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

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[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>.

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 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

[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).

The Commission's testimony before Congress regarding a proposed federal antitrust exemption for physician collective bargaining details the predictable dangers such bargaining 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:
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> - Consumers and employers would face higher prices for health insurance coverage.
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> - 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 . . .
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> - State and local governments would incur higher costs to provide health benefits to their employees.
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> - 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.
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> - 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.
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> 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

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[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).

their employee prescription 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]

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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.

II. Responses to Specific Questions Regarding HB 2360

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

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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).

is the impact on consumer welfare.[17] Thus, if a plaintiff cannot show that an 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

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[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 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).

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 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

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[21] RCW 43.72.300(2).

[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.

parties."[27]

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

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

[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).

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 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

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[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 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).

and the public interest may require such costly and uncertain regulation.

* * *

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,

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