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

Office of Policy Planning
Bureau of Economics
Bureau of Competition

January 30, 2008

Antonio Silva Delgado, President
Treasury and Financial Affairs Commission
Comisión de Hacienda y Asuntos Financieros
Cámara de Representantes de Puerto Rico

Dear Mr. Delgado:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] are pleased to respond to your request that we review and comment on the likely competitive effects of Senate Bill 2190 (S.B. 2190 or the Bill),[2] which would permit collective bargaining for health care providers in Puerto Rico. The Bill would provide for collective bargaining, on behalf of diverse individual and corporate health care service providers, on fees and other matters. In our judgment, such collective bargaining may raise prices for, and thereby reduce access to, health care services, without ensuring better quality care as a countervailing benefit for health care consumers. For those reasons, the Commission has enforced the antitrust laws when certain private groups of health care providers have colluded to fix prices, and the Commission consistently has opposed legislative proposals to exempt from antitrust scrutiny various categories of health care providers. In fact, S.B. 2190 would appear to authorize private parties to engage in actions that normally would be deemed *per se* violations of federal antitrust law, including price-fixing between competitors, unless protected by an immunity or exemption from antitrust scrutiny.

Interest and Experience of the Federal Trade Commission

Congress has charged the FTC with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[3] Pursuant to its statutory mandate, the Commission seeks to identify business practices and regulations

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

[2] P. del S. 2190, Senado de Puerto Rico, 15[ta.] Asamblea Legislativa (1 Oct. 2007) (hereinafter S.B. 2190 or the Bill). All references that follow, including quotations, are based on a certified translation of the Spanish language version of the Bill.

[3] Federal Trade Commission Act, 15 U.S.C. § 45.

that impede competition without offering countervailing benefits to consumers. For several decades, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[4] The FTC and its staff have issued studies and reports regarding various aspects of the health care industry,[5] and the Commission has brought numerous enforcement actions against entities in the industry that have violated federal antitrust laws.[6] In addition, the FTC and its staff have analyzed competition issues raised by proposed state and federal regulation of health care markets.[7]

More specifically, the FTC has focused on competition issues raised by collective bargaining by health care service providers. In addition to investigations conducted in the course of enforcement actions, the Commission and its staff have conducted more general inquiries into market issues pertinent to the Bill. For example, the FTC and the Department of Justice Antitrust Division (DOJ) jointly issued Health Care Statements dealing with, among other things, practitioner integration issues.[8] In 2003, FTC and DOJ considered diverse competition issues raised by health care markets in joint hearings.[9] Among the issues investigated in those hearings were the

[4] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products, available at* http://www.ftc.gov/bc/hcupdate031024.pdf.

[5] *See, e.g.,* Federal Trade Commission, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005), *available at* http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf; Federal Trade Commission, The Strength of Competition in the Sale of Contact Lenses: An FTC Study (2005), *available at http://www.ftc.gov/reports/contactlens/050214contactlensrpt.pdf*; Federal Trade Commission and Department of Justice, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004) (IMPROVING HEALTH CARE), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf;.

[6] *See, e.g.*, In the Matter of Colegio de Optometras, a Professional Association, Edgar Dávila García, O.D., and Carlos Rivera Alonso, O.D., individuals, FTC File No.: 051 0044 (Sept. 11, 2007) (Decision and Order) (price fixing and concerted refusal to deal with vision and health plans by optometrists); *available at* http://www.ftc.gov/os/caselist/0510044/070730decision.pdf; In the Matter of Advocate Health Partners, et al., FTC File No.: 031 0021 (Dec. 29, 2006) (Agreement Containing Consent Order to Cease and Desist) (horizontal agreements to fix prices, engage in collective bargaining, and refuse to deal individually with health plans by competing independent physicians and physician practice groups accounting for over 2,900 physicians in Chicago metropolitan area), *available at http://www.ftc.gov/os/caselist/0310021/061229agree0310021.pdf.*

[7] *See* Prepared Statement of the Federal Trade Commission Before the Antitrust Task Force of the H. Comm. the Judiciary, Concerning H.R. 971, "the Community Pharmacy Fairness Act of 2007," 110th Cong. (Oct. 18, 2007), available at http://www.ftc.gov/os/testimony/P859910pharm.pdf (analyzing critically proposal to exempt non-publicly traded pharmacies from antitrust scrutiny); see also FTC Staff Comment to the Hon. Nelie Pou Concerning New Jersey A.B. A-310 to Regulate Contractual Relationships Between Pharmacy Benefit Managers and Health Benefit Plans (April 2007), available at http://www.ftc.gov/opp/advocacy_date.shtm; Comments of the FTC Staff Before the FDA In the Matter of Request for Comments on Agency Draft Guidance Documents Regarding Consumer-Directed Promotion (May 10, 2004), available at http://www.ftc.gov/os/2004/05/040512dtcdrugscomment.pdf.

[8] *See* Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (Aug. 1996) (Health Care Statements), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf. An application is discussed *infra*, at text accompanying notes 51-53.

[9] *See* Hearings on Health Care and Competition Law and Policy, June 26, 2003. An overview of the

following: competition, regulation, and market entry issues for hospitals, diverse health care professionals and para-professionals; unionization issues for health care service providers; professional vertical and horizontal integration issues; and Medicaid and Medicare issues.[10] In 2004, the FTC and DOJ issued a report based on the hearings, a 2002 FTC-sponsored workshop, and independent research.[11]

Recent law enforcement matters in the Commonwealth of Puerto Rico are illustrative of the FTC's concerns in this area. The Commission recently approved a consent order against an association representing all optometrists in Puerto Rico, along with two of its leaders.[12] The complaint charged the respondents with violating the FTC Act by orchestrating and carrying out agreements among the association's members to refuse, and to threaten to refuse, to deal with payors, unless the payors raised the fees paid to the optometrists. More specifically, the complaint alleged that the Colegio de Optometras, a not-for-profit association of all 500 optometrists licensed to practice in Puerto Rico, led by Dr. Rivera (its president-elect) and Dr. Dávila (its treasurer), joined in a collective effort to force a particular vision plan to increase its reimbursement rates. Among other things, the FTC challenged Dr. Rivera's informing the plan that he had the authority to negotiate rates on behalf of the competing optometrists, threats by Colegio officers regarding a mass de-participation of the optometrists, and actual refusals by a number of optometrists to deal with the plan's patients. Further, the Colegio's officers illegally orchestrated collective negotiations with other plans in an effort to secure higher reimbursement rates for Colegio members. The consent order settling the Commission's charges bars the Colegio and the two leaders from engaging in such conduct in the future.[13]

Discussion

A. S.B. 2190 Establishes Collective Bargaining for Diverse Health Care Providers.

S.B. 2190 seeks to amend the Puerto Rican Insurance Code[14] to authorize collective bargaining on the part of diverse health care providers or their representatives regarding, e.g., fees, the formulation and application of reimbursement methods, and

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hearings, with links to agendas and supporting materials, including hearing transcripts and public comments, is available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

[10] *See id*.

[11] *See generally*, IMPROVING HEALTH CARE, *supra* note 5.

[12] *See supra* note 6 (regarding In the Matter of Colegio de Optometras, a Professional Association, Edgar Dávila García, O.D., and Carlos Rivera Alonso, O.D., individuals).

[13] As discussed below, limitations on, e.g., the size or scope of provider bargaining may affect assessments of the magnitude of risk or harm under competition law. The matter is cited as illustrative of the types of competitive concerns raised by unlawful collusion, as it pertains to health care in Puerto Rico.

[14] The Bill would add a Chapter XXI to law No. 77 of June 19, 1957, as amended.

other matters.[15] Under the Bill, "providers" include individual and corporate providers of health care services, including "all doctors, hospitals, primary care facilities, diagnostic and treatment centers, dentists, laboratories, pharmacies, emergency medical services, pre-hospital services, or any other person authorized in Puerto Rico to provide health care services, whether to groups or individuals, which under contract with a health services organization provides health care services to subscribers or beneficiaries of a health care plan."[16] Under the most-recent Senate draft of the Bill, the size and scope of provider groups that would be permitted to engage in such collective bargaining is limited.[17] S.B. 2190 also stipulates that parties should submit to arbitration certain disputes or impasses that may arise, and it appears to restrict the ability of providers to strike.[18]

B. The Contemplated Collective Bargaining Could Be Anticompetitive and Detrimental to Health Care Consumers.

Since the advent of active antitrust enforcement in health care services markets, health care providers have sought antitrust exemptions in state and federal legislatures. Although varied in certain regards, such proposals have all, at bottom, sought protection from antitrust scrutiny for anti-competitive conduct that would tend to raise the prices of health care services without conferring countervailing benefits on health care consumers. Recognizing that many Americans face difficult health care choices in the market already, the FTC consistently has opposed such proposals. The Commission has enforced the antitrust laws when certain private groups of health care providers have colluded to fix prices,[19] and the Commission has opposed legislative proposals to exempt from antitrust scrutiny various categories of health care providers.[20]

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[15] *See* Draft Article 31.030 (Authorized Collective Bargaining).

[16] *Id.* at Article 31.020.

[17] "Groups or corporations authorized to bargain collectively shall not exceed twenty individuals, or 20% of the providers for that specialty or service in that geographic area, whichever is less." *Id.* at Article 31.030.

[18] *See id.* at Article 31.040 (Method for Resolving Disputes or Impasses in Bargaining) and 31.060 (Prohibition of Specific Joint Actions). In particular, the Bill states that it should not be interpreted as authorizing coordinated stoppages of services and that such stoppages may be subject to federal or state antitrust actions as may be applicable independent of the Bill. *Id.* at 31.060. The Bill also states that the Office of Monopolistic Affairs shall in some fashion supervise the bargaining the Bill seeks to authorize, although it does not specify the criteria under which such bargaining would be evaluated.

[19] *See, e.g.*, In the Matter of Colegio de Optometras de Puerto Rico, *supra* note 6 (price fixing and concerted refusal to deal with vision and health plans by optometrists); In the Matter of Advocate Health Partners, et al., *supra* note 6 (horizontal agreements to fix prices, engage in collective bargaining, and refuse to deal individually with health plans by competing independent physicians and physician practice groups accounting for over 2,900 physicians in Chicago metropolitan area).

[20] *See, e.g.*, Letter from Federal Trade Commission Staff to the Hon. Dennis Stapleton, Ohio House of Representatives (Oct. 16, 2002) (criticizing proposed antitrust exemption for home health care providers), *available at* http://www.ftc.gov/os/2002/10/ohb325.htm; *see also* Prepared Statement of the Federal Trade Commission Concerning H.R. 971, *supra* note 7 (analyzing critically proposal to exempt non-publicly traded pharmacies from antitrust scrutiny); Testimony of Robert Pitofsky, Chairman, Federal Trade Commission, on H.R. 1304, the "Quality Health-Care Coalition Act of 1999" (June 22,

In the FTC staff's judgment, S.B. 2190 raises the same sorts of competition concerns as have those cases and legislative proposals. As the Commission explained in recent testimony before Congress,[21]

> The Commission's experience indicates that the conduct that the proposed exemption would allow could impose significant costs on consumers, private and governmental purchasers, and taxpayers, who ultimately foot the bill for government-sponsored health care programs. Past antitrust challenges to collective negotiations by health care professionals show that groups have often sought fee increases of 20 percent or more.[22] For example, in 1998, an association of approximately 125 pharmacies in northern Puerto Rico settled FTC charges that the association fixed prices and other terms of dealing with third-party payers, and threatened to withhold services from Puerto Rico's program to provide health care services for indigent patients.[23] According to the complaint, the association demanded a 22 percent increase in fees, threatened that its members would collectively refuse to participate in the indigent care program unless its demands were met, and thereby succeeded in securing the higher prices it sought.

In other cases, the Commission has accepted consent orders settling charges that physician collective bargaining forced health plans to raise their reimbursement rates[24] – with the attendant risk of increases in premiums for policy holders.

1999), *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm (regarding federal legislation that would have exempted all health care workers from antitrust scrutiny).

[21] *See* Prepared Statement of the Federal Trade Commission Before the Antitrust Task Force of the H. Comm. the Judiciary, Concerning H.R. 971, *supra* note 7, at 9-10.

[22] *See, e.g.*, Asociacion de Farmacias Region de Arecibo, 127 F.T.C. 266 (1999) (consent order) (22 percent higher); Advocate Health Partners, et al., C-4184 (consent order issued Feb. 7, 2007) (20-30 percent higher); Health Care Alliance of Laredo, C-4158 (consent order issued March 23, 2006) (30 percent higher regarding one payer; 20-90 percent higher for another payer, depending on the particular procedure); San Juan IPA, Inc., 139 F.T.C. 513 (2005) (consent order) (up to 60 percent higher), all *available at* http://www.ftc.gov/bc/healthcare/antitrust/commissionactions.htm. As above, citation to past cases illustrates types of consumer and competitive harm that may be done by such collective bargaining, but assessing particular risks or magnitudes of harm would depend on detailed analysis of particular markets that could be affected by the Bill.

[23] *See* Asociacion de Farmacias Region de Arecibo, *id.*

[24] *See, e.g.*, R.T. Welter & Assocs., Inc. (Professionals in Women's Care), Dkt. No. C-4063 (Oct. 8, 2002) (consent order), *available at* http://www.ftc.gov/os/2002/10/piwcdo.pdf; System Health Providers, File No. 011 0196 (Aug. 20, 2002) (proposed consent order accepted for placement on public record for comment), *available at* http://www.ftc.gov/os/2002/08/shpdo.pdf; Aurora Associated Primary Care Physicians, L.L.C., Dkt. No. C-4055 (July 16, 2002) (consent order), *available at* http://www.ftc.gov/os/2002/07/aurorado.pdf; Physician Integrated Services of Denver, Inc., Dkt. No. C-4054 (July 16, 2002) (consent order), *available at* http://www.ftc.gov/os/2002/07/pisddo.pdf; Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

Although the magnitude of consumer harm can vary according to the particulars of each market, the competition analysis is consistent across different types of health care service providers.[25] Just this year the Antitrust Modernization Commission (AMC) – the body created by Congress to evaluate the application of our nation's antitrust laws – addressed the subject of antitrust exemptions. The AMC urged Congress to exercise caution when considering proposals for new antitrust exemptions, because such exemptions typically "create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality, and reduced innovation."[26]

The stated purpose of S.B. 2190 is to "create a competitive equilibrium in contracting health services."[27] In staff's judgment, such attempts at market intervention are unlikely to further competition. In spite of the significant consumer harms that can flow from provider collective bargaining, proponents of collective bargaining exemptions frequently argue that they are necessary to "level the playing field" between, e.g., physicians and health plans. This argument, however, presupposes that providers are at the mercy of monopsony health plans. Even if that were the case – an assumption that has not been demonstrated to be true across the diverse markets at issue here – attempts to counterbalance such monopsony power with a provider cartel would *not* be likely to benefit consumers. If a health plan did possess significant market power, health care consumers could be doubly harmed by provider collective bargaining, as consumers could be forced to bear the brunt of the elevated fees charged by the provider cartel *on top of* any markup already charged by that health plan because of its market power. Without antitrust enforcement to block such price fixing, prices for health care services could rise substantially.

Antitrust law and the enforcement agencies recognize the risks that can attend undue buyer power, which is known as "monopsony power."[28] In principle, monopsony power enables buyers to depress prices below competitive levels. In response to reduced prices, sellers or providers of goods or services may reduce output, ultimately leading to higher consumer prices, lower quality, or the substitution of less efficient alternative products and services. It is important, however, to distinguish between this potential type of buyer power, which can harm competition and

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[25] That is, the competition concerns are analogous across these various markets. The magnitude of potential consumer harm is difficult to predict without detailed analysis of, e.g., market size, market power, conduct, and other factors for particular service provider markets. In addition, it is difficult to estimate the extent to which consumer harm might be mitigated by the Bill's apparent no-strike provision, limitations on the scope or size of bargaining units, or the stipulation of government oversight, especially as the criteria under which bargaining should be evaluated under draft Article 31.040 are unclear.

[26] Antitrust Modernization Commission, Report and Recommendations (April 2007) at 335, *available at* http://www.amc.gov/report_recommendation/toc.htm.

[27] S.B. 2190, Statement of Purpose.

[28] Or "oligopsony," when it results from the combination of more than one buyer.

consumers, and disparities in bargaining power, which are common throughout the economy and can result in lower input costs and lower prices for consumers. The apparent disparities noted in the Bill chiefly would fall into the latter category of simple, and potentially pro-consumer, bargaining disparities.

At the same time, the FTC is mindful of the potential for harm in aggregations of market power by purchasers in the health care sector. In 2004, the FTC conducted a thorough investigation of Caremark Rx's acquisition of Advance PCS, two large national PBM firms. As part of its analysis, the Commission carefully considered whether the proposed acquisition would be likely to create monopsony power with regard to PBM negotiations with retail pharmacies and ultimately determined it would not.[29] For its part, under the clearance arrangement between the two enforcement agencies, the Department of Justice, rather than the FTC, has investigated various mergers of health plans.[30] In brief, the enforcement agencies already can and do scrutinize buying power in health care markets, and they have the means to address such power when it proves to be anticompetitive and anti-consumer.

In addition, although S.B. 2190 expresses a concern that current bargaining arrangements have a negative impact on the quality of health care, we believe that the proposed collective bargaining would not tend to improve the quality of care. Indeed, collusion could grant competing sellers a powerful weapon to obstruct innovative arrangements for the delivery and financing of health care goods and services while, at the same time, dulling the competitive pressures that drive providers to improve quality and efficiency in order to compete more effectively.

Unless shielded from antitrust scrutiny by an exemption or immunity, the private conduct contemplated by the Bill would violate the antitrust laws. Specifically, the Bill would permit competing providers to agree on the prices they would accept for their services, which constitutes *per se* illegal price fixing. The Health Care Statements issued by the FTC and DOJ address this issue directly.[31] In Example 3 of Statement 8, competing providers form a hypothetical independent practice association (IPA) to "combat the power" of managed care plans by negotiating with them collectively rather than individually.[32] The IPA involves no integration that is likely to result in significant efficiencies (*e.g.*, no financial risk-sharing among the members; no indicia of clinical integration, such as joint development of protocols for improving care; etc.).

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[29] *See* Statement of the Federal Trade Commission, In the Matter of Caremark Rx, Inc./AdvancePCS, File No. 031 0239 (Feb, 11, 2004).

[30] *See, e,g*., United States v. United Health Group, Inc., and Pacificare Health Systems, Inc., 2006 U.S. Dist. Lexis 45938 (D.D.C. 2006), *available at* http://www.usdoj.gov/atr/cases/unitedhealth.htm; United States v. Aetna, Inc, and The Prudential Insurance Company of America, 1999 U.S. Dist. Lexis 19691 (N.D. Tex. 1999), *available at* http://www.usdoj.gov/atr/cases/indx142.htm.

[31] *See generally* Health Care Statements, *supra* note 8.

[32] Although the professional health care providers in the hypothetical are physicians, the antitrust analysis is functionally the same across categories of health care providers.

This combination – collective negotiation over price and no significant efficiency-enhancing integration – means that the agreement to bargain "will be treated as *per se* illegal price fixing."[33] In short, collective bargaining over prices is *per se* illegal price fixing[34] and is inconsistent with antitrust law and policy.[35]

Certain provisions of the Bill could serve to mitigate consumer harm. For example, S.B. 2190 stipulates the arbitration of certain disputes and appears to restrict the ability of providers to strike.[36] In addition, the size and scope of provider groups that would be permitted to engage in collective bargaining is limited.[37] These limitations are not adequate, however, to remove competitive concerns or to insure that the contemplated collective bargaining would be consistent with federal antitrust law. They do not, for example, fit the model of any of the antitrust safety zones for health care service providers described jointly by the FTC and DOJ.

As noted above, the magnitude of consumer harm caused by anticompetitive collective bargaining can vary according to market particulars and the nature of the collective bargaining at issue. For that reason, the FTC staff has discussed extensively in the Health Care Statements – and elsewhere – permissible forms of professional integration for health care providers.[38] The Health Care Statements contain, for example, descriptions of certain "antitrust safety zones that describe physician network

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[33] Health Care Statements, *supra* note 8, at Example 3, Statement 8.

[34] *See, e.g.*, Federal Trade Commission v. Superior Court Trial Lawyers Assoc., 493 U.S. 411, 422 (1990).

[35] As the Supreme Court has observed, "The preservation of the free market and of a system of free enterprise without price fixing or cartels is essential to economic freedom." FTC v. Ticor Title Ins. Co., 504 U.S. 621, 632 (1992) (citing United States v. Topco Associates, Inc., 405 U.S. 596, 610 (1972)). We also note that, with reference to the spillover effects discussed above, such conduct may violate the antitrust laws independent of any explicit agreement to negotiate price with such payers. *See, e.g.* , United States v. General Motors Corp., 384 U.S. 127, 142-43, 1966 Trade Cas. (CCH) P71750 (1966) ("it has long been settled that explicit agreement is not a necessary part of a Sherman Act conspiracy"); Alvord-Polk, Inc. v. F. Schumacher & Co., 37 F.3d 996, 1000, 1994-2 Trade Cas. (CCH) P70741 (3d Cir. 1994); ES Dev., Inc. v. RWM Enterprises, Inc., 939 F.2d 547, 553, 1991-2 Trade Cas. (CCH) P69505 (8th Cir. 1991).

[36] S.B. 2190 at Article 31.040 (Method for Resolving Disputes or Impasses in Bargaining) and 31.060 (Prohibition of Specific Joint Actions). In particular, the Bill states that it should not be interpreted as authorizing coordinated stoppages of services and that such stoppages may be subject to federal or state antitrust actions as may be applicable independent of the Bill. *Id.* at 31.060. The Bill also states that the Office of Monopolistic Affairs shall in some fashion supervise the bargaining the Bill seeks to authorize, although it does not specify the criteria under which such bargaining would be evaluated.

[37] "Groups or corporations authorized to bargain collectively shall not exceed twenty individuals, or 20% of the providers for that specialty or service in that geographic area, whichever is less." *Id.* at Article 31.030.

[38] *See, e.g.*, Health Care Statements, *supra* note 8; the Statements suggest that "[i]nterested parties should examine the business review letters issued by the [DOJ] and the advisory opinions issued by the [FTC] and its staff for additional guidance on the application and interpretation of these statements." *See, e.g.*, FTC Staff, Greater Rochester Independent Practice Assoc., Inc., Advisory Opinion (Sept. 17, 2007), *available at* http://www.ftc.gov/bc/adops/gripa.pdf.

joint ventures that are highly unlikely to raise substantial competitive concerns, and therefore will not be challenged by the Agencies [FTC and DOJ] under the antitrust laws, absent extraordinary circumstances."[39] One such safety zone is described for "an exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market."[40] Another regards "a non-exclusive physician network joint venture," which may fall within the safety zone if the "participants share substantial financial risk and constitute 30 percent or less of the physicians … in the relevant geographical market."[41]

In view of these safety zones, certain provisions of S.B. 2190 are especially noteworthy. In particular, the Bill states that "[g]roups or corporations authorized to bargain collectively shall not exceed twenty individuals, or 20% of the providers for that specialty or service in that geographic area, whichever is less."[42] Although such a provision might work, under certain circumstances, to reduce the degree of harm caused by anticompetitive bargaining, the provision is not coextensive with any or all of the safety zones described in the Health Care Statements. The Bill's provision is not adequate to eliminate the risk of competitive concerns, and it does not restrict bargaining conduct to conduct consistent with federal antitrust law. Missing, on the face of the provision, is one of the key indicia of permissible physician joint ventures: "the participants … must share substantial financial risk in providing all the services that are jointly priced through the network."[43] Without any indication of meaningful financial or clinical integration, the promise of significant efficiencies in managing costs or quality of care is undercut, and the resulting collusion, to the extent it would be effective at all, is liable to exert pressure only towards increased prices.

Although the degree of competitive harm that may result from S.B. 2190's bargaining conditions may vary across types of providers or locales[44] – as could the question of the lawfulness of particular conduct – the risk of harm, and unlawful anticompetitive conduct, remains. Unless Puerto Rico establishes standards and a regulatory scheme that meets the Supreme Court's requirements for clear articulation and active state supervision, enactment of the law may encourage private health-care

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[39] Health Care Statements, *supra* note 8, at 62-63.

[40] *Id.* at 64-65.

[41] *Id.* at 65.

[42] S.B. 2190, Article 31.040.

[43] Health Care Statements, *supra* note 8, at 67. The Statements go on to explain that risk sharing is required "not because [it] is an end in itself, but because it normally is a clear and reliable indicator that a physician network involves sufficient integration by its physician participants to achieve significant efficiencies." Id. at 67-68.

[44] We note too, that S.B. 2190 seems to use "geographic area" to mean "the service area of a health care plan," Article 31.030, and that this may not be the same as a "geographic area" for purposes of antitrust analysis.

providers to engage in conduct that could expose them to liability under the federal antitrust laws. The state action doctrine – first articulated by the Supreme Court in *Parker v. Brown*[45] – shields certain anticompetitive conduct by the states from federal antitrust scrutiny. Although a legal analysis of the state action doctrine, and its application to S.B. 2190 and private conduct related to the Bill, is beyond the scope of this letter, we note that it is settled law that states cannot immunize private anticompetitive conduct merely by stipulating the application of state action immunity.[46]

Parker represents the Court's reading of the preemptive reach of the Sherman Act,[47] a reading "grounded in principles of federalism."[48] In *Parker*, the Court found "nothing in the language of the Sherman Act or its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by the legislature."[49] Accordingly, the Court held that Sherman Act does not prohibit state regulation that tends to suppress competition when "the state itself exercises its legislative authority" and, "as sovereign," adopts and enforces such regulation.[50] Notably, however, the Court has recognized that the principles of federalism underlying the state action doctrine are best served if *Parker* immunity is narrowly construed: "Neither federalism nor political responsibility is well served by a rule that essential national policies are displaced by state regulations intended to achieve more limited ends."[51]

Under the state action doctrine, the conduct of the state, as sovereign, generally is immune from antitrust scrutiny. However, "[t]he national policy in favor of competition cannot be thwarted by casting … a gauzy cloak of state involvement over what is essentially a private price fixing arrangement."[52] Although states *themselves* may adopt and implement policies in tension with federal antitrust law, subordinate political entities, including state regulatory boards and municipalities, "are not beyond the reach of the antitrust laws because they are not themselves sovereign."[53] Private

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[45] 317 U.S. 341 (1943).

[46] *See* text accompanying notes 48-58, infra, regarding certain state action doctrine limits. Analysis of the question whether the Order is preempted by the federal Social Security Act and its implementing regulations is also outside the scope of this letter.

[47] "We may assume also, without deciding, that congress could, in the exercise of its commerce power, prohibit a state from maintaining … [such a program] because of its effect on interstate commerce." *Id.* at 350.

[48] FTC v. Ticor Title Ins. Co., *supra* note 35, at 633.

[49] 317 U.S. at 350-351.

[50] *Id.* at 352.

[51] FTC v. Ticor Title Ins. Co., *supra* note 35, at 636.

[52] 317 U.S. at 351.

[53] Town of Hallie v. City of Eau Claire, 471 U.S. 34, 38 (1985) (municipality not the sovereign); *see also* Southern Motor Carriers Rate Conference v. United States, 471 U.S. 48, 62-63 (1985) (state Public Service Commissions "acting alone" could not shield anticompetitive conduct from antitrust scrutiny); Goldfarb v. Virginia State Bar, 421 U.S. 773, 791-92 (1975) (state bar association, which was state

parties, moreover, are not insulated from antitrust scrutiny merely because a state legislature stipulates their immunity.[54] When a state expresses a policy to displace competition in favor of regulation, but delegates to private parties the implementation of that policy, *Parker* immunity requires establishing that the anticompetitive conduct is sufficiently "the state's own."[55] Two tests are required for that purpose: "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the State itself."[56] Because various health care providers under the Bill are not State employees, collective bargaining by them or their privately elected representatives cannot be immune unless it passes both of these tests. For example, in *California Retail Liquor Dealers Association v. Midcal Aluminum*,[57] California's system for wine pricing was not immune from antitrust scrutiny because the legislature itself did not establish prices, review the reasonableness of price schedules, or engage in any "pointed reexamination" of the program – hence, failing the active supervision test.[58] Although S.B. 2190 states that the Office of Monopolistic Affairs will "supervise and look into" the contemplated bargaining, the Bill specifies neither the process of such supervision nor the criteria under which anticompetitive conduct would be evaluated for possible approval.[59]

Conclusions

Since the advent of active antitrust enforcement in health care services markets, health care providers have sought antitrust exemptions in state and federal legislatures. Although varied in certain regards, such proposals have all, at bottom, sought protection from antitrust scrutiny for anti-competitive conduct that would tend to raise the prices of health care services without conferring countervailing benefits on health care consumers. Recognizing that many Americans face rising costs and difficult health care choices in the market already, the FTC consistently has opposed such proposals.

In staff's judgment, S.B. 2190 raises the same competition concerns raised by those prior legislative proposals. Horizontal price fixing by independent health care

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agency for certain purposes, not entitled to state action exemption).

[54] Midcal Aluminum, 445 U.S. at 106 ("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.")

[55] FTC v. Ticor Title Ins. Co., *supra* note 35, at 635.

[56] Midcal Aluminum, 445 U.S. at 105 (quoting City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978).

[57] *Supra* note 54.

[58] Midcal Aluminum, 445 U.S. at 105-106.

[59] S.B. 2190, Article 31.030. The same provision stipulates that "[t]he Office of the Commissioner of Insurance shall have the responsibility to balance the results of the bargaining process with the provisions of the Insurance Code. For this, the necessary statutory mechanisms shall be established." Because neither the relevant statutory provision nor its regulatory implementation is yet established, it is not possible to evaluate the conduct or effects of such potential balancing.

providers tends to work to the substantial detriment of health care consumers and is inconsistent with federal antitrust law and policy. The staff is concerned, therefore, that the proposed legislation may raise prices for – and thereby reduce access to – vital health care goods and services for Puerto Rican health care consumers, while failing to improve the quality of care for those still able to afford it.

Respectfully submitted,

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