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

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

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

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

II. The Exemption Would Harm Consumers

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

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

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

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

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

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

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

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

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

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

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

provider organizations ("PPOs").[26]

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

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

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

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

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

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

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

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

III. There Are Better Ways To Protect Consumers

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

Proposals for reform include:

Increasing Consumers' Ability To Choose Their Health Plan.

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

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

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

Improving Consumer Information.

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

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

Regulation of Plan Behavior.

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

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

Conclusion

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

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

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

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

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

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

5. *Id.* at 234-35.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35. Report at 3-4.

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

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
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May 13, 1999

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

Dear Representative Oliveira:

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

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

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

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

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

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

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

other.[3]

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

Sincerely yours,

William J. Baer

Enclosure

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

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

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

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

Bureau of Competition

Richard A. Feinstein
Assistant Director

Direct Dial
(202) 326-3688

October 29, 1999

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

Re: Physicians Negotiation Act of 1999

Dear Mr. Rigsby:

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

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

Background

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

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

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

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

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

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

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

enclosed for your information.

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

The District of Columbia Bill

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

The Scope of Permitted Conduct

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

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

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

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

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

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

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

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

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

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

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

Immunity Issues

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

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

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

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

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

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

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

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

* * *

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

Sincerely,

Richard A. Feinstein
Assistant Director

Attachments

Endnotes

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

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

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

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

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

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

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

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

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

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

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

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

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March 19, 2002

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

Re: SB 37; Physician Negotiations with Health Care Insurers

Dear Representative Murkowski:

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

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

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

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

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

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

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

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

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

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

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

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

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

CES/sjm

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1125 Washington Street SE • PO Box 40100 • Olympia WA 98504-0100

February 4, 2002

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

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

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

Dear Senator Prentice and Representative Cody:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Chris

CHRISTINE O. GREGOIRE
Attorney General

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

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

Bureau of Competition
Office of Policy Planning
Northwest Region

February 8, 2002

By Facsimile and First Class Mail

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

Re: Washington House Bill 2360

Dear Representative Benson:

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

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

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

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

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

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

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

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

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

I. Physician Collective Bargaining Will Likely Harm Consumers

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

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

[5] RCW 43.72.300(1).

would create for consumers:[6]

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

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

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

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

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

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

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

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

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

II. Responses to Specific Questions Regarding HB 2360

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

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

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

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

[12] Id. at 6.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[21] RCW 43.72.300(2).

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

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

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

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

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

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

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

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

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

[26] Id. at 106.

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

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

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

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

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

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[28] Id. at 634.

[29] RCW 43.72.310(1).

[30] RCW 43.72.310(3).

[31] RCW 43.72.310(6).

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

[33] RCW 43.72.310(1).

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

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

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

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

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

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

[36] RCW 43.72.310(6).

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

[38] RCW 43.72.

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

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

Sincerely,

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

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

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

H-4217.1

SUBSTITUTE HOUSE BILL 2360

State of Washington 57th Legislature 2002 Regular Session

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

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

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

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

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

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

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

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

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

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H-2875.9

HOUSE BILL 2360

State of Washington 57th Legislature 2002 Regular Session

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Gains in cost efficiency of health services;

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

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

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

These benefits must outweigh disadvantages including and not limited to:

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

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

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

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

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

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

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

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

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

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

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

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

--- END ---

SB

176

Senate Bill 176 **"An Act relating to distributorships."**

Sponsor: **Senate Labor & Commerce Committee *by request***

SPONSOR STATEMENT

The proposed Alaska Small Business Protection Act bill is necessary to level the playing field between large, well-financed manufacturers and distributors, and small businesses in Alaska. Passage of this legislation will protect Alaska's small businesses from unreasonable manipulation by manufacturers and distributors, foster economic growth and development, and keep capital in Alaska.

Alaska is one of the few states without a law addressing distributorship agreements. This bill fixes gross inequities that occur as Alaskan businesses develop markets for products and services based upon specific product lines under distributorship agreements.

As small businesses invest capital and commit to growth and infrastructure based on distributorship agreements, they inherently become dependent upon those product lines. In many cases, this dependency allows manufacturers to unilaterally force changes in distribution contracts to the detriment of Alaskan businesses, and ultimately, the employees and other entities with whom they have committed in order to fulfill obligations under the original contract.

In many cases, if Alaska's businesses do not agree with new contract terms demanded by the manufacturer/distributor, they are terminated and left with inventory they are unable to sell and which typically, manufacturers/distributors refuse to buy back. This loss of capital ranges from $500 to $500,000 or more, depending upon the business and the amount of inventory required to fulfill the terms of the original agreement. Additionally, many of these contracts make it possible to unilaterally terminate the distributorship agreement if a small business owner wishes to sell his or her business, thereby eliminating much or all of the goodwill value established over years of service.

While businesses are free to sue to recover losses, making claims in civil court is extremely cost prohibitive, especially for a business that may have had its entire income stream cut off. In one prominent 1995 Anchorage case, the small business was selling approximately $2.0 million per year in product. It had $700,000 invested in inventory at the time of termination that the manufacturer/distributor refused to repurchase. However, after the Alaskan business successfully won its case in court, the manufacturer/distributor appealed the outcome. The case continues to date, with legal fees and court costs in excess of one million, and climbing. Many Alaskan small business distributors cannot afford the massive legal costs to pursue these claims through the courts, and still remain in business.

Senate Bill 176 **"An Act relating to distributorships."**

Sponsor: **Senate Labor & Commerce Committee *by request***

SECTIONAL ANALYSIS

The proposed Alaska Small Business Protection Act bill is necessary to level the playing field between large, well-financed manufacturers and distributors, and small businesses in Alaska. Passage of this legislation will protect Alaska's small businesses from unreasonable manipulation by manufacturers and distributors, foster economic growth and development, and keep capital in Alaska.

Section 1. Amends AS 45.45 by adding new sections dealing with distributorships, and agreements between distributors and dealers. It evens out the playing field between large, well-financed distributors/manufacturers and Alaska's small businesses, requiring fair play in regard to distributorship agreement relationships through specified rules and courses of action.

Alaska is one of the few states without a law specifically addressing distributorship agreements. This bill fixes gross inequities that occur as Alaskan businesses develop markets for products and services based upon specific product lines under distributorship agreements.

As small businesses invest capital and commit to growth and infrastructure based on distributorship agreements, they inherently become dependent upon those product lines. In many cases, this dependency allows manufacturers to unilaterally force changes in distribution contracts to the detriment of Alaskan businesses, and ultimately, the employees and other entities with whom they have committed in order to fulfill obligations under the original contract.

In many cases, an Alaskan business serves a particular field, such as the oil or fishing industry, and is "locked in" to specific product or service lines dictated by industry need. Arbitrary loss of a product line or right to provide goods or services can spell the end for many of these businesses, with economic upheaval suffered by employees and other businesses entities dependent upon the dealer.

Sec. 45.45.700. Prevents coercion of a dealer to perform certain acts by using duress or threats to terminate distributorship agreement or another agreement between the distributor or the dealer. Defines "certain acts" as (1) the purchase or delivery of merchandise that has not been ordered by the dealer; (2) the assignment, sale or disposal of a contract or property; or (3) the expenditure of money.

Sec. 45.45.710. Defines actions constituting unfair termination of a distributorship as (1) termination without due regard to the value of the dealer's business, or without just provocation; or (2) by making or causing substantial change to the economic position of the dealer in a way that is detrimental to that dealer.

While businesses are free to sue to recover losses, making claims in civil court can be extremely cost prohibitive, especially for a business that may have had its entire income stream cut off. In one prominent 1995 Anchorage case, the small business was selling approximately $2.0 million per year in product under a distributorship agreement. It had $700,000 invested in inventory at the time of termination that the distributor refused to repurchase. However, after the Alaskan business successfully won its case in court, the distributor appealed the outcome. The case continues to date, with legal fees and court costs in excess of one million, and climbing. Many Alaskan small business distributors cannot afford the massive legal costs to pursue these claims through the courts, and still remain in business.

Sec. 45.45.715. Provides for civil action in court by the dealer if a distributor violates Sections 700 or 710 above. (1) Allows the dealer to recover damages suffered as a result of the termination; (2) enjoins the distributor from terminating the distributorship agreement; (3) enjoins the distributor from making or causing a substantial change in the economic position of the dealer that is detrimental to the dealer; and (4) provides that an injunction may be obtained by the dealer provided the dealer demonstrates there is a reasonable likelihood that the termination will result in a loss of goodwill for the dealer's business or a decline in the value of that business.

In many cases, if Alaska's businesses do not agree with new contract terms demanded by the manufacturer/distributor, they are terminated and left with inventory they are unable to sell and which typically, manufacturers/distributors refuse to buy back. This loss of capital ranges from $500 to $500,000 or more, depending upon the business and the amount of inventory required to fulfill the terms of the original agreement.

This bill also provides legal protections in the case of the dealer's death. The loss of life is always traumatic – in the very least, financially, and emotionally. By setting out specific rules in Alaska law, the settling of the estate in regard to the distributorship agreement and the financial disposition of the dealer's business is less likely to result in expensive legal battles and additional strain to the deceased's heirs.

Additionally, many of these contracts make it possible to unilaterally terminate the distributorship agreement if a small business owner wishes to sell his or her business, thereby eliminating much or all of the goodwill value established over years of service.

Sec. 45.45.720. Provides for disposition of merchandise purchased from the distributor, and remaining in dealer's inventory upon contract termination. Requires the distributor to pay the dealer for merchandise held as of the date of contract termination if the dealer does not wish to keep said merchandise. This section also provides that the distributor will pay 100 percent of original cost of current and unused merchandise, and return transportation charges; or 85 percent of the current net price for repair parts, including superceded parts; and 5 percent of the current net price of repair parts to cover the handling, packing and transportation of those repair parts back to the distributor. If a repair part is not listed, then the current net price is the higher of the original purchase price or the latest price published by the

distributor for the repair part, if the dealer has actual proof of purchase of the repair part from the distributor, and if the repair part was purchased within ten years before the termination.

Once payment has been made, title to merchandise passes to the distributor making the payment, and the distributor is entitled to possession of said merchandise.

Sec. 45.45.725. Requires distributor to make payment to dealer no later than three months following termination of agreement. Also requires a final, detailed statement of account for the merchandise.

Sec. 45.45.730. Provides remedy if distributor fails or refuses to make payment for merchandise as provided in above sections. The dealer is entitled to bring action in court for the amount of the payments.

Sec. 45.45.735. Provides, upon death of the dealer, for repurchase of merchandise by the distributor if the distributorship agreement is not continued from the personal representative, heirs, or devisees of the dealer. The same repurchase terms apply as noted in Sections 720(a) and (c), 725 and 730.

Sec. 45.45.740. Prohibits termination of existing agreement by the distributor if the termination is based upon (1) a change of management or ownership of the dealership, unless the distributor can show that said change would be detrimental to the representation or reputation of the distributor's products; (2) refusal by the existing dealer to purchase or accept delivery of merchandise or a service, unless necessary for the operation of the distributor's merchandise that is sold by the dealer; (3) the fact that the existing dealer owns, has an interest in, participates in the management of, or holds another distributor agreement for the sale or lease of line-make merchandise in the same facilities where the dealer sells or leases the distributor's merchandise; or (4) refusal by the existing dealer to participate in a national advertising campaign or contest, to purchase promotional products or display devices, or to display decoration or materials at the expense of the existing dealer.

Sec. 45.45.745. Requires the distributor to purchase that portion of the dealer's business adversely affected if the distributor wants to terminate the distributorship agreement, or wants to substantially change or actually changes the competitive situation of the distributor's dealer. Purchase would include good will, assets, and machinery, at commercially reasonable business valuations.

The following sections prohibit a distributor from requiring a dealer "sign away his or her rights" in the distributorship agreement, obligate him or herself to pay the distributor's legal fees, or from otherwise circumventing Alaska law in regard to distributorship agreements. It allows a common sense approach to dispute resolution, as long as the distributor does not dictate the terms of conflict resolution via binding arbitration in the agreement before a conflict arises.

Sec. 45.45.750. Prohibits a distributor from requiring a dealer to agree to any of the following terms in a distributorship agreement, or in another agreement that is ancillary to a distributor agreement, as a condition of an offer, grant, or renewal of a distributorship or ancillary agreement: (1) a requirement that the dealer waive a trial by jury in court cases involving the distributor; (2) a requirement that disputes between the distributor and the dealer be submitted to binding arbitration or to any other binding alternative dispute resolution procedure, unless agreed to by both parties at the time of the dispute; (3) a requirement that the dealer pay the attorney fees of the distributor; or (4) a requirement that the agreement be subject to the laws of any state other than Alaska.

This section also provides that the provisions of this section do not apply to an agreement where a lease or sale of real property is the main purpose of the agreement.

Sec. 45.45.750. Provides exemptions where these sections do not apply – specifically, (1) a distributor agreement that would be considered a franchise regulated by 15 USC 2801-2841 (Petroleum Marketing Practices Act); and (2) a situation regulated by AS 45.50.800 – 45.50.850; or (3) a distributor agreement for the sale, repair, or servicing of motor vehicles that are required to be registered under AS 29.10.

Sec. 45.45.790. Defines "dealer" to mean a person who enters into a distributorship agreement, and who, under the agreement, receives (purchases) merchandise or services from a distributor.

"Distributor" is defined as a person who enters into a distributorship agreement, and who, under the agreement, provides (sells) merchandise or services to a dealer. The term "distributor" also includes a wholesaler, a manufacturer, a person that is a parent corporation or an affiliated corporation of a person identified as a wholesaler or manufacturer, or a field representative, an officer, and agent, or another direct or indirect representative of a person identified as a "distributor."

A "distributor agreement" means an agreement, whether express, implied, oral or written, between two persons by which a person receives the right to (1) sell or lease merchandise or services at retail or wholesale; or (2) use a trade name, trademark, service mark, logotype, advertising, or other commercial symbol; and (3) in which the parties to the agreement have a joint interest, whether equal or unequal, in the offering, selling, or leasing of the merchandise or services.

"Merchandise" includes parts and accessories.

"Terminate" means failing to renew.

Section 2. This section adds a new section to the uncodified law of the State of Alaska, and amends Rule 65(b), Alaska Rules of Civil Procedure, by specifying the type of

damages that must be shown in order to receive an injunction, which may be interpreted to include a temporary restraining order.

Section 3. Provides for an effective date for applicability of this Act – on or after the effective date of this Act, or on or after January 1, 2001, if the distributorship agreement is still in effect on the effective date of this Act. Provides that AS 45.45.715 and AS 45.45.745 only apply to a distributorship agreement entered into on or after the effective date of this Act.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 176
(S) Publish Date: 4/25/01

Revision Date/Time (Note if correction): 04/16/2001 2:35p.m.
Dept. Affected: DCED
Title: An act relating to Distributorships
BRU: Banking, Securities &
Component: Corporations
Sponsor: Senate Labor & Commerce By Request
Requester: Senate Labor and Commerce
Component Number: 1233

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 ( )	0.0	0.0	0.0	0.0	0.0	0.0

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: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This Legislation has no fiscal impact on this Department.

Prepared by: Franklin Terry Elder, Director
Phone 907-465-2521
Division: Banking, Securities & Corporations
Date/Time 04/16/2001 2:35p.m.
Approved by: Commissioner Deborah B. Sedwick
Date 4/16/2001
Agency: Department of Community & Economic Development

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

Subject: Fwd: Re: Distributor bill
Date: Fri, 04 May 2001 08:59:37 -0800
From: "Clyde Sniffen" <Clyde_Sniffen@law.state.ak.us>
To: <Amy_Erickson@legis.state.ak.us>

Amy . . .

Here is the e-mail I sent to Chrystal with two suggested changes to SB 176.

Let me know if you have any questions.

Clyde "Ed" Sniffen, Jr.
Assistant Attorney General
Fair Business Practices Section
Department of Law
1031 W. 4th Ave. #200
Anchorage, AK 99501
(907) 269-5100
(907) 276-8554 (fax)
Clyde_Sniffen@law.state.ak.us

Subject: Re: Distributor bill
Date: Thu, 26 Apr 2001 13:38:25 -0800
From: "Clyde Sniffen" <Clyde_Sniffen@law.state.ak.us>
To: "Chrystal Smith" <Chrystal_Smith@law.state.ak.us>

Change 45.710(a)(1) to read like this:

(1) the fair market value for merchandise that is unused and for which the retailer has paid the distributor, plus 100 percent of the transportation charges paid by the dealer to return the merchandise to the distributor. "Fair market value" as used herein means the amount the distributor would realize from the sale of the merchandise to another retailer using reasonable good faith efforts. "Unused" means unopened merchandise still in the original factory packaging or container; . . . .

This will protect distributors from becoming "insurers" of old inventory, and from having to pay for merchandise that cannot be resold.

I would also change 45.45.770(3) as follows:

(3) a distributorship or franchise agreement for the sale, repair, or servicing of motor vehicles that are required to be registered under AS 28.10, including any person required to be licensed under AS 45.45.200.

Ed

ALASKAN BREWING CO.

5429 Shaune Dr., Juneau, AK 99801-9540 • Ph: 907.780.5866 • Fx: 907.780.4514 • Web: alaskanbeer.com • Email: info@alaskanbeer.com

Representative Lisa Murkowski
Chair Labor & Commerce
State of Alaska

May 4, 2001

RE: SB 176

Dear Representative Murkowski:

The intent of SB 176 is to try to protect the interests of small in-state dealers from larger more powerful outside distributors.

SB 176 defines "Distributors" to include in-state manufacturers. In the case of the small Brewers in Alaska, who manufacture beer, we sell our product to much larger Companies (wholesalers) that are predominantly owned and or controlled by outside interests. Thus the roles considered in SB 176 are reversed, the in-state brewers are small and our wholesale dealers are large.

In the distribution of beer a brewery traditionally selects one wholesaler to sell his products in the State of Alaska. This gives the wholesaler a lot of control over the success of that brewery's sales. The majority of beer wholesalerships that distribute beer in Alaska are part of larger interests located outside the State of Alaska, distribute in multiple states and typically carry many product lines selling many different beverages. For the in-state brewer who has given the distribution of his product to one distributor he has no such diversity and is quite small compared to the wholesaler.

I support the language that has been proposed, from Senator Leman's office, excluding the in-state manufacturers (Breweries, wineries, brewpubs and distilleries) regulated under Title 4. I believe this would still satisfy the intent of SB 176, without changing the present relationship between the in-state manufactures, regulated under Title 4, and their wholesaler.

Thank you,

Geoffrey Larson,
Alaskan Brewing

John E. Haxby

PO BOX 111098
ANCHORAGE, ALASKA. 99511

May 2, 2001

The Honorable Lisa Murkowski
Alaska House of Representatives
State Capitol
Juneau AK 99801

VIA FACSIMILE: 907-465-2293

Re: SB 176, Small Business Protection Act

Dear Representative Murkowski,

SB 176 passed the Senate this afternoon on reconsideration with excellent support, 18-1. I am very interested in seeing this bill passed in the House and hope that it can be signed into law following this session.

SB 176 is good for Alaskan businesses and their employees. It will help keep Alaskan businesses strong, and Alaskans working. It will level the playing field between big business Outside, and Alaska's small businesses.

I respectfully request that you schedule a hearing as soon as possible. I have very high hopes that we can get this measure passed into law this session.

Your assistance is very much appreciated. Please let me know how I can help.

Very truly yours

John E. Haxby

PO Box 111098
Anchorage, Alaska. 99511• USA

TEL 907-345-6800

FAX 907-345-0311
Email-john@acfm.com

acfm.com
907-345-6800

WAUKESHA ALASKA CORPORATION
— power systems engineering & fabrication —

May 2, 2001

The Honorable Lisa Murkowski
Alaska House of Representatives
State Capitol
Juneau AK 99801

VIA FACSIMILE: 907-465-2293

Re: SB 176, Small Business Protection Act

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Your assistance is very much appreciated. Please let me know how I can help.

Very truly yours

Roger R Haxby

Roger R. Haxby
President

YOUNG'S GEAR, INC

1711 VAN HORN RD
FAIRBANKS, AK 99701
907-456-6464 / 800-478-171
FAX 907-451-7498

239 E. INTERNATIONAL AIRPORT RD
ANCHORAGE, AK 99518
907-561-2106 / 800-561-2106
FAX 907-561-3334

TO: Honorable Lisa Murkowski DATE: 5-3-01

ATTENTION: Alaska House of Rep

RE: SB 176, Small Business Protection Act.

Am very glad the SB 176 passed by 18-1.

As a small business owner I strongly urge the passage of this bill. I have had my Company experience bad repurcussions because the lack of this type of bill.

Please help make this law!

THANK YOU

Ron Young

NUMBER OF PAGES

ARS ALASKA RUBBER & SUPPLY INC.

5811 Old Seward Highway • Anchorage, Alaska 99518-1479
(907) 562-2200 • FAX (907) 561-7600 • (800) 478-7600

3-May-01

The Honorable Lisa Murkowski
Alaska House of Representatives
State Capitol
Juneau AK 99801

VIA FACSIMILE: 907-465-2293

Re: SB 176, Small Business Protection Act

Dear Representative Murkowski,

SB 176 passed the Senate yesterday on reconsideration with excellent support, 18-1. I am very interested in seeing this bill passed in the House and hope that it can be signed into law following this session.

SB 176 is good for Alaskan businesses and their employees. It will help keep Alaskan businesses strong, and Alaskans working. It will also level the playing field between big business Outside, and Alaska's small businesses. We were terminated by one of our largest suppliers in 1995 and decided to fight back. We won in court and they have appealed it all the way to the Ninth Circuit. We have prevailed in every trial, but the appeals keep coming. This now has a price tag to us of over One Million in legal fees and it isn't over yet. Hindsight would tell us not to have started this battle but now we're in it and have to finish. Had there been a law such as SB176 six years ago, we would not still be going through this ordeal.

I respectfully request that you schedule a hearing as soon as possible. I have very high hopes that we can get this measure passed into law this session.

Your assistance is very much appreciated. Please let me know how I can help.

Sincerely,

Janeece Higgins

Janeece Higgins
General Manager

E-Mail: akrubber@arctic.net • Web Site: www.akra.org/akrubber

AMENDMENT

OFFERED BY:
TO: CSSB 176(L&C)(TITLE AM)

TITLE WILL HAVE TO BE AMENDED TO INCLUDE THESE EXCEPTIONS.

Page 5, Line 26:
Following "to be registered under AS 28.10"

Insert

"(4) a person licensed as a
(A) brewer under AS 04.11.130;
(B) brewpub under AS 04.11.135;
(C) winery under AS 04.11.140; or
(D) wholesaler under AS 04.11.160

JUSTIFICATION: This bill actually reverses the burden on small Alaska brewers, brewpubs, wineries and wholesale distributors of alcohol, who would be unintentionally harmed by its provisions. One brewer called the office today saying that distributorship agreements under this bill could actually be used to force small brewers out of business, since they are classed as "manufacturers". The bill hurts rather than protects them.

SB

191

Alaska State Legislature

Chairman,
Judiciary Committee
Administrative Regulations
Revenue Committee

Vice Chairman,
Resources Committee

Senator Robin L. Taylor

State Capitol
Juneau, Alaska 99801-1182
(907) 465-3873
Fax: (907) 465-3922

50 Front Street
Suite 203
Ketchikan, Alaska 99901
(907) 225-8088
Fax: (907) 225-0713

SPONSOR STATEMENT
SB 191

"An Act relating to insurance pooling by members of an airline employers association."

SB 191 would allow Alaska's air carriers to pool for property/casualty insurance. This is not a new concept. Since 1988, the pooling concept has been working effectively for the majority of Alaska's local governments and school districts, and has reduced insurance costs and increased loss control and safety.

Transportation is a key component of a healthy economy. Nowhere in the nation do people rely as heavily on commercial air carriers as we do in Alaska. Many Alaskans tasted life without air service when our airspace was closed in the aftermath of the September 11th terrorist attacks. Medical emergencies, stranded hunters and grocery shipments were all put on hold until special arrangements could be made allowing planes and helicopters to occupy the closed air space. Alaskans depend heavily on affordable air service for our very existence.

The effects of the September 11th attacks threaten the viability of many of Alaska's air carriers as aviation insurance rates have risen even further than previously predicted. Although the aviation insurance market has been hardening for many years, the cost of insurance has reached a crisis point since last fall, increasing 20 to 300 percent, depending on a company's claims. Many insurance companies have left the Alaska market, making the purchase of aviation insurance even more difficult. Increased insurance costs mean higher costs of transportation for all goods and services in the majority of Alaska's communities.

SB 191 permits air carriers to group together to self-insure, purchasing reinsurance over a large self-insured retention. With this large 'deductible", air carriers share a financial stake in each other's claims. This motivates the industry to police itself, with more focus on loss prevention, safety, and training. Pools produce not only cost relief, but also increased passenger and pilot safety.

Patterned after the very successful statute which allows cities, boroughs, school districts and REAA's to pool, this bill imposes stricter financial requirements on a joint aviation insurance arrangement to further protect Alaskans and ensure the financial strength of the pool. SB 191 is a necessary tool for keeping Alaska's transportation network safe and viable while positively affecting the economy.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 191
(S) Publish Date: 5/2/01

Revision Date/Time (Note if correction): 04/13/2001 4:35p.m.
Dept. Affected: DCED
Title: An Act relating to insurance pooling by members of an airline employers association.
BRU: Insurance
Component: Insurance Operations
Sponsor: Senator Taylor
Requester: Senate Labor & Commerce
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	0.0	0.0	0.0	0.0	0.0	0.0
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

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

AS 21.76.020(a) provides: "A joint insurance arrangement may not be considered insurance for the purpose of any other law of the state and is not subject to regulations adopted by the director."

Therefore, this legislation will have no fiscal impact on the department.

Prepared by: Robert A. Lohr, Director
Phone 907-269-7900
Division Insurance
Date/Time 04/13/2001 4:35p.m.
Approved by: Commissioner Deborah B. Sedwick
Date 4/13/2001
Agency Department of Community & Economic Development

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

SB

215

ALASKA STATE LEGISLATURE
SENATE DISTRICT I

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John J. Cowdery
Senate Transportation Committee, Chair
World Trade State & Federal Relations, Chair
Legislative Council, Rules, Judiciary

CS Senate Bill 215 (FIN) **"An Act relating to licensing common carriers to dispense alcoholic beverages; and providing for an effective date."**

Sponsor: **Senator John Cowdery**

Sponsor Statement

The purpose of CSSB 215 (FIN) is to reduce the administrative and clerical burden to common carriers when licensing vehicles, boats, aircraft, or railroad buffet cars, via a modification of the current licensing requirements for beverage dispensary licenses.

CSSB 215 (FIN) would simplify the current licensing process for the Alcoholic Beverage Control Board, and at the same time, reduce fees to licensees to more accurately reflect the actual costs to the Board of issuing licenses.

CSSB 215 (FIN) removes a competitive disadvantage experienced by intrastate operators and also brings Alaska's licensing costs more in line with similar fees levied by other states.

One of the major air carriers operating in Alaska is required to maintain over 100 licenses in order to meet Alaska's ABC laws. The bill would change the law to require a fee of $1,000 for each of the first 10 licenses and then charge a fee of $100 per license for each additional license.

This bill will lower revenues to the State of Alaska by the following amounts:

FY 2003	$22,700
FY 2004	39,500

FY 2005	27,200
FY 2006	0
FY 2007	27,200

Currently Alaska Airlines pays $45,900 per year for their licenses. Under this bill they will compensate the State of Alaska $19,200 every two years. Currently Alaska Airlines pays fees to other states in the amount of:

California	$1,612
Illinois	1,260
Oregon	202
Virginia	1,870
Washington	1,255

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 215
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Revenue
Title: Common Carrier Liquor License
BRU: Alcoholic Beverage Control Board
Component: Alcoholic Beverage Control Board
Sponsor: Senator Cowdery
Requester: Senate Transportation Committee
Component No.: 100

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 ( )	(22.7)	(39.5)	(27.2)	0.0	(27.2)	

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)*

Liquor licenses are issued for two years, renewable at either an even or odd year. As part of the change in fees for common carriers that this legislation proposes (reducing fees for multiple-license holders), a change in the biennial period for all common carriers is also being proposed, making all common carrier licenses renewable in odd years. At present, Alaska Airlines would be the largest entity to benefit from this legislation. The company currently has 104 common carrier licenses -- 92 renewable in odd years and 12 renewable in even years. Therefore, the savings to Alaska Airlines (and cost to the State of Alaska in reduced license revenues) is based on 94 aircraft being licensed at the reduced rate (94 X $600 discount).

Prepared by: Dawn Holland-Williams
Phone 269-0359
Division: Alcoholic Beverage Control Board
Date/Time 1/17/02 1:28 PM
Approved by: Larry Persily, Deputy Commissioner
Date 01/17/2002
Agency: Department of Revenue

Alaska Airlines

Senate Transportation Committee Hearing
SB 215
Common Carrier Liquor Licenses
Testimony by William L. MacKay, Vice President-Public & Government Affairs

Alaska Airlines has requested that the current licensing requirements for common carrier beverage dispensary licenses be modified for two reasons. First, to simplify the requirements so that adding additional aircraft will not require an entirely new application process, involving filling out the application, supplying supporting exhibits, and posting and publishing the application for a license. Alaska and the Board agree that modifying the statute to simplify obtaining additional common carrier licenses will reduce the clerical and administrative work for both Alaska Airlines and the Board and is therefore in the public interest.

Secondly, Alaska Airlines would like the fees reduced. Alaska Airlines currently has 102 aircraft and plans to add additional aircraft each year. The growth of the fleet substantially exceeds the growth of its intrastate flying. Alaska Airlines recently began service from Seattle to Washington D.C. and will soon commence service from Seattle to Denver and Boston. The Company does not have an effective means of limiting the aircraft that serve Alaska to a select few and instead operates all of its aircraft in Alaska, often to enable it to provide single plane service from cities in Alaska to cities south or east of Seattle. Since every aircraft must be separately licensed, and every license costs Alaska Airlines $450 a year (a $700 biannual fee plus a $200 license fee), the license fees have become quite high and will continue to escalate at a faster rate than the Company's intrastate flying will escalate. Alaska Airlines only operates a small portion of its fleet on intrastate routes on any given day. In addition, it should be noted that none of the other major airlines serving Alaska, with the possible exception of Delta, obtain Alaska liquor licenses since they do not operate intrastate. Alaska Airlines believes that it pays substantially more for common carrier licenses than any other licensee in Alaska. It seems fair to reduce the fees to more accurately reflect the costs to the Board of issuing licenses and the intrastate presence that Alaska Airlines actually has. If the proposed bill becomes law, Alaska Airlines will still pay more in fees to Alaska than it pays in any other state.

BOX 68900 SEATTLE, WA 98168-0900/206-433-3200

Current System-wide State License Fees:

License Fees
Fleet of 102

	Master	Per AC	Total	
Alaska		450.00	45,900.00 *	
Phoenix, Arizona	275.00	n/a		
Tucson, Arizona	275.00	n/a	550.00	
California	400.00	12.00	1,612.00	
Illinois	n/a	60.00	1,260.00	700 & 900's only
Oregon	202.60	n/a	202.60	
Virginia	1,870.00	n/a	1,870.00	
Washington	750.00	5.00	1,255.00	

* **Annual Cost; however required to file Biannually @ $900.00 per aircraft**

SB215 - License Renewal Breakdown

	FY 2003		**Reduced revenues to state - $22,700**
	Ak Air - 92	Loss of (82 x $600) {$49,200 - (10 x $350) + (2 x $50)} = **$45,600**	
	Others - 22	Gain of (18 x $350) **$6,300**	
Seasonal	Westours - 2	Gain (8 x $350) {$2,800 + (3 x $50)} = **$2,950**	
	Others - 43	Gain of (39 x $350) **$13,650**	
	FY 2004		**Reduced revenues to state - $39,500**
	Ak Air - 12	Loss of (12 x $700) **$9,400** - change in biennial period	
	Others - 18	Loss of **$12,600**	
Seasonal	Westours - 11	Loss of (11 x $350) **$3,850** - change in biennial period	
	Others - 39	Loss of (39 x $350) **$13,650**	
	FY 2005		**Reduced revenues to state - $27,200**
	AK Air	Loss of (94 x $600) **$56,400**	
	Others	Gain of (18 x $700) **$12,600**	
Seasonal	Westours	Gain (8 x $350) {$2,800 + (3 x $50)} = **$2,950**	
	Others	Gain of (39 x $350) **$13,650**	
	FY 2006	No Licenses Expected	**Reduced revenues to state - $0**
	FY 2007		**Reduced revenues to state - $27,200**
	Ak Air	Loss of (94 x $600) **$56,400**	
	Others	Gain of (18 x $700) **$12,600**	
Seasonal	Westours	Gain (8 x $350) {$2,800 + (3 x $50)} = $2,950	
	Others	Gain of (39 x $350) **$13,650**	

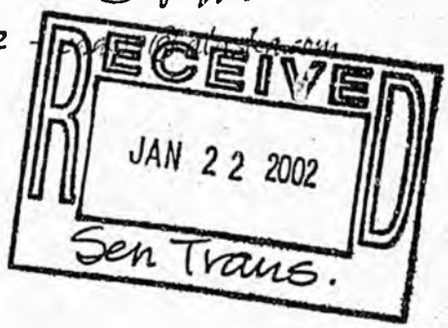
THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

Annual Fees (based upon 90 Aircraft in fleet)

Alcohol Tobacco & Firearms Individual licenses placed on board	$22,500	$250 per Aircraft -
Alaska * Individual licenses placed on board	$40,500	$900 (700 Lic +200 Filing) per aircraft
Arizona One license posted in office location	$ 275	
California Individual licenses placed on board	$ 1,468	$400 Fee + $12 per a/c for duplicate licenses
Oregon One license posted in office location	$ 203	
Nevada	$ 0	
Washington Individual licenses placed on board	$ 1,200	$750 fee + $5 per a/c for duplicate licenses

*All licensing fees are annual except Alaska. Alaska has a statutory Biannual licensing requirement. ($81,000 payment)

CAAPS Council on Alcohol Abuse and Public Safety-Alaska
Box 23007 - Juneau, Alaska 99802 - (907) 586-3032



ADVISORY - SB 215

To All participants:

Should you take any position whatsoever as individuals, we recommend that you indicate that there is no objection to, or support at all for passage of this measure.

- This is not an alcohol bill. It is a revenue reduction measure.
- The principal outcome of this bill, if enacted, will be a reduction of $56,400 in the beverage dispensary license costs to Alaska Airlines. No other licensee would benefit much if at all from this measure.
- Alaska Airlines has 104 common carrier dispensing licenses, one for each aircraft. Current cost $700 each, This bill would reduce the fee from $700 to $100 for 94 of those licenses. A direct savings to Alaska Airlines of $56,400 a year. In the big picture, not an amount worth wasting any time on, or investing any political capital. It is a non-issue from our view.
- Alaska Airlines also has one full dispensing license at the Board Room in Anchorage. This is a standard $2500 fee license, and this legislation has no effect at all on that or any other full dispensary license.
- SB 215 would have absolutely no effect whatsoever on our issues . . . consumption or availability.
- Alaska Airlines will not reduce or increase the price of alcoholic beverages sold in-flight. There will be absolutely no changes in consumption from this bill.
- You have chosen wisely, to focus on passage of a substantial increase in the 1983 level alcohol excise tax this session. That single issue will require your active participation, and we will keep you posted on the progress of several pieces of legislation currently under consideration, should you choose to get involved.

We recommend you take absolutely no position for or against this measure. If the legislature wishes to contribute to the economic picture at Alaska Airlines as a part of an effort to increase or protect tourism, or for any other reason, that is their business.

Howard Scaman

Subject: Corrections to CSSB 215(FIN)
Date: Wed, 08 May 2002 11:37:31 -0800
From: Douglas Griffin <doug_griffin@revenue.state.ak.us>
Organization: State of Alaska - Department of Revenue - ABC
To: amy_erickson@legis.state.ak.us

The increase in Common Carrier licenses from $700 for a two year license to $1,000 will generate revenue that is not reflected in the present fiscal note. The revenue increase is moderated by the large number of seasonal common carrier licenses (provided for under AS 04.11.680(a)) that allow six month operation during the visitor season for one half the cost.

The increased revenue will equal $12,600 during even fiscal years and $8,350 during odd fiscal years. This means that once the transition to the new rate structure takes place the State will lose only $25,600 during a given two year cycle instead of the $46,400 reflected in the fiscal note.

I regret my misunderstanding of the present bill and confusion it may have caused for you and the House Labor and Commerce Committee.

SB 220

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sponsor Statement

CS SB 220 (L&C)

"An Act relating to the scope of practice authorized under a license to practice hairdressing."

Committee Substitute for Senate Bill 220 (L&C) amends A.S. 08.13.170 (f), authorizing the Board of Barbers and Hairdressers to issue a hairdressing license that includes the temporary removal of superfluous hair on the face and neck and the application of basic make-up. These services are typically assumed to be available from a hairdresser.

The removal of unwanted hair by means of hair waxing and the application of basic make-up are services that Hairdressers should be allowed to practice. Hairdressers are trained and tested in these areas and have always performed these services. Both waxing and basic make-up are a part of the curriculum required to graduate; by statute, current training required for a hairdressing license is 1650 hours. Included in the 1650 hours are fifteen practical operations of eyebrow arching and hair removal by means of waxing, tweezing and the use of depilatories and fifteen basic make-up applications including skin analysis, complete and corrective make-up and the application of false eyelashes (12 AAC 09.160). Although the curriculum requires that they perform these operations during the instructional phase, once they are licensed, Alaska State law prohibits them from performing either service for their clients.

I respectfully request your support of CS SB 220 (L&C), allowing trained professionals to continue a practice that they are fully qualified to do.

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SB 220 (L&C)
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: An Act relating to the scope of practice authorized under a license to practice hairdressing
BRU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: Senator Green
Requester: Senate Rules
Component No.: 2360

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 ( )	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

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)*

New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Administrative Manager
Phone (907) 465-2144
Division: Occupational Licensing
Date/Time 3/27/02 3:28 PM
Approved by: Deborah B. Sedwick, Commissioner
Date 3/27/2002
Agency: Department of Community & Economic Development

(Revised 9/2001 OMB)