

**ALASKA LEGISLATURE**

**2343**

**HOUSE and SENATE FINANCE COMMITTEE FILES,**

**2001 - 2002**

**\*Section 3**

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 The law would be repealed July 1, 2006.

# Alaska State Legislature

Session:  
State Capitol  
Juneau, AK 99801  
Phone: (907) 465-2327  
Fax: (907) 465-5241



Interim  
119 N. Cushman  
Fairbanks, AK 99701  
Phone: (907) 456-8161

Senator Pete Kelly  
District P

## CSSB 37 ( ) Version 22-LS0323\B

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

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

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

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

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

# Senate Bill 37

## How does it work?

Group of physicians wishing to jointly negotiate

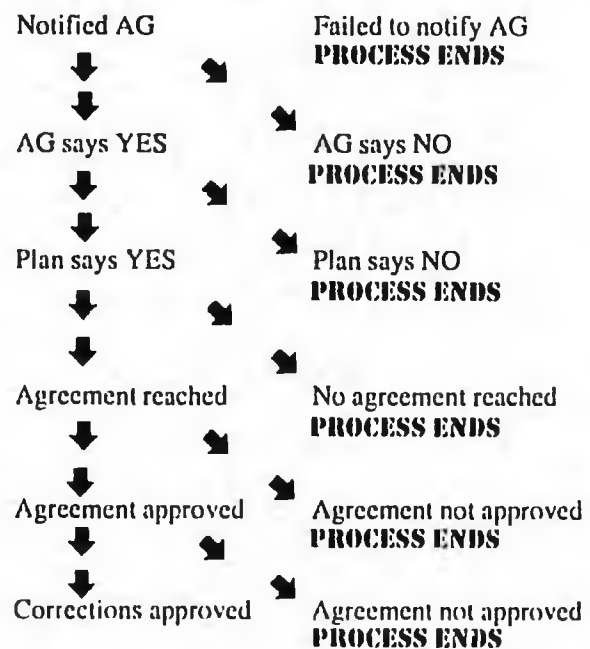
*Appoint an exclusive representative*

Authorized third party

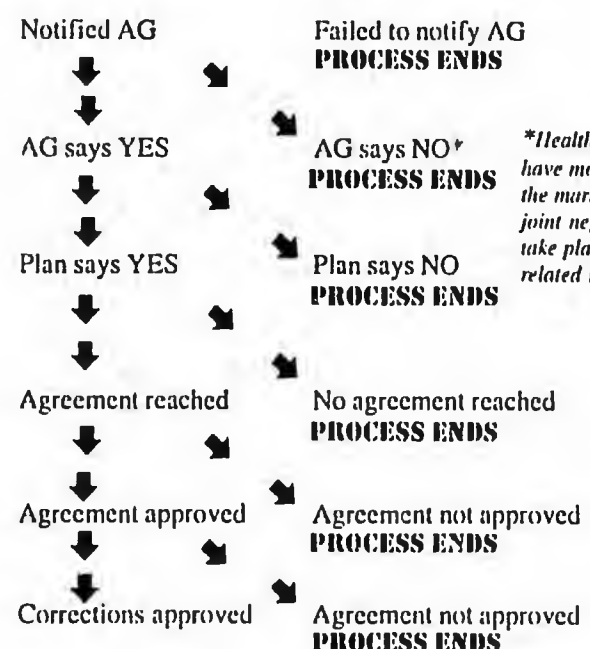
*(May not represent more than 30% of doctors in a geographic service area unless the health plan has a market share of more than 5% in that same geographic service area)*

Non-Fee Related Items

Fee Related Items



1. Notifies the Attorney General and health care plan of desire to negotiate
2. Attorney General decides if negotiations may take place
3. Health care plan decides whether to negotiate
4. Agreement between physicians and health plan reached
5. Submit to Attorney General for approval



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

## **How does SB 37 benefit consumers?**

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

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

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

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

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

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

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

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

FROM THE TEXAS HANDBOOK:

How will this bill improve patient care?

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

SB37  
"State Action Doctrine"

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

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

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

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

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

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

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

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

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

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

Provided by: ASMA

# Alaska State Medical Association

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

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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?

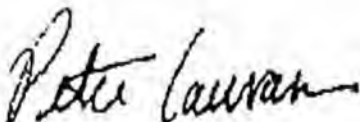
- It allows independent, competing physicians to jointly negotiate terms of physicians services agreements with the insurance companies without violating federal anti-trust laws.
- It can only be created by an Act of the State Legislature that:
  1. Clearly establishes a state policy;
  2. Clearly describes 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,



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

LP

*Alaska Physicians & Surgeons, Inc.*  
4120 Laurel Street, Suite 206  
Anchorage, Alaska 99508  
Phone: 561-7705 Fax: 561-7704  
E-mail akphys@alaska.net

February 28, 2001

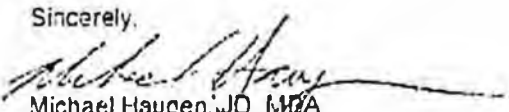
Senator Randy Phillips  
Alaska State Senate  
State Capitol Building  
Juneau, Alaska 99801-1182

Dear Senator Phillips,

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

- The Attorney General's Office - In discussions with Mr. Sniffen, the Assistant Attorney General in charge of anti-trust, his primary concern seems to be that the bill is not specific enough in its description of what constitutes adequate state oversight. We feel that the language in the bill is specific enough, and gives the Attorney General's office broad latitude in writing enabling administrative rules, to clarify the Attorney General's "active state oversight" function.
- The Unions - Last year both the AFL-CIO, and the Teamsters opposed the bill primarily on the grounds that they would be forced to negotiate with physicians about contract terms for their self insured plans, and that those negotiations would raise medical costs to their union members. A secondary concern was that because their plans are self insured, they should be exempted from negotiating with physicians, because self-insured plans are generally subject to ERISA preemption. We strongly feel that these concerns are misplaced, because the bill clearly states that all negotiations are voluntary not mandatory. Second, if there is a question as to whether or not a union's self insured plan would be exempted under ERISA, the union and/or the physicians can ask the Attorney General's office for a legal opinion prior to negotiations.
- Insurers - Blue Cross Blue Shield and Aetna were the chief insurance opponents of the bill last year were. Their primary argument seemed to be that if physicians were allowed to negotiate as a group, the effect would be to drive up the cost of health care in Alaska, because the bill would give physicians too much bargaining power. From our standpoint, the insurers repeatedly failed to address the bill's requirement that any contract ultimately must be approved by, and is subject to an Attorney General's veto, if financial or non-financial contract terms are deemed not to be in the best interest of the citizens of Alaska.
- The Division of Insurance - My association is still unclear about the issues of concern that the Division of Insurance has and would appreciate if you could have them specify in writing, at the earliest possible time, what their concerns are, and have them include suggested amendments to the bill.
- My association is aware that there are currently 4 separate fiscal notes attached to SB37. As you may recall from last year's debate over the bill, a larger fiscal note was attached, which included an assumption that if the bill passed, there would be upward of 1,000 contracts that the Attorney General's office would have to review and approve. Speaking as one who would be negotiating these contracts, that figure was wildly exaggerated. I predict no more than 10 to 20 contracts would need to be reviewed in any given year, and that would not be likely occur until 3 years after the implementation of the bill. We are seeking clarification from the 4 fiscal note authors as to the assumptions that went into their fiscal notes' conclusions. We would appreciate your help in getting that information as soon as possible.

Sincerely,

  
Michael Haugen, JD, MPA  
Executive Director



**SENATE COMMITTEE REPORT  
First Committee of Referral**

DATE: 1/22/01

FURTHER: Labor and Commerce  
Finance

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

DATE TURNED  
IN TO OFFICE: 2-22-01

Judiciary Committee considered      SENATE BILL NO. 37

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

and recommends:

- be replaced with \_\_\_\_\_ CS SB 37 ( JUD )
- adopt previous \_\_\_\_\_ CS \_\_\_\_\_ ( \_\_\_\_\_ )
- attached amendment(s)
- adopt Letter of Intent by \_\_\_\_\_ Committee
- further referral to \_\_\_\_\_ Committee

- Senate Bill:**  
 same title  
 new title  
**House Bill:**  
 same title  
 technical title  
 new: SCR # \_\_\_\_\_

**NEW FISCAL NOTE(S):**

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

**PREVIOUS FISCAL NOTE(S):**

Department	Date	Fiscal	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
<i>John Conder</i>			✓	
<i>John S. Ellis</i>		✓		
<i>W. Douglas</i>		✓		
<i>Gene Theriault</i>			✓	
CHAIR: <i>John Taylor</i>			✓	

# STATE OF ALASKA

DEPARTMENT OF LAW  
OFFICE OF THE ATTORNEY GENERAL

TONY KNOWLES, GOVERNOR

1031 WEST 4<sup>TH</sup> AVENUE, SUITE 200  
ANCHORAGE, ALASKA 99501-5903  
PHONE: (907) 269-5100  
FAX: (907) 276-3697

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.

Senator Robin Taylor  
Chair Senate Judiciary Committee

January 19, 2001  
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## 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

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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

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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. This 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 shielded 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

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Chair Senate Judiciary Committee

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conduct." *Patrick v. Burget*, 486 U.S. 94, 100 (1988). In this context the issue is whether "the state has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among the parties." *Ticor*, 112 S. Ct. at 2177. The Court has held that a state did not actively supervise price arrangements when it did not establish the prices, review the reasonableness of the prices, monitor market conditions, or engage in any pointed reexamination of the program. *Midcal*, 445 U.S. 92, 105-106 (1980).

Several aspects of the provisions of SB 37 raise questions as to the adequacy of state supervision authorized by the bill, thereby reducing the likelihood that the legislation meets the requirements of the state action doctrine immunizing physicians from prosecution under federal antitrust laws. First, the limited nature of information that a third party representative must provide to the Attorney General to obtain approval to negotiate raises the question as to the extent the Attorney General can exercise sufficient independent judgment and control to make the determinations required under the bill. For example, the Attorney General must determine whether the third party has complied with the physician market share limits under the bill in order to decide whether the proposed negotiations exceed the authority granted under the chapter. The third party, however, is not required to provide any information necessary to make such a determination, such as information relating the physicians they represent, their specialty areas, market shares, etc.

Second, the bill imposes substantial responsibilities on the Attorney General to approve or not approve a proposed negotiated contract, utilizing specific criteria, but provides only a very short time frame (30 days) within which to make that fact intensive determination, and does not require that the parties provide any information to the Attorney General to make such a determination. Moreover, the regulatory scheme established by the bill contains no mechanism for members of the public, or others affected by the decision, to offer evidence and argument relating to the costs or benefits of the proposed contracts. All of these factors suggest that no substantive review is contemplated by the legislation, nor would the Attorney General be in a position to exercise independent judgment and control in determining the reasonableness of negotiated terms of the contract.

Finally, rather than putting the burden on the proponents of a contract to demonstrate that the proposed contract complies with the articulated standards, SB 37 puts the burden on the Attorney General to make that determination without any information to assist in the review. This is contrary to established legal principles that the party requesting a change from the status quo has the burden of proving that the requested action is justified. The proponents of a negotiated contract are the entities with the information and knowledge necessary to establish that the criteria have been met. SB 37's failure to place the burden on the proponents of the contract to demonstrate that the standards for approval have been met is further indicia that a substantive review of the contract terms is not contemplated by the legislation.

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Chair Senate Judiciary Committee

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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 affect 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.

Senator Robin Taylor  
Chair Senate Judiciary Committee

January 19, 2001  
Page 7

#### 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.

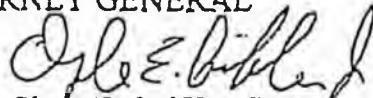
By using the term "health benefit plan" in the bill, insurance companies are not subject to the bill's requirements as may have been intended. If this is not the legislature's intent, then the bill should be amended to clarify that insurers are subject to this bill.

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 Beltr, Department of Law  
Chrystal Smith, Department of Law



Bureau of Competition  
William J. Baer, Director  
Direct Dial  
(202) 325-2932

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

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.<sup>(1)</sup> 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.

# CORRECTION

THE FOLLOWING DOCUMENT(S)  
HAVE BEEN REFILMED TO  
ASSURE LEGIBILITY OR PAGINATION



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Central Microfilm Services  
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State of Alaska



Bureau of Competition  
William J. Baer, Director  
Direct Dial  
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UNITED STATES OF AMERICA  
FEDERAL TRADE COMMISSION  
WASHINGTON, D.C. 20580

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It is not clear, however, to what extent these differences would reduce the potential for anti-competitive 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 specialties, 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.<sup>(2)</sup> 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 contract 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.<sup>(3)</sup>

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

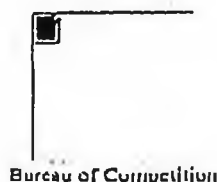
Sincerely yours,

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 specialties 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. Burgut*, 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.



Bureau of Competition

Richard A. Feinstein  
Assistant DirectorDirect Dial  
(202) 326-3689UNITED STATES OF AMERICA  
FEDERAL TRADE COMMISSION  
WASHINGTON, D.C. 20589

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.<sup>(1)</sup> In addition, health care professionals can, through their professional societies and other groups, jointly

provide information and express opinions to health plans.<sup>(2)</sup> 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 do not meet those terms.<sup>(3)</sup> 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.<sup>(4)</sup> 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.<sup>(5)</sup>

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.<sup>(6)</sup>

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.<sup>(7)</sup> 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 than 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.<sup>(8)</sup> 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.<sup>(9)</sup> 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.<sup>(10)</sup> 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 Assn 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.<sup>(11)</sup> 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

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#### 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](http://www.ftc.gov/reports/hlth3s.htm)).
2. See, e.g., *Schaecher v. American Academy of Ophthalmology*, 870 F.2d 397 (7<sup>th</sup> 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 zones" 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 to the Board's federal enabling legislation. See *Hecht v. Pro-Football, Inc.*, 444 F.2d 931 (D.C. Cir 1971).

# STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

TONY KNOWLES, GOVERNOR

1031 WEST 4<sup>TH</sup> AVENUE, SUITE 200  
ANCHORAGE, ALASKA 99501-5903  
PHONE: (907)269-5100  
FAX: (907)276-8554

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."<sup>1</sup> According to the report, eighteen states had statutes (at that time)

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<sup>1</sup> 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 if it consists 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).<sup>2</sup>

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 through "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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<sup>2</sup> 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 (1<sup>st</sup> 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 may not apply.

#### 4. Conclusion.

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

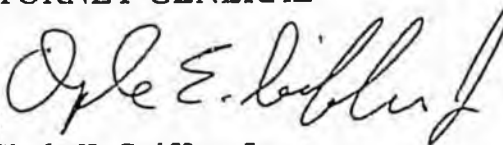
Senator Robin Taylor  
Chair, Senate Judiciary Committee

January 30, 2001  
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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

**THE ROLE OF ANTI-TRUST LAW IN THE  
WASHINGTON STATE HEALTH CARE MARKET**

**REPORT TO THE WASHINGTON STATE LEGISLATURE  
DECEMBER 15, 1995**

**Christine O. Gregoire**  
**Attorney General**  
**Jon P. Ferguson**  
**Senior Counsel**

**Prepared by:**

**Tina E. Kondo**  
**Assistant Attorney General**

**David G. Forster**  
**Law Clerk**

**Office of the Attorney General**  
**State of Washington**  
**Anti-trust Section**  
**Seattle, Washington**

**Richard J. Arnould, Ph.D.**  
**Director, Program in Health**  
**Economics, Management and Policy**

**Lawrence DeBrock, Ph.D.**  
**Associate Professor of Economics**

**Tom Gift**  
**Graduate Assistant**

**University of Illinois**  
**Champaign, Illinois**

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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."<sup>138</sup>

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.<sup>139</sup> 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."<sup>140</sup> 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.<sup>141</sup> 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.<sup>142</sup> In contrast, only 27 of 229 hospital mergers were investigated by the DOJ and FTC during the

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<sup>138</sup>1995 Wash. Laws Ch. 267, § 9.

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

<sup>140</sup>David Burda, Mergers Thrive Despite Wailing About Adversity, Modern Healthcare, October 12, 1992, at 26.

<sup>141</sup>*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).

<sup>142</sup>David Burda, Mergers Thrive Despite Wailing About Adversity, Modern Healthcare, October 12, 1992, at 26.

1987-91 time period, leading to only 3 actions.<sup>143</sup> 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.<sup>144</sup> 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 statutes 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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<sup>143</sup>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.

<sup>144</sup>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.<sup>145</sup> 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.<sup>146</sup> 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."<sup>147</sup>

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.<sup>148</sup> 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.<sup>149</sup>

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

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<sup>145</sup>See table IX.B.

<sup>146</sup>RCW 43.72.310(2)(a) (1994).

<sup>147</sup>RCW 43.72.310(3) (1994), amended by 1995 Wash. Laws Ch. 267, § 8(3).

<sup>148</sup>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.

<sup>149</sup>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.<sup>150</sup> 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.<sup>151</sup> 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.<sup>152</sup>

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.<sup>153</sup>

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.<sup>154</sup> Washington's statute declares an intention to displace competition and to immunize activity approved pursuant to the statute.<sup>155</sup>

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

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<sup>150</sup>RCW 43.72.310(4) (1994).

<sup>151</sup>*Id.*

<sup>152</sup>*Id.*

<sup>153</sup>RCW 43.72.310(2)(a) (1994).

<sup>154</sup>See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980), *supra*; pp. 12-13.

<sup>155</sup>RCW 42.73.300 (1994).

the standards of Ticor.<sup>156</sup> 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.<sup>157</sup> 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.<sup>158</sup>

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

<sup>157</sup>RCW 43.73.310(6) (1994).

<sup>158</sup> 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 <b><u>REPEALED</u></b>	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 ( <b><u>REPEALED BY</u></b> 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); <u>amended by 1995 Mont. Laws ch 378</u> .	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); <u>Recodified as</u> Tex. Health & Safety Code Ann. §§ 314.001 to 008. <u>by</u> Tx. Legis. Ch. 76, § 17.01(25) (1995).	None
Washington	(1) Cooperative agreements  (2) Cooperative agreements, including joint ventures, acquisitions, and mergers	Rural hospital districts  Health plans, health care facilities including hospitals, and health care providers	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).  Washington Health Services Act of 1993 (1993 Washington Laws ch. 492); Wash. Rev. Code § 43.72.310 (1994); <u>Temporarily suspended by</u> 1995 Washington Laws ch. 267, § 9).	None  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
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\* 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.<sup>159</sup>

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.<sup>160</sup> Therefore, the rate of antitrust filings did not appear to be lower for immunity states.<sup>161</sup>

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.<sup>162</sup>

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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<sup>159</sup>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.

<sup>160</sup>Eighteen states have immunity statutes; thirty-two do not.

<sup>161</sup>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.

<sup>162</sup>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.<sup>163</sup> 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.<sup>164</sup> 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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<sup>163</sup>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.

<sup>164</sup>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**

	<b>Consent Decrees</b>	<b>Assurance of Discontinuance</b>	<b>Settlement Agreement</b>	<b>Voluntary Compliance</b>	<b>Informal Business Review</b>
<b>Hospital Mergers</b>	2 (Kentucky, New Hampshire)	1 (Massachusetts)			
<b>HMO Mergers</b>		1 (Massachusetts)			
<b>Health System Mergers</b>	2 (Pennsylvania)				
<b>Health System Acquisition of Hospital</b>					
<b>Hospital Chain Merger</b>					
<b>Boycott</b>	1 (Arizona)	1 (Massachusetts)			
<b>Joint Venture by Home Health Providers</b>					1 (Maryland)
<b>§ 2 Exclusive Dealing</b>			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*.<sup>165</sup> 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.<sup>166</sup> 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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<sup>165</sup>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).

<sup>166</sup>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.<sup>167</sup> 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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<sup>167</sup>Sec. 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
<b>Hospital Mergers</b>	2 (Texas, Florida)		1 (Florida)		
<b>HMO Mergers</b>					
<b>Health System Mergers</b>					
<b>Health System Acquisition of Hospital</b>	1 (Tennessee)				
<b>Hospital Chain Merger</b>	1 (Florida)				
<b>Boycott</b>					
<b>Joint Venture</b>					
<b>§ 2 Exclusive Dealing</b>					
<b>§ 2 Acquisitions</b>					
<b>§ 1 Restraint of Trade</b>					

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

## XI. CONCLUSION

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

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

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

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

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

# STATE OF ALASKA

DEPARTMENT OF LAW  
OFFICE OF THE ATTORNEY GENERAL

TONY KNOWLES, GOVERNOR

1031 WEST 4<sup>TH</sup> AVENUE, SUITE 200  
ANCHORAGE, ALASKA 99501-5003  
PHONE: (907)269-5100  
FAX: (907)276-8554

March 8, 2001

Senator Randy Phillips  
Chair, Senate Labor and Commerce Committee

Re: CSSB 37

Dear Chairman Phillips:

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

The thrust of the Department's concern is that this bill violates state and federal antitrust law. To avoid this potential conflict, the bill must satisfy the "state action" doctrine, which requires two things: (1) clear and specific legislative intent to provide antitrust immunity, and (2) active state supervision. "Active state supervision" means the state must "exercise sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention."

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

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

Senator Randy Phillips  
Chair, Senate Labor and Commerce Committee

March 8, 2001  
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Washington's statute is attached; it contains language the Department would consider appropriate to address the antitrust elements of CSSB 37, with some limited modification as proposed below. The key elements of Washington's statute are:

1. The statute does not authorize activities that would constitute *per se* violations of state and federal antitrust laws. This includes price-related terms, and prohibits boycotts, coercion, intimidation, or any other coercive activity;
2. A health carrier can request that the Department of Health obtain an informal opinion from the Attorney General as to whether the conduct is authorized. The Attorney General can request additional information to make this decision. A health care entity can also petition the Department directly, without requesting Attorney General approval;
3. After receiving an opinion from the Attorney General, the Department of Health may authorize the conduct, and adopt rules governing the conduct, including rules on specific contract clauses;
4. If the Attorney General determines the activity is not authorized, the health care entity can petition the Department of Health to approve the request anyway;
5. In authorizing conduct and adopting rules of conduct, the Department of Health, with advice from the Attorney General, must consider the benefits of such conduct in furthering the goals of health care reform. The benefits must outweigh the anti-competitive nature of the conduct, and any adverse impact on the quality, availability, or price of health care;
6. The Department of Health, with the assistance of the Attorney General, must actively supervise the conduct to determine whether it should continue, or whether other alternatives are available. This supervision includes submission of annual (or more frequent) progress reports and continued evaluations.

Senator Randy Phillips  
Chair, Senate Labor and Commerce Committee

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The Department would request the following additions to this statute:

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

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

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

1. Submission of more-detailed information by a physician representative which includes descriptions of the geographic and product markets affected by the proposed negotiations; anticipated price increases; and other impacts on health care;
2. A restriction that limits any bargaining group to 20 percent of the providers in either the geographic or product market, i.e., no more than 20 percent of physicians in any given area or within any given specialty;
3. At least 90 days to review and approve proposed negotiations;
4. A statement that collective activity by physicians who are contemplating a request for collective negotiations is not authorized;
5. If Washington's terminology is to be used, there needs to be some clarification about what a "health carrier" is, and if that term is meant to be different from "health insurers."

Senator Randy Phillips  
Chair, Senate Labor and Commerce Committee

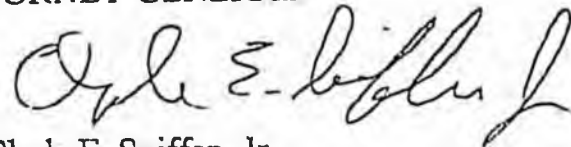
March 8, 2001  
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The Department of Law has restricted its comments to the antitrust issues raised in this bill, and these suggestions should not be taken as an endorsement of this bill.

Sincerely,

BRUCE M. BOTELHO  
ATTORNEY GENERAL

By:



Clyde E. Sniffen, Jr.  
Assistant Attorney General

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

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43.72.300

STATE GOVERNMENT—EXECUTIVE

HEALTH

43.72.300. Managed competition—Findings and intent

(1) The legislature recognizes that competition among health care providers, facilities, payers, and purchasers will yield the best allocation of health care resources, the lowest prices for health care services, and the highest quality of health care when there exists a large number of buyers and sellers, easily comparable health plans and services, minimal barriers to entry and exit into the health care market, and adequate information for buyers and sellers to base purchasing and production decisions. However, the legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

(2) The legislature therefore intends to exempt from state anti-trust laws, and to provide immunity from federal anti-trust laws through the state action doctrine for activities approved under this chapter that might otherwise be constrained by such laws and intends to displace competition in the health care market: To contain the aggregate cost of health care services; to promote the development of comprehensive, integrated, and cost-effective health care delivery systems through cooperative activities among health care providers and facilities; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure universal access to a publicly determined, uniform package of health care benefits; and to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care services, providers of health care services, health care facilities, and Washington residents. To these ends, any lawful action taken pursuant to chapter 492, Laws of 1993 by any person or entity created or regulated by chapter 492, Laws of 1993 are declared to be taken pursuant to state statute and in furtherance of the public purposes of the state of Washington.

(3) The legislature does not intend and unless explicitly permitted in accordance with RCW 43.72.310 or under rules adopted pursuant

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43.72.310

STATE GOVERNMENT—EXECUTIVE

HEA

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

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

(a)

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

(b)  
" (c)  
(d)  
(e)

(b) Shall adopt rules governing conduct among providers, health care facilities, and health carriers including rules governing provider and facility contracts with health carriers, rules governing the use of "most favored nation" clauses and exclusive dealing clauses in such contracts, and rules providing that health carriers in rural areas contract with a sufficient number and type of health care providers and facilities to ensure consumer access to local health care services;

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(c) Shall adopt rules permitting health care providers within the service area of a plan to collectively negotiate the terms and conditions of contracts with a health carrier including the ability of providers to meet and communicate for the purposes of these negotiations;

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(d) Shall adopt rules governing cooperative activities among health care facilities and providers; and

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(e) Effective July 1, 1997, in addition to the rule-making authority granted to the department under this section, the department shall have the authority to enforce and administer rules previously adopted by the health services commission and the health care policy board pursuant to RCW 43.72.310.

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(3) A health carrier, health care facility, health care provider, or any other person involved in the development, delivery, and marketing of health care services or health plans may file a written petition with the department of health requesting approval of conduct that could tend to lessen competition in the relevant market. Such petition shall be filed in a form and manner prescribed by rule of the department of health.

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The department of health shall issue a written decision approving or denying a petition filed under this section within ninety days of receipt of a properly completed written petition unless extended by the department of health for good cause shown. The decision shall

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## GOVERNMENT—EXECUTIVE

for good cause shown. If the conduct is not authorized by a carrier or organization making the health for review and approval, subsection (3) of this section.

on of the attorney general and department of health:

th carrier, health care facility, person that could tend to lessen competition on a strong showing that the goals of chapter 492, Laws of 1991 are impractical;

duct among providers, health care facilities, and rules governing provider contracts, rules governing the use of exclusive dealing clauses in such contracts, health carriers in rural areas, and type of health care providers that are to local health care services;

alth care providers within the region to negotiate the terms and conditions of a carrier including the ability of a carrier for the purposes of these negoti-

erative activities among health

on to the rule-making authority of this section, the department shall administer rules previously adopted by the health care policy board

cility, health care provider, or health plan, delivery, and market. Health plans may file a written petition requesting approval of conduct that affects the relevant market. Such approval shall be in the manner prescribed by rule of the

le a written decision approving or disapproving a petition within ninety days of the filing of a petition unless extended by rule of the department if use shown. The decision shall

## HEALTH SYSTEM REFORM

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

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

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

(b) Gains in cost efficiency of health services;

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

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

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

These benefits must outweigh disadvantages including and not limited to:

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

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

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

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

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

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Conduct ordered discontinued by the department of health shall no longer be deemed to be taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(7) Nothing contained in chapter 492, Laws of 1993 is intended to in any way limit the ability of rural hospital districts to enter into cooperative agreements and contracts pursuant to RCW 70.44.450 and chapter 39.34 RCW.

(8) The secretary of health shall from time to time establish fees to accompany the filing of a petition or a written request to the department to obtain an opinion from the attorney general under this section and for the active supervision of conduct approved under this section. Such fees may vary according to the size of the transaction proposed in the petition or under active supervision. In setting such fees, the secretary shall consider that consumers and the public benefit when activities meeting the standards of this section are permitted to proceed; the importance of assuring that persons sponsoring beneficial activities are not foreclosed from filing a petition under this section because of the fee; and the necessity to avoid a conflict, or the appearance of a conflict, between the interests of the department and the public. The total fee for a petition under this section, a written request to the department to obtain an opinion from the attorney general, or a combination of both regarding the same conduct shall not exceed the level that will defray the reasonable costs the department and attorney general incur in considering a petition and in no event shall be greater than twenty-five thousand dollars. The fee for review of approved conduct shall not exceed the level that will defray the reasonable costs the department and attorney general incur in conducting such a review and in no event shall be greater than ten thousand dollars per annum. The fees shall be fixed by rule adopted in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW, and shall be deposited in the health professions account established in accordance with RCW 43.70.320.

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

Historical and Statutory Notes

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

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

Administrative Code References

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

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

**Chapter 246-25 WAC**  
**ANTITRUST IMMUNITY AND COMPETITIVE OVERSIGHT**

(Formerly Chapter 245-02 WAC)

Last Update: 1/28/99

WAC

**SUBSTANTIVE RULES**

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

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

WAC 246-25-010 Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**WAC 246-25-025 Scope and applicability.**

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

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

**WAC 245-25-030 Cooperative activities--Policy statement.**

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

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

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

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

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

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

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

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

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

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

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

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

(d) Patient referral procedures;

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

(f) Quality assurance programs;

(g) Health service utilization review procedures; and

(h) Carrier provider selection and termination criteria, or whether to engage in selective contracting.

Nothing herein shall be construed to allow a boycott.

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

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

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

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

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

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

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

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

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

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

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

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

prepaid comprehensive health services; and

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

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 43.72.310, 99-04-049, recodified as § 246-25-040, filed 1/28/99, effective 1/28/99; 9C-11-133, § 245-02-040, filed 5/22/96, effective 6/22/96; 95-04-115, § 245-02-040, filed 2/1/95, effective 10/1/95.]

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

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

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

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

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

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

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

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

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

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

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

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

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

**PROCEDURAL RULES**

**WAC 246-25-100 Purpose.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Its business address(es);

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

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

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

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

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

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

(c) The products and services involved or affected;

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

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

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

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

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