. Indeed, one

of the dissenters to the *Home Oxygen* remarked that an urban population dilutes a market share that might otherwise raise a suspicion of anti-competitive conduct.

> "Assuming *arguendo* that the alleged product and geographic markets are relevant antitrust markets, these market shares alone do not justify an inference of market power. In addition to the respondents, the evidence indicates that there are nine competing sellers of home oxygen in Alameda County and eight competing sellers in Contra Costa County. Some of these firms have market shares of about 10%."

In *Physicians Group, Inc.*, 120 F.T.C. 567 (1995), the FTC ordered dissolution of an IPA located in Pittsylvania County and Danville, Virginia, for alleged conspiracy to prevent or delay the entry of third party payors into the area. Assuming that the affected market included a relatively small population (and the order gives no indication that it did), the FTC neglected to describe the market share allegedly held by the IPA, and how many physicians in the area were not affiliated with the IPA. Therefore, any comparison with the structural settlement imposed in this case is meaningless, since comparable data is unavailable for the *Physicians' Group* case.

The scenario existing in Fairbanks is more like the fact patterns in *In re Mesa County Physicians Independent Practice Association, Inc.*, 1999 F.T.C. Lexis 67 (May 20, 1999) and *In re Montana Associated Physicians, Inc.*, 123 F.T.C. 62 (1997). Both cases emanated from rural areas and involved IPAs that, like AHN, employed a "messenger" model. Nonetheless, the FTC did not cite either decision in its analysis of the Consent Agreement.

In *Mesa County*, the Mesa County IPA served the city of Grand Junction, Colorado (population 37,600). The IPA's physicians constituted 85% of the physicians in Mesa County, including 90% of the primary care physicians. The FTC charged that Mesa County IPA contracted with Rocky Mountain HMO but discouraged its physicians from contracting with other third party payors, or encouraged them to do so only on terms approved by Mesa County IPA. As a result of Mesa County IPA's conduct, a large number of third party payors were allegedly excluded from doing business in Mesa County.

The consent decree subsequently entered against Mesa County IPA ordered penalties directed to the IPA's conduct that were similar to conduct–oriented penalties proposed in this case. For example, Mesa County IPA could not negotiate on behalf of any participating physicians with any payor or provider, nor could Mesa County IPA deal or refuse to deal with any payor or provider or determine any terms upon which providers and payors could deal with each other. However, the *Mesa County* consent decree contained no structural elements. Apparently, the FTC believed that it could restore equanimity to the health care market in Mesa County by correcting anti-competitive conduct alone without adding a layer of structural sanctions. See also *In re Montana Associated Physicians, Inc.*, 123 F.T.C. 62 (1997)(IPA comprised of 43% of all Billings physicians, and 80% of all physicians not part of a specialty practice or employed by a hospital. IPA was punished for

alleged anti-competitive conduct with third party payors, but no structural penalties were imposed by the FTC).

Adequate Oversight of the Proposed Settlement May Be Achieved Without a Structural Settlement

Finally, the majority contends that the structural element of the consent decree is necessary to avoid "detailed oversight" by the Commission. The FTC's contention lacks merit. The Consent Agreement already incorporates stringent oversight by the FTC, in the form of frequent and detailed reporting requirements for AHN to prove that it is in compliance with the Agreement. AHN must, for instance, file reports every 60 days, for five years, identifying payors contacted by AHN, demonstrating shared financial risk by participating physicians, and providing minutes of annual meetings. AHN must also, for a period of 10 years, notify the FTC of actions furthering qualified joint risk sharing arrangements between physicians and any other arrangement involving third party payors and AHN acting as agent for two or more Fairbanks physicians.

IV. CONCLUSION

The AMA urges the FTC to reconsider the terms of the proposed Consent Agreement. The attempt to restructure AHN according to arbitrary market shares is unnecessary at best and, at worst, will so constrict the Fairbanks physician population as to undermine the aims intended by the sanctions.

Sincerely,

E. Ratcliffe Anderson, Jr., MD

cc: James J. Jordan
Michael L. Ile, JD
Anne M. Murphy, JD
Ross N. Rubin, JD
Carolyn Quinn, JD

Alaska State Medical Association

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

October 17, 2000

Federal Trade Commission
Office of the Secretary
600 Pennsylvania Avenue, N.W.
Washington DC 20580

RE: In the Matter of Alaska Healthcare Network, Inc. File No. 991-0103

Dear Commissioners:

The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them. ASMA appreciates the opportunity to provide commentary in the above subject matter. ASMA understands that the allegations made by the FTC are just that, allegations; and that the agreement to be entered into by Alaska Healthcare Network, Inc. (AHN) does not constitute any admission of wrongdoing, or that the facts alleged by the FTC are true.

ASMA's comments fall into two general categories. The first being related to an element in the Decision and Order which defines the term "payor". The second category relates to the characterizations made about the Alaska, medical market place.

In the Decision and Order relating to this matter, a definition of term "payor" is found. Included in that definition of "payor" is the clause "government health benefits program". The inclusion of this clause would seem to imply that any organization of independently practicing physicians could not jointly deal with government or its agent unless it complied with appropriate guidelines regarding anti-trust. (e.g., such would not be allowed unless, for example, the group of physicians was fully clinically and financially integrated.) The logical extrapolation would be that an organization such as ASMA could not deal with HCFA or one of its agents regarding Medicare reimbursement issues. The same would hold true for Tri-care and the various governmental agencies involved with that system. (For your information, federal government officials have asked ASMA to work with them specifically regarding payment issues in Alaska). It is ASMA's understanding that the ability to collectively interact with the government is protected by the United States Constitution. It would appear that the inclusion of government health benefits program in the definition of payor would be unconstitutional.

ASMA's review of the Complaint, Decision and Order, Agreement Containing Consent Order, and the Analysis of Agreement Containing Consent Order to Aid Public Comment leads to the conclusion that the Alaska market place is not understood. The separate statement made by Commissioners Arron Swindle and Thomas B. Leary is predicated on what would seem to be the same conclusion (particularly for the "structural" remedy included). In part, Swindle and Leary state "..., we are not persuaded that this provision will operate in a rational and predictable way in a market as small as Fairbanks. ...". ASMA contends that same statement holds true for the entire state. Alaska is huge geographically but extremely small population wise. The majority of our population is concentrated in a few locations (e.g., Anchorage, Fairbanks, and Juneau) with the rest dispersed over an area twice the size of Texas. These cities that contain the majority of

our population are the service centers for the entire State, which includes medical care and particularly specialty care. The "private" payor health plan marketplace is miniscule when you remove those people covered under governmental plans (notably federal employees, military personnel and their dependents, and Alaska Natives). Attachment A to the Decision and Order is an indication of the market for health plans in Alaska. (ASMA believes that some entities named are not identified correctly. "Adar Corporation" is possibly Admar Corporation a part of Principal Mutual Insurance Company. "GERA" is probably GEHA. Also, "Blue Cross of Washington and Alaska" is now known as Premera Blue Cross, a Washington state corporation, which does business in Alaska as Blue Cross Blue Shield of Alaska.) The dominant participants in the market are Aetna and Premera Blue Cross who through their fully insured plans and as acting as administrators for various self-insured plans represent well over 50% of the entire Alaska health plan market. Obviously, such a circumstance could give rise to unfair, oligopsonic practices when it comes to contracting with medical care providers in Alaska for their services. This type of market dominance by a few payors is a historical fact in Alaska. As pointed out by Commissioners Swindle and Leary, the effect of the "structural remedy", due to the "grand-fathered" groups, in those specialties identified in their statement, is to inhibit the formation of presumably similar, efficient practice groups. The bottom line is that a few practitioners are left to negotiate on an individual basis with two oligopsonic insurers; essentially on a "take it or leave it" basis.

Alaska has a long history of not having a large number of payors in our health plan market for a number of reasons. The biggest reason is the relative, small size of our population coupled with our geographic separation from the rest of the United States. A payor's decision to enter the Alaska marketplace is just that—to enter Alaska or not enter Alaska. An insurer domiciled outside of Alaska is not going to enter Alaska on whether or not it plans on doing business in one community or another. The numbers are so small that ASMA contends such entry decisions are made on a statewide basis. To give you a further idea of Alaska's quest for payors you only need to look to Premera Blue Cross. It is a "hospital or medical service corporation" under Alaska's insurance law (AS 21.87). For an entity to operate in Alaska as a hospital or medical service corporation, it must be an Alaska domiciled corporation. Premera Blue Cross (formally known as Blue Cross of Washington and Alaska) is a Washington state corporation. It operates only in Alaska because it was "grand-fathered" when Alaska became a state in 1959. Alaska's Legislature, although having had many legislative sessions in which to do so, has not ever taken action to eliminate the "grand-father" provision applicable only to Premera Blue Cross. ASMA believes this to be the case because of the fear that such action would cause Premera Blue Cross to leave Alaska and thus further reducing the number of payors participating in our market place.

The term "HMO" is used throughout the various documents involved in this matter. To the best of ASMA's knowledge, no HMO, as defined in Alaska Statute, operates in Alaska at the present time or has ever operated in Alaska. The use of this term in the various documents could lead a reader to believe that HMO's are a competitive factor in Alaska. That is not true now nor has it ever been. Again, the demographics of Alaska probably are still such that an HMO operation would not be economically feasible. Certainly, health plans in Alaska do include elements of "managed care". Of course, managed care runs the spectrum for an insured plan having a pre-authorization requirement for a specific medical service all the way to a full, staff model HMO.

ASMA is concerned that some unintended consequences of the "structural" remedy may occur which would be detrimental to access to health care for Alaskans and which could also adversely impact the cost. Commissioners Swindle and Leary state in part "...The imposition of such a structural relief in a setting like Fairbanks results in anomalies that would not arise in a larger urban area...". ASMA agrees with that statement and would further assert this statement holds true for the entire State. The anomalies would result in detrimental unintended consequences. This particularly would hold true for specialists and sub-specialists that serve a much larger geographic area than that in which they reside. Such limitations as the 30% or 50% "cap" could lead to situations detrimental to the public's health if such benchmarks are considered as setting precedents for other situations. For example, if such regulatory structures would prevent an additional

needed sub-specialist from being recruited, this could lead to "burn-out" for the existing group of sub-specialists which could result in medical errors, delayed or no treatment, or increased costs by having to transport a patient out of Alaska for treatment.

The practice of medicine in frontier States such as Alaska is not as "economically efficient" as it is in other more populous areas. That classic inefficiency is exacerbated as you look at the more rural areas of Alaska. For example, it might be the norm for a particular practice specialty to be one practitioner for each 5,000 in population. First, assume for the moment that a mythical town in Alaska exists with 3,500 in population. Such a town would not be connected by road, but probably only accessible by air. You can't recruit a fraction of a doctor so you recruit one. However, a single doctor in such a setting is now on duty, to use the vernacular, 24/7/365. This has proven to be a formula for disaster which results in professional isolation, and "burn-out" which results in high turnover. Certainly, another physician could be recruited or perhaps all patients could be transported by air-ambulance to another locale for treatment. These approaches would add to the cost.

Recruitment of physicians to Alaska continues to be a significant issue in Alaska. Alaska has been a net importer of physicians throughout its history. Alaska has no medical school. It has only 10 slots at the University of Washington Medical School each year through a special arrangement. The current situation in Alaska is that about half of the private practice physicians are age 51 and older. So, recruitment is a significant issue at the present time and any thing which hampers recruitment of new physicians is to the detriment of our public's health.

Again, thank you for this opportunity to comment. ASMA feels that any decision made by you should be made with a good understanding of the environment involved. In summary, we feel that the definition of "payor" including government health benefit plans presents a Constitutional problem. Furthermore, ASMA believes the "structural" remedy to be inappropriate for Fairbanks and for any area in Alaska.

Sincerely,

BY: James J. Jordan
Executive Director

FOR: Alaska State Medical Association

cc: Senator Ted Stevens
Senator Frank Murkowski
Congressman Don Young
Governor Tony Knowles
Senator Drue Pearce, President, Alaska State Senate
Representative Brian Porter, Speaker, Alaska House of Representatives

JJJ/kms

February 3, 2001

to:
Senator Robin Taylor
Re: SB 37 relating to Nurse Practitioners

I have grave concerns about SB 37 now before your committee which runs counter to Alaskan values of fair play in the labor marketplace.

Nurse Practitioners are highly skilled health care providers who are critically needed in Alaska.

NPs must be adequately compensated for their services and allowed to practice competitively in their profession.

Please do not pass this proposed legislation that is detrimental to Nurse Practitioners in Alaska.

Sincerely,

Ruth Bohms
(Alaskan of 50 years residency)
P.O. Box 80155
Fairbanks, Alaska 99708
(907) 479-6970

Letter of Opposition

Subject:
Date: Sun, 18 Feb 2001 11:16:04 -0900
From: "Roberta" <roberta1@gci.net>
To: <Senator_Robin_Taylor@legis.state.ak.us>

I am a student midwife and as such I am concerned about allowing physicians to unite together to negotiate contracts. This would effectively decrease the ability of advanced nurse practitioners to compete. Nurse-midwives, and advanced nurse practitioners are highly skilled in caring for people at the healthy end of the spectrum. People who utilize advanced nurse practitioners are generally very satisfied with their care and received much more one on one time with the care giver than generally given by a physician. Ideally, advanced nurse practitioners work independently, utilizing physicians as the next step in care when the client's problems are outside of their scope of care.

Letter of Opposition

Statement

of the

American Medical Association

to the

Committee on Finance
Alaska Senate

RE: Senate Bill 37

Presented by Donald J. Palmisano, MD, JD
Member, AMA Board of Trustees

January 18, 2001

Introduction

Good morning. My name is Donald Palmisano. I am a practicing surgeon from New Orleans and a member of the American Medical Association's Board of Trustees. I am pleased to provide testimony today on behalf of the American Medical Association and to be joining my colleagues at the Alaska State Medical Association in support of Alaska Senate Bill 37. I am particularly pleased to be here in Alaska, a state that has shown great courage in addressing patient protection issues in the past and a state that has undertaken a number of health care issues of national importance.

As legislators, you are fortunate to have yet another opportunity to be a leader among states in addressing an issue that has reached a level of national crisis – that of health plans' inappropriate leverage over physicians and patients. Alaska Senate Bill 37 will enable the state of Alaska to begin to correct this gross imbalance in power by allowing physicians to negotiate patient care issues with health plans. We view Senate Bill 37 as a critical first step in addressing this issue with national ramifications.

Leverage of Health Plans Over Physicians and Patients

The severe imbalance of power between health plans and physicians has reached critical -- even dangerous -- levels across this nation. This imbalance has given health plans the power to determine what kind of medical care a doctor may render to a patient. In many communities around the country, dominant health plans virtually dictate contract terms to physicians. This is achieved by requiring the physician who wishes to be part of the plan to agree to its contract terms – terms that threaten the health of patients because they are primarily directed at controlling the cost of care provided to the patients.

Terms that tell a physician when a patient can be referred to a specialist -- terms that tell the physician what kinds of medication can be prescribed for sick patients -- and punitive terms that withhold compensation from physicians who see sick patients too many times. There are even contract terms called "all products clauses" or "tied products clauses" that force physicians to participate in all of the company's present and future plans – even those plans that physicians find ethically or financially unacceptable. Fortunately, this legislature has addressed the issue of all products clauses by enacting legislation in 2000 that prohibits such clauses in physician contracts. But there are many more issues that remain to be addressed.

Now, I ask you - what party with *any* ability to negotiate would agree to such one-sided and onerous contract terms that can be unilaterally changed by the health plan at any

time? Only a party that has absolutely *no* leverage in contract negotiations. In fact, there rarely are contract negotiations. The contracts are issued on a "take it or leave it" basis.

Adverse Effects of Leverage of Health Plans on Physicians and Patients

In many markets, these health plans control such a large percentage of patients that physicians must contract with them to have a viable practice. There simply are not enough patients outside of managed care to provide most physicians in the market with the patient volume necessary to maintain a financially viable practice. Moreover, in many markets, a small number of health plans account for the *bulk* of the patients. When only a few health plans control *most* of the patients in a market and all use similar contracts, failure to comply with contract terms means putting *all* of the contracts at risk -- and the viability of the practice – and the *patients* seen by that practice --at risk. The results of this practice have been devastating to physicians and patients alike – particularly in communities where just a few physician practices take care of *most* of the patients in that community. Not only has medical decision-making power become concentrated in fewer hands – and we believe the *wrong* hands- but physicians whose contracts are terminated for refusing to agree to a plan's terms have been forced to close their practices and their patients forced to find new doctors to take care of them.

Current Law

The antitrust laws have been interpreted to allow health plans such a high degree of leverage that an appropriate balance of interests no longer exists. As a result, the power of health plans to determine the kind of health care that patients receive is virtually

unchecked. In fact, large health plans actually use the threat of federal antitrust law enforcement to bully physicians and networks into accepting contracts that they believe adversely affect patient care – all to save the health plans money. And so, while a dominant health plan has little or no fear under the antitrust laws, two or more physicians do.

Under current state and federal law, two or more independently practicing physicians can not come together to discuss the terms of a health plans contract and attempt to work out a fair contract that will enable a physician to deliver quality patient care. For many years, the American Medical Association has pursued federal antitrust relief that would give independent physicians the ability to collectively negotiate with health plans. While progress is being made at the federal level, the fact remains that the antitrust laws have not yet been amended.

The critical need for such legislation has been seen right here in Alaska. I'm sure many of you are familiar with the Federal Trade Commission action taken against a Fairbanks IPA, the Alaska Health Network. The Federal Trade Commission alleged that the IPA was engaged in anti-competitive activities that prevented other insurers from entering Fairbanks. The FTC's consent decree placed restrictions on the percentage of physicians that could be represented from 5 specialties. Unfortunately, the consent decree did not recognize Alaska's marketplace or its domination by a very few insurers The passage of Senate Bill 37 would go far to alleviate the misunderstanding of the Alaska marketplace and would actually allow Alaska state officials to determine the number of physicians

who could join together to negotiate based on a sound understanding of their state marketplace.

Because health plans are using their increased market power to coerce physicians to agree to health plan policies or terms that are not best for patients, we must seek relief on a state-by-state basis. It is critical that we pursue other options to begin to provide immediate relief to physicians and prevent further erosion of physician control in delivering quality patient care. Alaska Senate Bill 37 provides this critical opportunity.

The State Action Doctrine

Alaska Senate Bill 37 provides a legally sound way for Alaska physicians to collectively negotiate with health plans over the terms of their contracts. The concept set forth in Senate Bill 37 is known as the state action doctrine. This doctrine has been successfully employed to permit a defined group of individuals to engage in a state-sanctioned activity where that activity is closely monitored by the state.

The state action doctrine already has been used in many states to permit health care entities to engage in transactions such as mergers and joint ventures where the benefits to the delivery of health care to patients could be demonstrated. For example, many states currently have laws permitting joint ventures and mergers of health care entities that would increase access to health care in rural areas.

The use of the state action doctrine proposed in Senate Bill 37 would extend state sanctioned activity to physicians who are unable to negotiate contract terms that would be favorable to their patients. What this bill does not do is seek an exemption from the antitrust laws like health plans currently have.

In order for physicians to engage in negotiations with health plans, they must comply with the two traditional principles of state action doctrine: 1) state approval to collectively negotiate with health plans and 2) ongoing oversight of the activity by the state.

In instances where a state would approve such negotiations, physicians would be provided with a venue to ensure that where a health plan has substantial market power, individual physicians could discuss contract terms and conditions and communicate any concerns to the health plans in a single unified voice. The built-in safeguards of this application of the state action doctrine would protect the public's interest in competition by restricting the number of physicians included in a given group and, most importantly, by prohibiting any activities that would adversely affect patient care, such as a boycott or a strike.

In this fashion, physicians could actually further the interests of their patients that are threatened by restrictive contract terms and, at the same time, not pose any threat of disrupting the delivery of or access to health care during the process of approved negotiations.

Conclusion

This is your opportunity to take an active role in correcting the imbalance in leverage between health plans and physicians. This imbalance has already reached critical levels across our nation – please make Alaska a leader by empowering Alaska physicians to put the health of their patients first.

Senate Bill 37
How does it work?

Group of physicians wishing to jointly negotiate

Appoint an exclusive representative

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

Authorized third party

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

Fee Related Items

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

**Health care plan must have more than 15% of the market share for joint negotiat ons to take place fo:· fee-related items*

Add'l Information

SB 37 –
Relating to collective negotiation by physicians with health benefit plans; to health benefit plan contracts with individual competing physicians

Overview

- Collective negotiation of price and price-related terms by physicians is considered "per se" illegal price fixing in violation of state and federal antitrust laws. SB 37 would displace free market competition and state antitrust laws and allow competing physicians to collectively negotiate with health plans on non-price and price terms of a contract under certain circumstances.

- SB 37 attempts to provide the physicians with immunity from prosecution under federal antitrust laws, through the state action doctrine, by establishing a review of the negotiations and contracts by the Office of the Attorney General..

- SB 37's authorization of collective bargaining presents a serious risk of anticompetitive harm. According to the Federal Trade Commission (FTC), allowing physicians to collectively negotiate on price terms will not ensure better care for patients, and it may result in substantial harm to consumers. The FTC's conclusions are based on prior investigations and enforcement actions where such results occurred when physicians collectively negotiated price terms.

Immunity Issues – State Action Doctrine

- Under the "state action" doctrine, states may override the national policy favoring competition and provide that regulation rather than market forces will govern aspects of their economies. A state may only displace competition with active state supervision if the displacement is both 1) intended by the state and 2) implemented in its specific detail. 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.

- For exemption from federal antitrust law under the state action doctrine, the state must exercise sufficient independent judgment and control so that the details of the rates or prices are established as a product of deliberate state intervention, not simply by agreement among the parties. 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.

- Provisions of SB 37 raise questions about the adequacy of state supervision authorized. It is questionable whether the legislation would meet the requirements of the state action doctrine. Among other things,

  - The bill requires a third-party representative to provide only limited information to the Attorney General to obtain approval to negotiate. 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, but the third party is not required to provide any of the information necessary to make such a determination.

  - The bill imposes substantial responsibilities on the Attorney General to approve or not approve a proposed negotiated contract, using specific criteria, but provides only a very short time frame (30 days) within which to make that fact-intensive determination. The bill does not require that the parties provide any information to the Attorney General to make such a determination.

  - 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.

Market Share

- SB 37 appears to make the concept of market power an important limitation on physicians' ability to collectively negotiate price terms, but these provisions are not based on accepted concepts of market power in a legal or economic sense. Specifically, a 15% market share is not ordinarily presumed to constitute market power.

- The bill's limits on physician group size do not reflect the potential market power (ability to raise prices above competitive levels) of physician groups. This may result in a disproportionately large physician group, or specialty group within a physician group (up to 100% of the physicians in a specialty group in a geographic service area) negotiating with a small health plan (as small as 2-3% market share), resulting in substantial and disproportionate market power by the physicians."

Boycotts

- SB 37 prohibits competing physicians from engaging in boycotts relating to the non-price terms and conditions listed in the bill. However, there is no such

prohibition on engaging in boycotts relating to price and price-related terms and conditions.

- SB 37 does not clearly prohibit concerted action, such as a boycott. It only states that such action is not authorized. A boycott or strike by physicians in response to a health plan's refusal to collectively negotiate on price terms would not be prohibited.

Application of Bill's Provisions

- The bill is not clear on how these provisions apply to an insurance company based on the use of the term "health benefit plan." By definition, "health benefit plan" does not refer to insurance companies. The bill relies on the definition of health benefit plan in AS 21.54.500(15). This definition incorporates the ERISA (Employment Retirement Income Security Act of 1974) definition of "employee welfare plan," which includes a "plan, fund, or program established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits," among other things. Accordingly, the determination under the bill of a health benefit plan's market share will be based on the market share of an individual employer's or employee organization's health benefit plan, not on the market share of the insurance company that may be providing insurance to the plan.

- Another area in which the bill is unclear is whether negotiation with an authorized third party is mandatory for health benefit plans. The language in AS 23.50.020(c)(2) implies that any health benefit plans would be required to negotiate with an authorized third party unless it could prove it died not have substantial market power. However, written testimony submitted to the committee and proposed AS 23.50.020(f)(2, indicated the contrary.

ERISA Preemption

- Since the bill applies to "health benefit plans" it raises a federal preemption issue under ERISA. ERISA preempts all state laws that relate to employee benefit plans, which by definition includes "health benefit plans." ERISA regulates the administration of employee health care benefits as well as the structure of the plans.

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FACSIMILE TRANSMITTAL SHEET

TO:SENATOR ROBIN TAYLOR

CC. SENATOR KIM ELTON

FROM: CAROLE S. EDWARDS, RN,BSN

DATE: 2/05/01

FAX NUMBER	TOTAL NO. OF PAGES INCLUDING COVER:
907-465-3922	1

MESSAGE: I am a registered nurse living in Juneau. I oppose SB 37. I believe that if this bill is passed it will remove antitrust protections that ANPs (Advanced Nurse Practitioners) and CNMs (Certified Nurse Midwives) need to shield them from discriminatory practices by physicians and employers. Alaskans have the right to choose the health care provider who best meets their needs. This bill will both limit choice and increase costs. In 1998 over 1400 Alaskan chose a CNM to attend the birth of their baby. These women should be able to continue to make this choice. This bill would protect price fixing, drive up health care costs, and let physicians obstruct opportunities for ANPs and CNMs to participate as providers in health benefit plans. Please vote NO on SB 37. Carole S. Edwards, RN

Letter of Opposition

FAX Transmission

TO:
Robin Taylor
Chair, Judiciary Committee

Fax number: (907) 465-3922

From:
Cathy Giessel
12701 Ridgewood Rd
Anchorage, AK 99516

cgiessel@mac.com
(907) 345-5470

Total pages in transmission: 2

February 8, 2001

Robin Taylor, Chair, Judiciary Committee

Mr. Taylor,
I am writing concerning SB 37, which would give broad antitrust immunity to physicians negotiating collectively with insurance companies. I am asking you to **VOTE NO ON SENATE BILL 37.**

I am a nurse practitioner and I would be negatively affected by the enactment of this legislation. This bill would remove antitrust protections which NPs and other non-physician practitioners need to shield them from discriminatory practices undertaken by physicians, employers, and other entities. SB 37 would protect price fixing, drive up health care costs, and let physicians obstruct opportunities for NPs and other non-physician practitioners to participate as providers in health benefit plans.

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

Nurse practitioners focus on wellness and illness prevention, which ultimately lowers health care costs. We provide a vital service in this state, where many rural clinics are staffed ONLY by non-physician providers. In addition, NPs provide cost effective care. As an example, I work at a nurse practitioner owned and operated clinic. Our fee for an average visit is almost HALF the cost of the same visit at the physician owned urgent care center located around the corner. The health care is of equal quality as the more expensive clinic or physician's office for the most common complaints. If physicians are given preferential treatment in price setting negotiations with insurance companies, our patients with insurance will be forced to pay more for health care from an NP or prohibited from choosing an NP as their health care provider.

Instead of hampering NPs and other non-physician practitioners from providing services to Alaskans, the state legislature should be focusing on how to unencumber them. There is an interesting article in the Harvard Business Review, Sept/Oct 2000 issue, pgs, 102 -112. The title is "Will disruptive innovations cure health care?" and the article speaks to the very issues I am discussing here. You might find it interesting reading as you consider SB 37.

I appreciate your service to Alaska as you serve in the Legislature. Please consider carefully who will benefit from SB 37 and whether this is in the best interest of the Alaskan people. Then I would urge you to VOTE NO ON SB 37.

Respectfully,

Cathy Giessel, MSN, RN, FNP-CS
cgiessel@mac.com
(lifelong Alaska resident; District 16, Precinct 353, Republican Party Committeewoman for 12+ years)

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February 2, 2001

Senator Robin Taylor
Chairman Senate Judiciary Cr ittee
PO Box 1441
Wrangell, AK 99929

Re: Response to request for additional information on the State Action Doctrine & SB37

Dear Senator Taylor:

Attached are two legal analyses of the Texas Physician Negotiation Bill written just prior to its passage in 1999. The first, written by Donald Wilcox (general counsel for the Texas Medical Association) we feel clearly outlines the federal case law and reasoning why all states have it within their purview to create exceptions to federal anti-trust law through the State Action Doctrine.

The general conclusion we drew from Mr. Wilcox's analysis of existing case law, was that the state oversight function required under the State Action Doctrine, while significant and real, was never intended to be so onerous or burdensome, that it effectively made any state action doctrine exception unworkable.

We included the Vinson & Elkins opposing opinion because it is referred to in Mr. Wilcox's analysis.

If you have any question please give me a call at 561-7705.

Sincerely,

Michael Haugen, MD, MBA
Executive Director

Add'l Information

PHYSICIANS CARING FOR TEXANS

Texas Medical Association

June 15, 1999

Honorable George W. Bush
Governor, State of Texas
State Capitol
P.O. Box 12428
Austin, TX 78711-2428

Re: Senate Bill 1468 -- An Act Relating to the Regulation of Physician Joint Negotiation

Dear Governor Bush:

I am writing on behalf of the Texas Medical Association ("TMA") and the American Medical Association ("AMA") in consultation with its counsel, Sidley and Austin, to respond to the June 3, 1999, letter to you from Vinson & Elkins – on behalf of an unidentified client – addressing S.B. 1468 (the "Act"). Contrary to the assertions made by Vinson & Elkins, we believe the Act will prove effective in its principal purpose of shielding physicians from the effects of the antitrust laws. We further believe the Act is valid under the Texas Constitution, is consistent with public policy, and will advance the public interest in health care.

The Act will allow meaningful, state supervised joint negotiations by physicians with health plans. New opportunities to enter into genuine, fair working relationships as well as opportunities to repair broken ones will occur. It will enhance the environment for allowing physicians to continue to provide genuine, competent medical treatment to patients in managed care settings.

We urge you to sign S.B. 1468 into law.

1. **The Act Will Shield Physicians from the Antitrust Laws Under the State Action Doctrine.**

As Vinson & Elkins notes, the primary purpose of the Act is to permit physicians to jointly negotiate the terms and conditions of their contracts with health benefit plans, without fear of reprisal under the antitrust laws. As health benefit plans have grown and consolidated, the playing field in the health care arena has shifted dramatically. In communities where a few health benefit plans dominate the market, fair negotiations between physicians and plans are unobtainable absent joint action by physicians. See Art. 29.01. Unfair contractual terms, including unjustified and inequitable reductions in compensation, are not just bad for physicians; they also threaten to decrease both the quality and quantity of health care services provided, which is bad for consumers.

To rectify this situation in communities where warranted, the Act permits physicians to jointly negotiate with health benefit plans. The Act also provides mechanisms for review and approval (or disapproval) of joint physician action by the Attorney General, so as to immunize the joint

action from the antitrust laws. Contrary to the position taken in the Vinson & Elkins letter, we believe firmly that the Act meets the requirements to shield joint physician action under the state action doctrine.

The state action doctrine shields private conduct if a two-prong test is met: (1) the challenged conduct is the result of a clearly articulated and affirmatively expressed state policy; and (2) the joint action is actively supervised by the state. California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980). Vinson & Elkins concedes that the "clearly articulated state policy" requirement is met. The only question relates to the "active supervision" requirement.

As a preliminary matter, Vinson & Elkins suggests that satisfaction of the active supervision requirement is "more problematic" in cases such as this where the joint action involves price-setting. To the contrary, most issues that arise under the state action doctrine involve joint price-setting. See, e.g., Federal Trade Comm'n v. Ticor Title Ins. Co., 504 U.S. 621 (1992); Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985); Midcal, supra; Parker v. Brown, 317 U.S. 341 (1943); see also DFW Metro Line Services v. Southwestern Bell Tel. Co., 988 F.2d 601, 605 (5th Cir. 1993). Indeed, the very purpose for the creation of the state action doctrine was to protect joint activity that is undertaken pursuant to a clearly articulated state policy to supplant or limit competition -- including competition on price. Southern Motor Carriers, 471 U.S. at 55-56.

There is thus no distinction between application of the active supervision requirement in cases involving joint price-setting and application of the requirement in cases involving other types of joint action. The fundamental inquiry remains the same. As stated by the U.S. Court of Appeals for the Fifth Circuit, to achieve active state supervision, "state officials must be vested with the power to review particular anti-competitive acts and to disapprove those actions that do not comply with state policy." DFW Metro Line, 988 F.2d at 606, citing Ticor, 504 U.S. at 634-35.

We believe the active supervision requirement is met by the Act here. Specifically, the Act *requires* review and approval by the Attorney General before a joint negotiation may take place between physicians (through a qualified physicians' representative, as defined in the Act) and a health benefit plan. Art. 29.09. The Act also requires subsequent review and approval before a proposed contract between physicians and a health benefit plan may take effect. Id. The Act specifically identifies detailed information that must be provided in a physicians' representative's report, which must be submitted to the Attorney General for consideration prior to negotiation. Art. 29.08. The Attorney General is instructed to review this information and to permit the joint negotiation to take place *only if* he determines that the benefits of the joint negotiation outweigh the disadvantages attributable to a reduction in competition that may result from the joint negotiation. Art. 29.09(b). Similarly, any proposed contract that is a product of an approved joint negotiation must be submitted with a proposed plan of action, for review by the Attorney General under the same standards. Art. 29.08(2), 29.09(b).

Plainly, state supervision under the Act will be active. Joint action by physicians is allowed under the Act only if the Attorney General reviews the joint action and approves it. See DFW

Metro Line, 988 F at 606. "Rubber stamping" by the Attorney General (Vinson & Elkins letter at 3) is clearly not permitted.

The Act stands in sharp contrast to regimes that have failed the active supervision requirement. In Midcal, for example, a California system for regulating wine prices merely required that the prices be filed with the state. The state did not review and approve the prices at all. 445 U.S. at 105-06. Here, the Act requires active review and approval by the Attorney General before joint negotiations may take place and before a proposed contract may go into effect.

In Ticor, the Supreme Court dealt with "negative option regimes," in which a rate or practice goes into effect unless the state regulatory agency rejects it within a specified time. The Supreme Court held that the negative option regimes at issue in Ticor failed the active supervision requirement because the rate filings were at most checked for mathematical accuracy. Some were unchecked altogether. Ticor, 504 U.S. at 638.

The Act, in contrast, is no negative option regime. A joint negotiation may not take place, and a contract may not be implemented, unless and until the Attorney General reviews and approves them. See North Star Steel Texas, Inc. v. Entergy Gulf States, Inc., 33 F. Supp. 2d 557, 565 (S.D. Tex. 1998) (distinguishing Ticor, the court found that the defendant utility was entitled to state action immunity because the Public Utilities Regulatory Act forbid utilities from providing electrical service or offering a new rate without express permission from the Public Utility Commission).

Vinson & Elkins suggests that the Act may nevertheless fail the active supervision requirement because the Act does not "appear" to require the Attorney General to evaluate the specifics of any agreements on fees between physicians and a health benefit plan. (Vinson & Elkins letter at 2.) The Act, in fact, specifically contemplates that the Attorney General will review proposed fees in any proposed contracts, as part of his determination of whether the likely benefits of the proposed contract outweigh the disadvantages attributable to a reduction in competition that may result from the proposed contract. Art. 29.09(b).

Moreover, contrary to Vinson & Elkins' suggestion, the active supervision requirement does not compel ongoing review and re-review of approved contracts. The ratemaking regimes that the Supreme Court sustained in Southern Motor Carriers did not involve such ongoing supervision. Rather, the government conceded that active supervision existed by virtue of the review that occurred each time a new rate was proposed. See Southern Motor Carriers, 471 U.S. at 66; United States v. Southern Motor Carriers Rate Conf., Inc., 467 F. Supp. 471, 476-77 (N.D. Ga. 1977). In fact, active supervision was deemed to exist even though the relationship between the motor carriers and the state regulatory commissions was "friendly to intimate." Id. at 477.

Even if ongoing supervision were required, that will happen under the Act. Contracts between physicians and health benefit plans generally run one to three years in length. As a result, physicians' representatives will be returning to the Attorney General for authority to negotiate

contracts and for approval of proposed contracts on a regular basis. Contracts will thus be reviewed and re-reviewed by the Attorney General on an ongoing basis.

Vinson & Elkins also seems to suggest that the Attorney General will not carry out the active supervision called for under the Act because he will have to "dedicate significant resources" to do so. (Vinson & Elkins letter at 3.) But the Attorney General has expressed his support for the Act and his intention to carry out his responsibilities under it. In addition, the Act specifically creates a source of "resources" to permit its implementation. See Art. 29.13 (authorizing the Attorney General to set fees to be paid by physicians' representatives in amounts reasonable and necessary to cover the costs incurred in administering the Act).

Finally, Vinson & Elkins argues that the Act does not provide certainty for physicians to assure them that joint negotiations with health benefit plans will garner state action immunity. We candidly admit that absolute certainty is unattainable, unless and until a court challenge were to occur. Nevertheless, we are confident that, based on legal precedent, the Act satisfies the state action doctrine, and that a court would find such. (We also would suggest that under Vinson & Elkins' theory, no beneficial economic regulatory regime involving interaction between state and private actors would ever be enacted for fear of "after-the-fact evaluation.")

2. The Act Is Valid Under the Texas Constitution.

One of the greatest benefits of legislative delegation is that it places responsibility in the hands of those individuals who are best equipped to deal with such tasks. Requiring the Texas Legislature to define what constitutes a "substantial market power" or exactly when the 10% limitation on the size of the collective bargaining unit should be raised or lowered would not only place an undue burden on the legislature but would also create static guidelines for dealing with a dynamic and volatile marketplace. In an effort to address the ever-changing health care marketplace and apply the law in an equitable manner, the drafters of the Act have delegated rule-making authority to the well versed office of the Attorney General. In its letter to the Governor, Vinson and Elkins chooses to examine but one decision out of a body of case law regarding legislative delegation to assert that the language of the Act violates the separation of powers as set out by the Texas Constitution. However, a comprehensive examination of the applicable authorities reveals the position held by the State of Texas that legislative delegation, including the language of the Act, is constitutional.

The Texas Supreme Court in Dallas v. Higginbotham, 143 S.W.2d 79 (Tex. 1940) created six categories of acceptable legislative delegation. One of these categories includes cases where the legislature delegates authority because it is more practical and efficient to do so than to promulgate rules and guidelines in furtherance of the applicable laws. The court held in Higginbotham, as long as a legislative delegation fit one of the six categories and there were sufficient standards in place to guide the agency or body to whom the delegation was made, the delegation would be considered constitutional.

In a time when mergers, buyouts and new acronyms are sprouting up weekly, if not daily, and the bankruptcy code is a way of life, defining what particularly constitutes a "substantial market power" via legislation is a virtual impossibility. Thus, it is more practical and efficient to leave such analysis to office of the Attorney General than to require the Texas Legislature to more specifically define the issues of the Act (Vinson & Elkins letter at 4). As such, the language of the Act falls within one of the Constitutional exceptions laid out in Higginbotham.

Post Higginbotham, Jordan v. State Board of Insurance, 334 S.W.2d 278 (Tex. 1960) delineated "sufficient standards to guide the delegate in its functioning" as the paramount criteria for determining the constitutionality of legislative delegation. Consistent with Higginbotham and subsequent judicial decisions, Jordan also advocates a broad interpretation of what may constitute a "sufficient standard." So long as *the idea to be conveyed is reasonably clear* in the phrasing used in a statute which delegates legislative authority, the statute will pass constitutional muster. Jordan, 334 S.W.2d at 510. The court in Jordan, quoting from Professor Davis' "Administrative Law Treatise", lists some of the terms of art which the Supreme Court of the United States has held as sufficient. These include:

"Just and reasonable"
"Public interest"
"Unreasonable obstruction"
"Reciprocally unequal and unreasonable"
"Public convenience, interest or necessity"
"Tea of inferior quality"
"Unfair methods of competition"
"Reasonable variations"

Following the lead of Jordan, "substantial market power" and the other terms of art contained in the Act satisfy the requirements for the constitutionality of legislative delegation. A body of law which addresses the meaning of "substantial market power" and "geographic region" currently exists and could be utilized by the Attorney General in interpreting and promulgating guidelines for the Act.

Rather than looking at the "big picture" regarding legislative delegation, Vinson and Elkins has focused on a single case which makes the greatest attempt at limiting the ability of the legislature to delegate its power. Vinson and Elkins uses the split decision in Texas Antiquities to raise the issue of "vagueness" relative to the legislative delegation of the bill and how the Attorney General is to carry out the provisions of the Act. However, the holding in Texas Antiquities is inconsistent with subsequent applicable case law regarding legislative delegation and, in fact, the court in Texas Antiquities balks at overturning the then existing case law. Texas Antiquities, 554 S.W.2d at 928. The more encompassing analysis of cases prior to and following *Texas Antiquities* contained herein yields the conclusion that indeed, the Act is constitutional.

Consistently, the Legislature has been given great latitude in the delegation of its power. State v. Texas Mun. Power Agency, 565 SW2d 258 (Tx. Ct. App. 1978), Railroad Comm'n v. Lone Star Gas Co., 844 S.W.2d 679 (Tex. 1992) and Edgewood Indep. School Dist. v. Meno, 917 S.W.2d 717 (Tex. 1992), all advocate empowerment regarding legislative delegations and the accompanying standards for guiding the promulgation of rules and regulations. "Such standards may be broad... [when] conditions must be considered which cannot be conveniently investigated by the legislature." State v. Texas Mun. Power Agency, 565 S.W.2d at 273. "It is utterly impossible for the Legislature to meet the demands of every detail in the enactment of laws relating to the production of oil and gas." Corselius v. Harrell, 186 S.W.2d 961, 964 (Tex. 1945).

The language of the Act easily falls within what is accepted under Texas law and does not violate the Texas Constitution. Legislative delegation allows the legislature to focus on policy and principles while allowing specially equipped agencies to promulgate rules and regulations in furtherance of the goals of the legislature and the public. By placing the implementation of the Act in the experienced hands of the Attorney General, the drafters have not only ensured that the Physician Negotiation Bill will reach its full potential but also relieved the legislation of a burden with which it is not prepared to deal.

3. **The Act Is Consistent with Public Policy and Advances the Public Interest in Health Care.**

Contrary to Vinson & Elkins' assertions, the Act is consistent with public policy and advances the public interest in health care. First, the Act does not give physicians permission to collectively boycott health benefit plans or to "coerce" plans to accede to their terms. Such conduct is expressly prohibited by the Act. Art. 29.10. In addition, health benefit plans remain free to reject joint negotiations and proposed contracts. Art. 29.08(3). Thus, if a health benefit plan and a group of physicians fail to reach mutually agreeable terms, the physicians are then obligated to individually determine whether to accept or reject proposed contracts from health benefit plans.

Second, Vinson & Elkins' criticism of the 10 percent threshold in the Act is meritless. See Art. 29.09(b). Vinson & Elkins suggests that groups of physicians comprising less than 10 percent of all physicians in a geographic service area may be able to wield market power over health benefit plans. The Act, however, expressly authorizes the Attorney General to limit the amount of physicians in a joint negotiating group to less than 10 percent if such circumstances arise. Id. Acknowledging this fact, Vinson & Elkins nevertheless complains that the Act provides no criteria to guide the Attorney General in making the determination. But the Attorney General's office is well-versed in antitrust law, and the criteria for defining geographic markets and identifying market power are well-defined in state and federal court antitrust decisions. There is no need to regurgitate these principles in the Act.

Third, the statutory safeguards against improper collusive behavior on the part of physicians are clear and transparent. Vinson & Elkins simply ignores them. The Attorney General will play an active role in supervising joint negotiations by physicians with health benefit plans. Art. 29.09. In addition, the Act clearly outlaws concerted refusals to deal. Art. 29.10.

Finally, in enacting S.B. 1468, Texas will not be "a beacon state for ... anti-competitive and unconstitutional legislation." (Vinson & Elkins letter at 5.) Rather, Texas will be a beacon state for restoring competitive balance in health care markets where state intervention is genuinely needed. The current "health plan take all" system threatens to chase physicians out of the practice of medicine, to discourage our young from embarking on medical careers, and to decrease the quality and quantity of health care services available to the citizens of the State of Texas – which in turn will lead to higher prices for medical care. The Act is good for physicians, it is good for consumers, and it is good for health plans that are genuinely interested in ensuring that quality, affordable health care services continue to be available throughout this State.

We urge you to sign into law S.B. 1468.

Very truly yours,

Donald P. Wilcox
General Counsel

Vinson & Elkins
ATTORNEYS AT LAW

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June 3, 1999

Honorable George W. Bush
Governor, State of Texas
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P. O. Box 12428
Austin, Texas 78711-2428

Re: Senate Bill 1468 - An Act Relating to the Regulation of Physician Joint Negotiations

Dear Governor Bush:

A client has requested that this Firm review and analyze Senate Bill No. 1468 (the "Act"). As will be set forth in greater detail below, we believe that this Act may prove to be ineffective to achieve its principal purpose of shielding doctors from the effects of the antitrust laws, may violate the Texas Constitution, and may have results contrary to public policy. Thus, we urge that you veto SB 1468.

A. The Act

As passed by the Legislature, the Act authorizes competing physicians in a "service area of a health benefit plan" to meet and communicate for the purpose of jointly negotiating certain non-price terms and conditions of contracts with health benefit plans subject to certain conditions. In addition, competing physicians also can meet, communicate and jointly negotiate with a health benefit plan concerning price-related terms when the Attorney General has determined that the plan has substantial market power and when the price-related terms and conditions have already affected or threaten to adversely affect the quality and availability of patient care. Actual negotiations with a plan must be conducted by a "physicians' representative" who must make an initial filing with the Attorney General concerning joint negotiations and file a copy of any proposed agreement reached for approval by the Attorney General. The Attorney General is required to approve a request to enter into joint negotiations or a proposed contract if the Attorney General determines "that the applicants have demonstrated the likely benefits resulting from the joint negotiation or the proposed contract outweigh the disadvantages attributable to a reduction in competition that may result from the joint negotiation or proposed contract." Although joint negotiation is generally limited to no more than 10% of the physicians in the health benefit plan's defined geographic service area, a higher percentage of physicians may participate in cases "where in conformance with the other provisions of this subsection conditions support the approval of a greater or lesser percentage."

B. **State Action Doctrine**

The ostensible purpose of the Act is to allow physicians to jointly negotiate the terms and conditions of their contracts with health benefit plans without fear of possible liability under the antitrust laws. In order for such collective private activity to be shielded from the antitrust laws, the Act must satisfy the state action doctrine under *California Retail Liquor Dealers Association v. Midcal 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 Insurance Co.*, 504 U.S. 621 (1992). Under this doctrine, private action is immune from antitrust liability 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 itself.

Midcal, 445 U.S. at 105.

Although the Act may satisfy the first requirement of the state action doctrine, satisfaction of the second prong of the doctrine is much more problematic, particularly when the issue to be jointly negotiated involves price. The United States Supreme Court has stated on more than one occasion that no antitrust offense is more pernicious than price fixing. Accordingly, the Court has strictly construed the active supervision requirement because of the gravity of a price-fixing offense.

Any active supervision by the State of Texas under the Act falls to the Attorney General. Such supervision, however, is limited to approval or disapproval of the initiation of joint negotiations and of any contract that may result from such negotiations. The Act does not appear to require the Attorney General to take steps to determine the specifics of any jointly negotiated physician fees, such as reviewing empirical data to determine the reasonableness of the fees.

Further, the Act does not provide for any continuing jurisdiction of the Attorney General to monitor the performance of the contract, to require changes in the contract as competitive conditions may change, or to entertain challenges to the contract by any aggrieved party. This type of static "supervision" appears to fall short of the type of active supervision required under the state action doctrine. *See Midcal*, 445 U.S. at 105-06 (challenged private program was not immune because, in part, state did not monitor market conditions or engage in any "pointed reexamination" of the program); *North Carolina ex rel. Edmisten v. P.I.A. Asheville*, 740 F2d 274 (4th Cir. 1984). *See also DFW Metro Line Services v. Southwestern Bell Telephone Corp.*, 988 F.2d 601, 605-06 (5th Cir. 1993) (court discusses substantial ongoing supervision by state agency in applying *Midcal*); *North*

Star Steel Texas, Inc. v. Entergy Gulf States, 33 F. Supp. 2d 557, 564-67 (S.D. Tex. 1998) (same); *Destec Energy, Inc. v. Southern California Gas Co.*, 5 F. Supp. 3d. 433, 454-58 (S.D. Tex. 1997) (same).

Moreover, even if the state action doctrine were not to require continuing jurisdiction by the Attorney General over jointly negotiated contracts, it is clear that active supervision requires a determination that the State "has exercised sufficient independent judgment and control so the details . . . have been established as a product of deliberate state intervention, not simply by agreement among private parties." *FTC v. Ticor Title Insurance Co.*, 504 U.S. 621, 634-35 (1992). Active state supervision, therefore, is not satisfied by the "rubber stamping" of decisions made by private actors. In order to satisfy this standard, the Attorney General would have to dedicate significant resources to determine whether the proposed jointly negotiated contracts should be approved. Such a burden would be exacerbated by the fact that health service areas are generally local and market conditions within them would vary greatly.

Most important for the State of Texas is that the absence of the requisite level of state involvement under the Act may not shield physicians from the effects of antitrust laws. If challenged, the party claiming the immunity must show that the state, in fact, undertook the necessary steps to actively supervise the process for the immunity to apply. Private physicians may not know until after their participation in activities that violate antitrust laws whether the state's supervision was "active" enough. Such an after-the-fact evaluation of a state's exercise of its supervisory powers is extremely dangerous for private parties who have no control over whether the degree of scrutiny that their filings may receive will meet the active supervision requirement.

C. The Texas Constitution

In addition to questions concerning the efficacy of the Act in shielding private actors from antitrust liability, the Act suffers from infirmity under the Texas Constitution.

Article II, section 1 of the Texas Constitution provides:

> The powers of the Government of the State of Texas shall be divided into three distinct departments, each of which shall be confided to a separate body of magistracy, to wit: Those which are Legislative to one; those Executive to another, and those which are Judicial to another; and no person, or collection of persons, being of one of these departments, shall exercise any power, properly attached either of the others, except in the instances herein expressly permitted.

This principle of separation of powers has been held to allow the delegation of legislative power in implementing legislation only when reasonable guidelines have been

provided for proper implementation of the legislative scheme. *See Edgewood ISD v. Meno*, 917 S.W.2d 717, 741 (Tex. 1995); *Railroad Comm'n v. Lone Star Gas Co.*, 844 S.W.2d 679, 689 (Tex. 1992). In the present case, the Legislature has provided insufficient direction to the Attorney General for the exercise of the authority delegated to him under this Act.

Among the issues that appear to be accorded to the Attorney General for determination are the following:

a. deciding which terms and conditions subject to negotiation are non-fee or fee-related;

b. determining under what circumstances the 10% limitation on the size of the collective bargaining unit should be raised or lowered;

c. determining whether the likely benefits of each proposed joint negotiation outweigh the prospective disadvantages;

d. determining whether the likely benefits of each proposed contract outweigh the prospective disadvantages;

e. determining whether a plan has substantial market power; and

f. determining the deficiencies and specific remedial measures for each rejected filing.

The Act itself, however, provides very little legislative guidance as to how any of these matters are to be determined by the Attorney General. The "Findings and Purposes" set forth in the Act are no more than boilerplate and the "Definitions" are few and provide no enlightenment on these issues. Most importantly, the Findings and Purposes clause under Article 29.01 of the Act provides that in some instances health plans dominate the market *to such a degree* that fair negotiations between physicians and the plan are unobtainable. The Act does not, however, clearly articulate and affirmatively express as state policy what constitutes market domination by a health plan that would make collective negotiation by physicians necessary to effect state policy. Under these circumstances, the Act violates the Texas Constitution as an improper delegation of authority. *See Texas Antiquities Commission v. Dallas County Community College District*, 554 S.W.2d 924, 928 (Tex. 1977).

D. Public Policy

In addition to the problems set forth above, the Act raises serious public policy concerns that should militate against its approval.

First, although the Act purports not to authorize physicians to throat retaliatory joint action such as a boycott or strike, or to jointly coordinate any "cessation, reduction, or limitation of health care service", the purpose of the bill clearly is to allow competing physicians to collectively refuse to deal with a health plan if the health plan does not accede to the physicians' joint demands. An inescapable result of such concerted refusal to deal would be to coerce health plans in many cases to agree to the physicians' terms and conditions, including higher fees, which would lead to higher premiums or higher co-insurance and deductible amounts.

Second, although the Act limits joint negotiations generally to no more than 10% of physicians in a health benefit plan's defined geographic service area, the Act ignores that a jointly negotiating group of physicians may constitute less than 10% of the total number of physicians throughout the entire geographic service area (such as a county or multi-county area), but may be able to exercise significant market power in a geographic submarket (such as a city or town). In addition, the Act ignores the prospect that every group of specialists that is a necessary component of a health plan's provider network (e.g., surgeons, neurologists, anesthesiologists, cardiologists, dermatologists, endocrinologists, otolaryngologists, radiologists, urologists, ophthalmologists) may effectively form a monopoly in a particular community as long as the group does not comprise more than 10% of the total number of physicians in a geographic service area. In this situation, it is unlikely that a particular specialty within a defined geographic service area would exceed 10% of the total number of physicians, but nevertheless could exercise significant market power within their specialty. Although the Attorney General apparently is granted the power to condition approval upon participation by a greater or lesser percentage of doctors, as set forth above, there are no statutory criteria set forth to guide the Attorney General in that determination.

Third, competition is the fundamental premise of our economic system. The statutory "safeguards" against improperly collusive behavior on the part of competing physicians are woefully inadequate. The Act is a large step toward eliminating competition among physicians in the State of Texas.

Texas should not be a beacon state for this kind of anti-competitive and unconstitutional legislation.

Please veto SB 1468.

Respectfully submitted,

Vinson & Elkins L.L.P.

COPY

Blue Cross
of Washington and Alaska

An Independent Licensee of the Blue Cross and Blue Shield Association

ALASKA PARTICIPATING PHYSICIAN AGREEMENT

[redacted]

This is an agreement between Blue Cross of Washington and Alaska (hereafter "BCWA") and [redacted] hereafter "the Physician").

I. BCWA AGREES:

A. To list the Physician as a participating physician on informational materials and encourage enrollees to use the services of participating physicians.

B. To remit timely payments directly to the Physician for medically necessary covered services rendered to enrollees. Payment will be the BCWA allowable amount for such services, less any applicable enrollee deductible, copayment or coinsurance amount. BCWA will have no obligation to pay claims that are received more than 365 days after the date services are rendered.

C. To pay claims consistent with BCWA utilization standards and determination of medical necessity.

II. THE PHYSICIAN AGREES:

A. To provide professional services to enrollees on the same basis as such services are provided to patients who are not enrollees, and be solely responsible for the quality of services rendered.

B. To bill BCWA directly for covered services provided to enrollees, in a manner acceptable to BCWA and in the amount of his/her usual fee.

C. To accept BCWA's allowable amount as payment in full and not bill the enrollee, except for: 1) applicable deductibles, copayments and coinsurance; and 2) services that are not covered by the subscriber's contract with BCWA, and not to seek payment from enrollees for the provision of services which would have been covered services but which BCWA has deemed not to have been medically necessary unless the enrollee understood prior to services that they would not be covered and agreed in writing to assume financial responsibility therefore. The Physician's charge to the enrollee for deductibles, copayments or coinsurance in combination with BCWA's payment will not exceed BCWA's allowable charge. In no event, including but not limited to nonpayment by BCWA, BCWA insolvency or breach of the Agreement, shall the Physician bill the enrollee any sum in addition to those listed above, or have any recourse against the enrollee for services provided pursuant to this Agreement. This is understood to be for the benefit of the enrollee.

D. To cooperate with BCWA utilization management programs.

E. To allow BCWA to review and duplicate any data and other records maintained with respect to enrollees or this Agreement in accordance with patient release forms maintained by the physician. These activities will be allowed upon reasonable notice during regular business hours. The Physician will allow BCWA continued access to these records for eighteen months after the termination of the Agreement.

F. To refund monies to BCWA if it is determined that payment was based upon erroneous or incomplete information, or if benefits were misapplied.

G. To maintain such policies of general comprehensive liability and malpractice insurance as may be appropriate to insure against any claims in connection with the acts or omissions of the Physician and his/her employees pursuant to this Agreement. Upon request, the Physician will submit to BCWA evidence of insurance in a form acceptable to BCWA. The Physician will also promptly notify BCWA of any revocation, suspension, limitation, or other termination of any such policy, and any disciplinary proceedings or relevant legal actions brought against the Physician, including but not limited to malpractice.

III. BOTH AGREE:

A. To take all reasonable precautions to prevent the unauthorized disclosure of any information obtained pursuant to this Agreement.

B. To abide by rules and procedures issued by BCWA from time to time. Such rules will be binding equally upon BCWA and the Physician.

C. To maintain in good standing all licenses required by law and submit evidence of licensure to the other party upon request. BCWA and the Physician will also promptly notify one another of any action against the party's licenses, any changes in business address, or any legal or governmental action, other problem, or situation that might impair the party's ability to carry out the party's responsibilities under this Agreement.

D. This Agreement will be construed in accordance with the procedural and substantive laws of the State of Alaska.

E. The provisions of this Agreement will apply to services provided to enrollees covered by BCWA, including those covered under programs of other Blue Cross and Blue Shield Plans which have a reciprocal agreement directly with BCWA or through the Blue Cross and Blue Shield Association. In addition, this Agreement will apply to enrollees or members of BCWA subsidiaries and affiliates where their subscriber/member agreements and administrative rules allow.

✓ (F) Neither of the parties nor any of their respective employees will be construed to be the agent, employee or representative of the other for any purpose, or liable for any acts or omission of the other, except BCWA will be the administrative agent of the Physician for the limited purpose of paying the Physician for covered services provided to enrollees.

G. Neither party will assign this Agreement without the written consent of the other party, except that if BCWA merges or consolidates with another entity, this Agreement will remain in full force and effect.

H. Neither party will use the other party's name, symbols, trademarks or service marks without the prior written consent of that party, except as provided in Part I. A. of this Agreement.

✓ (I) Except as otherwise provided herein, BCWA may amend this Agreement at any time effective upon thirty (30) days advance written notice to the Physician. The amendment will be binding upon the Physician unless BCWA is otherwise notified by the Physician within this period.

J. Both parties will resolve any differences regarding payment and medical necessity as follows:

1. The Physician and BCWA will communicate directly in an effort to mutually resolve the dispute.

✓ (2) If the Physician and BCWA still cannot resolve the dispute after submitting to review, the dispute will be settled by arbitration before the American Arbitration Association in accordance with its rules and regulations.

K. The Physician hereby expressly acknowledges its understanding that this Agreement constitutes a Contract between the Physician and Blue Cross of Washington and Alaska (BCWA), that BCWA is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association"), permitting BCWA to use the Blue Cross Service Mark in the States of Washington and Alaska and the Blue Shield Service Mark in the Counties of Chelan and Douglas of the State of Washington and for the State of Alaska, and that BCWA is not contracting as an agent of the Association. The Physician further acknowledges and agrees that it has not entered into this Agreement/Contract based upon representations by any person other than BCWA and that no person, entity or organization other than BCWA shall be held accountable or liable to the Physician for any of BCWA's obligations to the Physician created under this Agreement/Contract. This paragraph shall not create any additional obligations whatsoever on the part of BCWA other than those obligations created under other provisions of this Agreement/Contract.

IV. TERM AND TERMINATION:

A. This Agreement will take effect on the date countersigned by BCWA and will remain in effect until terminated as provided below.

B. This Agreement may be terminated without cause by either party upon thirty (30) days written notice.

C. This Agreement may be terminated by either party effective upon written notice if the other party fails to comply with any of the provisions of this Agreement.

D. If this Agreement is terminated, its provisions will continue in effect with respect to:

1. Payments accrued to the Physician prior to termination.

2. The Physician's agreement not to seek compensation from enrollees for covered services or services determined not to be medically necessary which are provided prior to termination.

3. Completion of treatment of enrollees receiving care at the time this Agreement terminates. However, if the Physician terminates this Agreement, termination shall not be effective as to any subscriber agreement in force on the date of the termination until the termination of the subscriber agreement or the next anniversary of the subscriber, whichever date is earlier.

E. If the Agreement is terminated, the Physician will inform all enrollees that seek his/her services.

Blue Cross of Washington and Alaska

By:

Type or Print Name

Title

PO Box 327
Address

Seattle, Washington 98111-0327
City, State ZIP Code

Month/Day/Year

Physician

[redacted]

Signature of Physician

[redacted]

Type or Print Name

[redacted]

IRS/Social Security Number

[redacted]

Address

[redacted]

City, State ZIP Code

[redacted]

Month/Day/Year

Alaska State Medical Association
September 4, 1998

Participating Physician Agreements in Alaska

A Topic-by-Topic Comparison of the AMA model agreement with those from Blue Cross of Washington and Alaska

Prepared for the Alaska State Medical Association
by the law firm of Biss & Holmes

Copies of the AMA model physician agreement are available to ASMA members upon request.

Please note: This comparison is not intended as legal advice and is not a substitute for direct consultation with an attorney. Physicians are encouraged to consult with their own legal counsel and other advisors regarding the specific terms of participating agreements.

Definitions

AMA Model Form

Contains an extensive definition section to aid in understanding and interpreting the agreement. Medically necessary standard is based on reasonably prudent physician standard vs common approach of determination by plan medical director.

BCWA

This agreement does not have a separate definition section. Among the significant terms used in the Agreement which are not defined but have been defined by the AMA are: Claim. Copayment. Covered Services. Emergency condition. Enrollees. Medically Necessary. Utilization Review.

Specifically, no payment is to be made to the physician unless the services are medically necessary, but that term is never defined by the Agreement.

Delivery of Services

AMA Model Form

Contemplates a separate schedule for each plan covered by the Agreement listing covered services. Plan provides that if description of covered services is materially lacking, plan must pay physician for each service performed for benefit of Enrollee. List of covered services must be attached before physician signs agreement. Requires plan to be bound by its verification of eligibility and/or coverage. Makes plan responsible for care rendered to those claiming to be Enrollees if the physician is unable to verify eligibility after following plan procedure. Provides that revisions or amendments will not be enforceable unless they have been provided to the physician.

Blue Cross

Allows for physicians to bill the plan for medically necessary covered services. Covered services are not defined in or attached to the agreement, the same apparently being whatever BCWA decides they are at any given time. There is no provision that covered service be defined in advance or that physicians receive advance written notice of any changes in covered services (nor a provision telling physicians how to determine what is a covered service).

In addition, the physician is obligated to provide services to those covered by other Blue Cross and Blue Shield Plans a well as their subsidiaries and affiliates, none of which is described. Even if it were possible for the physician to obtain a copy of BCWA's list of covered services, it may be almost impossible for the physician to obtain information on what is a covered service under the other affiliated plans. Company is not bound by its verification of eligibility. Allows plan to recapture payments to physicians if it misapplied its benefits.

Compensation

AMA Model Form

Requires that the compensation schedule be attached and made a part of the Agreement. A separate schedule must be attached for each affiliated plan which is covered under the agreement. It must specify the manner of payment. It addresses the manner in which copayments are to be collected and addresses coordination of benefits. The agreement requires payment within forty-five (45) days of receipt of the submission of a claim or notification to the physician of the need for more information within that time period and payment within thirty (30) days of receipt of the missing information. Requires payment of interest for delay beyond terms of agreement.

Blue Cross

No compensation schedule attached to the Agreement. Allows the compensation schedule to be set from time to time in the sole discretion of the company. Company can set new fees and rates unilaterally, at any time, at its discretion. There is no necessity that the fee schedule be set in advance or that physicians receive advance written notice of any changes in allowed amounts. (See AS 21.87.140(c)(1) requiring the physician to be compensated for services in accordance with the terms to be contained in the agreement or attached to and made a part of the agreement.) Requires submission of claims within 365 days of service. States that disputes regarding payment and medical necessity will be mutually resolved or submitted to arbitration before the American Arbitration Association. The term "medically necessary" is not defined. Presumably this is whatever the company's medical director says is medically necessary. (The AMA defines it as what a reasonably prudent physician would deem necessary for the diagnosis or treatment of illness or injury.) Disagreements over medical necessity, apparently even those requiring emergency treatment, are to be mutually discussed, then must go through an expensive and time consuming arbitration process.

Requires physician to refund monies to company if company determines that payment was based upon erroneous or incomplete information or if it misapplied benefits.

The physician must bill in a manner acceptable to BCWA, which is undefined in the contract. Requires company to pay claims in a timely fashion without defining what is timely or requiring interest to be paid on those claims not paid in a timely fashion. There is no discussion of how copayments or coinsurance are to be handled. The physician agrees to accept the BCWA payment as payment in full and not to otherwise bill the Enrollee except for deductibles, copayments, coinsurance, non covered services or covered services not deemed medically necessary if the patient agreed in writing before the treatment.

Physician Duties

AMA Model Form

Requires the physician to be licensed, in good standing and not to discriminate. It requires the physician to comply with the policies and procedures established by the plan to the extent the physician has received notice of the same. Requires policies and procedures to be attached to the contract, not to be changed without thirty days written notice to the physician and prohibits company from modifying policies and procedures in a way which would have a material effect on the contract without written consent of the physician. The physician agrees to advise Enrollees of the company grievance procedures. Contains a provision that nothing in the Agreement should be construed to force any physician to take any action inconsistent with his/her professional judgment in providing care to a patient.

Blue Cross

Requires physicians to provide services to Enrollees on same basis as services are provided to patients who are not Enrollees. This could be construed as an attempt to require the physician to charge no more that (s)he does to any other non-governmental payor for similar services. Requires physician to cooperate with BCWA utilization management programs, which are undefined. Does not provide for any appeal process concerning utilization management decisions. The physician must abide by BCWA's policies and procedures which are undefined and may be modified by the company at its sole discretion. Does not contain a provision stating physician need not take any action inconsistent with professional judgment in providing care to the patient.

Company Obligations

AMA Model Form

The company should list each payor and plan and update them promptly to reflect additions or deletions. Company shall notify physician of all policies, procedures, rules, regulations that it considers material to performance of Agreement as well as amendments. Thirty day notice of any changes. No modifications allowed in a manner that would have a material adverse effect on contract without physician approval. Provides a right and a mechanism to appeal any Utilization Review or Quality Management decision by the company that is ultimately decided not by the company in its sole discretion but by independant peers. Decisions are rendered within thirty (30) days except for those utilization review decisions related to emergency care, which shall be heard more quickly. Requires the company to establish and maintain systems to process and resolve grievances by physicians towards the company. Requires the company and not physicians to explain details of health plan policies to patients. Requires the company to provide the physician with quarterly financial statements accurately depicting the financial condition of the company.

Blue Cross

There is no list of payors or plans, only a reference that other Blue Cross and Blue Shield plans with reciprocal agreements are included. See above description under Physician duties. The physician must abide by BCWA's policies and procedures which are undefined and may be modified by the company at its sole discretion even if they should have a materially adverse effect on the contract. There is no definition of utilization review, no mechanism for expedited decision concerning emergency medical care and no mechanism of determination by independent peers. The questions appear to be subject to arbitration pursuant to the rules of the American Arbitration Association. No grievance procedure is spelled out. No discussion of who is required to explain plan details to patients.

Records/Confidentiality

AMA Model Form

Gives each party right to access to and right to examine records of the other which relate to any Covered Services or payments provided under this Agreement. Requires company to obtain from the Enrollee a consent for the release of medical information narrowly tailored

to accomplish the purpose necessary. Company agrees not to release such information to other parties without written consent of the patient. Costs associated with this are paid by the company. Insures that only medical records and precise schedules of compensation are confidential. Within strict limits it allows the company to prepare and disclose to a third party a report of the physician's quality data relating to utilization and Enrollee satisfaction surveys, but does not allow for disclosure of identity of individual physicians. The report must be provided to the physician for review at least 30 days before it is given to a third party.

Blue Cross

Allows BCWA to review and duplicate any data or records maintained by the physician with respect to an Enrollee for a period of eighteen (18) months after termination of the Agreement. Does not require company to pay for copies. Appears to make physician responsible for obtaining release from patient and paying for copies of records. Does not give physician right of access to company records pertaining to covered services or claims. Contains a vague provision requiring company and physician to take all reasonable precautions to prevent unauthorized disclosure of any information obtained pursuant to Agreement. Does not give physicians right to review quality assurance data, utilization surveys, etc.

Insurance

AMA Model Form

Requires the physician to maintain E&O insurance.

Blue Cross

Requires the physician to maintain E&O insurance. Fails to disclose what is an appropriate amount of E&O insurance.

Term and Termination

AMA Model Form

Agreement runs until terminated except that covered services and compensation schedules are to be renegotiated annually and renewed or rejected individually. Ninety (90) days written notice of any proposed change is required. In the event parties cannot agree on

new schedules either may terminate the contract. Contract can be terminated for cause, otherwise either party may cancel by giving four month (120 days) notice. When the contract is terminated by either party a reason for such termination must be stated in writing. This provides assistance to physicians who fear they are being unfairly discriminated against or punished for violation of some "gag" rule. It also insures that there is no mistake of fact which was relied upon when the other party decided to terminate.

Dispute resolution procedures are available to either party in event of a termination. If company is in financial difficulty the agreement may be terminated. Agreement may be terminated by either party for "cause", but only after giving the other party written notice of the deficiency and thirty days to cure the deficiency. Company remains liable to pay for covered services then being rendered until the episode of illness is complete.

Blue Cross

Can be terminated by either party on thirty (30) days written notice. Can be terminated immediately by either party upon written notice for failure to comply with any of the provisions of the Agreement. Payments then accrued to the physician will be made. Physician agrees that regardless of termination (s)he will continue to treat any Enrollee until the termination of that Enrollee's agreement or the next anniversary of the subscriber, whichever is earlier. This really means that the physician can be forced to continue providing services for one year or more after (s)he has given notice of termination. (This last provision appears mandated, as to Blue Cross, by AS 21.87.140(c)(3).) Physician is required to notify enrollees seeking services that agreement has been terminated. There is no opportunity to cure any alleged breach of the agreement. No reasons for termination are necessary. Company does not remain liable to pay for services related to an ongoing episode of illness.

Dispute Resolutions

AMA Model Form

Provides for an initial meeting within seven (7) days by parties with decision making authority followed by Mediation within thirty days (30) with each party to bear its proportionate share of costs. If unsuccessful this is followed by binding arbitration held in the state where services were performed and conducted according to procedures of the Health Lawyers Association of America Alternative Dispute Resolution Project. Also provides for appeal of quality assurance and utilization review decisions. See Company's Obligations discussed above.

Blue Cross

Only disputes regarding payment and medical necessity are part of the process. First step is for physician and company to communicate directly in attempt to mutually resolve dispute. Second step is for arbitration before American Arbitration Association. No time limits are set for the procedures, nor is there a provision for who bears the costs or where the procedures should take place. Does not provided a right or mechanism to appeal any Utilization Review or Quality Management decision by the company to independent peers and there is no provision to review decisions related to emergency medical care, which should be heard more quickly. There is no grievance procedure.

Amendments/Miscellaneous

AMA Model Form

The Agreement cannot be assigned to an unrelated entity, by either party, without prior written consent of other party. No one except for enrollees has any third party rights under the agreement. The agreement may not be modified without express written approval of both parties. Requires notice to other party of legal matters instituted against either party relating to the Agreement or services provided under the agreement.

Blue Cross

It is possible that this agreement has been filed with and approved by the Director of the Division of Insurance (See AS 21.87.140(d).) The agreement allows the company to set the fee schedules, policies and procedures and covered services at its discretion. The company may amend the Agreement at any time with thirty (30) days written notice to the physician. The amendment becomes binding upon the physician unless BCWA is otherwise notified by the physician within this period. Neither party can assign this Agreement without the written consent of the other except that it allows BCWA to merge or consolidate with another entity. States that Agreement is interpreted according to Alaska law but does not say that any arbitration, mediation, litigation, etc. must take place in Alaska.