A. Minimum Threshold for Health Plan Market Power

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

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

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

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

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

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

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

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

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

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

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

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

B. Limitations on Size of Physician Negotiating Group

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

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

C. Exclusion of Physician Boycott Conduct

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

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

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

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

III. State Action Immunity

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

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

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

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

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

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

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

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

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

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

Lack of Active Supervision

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

1. Review of Composition of Physician Groups

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

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

2. Review of "Brief Report" on Proposed Negotiations

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

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

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

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

3. Review of Collectively Negotiated Contracts

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

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

(a) Insufficient Information

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

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

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

information of any kind.[29]

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

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

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

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

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

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

(b) Insufficient Time

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

IV. Transparency

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

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

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

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

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

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

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

Sincerely,

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Prepared Statement
of the
Federal Trade Commission

Presented by

Robert Pitofsky, Chairman [1]
Federal Trade Commission

Before The
Committee on the Judiciary
United States House of Representatives

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

June 22, 1999

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. The Exemption Would Harm Consumers

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

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

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

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

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

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

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

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

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

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

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

provider organizations ("PPOs").[26]

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

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

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

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

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

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

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

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

III. There Are Better Ways To Protect Consumers

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

Proposals for reform include:

Increasing Consumers' Ability To Choose Their Health Plan.

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

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

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

Improving Consumer Information.

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

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

Regulation of Plan Behavior.

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

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

Conclusion

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

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

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

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

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

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

5. *Id.* at 234-35.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35. Report at 3-4.

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

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

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

May 13, 1999

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

Dear Representative Oliveira:

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

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

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

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

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

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

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

other.[3]

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

Sincerely yours,

William J. Baer

Enclosure

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

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

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

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

Bureau of Competition

Richard A. Feinstein
Assistant Director

Direct Dial
(202) 326-3688

October 29, 1999

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

Re: Physicians Negotiation Act of 1999

Dear Mr. Rigsby:

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

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

Background

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

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

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

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

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

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

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

enclosed for your information.

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

The District of Columbia Bill

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

The Scope of Permitted Conduct

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

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

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

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

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

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

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

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

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

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

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

Immunity Issues

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

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

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

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

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

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

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

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

* * *

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

Sincerely,

Richard A. Feinstein
Assistant Director

Attachments

Endnotes

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

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

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

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

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

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

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

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

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

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

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

Alaska State Medical Association

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February 11, 2002

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

Dear Representative Murkowski:

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

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

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

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

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

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

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

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

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

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

Sincerely,

James J. Jordan

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

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February 5, 2002

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

Dear Representative Murkowski:

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

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

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

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

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

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

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

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

Sincerely,

Michael Haugen, JD, MBA
Executive Director

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March 13, 2002

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

Dear Representative Murkowski:

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

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

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

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

- The nurses claim the bill would increase costs and reduce service.

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

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

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

Sincerely,

Michael Haugen, JD, MBA
Executive Director

c: Senator Pete Kelly

ORTHOPEDIC
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3340 Providence Drive, Suite 564 · Anchorage, Alaska 99508
Edward M. Voke, M.D. · Robert J. Hall, M.D. · Cindy M. Lee, D.O.

April 4, 2001

SB37- Physician Negotiation Bill

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

Dear Senator Kelly:

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

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

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

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

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March 28, 2001

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

RE: SB 37

Dear Senator Kelly:

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

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

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

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

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

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

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

Sincerely,

Peter Lawrason

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

c.c. Senate Finance Committee Members.

GRIFFITH C. STEINER, M.D.

OPHTHALMOLOGY

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

March 29, 2001

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

RE: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

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

GCS:jes

Summit
Family
Practice

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

March 29, 2001

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

Re: SB37-Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

S. Lynn Hornbein, MD

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

Providence Anchorage Anesthesia Medical Group, P.C.

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

March 29, 2001

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

Re: SB37-Physician Negotiation bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

Milton Hummer MD.

Milton Hummer, M.D.

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

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

Katmai Oncology Group

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

March 30, 3001

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

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

Dale Webb, MD

JOHN M. TROXEL, M.D.

DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY

3340 PROVIDENCE DRIVE
SUITE #359
ANCHORAGE, AK 99508

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

March 30, 2001

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

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly,

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

Sincerely,

John Troxel, M.D.

Alaska Ear Nose & Throat

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

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

March 30, 2001

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

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Respectfully,

Jerome List, DDS, MD

A Professional Corporation

Obstetrics and Gynecology

March 29, 2001

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

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

2841 DeBarr Road, Suite 45, Anchorage, Alaska 99508 Phone (907) 336-6375 • FAX (907) 336-7211

Roland E. Gower, M.D.
A Professional Corp.
3841 DeBarr Rd. #41
Anchorage, Alaska 99508
907-270-3564

Practice Limited to General Surgery By Appointment Only

March 29, 2001

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

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

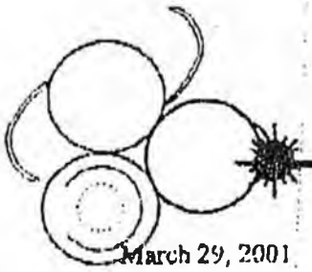
I am a private practicing surgeon in Anchorage. I support SB37 and ask that you and your Senate colleagues pass it on to the House. I feel that passage of the Physician Negotiation Bill will allow physicians to be better advocates for patients when dealing with third party payors over contracting issues.

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

Sincerely,

Roland E. Gower, MD

REG/eas



Grendahl Eye Associates

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

March 29, 2001

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

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

Marvin Grendahl, MD

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

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

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

March 29, 2001

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

Re. SB37-Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

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

OPHTHALMIC ASSOCIATES
a PROFESSIONAL CORPORATION

642 WEST SECOND AVENUE
ANCHORAGE, ALASKA 99501-2242
TELEPHONE (907) 276-1617
FAX (907) 278-1705

835 E. WESTPOINT DR., SUITE 207
WASILLA, ALASKA 99654-7143
TELEPHONE (907) 373-2229
FAX (907) 373-7778

CORDOVA (907) 270-1617
KODIAK (907) 486-4768

March 30, 2001

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

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

_____, M.D.

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

April 2, 2001

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

Re: SB37-Physican Negotiation Bill

Dear Senator Kelly

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

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

The Alaska Attorney General has veto power over the final contracts, including fee schedules. This veto power should help alleviate the concerns of those who claim that passage of this bill will simply allow physicians to increase of the cost of medicine.

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

Sincerely,

William C. Compton, MD

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

March 29, 2001

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

Re: SB37-Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

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

Sincerely,

S. Lynn Hornbein, MD

MEDICAL PARK FAMILY CARE, Inc.
"Family Thorough Concerned"

F. LELAND JONES, M.D.
KENNETH S. LAUFER, M.D.
R. MATISON WHITE, JR., M.D.
RICHARD R. TAYLOR JR., M.D.
CHARLES L. AARONS, M.D.

GLENN J. SCHULTES, M.D.
GARY L. CHILD, D.O.
TIMOTHY COALWELL, M.D.
MARIO A. LANZA, M.D
MICHELE A. CHASE, M.D.
DARREN B. LEWIS, M.D.

Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BOULEVARD, ANCHORAGE ALASKA 99508

March 29, 2001

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

RE: SB37 - Physician Negotiation Bill

Dear Senator Kelly,

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

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

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

Sincerely,

Mario Lanza

Mario A. Lanza, MD

March 30,2001

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

Re: SB37 Physician Negotiation Bill

Dear Senator Kelly,

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

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

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

Sincerely,

Michael D. Manuel, M.D.

Harbir S. Makin, M.D.

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE

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

March 29, 2001

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

Re: SB37 – Physician Negotiation Bill

Dear Senator Kelly:

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

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

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

Sincerely,

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

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

Dear Sen. Kelly:

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

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

Again, thanks for working for us in Juneau.

Dave Eichler

Providence Anchorage Anesthesia Medical Group, P.C.

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

March 29, 2001

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

Re: SB37-Physician Negotiation bill

Dear Senator Kelly:

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

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

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

Sincerely,

Steven Rosenfield, M.D.

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

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

March 24, 2002

Honorable Mr. Rokeburg,

I encourage you to look favorably on SB37.

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

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

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

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

Sincerely,

John DeKeyser

Sincerely,

John DeKeyser

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

Norman Rokeberg

RE: Senate Bill 37

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

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

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

Thank you!

Yolanda A. Meza CNM, MS

CECONSULTING

3998 DIANE ROAD

JUNEAU, ALASKA 99801

PHONE 907-789-3345 FAX 907-789-5022

FACSIMILE TRANSMITTAL SHEET

TO: NORMAN ROKEBERG, CHAIR, HOUSE JUDICIARY COMMITTEE

FROM: CAROLE S. EDWARDS, RN,BSN

DATE: 4/7/02

FAX NUMBER
907-465-2040

TOTAL NO. OF PAGES INCLUDING COVER:
1

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

Carole S. Edwards RN

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

Rep. Rokeberg,

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

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

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

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

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

Bradley K. Cruz, MD
Anchorage
7 Apr 2002

April 8, 2002

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

RE: Senate Bill 37

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

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

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

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

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

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

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

Respectfully,

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

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

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

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

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

Vote No on S.B. 37

Thank you
Deidre Strather
4/8/02

RE: Senate Bill 37

Representative Norm Rokeberg,

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

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

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

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

PLEASE VOTE NO ON SENATE BILL 37!

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

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

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

From: Martha Linden, C.N.M., ANP

RE: Senate Bill 37

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

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

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

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

Thank you!

Martha Linden CNM

AaNA Alaska Nurses Association

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April 8, 2002

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

RE: Senate Bill 37

Dear Mr. Chairman:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Patricia Senner, MS, RN, ANP
President, AaNA

Mary Kutney, RN, ANP
President, ANPA

Yolanda Meza, MS, CNM
President, AK-ACNM

Kathy Madej, CRNA
President AkANA

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

Primary care

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

Sue Horrocks, Elizabeth Anderson, Chris Salisbury

Abstract

Objective To determine whether nurse practitioners can provide care at first point of contact equivalent to doctors in a primary care setting.

Design Systematic review of randomised controlled trials and prospective observational studies.

Data sources Cochrane controlled trials register; specialist register of trials maintained by Cochrane Effective Practice and Organisation of Care Group, Medline, Embase, CINAHL, science citation index, database of abstracts of reviews of effectiveness, national research register, hand searches, and published bibliographies.

Included studies Randomised controlled trials and prospective observational studies comparing nurse practitioners and doctors providing care at first point of contact for patients with undifferentiated health problems in a primary care setting and providing data on one or more of the following outcomes: patient satisfaction, health status, costs, and process of care.

Results 11 trials and 25 observational studies met all the inclusion criteria. Patients were more satisfied with care by a nurse practitioner (standardised mean difference 0.27, 95% confidence interval 0.07 to 0.47). No differences in health status were found. Nurse practitioners had longer consultations (weighted mean difference 3.67 minutes, 2.05 to 5.29) and made more investigations (odds ratio 1.22, 1.02 to 1.46) than did doctors. No differences were found in prescriptions, return consultations, or referrals. Quality of care was in some ways better for nurse practitioner consultations.

Conclusion Increasing availability of nurse practitioners in primary care is likely to lead to high levels of patient satisfaction and high quality care.

Introduction

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

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

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

Methods

Selection of studies for review

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

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

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Sue Horrocks *research associate*
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Elizabeth Anderson *senior lecturer*

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

BMJ 2002;324:819–23

Additional tables and references appear on bmj.com

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

Identification of studies

We identified studies from searches of electronic databases and hand searches of recent editions of relevant journals, bibliographies and reference lists of other reviews and papers.[8 9] We scrutinised the following databases with no language restrictions: Medline (1966-2001), Embase (1980-2001), CINAHL (1982-2001), science citation index, database of abstracts of reviews of effectiveness, national research register, Cochrane controlled trials register and the specialist register of trials maintained by the Cochrane Effective Practice and Organisation of Care Group. We used the Cochrane optimal search strategy for randomised controlled trials, with advice from university librarians. All educational centres offering training for nurse practitioners in the United Kingdom and nurse practitioner organisations in the United States, South Africa, and Australia were approached for any unpublished studies. We contacted authors of included studies for additional research and for missing data. Data were extracted by one reviewer (SH) and one of two other reviewers (EA or CS) working independently. Disagreements were resolved by discussion with the third reviewer.

Assessment of study quality

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

Data analysis

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

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

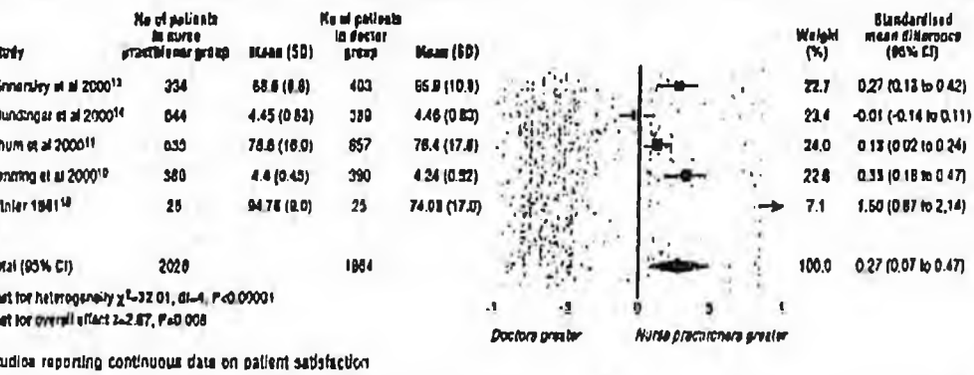
Results

Searches identified 119 potentially relevant papers, of which 95 reporting 34 studies fulfilled the inclusion and exclusion criteria. These papers comprised 11 randomised controlled trials (table A on bmj.com) and 23 observational studies (table B on bmj.com). Tables C and D on bmj.com show the quality assessment of the included studies.

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

Patient satisfaction

Nine randomised trials reported patient satisfaction (one of these was unpublished).[10–18] One paper could not be included in a meta-analysis owing to a lack of detail in the reporting of results.[13] Five trials reported continuous data on patient satisfaction (figure). These



Studies reporting continuous data on patient satisfaction

Process measures

	No of studies	No in intervention group	No in control group	Odds ratio or weighted mean difference (95% CI)	Heterogeneity χ^2	Heterogeneity P value	Overall effect Z value	Overall effect P value
Consultation length	5	2277: mean 14.89 min	2286: mean 11.14 min	3.97 (2.05 to 5.29)*	81.87 df=4	<0.00001	4.44	0.00001
Prescriptions	4	1685/2503	1944/2861	1.02 (0.90 to 1.15)	9.26 df=3	0.05	0.22	0.8
Investigations	5	932/2573	1015/2898	1.22 (1.02 to 1.46)	6.31 df=4	0.18	2.18	0.03
Return consultations	6	836/2819	919/3247	1.06 (0.87 to 1.28)	12.06 df=5	0.034	0.54	0.6
Referrals	2	44/1293	53/1367	0.71 (0.80 to 1.70)	4.07 df=1	0.044	0.76	0.4

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

were all in general practice settings, three in the United Kingdom and two in the United States.[9–12 14 15]

The figure presents the summary statistics for studies using continuous data. These suggest that patients were more satisfied with consultations with nurse practitioners than those with doctors. The results showed considerable heterogeneity, which was explored by comparing studies of individual consultations with care over time and by comparing studies based on nurse practitioners with different levels of training. Although there remained considerable heterogeneity between the studies, all analyses suggested that patients were more satisfied with consultations with nurse practitioners. Three randomised controlled trials reported results with dichotomous data.[11–13] Two of them were set in emergency units.[16 17] No significant difference was found in patient satisfaction for patients attending either provider with these studies (all studies (n=3), odds ratio 1.56, 0.56 to 4.34; overall effect $z=0.85$, $P=0.4$; and all studies of emergency units (n=2), 3.27, 0.41 to 25.98; $z=1.12$, $P=0.3$).

Health status

Any measure used by the authors to determine either health status or quality of life and its validity for this purpose were recorded. Seven randomised controlled trials reported on these outcomes.[10–12 14 16 19 20] These results were not analysed with meta-analysis because of the heterogeneity between measures and episode of care length, but a comparison of the results showed no significant differences in patient health outcomes (table E on bmj.com).

Process measures

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

Quality of care

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

Discussion

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

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

Limitations of the review

Ambiguity exists over the use of the term "nurse practitioner," with much debate about this role.[22 23] The overlap between nursing roles in the United Kingdom and the introduction of another advanced practice nursing title, nurse consultant, adds to the difficulty in understanding the role definitions in nursing.[24 25] Although specific training for nurse practitioners is available, the content of this varies.[26] Because of this ambiguity, the definition used in our review was purposefully inclusive.

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

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

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

It was not possible to conduct a robust economic analysis of the costs of care from nurse practitioners compared with doctors. Only five studies provided data about costs.[10 12 13 15 24] These used different approaches to the valuing of resources and were inadequately powered for economic analysis. The lack of good evidence about the economic impact of substituting nurse practitioners for doctors needs to be addressed in future research, otherwise changes may be introduced that are thought to be efficient when they may not be so.[27]

Policy implications

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

Unresolved issues

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

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

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

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

What is already known on this topic

Nurse practitioners have existed in North America for many years

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

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

What this study adds

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

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

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

Conclusion

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

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

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

Funding: South and West Research and Development Directorate. The views expressed are those of the authors and not necessarily those of the NHS Executive South West.

Competing interests: None declared.

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(Accepted 11 March 2002)

A memorable patient

Bridging medicine

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

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

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

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

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

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

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

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

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

TO:

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

Scott Ogan, Vice Chair, House Judiciary Committee (Room 108)
1-800-862-3878 (Tel)
1-907-465-3265 (Fax)

John Coghill (Room 102)
1-877-465-3719 (Tel)
1-907-465-3258 (Fax)

Jeannette James (Room 214)
1-800-565-3743 (Tel)
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Kevin Meyer (Room 110)
1-866-465-4945 (Tel)
1-907-465-3476 (Fax)

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

Albert Kookesh (Room 114)
1-888-288-3473 (Tel)
1-907-465-2827 (Fax)

RE: Senate Bill 37

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

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

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

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

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

Mary Anne Wilson, ANP
337-1005

1982 Waldron Drive
Anchorage, Alaska 99507

April 9, 2002

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

Scott Ogen, Vice Chair, House Judiciary Committee
1-907-465-3265

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1-907-465-2827

Re: Senate Bill 37

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

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

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

I urge you to VOTE NO ON SENATE BILL 37

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

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

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

April 5, 2002

The Honorable Norman Rokeberg, Chair
and Members
House Judiciary Committee

Re: SB 37

Dear Representative Rokeberg:

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

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

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

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

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

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

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

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

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

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

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

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

CES/sjm/lb

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

TONY KNOWLES, GOVERNOR

1031 WEST 4TH AVENUE, SUITE 200
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March 19, 2002

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

Re: SB 37; Physician Negotiations with Health Care Insurers

Dear Representative Murkowski:

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

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

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

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

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

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

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

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

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

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

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

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

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

CES/sjm

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

February 4, 2002

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

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

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

Dear Senator Prentice and Representative Cody:

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

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

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