ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672
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TABLE IX.C.1
STATE ACTIVITY IN STATES WITHOUT ANTITRUST IMMUNITY STATUTES FOR HEALTH CARE PROVIDERS

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

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

2. Health Care Enforcement in States with Immunity Statutes

a. Health Care Activity Approved Pursuant to an Immunity Process

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 As noted above, there were eleven petitions filed originally, but six were withdrawn with the transaction still proceeding.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

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

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

b. Antitrust Enforcement Activity Outside of an Immunity Process

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

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

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

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

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

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

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

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

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

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

TABLE IX.C.2

STATE ACTIVITY IN STATES WITH ANTITRUST IMMUNITY STATUTES FOR HEALTH CARE PROVIDERS

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

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

XI. CONCLUSION

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

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

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

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

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

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

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.

Alaska State Medical Association

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

April 23, 2001

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

Subject: SB37 – Physician Joint Negotiation

Dear Representative Murkowski:

The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them. ASMA urges you to support and vote for SB37.

SB37 would allow independently practicing physicians to jointly negotiate the terms of physician services agreements with insurance companies without violating federal antitrust laws. The legal theory (State Action Doctrine Exception) is based on a 1943 U.S. Supreme Court case, Parker v Brown. This case sets out two criteria for the states to allow such an exception. First, there has to be a clearly articulated and affirmatively expressed state policy. The second is that any such negotiation must be subject to active state supervision. SB 37, we believe, affirmatively meets both those criteria.

SB 37 is based on the model law constructed by the American Medical Association legal staff and its counsel Sidley and Austin. SB 37 is also similar to bills passed in Texas and the District of Columbia to accomplish the same purpose. ASMA feels the structure in SB 37 for the active oversight is stronger than either Texas' or the District of Columbia's bills. District of Columbia utilized Mr. Charles James as its outside legal consultant. (At the time Mr. James was a partner in the firm of Jones, Day, Reavis, & Pogue. Currently President Bush has nominated Mr. James to head the Antitrust Division at the Department of Justice. He also previously worked there as well as in the Federal Trade Commission during the Regan Administration.)

The protected negotiations that would be allowed for by SB 37 would be entirely voluntary on behalf of any party. Importantly, SB 37 would not, in any circumstance, allow any group of doctors to strike or engage in a boycott.

Again, ASMA asks you to support SB 37. Basic fairness in the physician services contracting process will result and a more physician friendly environment will be created to assist in our on-going process of recruiting qualified physicians in sufficient numbers.

Sincerely,

Peter Lawrason

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

ORTHOPEDIC
physicians anchorage

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

April 17, 2001

SB37-Physician Negotiation Bill

Representative Lisa Murkowski
Chair-House Labor & Commerce Committee
State Capitol Building
Juneau, Alaska 99801

Dear Representative Lisa Murkowski:

Our office would like to take this opportunity to heighten your awareness of the concerns we, and many Alaska physicians, have concerning SB37. We understand that since passage of this bill by the Senate, it is currently before your committee in the House. We feel it is imperative that your committee refers this bill for consideration as early as possible. The passage of SB37 before the conclusion of this legislative session is vital to maintaining a healthy climate for medical care in Alaska.

Alaska physicians are barred from collectively discussing many important issues with third party payors. These issues range from fee for service to patient referrals outside the PPO structure. These issues, and others, directly and indirectly affect patient care. With the limited number of physicians and specialists available in Alaska, the ability to discuss and negotiate these issues is imperative.

SB37 would allow groups of independent physicians to negotiate with health benefit plans, with an "active state oversight" of the process. It is important to note that all negotiations are voluntary, and any party can withdraw at any time. In addition, the Alaska Attorney General has veto power over the final contracts, including the fee schedule. This veto power should help alleviate the concerns of some legislators who claim that passage of this bill will simply allow physicians to inappropriately raise the cost of medical care.

Telephone (907) 562-2277 · Fax (907) 563-3460
E-Mail: theorthodocs@alaska.com

We would encourage those who oppose this bill to educate themselves on the many costs of medical care. These costs exist not only in the area of operating a medical practice and providing the best medical care to our patients today, but the costs that would be incurred to the patient in terms of receiving the best medical care available in the Alaska community. Without the ability to collectively negotiate terms of contractual agreements with health insurance providers, the ability for physicians and patients to independently establish care plans would be impeded. As with many other states, the ultimate decisions for care would lie with the insurance provider.

Bringing SB37 to this point has involved a great deal of compromise on the part of physicians over the last two years. We sincerely hope you and your House collegues will expedite passage of this important bill and ensure that choices for the best medical care continues to be available for Alaskans.

Respectfully,

Edward M. Voke, M.D.

Robert J. Hall, M.D.

Cc: Alaska Physicians and Surgeons
Senator Ted Steven

Fairbanks Clinic

Quality Care Since 1932

April 19, 2001

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

Dear Representative Murkowski:

I am writing concerning SB 37, the physician joint negotiation bill. This bill has spent the past 15 months being debated in the senate and after quite a bit of "give and take", as well as hearings, it passed the senate and is now moving to the house.

I am asking that you support this bill and do what you can to hear SB 37 at the earliest possible date and move the bill expeditiously. The bill has been somewhat modified from its original form through the legislative process in the senate. It is still basically similar to its original form. We feel the bill is beneficial to the patients of Alaska and feel that it should help in "somewhat leveling the negotiation field" between doctors and third party payers.

You may recall that I met with you in January. During our meeting we discussed this bill as well as other medical issues before the house. We are very hopeful that the house can pass this bill before the end of this year's session. As you may recall, the bill does have more than adequate supervision by the State of Alaska and keep in mind that all negotiations are completely voluntary on the part of all parties. You have heard, or possibly will hear arguments that this is likely to increase the cost of medical care in the State of Alaska. We would argue this would not be the case. If anything, it would provide a forum for greater competition by both physicians and third party payers.

Please do what you can to support the bill and move it expeditiously as possible and if you have any questions whatsoever, please don't hesitate to call me. My work number is (907) 452-1761, and my home number is (907) 457-2950.

Sincerely,

Peter Lawrason, M.D.
President, Alaska State Medical Association

1919 Lathrop St., Suite 100 • Fairbanks, Alaska 99701
(907) 452-1761

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

TONY KNOWLES, GOVERNOR

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

March 8, 2001

Senator Randy Phillips
Chair, Senate Labor and Commerce Committee

Re: CSSB 37

Dear Chairman Phillips:

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

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

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

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

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

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

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

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

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

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

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

The Department would request the following additions to this statute:

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

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

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

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

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

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

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

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

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

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

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

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

CES/sjm

43.72.300. Managed competition—Findings and intent

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

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

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

RNMENT—EXECUTIVE

ings and intent

tition among health care will yield the best alloca- prices for health care care when there exists a comparable health plans exit into the health care yers and sellers to base ever, the legislature finds health care coverage do to base purchasing deci- ers of health care services lop economies of scale or cious service; that health iance organizations face care coverage to those for health care coverage; sion of health care cover- market for health care

empt from state anti-trust al anti-trust laws through roved under this chapter uch laws and intends to market: To contain the promote the development ctive health care delivery ng health care providers health care coverage; to ng health care coverage ention, and the ameliora- sal access to a publicly e benefits; and to create s, treatment, and medical age, payers of health care health care facilities, and awful action taken pursu- erson or entity created or are declared to be taken of the public purposes of

unless explicitly permitted er rules adopted pursuant

to chapter 492, Laws of 1993, does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal anti-trust laws including but not limited to conspiracies or agreements:

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

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

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

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

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

(f) Among health carriers and purchasers to attract or discourage enrollment of any Washington resident or groups of residents in a health plan based upon the perceived or actual risk of loss in including such resident or group of residents in a health plan or purchasing group.

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

Historical and Statutory Notes

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

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

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

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

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

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

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

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

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

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

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

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

for good cause shown. If the conduct is not authorized by n or organization making the health for review and approv- subsection (3) of this section.

'n of the attorney general and tment of health:

:h carrier, health care facility, 'son that could tend to lessen ion a strong showing that the goals of chapter 492, Laws of e is impractical;

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erative activities among health

n to the rule-making authority section, the department shall 'nister rules previously adopted d the health care policy board

:ility, health care provider, or lopment, delivery, and market- lans may file a written petition sting approval of conduct that the relevant market. Such anner prescribed by rule of the

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

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

Historical and Statutory Notes

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

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

Administrative Code References

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

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

Chapter 246-25 WAC
ANTITRUST IMMUNITY AND COMPETITIVE OVERSIGHT

(Formerly Chapter 245-02 WAC)

Last Update: 1/28/99

WAC

SUBSTANTIVE RULES

PROCEDURAL RULES

SUBSTANTIVE RULES

WAC 246-25-010 Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 246-25-025 Scope and applicability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Patient referral procedures;

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

(f) Quality assurance programs;

(g) Health service utilization review procedures; and

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

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

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

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

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

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

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

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

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

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

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

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

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

prepaid comprehensive health services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROCEDURAL RULES

WAC 246-25-100 Purpose.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Its business address(es);

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

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

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

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

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

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

(c) The products and services involved or affected;

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Avoid duplication of health services resources;

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

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

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

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

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

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

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

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

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

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

Murkowski
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Division of Insurance
April 20, 2001

SUMMARY OF INSURANCE MARKET AND LEGAL ISSUES WITH SB 37

Insurance Market Issues

- All studies including the AMA study show that this type of legislation will increase the cost of health care. Many small employers and individuals in particular stand to suffer with any increases in the cost of health insurance. The inevitable result is that they will not be able to afford to purchase insurance coverage for employees or themselves and will become uninsured.

- SB 37 is designed to level the playing field between health care providers and HMOs. Alaska does not have HMOs and insurers do not negotiate actual fees with providers. They try to get providers to discount and from what the division has heard providers in Alaska are not receptive to discounts.

- Unlike in certain areas of the lower 48, providers in Alaska do not need to enter into contracts with insurers in order to get patients, simply because there not an excess of providers available to serve the Alaska population.

Legal Issues

- The market power provisions in SB 37 are not based on accepted concepts of market power in a legal or economic sense. Without actual market power by a health plan there is no justification for collective negotiations by physicians.

- The prohibition on boycotts and concerted action by physicians may not provide adequate protection to consumers. SB 37 facilitates coordinated conduct by physicians including refusals to deal that would be difficult to detect and prosecute.

- Adequacy of state supervision required to meet the requirements of the "state action doctrine" immunizing physicians from prosecution under federal antitrust is questionable in SB 37. Therefore, physicians who choose to collectively negotiate may not be protected.

- SB 37 applies to "health benefit plans" which are regulated under federal ERISA laws. ERISA may preempt any state law that relates to the administration and structure of an employee benefit plan. Therefore, SB 37 may be preempted under ERISA.

WHY CS SB 37(FIN) IS FLAWED

- **There is no evidence this legislation is needed.**

- **The provisions of CS SB 37(Fin) will not satisfy federal antitrust law requirements for the "State Action Doctrine." Passage of SB 37 will not keep the Federal Trade Commission from regulating activities of physicians.**

- **The activities that would be allowed under CS SB 37 (Fin) violate state and Federal antitrust law.**

- **CS SB 37(Fin) works like this:**

  - It allows 100% of physicians to meet and discuss non-price issues ***among themselves*** with ***no state oversight***, and prior to hiring a representative. AS 23.50.020(a).

  - It allows 100% of physicians to meet and discuss price terms among themselves once non-price terms have been negotiated with ***no state oversight.*** AS 23.50.020(d).

  - It does not require any state oversight until the physicians decide to negotiate with a health plan, and hire a representative. AS 23.50.020(h). Before this happens, substantial anticompetitive conduct has already occurred.

  - Once a representative is hired, the ***Attorney General has no authority to stop non-price negotiations***. The representative only needs to give the Attorney General notice of the negotiations. AS 23.50.020(c).

  - The Attorney General is ***required*** to approve price negotiations once non-price negotiations are completed if a joint request is made by the health plan and the physicians. AS 23.50.020(e).

  - The Attorney General's role is limited to a review of limited information provided by the representative (not the health plan) prior to negotiations, and another limited review of the proposed contract after negotiations. 23.50.020(h),(i).

- **The original SB 37 included a sunset provision. That provision was taken out of CS SB 37(Fin).**

- **It is very likely to increase health care costs to consumers.**

- **There is concern that ERISA will preempt SB 37 given the way health benefit plans are defined.**

April 22, 2001

Representative Lisa Murkowski
Alaska House of Representatives
State Capitol Building
Juneau, AK 99801-1182

Dear Representative Murkowski,

I am writing to testify regarding SB37, which I understand is now in your committee on Labor & Commerce and is scheduled for a hearing on Monday, April 23rd. As a lifelong Fairbanksan, I've been a small businessman, active leader in community service and other fields, and am currently a pastor in a church of over a thousand people. This background with a broad cross-section of Alaskans causes me great concern over SB37, especially as currently constituted and given that my spouse is a Certified Direct-entry Midwife. I urge a strenuous review of this bill in its implications, as well as its apparent features.

Although I've only been aware of the bill for 3 weeks, I've found a high level of concern, even anxiety, among non-doctor medical providers such as midwives, nurse practitioners, chiropractors, and the like when discussing this bill with them. Also, independent support services, such as medical lab technician or physical therapy enterprises, not connected to/owned by doctor related corporations or clinics share these concerns. Most of all, the clients who choose to use all of these providers are very concerned about limitations of choice and possible cost effects of this bill, when they are informed of it.

I know these various practitioners and their associations, along with insurance companies, are making their specific concerns known about the language and operation of this bill. I urge you to listen carefully and give full weight to their inherent problems with the bill and their solutions to dealing with them, if it has to pass. For example, the sunset clause initially in the bill is critical as SB37's outworkings, if passed, must have opportunity for assessment and response. For that same reason of guarding against what may happen in terms of competitive balance, consumer choice, restraint of trade, etc., the review process language of SB37's Labor & Commerce version (sec. 23.50.020[g], page 6, lines 2-9) should be the starting point for the review process design. These are simple safeguards and, if this bill must pass, they are minimum concessions to maximum concerns.

I know that all of these non-doctor medical professionals and the insurance companies are special interests - but so are the doctors and, certainly, the American Medical Association which has tried (& failed) to pass legislation similar to SB37 at the national level and is now trying to do so in individual states like Alaska. Please listen to both sides as they present their respective arguments and consider these two elements:

1.) What are the de facto, as well as de jure, implications of this bill for the public (by definition, NOT a special interest) which consistently chooses to use midwives, chiropractors, nurse practitioners, nurse midwives, and the like for lower cost and personal need? As people

who would be characterized as more conservative than liberal, we know and have drawn attention to unintended consequences and human nature outworkings of legislation for years. This bill has those possibilities all over it.

2.) Why, as the party that carries the free market and entrepreneurial banner, should we pass legislation vulnerable to upsetting the dynamics of competition and injuring the small business/small nonprofits that are the providers of these non-doctor medical services? It is not the intent of SB37 that could have these results, but the implications. I know, again, most Republican legislators realize further intrusion (of which there is already plenty) by government in markets is a very dicey proposition, especially where anti-trust and restraint of trade issues are involved. No true conservative wants to award unintended advantages that negate choice and cost market dynamics when a bill is actually put into practice.

In summary, this bill could have unforeseen and out of proportion effects on medical services, costs, and providers. It needs to be carefully scrutinized and given the best possible provisions addressing these issues, if it should even be passed at all. For specifics on these implementation concerns, the Alaska Nurse Practitioners Association, College of Nurse Midwives, and others have given ample input you should fully examine. In addition, I'm writing a further letter to my friend and next door neighbor, Pete Kelly (SB 37's sponsor) since he deserves to know why I am speaking on it. Perhaps he might show it to you, if a more detailed explanation of the points I've raised is desired. To close, I ask that you apply the first principle of medicine to the consideration of this bill as it relates to medical providers and the public: "First, do thy patient no harm". Thank you for your attention to this matter and your service to this state we love.

Sincerely,

Alan Corrick

Alan Corrick

P.S. My phone numbers are 452-5071 at home and 457-4673, ext. 231 (my secretary) at work, while my e-mail is cellgroups@doorofhopechurch.org and fax # is 479-3613, if you should wish to contact me.

PATRICIA A. HONG, RN, CCRN

5654 Chilkoot Ct G201, Anchorage, AK 99504

April 20, 2001

Representative Lisa Murkowski
State Capitol
Juneau, Alaska 99801-1182
907-465-2293 (Fax)

Dear Representative Murkowski:

I am writing in regard to SB 37, which has been referred to the House Labor & Commerce Committee for consideration.

The Alaska Nurses Association, The Alaska Nurse Practitioners Association, and the Alaska Chapter of the American College of Nurse-Midwives testified against this bill in the Senate Judiciary and Labor & Commerce Committees. While we oppose this bill at a fundamental level, the CS that emerged from the Labor & Commerce committee was a version we felt we could live with.

It was then referred to Senate Finance where some changes were made that we feel adversely affect our interests. First of all the review process contained in CSSB 37(FIN), Sec.23.50.020(1), Page 6, Lines 10-16 is, in our opinion, not sufficient. We would like, at a minimum, the language from CSSB37(L&C), Sec.23.50.020(g), Page6, Lines 2-9 reinstated. The language in the L&C version provides for review and comment by interested parties. It further specifies that the Attorney General must include a review of any harm to consumers of non-physician providers that might be contained in any contract.

The sunset clause that was initially included in this bill was also deleted at the 6:00 PM Senate Finance Committee meeting on 3/28/01, where no testimony was taken. We would like the sunset clause reinstated. We would like language that ensures that consumers have protection and continue to have full choice of providers and a sunset clause so that we are guaranteed the opportunity to revisit this bill after everyone has had a chance to see it in operation.

Nurse Practitioners and Nurse Midwives provide affordable, high quality, health care. They offer a cost effective alternative for Alaskans. They do compete, sometimes against all odds, with physicians. They need, at least, the protections described above in order to remain viable in the competitive healthcare marketplace.

Thank you for your time and consideration. I look forward to hearing from you on this matter of importance to all Alaskan healthcare consumers and providers.

Sincerely,

Patricia A. Hong, MA, RN, CCRN

CAROLE S. EDWARDS, RN
3998 DAINE ROAD
JUNEAU, ALASKA 99801
April 22, 2001

Representative Lisa Murkowski
State Capitol
Juneau, Alaska 99801

Dear Representative Murkowski:

I am writing in regard to SB 37, which has been referred to the House Labor & Commerce Committee for consideration.

The Alaska Nurses Association, The Alaska Nurse Practitioners Association, and the Alaska Chapter of the American College of Nurse Midwives testified against this bill in the Senate Judiciary and Labor & Commerce Committees. While we oppose this bill at a fundamental level, the CS which emerged from the labor & Commerce committee was a version we felt we could live with.

It was then referred to Senate Finance where some changes were made that we feel adversely affect our interests. First of all the review process contained in CSSB37(FIN), Sec.23.50.020(i), Page 6, Lines 10-16 is, in our opinion, not sufficient. We would like, at a minimum, the language from CSSB37(L&C), Sec.23.50.020(g), Page 6, Lines 2-9 reinstated. The language in the L&C version provides for review and comment by interested parties. It further specifies that the Attorney General must include a review of any harm to consumers or non physician providers that might be contained in any contract.

The sunset clause that was initially included in this bill was also deleted at the 6:00PM Senate Finance Committee meeting on 3/28/01, where no testimony was taken. We would like the sunset clause reinstated. Fundamentally, we would like this bill to disappear. Barring that, we would like the language that protects nursing interests and we would like a sunset clause so that we are guaranteed the opportunity to revisit this bill after everyone has had a chance to see it in operation.

Nurse Practitioners and Nurse-Midwives provide affordable, high quality, health care. They offer a cost effective alternative for Alaskans. They compete, sometimes against all odds, with physicians. They need, at least, the protections I've described in order to remain viable in the competitive healthcare marketplace.

Thank your for your time and consideration.

Sincerely,

Carole S. Edwards

Carole S. Edwards, RN

Providence Anchorage Anesthesia Medical Group, P.C.

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

April 11, 2001

Representative Lisa Murkowski
Chair-House Labor and Commerce Committee
State Capitol Building
Juneau, AK 99801

RE: SB37 – Physician Negotiation Bill

Dear Representative Murkowski:

I am a private practice physician in Anchorage, Alaska. I have been informed that SB37 has passed the Senate, (13-6) and is currently before your committee in the House. As you know the legislative session is fast approaching its conclusion. Before the House has an opportunity to vote on the bill, SB37 has three committee referrals, the first if which is before your committee. I am respectfully requesting that you bring the bill up for consideration at the earliest possible opportunity.

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

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

Getting SB37 to this point has involved a great deal of compromise on the part of the physician community, and has taken the better part of two years. I sincerely hope that you and your House colleagues do whatever you can to expedite passage of this important bill.

Sincerely,

Mary Lanza, M.D.

GRIFFITH C. STEINER, M.D.

OPHTHALMOLOGY

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

April 12, 2001

Representative Lisa Murkowski
Chair – House Labor and Commerce Comm.
State Capitol Building
Juneau, AK 99801

RE: SB-37 – Physician Negotiation Bill

Dear Lisa,

I have been informed that SB37 has passed the Senate, (13-6) and is currently before your committee in the House. Before the House has an opportunity to vote on the bill, SB37 has 3 committee referrals, the first of which is before your committee. I am respectfully requesting that you bring the bill up for consideration at the earliest possible opportunity.

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

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

Getting SB37 to this point has involved a great deal of compromise on the part of the physician community and has taken the better part of two years. I sincerely hope you and your House colleagues do whatever you can do to expedite passage of this important bill.

Sincerely,

Griffith C. Steiner, M. D.

Most importantly we can collectively negotiate how we provide care so third party payors cannot dictate this to us and our patients.

Thank you!

Alaska Rehabilitation Medicine, Inc.

A PROFESSIONAL CORPORATION
Physical Medicine and Rehabilitation
Electrodiagnosis

Shawn Hadley, M.D.* ** • Joella Beard, M.D.* • Clyde Bullion, PA-C
**Diplomate, American Board of Physical Medicine and Rehabilitation*
***Diplomate, American Board of Electrodiagnostic Medicine*

April 11, 2001

Representative Lisa Murkowski, Chair
House Labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

RE: Senate Bill 37—Physician Negotiation Bill

Dear Representative Murkowski:

I have been a private practice physician in Anchorage since 1984. I am aware that SB 37 has passed the Senate by a wide margin and is currently in your committee. I feel I am representative of a number of private practice physicians requesting consideration of this bill as soon as possible.

As you know, SB 37 would allow independent physicians to negotiate in groups with health benefit plans. This allows us as individual physicians to help "level the playing field" when we are dealing with large corporate health insurance companies. It is my understanding that there are provisions in this bill to provide state oversight of the process to avoid potential abuses of the process.

Having practiced in Anchorage since 1984, I have seen my costs of doing business continually rise. This is true in all areas relating to my practice. The current difficulty is in recruiting and retaining office staff, both professional and clerical, and it is important that physicians be able to deal fairly with these large entities to make sure that we are able to continue to provide the excellent quality of care for which we are known in this state.

Getting SB 37 to this point in the legislative process has involved considerable work on the part of many parties over the past two years. I encourage you and your colleagues in the State House to do whatever you can to expedite passage of this bill important to private practice providers "in the trenches."

Sincerely,

Shawn Hadley, M.D.

SH:smb

3300 Providence Drive, Suite 01, Anchorage, Alaska 99508 • Telephone (907) 562-2600 • Fax (907) 562-2602

April 11, 2001

Representative Lisa Murkowski
Chair, House Labor and Commerce Committee
State Capitol Building
Juneau

Dear Representative Murkowski :

Please give consideration to supporting SB37, the physician's negotiation Bill.

When a patient develops an illness, especially an expensive illness, their physician remains their ally. Often their insurance company becomes the adversary . The physician also remains the primary patient advocate when some discounted other aspect of their health plan goes awry. A suffering patient can look into the eye of their physician to seek compassion. (Nurses are, by nature, compassionate but are often under the employ of a more remote entity.) Suffering patients have a much more remote relationship with insurance executives and clerks, hospital administrators, and even legislators.

I believe that SB37 is an important bill strengthening the doctor-patient relationship. Please give it your support. I remain

Sincerely Yours,

Robert W. Arnold

Robert W. Arnold, M.D.

Pediatric Ophthalmology and Strabismus, Ophthalmic Associates, a P.C.
542 West Second Avenue Anchorage Alaska 99501-2242

ALASKA NEUROLOGICAL CONSULTANTS, L.L.C.

Mary Downs, M.D.
Board Certified Neurology

Wayne Downs, M.D.
Board Certified Neurology

Kenneth R. Pervier, M.D.
Board Certified Neurology

Marjorie J. Smith, M.D.
Board Certified Neurology & Psychiatry

Ph: (907) 276-3727
Fax: (907) 276-3622
2751 DeBarr Rd, Ste. 200
Anchorage, Alaska 99508

April 11, 2001

Representative Lisa Murkowski
Chair – House Labor & Commerce Committee
State Capitol Building
Juneau, AK 99801

Dear Representative Murkowski:

RE: SB37 – Physician Negotiation Bill

I am a private practice physician in Anchorage, Alaska. I have been informed that SB37 has passed the Senate, 13-6, and is currently before your committee in the House. As you know, the legislative session is fast approaching its conclusion. Before the House has an opportunity to vote on the bill, SB37 has three committee referrals, the first of which is before your committee. I am respectfully requesting that you bring the bill up for consideration at the earliest possible opportunity.

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

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

Getting SB37 to this point has involved a great deal of compromise on the part of the physician community and has taken the better part of two years. I sincerely hope you and your House colleagues will do whatever you can do to expedite passage of this important bill.

Sincerely,

Marjorie Smith, M.D.
MS/clb

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

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

April 12, 2001

Representative Lisa Murkowski
Chair- House Labor and Finance Committee
State Capitol Building
Juneau, AK 99801

Re: SB57-Physician Negotiation Bill

Dear Representative Murkowski:

I am writing to ask your favorable consideration on SB-57. The way I see this bill, it will help to level the playing field where the players are individual physicians and the insurance companies and the referee is the attorney general. Considerable time and effort has already been put into this bill and I want to thank you in advance for your effort and that of your committee.

Sincerely,

John DeKeyser, M.D.

P.S.: Hi Lisa. I hope all is going well for you, Vern & the kids. Thanks for all your hard work in Juneau.

Buff B. Burtis M.D., FCCP

John M. Clark M.D., FCCP

Pulmonary Disease
Internal Medicine

Pulmonary Associates
3340 Providence Drive, Suite 354
Anchorage, AK 99508
Telephone (907) 562-2445
Fax (907) 561-5205

April 9, 2001

Representative Lisa Murkowski
Chair of House Labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

Re: SB37- Physician Negotiation Bill

Dear Representative Murkowski,

Please vote for SB37 which has passed the Senate 13-6. This bill would assist Alaska's physicians in gaining a more level playing field in their negotiations with third parties or insurance companies about payment of fees.

The interests of the state and public are well protected by the voluntary basis for physician and third party negotiations and with the veto power of the Alaska Attorney General.

The Alaskan physician is a major health care advocate. The continued restricting and muffling of physician's voices in health care matters is no longer warranted. Freedom of speech and bargaining are important to all our citizens, including physicians.

Cordially,

Buff B. Burtis, M.D., F.C.C.P.

BBB/lej

cc: M. Haugen

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

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

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

Expenditures/Revenues (Thousands of Dollars)

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

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

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

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

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

SB 37 provides a method for physicians to collectively negotiate certain terms and conditions of contracts with a health benefit plan. If an authorized third party negotiates with the health benefit plan, the subject matter of the negotiations must be reviewed and approved by the attorney general, who then receives various reports on the progress of the negotiations. Once a negotiated contract proposal is reached, it is to be reviewed and approved by the attorney general, using specific criteria, within thirty days. The bill provides that registration fees for authorized third parties will be established to approximately equal the regulatory costs for the attorney general's oversight of joint negotiations between physicians and health benefit plans. The bill further contains a sunset provision, repealing the new program on July 1, 2006.

If enacted, this legislation places substantial responsibilities on the attorney general to approve proposed negotiations, monitor reports of on-going negotiations, and to make a very fact intensive determination whether to approve or not approve a proposed negotiated contract

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

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ANALYSIS CONTINUATION

within a very short time frame. The economic and patient care detriment or benefit criteria the attorney general is directed to base approval or disapproval on will require significant analysis by expert health care economic assistance, as well as additional legal resources.

Under this bill, competing physicians within the service area of a health benefit plan can collectively negotiate certain defined terms and conditions of contracts with the health benefit plan. Negotiations can include fee and price related terms and conditions when the health benefit plan has a market share greater than 15 percent in the geographic service area of the negotiating physicians.

It is difficult to predict how many contracts and reports during a given year that the attorney general's office will have to review and approve. There are 2,050 licensed physicians currently in the State of Alaska, and we conservatively estimate more than 7,000 health benefit plans will be potentially subject to this bill. Given these numbers, we would anticipate the volume of collective negotiations under the bill to be significant enough that we will need additional resources to complete the required reviews and approvals.

The Department of Law anticipates a minimum of one new full-time equivalent attorney position and one full-time equivalent paraprofessional position will be needed to handle this new workload. Extensive regulation development will be necessary to implement the legislation by defining terms and setting forth the reporting requirements that authorized third parties will be required to submit in order to reduce, or preferably eliminate, investigation time during the 30 day review period. Once regulations are complete, these positions will perform the necessary investigation, review, and antitrust analyses on the collective bargaining reports submitted by the authorized third party, and represent the state when decisions of the attorney general are challenged.

Requests for approval of proposed negotiations and review of negotiated contracts by the attorney general are unlikely to be spread evenly throughout the course of a year. Instead, they may come at any time, and in any volume. Thus, we assume it will be more efficient to hire expert health care economic assistance by contract on an as needed basis. $100,000 is included for outside expert costs (500 hours at an estimated average cost of $200/hour).

In-house estimates are based on the department's FY 2002 standard full-time equivalent attorney and paraprofessional schedules, which include clerical support, communications, space, supplies, data processing, and other normal overhead expenses. (FTE attorney: $141,776, FTE paraprofessional: $92,230). Each position estimate also includes an additional $6,500 for one-time equipment purchases and $5,000 for direct case costs, costs that cannot be included in the rate as overhead.

The bill assumes fees for the registration of authorized third parties will be established to cover the cost of the program upon implementation. In the first year, it will take several months to establish the regulatory framework. During this time, no fees will be generated. General funds are necessary for the first year to implement the program, at which point, the fees will be set to cover all program costs. The Department of Law estimates, based on Texas' experience, that at least nine months will be required to get regulations in place. Accordingly, funds are split 70/30 general fund and general fund program receipts in FY 2002.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

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

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

Expenditures/Revenues (Thousands of Dollars)

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

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

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

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

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

A part-time administrative clerk III position is needed in order to gather and report the health benefit plan market share information required under Sec. 23.50.020 (e)(6), page 4, lines 12&13. This position would be responsible for developing and sending out surveys, requesting data from over 18,000 employers in the state and for performing reasonableness checks on the data submitted, entering the data into a spreadsheet, and developing the required market share reports. Since the Division of Insurance does not have regulatory authority over health benefit plans (employers), it is anticipated that employers will be reluctant to respond to the survey (about 30% response rate). Therefore, a significant amount of this employee's time is anticipated to be spent following up with employers who do not respond to the survey.

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

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(Rev 11/2000 OMB)

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: SB 37
(S) Publish Date: 2/22/01

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

Expenditures/Revenues (Thousands of Dollars)

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

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

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	*	*	*	*	*	*

Estimate of any current year (FY2001) cost: *

POSITIONS

Full-time						
Part-time						
Temporary						

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

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

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

Prepared by: Guy Bell, Director — Phone 465-4471
Division: Retirement and Benefits — Date/Time January 18, 2001
Approved by: Commissioner Jim Duncan — Date January 19,2001
Agency: Department of Administration

For distribution information, call the Governor's Legislative Office

(Rev 11/2000 OMB)

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

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

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

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

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

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

For distribution information, call the Governor's Legislative Office

(Rev 11/2000 OMB)

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 5
Bill Version: CSSB 37 (FIN)
(S) Publish Date: 3/29/01

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

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

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

Prepared by: SENATE FINANCE COMMITTEE
Phone: 465-1881

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

Alaska Physicians & Surgeons, Inc
4120 Laurel Street, Suite 206
Anchorage, Alaska 99508
Ph: 907-561-7705 Fax: 907-561-7704
E-Mail: akphys@alaska.net
Website: www.apsdoctors.org

March 13, 2002

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

Dear Representative Murkowski:

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

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

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

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

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

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

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

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

Sincerely,

Michael Haugen, JD, MBA
Executive Director

c: Senator Pete Kelly

Frank H. Moore MD
PO Box 773329
Eagle River, AK 99577
907-694-5865

4/23/01

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

Dear Representative Murkowski,

I am writing this letter to ask you to support Senate Bill 37. I am a practicing Emergency Physician who works at Providence Alaska Medical Center. This bill is important to me, and to my patients because it would allow me to negotiate with the large, and getting larger insurance companies and health plans about issues affecting my patients without violating federal antitrust laws. Without this legislation, it will be very difficult for me, as an individual physician, to deal with the massive insurance companies that are dominating the medical landscape.

Please help us by passing this bill onto the full house, and support it when it gets to the floor

Sincerely yours,

Frank H. Moore MD

Frank H. Moore MD

To:

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

Fax #: 907-465-2293

From:

DANIEL SAFRANEK, MD
940 P Street
Anchorage, AK 99501
ph (907) 277-7327
FAX (907) 277-7328
e-mail ann.daniel@worldnet.att.net

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

I would like to voice my support of Senate Bill 37. Senate Bill 37 is very important for emergency physicians and their patients in Alaska and I urge you to support this important measure.

The federal antitrust laws severely limit what physicians can do to have even minimal bargaining power with large, dominant health plans. Senate Bill 37, which passed the Senate last week, allows physicians to "collectively negotiate" with insurance companies over fees and other issues without "running afoul of antitrust laws," according to reports in the AP/Anchorage Daily News. According to state Sen. Pete Kelly (R), the bill's sponsor, doctors "can be left to the mercy of huge insurance companies" that set fees and other conditions on medical care. "One of the problems that we have now is that physicians are left with somewhat of a take-it-or-leave-it environment when they're dealing with large insurance companies that are getting larger and larger as time goes by," Kelly said. Under state and federal antitrust laws, doctors "cannot even meet" to discuss an insurance company's conditions. Kelly said that the legislation "was not just about fees and doctors' incomes," but about patients and conditions that "may be dictated by insurance companies," including "what constitutes necessary care."

As an Alaska emergency physician, I have an ethical duty to act in my patients' best interest. For this reason, I urge you to support Senate Bill 37. I believe the bill will help in improving patient care through better communication between physicians, health plans, and patients.

Sincerely,

MD

DANIEL SAFRANEK, MD

940 P Street
Anchorage, AK
99501

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

I would like to voice my support of Senate Bill 37. Senate Bill 37 is very important for emergency physicians and their patients in Alaska and I urge you to support this important measure.

The federal antitrust laws severely limit what physicians can do to have even minimal bargaining power with large, dominant health plans. Senate Bill 37, which passed the Senate last week, allows physicians to "collectively negotiate" with insurance companies over fees and other issues without "running afoul of antitrust laws," according to reports in the AP/Anchorage Daily News. According to state Sen. Pete Kelly (R), the bill's sponsor, doctors "can be left to the mercy of huge insurance companies" that set fees and other conditions on medical care. "One of the problems that we have now is that physicians are left with somewhat of a take-it-or-leave-it environment when they're dealing with large insurance companies that are getting larger and larger as time goes by," Kelly said. Under state and federal antitrust laws, doctors "cannot even meet" to discuss an insurance company's conditions. Kelly said that the legislation "was not just about fees and doctors' incomes," but about patients and conditions that "may be dictated by insurance companies," including "what constitutes necessary care."

As an Alaska emergency physician, I have an ethical duty to act in my patients' best interest. For this reason, I urge you to support Senate Bill 37. I believe the bill will help in improving patient care through better communication between physicians, health plans, and patients.

Sincerely,

Eva M Carey, M.D.

Finally, we believe it is essential that the program be administered strictly but not rigidly. We believe that discretion should be vested in the State Board of Education & Early Development so that the standards will not be compromised. Flexibility is especially important for special needs students and students who come from homes where English is a second language. Moreover, there must be a way to make allowances for transient students who, as a result of family circumstances, must enter an Alaska school in the latter years of their secondary education.

We hope you will continue on the course you have set for education in the state and will make those few remaining adjustments that will make secondary education in Alaska a challenging, yet fair, experience.

Sincerely,

Richard L. Morrison
Chairman 2000-01

cc: The Honorable Governor Tony Knowles
Senator Lyda Green
Representative Fred Dyson
Commissioner Shirley Holloway
Anchorage Caucus

Tim Samuelson, M.D.

Honorable Lisa Murkowski
Alaska State Legislature
State House of Representatives
Room 408
Juneau, AK 99801

Re: Senate Bill 37

Dear Ms. Murkowski,

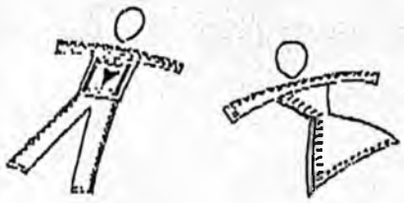
I am writing to support passage of Senate Bill 37. I am an emergency physician and I think the bill is very important for emergency physicians and their patients in Alaska.

Although it might appear to some that this bill is an attempt to help doctors make more money, the actual result will be to give patients more of a voice with insurance companies and other 3rd party payers. We physicians have a duty to act in our patients' best interests and if physicians have the ability to debate and bargain with these payers, we will be better able to get these payers to be more interested in quality patient care. This bill will put physicians into a stronger position to deal with these 3rd party payers. We physicians are in a better position to decide what is in the patient's best interest medically, not these companies – yet they are in the position to dictate to us what they will or will not cover.

For these reasons, I urge you to support this bill.

Sincerely,

University of Alaska Anchorage



Student HEALTH Center

Representative Lisa Murkowski
State Capitol
Juneau, Alaska 99801-1182
907-465-2293 (Fax)

Dear Representative Murkowski:

I am writing in regard to SB 37, which has been referred to the House Labor & Commerce Committee for consideration.

The Alaska Nurses Association, The Alaska Nurse Practitioners Association, and the Alaska Chapter of the American College of Nurse-Midwives testified against this bill in the Senate Judiciary and Labor & Commerce Committees. While we oppose this bill at a fundamental level, the CS which emerged from the Labor & Commerce committee was a version we felt we could live with.

It was then referred to Senate Finance where some changes were made that we feel adversely affect our interests. First of all the review process contained in CSSB 37(FIN), Sec.23.50.020(i), Page 6, Lines 10-16 is, in our opinion, not sufficient. We would like, at a minimum, the language from CSSB37(L&C), Sec.23.50.020(g), Page6, Lines 2-9 reinstated. The language in the L&C version provides for review and comment by interested parties. It further specifies that the Attorney General must include a review of any harm to consumers or non physician providers that might be contained in any contract.

The sunset clause that was initially included in this bill was also deleted at the 6:00 PM Senate Finance Committee meeting on 3/28/01, where no testimony was taken. We would like the sunset clause reinstated. Fundamentally, we would like this bill to disappear. Barring that, we would like language that protects our interests and we would like a sunset clause so that we are guaranteed the opportunity to revisit this bill after everyone has had a chance to see it in operation.

Nurse Practitioners and Nurse-Midwives provide affordable, high quality, health care. We offer a cost effective alternative for Alaskans. We compete, sometimes against all odds, with physicians. We need, at least, the protections I've described in order to remain viable in the competitve healthcare marketplace.

Thank you for your time and consideration. I look forward to hearing from you on this matter of importance to all Alaskan healthcare consumers and providers.

Sincerely,

Mary Anne Wilson, ANP
ANPA Legislative Representative

University of Alaska Anchorage - Student Health Center
3211 Providence Drive, Anchorage, Alaska 99508
Tel: (907) 786-4040 Fax: (907) 786-4049

Owen R. Bell, M.D.
Wendy Thon, ANP, RN-C
Martha Linden, CNM, MSN

Professional Corporation

To: Lisa Murkowski, Chair
House Labor & Commerce

RE: Senate Bill 37

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

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

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

Thank you!

Martha Linden

Martha Linden, C.N.M.

2501 E. 42nd Avenue • Anchorage, Alaska 99508 • (907) 561-1925 • Fax (907) 561-1429

HIAA

Health Insurance Association of America

March 21, 2002

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

Re: Senate Bill 37

Dear Representative Murkowski:

This letter pertains to the working draft committee substitute 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 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.

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

[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.

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. 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% threshold? The burden should be to prove the carrier possesses greater than the 15% 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% substantial market power as measured by covered lives, including Medicaid and 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. The working draft of CSSB 37 is aimed at the private market and inclusion of Medicaid and Medicare confuses the process.

---

[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.

In Section 23.50.020 (e)(f), an authorized third party may not represent more than 30% of the physicians unless the carrier possesses more than 5% 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% 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% of the market yet is not deemed to possess substantial market power. A carrier with 5.01% 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 the working draft to 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 itindall@hiaa.org.

Sincerely,

Jeffrey E. Tindall
Legislative Director

cc: Reed Stoops

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

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

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title "An Act relating to collective negotiation by physicians with health benefits....
BRU Centralized Admin Svcs.
Component Retirement & Benefits
Sponsor Senator Pete Kelly
Requester House Labor & Commerce
Component No. 64

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This version of the bill does not include self-insured plans; it will not apply to the State health plans.

Prepared by: Guy Bell, Director
Phone 465-4471
Division Retirement & Benefits
Date/Time 3/21/02 4:34 PM
Approved by: Jim Duncan, Commissioner
Date 3/21/2002
Agency Department of Administration

(Revised 9/2001 OMB)

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

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

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: An Act relating to collective negotiation by physicians with health benefits plans
BRU: Insurance Operations (116)
Component: Insurance
Sponsor: Senator Kelly
Requester: House Labor & Commerce
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services	23.7	24.3	25.0	25.7	26.4	27.2
Travel						
Contractual						
Supplies	1.5	1.5	1.5	1.5	1.5	1.5
Equipment	5.0	0.0	0.0	0.0	0.0	0.0
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	30.2	25.8	26.5	27.2	27.9	28.7
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	30.2					
1005 GF/Program Receipts		25.8	26.5	27.2	27.9	28.7
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	30.2	25.8	26.5	27.2	27.9	28.7

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

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

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

A part-time administrative position is needed in order to gather and report the health benefit plan market share information required under Sec. 23.50.020(g)(6). This position would be responsible for developing and sending out surveys requesting data from over 18,000 employers in the state and for performing reasonableness checks on the data submitted, entering the data into a spreadsheet, and developing the required market share reports. Since the Division of Insurance does not have regulatory authority over health benefit plans (employers), it is anticipated that employers will be reluctant to respond to the survey (about 30% response rate). Therefore, a significant amount of this employee's time is anticipated to be spent following up with the employers who do not respond to the survey.

Prepared by: Robert A. Lohr, Director
Phone
Division: Insurance
Date/Time: 3/19/02 3:25 PM
Approved by: Deborah B. Sedwick, Commissioner
Date: 3/19/2002
Agency: Department of Community & Economic Development

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

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

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

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services	134.5	134.5	134.5	134.5	134.5	134.5
Travel	5.3	5.3	5.3	5.3	5.3	5.3
Contractual	80.6	80.6	80.6	80.6	80.6	80.6
Supplies	2.3	2.3	2.3	2.3	2.3	2.3
Equipment	13.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	235.7	222.7	222.7	222.7	222.7	222.7
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	0.0	222.7	222.7	222.7	222.7	222.7

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	235.7					
1005 GF/Program Receipts		222.7	222.7	222.7	222.7	222.7
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	235.7	222.7	222.7	222.7	222.7	222.7

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

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

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

CSSB 37 (FIN) provides a method for physicians to collectively negotiate certain terms and conditions of contracts with a health benefit plan. If an authorized third party negotiates with the health benefit plan, the subject matter of the negotiations must be reviewed and approved by the attorney general, who then receives various reports on the progress of the negotiations. Once a negotiated contract proposal is reached, it is to be reviewed and approved by the attorney general, using specific criteria, within thirty days. The bill provides that registration fees for authorized third parties will be established to approximately equal the regulatory costs for the attorney general's oversight of joint negotiations between physicians and health benefit plans.

If enacted, this legislation places substantial responsibilities on the attorney general to approve proposed negotiations, monitor reports of on-going negotiations, and to make a determination whether to approve or not approve a proposed

Prepared by: Joan M. Kasson
Phone (907) 465-5370
Division Attorney General's Office
Date/Time 3/20/02 11:59 AM
Approved by: Kathryn Daughhetee for Bruce M. Botelho, Attorney General
Date 3/20/2002
Agency Department of Law

(Revised 9/2001 OMB)

ANALYSIS CONTINUATION

negotiated contract within a very short time frame. The economic and patient care detriment or benefit criteria the attorney general is directed to base approval or disapproval on will require significant analysis by expert health care economic assistance, as well as additional legal resources.

Under this bill, competing physicians within the service area of a health benefit plan can collectively negotiate certain defined terms and conditions of contracts with the health benefit plan. Negotiations can include fee and price related terms and conditions.

CSSB 37 (FIN) excludes all self-insured plans. It is difficult to predict how many contracts and reports during a given year that the attorney general's office will have to review and approve. There are 2,050 licensed physicians currently in the State of Alaska, and we conservatively estimate more than 5,000 insured health benefit plans will be potentially subject to this bill. Given these numbers, we would anticipate the volume of collective negotiations under the bill to be significant enough that we will need additional resources to complete the required reviews and approvals.

The Department of Law anticipates a minimum of one-half of a full-time equivalent attorney position and one full-time equivalent paraprofessional position will be needed to handle this new workload. Extensive regulation development will be necessary to implement the legislation by defining terms and setting forth the reporting requirements that authorized third parties will be required to submit in order to reduce, or preferably eliminate, investigation time during the 30 day review period. Once regulations are complete, these positions will perform the necessary investigation, review, and antitrust analyses on the collective bargaining reports submitted by the authorized third party, and represent the state when decisions of the attorney general are challenged.

Requests for approval of proposed negotiations and review of negotiated contracts by the attorney general are unlikely to be spread evenly throughout the course of a year. Instead, they may come at any time, and in any volume. Thus, we assume it will be more efficient to hire expert health care economic assistance by contract on an as needed basis. $50,000 is included for outside expert costs (250 hours at an estimated average cost of $200/hour).

In-house estimates are based on the department's FY 2003 standard half-time equivalent attorney and full-time paraprofessional schedules, which include clerical support, communications, space, supplies, data processing, and other normal overhead expenses. (one-half FTE attorney: $70,455, FTE paraprofessional: $92,230). Each position estimate also includes an additional $6,500 for one-time equipment purchases and $5,000 for direct case costs, costs that cannot be included in the rate as overhead.

The bill assumes fees for the registration of authorized third parties will be established to cover the cost of the program upon implementation. It will take at least several months to establish the regulatory framework. During this time, no fees will be generated. General funds are necessary for the first year to implement the program, at which point, the bill envisions that fees will be set to cover all program costs.

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

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[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.

(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 programs.
> - State and local governments would incur higher costs to provide health

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[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).

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 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

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[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).

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

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.

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

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

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 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]

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[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).

[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.]

> 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 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.

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[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 (1988) (consent order).

[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).

A. Minimum Threshold for Health Plan Market Power

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

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

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

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

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

Although the Alaska bill's definition of "substantial market power" is not entirely clear, one thing is certain: it does not define antitrust markets in a legal or economic sense. For example, it uses as a proxy for a relevant geographic market the health plan's "service 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

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

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

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

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

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

B. Limitations on Size of Physician Negotiating Group

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

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

C. Exclusion of Physician Boycott Conduct

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

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

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

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

III. State Action Immunity

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

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

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

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

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

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

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

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

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

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

Lack of Active Supervision

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

1. Review of Composition of Physician Groups

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

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

2. Review of "Brief Report" on Proposed Negotiations

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

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

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

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

3. Review of Collectively Negotiated Contracts

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

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

(a) Insufficient Information

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

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

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

information of any kind.[29]

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

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

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

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

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

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

(b) Insufficient Time

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

IV. Transparency

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

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

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

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

* * *

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

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

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

Sincerely,

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

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

Prepared Statement
of the
Federal Trade Commission

Presented by

Robert Pitofsky, Chairman [1]
Federal Trade Commission

Before The
Committee on the Judiciary
United States House of Representatives

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

June 22, 1999

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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