ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10304 HOUSE JUDICIARY

149

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

Sincerely,

Chris

CHRISTINE O. GREGOIRE
Attorney General

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

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

Bureau of Competition
Office of Policy Planning
Northwest Region

February 8, 2002

By Facsimile and First Class Mail

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

Re: Washington House Bill 2360

Dear Representative Benson:

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

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

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

---

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

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

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

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

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

- House Bill 2360 seeks to immunize conduct that the federal antitrust laws regard as illegal price fixing. Such conduct raises the most significant competitive concerns.
- The Bill is not needed to allow providers to exchange information among themselves in circumstances where the exchange is unlikely to harm consumers. Such conduct is competitively neutral or beneficial, and is not illegal under the antitrust laws.
- The Bill – despite its intended effect – may not confer federal antitrust immunity because fee agreements between health insurers and providers are not entitled to immunity under the McCarran-Ferguson Act, the federal statute that immunizes, under certain circumstances, the "business of insurance."
- Finally, House Bill 2360 cannot be said to be likely to provide federal antitrust immunity under the "state action" doctrine because it may not provide sufficient "active supervision" of the anticompetitive conduct at issue.

I. Physician Collective Bargaining Will Likely Harm Consumers

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

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

[5] RCW 43.72.300(1).

would create for consumers:[6]

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

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

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

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

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

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

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

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

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

II. Responses to Specific Questions Regarding HB 2360

---

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

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

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

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

[12] Id. at 6.

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

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

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

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

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

---

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

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

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

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

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

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

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

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

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

---

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

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

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

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

[21] RCW 43.72.300(2).

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

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

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

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

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

---

[13] See Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (Aug. 1996) ("Health Care Guidelines") *available at* <http://www.ftc.gov/reports/hlth3s.htm>.

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

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

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

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

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

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

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

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

---

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

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

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

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

[21] RCW 43.72.300(2).

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

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

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

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

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

---

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

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

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

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

[26] Id. at 106.

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

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

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

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

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

---

[28] Id. at 634.

[29] RCW 43.72.310(1).

[30] RCW 43.72.310(3).

[31] RCW 43.72.310(6).

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

[33] RCW 43.72.310(1).

[34] See Letter of Hon. Christine O. Gregoire to Washington Legislature on SB 6642/HB 2360 (Feb. 4, 2002) at 3. For example, if a group of providers were to negotiate a 20% fee increase after the legislation was passed, how much would the providers have to increase their services or improve their quality of care

indefinite,[35] as are the "annual or more frequent reviews" DOH is expected to provide with OAG's "assistance."[36]

Even if the reviewing agencies are able to overcome these informational obstacles, it is unclear whether House Bill 2360 would survive court scrutiny. In order to constitute active supervision, state agencies must "have *and exercise* power to review" the challenged anticompetitive conduct.[37] Thus, the scope of actual agency conduct under the bill would be highly relevant to the state action inquiry. Currently, the DOH appears to have no formal program for overseeing collective provider conduct and no budget for such a function. Under the existing state antitrust immunity statute,[38] the OAG has conducted several investigations of proposed provider alliances and similar conduct in order to advise DOH. But as presently structured and funded, neither DOH nor OAG may be able to actively supervise the broad range of collective activity the Bill would authorize. And if the state regulatory scheme does not satisfy the requirements of the state action defense, private parties who engage in collective negotiation of fees will run the risk of potentially significant financial liability for their actions.

House Bill 2360 also raises a broader policy issue: how much costly regulatory oversight is the state willing to undertake to ensure that consumers are not harmed by the price fixing the Bill would permit? Regulations issued under the existing immunity statute do not allow providers to engage in collective negotiation of prices.[39] If Washington reversed that determination and authorized provider price fixing, but still wished to protect consumers from the predictable consequences of such price fixing, it would have to engage in price regulation. Yet as the experience of public utility commissions indicates, price regulation can be a complex, time-consuming, and expensive effort, requiring attention to numerous cost, risk, quality, and service issues with no assurance of achieving the correct result. If the state decides to replace the market with collective determination of prices, protecting consumers and the public interest may require such costly and uncertain regulation.

* * *

---

to justify the higher fees? The Bill does not say. It lists several general factors the agencies must consider in evaluating a price increase, but it does not explain how much weight to give them.

[35] Rather than setting forth clear standards, the Bill simply provides that such standards will be articulated through subsequent DOH rulemaking. See RCW 43.72.310(2)(b)-(c).

[36] RCW 43.72.310(6).

[37] Patrick, 486 U.S. at 101 (emphasis added).

[38] RCW 43.72.

[39] WAC § 246-25-040 (finding that the costs of collective fee negotiations far outweigh any possible benefits).

We hope you find these comments helpful. If you have additional questions, please contact Jeff Brennan at (202) 326-3688 or John Kirkwood at (206) 220-4484. Our view, in short, is that House Bill 2360 poses substantial risks for residents of the State of Washington. The Bill would authorize provider price fixing and thus threatens consumers with higher prices and restricted access to health care – without compensating benefits. In addition, if the state did not engage in sufficient supervision to exercise genuinely independent control over collectively bargained fees, the Bill would fail to confer "state action" immunity and would expose providers who engage in collective bargaining to a significant risk of liability and damages.

Sincerely,

Joseph J. Simons, Director
Jeffrey W. Brennan, Assistant Director
Bureau of Competition

R. Ted Cruz, Director
John T. Delacourt, Attorney
Office of Policy Planning

Charles A. Harwood, Director
John B. Kirkwood, Attorney
K. Shane Woods, Attorney
Northwest Region

H-4217.1

SUBSTITUTE HOUSE BILL 2360

State of Washington 57th Legislature 2002 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Conway, Campbell, Cody, Edwards, Wood and Schual-Berke)

Read first time 02/08/2002. Referred to Committee on .

AN ACT Relating to the regulation of negotiations between health care providers and health carriers; and creating a new section.

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

NEW SECTION. Sec. 1. (1) There is hereby established a joint select committee on collective negotiations to study the regulation of collective negotiations between health care providers and health insurance carriers authorized under chapter 43.72 RCW. The committee shall be composed of (a) two members of the house of representatives, one from each political caucus to be appointed by the speaker; (b) two members of the senate, one from each political caucus appointed by the president of the senate; and (c) ex officio representatives of the office of the attorney general, the office of the insurance commissioner, and the department of health respectively. The chair of the committee shall be selected by legislative members. In its deliberations, the committee shall consult with health care provider professional associations, health carriers, and other state agencies directly affected by the activities of collective negotiations.

(2) The committee shall review (a) the appropriateness of collective negotiations on the terms and conditions of contracts

between health care providers and health carriers, including reimbursement for provider services; (b) the benefits of voluntary mediation and arbitration in case of impasse for furthering dispute resolution; (c) the appropriateness of requiring health carriers and health care providers to enter into collective negotiations in good faith; (d) the impact of collective negotiations on the access of the public to health care providers, on the costs of health care services, and on state and federal antitrust laws; and (e) such other matters related to the purposes of this study.

(3) The committee may use the staffing and support resources of the office of program research of the house of representatives and the office of senate committee services within available funds.

(4) The committee shall report to the legislature by the first day of the regular legislative session commencing in January 2003 on its findings and recommendations, together with any legislative proposals implementing them. The authority of the committee expires at such time.

--- END ---

H-2875.9

HOUSE BILL 2360

State of Washington 57th Legislature 2002 Regular Session

By Representatives Conway, Campbell, Cody, Edwards, Wood and Schual-Berke

Read first time 01/16/2002. Referred to Committee on Health Care.

AN ACT Relating to the regulation of negotiations between health providers and health carriers; amending RCW 43.72.300 and 43.72.310; adding a new section to chapter 43.72 RCW; and creating a new section.

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

Sec. 1. RCW 43.72.300 and 1997 c 274 s 6 are each amended to read as follows:

(1) The legislature recognizes that competition among health care providers, facilities, payers, and purchasers will yield the best allocation of health care resources, the lowest prices for health care services, and the highest quality of health care when there exists a large number of buyers and sellers, easily comparable health plans and services, minimal barriers to entry and exit into the health care market, and adequate information for buyers and sellers to base purchasing and production decisions. ((~~However~~)) The legislature further recognizes, however, that managed competition may be adversely affecting the supply of health care providers in this state. The provision of health services by health care providers in participating provider agreements with health carriers, while resulting in health cost containment, is leading to a flight of these providers to other

areas of the country where bureaucratic demands on practices are less cumbersome and reimbursement levels are noticeably higher, causing a serious drain on the supply of health care providers available for serving patients and otherwise threatening public access to health care services in the state. As the marketplace of health carriers tends to be more concentrated than the market for health care providers, there is often a disparity of bargaining power between them, resulting in a dramatic disadvantage of health care providers in their efforts to negotiate the terms and conditions of their contracts with health carriers. This inequality of bargaining power is exacerbated by the absence of a health carrier's obligation to bargain in good faith. The prohibition under current law to negotiate appropriate reimbursement levels forces health care providers to either accept the contract proposals offered by health carriers or seek more acceptable terms available in other states. The requirement of good faith negotiations is a recognized and proven process for inducing parties in dispute to resolve their differences professionally with accommodations resulting in their mutual benefit. In addition, the legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

(2) The legislature further finds that the regulation of health insurance by whatever means authorized by state law is within the sovereign and constitutional powers of state government to further its interests in protecting the health, safety, and welfare of the people of the state, and includes regulating the procedures under which health carriers negotiate the terms and conditions of contracts for health care provider services, including reimbursement for these services. The legislature therefore intends to exempt from state anti-trust laws, and to provide immunity from federal anti-trust laws through the state action doctrine for collective negotiations by health care providers with health carriers, including customary communications between health

care providers with those negotiating for them to inform and advance the negotiations with other activities approved under this chapter that might otherwise be constrained by such laws and intends to displace competition in the health care market: To contain the aggregate cost of health care services; to promote the development of comprehensive, integrated, and cost-effective health care delivery systems through cooperative activities among health care providers and facilities; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure universal access to a publicly determined, uniform package of health care benefits; and to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care services, providers of health care services, health care facilities, and Washington residents. To these ends, any lawful action taken pursuant to ((~~chapter 492, Laws of 1993~~)) this section and RCW 43.72.310 by any person or entity created or regulated ((~~by chapter 492, Laws of 1993~~)) under these sections are declared to be taken pursuant to state statute and in furtherance of the public purposes of the state of Washington.

(3) The legislature does not intend and, unless explicitly permitted in accordance with this section and RCW 43.72.310 or under rules adopted ((~~pursuant to chapter 492, Laws of 1993~~)) under these sections, does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal anti-trust laws including but not limited to conspiracies or agreements:

(a) Among competing health care providers not to grant discounts, not to provide services, or to fix the price of their services;

(b) Among health carriers as to the price or level of reimbursement for health care services;

(c) Among health carriers to boycott a group or class of health care service providers;

(d) Among purchasers of health plan coverage to boycott a particular plan or class of plans;

(e) Among health carriers to divide the market for health care coverage; or

(f) Among health carriers and purchasers to attract or discourage enrollment of any Washington resident or groups of residents in a

health plan based upon the perceived or actual risk of loss in including such resident or group of residents in a health plan or purchasing group.

Sec. 2. RCW 43.72.310 and 1997 c 274 s 7 are each amended to read as follows:

(1) A health carrier, health care facility, health care provider, or other person involved in the development, delivery, or marketing of health care or health plans may request, in writing, that the department of health obtain an informal legal opinion from the attorney general as to whether particular conduct is authorized by ((~~chapter 492, Laws of 1993~~)) this section and RCW 43.72.300. Trade secret or proprietary information contained in a request for informal opinion shall be identified as such and shall not be disclosed other than to an authorized employee of the department of health or attorney general without the consent of the party making the request, except that information in summary or aggregate form and market share data may be contained in the informal opinion issued by the attorney general. The attorney general shall issue such opinion within thirty days of receipt of a written request for an opinion or within thirty days of receipt of any additional information requested by the attorney general necessary for rendering ((~~an~~)) a legal opinion unless extended by the attorney general for good cause shown. If the attorney general concludes that such conduct is not authorized by ((~~chapter 492, Laws of 1993~~)) this section and RCW 43.72.300, the person or organization making the request may petition the department of health for review and approval of such conduct in accordance with subsection (3) of this section.

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

(a) May authorize conduct by a health carrier, health care facility, health care provider, or any other person that could tend to lessen competition in the relevant market upon a strong showing that the conduct is likely to achieve the policy goals of ((~~chapter 492, Laws of 1993~~)) this section and RCW 43.72.300 and a more competitive alternative is impractical;

(b) Shall adopt rules governing conduct among providers, health care facilities, and health carriers including rules governing provider and facility contracts with health carriers, rules governing the use of "most favored nation" clauses and exclusive dealing clauses in such

contracts, and rules providing that health carriers in rural areas contract with a sufficient number and type of health care providers and facilities to ensure consumer access to local health care services;

(c) Shall adopt rules permitting health care providers within the service area of a plan to collectively negotiate all the terms and conditions of contracts, including reimbursement for provider services, with a health carrier ((~~including~~)). The rules must include the ability of providers to meet and communicate for the purposes of these negotiations, a requirement for representatives of health care providers and health carriers to negotiate in good faith, and options for voluntary mediation or arbitration in case of impasse. The rules must provide for the exclusion of agencies and subdivisions of the state of Washington from the requirements of this subsection. For the purpose of collective negotiation under this act, health care providers include those health care practitioners regulated under Title 18 RCW by the department of health to practice health or health-related services or otherwise practicing health care services in this state consistent with state law;

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

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

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

The department of health shall issue a written decision approving or denying a petition filed under this section within ninety days of receipt of a properly completed written petition unless extended by the department of health for good cause shown. The decision shall set forth findings as to benefits and disadvantages and conclusions as to whether the benefits outweigh the disadvantages.

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

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

(b) Gains in cost efficiency of health services;

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

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

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

These benefits must outweigh disadvantages including and not limited to:

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

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

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

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

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

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

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

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

NEW SECTION. Sec. 3. A new section is added to chapter 43.72 RCW to read as follows:

The insurance commissioner may, subject to a hearing if one is demanded, revoke, suspend, or refuse to accept or renew registration from any health carrier, issue a cease and desist order, or bring an

action in any court of competent jurisdiction to enjoin a health carrier from doing any further business in this state, if the health carrier violates the provisions of RCW 43.72.310(2)(c) or any rules promulgated under that subsection. After hearing or upon stipulation by the registrant and in addition to or in lieu of the suspension, revocation, or refusal to renew any registration of a health carrier, the commissioner may levy a fine against the party involved for each offense in an amount not less than ten thousand dollars. The order levying the fine shall specify the period within which the fine shall be fully paid. The period shall not be less than thirty days from the date of the order. Upon failure to pay any fine when due, the insurance commissioner shall revoke the registration of the health carrier and the fine shall be recovered in a civil action brought in behalf of the commissioner by the attorney general. Any fine collected shall be paid by the commissioner to the state treasurer for deposit in the general fund.

NEW SECTION. Sec. 4. This act is remedial in nature and shall be construed to effect the purposes expressed in section 1 of this act.

--- END ---

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

Bureau of Competition
Office of Policy Planning

By Facsimile and First Class Mail

January 18, 2002

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

Re: Alaska Senate Bill 37

Dear Representative Murkowski:

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

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

I. Physician Collective Bargaining

The Commission's opposition to legislation intended to create an antitrust exemption for physician

---

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

collective bargaining has historically focused on two fundamental points, both of which are relevant to your consideration of Senate Bill 37:

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

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

A. Consumer Harm

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

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

---

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

programs.

- State and local governments would incur higher costs to provide health benefits to their employees.

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

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

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

Prior Commission cases illustrate the types of physician conduct that have raised problems. Price-fixing is one type of such conduct, and last year's *Alaska Health Network, Inc.*[6] case is a prime example. In that case, the Commission alleged that competing physicians organized and conspired to fix the prices and other competitively significant terms on which they would deal with health plans in

---

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

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

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

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

Fairbanks, Alaska. Another type of conduct is price-related group boycotts, such as the one addressed in the *M.D. Physicians of Southwest Louisiana, Inc.*[7] case. There, the Commission charged a group of competing physicians with conspiring not to deal with certain third-party payers, as part of an unlawful enterprise designed to prevent managed care contracts from taking hold in the Lake Charles, Louisiana region.

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

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

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

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

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

---

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

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

B. Quality of Care

Proponents of antitrust exemptions for physicians often suggest that greater physician bargaining power against health plans would result in increased quality of care for patients. This claim fails for two reasons: (1) physician collective bargaining has historically focused on physician compensation, rather than patient care; and (2) current antitrust law already permits physicians to work collectively on legitimate quality of care issues.

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

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

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

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

> [T]he antitrust laws do not prohibit medical societies and other groups from engaging in collective discussions with health plans regarding issues of patient care. Among other

---

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

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

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

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

things physicians may collectively explain to a health plan why they think a particular policy or practice is medically unsound, and may present medical or scientific data to support their views . . . .[13]

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

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

II. The Alaska Bill

Nonetheless, Senate Bill 37, like its federal and state counterparts, seeks to confer antitrust immunity with respect to collective physician conduct. To be sure, Senate Bill 37 also contains a number of provisions designed to protect consumers from the potential harms arising from a physician collective bargaining exemption. In some respects, these provisions resemble protections contained in physician collective bargaining bills introduced in Texas and the District of Columbia, on which the

---

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

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

[15] Id. at 314; see also Southbank IPA, 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1938) (consent order).

Commission staff also has commented.[16] As with the protections in the Texas and District of Columbia bills, these provisions – addressing a health plan's market power, the size of the physician bargaining group, and potential boycott conduct – do not alleviate the risk of substantial consumer harm resulting from a collective bargaining exemption.

A. Minimum Threshold for Health Plan Market Power

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

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

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

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

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

---

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

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

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

Furthermore, by setting the market power threshold at a 15 percent market share, the bill would authorize anticompetitive behavior by physicians in many situations in which the health plan would not in fact possess market power. Indeed, 15 to 20 percent is below the level courts typically require before upholding a finding of market power.[18] Finally, the bill does not take into account that even a plan with a large share of a market might be constrained from exercising market power if new entry by competing plans is easy.

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

In addition, it should be noted that the bill's restrictions on collective fee negotiation to situations where the health plan consents to such negotiations would offer only limited protection to consumers. Such a restriction could limit certain kinds of anticompetitive effects, by preventing groups without health plan consent from engaging in even preliminary bargaining activities (such as physicians entering into agreements on the fee levels to be sought) that could facilitate anticompetitive agreements with respect to physicians' individual dealings with health plans. Nonetheless, a variety of risks remain. First, although participation is voluntary, some health plans may feel compelled to deal with a group if it

---

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

includes most of the physicians in a particular specialty or many physicians with large numbers of loyal patients. Second, even absent any implicit coercion, in some circumstances a health plan may find it less troublesome to simply accede to price-setting by physicians and then pass the higher costs on to consumers. In either case, such behavior presents a risk not only to the enrollees of the particular plan in question, but also to other consumers, because a group of physicians organized to bargain with one health plan could more easily collude in its dealings with other health plans that eschew collective bargaining.

B. Limitations on Size of Physician Negotiating Group

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

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

C. Exclusion of Physician Boycott Conduct

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

Although this provision is likely to prevent Senate Bill 37 from being used as legal cover for explicit boycott threats, it does not protect consumers from all boycott-related concerns arising from physician collective bargaining. As the Commission has previously observed, collective negotiations

can by their very nature convey an implicit threat that, if the health plan does not agree to terms acceptable to the physician group as a whole, it will be prevented from successfully negotiating agreements with the members of the group separately.[19] Furthermore, by immunizing agreements among competing physicians on the fees and other terms they will accept from health plans, the bill facilitates coordinated conduct – such as collusive refusals to deal – that, even though not immune, would be difficult to detect and prosecute.

III. State Action Immunity

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

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

---

[19] See Alaska Healthcare Network, Inc., Docket No. C-4007, 2001 WL 443471 (F.T.C. Apr. 25, 2001) ("Payors believed that they could not go around [Alaska Healthcare Network] to contract individually with physicians in Fairbanks, and thus that they had no alternative but to reach agreement with AHN or to give up their planned entry into Fairbanks."). See also Michigan State Medical Society, 101 F.T.C. 191, 296 n.32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations).

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

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

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

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

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own."[24] Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties."[25] In this instance, the bill does not appear to provide the Attorney General with the means to exercise sufficient independent judgment and control.

Lack of Active Supervision

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

1. Review of Composition of Physician Groups

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

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

---

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

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

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

2. Review of "Brief Report" on Proposed Negotiations

The power to approve or disapprove a "brief report" on any proposed collective negotiations is provided by Section (h)(1)(B). This provision appears to provide the Attorney General with authority to disapprove proposed negotiations if the physician group is found to be "not appropriate to represent the interests involved in the proposed negotiations."[27] It is unclear, however, what authority this actually would confer, or how the Attorney General could make such an assessment on the basis of the limited information that the third party representative is required to submit. The report would describe the proposed subject matter of the negotiations and a statement of the expected efficiencies or benefits, but it would not supply a wide variety of information that would enable the Attorney General to assess the likely competitive effects of the negotiations. Further, there is no provision for the Attorney General to require submission of additional information, nor any mechanism by which to receive input from other physicians, affected health plans, or patients.

3. Review of Collectively Negotiated Contracts

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

---

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

"undertake[] the necessary steps to determine the specifics of the ratesetting scheme."[28] Senate Bill 37 falls far short of providing the information necessary for state officials to make such a determination. Moreover, what little information is provided is all at the initiative of third parties. The bill does not authorize the Attorney General to request or gather specific additional information of any kind.[29]

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

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

---

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

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

In addition, Section (h)(3) requires an authorized third party to provide the Attorney General with all communications "to be made to physicians" related to negotiations. This requirement, however, omits at least four additional categories of potentially critical competitive information: (1) communications from physicians to authorized third parties, (2) communications from authorized third parties to health plans, (3) communications between physicians, and (4) communications between authorized third parties.

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

(b) Insufficient Time

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

IV. Transparency

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

---

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

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

care costs.

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

* * *

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

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

Thank you for your inquiry. We hope you find these comments helpful. Should you have any additional questions, please feel free to contact Jeff Brennan at (202) 326-[illegible]688.

Sincerely,

Joseph J. Simons, Director
Jeffrey W. Brennan, Assistant Director
Bureau of Competition

R. Ted Cruz, Director *
John T. Delacourt, Attorney
Office of Policy Planning

Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

For Release: January 31, 2002

FTC Staff Opposes Alaska Proposal to Allow Physician Collective Bargaining

Proposed Legislation Would Significantly Increase Consumer Health Care Costs

Related Documents:

Alaska Senate Bill 37, V020003 [PDF 39KB] (January 18, 2002)

A bill pending before the Alaska legislature that seeks to authorize competing physicians to engage in collective bargaining with health plans over fees and other terms would significantly increase health care costs and harm consumers, according to the staff of the Federal Trade Commission. The Commission has opposed similar legislation at the federal level, and Commission staff have expressed concerns about similar bills before state legislatures on a number of occasions.

In response to a request for comment on Alaska Senate Bill 37 from Representative Lisa Murkowski, Chair of the Labor and Commerce Committee of the Alaska House of Representatives, staff of the Bureau of Competition and the Office of Policy Planning note that the bill would authorize horizontal price fixing by physicians, as well as collusive refusals to deal with health plans.

According to the FTC staff opinion, such anticompetitive physician conduct is likely to result in substantial consumer harm. Consumers and employers would face higher prices for health insurance coverage. Consumers would also face a reduction in access to care, as increasing costs would likely result in a reduction in health care benefit options. State Medicaid programs using managed care strategies would be forced to increase their budgets, cut optional benefits, or reduce the number of covered beneficiaries. And state and local programs providing care for the uninsured would be adversely affected as well, as an increase in health care costs would likely add additional consumers to the ranks of the uninsured.

In addition, FTC staff conclude that the proposed regulatory structure to be established by the Alaska bill does not satisfy the Supreme Court's requirements under the "state action" doctrine, which allows a state to override the national policy favoring competition only where it expressly decides to govern aspects of its economy by state regulation rather than market forces. Under that doctrine, a state may not simply authorize private parties to violate the antitrust laws; instead, it must actually substitute its own active control for the discipline that competition would otherwise provide. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct.

As the FTC staff opinion further explains, Senate Bill 37 falls far short of the "active supervision" required by Supreme Court case law. The opinion notes that the Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has

effectively made [the challenged] conduct its own." The Court has also held that active supervision requires a state to exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." In this instance, the bill does not provide the Attorney General with the means to exercise sufficient independent judgment and control, according to the FTC staff opinion. As a result, anticompetitive conduct undertaken in conformity with the bill would not be immunized, and could subject physicians to antitrust liability.

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

The letter represents the views of the FTC's Bureau of Competition and Office of Policy Planning. Although it does not necessarily represent the views of the Commission or any individual Commissioner, the Commission authorized submission of the letter by a vote of 5-0.

Copies of the staff opinion letter are available from the FTC's Web site at http://www.ftc.gov and also from the FTC's Consumer Response Center, Room 130, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580. The FTC's Bureau of Competition seeks to prevent business practices that restrain competition. The Bureau carries out its mission by investigating alleged law violations and, when appropriate, recommending that the Commission take formal enforcement action. To notify the Bureau concerning particular business practices, call or write the Office of Policy and Evaluation, Room 394, Bureau of Competition, Federal Trade Commission, 600 Pennsylvania Ave, N.W., Washington, D.C. 20580, Electronic Mail: antitrust@ftc.gov; Telephone (202) 326-3300. For more information on the laws that the Bureau enforces, the Commission has published "Promoting Competition, Protecting Consumers: A Plain English Guide to Antitrust Laws," which can be accessed at http://www.ftc.gov/bc/compguide/index.htm.

MEDIA CONTACT:
Howard Shapiro,
Office of Public Affairs
202-326-2176

STAFF CONTACT:
Jeffrey W. Brennan
202-326-3688

(FTC Matter No.: V020003)

(http://www.ftc.gov/opa/2002/01/alaskaphysicians.htm)

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)276-3697

January 19, 2001

Senator Robin Taylor
Chair, Senate Judiciary Committee
State Capitol Building
Juneau, Alaska 99801-1182

Re: SB 37 – Physician Negotiations with Health Benefit Plans.

Dear Senator Taylor:

The State of Alaska, Department of Law submits the following written comments regarding SB 37. "An Act relating to collective negotiation by physicians with health benefit plans; and to [allow] health benefit plan contracts with individual competing physicians." This bill is essentially identical to CS for Senate Bill 256 (Fin) introduced by Senator Kelly during the Twenty-First Legislature in 2000. The following comments, therefore, are essentially the same comments provided by the department to Senator Tim Kelly last year, with minor modifications.

In general, the department has serious legal and policy concerns regarding the collective negotiation aspects of this bill. We believe the bill, if passed, may result in substantial harm to consumers in the form of increased health care costs and reduced health care options. Further, the level of state involvement provided in the bill may not be sufficient under the state action doctrine to immunize physicians from federal anti-trust enforcement.

I. Purpose of Senate Bill 37.

Collective negotiations of price and price related terms by physicians is considered "per se" illegal price fixing in violation of state and federal antitrust laws. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). SB 37 attempts to displace free market competition and allow competing physicians to collectively negotiate with health plans on non-price and price terms of a contract under certain circumstances. The bill also attempts to provide the physicians immunity from prosecution under federal antitrust laws, through the state action doctrine, by establishing a review process of the negotiations and contracts through the Office of the Attorney General.

II. Issues relating to SB 37.

A. Harm to Consumers.

The Department of Law agrees with the concerns relating to collective negotiations by physicians raised by Federal Trade Commission (FTC) representative, Richard Feinstein, in the oral testimony given before the Finance Committee on February 25, 2000, and in the letters submitted to the Committee dated May 13, 1999, and October 29, 1999, relating to collective negotiation legislation in Texas and Washington, D.C. Those letters are attached. Since that time, Texas legislation has been enacted, but not implemented because of serious issues related to the drafting of regulations.

Specifically, according to the FTC, allowing physicians to collectively negotiate on price terms will not ensure better care for patients, and may result in substantial harm to consumers. For instance, likely increased rates negotiated by physicians under negotiated contracts threatens to raise health care costs for individuals, employers, and state and federal governments, and may reduce access to care and increase the number of uninsured. The FTC's conclusions are based on prior investigations and enforcement actions where similar results occurred when physicians collectively negotiated price terms. *See* October 29, 1999 letter from FTC to Robert R. Rigsby, Office of Corporate Counsel, Washington, D.C., pg. 2.

Further, as discussed by Robert Lohr, Director, Alaska Department of Community and Economic Development, Division of Insurance, in his March 30, 2000, letter submitted to the Senate Finance Committee, a recent study conducted by Charles Rivers Associates, Inc., estimates that private health insurance premiums would rise by approximately 5 to 13 percent under the pending federal legislation (H.R. 1304) permitting health care professionals to negotiate collectively with health care plans. Based on this study, and Mr. Lohr's discussions, it can be assumed that Alaska will experience similar increased health care costs as a result of collective negotiations by physicians, absent adequate limits on the collective bargaining.

B. Limits on collective bargaining are not sufficient to protect consumers from substantial harm.

1. Market share limits.

SB 37 provides that health plans must have substantial market power, defined as 15% of the market share, before they will be subject to ***price*** negotiations by physicians. Where a health plan has less than 5% market share, the physician group may not exceed 30% of the market in the physician's geographic service area. ***Non-price terms*** can be negotiated regardless of market share.

Although the bill appears to make the concept of market power an important limitation on physician's ability to collectively negotiate price terms, these provisions are not based on accepted concepts of market power in a legal or economic sense. See FTC letter dated October

29, 1999. Specifically, a 15% market share is not ordinarily presumed to constitute market power. Accordingly, even though a health plan may meet the presumption of market power under the bill, it may not, in fact, have the market power which gives them the ability to reduce prices below competitive levels. Absent a showing that ***actual market power*** is held by a health plan, there is no justification for collective negotiations.

Further, the bill's limits on physician group size do not reflect the potential market power (ability to raise prices) of physician groups. Currently, SB 37 lacks a cap on the market share of a physician group when negotiating ***price terms*** with a health plan that has greater than 5% of the market share. This may result in a disproportionately large physician group (up to 100% of the market share in a geographic market) negotiating with a small health plan (as small as 5% market share), resulting in substantial market power by the physicians. The limit on the market share of physicians groups and the corresponding market share limit placed on health plans does not necessarily reflect ***actual market power***, and may underestimate the economic clout of a physician group which is dealing with a small health plan.

The bill attempts to cure the above problems by giving the Attorney General the authority to limit the percentage of practicing physicians represented by an authorized third party. The limitation provides, however, that the number of physicians, under any circumstance, cannot be less than 30% of the market of practicing physicians in the geographic service area. This does nothing to cure the problem, and the bill still provides the potential for a physician group to be formed with significant economic clout. There is an exception in the bill which states the limit does not apply if the market of practicing physicians in the geographic service area or proposed geographic service area consists of 40 or fewer individuals. This leaves smaller towns such as Barrow, Sitka, or Ketchikan vulnerable to physician groups that could exercise market power.

2. Prohibition on boycotts/concerted action.

Another limitation in SB 37 relates to the prohibitions on boycotts and concerted action by physicians. The two sections in the bill that address these provisions raise significant questions of interpretation and may not offer adequate protections to consumers.

Section 23.50.020 (a) prohibits competing physicians from engaging in boycotts relating to the non-price terms and conditions listed in that subsection. A similar prohibition is conspicuously absent from the price and price related terms and conditions listed in subsection (c). It is not clear whether this omission was purposeful. The effect is significant, however, in that the prohibition on boycotts is absent for price and price related terms.

Subsection (k) of the bill, relating to concerted action by physicians, does not fully correct the problem. Subsection (k) provides that new section 23.50.020 does not authorize competing physicians to act in concert in response to a report issued by an authorized third party related to the third party's discussions or negotiations with a health benefit plan. First, this section does not clearly prohibit concerted action, such as boycotts. It only states that it is not authorized by the section. Subsection (k) needs to be amended to provide that concerted action

is clearly prohibited, as it is in subsection (a). Second, the only conduct that is affected under subsection (k) is concerted action ***in response to*** third party discussions/negotiations with health plans. Concerted conduct by physicians ***prior to, or during*** negotiations, is not affected by this section. Therefore, for instance, a boycott or strike by physicians in response to a health plan's refusal to collectively negotiate with a physician group on price terms would not be prohibited by this subsection.

Another issue, which must be clarified, relates to the definition of boycott. As the FTC points out in its letter to the Washington D.C. Corporate Counsel, dated October 29, 1999, it is unclear whether the boycott prohibition is intended to bar agreements not to deal with health plans except on collectively-determined terms, or whether it would only prohibit agreements to withhold services from third parties, in order to pressure health plans to accede to the contract terms demanded by the physician group. *Id* at pg. 4. The bill needs to be clarified to indicate which type of boycott is prohibited by this section, the former being the much more coercive type of boycott which should not be allowed.

Even if the bill was amended, as suggested above, so that it was clear that all types of boycotts and concerted action are prohibited, SB 37's authorization of collective bargaining would still present a serious risk of anticompetitive harm. The FTC has previously observed that collective negotiations by nature convey an implied threat that if the health plan does not agree to the terms presented by the physician group the plan will be unable to obtain agreements with individual group members. *Id.* By immunizing agreements among physicians on the prices and other terms they will accept from a health plan, SB 37 facilitates coordinated conduct among physicians, such as collusive refusals to deal that, even though not authorized by the bill, would be difficult to detect and prosecute. Because the purpose of the bill is to allow physicians to exert leverage over health plans in order to get more favorable terms, prohibiting concerted action by physicians would likely not eliminate the coercive force of collective bargaining, or obviate concerns that the bill would increase the likelihood of concerted refusals to contract with health plans. *Id.*

C. Immunity Issues – State Action Doctrine

In order for collective private activity, such as proposed in this bill, to be shielde from the antitrust laws, the bill must satisfy the "state action doctrine" as set out in *California Retail Liquor Dealers Assn. V. Mid Cal Aluminum, Inc.* 445 U.S. 97 (1980); *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48 (1985) and *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621 (1992). Under this doctrine, antitrust liability is avoided only if (1) the challenged action is the result of a clearly articulated and affirmatively expressed state policy to supplant competition, and (2) the action is "actively supervised" by the state. Actual state involvement, not deference to private price fixing arrangements under the general auspices of state law, is the precondition for immunity from federal law. *Ticor*, 504 U.S. at 621, 112 S. Ct. 2169, 2176 – 77.

Active supervision, for the purpose of obtaining immunity under federal antitrust law means the regulatory agency must "have and exercise ultimate control over the challenged

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

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

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

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

For these reasons, it may be found that the level of state involvement provided in SB 37 may not be sufficient "active state supervision" under the state action doctrine to immunize physicians from federal antitrust enforcement.

D. Issues relating to Geographic Service Area

1. AS 23.50.020(d) refers to geographic service area, which is defined to mean the "geographic area of the physicians seeking to jointly negotiate." This definition raises a couple of issues that need to be addressed. First, it is unclear what standards are to be used to determine the geographic area of a physician under the definition. This will need to be clarified before an accurate and consistent market share analysis can be performed under the bill. Second, a health plan's market share is calculated based on the physician group's geographic service area. It will need to be confirmed that information can, in fact, be obtained about a health plan's market share within a particular physician group's geographic service area. If it cannot, then the market share analysis contemplated in the bill will not be able to be performed.

2. AS 23.50.020(h) – (j) provides standards for approval by the Attorney General of a collective negotiation. A number of the standards, however, appear vague, making it impossible to determine what factors are contemplated under the standard and whether the factors are appropriate for the Attorney General's consideration. For instance, it is not clear what sort of factors or terms would fall under the category "promotion of health care infrastructure and medical advancement" found in subsection (i)(3). Also, to provide a balanced consideration of factors, the standards should be amended under subsection (j) to allow the Attorney General to consider whether the proposed contract terms impose impediments or decrease access to quality patient care, when weighing the anticompetitive effects of the contract terms.

III. ERISA Preemption Issues.

The collective negotiation provisions of this bill apply to "health benefit plans" instead of "health care insurers." We understand that this wording was intended to include self-funded health plans within the scope of the bill in addition to fully insured plans. This change, however, raises a federal preemption issue under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA preempts all state laws that relate to an employee benefit plan, which by definition includes a "health benefit plan." ERISA regulates the administration of employee health care benefits as well as the structure of the plans. While there is case law that may seem to narrow the breadth of the broad ERISA preemption, this bill is still a high risk of preemption to the extent that the bill will affects the benefits and administration of a health benefit plan. This risk can be avoided by restricting the application of the bill to entities traditionally regulated under Alaska's insurance laws, which was the approach used by Texas in similar legislation passed in 1999.

IV. Miscellaneous Issues.

Written testimony submitted to various committees last year, and proposed AS 23.50.020(f)(2) indicate that negotiation with an authorized third party is not mandatory for health benefit plans. However, the language in proposed AS 23.50.020(c) and (d) imply that all health benefit plans are required to negotiate with an authorized third party unless it can prove that it does not have substantial market power. The bill needs to clarify whether such negotiations are voluntary or not.

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

If you have any questions regarding these written comments, please let us know.

Very truly yours,

BRUCE M. BOTELHO
ATTORNEY GENERAL

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

cc: Members, Senate Judiciary Committee
Senator Pete Kelly
Mike Abbot, Office of the Governor
Robert Lohr, Division of Insurance
Deborah Behr, Department of Law
Chrystal Smith, Department of Law

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

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

May 13, 1999

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

Dear Representative Oliveira:

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

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

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

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

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

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

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

Sincerely yours,

William J. Baer

Enclosure

---

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 achie ed. In addition, the representative must furnish for the Mayor's approval, prior to dissemination, a copy of "all communications to be made to physicians related to negotiations, discussions, and health plan offers." The bill does not grant the Mayor the power to review and disapprove contract terms or other matters on the ground that they are unreasonable, unjust, or otherwise contrary to the interests of consumers.

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

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

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

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

* * *

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

Sincerely,

Richard A. Feinstein
Assistant Director

Attachments

Endnotes

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

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

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

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

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

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

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

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

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

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

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

DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE

TABLE OF CONTENTS

DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE

INTRODUCTION

In September 1993, the Department of Justice and the Federal Trade Commission (the "Agencies"), issued six statements of their antitrust enforcement policies regarding mergers and various joint activities in the health care area. The six policy statements addressed: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) health care providers' joint purchasing arrangements; and (6) physician network joint ventures. The Agencies also committed to issuing expedited Department of Justice business reviews and Federal Trade Commission advisory opinions in response to requests for antitrust guidance on specific proposed conduct involving the health care industry.

The 1993 policy statements and expedited specific Agency guidance were designed to advise the health

care community in a time of tremendous change, and to address, as completely as possible, the problem of uncertainty concerning the Agencies' enforcement policy that some had said might deter mergers, joint ventures, or other activities that could lower health care costs. Sound antitrust enforcement, of course, continued to protect consumers against anticompetitive activities.

When the Agencies issued the 1993 health care antitrust enforcement policy statements, they recognized that additional guidance might be desirable in the areas covered by those statements as well as in other health care areas, and committed to issuing revised and additional policy statements as warranted. In light of the comments the Agencies received on the 1993 statements and the Agencies' own experience, the Agencies revised and expanded the health care antitrust enforcement policy statements in September 1994. The 1994 statements, which superseded the 1993 statements, added new statements addressing hospital joint ventures involving specialized clinical or other expensive health care services, providers' collective provision of fee-related information to purchasers of health care services, and analytical principles relating to a broad range of health care provider networks (termed "multiprovider networks"), and expanded the antitrust "safety zones" for several other statements.

Since issuance of the 1994 statements, health care markets have continued to evolve in response to consumer demand and competition in the marketplace. New arrangements and variations on existing arrangements involving joint activity by health care providers continue to emerge to meet consumers', purchasers', and payers' desire for more efficient delivery of high quality health care services. During this period, the Agencies have gained additional experience with arrangements involving joint provider activity. As a result of these developments, the Agencies have decided to amplify the enforcement policy statement on physician network joint ventures and the more general statement on multiprovider networks.

In these revised statements, the Agencies continue to analyze all types of health care provider networks under general antitrust principles. These principles are sufficiently flexible to take into account the particular characteristics of health care markets and the rapid changes that are occurring in those markets. The Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, their goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition.

The revisions to the statements on physician network joint ventures and multiprovider networks are summarized below. In addition to these revisions, various changes have been made to the language of both statements to improve their clarity. No revisions have been made to any of the other statements.

Physician Network Joint Ventures

The revised statement on physician network joint ventures provides an expanded discussion of the antitrust principles that apply to such ventures. The revisions focus on the analysis of networks that fall outside the safety zones contained in the existing statement, particularly those networks that do not involve the sharing of substantial financial risk by their physician participants. The revised statement explains that where physicians' integration through the network is likely to produce significant efficiencies, any agreements on price reasonably necessary to accomplish the venture's procompetitive benefits will be analyzed under the rule of reason.

The revised statement adds three hypothetical examples to further illustrate the application of these principles: (1) a physician network joint venture that does not involve the sharing of substantial financial

risk, but receives rule of reason treatment due to the extensive integration among its physician participants; (2) a network that involves both risk-sharing and non-risk-sharing activities, and receives rule of reason treatment; and (3) a network that involves little or no integration among its physician participants, and is per se illegal.

The safety zones for physician network joint ventures remain unchanged, but the revised statement identifies additional types of financial risk-sharing arrangements that can qualify a network for the safety zones. It also further emphasizes two points previously made in the 1994 statements. First, the enumeration in the statements of particular examples of substantial financial risk sharing does not foreclose consideration of other arrangements through which physicians may share substantial financial risk. Second, a physician network that falls outside the safety zones is not necessarily anticompetitive.

Multiprovider Networks

In 1994, the Agencies issued a new statement on multiprovider health care networks that described the general antitrust analysis of such networks. The revised statement on multiprovider networks emphasizes that it is intended to articulate general principles relating to a wide range of health care provider networks. Many of the revisions to this statement reflect changes made to the revised statement on physician network joint ventures. In addition, four hypothetical examples involving PHOs ("physician-hospital organizations"), including one involving "messenger model" arrangements, have been added.

Safety Zones and Hypothetical Examples

Most of the nine statements give health care providers guidance in the form of antitrust safety zones, which describe conduct that the Agencies will not challenge under the antitrust laws, absent extraordinary circumstances. The Agencies are aware that some parties have interpreted the safety zones as defining the limits of joint conduct that is permissible under the antitrust laws. This view is incorrect. The inclusion of certain conduct within the antitrust safety zones does not imply that conduct falling outside the safety zones is likely to be challenged by the Agencies. Antitrust analysis is inherently fact-intensive. The safety zones are designed to require consideration of only a few factors that are relatively easy to apply, and to provide the Agencies with a high degree of confidence that arrangements falling within them are unlikely to raise substantial competitive concerns. Thus, the safety zones encompass only a subset of provider arrangements that the Agencies are unlikely to challenge under the antitrust laws. The statements outline the analysis the Agencies will use to review conduct that falls outside the safety zones.

Likewise, the statements' hypothetical examples concluding that the Agencies would not challenge the particular arrangement do not mean that conduct varying from the examples is likely to be challenged by the Agencies. The hypothetical examples are designed to illustrate how the statements' general principles apply to specific situations. Interested parties should examine the business review letters issued by the Department of Justice and the advisory opinions issued by the Federal Trade Commission and its staff for additional guidance on the application and interpretation of these statements. Copies of those letters and opinions and summaries of the letters and opinions are available from the Agencies at the mailing and Internet addresses listed at the end of the statements.

The statements also set forth the Department of Justice's business review procedure and the Federal Trade Commission's advisory opinion procedure under which the health care community can obtain the Agencies' antitrust enforcement intentions regarding specific proposed conduct on an expedited basis. The statements continue the commitment of the Agencies to respond to requests for business reviews or advisory opinions from the health care community no later than 90 days after all necessary information is received regarding any matter addressed in the statements, except requests relating to hospital mergers

outside the antitrust safety zone and multiprovider networks. The Agencies also will respond to business review or advisory opinion requests regarding multiprovider networks or other non-merger health care matters within 120 days after all necessary information is received. The Agencies intend to work closely with persons making requests to clarify what information is necessary and to provide guidance throughout the process. The Agencies continue this commitment to expedited review in an effort to reduce antitrust uncertainty for the health care industry in what the Agencies recognize is a time of fundamental change.

The Agencies recognize the importance of antitrust guidance in evolving health care contexts. Consequently, the Agencies continue their commitment to issue additional guidance as warranted.

---

1. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON MERGERS AMONG HOSPITALS

Introduction

Most hospital mergers and acquisitions ("mergers") do not present competitive concerns. While careful analysis may be necessary to determine the likely competitive effect of a particular hospital merger, the competitive effect of many hospital mergers is relatively easy to assess. This statement sets forth an antitrust safety zone for certain mergers in light of the Agencies' extensive experience analyzing hospital mergers. Mergers that fall within the antitrust safety zone will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.(1) This policy statement also briefly describes the Agencies' antitrust analysis of hospital mergers that fall outside the antitrust safety zone.

A. *Antitrust Safety Zone:* Mergers Of Hospitals That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge any merger between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years, absent extraordinary circumstances. This antitrust safety zone will not apply if that hospital is less than 5 years old.

The Agencies recognize that in some cases a general acute care hospital with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients will be the only hospital in a relevant market. As such, the hospital does not compete in any significant way with other hospitals. Accordingly, mergers involving such hospitals are unlikely to reduce competition substantially.

The Agencies also recognize that many general acute care hospitals, especially rural hospitals, with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients are unlikely to achieve the efficiencies that larger hospitals enjoy. Some of those cost-saving efficiencies may be realized, however, through a merger with another hospital.

B. The Agencies' Analysis Of Hospital Mergers That Fall Outside The Antitrust Safety Zone

Hospital mergers that fall outside the antitrust safety zone are not necessarily anticompetitive, and may be procompetitive. The Agencies' analysis of hospital mergers follows the five steps set forth in the Department of Justice/ Federal Trade Commission *1992 Horizontal Merger Guidelines*.

are likely to be national or at least regional in scope. Thus, while County and SMC might well account for more than 35 percent of the total sales of many hospital supplies in Smalltown or Rural County, they and the other hospitals in Big City that will participate in the arrangement together would likely not account for significant percentages of sales in the actual relevant markets. Thus, the first criterion for inclusion in the safety zone is likely to be satisfied.

The Agencies would then inquire whether the supplies to be purchased jointly account for less than 20 percent of the total revenues from all products and services sold by each of the competing hospitals that participate in the arrangement. In this case, County and SMC are competing hospitals, but this second criterion for inclusion in the safety zone is also likely to be satisfied, and the Agencies would not challenge the joint purchasing arrangement.

***

Hospitals or other health care providers that are considering joint purchasing arrangements and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of health care providers considering a joint purchasing arrangement within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

---

8. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PHYSICIAN NETWORK JOINT VENTURES

Introduction

In recent years, health plans and other purchasers of health care services have developed a variety of managed care programs that seek to reduce the costs and assure the quality of health care services. Many physicians and physician groups have organized physician network joint ventures, such as individual practice associations ("IPAs"), preferred provider organizations ("PPOs"), and other arrangements to market their services to these plans.[21] Typically, such networks contract with the plans to provide physician services to plan subscribers at predetermined prices, and the physician participants in the networks agree to controls aimed at containing costs and assuring the appropriate and efficient provision of high quality physician services. By developing and implementing mechanisms that encourage physicians to collaborate in practicing efficiently as part of the network, many physician network joint ventures promise significant procompetitive benefits for consumers of health care services.

As used in this statement, a physician network joint venture is a physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services.[22] Other types of health care network joint ventures are not directly addressed by this statement.[23]

This statement of enforcement policy describes the Agencies' antitrust analysis of physician network joint ventures, and presents several examples of its application to specific hypothetical physician network joint ventures. Before describing the general antitrust analysis, the statement sets forth antitrust safety zones that describe physician network joint ventures that are highly unlikely to raise substantial competitive concerns,

and therefore will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.

The Agencies emphasize that merely because a physician network joint venture does not come within a safety zone in no way indicates that it is unlawful under the antitrust laws. On the contrary, such arrangements may be procompetitive and lawful, and many such arrangements have received favorable business review letters or advisory opinions from the Agencies.(24) The safety zones use a few factors that are relatively easy to apply, to define a category of ventures for which the Agencies presume no anticompetitive harm, without examining competitive conditions in the particular case. A determination about the lawfulness of physician network joint ventures that fall outside the safety zones must be made on a case-by-case basis according to general antitrust principles and the more specific analysis described in this statement.

A. *Antitrust Safety Zones*

This section describes those physician network joint ventures that will fall within the antitrust safety zones designated by the Agencies. The antitrust safety zones differ for "exclusive" and "non-exclusive" physician network joint ventures. In an "exclusive" venture, the network's physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans. In a "non-exclusive" venture, on the other hand, the physician participants in fact do, or are available to, affiliate with other networks or contract individually with health plans. This section explains how the Agencies will determine whether a physician network joint venture is exclusive or non-exclusive. It also illustrates types of arrangements that can involve the sharing of substantial financial risk among a network's physician participants, which is necessary for a network to come within the safety zones.

1. Exclusive Physician Network Joint Ventures That The Agencies Will Not Challenge, Absent Extraordinary Circumstances

The Agencies will not challenge, absent extraordinary circumstances, an exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 20 percent or less of the physicians(25) in each physician specialty with active hospital staff privileges who practice in the relevant geographic market.(26) In relevant markets with fewer than five physicians in a particular specialty, an exclusive physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty, on a non-exclusive basis, even though the inclusion of that physician results in the venture consisting of more than 20 percent of the physicians in that specialty.

2. Non-Exclusive Physician Network Joint Ventures That The Agencies Will Not Challenge, Absent Extraordinary Circumstances

The Agencies will not challenge, absent extraordinary circumstances, a non-exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 30 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market. In relevant markets with fewer than four physicians in a particular specialty, a non-exclusive physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty, even though the inclusion of that physician results in

the venture consisting of more than 30 percent of the physicians in that specialty.

3. Indicia Of Non-Exclusivity

Because of the different market share thresholds for the safety zones for exclusive and non-exclusive physician network joint ventures, the Agencies caution physician participants in a non-exclusive physician network joint venture to be sure that the network is non-exclusive in fact and not just in name. The Agencies will determine whether a physician network joint venture is exclusive or non-exclusive by its physician participants' activities, and not simply by the terms of the contractual relationship. In making that determination, the Agencies will examine the following indicia of non-exclusivity, among others:

(1) that viable competing networks or managed care plans with adequate physician participation currently exist in the market;

(2) that physicians in the network actually individually participate in, or contract with, other networks or managed care plans, or there is other evidence of their willingness and incentive to do so;

(3) that physicians in the network earn substantial revenue from other networks or through individual contracts with managed care plans;

(4) the absence of any indications of significant de-participation from other networks or managed care plans in the market; and (5) the absence of any indications of coordination among the physicians in the network regarding price or other competitively significant terms of participation in other networks or managed care plans.

Networks also may limit or condition physician participants' freedom to contract outside the network in ways that fall short of a commitment of full exclusivity. If those provisions significantly restrict the ability or willingness of a network's physicians to join other networks or contract individually with managed care plans, the network will be considered exclusive for purposes of the safety zones.

4. Sharing Of Substantial Financial Risk By Physicians In A Physician Network Joint Venture

To qualify for either antitrust safety zone, the participants in a physician network joint venture must share substantial financial risk in providing all the services that are jointly priced through the network.(27)

The safety zones are limited to networks involving substantial financial risk sharing not because such risk sharing is a desired end in itself, but because it normally is a clear and reliable indicator that a physician network involves sufficient integration by its physician participants to achieve significant efficiencies.(28) Risk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians.

The following are examples of some types of arrangements through which participants in a physician network joint venture can share substantial financial risk:(29)

(1) agreement by the venture to provide services to a health plan at a "capitated" rate;(30)

(2) agreement by the venture to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;(31)

(3) use by the venture of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:

(a) withholding from all physician participants in the network a substantial amount of the compensation

due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole; or

(b) establishing overall cost or utilization targets for the network as a whole, with the network's physician participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and

(4) agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialities offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors.(32)

The Agencies recognize that new types of risk-sharing arrangements may develop. The preceding examples do not foreclose consideration of other arrangements through which the participants in a physician network joint venture may share substantial financial risk in the provision of medical services through the network.(33) Organizers of physician networks who are uncertain whether their proposed arrangements constitute substantial financial risk sharing for purposes of this policy statement are encouraged to take advantage of the Agencies' expedited business review and advisory opinion procedures.

B. The Agencies' Analysis Of Physician Network Joint Ventures That Fall Outside The Antitrust Safety Zones

Physician network joint ventures that fall outside the antitrust safety zones also may have the potential to create significant efficiencies, and do not necessarily raise substantial antitrust concerns. For example, physician network joint ventures in which the physician participants share substantial financial risk, but which involve a higher percentage of physicians in a relevant market than specified in the safety zones, may be lawful if they are not anticompetitive on balance.(34) Likewise, physician network joint ventures that do not involve the sharing of substantial financial risk also may be lawful if the physicians' integration through the joint venture creates significant efficiencies and the venture, on balance, is not anticompetitive.

The Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, their goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition.

1. Determining When Agreements Among Physicians In A Physician Network Joint Venture Are Analyzed Under The Rule Of Reason

Antitrust law treats naked agreements among competitors that fix prices or allocate markets as per se illegal. Where competitors economically integrate in a joint venture, however, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason.(35) In accord with general antitrust principles, physician network joint ventures will be analyzed under the rule of reason, and will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies.(36)

Where the participants in a physician network joint venture have agreed to share substantial financial risk as defined in Section A.4. of this policy statement, their risk-sharing arrangement generally establishes both an overall efficiency goal for the venture and the incentives for the physicians to meet that goal. The setting of price is integral to the venture's use of such an arrangement and therefore warrants evaluation under the rule of reason.

Physician network joint ventures that do not involve the sharing of substantial financial risk may also involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies. Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

The foregoing are not, however, the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis, and the Agencies will consider other arrangements that also may evidence such integration. However, in all cases, the Agencies' analysis will focus on substance, rather than form, in assessing a network's likelihood of producing significant efficiencies. To the extent that agreements on prices to be charged for the integrated provision of services are reasonably necessary to the venture's achievement of efficiencies, they will be evaluated under the rule of reason.

In contrast to integrated physician network joint ventures, such as these discussed above, there have been arrangements among physicians that have taken the form of networks, but which in purpose or effect were little more than efforts by their participants to prevent or impede competitive forces from operating in the market. These arrangements are not likely to produce significant procompetitive efficiencies. Such arrangements have been, and will continue to be, treated as unlawful conspiracies or cartels, whose price agreements are per se illegal.

Determining that an arrangement is merely a vehicle to fix prices or engage in naked anticompetitive conduct is a factual inquiry that must be done on a case-by-case basis to determine the arrangement's true nature and likely competitive effects. However, a variety of factors may tend to corroborate a network's anticompetitive nature, including: statements evidencing anticompetitive purpose; a recent history of anticompetitive behavior or collusion in the market, including efforts to obstruct or undermine the development of managed care; obvious anticompetitive structure of the network (*e.g.*, a network comprising a very high percentage of local area physicians, whose participation in the network is exclusive, without any plausible business or efficiency justification); the absence of any mechanisms with the potential for generating significant efficiencies or otherwise increasing competition through the network; the presence of anticompetitive collateral agreements; and the absence of mechanisms to prevent the network's operation from having anticompetitive spillover effects outside the network.

2. Applying The Rule Of Reason

A rule of reason analysis determines whether the formation and operation of the joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the joint venture. The rule of reason analysis takes into account characteristics of the particular physician network joint venture, and the competitive environment in which it operates, that bear on the venture's likely effect on competition.

A determination about the lawfulness of a network's activity under the rule of reason sometimes can be reached without an extensive inquiry under each step of the analysis. For example, a physician network joint venture that involves substantial clinical integration may include a relatively small percentage of the physicians in the relevant markets on a non-exclusive basis. In that case, the Agencies may be able to conclude expeditiously that the network is unlikely to be anticompetitive, based on the competitive environment in which it operates. In assessing the competitive environment, the Agencies would consider such market factors as the number, types, and size of managed care plans operating in the area, the extent of physician participation in those plans, and the economic importance of the managed care plans to area physicians. *See infra* Example 1. Alternatively, for example, if a restraint that facially appears to be of a kind that would always or almost always tend to reduce output or increase prices, but has not been considered per se unlawful, is not reasonably necessary to the creation of efficiencies, the Agencies will likely challenge the restraint without an elaborate analysis of market definition and market power.(37)

The steps ordinarily involved in a rule of reason analysis of physician network joint ventures are set forth below.

Step one: Define the relevant market. The Agencies evaluate the competitive effects of a physician network joint venture in each relevant market in which it operates or has substantial impact. In defining the relevant product and geographic markets, the Agencies look to what substitutes, as a practical matter, are reasonably available to consumers for the services in question.(38) The Agencies will first identify the relevant services that the physician network joint venture provides. Although all services provided by each physician specialty might be a separate relevant service market, there may be instances in which significant overlap of services provided by different physician specialties, or in some circumstances, certain nonphysician health care providers, justifies including services from more than one physician specialty or category of providers in the same market. For each relevant service market, the relevant geographic market will include all physicians (or other providers) who are good substitutes for the physician participants in the joint venture.

Step two: Evaluate the competitive effects of the physician joint venture. The Agencies examine the structure and activities of the physician network joint venture and the nature of competition in the relevant market to determine whether the formation or operation of the venture is likely to have an anticompetitive effect. Two key areas of competitive concern are whether a physician network joint venture could raise the prices for physician services charged to health plans above competitive levels, or could prevent or impede the formation or operation of other networks or plans.

In assessing whether a particular network arrangement could raise prices or exclude competition, the Agencies will examine whether the network physicians collectively have the ability and incentive to engage in such conduct. The Agencies will consider not only the proportion of the physicians in any relevant market who are in the network, but also the incentives faced by physicians in the network, and whether different groups of physicians in a network may have significantly different incentives that would reduce the likelihood of anticompetitive conduct. The Department of Justice has entered into final judgments that permit a network to include a relatively large proportion of physicians in a relevant market where the percentage of physicians with an ownership interest in the network is strictly limited, and the network subcontracts with additional physicians under terms that create a sufficient divergence of economic interest between the subcontracting physicians and the owner physicians so that the owner physicians have an incentive to control the costs to the network of the subcontracting physicians.(39) Evaluating the incentives faced by network physicians requires an examination of the facts and circumstances of each particular case. The Agencies will assess whether different groups of physicians in the network actually have significantly divergent incentives that would override any shared interest, such

as the incentive to profit from higher fees for their medical services. The Agencies will also consider whether the behavior of network physicians or other market evidence indicates that the differing incentives among groups of physicians will not prevent anticompetitive conduct.

If, in the relevant market, there are many other networks or many physicians who would be available to form competing networks or to contract directly with health plans, it is unlikely that the joint venture would raise significant competitive concerns. The Agencies will analyze the availability of suitable physicians to form competing networks, including the exclusive or non-exclusive nature of the physician network joint venture.

The Agencies recognize that the competitive impact of exclusive arrangements or other limitations on the ability of a network's physician participants to contract outside the network can vary greatly. For example, in some circumstances exclusivity may help a network serve its subscribers and increase its physician participants' incentives to further the interests of the network. In other situations, however, the anticompetitive risks posed by such exclusivity may outweigh its procompetitive benefits. Accordingly, the Agencies will evaluate the actual or likely effects of particular limitations on contracting in the market situation in which they occur.

An additional area of possible anticompetitive concern involves the risk of "spillover" effects from the venture. For example, a joint venture may involve the exchange of competitively sensitive information among competing physicians and thereby become a vehicle for the network's physician participants to coordinate their activities outside the venture. Ventures that are structured to reduce the likelihood of such spillover are less likely to result in anticompetitive effects. For example, a network that uses an outside agent to collect and analyze fee data from physicians for use in developing the network's fee schedule, and avoids the sharing of such sensitive information among the network's physician participants, may reduce concerns that the information could be used by the network's physician participants to set prices for services they provide outside the network.

Step three: Evaluate the impact of procompetitive efficiencies.[(40)] This step requires an examination of the joint venture's likely procompetitive efficiencies, and the balancing of these efficiencies against any likely anticompetitive effects. The greater the venture's likely anticompetitive effects, the greater must be the venture's likely efficiencies. In assessing efficiency claims, the Agencies focus on net efficiencies that will be derived from the operation of the network and that result in lower prices or higher quality to consumers. The Agencies will not accept claims of efficiencies if the parties reasonably can achieve equivalent or comparable savings through significantly less anticompetitive means. Inmaking this assessment, however, the Agencies will not search for a theoretically least restrictive alternative that is not practical given business realities.

Experience indicates that, in general, more significant efficiencies are likely to result from a physician network joint venture's substantial financial risk sharing or substantial clinical integration. However, the Agencies will consider a broad range of possible cost savings, including improved cost controls, case management and quality assurance, economies of scale, and reduced administrative or transaction costs.

In assessing the likelihood that efficiencies will be realized, the Agencies recognize that competition is one of the strongest motivations for firms to lower prices, reduce costs, and provide higher quality. Thus, the greater the competition facing the network, the more likely it is that the network will actually realize potential efficiencies that would benefit consumers.

Step four: Evaluation of collateral agreements. This step examines whether the physician network joint venture includes collateral agreements or conditions that unreasonably restrict competition and are unlikely

to contribute significantly to the legitimate purposes of the physician network joint venture. The Agencies will examine whether the collateral agreements are reasonably necessary to achieve the efficiencies sought by the joint venture. For example, if the physician participants in a physician network joint venture agree on the prices they will charge patients who are not covered by the health plans with which their network contracts, such an agreement plainly is not reasonably necessary to the success of the joint venture and is an antitrust violation.(41) Similarly, attempts by a physician network joint venture to exclude competitors or classes of competitors of the network's physician participants from the market could have anticompetitive effects, without advancing any legitimate, procompetitive goal of the network. This could happen, for example, if the network facilitated agreements among the physicians to refuse to deal with such competitors outside the network, or to pressure other market participants to refuse to deal with such competitors or deny them necessary access to key facilities.

C. Examples Of Physician Network Joint Ventures

The following are examples of how the Agencies would apply the principles set forth in this statement to specific physician network joint ventures. The first three are new examples: 1) a network involving substantial clinical integration, that is unlikely to raise significant competitive concerns under the rule of reason; 2) a network involving both substantial financial risk-sharing and non-risk-sharing arrangements, which would be analyzed under the rule of reason; and 3) a network involving neither substantial financial risk-sharing nor substantial clinical integration, and whose price agreements likely would be challenged as per se unlawful. The last four examples involve networks that operate in a variety of market settings and with different levels of physician participants; three are networks that involve substantial financial risk-sharing and one is a network in which the physician participants do not jointly agree on, or negotiate, price.

1. Physician Network Joint Venture Involving Clinical Integration

Charlestown is a relatively isolated, medium-sized city. For the purposes of this example, the services provided by primary care physicians and those provided by the different physician specialties each constitute a relevant product market; and the relevant geographic market for each of them is Charlestown.

Several HMOs and other significant managed care plans operate in Charlestown. A substantial proportion of insured individuals are enrolled in these plans, and enrollment in managed care is expected to increase. Many physicians in each of the specialties participate in more than one of these plans. There is no significant overlap among the participants on the physician panels of many of these plans.

A group of Charlestown physicians establishes an IPA to assume greater responsibility for managing the cost and quality of care rendered to Charlestown residents who are members of health plans. They hope to reduce costs while maintaining or improving the quality of care, and thus to attract more managed care patients to their practices.

The IPA will implement systems to establish goals relating to quality and appropriate utilization of services by IPA participants, regularly evaluate both individual participants' and the network's aggregate performance with respect to those goals, and modify individual participants' actual practices, where necessary, based on those evaluations. The IPA will engage in case management, preauthorization of some services, and concurrent and retrospective review of inpatient stays. In addition, the IPA is developing practice standards and protocols to govern treatment and utilization of services, and it will actively review the care rendered by each doctor in light of these standards and protocols.

There is a significant investment of capital to purchase the information systems necessary to gather

aggregate and individual data on the cost, quantity, and nature of services provided or ordered by the IPA physicians; to measure performance of the group and the individual doctors against cost and quality benchmarks; and to monitor patient satisfaction. The IPA will provide payers with detailed reports on the cost and quantity of services provided, and on the network's success in meeting its goals.

The IPA will hire a medical director and a support staff to perform the above functions and to coordinate patient care in specific cases. The doctors also have invested appreciable time in developing the practice standards and protocols, and will continue actively to monitor care provided through the IPA. Network participants who fail to adhere to the network's standards and protocols will be subject to remedial action, including the possibility of expulsion from the network.

The IPA physicians will be paid by health plans on a fee-for-service basis; the physicians will not share substantial financial risk for the cost of services rendered to covered individuals through the network. The IPA will retain an agent to develop a fee schedule, negotiate fees, and contract with payers on behalf of the venture. Information about what participating doctors charge non-network patients will not be disseminated to participants in the IPA, and the doctors will not agree on the prices they will charge patients not covered by IPA contracts.

The IPA is built around three geographically dispersed primary care group practices that together account for 25 percent of the primary care doctors in Charlestown. A number of specialists to whom the primary care doctors most often refer their patients also are invited to participate in the IPA. These specialists are selected based on their established referral relationships with the primary care doctors, the quality of care provided by the doctors, their willingness to cooperate with the goals of the IPA, and the need to provide convenient referral services to patients of the primary care doctors. Specialist services that are needed less frequently will be provided by doctors who are not IPA participants. Participating specialists constitute from 20 to 35 percent of the specialists in each relevant market, depending on the specialty. Physician participation in the IPA is non-exclusive. Many IPA participants already do and are expected to continue to participate in other managed care plans and earn substantial income from those plans.

Competitive Analysis

Although the IPA does not fall within the antitrust safety zone because the physicians do not share substantial financial risk, the Agencies would analyze the IPA under the rule of reason because it offers the potential for creating significant efficiencies and the price agreement is reasonably necessary to realize those efficiencies. Prior to contracting on behalf of competing doctors, the IPA will develop and invest in mechanisms to provide cost-effective quality care, including standards and protocols to govern treatment and utilization of services, information systems to measure and monitor individual physician and aggregate network performance, and procedures to modify physician behavior and assure adherence to network standards and protocols. The network is structured to achieve its efficiencies through a high degree of interdependence and cooperation among its physician participants. The price agreement, under these circumstances, is subordinate to and reasonably necessary to achieve these objectives.(42)

Furthermore, the Agencies would not challenge under the rule of reason the doctors' agreement to establish and operate the IPA. In conducting the rule of reason analysis, the Agencies would evaluate the likely competitive effects of the venture in each relevant market. In this case, the IPA does not appear likely to limit competition in any relevant market either by hampering the ability of health plans to contract individually with area physicians or with other physician network joint ventures, or by enabling the physicians to raise prices above competitive levels. The IPA does not appear to be overinclusive: many primary care physicians and specialists are available to other plans, and the doctors in the IPA have been selected to achieve the network's procompetitive potential. Many IPA participants also participate in other

managed care plans and are expected to continue to do so in the future. Moreover, several significant managed care plans are not dependent on the IPA participants to offer their products to consumers. Finally, the venture is structured so that physician participants do not share competitively sensitive information, thus reducing the likelihood of anticompetitive spillover effects outside the network where the physicians still compete, and the venture avoids any anticompetitive collateral agreements.

Since the venture is not likely to be anticompetitive, there is no need for further detailed evaluation of the venture's potential for generating procompetitive efficiencies. For these reasons, the Agencies would not challenge the joint venture. However, they would reexamine this conclusion and do a more complete analysis of the procompetitive efficiencies if evidence of actual anticompetitive effects were to develop.

2. Physician Network Joint Venture Involving Risk-Sharing And Non-Risk-Sharing Contracts

An IPA has capitation contracts with three insurer-developed HMOs. Under its contracts with the HMOs, the IPA receives a set fee per member per month for all covered services required by enrollees in a particular health plan. Physician participants in the IPA are paid on a fee-for-service basis, pursuant to a fee schedule developed by the IPA. Physicians participate in the IPA on a non-exclusive basis. Many of the IPA's physicians participate in managed care plans outside the IPA, and earn substantial income from those plans.

The IPA uses a variety of mechanisms to assure appropriate use of services under its capitation contracts so that it can provide contract services within its capitation budgets. In part because the IPA has managed the provision of care effectively, enrollment in the HMOs has grown to the point where HMO patients are a significant share of the IPA doctors' patients.

The three insurers that offer the HMOs also offer PPO options in response to the request of employers who want to give their employees greater choice of plans. Although the capitation contracts are a substantial majority of the IPA's business, it also contracts with the insurers to provide services to the PPO programs on a fee-for-service basis. The physicians are paid according to the same fee schedule used to pay them under the IPA's capitated contracts. The IPA uses the same panel of providers and the same utilization management mechanisms that are involved in the HMO contracts. The IPA has tracked utilization for HMO and PPO patients, which shows similar utilization patterns for both types of patients.

Competitive Analysis

Because the IPA negotiates and enters into both capitated and fee-for-service contracts on behalf on its physicians, the venture is not within a safety zone. However, the IPA's HMO contracts are analyzed under the rule of reason because they involve substantial financial risk-sharing. The PPO contracts also are analyzed under the rule of reason because there are significant efficiencies from the capitated arrangements that carry over to the fee-for-service business. The IPA's procedures for managing the provision of care under its capitation contracts and its related fee schedules produce significant efficiencies; and since those same procedures and fees are used for the PPO contracts and result in similar utilization patterns, they will likely result in significant efficiencies for the PPO arrangements as well.

3. Physician Network That Is Per Se Unlawful

A group of physicians in Clarksville forms an IPA to contract with managed care plans. There is some limited managed care presence in the area, and new plans have announced their interest in entering. The physicians agree that the only way they can effectively combat the power of the plans and protect themselves from low fees and intrusive utilization review is to organize and negotiate with the plans

collectively through the IPA, rather than individually.

Membership in the IPA is open to any licensed physician in Clarksville. Members contribute $2,000 each to fund the legal fees associated with incorporating the IPA and its operating expenses, including the salary of an executive director who will negotiate contracts on behalf of the IPA. The IPA will enter only into fee-for-service contracts. The doctors will not share substantial financial risk under the contracts. The Contracting Committee, in consultation with the executive director, develops a fee schedule.

The IPA establishes a Quality Assurance and Utilization Review Committee. Upon recommendation of this committee, the members vote to have the IPA adopt two basic utilization review parameters: strict limits on documentation to be provided by physicians to the payers, and arbitration of disputes regarding plan utilization review decisions by a committee of the local medical society. The IPA refuses to contract with plans that do not accept these utilization review parameters. The IPA claims to have its own utilization review/quality assurance programs in development, but has taken very few steps to create such a program. It decides to rely instead on the hospital's established peer review mechanisms.

Although there is no formal exclusivity agreement, IPA physicians who are approached by managed care plans seeking contracts refer the plans to the IPA. Except for some contracts predating the formation of the IPA, the physicians do not contract individually with managed care plans on terms other than those set by the IPA.

Competitive Analysis

This IPA is merely a vehicle for collective decisions by its physicians on price and other significant terms of dealing. The physicians' purpose in forming the IPA is to increase their bargaining power with payers. The IPA makes no effort to selectively choose physicians who are likely to further the network's achievement of efficiencies, and the IPA involves no significant integration, financial or otherwise. IPA physicians' participation in the hospital's general peer review procedures does not evidence integration by those physicians that is likely to result in significant efficiencies in the provision of services through the IPA. The IPA does not manage the provision of care or offer any substantial potential for significant procompetitive efficiencies. The physicians are merely collectively agreeing on prices they will receive for services rendered under IPA contracts and not to accept certain aspects of utilization review that they do not like.

The physicians' contribution of capital to form the IPA does not make it a legitimate joint venture. In some circumstances, capital contributions by an IPA's participants can indicate that the participants have made a significant commitment to the creation of an efficiency-producing competitive entity in the market.[43] Capital contributions, however, can also be used to fund a cartel. The key inquiry is whether the contributed capital is being used to further the network's capability to achieve substantial efficiencies. In this case, the funds are being used primarily to support the joint negotiation, and not to achieve substantial procompetitive efficiencies. Thus, the physicians' agreement to bargain through the joint venture will be treated as per se illegal price fixing.

4. Exclusive Physician Network Joint Venture With Financial Risk-Sharing And Comprising More Than Twenty Percent Of Physicians With Active Admitting Privileges At A Hospital

County Seat is a relatively isolated, medium-sized community of about 350,000 residents. The closest town is 50 miles away. County Seat has five general acute care hospitals that offer a mix of basic primary, secondary, and tertiary care services.

Five hundred physicians have medical practices based in County Seat, and all maintain active admitting privileges at one or more of County Seat's hospitals. No physician from outside County Seat has any type of admitting privileges at a County Seat hospital. The physicians represent 10 different specialties and are distributed evenly among the specialties, with 50 doctors practicing each specialty.

One hundred physicians (also distributed evenly among specialties) maintain active admitting privileges at County Seat Medical Center. County Seat's other 400 physicians maintain active admitting privileges at other County Seat hospitals.

Half of County Seat Medical Center's 100 active admitting physicians propose to form an IPA to market their services to purchasers of health care services. The physicians are divided evenly among the specialties. Under the proposed arrangement, the physicians in the network joint venture would agree to meaningful cost containment and quality goals, including utilization review, quality assurance, and other measures designed to reduce the provision of unnecessary care to the plan's subscribers, and a substantial amount (in this example 20 percent) of the compensation due to the network's physician participants would be withheld and distributed only if these measures are successfully met. This physician network joint venture would be exclusive: Its physician participants would not be free to contract individually with health plans or to join other physician joint ventures.

A number of health plans that contract selectively with hospitals and physicians already operate in County Seat. These plans and local employers agree that other County Seat physicians, and the hospitals to which they admit, are good substitutes for the active admitting physicians and the inpatient services provided at County Seat Medical Center. Physicians with medical practices based outside County Seat, however, are not good substitutes for area physicians, because such physicians would find it inconvenient to practice at County Seat hospitals due to the distance between their practice locations and County Seat.

Competitive Analysis

A key issue is whether a physician network joint venture, such as this IPA, comprising 50 percent of the physicians in each specialty with active privileges at one of five comparable hospitals in County Seat would fall within the antitrust safety zone. The physicians within the joint venture represent less than 20 percent of all the physicians in each specialty in County Seat.

County Seat is the relevant geographic market for purposes of analyzing the competitive effects of this proposed physician joint venture. Within each specialty, physicians with admitting privileges at area hospitals are good substitutes for one another. However, physicians with practices based elsewhere are not considered good substitutes.

For purposes of analyzing the effects of the venture, all of the physicians in County Seat should be considered market participants. Purchasers of health care services consider all physicians within each specialty, and the hospitals at which they have admitting privileges, to be relatively interchangeable. Thus, in this example, any attempt by the joint venture's physician participants collectively to increase the price of physician services above competitive levels would likely lead third-party purchasers to recruit non-network physicians at County Seat Medical Center or other area hospitals.

Because physician network joint venture participants constitute less than 20 percent of each group of specialists in County Seat and agree to share substantial financial risk, this proposed joint venture would fall within the antitrust safety zone.

5. Physician Network Joint Venture With Financial Risk-Sharing And A Large Percentage Of

Physicians In A Relatively Small Community

Smalltown has a population of 25,000, a single hospital, and 50 physicians, most of whom are family practitioners. All of the physicians practice exclusively in Smalltown and have active admitting privileges at the Smalltown hospital. The closest urban area, Big City, is located some 35 miles away and has a population of 500,000. A little more than half of Smalltown's working adults commute to work in Big City. Some of the health plans used by employers in Big City are interested in extending their network of providers to Smalltown to provide coverage for subscribers who live in Smalltown, but commute to work in Big City (coverage is to include the families of commuting subscribers). However, the number of commuting Smalltown subscribers is a small fraction of the Big City employers' total workforce.

Responding to these employers' needs, a few health plans have asked physicians in Smalltown to organize a non-exclusive IPA large enough to provide a reasonable choice to subscribers who reside in Smalltown, but commute to work in Big City. Because of the relatively small number of potential enrollees in Smalltown, the plans prefer to contract with such a physician network joint venture, rather than engage in what may prove to be a time-consuming series of negotiations with individual Smalltown physicians to establish a panel of physician providers there.

A number of Smalltown physicians have agreed to form a physician network joint venture. The joint venture will contract with health plans to provide physician services to subscribers of the plans in exchange for a monthly capitation fee paid for each of the plans' subscribers. The physicians forming this joint venture would constitute about half of the total number of physicians in Smalltown. They would represent about 35 percent of the town's family practitioners, but higher percentages of the town's general surgeons (50 percent), pediatricians (50 percent), and obstetricians (67 percent). The health plans that serve Big City employers say that the IPA must have a large percentage of Smalltown physicians to provide adequate coverage for employees and their families in Smalltown and in a few scattered rural communities in the immediate area and to allow the doctors to provide coverage for each other.

In this example, other health plans already have entered Smalltown, and contracted with individual physicians. They have made substantial inroads with Smalltown employers, signing up a large number of enrollees. None of these plans has had any difficulty contracting with individual physicians, including many who would participate in the proposed joint venture.

Finally, the evidence indicates that Smalltown is the relevant geographic market for all physician services. Physicians in Big City are not good substitutes for a significant number of Smalltown residents.

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would comprise over 30 percent of the physicians in a number of relevant specialties in the geographic market. However, the Agencies would not challenge the joint venture because a rule of reason analysis indicates that its formation would not likely hamper the ability of health plans to contract individually with area physicians or with other physician network joint ventures, or enable the physicians to raise prices above competitive levels. In addition, the joint venture's agreement to accept capitated fees creates incentives for its physicians to achieve cost savings.

That health plans have requested formation of this venture also is significant, for it suggests that the joint venture would offer additional efficiencies. In this instance, it appears to be a low-cost method for plans to enter an area without investing in costly negotiations to identify and contract with individual physicians.

Moreover, in small markets such as Smalltown, it may be necessary for purchasers of health care services to contract with a relatively large number of physicians to provide adequate coverage and choice for enrollees. For instance, if there were only three obstetricians in Smalltown, it would not be possible for a physician network joint venture offering obstetrical services to have less than 33 percent of the obstetricians in the relevant area. Furthermore, it may be impractical to have less than 67 percent in the plan, because two obstetricians may be needed in the venture to provide coverage for each other.

Although the joint venture has a relatively large percentage of some specialties, it appears unlikely to present competitive concerns under the rule of reason because of three factors: (1) the demonstrated ability of health plans to contract with physicians individually; (2) the possibility that other physician network joint ventures could be formed; and (3) the potential benefits from the coverage to be provided by this physician network joint venture. Therefore, the Agencies would not challenge the joint venture.

6. Physician Network Joint Venture With Financial Risk Sharing And A Large Percentage Of Physicians In A Small, Rural County

Rural County has a population of 15,000, a small primary care hospital, and ten physicians, including seven general and family practitioners, an obstetrician, a pediatrician, and a general surgeon. All of the physicians are solo practitioners. The nearest urban area is about 60 miles away in Big City, which has a population of 300,000, and three major hospitals to which patients from Rural County are referred or transferred for higher levels of hospital care. However, Big City is too far away for most residents of Rural County routinely to use its physicians for services available in Rural County.

Insurance Company, which operates throughout the state, is attempting to offer managed care programs in all areas of the state, and has asked the local physicians in Rural County to form an IPA to provide services under the program to covered persons living in the County. No other managed care plan has attempted to enter the County previously.

Initially, two of the general practitioners and two of the specialists express interest in forming a network, but Insurance Company says that it intends to market its plan to the larger local employers, who need broader geographic and specialty coverage for their employees. Consequently, Insurance Company needs more of the local general practitioners and the one remaining specialist in the IPA to provide adequate geographic, specialty, and backup coverage to subscribers in Rural County. Eventually, four of the seven general practitioners and the one remaining specialist join the IPA and agree to provide services to Insurance Company's subscribers, under contracts providing for capitation. While the physicians' participation in the IPA is structured to be non-exclusive, no other managed care plan has yet entered the local market or approached any of the physicians about joining a different provider panel. In discussing the formation of the IPA with Insurance Company, a number of the physicians have made clear their intention to continue to practice outside the IPA and have indicated they would be interested in contracting individually with other managed care plans when those plans expand into Rural County.

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would comprise over 30 percent of the general practitioners in the geographic market. Under the circumstances, a rule of reason analysis indicates that the Agencies would not challenge the formation of the joint venture, for the reasons discussed below.

For purposes of this analysis, Rural County is considered the relevant geographic market. Generally, the Agencies will closely examine joint ventures that comprise a large percentage of physicians in the relevant

market. However, in this case, the establishment of the IPA and its inclusion of more than half of the general practitioners and all of the specialists in the network is the result of the payer's expressed need to have more of the local physicians in its network to sell its product in the market. Thus, the level of physician participation in the network does not appear to be overinclusive, but rather appears to be the minimum necessary to meet the employers' needs.

Although the IPA has more than half of the general practitioners and all of the specialists in it, under the particular circumstances this does not, by itself, raise sufficient concerns of possible foreclosure of entry by other managed care plans, or of the collective ability to raise prices above competitive levels, to warrant antitrust challenge to the joint venture by the Agencies. Because it is the first such joint venture in the county, there is no way absolutely to verify at the outset that the joint venture in fact will be non-exclusive. However, the physicians' participation in the IPA is formally non-exclusive, and they have expressed a willingness to consider joining other managed care programs if they begin operating in the area. Moreover, the three general practitioners who are not members of the IPA are available to contract with other managed care plans. The IPA also was established with participation by the local area physicians at the request of Insurance Company, indicating that this structure was not undertaken as a means for the physicians to increase prices or prevent entry of managed care plans.

Finally, the joint venture can benefit consumers in Rural County through the creation of efficiencies. The physicians have jointly put themselves at financial risk to control the use and cost of health care services through capitation. To make the capitation arrangement financially viable, the physicians will have to control the use and cost of health care services they provide under Insurance Company's program. Through the physicians' network joint venture, Rural County residents will be offered a beneficial product, while competition among the physicians outside the network will continue.

Given these facts, the Agencies would not challenge the joint venture. If, however, it later became apparent that the physicians' participation in the joint venture in fact was exclusive, and consequently other managed care plans that wanted to enter the market and contract with some or all of the physicians at competitive terms were unable to do so, the Agencies would re-examine the joint venture's legality. The joint venture also would raise antitrust concerns if it appeared that participation by most of the local physicians in the joint venture resulted in anticompetitive effects in markets outside the joint venture, such as uniformity of fees charged by the physicians in their solo medical practices.

7. Physician Network Joint Venture With No Price Agreement And Involving All Of The Physicians In A Small, Rural County

Rural County has a population of 10,000, a small primary care hospital, and six physicians, consisting of a group practice of three family practitioners, a general practitioner, an obstetrician, and a general surgeon. The nearest urban area is about 75 miles away in Big City, which has a population of 200,000, and two major hospitals to which patients from Rural County are referred or transferred for higher levels of hospital care. Big City is too far away, however, for most residents of Rural County to use for services available in Rural County.

HealthCare, a managed care plan headquartered in another state, is thinking of marketing a plan to the larger employers in Rural County. However, it finds that the cost of contracting individually with providers, administering the system, and overseeing the quality of care in Rural County is too high on a per capita basis to allow it to convince employers to switch from indemnity plans to its plan. HealthCare believes its plan would be more successful if it offered higher quality and better access to care by opening a clinic in the northern part of the county where no physicians currently practice.

All of the local physicians approach HealthCare about contracting with their recently-formed, non-exclusive, IPA. The physicians are willing to agree through their IPA to provide services at the new clinic that HealthCare will establish in the northern part of the county and to implement the utilization review procedures that HealthCare has adopted in other parts of the state.

HealthCare wants to negotiate with the new IPA. It believes that the local physicians collectively can operate the new clinic more efficiently than it can from its distant headquarters, but HealthCare also believes that collectively negotiating with all of the physicians will result in it having to pay higher fees or capitation rates. Thus, it encourages the IPA to appoint an agent to negotiate the non-fee related aspects of the contracts and to facilitate fee negotiations with the group practice and the individual doctors. The group practice and the individual physicians each will sign and negotiate their own individual contracts regarding fees and will unilaterally determine whether to contract with HealthCare, but will agree through the IPA to provide physician, administrative, and utilization review services. The agent will facilitate these individual fee negotiations by discussing separately and confidentially with each physician the physician's fee demands and presenting the information to HealthCare. No fee information will be shared among the physicians.

Competitive Analysis

For purposes of this analysis, Rural County is considered the relevant geographic market. Generally, the Agencies are concerned with joint ventures that comprise all or a large percentage of the physicians in the relevant market. In this case, however, the joint venture appears on balance to be procompetitive. The potential for competitive harm from the venture is not great and is outweighed by the efficiencies likely to be generated by the arrangement.

The physicians are not jointly negotiating fees or engaging in other activities that would be viewed as per se antitrust violations. Therefore, the IPA would be evaluated under the rule of reason. Any possible competitive harm would be balanced against any likely efficiencies to be realized by the venture to see whether, on balance, the IPA is anticompetitive or procompetitive.

Because the IPA is non-exclusive, the potential for competitive harm from foreclosure of competition is reduced. Its physicians are free to contract with other managed care plans or individually with HealthCare if they desire. In addition, potential concerns over anticompetitive pricing are minimized because physicians will continue to negotiate prices individually. Although the physicians are jointly negotiating non-price terms of the contract, agreement on these terms appears to be necessary to the successful operation of the joint venture. The small risk of anticompetitive harm from this venture is outweighed by the substantial procompetitive benefits of improved quality of care and access to physician services that the venture will engender. The new clinic in the northern part of the county will make it easier for residents of that area to receive the care they need. Given these facts, the Agencies would not challenge the joint venture.

***

Physicians who are considering forming physician network joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of physicians who are considering forming a network joint venture within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance about the information that

should be submitted.

---

9. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON MULTIPROVIDER NETWORKS

Introduction

The health care industry is changing rapidly as it looks for innovative ways to control costs and efficiently provide quality services. Health care providers are forming a wide range of new relationships and affiliations, including networks among otherwise competing providers, as well as networks of providers offering complementary or unrelated services.(44) These affiliations, referred to herein as multiprovider networks, can offer significant procompetitive benefits to consumers. They also can present antitrust questions, particularly if the network includes otherwise competing providers.

As used in this statement, multiprovider networks are ventures among providers that jointly market their health care services to health plans and other purchasers. Such ventures may contract to provide services to subscribers at jointly determined prices and agree to controls aimed at containing costs and assuring quality. Multiprovider networks vary greatly regarding the providers they include, the contractual relationships among those providers, and the efficiencies likely to be realized by the networks. Competitive conditions in the markets in which such networks operate also may vary greatly.

In this statement, the Agencies describe the antitrust principles that they apply in evaluating multiprovider networks, address some issues commonly raised in connection with the formation and operation of such networks, and present examples of the application of antitrust principles to hypothetical multiprovider networks. Because multiprovider networks involve a large variety of structures and relationships among many different types of health care providers, and new arrangements are continually developing, the Agencies are unable to establish a meaningful safety zone for these entities.

A. Determining When Agreements Among Providers In A Multiprovider Network Are Analyzed Under The Rule Of Reason

Antitrust law condemns as per se illegal naked agreements among competitors that fix prices or allocate markets. Where competitors economically integrate in a joint venture, however, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason.(45) In accord with general antitrust principles, multiprovider networks will be evaluated under the rule of reason, and will not be viewed as per se illegal, if the providers' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network providers are reasonably necessary to realize those efficiencies.(46)

In some multiprovider networks, significant efficiencies may be achieved through agreement by the competing providers to share substantial financial risk for the services provided through the network.(47) In such cases, the setting of price would be integral to the network's use of such an arrangement and, therefore, would warrant evaluation under the rule of reason.

The following are examples of some types of arrangements through which substantial financial risk can be

HIAA

Health Insurance Association of America

April 9, 2002

The Honorable Norm Rokeberg
Chair, House Judiciary Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Re: Senate Bill 37

Dear Representative Rokeberg:

This letter pertains to CSSB 37, concerning antitrust waivers for physicians, on behalf of the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. We represent many of the health insurance companies which would be subject to this legislation.

HIAA respectfully recommends the committee defeat this legislation since it is unnecessary and does not improve competition or, more importantly, benefit the citizens of Alaska. Health benefit plans are not prohibited from negotiating with independent physician groups under existing law and currently negotiate with large physician groups through an independent practice association, among others. In fact, without a physician antitrust waiver, physicians have *increasingly* joined these large groups to reduce administrative costs in negotiating contracts with managed care companies, risk sharing and the need to purchase expensive equipment. As recently as February 22, 2002, the Federal Trade Commission (FTC) permitted a multi-specialty physician practice association in Denver, Colorado to proceed to improve quality.[1] Approximately 60 percent of physicians nationally belong to groups with three or more physicians and the figures are expected to dramatically increase in the next few years[2]. Competition among health insurers in Alaska is impacted primarily by the small population base in the state, and the high costs of medical care, not due to the cost of negotiating contracts with physicians and other medical service providers.

Since the contract negotiation process does not influence competition, HIAA would respectfully request the legislature amend the legislative finding in Section 23.50.010(a) which alleges competition would be increased through a physician antitrust waiver. As the trade association that represents most of the carriers affected by this legislation and the carriers

[1] Federal Trade Commission letter authored by Jeffrey Brennan, Assistant Director, to John Miles of Ober, Kaler, Grimes & Shriver, dated February 19, 2002

[2] "Wall Street Comes to Washington: Analysts' Perspectives on Health System Change," Issue Brief, Center for Studying Health System Change, No. 17, December 1998

considering conducting business in Alaska, HIAA contends that competition would be diminished, and not improved, with the enactment of CSSB 37

The impact of the proposed CSSB 37 on small businesses could be devastating. When similar legislation was introduced at the federal level, Charles River Associates calculated that total annual personal health care spending would increase between 2.5 and 8.3 percent and that private health insurance premiums would annually increase by 4.7 to 13.2 percent as a result of this granting an antitrust waiver to physicians[3]. A premium increase at the conservative level of 4.7 percent, discounting any other factors which may increase premiums, could significantly decrease the ability of small employers to offer coverage to their employees because of the increased cost.

HIAA has significant specific concerns with CSSB 37. We support the comments in the FTC letter dated January 18, 2002 outlining the strong antitrust implications of the bill regardless of whether the issues negotiated on are fee or non-fee related, as well as their testimony before the House Labor and Commerce Committee (3/22/02). In addition, HIAA concurs with concerns raised by the Office of Attorney General (the entity charged with oversight of the proceedings under CSSB 37) as they have testified before the Senate Judiciary Committee (1/23/01) and the Senate Commerce and Labor Committee (3/8/01) that the legislation contains insufficient state supervision and would ultimately violate state and federal antitrust law[4]. Even if the legislature amended the bill to address the concerns of the Attorney General's Office and the FTC, we would respectfully recommend a thorough study of the issue before proceeding in order to examine the effects on Alaskans.

In addition, under Section 23.50.020(c), providers are permitted to negotiate with health plans over terms of fees and price if the plan exhibits substantial market power, presumably measured as 15 percent of the market under Section 23.50.020(f). This threshold appears extremely low to gauge substantial market power. HIAA would respectfully recommend, at a minimum, adhering to 30 percent of the market as recommended by FTC guidelines[5]. Increasing the substantial market threshold to 30 percent would also compare to the provisions in Section 23.50.020 (e)(6) and 23.50.020 (e)(7) which prohibits the Attorney General from limiting the representation of providers to less than 30 percent of the practicing physicians in the geographic service area. Further, why include a rebuttable presumption that a carrier has substantial market power and force the carrier to prove they do not meet the 15 percent threshold? The burden should be to prove the carrier possesses greater than the 15 percent of the market. Since few health insurers will possess the necessary market power to permit negotiations on fee-related issues, HIAA would respectfully suggest the legislature attempt to minimize the unnecessary administrative burden to all parties and amend this section

In Section 23.50.020 (e)(f)(2), health insurers must prove they possess lower than the 15 percent substantial market power as measured by covered lives, including Medicaid and

---

[3] The National Costs of Physician Antitrust Waivers, Charles River Associates Inc., March 2000, p. 21

[4] see also March 8, 2001 letter to Senate Commerce and Labor Chairman Randy Phillips, and February 5, 2001 letter to Senate Judiciary Chairman Robin Taylor, both from Attorney General Bruce Botelho

[5] Statements of Antitrust Enforcement Policy in Health Care, Issued by the U.S. Department of Justice and the Federal Trade Commission, page 65, August 1996

Medicare beneficiaries within a defined geographic area. HIAA respectfully requests both of these groups be removed from the definition of a covered life. The inclusion of the Medicare and Medicaid beneficiaries in this section may be interpreted as applying the entire legislation to these programs, which obviously is illegal in the case of Medicare, and may falsely illustrate a market power that is inapplicable to the negotiation process. CSSB 37 is aimed at the private market and inclusion of Medicaid and Medicare confuses the process.

In Section 23.50 020 (e)(f), an authorized third party may not represent more than 30 percent of the physicians unless the carrier possesses more than 5 percent of the market. HIAA would respectfully suggest amending this section to provide consistency with Section 23.50.020 (e)(f) where a carrier is deemed to have substantial market power if they enjoy 15 percent of the market. This section permits a third party representative to provide representation to all of the physicians in a designated market if a carrier has 5.01 percent of the market yet is not deemed to possess substantial market power. A carrier with 5.01 percent of the market has minimal effect on the market and should not provide all physicians with the ability to collectively negotiate as a single group. Neither of these thresholds meets the standards provided by the FTC. However, HIAA would respectfully request some equity and consistency in these provisions.

These issues raised are a few of the concerns of the insurance industry and amongst the challenges confronting the legislature with CSSB 37. HIAA respectfully believes the amendments to this bill neglect to address the concerns raised by the FTC or the Attorney General's Office and caution the committee members in their consideration. Thank you very much for considering our concerns. If you have any questions concerning our viewpoint, please contact me at 202.824.1708 or at jtindall@hiaa.org.

Sincerely,

Jeffrey E. Tindall
Legislative Director

cc: Reed Stoops

Testimony on HCS for Senate Bill 37
Mike Wiggins,
Aetna

Chairman Rokeberg and members of the House Judiciary Committee, my name is Mike Wiggins and I am the head of national accounts for the State of Alaska. In various capacities I have been involved in the health care insurance market in Alaska for the past 15.years, and have worked with Blue Cross, New York Life and more recently Aetna.

Aetna has opposed Senate Bill 37 and remains opposed to the latest draft of the bill. While the bill has been significantly narrowed from its original version, we still feel that it will neither benefit consumers nor competition in the Alaska health insurance market.

The major impact of the bill is to allow collective negotiations by physicians with health insurers on broad contractual items, which are listed on page 2 of the bill. Aetna and the Health Insurance Association of America which represents most of the other health insurers in the Alaska market agree with the Federal Trade Commission that bargaining on contractual issues will likely have a significant impact on the cost of health care and therefore is likely to increase the cost of insurance in Alaska. Since the bill only applies to the privately insured market (mainly individuals and small groups), it will have an adverse effect on the part of the market that already has the highest costs and in the market where the insured members are least able to afford increases. As you are aware there are two other bills pending before the legislature this year, which seek to find less expensive ways to provide health insurance in this sector of the market.

Two years ago, during the legislative session, Aetna participated extensively in the House Judiciary Committee proceedings on the Alaska " Patient Protection Act" which ultimately passed the Legislature . The main focus of that bill was to address the same contractual issues for which the physicians are now seeking the right of collective bargaining. That bill today provides safeguards in Alaska law and prohibits many of the practices such as "anti gag clauses" that physicians have testified, should be dealt with through the mechanism of SB 37.

Further, the FTC has testified that physician's groups are now permitted to bargain on "quality of care" issues within the federal constraints on antitrust. Passing a state law will not change the FTC's ultimate authority for evaluating and prosecuting. By adopting differing state and federal standards for antitrust actions, the situation will become more confusing, not less

Except for Blue Cross in a relatively small part of the total insurance market, we don't believe that any health insurer can be reasonably considered to have market power using the normal definition of that term. If HB 37 is intended to regulate Blue Cross in some fashion, as a nonprofit corporation they are subject to a different section of the insurance

statutes than the for profit insurers. Any concerns in the individual and small group market could be addressed under their unique part of Alaska's insurance statutes.

To address previous testimony by physicians on their inability to appeal claims that have been denied for "Medical Necessity", I have provided summary of State of Alaska - Aetna information to the committee illustrating the small number of these type appeals and their disposition. Ultimately, within the Aetna organization it is an independent physician and not a non-physician that decides the merits of these appeals.

Thank you for the opportunity to testify. I'll be glad to answer any questions from the committee.