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

Bureau of Competition
Bureau of Economics
Office of Policy Planning

March 18, 2009

Representative Tom Emmer
Minnesota House of Representatives
301 State Office Building
100 Rev. Dr. Martin Luther King, Jr. Boulevard
Saint Paul, Minnesota 55155

Re: **Minnesota House Bill H.F. No. 120 & Senate Bill S.F. No. 203**

Dear Representative Emmer:

This letter responds to your request for comment on Minnesota House Bill H.F. No. 120 and its companion Senate Bill S.F. No. 203.[1] These bills are intended to exempt from state and federal antitrust law certain anticompetitive activities by health care cooperatives in Minnesota, including illegal price fixing and collective negotiation of terms of dealing with purchasers of health care services. Further, nothing in the bills is likely to prevent the harmful effects that arise from immunizing price fixing. Instead, these bills would deprive health care consumers of the protections of the antitrust laws and the benefits of competition.

If the bills under consideration in Minnesota were to become law, all consumers — patients, employers, insurers, and federal, state, and local health care programs — likely would pay more for medical care. Additionally, the bills are unnecessary: current state and federal antitrust laws already permit doctors and other health care practitioners in many circumstances to cooperate in providing services when that cooperation improves the quality of, or access to, health care services.[2] Finally, it is questionable whether the regulatory scheme the bills

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

[2] Indeed, the Federal Trade Commission and its staff have provided substantial guidance to the industry regarding how such arrangements can operate and how they will be evaluated under long-standing antitrust law

(continued...)

contemplate would immunize health care cooperatives from liability for conduct that violates the federal antitrust laws.

Because they are likely to harm consumers, the Commission has long opposed federal and state legislative proposals that would create antitrust exemptions for collective bargaining by health care providers.[3] Similarly, the Congressional Budget Office believes that antitrust exemptions for health care providers would increase health care costs.[4] More generally, the bi-partisan Antitrust Modernization Commission observed "[t]ypically, antitrust exemptions 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."[5] That is precisely what the bills under consideration would do, if enacted. By raising health care costs, moreover, the bills would make it more expensive and more difficult to institute health care reform and expand health care coverage.

The bills' main proponent is the Minnesota Rural Health Cooperative (MRHC). As the MRHC has itself disclosed, the Commission staff has been investigating serious allegations that MRHC engaged in collective negotiation of physician, hospital, and pharmacy prices. MRHC representatives have made inaccurate statements at legislative hearings about the views of FTC

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[2](...continued)
principles. *See* FTC website, http://www.ftc.gov/bc/healthcare/industryguide/index.htm.

[3] *E.g.,* Prepared Statement of the Federal Trade Commission Concerning "The Community Pharmacy Fairness Act of 2007," Before the Antitrust Task Force of the Committee on the Judiciary, United States House of Representatives (October 17, 2007) http://www.ftc.gov/os/testimony/P859910pharm.pdf; Prepared Statement of the Federal Trade Commission on Examining Competition in Group Health Care (September 6, 2006) http://ftc.gov/os/testimony/P859910CompetitioninGroupHealthCareTestimonySenate09062006.pdf; Prepared Statement of the Federal Trade Commission Before the Committee on the Judiciary, United States House of Representatives, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999 " (June 22, 1999) http://www.ftc.gov/os/1999/06/healthcaretestimony.htm; FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (January 30, 2008) http://www.ftc.gov/os/2008/02/v080003puerto.pdf; FTC Staff Comment to the Honorable Dennis Stapleton Concerning Ohio H.B. 325 to Permit Competing Health Care Providers to Engage in Collective Bargaining With Health Plans (October 16, 2002) http://www.ftc.gov/os/2002/10/ohb325.htm; FTC Staff Comment to the Office of Corporation Counsel, District of Columbia Concerning Bill 13-333, the "Physicians Negotiation Act of 1999 " (October 29, 1999), http://ww.ftc.gov/be/hilites/rigsby.shtm; FTC Staff Comment to the Honorable Rene O. Oliveira Concerning Texas S.B. 1468, "An Act Relating to the Regulation of Physician Joint Negotiation" (May 13, 1999) http://www.ftc.gov/be/v990009.shtm.

[4]*See* Congressional Budget Office Cost Estimate, H.R. 1304, Quality Health-Care Coalition Act of 1999 (March 15, 2000) at 5, available at http://www.cbo.gov.

[5] Antitrust Modernization Commission, Report and Recommendations (April 2007) at 335, available at http://govinfo.library.unt.edu/amc/report_recommendation/toc.htm.

staff regarding both the merits of the bills and their effect on our investigation.[6] This letter is intended to provide you with FTC staff's analysis of the likely impact of these bills on Minnesota consumers and on the extent to which the bills, if enacted into law, will shield health care providers from antitrust scrutiny for otherwise illegal collective bargaining.

The Minnesota Bills

Like the other health care provider collective bargaining bills on which the Commission and Commission staff have commented, the pending bills are intended to confer authority for otherwise competing health care providers to agree on the prices and other terms they will accept from health plans, and to bargain jointly to obtain these collectively determined contract terms.[7] Although the bills state that "establishing a system of review and supervision of health care cooperative contractual negotiations" will assure that "competition is preserved," there is little reason to expect that this will be the case, because the bills' regulatory approach will not eliminate the likelihood of the type of harmful effects that arise from immunizing price fixing.

The bills require health care provider cooperatives to submit to the Minnesota Commissioner of Health all "contracts and business or financial arrangements under 62R.06." The bills then require the Commissioner to "review and authorize" the submitted contracts and business or financial arrangements.

Although the bills set up a scheme for state review, the nature of that review is limited. Indeed, both bills effectively establish a presumption in favor of approval. Unless the Commissioner makes an affirmative disapproval of an application, it will automatically be deemed approved 60 days after initial submission (if no additional information is requested), or 60 days after the submission of any additional information requested by the Commissioner. The Commissioner may not deny an application absent an affirmative determination of harm: "[t]he commissioner shall not deny any application unless the commissioner determines . . . that: (1) the anticompetitive effects of the arrangement on the marketplace exceed the procompetitive effects or efficiencies, or that any price agreements included in the arrangement are not necessary to achieve the efficiencies that are expected to result from the arrangement; or (2) the applicant has not provided complete or sufficient information requested by the commissioner to evaluate the impact of the proposed arrangement on the health care marketplace." Thus, as long

[6] We have asked the MRHC representatives to notify the relevant legislative committees that their prior representations of FTC staff views were not accurate.

[7] Chapter 62R already purports to exempt at least certain health care cooperative activity from antitrust challenge, but contains no mechanism for state supervision.
2008 Minnesota Statutes, § 62R.06, subd. 3, https://www.revisor.leg.state.mn.us/statutes/?id=62. This absence of state supervision means this provision cannot provide immunity from federal antitrust law. *See infra*. We understand that the bills are substantially similar to one that the Minnesota Legislature passed last year, but that did not become law due to a veto by the Governor of the larger bill within which the legislation was included.

as the applicant provides the information requested by the Commissioner, within a very limited time, the Commissioner must evaluate the potential competitive effects of the application, the potential efficiencies of the application, and determine which of these effects exceeds the other. Unless the Commissioner denies the application within 60 days, the application is approved by default.

Collective Bargaining by Health Care Providers Does Not Serve the Public Interest

Allowing health care professionals to collectively bargain will likely harm consumers. In brief, FTC staff has the following specific concerns:

- An exemption for collective bargaining by health care professionals would allow conduct that would otherwise constitute unlawful price fixing or other serious antitrust violations. The Commission's experience investigating numerous cases of collective bargaining by competing health care providers has shown that an antitrust exemption for such joint negotiations would cause consumers and employers, as well as federal, state, and local governments, to pay higher prices for health care.

- Such an exemption is not necessary to enable health care providers to negotiate collectively with health plans in various circumstances in which competition will be increased and consumers are likely to benefit. The Federal Trade Commission and the Department of Justice have issued health care policy statements that explain how health care providers can organize networks and other joint arrangements to deal collectively with health plans and other purchasers without running afoul of the antitrust laws.[8]

- An antitrust exemption for collective bargaining is not the way to improve health care quality. Immunizing collective bargaining imposes costs without any guarantee that patients' interests in quality care would be served.

We address these points in greater detail below.

The Bills Will Likely Raise Health Care Costs

H.F. No. 120 and S.F. No. 203 would permit health care providers, acting through health care cooperatives, to act collectively to compel purchasers and payers to pay higher prices to those providers in order to offer the providers' services to consumers. Private payers and governmental purchasers necessarily will pass along the cost of those higher prices to customers, employees, and taxpayers. The bill's oversight provision will not protect consumers from price fixing.

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

Two Commission settlements illustrate the type of harm that can occur. Collective fee demands by pharmacists in the State of New York in the 1980s cost the state an estimated $7 million in increased health benefits expenditures for state employees.[9] Morever, thirty-one anesthesiologists in Rochester, New York, allegedly conspired to increase their fees by negotiating collectively with third-party payers over reimbursement terms, by agreeing to threaten not to participate in certain health plans unless their fee demands were met and by actually de-participating when the payers rejected those demands.[10] We are aware that the anesthesiologists subsequently settled a private class action lawsuit for the same conduct for approximately $940,000, which was distributed to approximately 24,000 patients who allegedly were overcharged as a result of the anesthesiologists' challenged conduct.

A Congressional Budget Office (CBO) analysis of a federal bill to create antitrust exemptions for health care providers noted the bill's likely negative effects on private insurers and businesses, state tax revenues, and premiums for state-sponsored health insurance programs for their employees. The CBO estimated that this exemption would increase state expenditures for Medicaid and the State Children's Health Insurance Program (SCHIP) by $120 million in 2001 and by $2.3 billion over the 2001-2005 period.[11] Proportionally similar effects in Minnesota, albeit at higher levels due to cost increases and inflation since then, can be expected if the pending Minnesota bills are enacted.[12]

The CBO noted that "[b]y increasing costs to private health plans, [the bill] would result in higher private health insurance premiums. In the case of employer-sponsored health plans,

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[9] *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] *Rochester Anesthesiologists,* 110 F.T.C. 175 (1988) (consent order).

[11] *See* Congressional Budget Office Cost Estimate, H.R. 1304, Quality Health-Care Coalition Act of 1999 (March 15, 2000) at 5, available at http://www.cbo.gov. A study of the possible effects of the same exemption legislation on private payers prepared by Charles River Associates, Inc., on behalf of the Health Insurance Association of America, concluded that, if enacted, the bill could "increase private health insurance premiums by 5 to 13 percent," and "could increase national personal health care expenditures by $29 to $95 billion annually." *See* Charles River Associates, Inc., for Health Insurance Association of America, "Comments on American Medical Association-Sponsored Critique of Charles River Associates Study on Physician Antitrust Waivers" at 1 (April 6, 2000); Charles River Associates, Inc., for Health Insurance Association of America, "Updated National Projections, The Cost of Physician Antitrust Waivers" (March 3, 2000).

[12] In a recent article, Minnesota Governor Pawlenty stated that "[b]etween 2000 and 2006, healthcare spending in Minnesota increased more than 60%, from $19 billion to more than $30 billion." Gov. Tim Pawlenty, "The Minnesota Way," 39 *Modern Healthcare* 20 (January 19, 2009). Referring to Minnesota's 2008 healthcare reform legislation as "a crucial first step in . . . payment reform," and noting that Minnesota "is not immune to the current healthcare system's uneven quality and out-of-control costs," Governor Pawlenty called for a healthcare payment system that rewards value, rather than volume, and that will improve healthcare quality. We believe that the anticompetitive conduct that would be authorized by H.F. No.120 and S.F. No. 203 is inconsistent with Minnesota's health care reform goals.

higher premium contributions charged to employers would be passed on to employees in the form of lower cash wages and other fringe benefits," which in turn, "would lead to lower . . . state tax revenues."[13] Minnesota taxpayers, government, businesses, and employees of those businesses all will bear the burden of the higher prices that the bills will authorize health care cooperatives and their members to demand. Employers are likely to reduce or eliminate coverage for their employees, or to pass on to them more of those costs through higher insurance contribution rates, co-payments, and deductibles, or reduced coverage. Enactment of legislation to authorize certain health care providers to fix prices and artificially raise costs to businesses that provide health care benefits to their employees and to the taxpaying public appears particularly unjustifiable in the current economic environment.

The bills' provisions for state oversight would not ensure that consumers are protected from the significant harm likely to occur as a result of state-sanctioned price fixing. Apart from instances in which a contract application is incomplete or sufficient information to evaluate the application is not submitted to the reviewing official, the reviewing official may deny a contract application only after determining that the contract's anticompetitive effects exceed any procompetitive effects or efficiencies. Such a determination requires extensive factual investigation and analysis. Yet the bills require the investigation and analysis to be completed within a very limited time.[14] Further, it is also likely that an inquiry to determine the net competitive effects of a proposed contract could be done only if the regulator had access to data not likely to be in the hands of either the regulator or the parties to the contract. Absent access to compulsory process, however, the Commissioner is likely to have difficulty obtaining the necessary information from third parties within the short time limits that the bills provide. It is not clear, moreover, that the bills' designated reviewing officials would have the relevant expertise or the capability, including the appropriate resources, to make the kinds of evaluations and determinations regarding competition and market effects that are required if an application is to be denied.

Although the existing statute that the bills seek to amend bars a health care provider cooperative from engaging in acts of "coercion, intimidation, or boycott, or any concerted refusal to deal with, any health plan company seeking to contract with the cooperative on a

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[13] Congressional Budget Office Cost Estimate, H.R. 1304, *supra* note 12, at 1.

[14] The bills' default position, whereby a contract or other proposal would be deemed approved unless affirmatively rejected based on the bills' specified criteria and finding requirements, inverts the current legal standard applicable to such conduct under the antitrust laws. Long-established antitrust standards consider price agreements among competitors to be presumptively anticompetitive and unlawful unless they are shown by the participants to be reasonably necessary to create or further some procompetitive, efficiency-enhancing, joint activity. Even then, the price agreements may still be held unlawful after further analysis, if the participants possess market power and the overall effect of the activity in the market, on balance, is determined to be anticompetitive. *See, e.g., North Texas Specialty Physicians*, 2005-2 Trade Cas. (CCH) ¶ 75,032, *aff'd. sub nom. North Texas Specialty Physicians v. FTC*, 528 F.3d 346 (5th Cir. 2008); *Polygram Holding, Inc.,* 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003), *aff'd. sub nom. Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005).

competitive, reasonable, and nonexclusive basis,"[15] such a provision is unlikely to be effective. First, it will be difficult, if not impossible, to enforce. Coercion, intimidation, boycotts, and concerted refusals to deal are beyond the bill's protection only if the health plan offers "competitive" and "reasonable" terms. But it is unclear who decides which offers are "competitive" or "reasonable" or what the criteria are for determining whether the offers meet these tests. Second, even if cooperatives do not resort to overt coercion, their collective bargaining would still present a serious risk of anticompetitive harm. 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.[16] And the bills' immunity for collective bargaining would facilitate extensive communication among providers as to what prices they will accept. That could lead to secret agreements among the providers to refuse to deal except on collectively determined terms that, though not immune, would be difficult to detect and prosecute.

Finally, even if the bills work as intended, they still would lead to higher health care costs. The bills allow providers to agree on the fees that they will accept in their negotiations before they obtain the required approval. Thus, even if a contract were ultimately denied, the providers would have already agreed on acceptable price terms. The risk that such an agreement on fees would spill over into individual negotiations on price terms is substantial.

The Bills Are Not Likely to Improve Quality of, or Access to, Care

Despite the bills' references to improved access, quality, and competition, nothing in the bills would assure that these policy goals would be furthered. Allowing competing physicians and other health care providers to act as a price-fixing cartel through health care cooperatives, would not improve access to those services or increase competition. To the contrary, such higher prices will make it more difficult for consumers to gain access to needed services due to part or all of those costs being passed on to consumers by institutional purchasers and payers. Nor would higher payments to health care provider members of cooperatives provide any assurance of improved quality.

Further, the bills' presumption in favor of approval may allow cooperatives to impose terms and conditions for participation that restrict non-price competition in ways that directly undermine the goals of improved health care quality or access. For example, if the terms and conditions for participation in a cooperative specify doctors' office hours, participating doctors

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[15] Section 62R.08.

[16] *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 is inherent in collective negotiations).

could not compete by offering longer hours during the day or on weekends, impeding some patients' access to health care services.[17]

The Bills Are Unnecessary to Promote Arrangements That Will Benefit Consumers

There is no need to authorize price fixing to promote health care cooperative arrangements. Health care cooperatives currently operate in Minnesota, and to the extent that joint activity by health care cooperatives – including joint contracting for efficiency-enhancing, integrated programs – is intended and likely to create efficiencies, improve quality of and access to care, and have an overall procompetitive effect in the market, the antitrust laws already permit such conduct. The Federal Trade Commission and its staff have provided substantial guidance regarding how such arrangements can operate and will be evaluated under long-standing antitrust law principles.[18] The bills' exemption is simply unnecessary to permit that kind of legitimate activity. However, regardless of their stated intent to improve health care quality and access and to control costs, the bills' provisions condone conduct by health care cooperatives and their members that does nothing more than aggregate the participants' market power and use that power to demand higher payments for their services.

The Bills May Not Create State Action Immunity

The antitrust immunity that the bills are intended to confer can only be effective if there is adequate state supervision of the collective bargaining activities authorized by the statute.[19] For a law to exempt private conduct from antitrust laws, the state, among other things, must actively supervise the conduct at issue. Under Supreme Court precedent, this requirement means that purportedly state-approved rates or prices must be "established as a product of deliberate state intervention, not simply by agreement among private parties."[20] Here, it is unclear that the state's review will be sufficient to protect private parties from antitrust liability because (1) the state's review must occur in a limited time, (2) the rates are effective before state approval, and (3) the

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[17] Along with potentially undermining goals of improved health care quality and access, "collective bargaining over other, more clearly 'non-price' issues in a health plan contract can have a substantial effect on the ultimate costs paid by consumers." *See* the Prepared Statement of the Staff of the Bureau of Competition and the Office of Policy and Planning Before the Committee on Labor and Commerce, Alaska House of Representatives: The Threat of Consumer Harm Resulting from Physician Collective Bargaining Under Alaska Senate Bill 37, March 22, 2002, http://www.ftc.gov/be/hilites/cruz020322.shtm.

[18] *See supra* note 2.

[19] *Parker v. Brown,* 317 U.S. 341, 351 (1943).

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

rates are deemed approved even if no decision is made.[21] Thus, even if the legislature passes the bills, health care cooperatives may still be subject to federal antitrust laws.

Finally, we note that state action immunity is not retroactive. Even if there is state supervision sufficient to exempt a health care cooperative's conduct from the application of the federal antitrust laws, immunity would only arise for future supervised conduct. Past conduct that violated the federal antitrust laws would not be immune from prosecution.

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In summary, based on our expertise in analyzing competition in health care markets, we believe the bills, if enacted, would harm Minnesota consumers through higher prices for health care services, higher insurance premiums, lower levels of insurance coverage, and lower wages. All Minnesota taxpayers, moreover, would likely bear the burden of this proposal as state-sponsored insurance programs would have to pay more to provide coverage for the most vulnerable segments of the population.

We hope you find these comments helpful. Should you have any additional questions, please do not hesitate to contact Markus H. Meier, Assistant Director, Health Care Division, at 202-326-3759.

[21] *Id.* at 634-35 ("prices or rates are set as an initial matter by private parties, subject only to veto if the State chooses to exercise it, the party claiming immunity must show that state officials have undertaken the necessary steps to determine the specifics of the rate setting scheme").

Respectfully submitted,

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