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

Office of Policy Planning
Bureau of Economics
Bureau of Competition

October 20, 2011

Senator John J. Bonacic
New York State Senate
201 Dolson Avenue, Suite F
Middletown, NY 10940

Dear Senator Bonacic:

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 for comment on New York Senate Bill S.3186-A ("S.B. 3186" or "the Bill"), known as the "Health Care Consumer and Provider Protection Act," which would authorize independent health care providers to negotiate collectively a variety of contract provisions with certain health plans, including fees and other non-fee-related matters. We are concerned that the Bill, if enacted, will likely lead to increased costs, reduced innovation, and decreased access to health care for New York consumers, without countervailing benefits. We therefore recommend that the Bill be rejected by the New York State Assembly.

The Federal Trade Commission has consistently opposed legislative proposals to grant antitrust exemptions for collective negotiations among health care providers. Antitrust law already permits collaborations that benefit consumers, so the Bill is not needed to allow truly procompetitive cooperative activities by health care providers. To the extent that S.B. 3186 is designed to authorize conduct not already permitted under the antitrust laws, the Bill threatens to deprive health care consumers of the benefits of competition. The types of collective negotiations permitted by S.B. 3186 will likely raise prices and reduce access for health care services, without ensuring improved quality of care or other consumer benefits. In addition, the regulatory regime contemplated by the Bill may not meet the rigorous standards required to confer state action immunity from the federal antitrust laws to the providers.

Interest and Experience of the Federal Trade Commission

Congress has charged the Federal Trade Commission ("FTC" or "Commission") with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in commerce.[2] Pursuant to its statutory mandate, the FTC seeks to identify business practices and governmental regulations that may impede competition without also offering countervailing benefits to consumers.

Health care competition is critically important to the economy and consumer welfare. For this reason, anticompetitive conduct in health care markets has long been a key focus of FTC activity. The agency has brought numerous antitrust enforcement actions involving the health care industry.[3] In addition, the Commission and its staff have given testimony,[4] issued reports,[5] and engaged in advocacy to state legislatures regarding various aspects of competition in the health care industry. Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that would create antitrust exemptions for collective negotiations by health care providers when such exemptions are likely to harm consumers.[6]

The New York Bill

As we understand it, S.B. 3186 would authorize health care providers to collectively negotiate fee-related contract provisions with any health plan deemed to hold "substantial market share in a business line."[7] In addition, the Bill would allow health care providers to collectively negotiate numerous non-fee-related contract provisions with a health plan operating within the same service area as the health care providers, regardless of whether the plan holds substantial market share.[8] Competing health care providers would be allowed to communicate directly with each other regarding the contractual terms and conditions to be negotiated with a health care plan, including prices and other competitively sensitive information.[9] Actual negotiations with health plans must be accomplished through an authorized representative of the health care providers.[10]

Once competing health care providers establish terms to be negotiated, the health care providers' representative would be required to submit a report to the New York Attorney General identifying the proposed subject matter of anticipated collective negotiations with health plans, as well as any efficiencies or benefits expected to be achieved through the negotiations for health care providers and consumers.[11] With the advice of the Superintendent of Insurance and the Department of the Health Commissioner, the Attorney General must approve or disapprove any proposals for health care providers to engage in collective negotiations within 20 days. If a proposal is rejected, the Attorney General must provide an explanation of the proposal's deficiencies, along with suggestions to remedy these deficiencies.[12] If the Attorney General does not act, however, the report shall be deemed approved and the health care representative can begin negotiations with health plans. In the event that a health plan declines to negotiate, cancels negotiations, or fails to respond to a request for negotiation, the health providers' representative may request intervention by the Attorney General to require the health plan to participate in negotiations.[13] The Attorney General must then oversee a resolution process between the health care providers and the health plan, which may include appointing a mediator and, if necessary, a fact-finding board that would submit its recommendations to the Attorney General for a final decision.[14]

In the event that an agreement is reached between the health care providers and a health plan, the Attorney General would have 60 days to conduct a substantive investigation of the competitive impact of the proposed agreement before approving or

disapproving it.[15] In evaluating the competitive impact of the proposed agreement, the Attorney General would be authorized to collect information from health plans and health care providers operating in the same geographic area as the health care cooperative.[16] Once an agreement has been approved, the Attorney General would be required to monitor the agreement to ensure compliance with the conditions of approval.[17]

The Likely Effects of S.B. 3186

The Bill is designed to allow coordinated activity among competitors beyond what the antitrust laws permit, and therefore poses a substantial risk of consumer harm by increasing costs, impeding innovation, and decreasing access to health care. Indeed, at least ten organizations in New York have submitted memoranda in opposition to this legislation, primarily citing concerns about collective negotiations among health care providers potentially leading to increases in private insurance premiums that, in turn, could lead to an increase in the number of uninsured New York residents.[18] Furthermore, we believe it would be difficult to undo the consumer harm that is likely to occur once competitors have shared sensitive fee- and non-fee-related information in anticipation of collective negotiations, regardless of whether negotiations or agreements are approved under the regulatory scheme described in the Bill.

a) <u>The Bill Is Unnecessary to Promote Arrangements That Will Benefit Consumers</u>

As a preliminary matter, federal antitrust law already permits many joint activities by health care providers when such activities are procompetitive and likely to benefit consumers. Therefore, additional legislation is not necessary to promote the interests of New York health care consumers. We understand that some health care providers are concerned that they have limited leverage when negotiating with large health plans, and therefore would like to collaborate in their dealings with them. Consequently, we can understand why the New York legislature would want to provide a greater level of certainty to health care providers regarding potential antitrust risks. However, we believe that legislation allowing collective negotiations among health care providers, beyond what is permitted by the federal antitrust laws, would result in substantial harm to consumers rather than procompetitive benefits.

First, collective negotiations by providers may be lawful when they are reasonably necessary to create efficiencies, such as reducing the cost or improving the quality of health care services, or fostering innovation in health care delivery. Antitrust enforcement agencies recognize, for example, that effective clinical integration among health care providers may have the potential to achieve cost savings, improve health outcomes, and encourage innovation. The FTC, its staff, and the U.S. Department of Justice have provided substantial guidance to clarify that the antitrust laws do not prevent health care providers from engaging in these types of beneficial collaborations.[19] When in doubt about the potential antitrust risks associated with a proposed collaboration, health care providers may request an advisory opinion from FTC staff.[20]

Second, no antitrust exemption is needed to permit health care providers to discuss their concerns regarding health plan practices, whether among themselves or with health plans. Health care professionals may, under existing antitrust law, engage in collective advocacy to promote the interests of their patients, and also to express their opinions about other issues such as payment delays and dispute resolution procedures.[21]

b) <u>The Bill Poses a Substantial Risk of Consumer Harm</u>

In addition to being unnecessary, the Bill, if enacted, is likely to harm consumers. Regardless of its stated intent to address an imbalance in negotiating leverage between health care providers and health plans, the practical effect of the Bill will be to exempt some anticompetitive conduct from antitrust scrutiny. The underlying assumption of the legislation – that consumers would benefit from collective negotiations among providers – is fundamentally flawed. There is no credible economic theory supporting that notion, and no evidence demonstrating that collective negotiations among providers will do anything other than raise prices for consumers.[22] Indeed, the primary objective of permitting collective negotiations among health care providers is to raise reimbursement rates paid by health plans. These rate increases are inevitably passed on to consumers in the form of higher health insurance premiums or higher out-of-pocket expenses. Ultimately, there is no credible basis to conclude that the regulatory scheme contemplated by the Bill will be better for consumers than the outcomes achieved through competition among health care providers; indeed, evidence shows that such a deviation from the competitive process may only harm consumers.

The Bill is intended to extend antitrust immunity to health care providers that collectively negotiate agreements with health plans, thereby denying consumers the benefits of competition in health care markets. The Commission and its staff have long opposed blanket antitrust exemptions for health care providers. Indeed, for more than thirty years, the Federal Trade Commission has consistently challenged such collective negotiations by independent, competing health care providers because of their harmful effects on competition and consumers.[23] For example, in testimony before Congress regarding a proposed federal antitrust exemption for physician collective bargaining, the Commission detailed the predictable harm to consumers, including higher prices for health insurance coverage, a reduction in benefits as health insurance costs increase, higher out-of-pocket expenses for consumers not covered by insurance, and an increase in the portion of the population that is uninsured.[24]

The Bill further increases the risk of consumer harm because it effectively would require health plans to negotiate with health care providers.[25] This approach would decrease the incentives of health care providers to compete on price and quality, and would make it more difficult for health plans to resist provider pressure for higher fees. It also would threaten the ability of health plans to use selective contracting, a key mechanism for promoting quality and cost-containment goals.[26] As a result, consumers are likely to face significantly increased health care costs.

Furthermore, by immunizing agreements among competing physicians on the fees and other terms they will accept from health plans, the Bill is likely to facilitate other anticompetitive coordinated conduct, such as collusive refusals to deal. For example, while S.B. 3186 would not explicitly authorize providers to strike or boycott health benefit plans,[27] the Commission previously has observed that collective negotiations can convey an implicit threat: if the health plan does not agree to terms acceptable to the physician group as a whole, the plan may be prevented from successfully negotiating agreements with individual members of the group.[28] In the face of antitrust immunity for collective negotiations, this sort of collusive refusal to deal likely would be difficult to detect and prosecute.

c) Market Share Provisions Not Likely To Alleviate Risk of Consumer Harm

S.B. 3186 contains market share provisions purporting to reduce the potential for anticompetitive harm from collective negotiations among competing physicians. It is unlikely, however, that these provisions will be effective in protecting health care consumers.

First, the Bill authorizes health care providers to engage in collective negotiations on fee-related matters only in situations in which a health plan has "substantial market share in a business line."[29] The definition of "substantial market share in a business line" is unclear, however, and therefore will be difficult to implement in practice. Second, although the Bill limits the market share of health care provider negotiating groups, this limit only applies where health plans themselves have a very small share of the market.[30]

With respect to both of these market share provisions, the Bill fails to establish proper antitrust markets from either a legal or economic perspective. A high market share may indicate market power when based upon a properly defined antitrust market, including relevant product and geographic dimensions. Determining proper antitrust markets is among the most difficult issues in antitrust law, and it does not appear to be adequately addressed in the Bill. In addition, although the market share thresholds apparently are designed to offset health plans' market power, the Bill sets market share thresholds much lower than those commonly accepted by courts and others engaged in antitrust analysis. Consequently, the Bill is likely to authorize anticompetitive behavior by health care providers in situations where a health plan does not actually possess market power that would create an imbalance in negotiating leverage.[31]

Furthermore, the Bill would not apply any market power screen to negotiations involving non-fee-related matters. Non-fee matters can have a direct and substantial effect on provider fee levels and the cost of services that the health plan covers.[32] Agreements on non-fee terms also may limit the options available to health plans to meet consumer demand for high-quality and affordable health insurance.

The Bill May Not Create State Action Immunity

The federal antitrust immunity that the Bill purports to confer on collective negotiations by health care providers with health plans is effective only if the State of New York has clearly articulated an intent to replace competition in this area with a regulatory scheme, and then actively supervises this private conduct.[33] The active supervision test seeks to determine "whether the State has exercised sufficient independent judgment and control so that the details [of the restraint] have been established as a product of deliberate state intervention, not simply by agreement among private parties."[34] As explained by the United States Supreme Court in *Patrick v. Burget*, state officials must "have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy."[35] As the Court has made clear, private parties claiming state action immunity face a high bar.

Here, the review scheme contemplated by the Bill may not be sufficient to meet the active supervision prong of the state action doctrine. The health care providers' representative must furnish a copy of all communications related to negotiations, discussions, and offers made by the health care plan,[36] as well as any proposed agreements negotiated pursuant to the Bill.[37] It is unclear, however, to what extent state officials would be allowed to review particular contracts and fee arrangements between groups of providers and health plans to assess whether they comport with state policy goals. Likewise, while the New York Attorney General would be required to monitor agreements approved under this Bill to ensure ongoing compliance and would be allowed to revoke an approval if an agreement violates the goals of the legislation, it is unclear whether the New York Attorney General can fulfill these legislative requirements.

The Bill would impose substantial and ongoing oversight requirements on the New York Attorney General, yet these responsibilities may be difficult for the Attorney General to carry out given the required time frames, fact-intensive nature of the issues, and resources needed for a proper review. The Attorney General would have only 60 days to conduct a substantive competitive review of any agreement arising from collective negotiations.[38] Furthermore, the Bill does not clearly articulate a standard of review or the factors that must be considered by the Attorney General during its review. While the Bill would allow the Attorney General to set fees to cover the cost of administering this legislation, these fees are designated for the New York State Department of Health, *not* the Attorney General's office.[39] Thus, it is unclear whether the Attorney General would have the resources necessary to oversee the regulatory scheme described in the Bill.[40]

Conclusion

Our analysis of S.B. 3186 suggests that its passage would pose a significant risk of increased health care costs and decreased access to care for New York consumers. The antitrust immunity provisions in this legislation are unnecessary and would allow groups of independent health care providers to engage in unsupervised anticompetitive conduct. In summary, FTC staff is concerned that this legislation is likely to foster anticompetitive conduct that is inconsistent with federal antitrust law and policy, and that such conduct could harm New York health care consumers.

We appreciate your consideration of these issues.

Respectfully submitted,

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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 (Commission) or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

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

[3] *See* Federal Trade Commission, Overview of FTC Antitrust Actions in Health Care Services and Products, March 2011 [hereinafter FTC Health Care Overview], *available at* http://www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf.

[4] *See* Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Subcomm. On Courts and Competition Policy, *Antitrust Enforcement in the Health Care Industry*, Dec. 1, 2010; Prepared Statement of the Fed. Trade Comm'n Before the Subcomm. On Consumer Protection, Product Safety, and Insurance, Comm. on Commerce, Science & Transportation, *The Importance of Competition and Antitrust Enforcement to Lower-Cost, Higher-Quality Health Care*, July 16, 2009 (all testimonies *available at* http://www.ftc.gov/ocr/testimony/index.shtml).

[5] *See* FED. TRADE COMM'N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (Jun. 2009); FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005); FED. TRADE COMM'N AND U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (Jul. 2004) [hereinafter FTC/DOJ, A DOSE OF COMPETITION] (all reports *available at* http://www.ftc.gov/reports/index.shtm).

[6] *See* FTC Staff Comment to Senators Eric D. Coleman and John A. Kissel and Representatives Gerald Fox and John W. Hetherington of the Connecticut General Assembly Concerning House Bill No. 6343 to Exempt Certified Health Care Cooperatives From the Antitrust Laws (Jun. 2011); FTC Staff Comment to the Hon. Elliott Naishtat Concerning Texas S.B. 8 to Exempt Certified Health Care Collaboratives From the Antitrust Laws (May 2011); FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009); FTC Staff Comment to Antonio Silva Delgado of the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008); FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008); FTC Staff Comment to the Hon. Lisa Murkowski of the Alaska House of Representatives Concerning Alaska Senate Bill 37 to Permit Collective Bargaining by Health Care Providers (Jan. 2002); FTC Staff Comment to the Hon. Brad Benson of the State of Washington House of Representatives Concerning House Bill 2360 to Permit Collective Bargaining by Health Care Providers (Feb. 2002); FTC Staff Testimony Before the Alaska House of Representatives Concerning Alaska Senate Bill 37 to Permit Collective Bargaining by Health Care Providers (Mar. 2002); FTC Staff Comments to the Hon. Dennis Stapleton of the Ohio House of Representatives Concerning House Bill 325 to Permit Collective Bargaining by Health Care Providers (Oct. 2002); FTC Staff Comment to the Hon. Rene O. Oliveira of the Texas House of Representatives Concerning Senate Bill 1468 to Permit Collective Negotiations by Physicians (May 1999); FTC Staff Comment to Robert R. Rigsby of the District of Columbia Government Concerning Bill No. 13-333 to Permit Collective Bargaining by Physicians (Oct. 1999) (all advocacies *available at* http://www.ftc.gov/opp/advocacy_date.shtm). *See also* Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999," June 22, 1999, *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm.

[7] S.B. 3186 § 4922 (N.Y. 2011).

[8] S.B. 3186 § 4921 (N.Y. 2011). S.B. 3186 would not authorize strikes of health benefit plans by health care providers. S.B. 3186 § 4925 (N.Y. 2011). The statement of legislative intent clarifies that the Bill is not intended to affect collective bargaining relationships involving health care providers who are employees, or rights relating to collective bargaining arising under applicable federal/state collective bargaining statutes.

[9] S.B. 3186 § 4923.1(a) (N.Y. 2011).

[10] S.B. 3186 § 4923.1(c) (N.Y. 2011).

[11] S.B. 3186 § 4924.2 (N.Y. 2011).

[12] S.B. 3186 § 4924.4 (N.Y. 2011).

[13] S.B. 3186 § 4924.7 (N.Y. 2011).

[14] S.B. 3186 § 4924.8 (N.Y. 2011).

[15] S.B. 3186 § 4924.9 (N.Y. 2011).

[16] S.B. 3186 § 4924.10 (N.Y. 2011).

[17] S.B. 3186 § 4927 (N.Y. 2011).

[18] *See* Memoranda in Opposition to S.3186-A (Hannon)/A. 2474-A (Canestrari) from the National Federation of Independent Business (Jun. 22, 2011), Business Council of New York State (Jun. 22, 2011), Iroquois Health Care Alliance (Jun. 22, 2011), Hinman Straub Attorneys at Law on behalf of Blue Cross and Blue Shield Plans of New York (Feb. 7, Jun. 6, and Jun. 21, 2011), Rochester Business Alliance (Jun. 22, 2011), Unshackle Upstate (Jun. 21, 2011), New York Health Plan Association (Jun. 22, 2011), Employer Alliance for Affordable Health Care (Jun. 2011), Coalition of New York Public Health Plans (Jun. 2011), Center for Medical Consumers and New York Public Interest Research Group (Jun. 2011).

[19] *See, e.g.*, U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy In Health Care* (1996) [hereinafter DOJ/FTC, *1996 Health Care Statements*], *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm; TriState Health Partners, Inc., Letter from Markus Meier, FTC to Christi Braun, Ober, Kaler, Grimes & Shriver, April 13, 2009; Greater Rochester Independent Practice Association, Inc., Letter from Markus Meier, FTC to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, Sept. 17, 2007, letters *available at* http://www.ftc.gov/bc/healthcare/industryguide/advisory.htm. *See also* Fed. Trade Comm'n & U.S. Dep't of Justice, *Antitrust Guidelines for Collaborations Among Competitors*, April 2000, *available at* http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf. Most recently, the FTC and DOJ Antitrust Division jointly released a proposed statement explaining how the antitrust agencies will apply U.S. antitrust law to the new Medicare Shared Savings Program Accountable Care Organizations created by the Affordable Care Act of 2010. Fed. Trade Comm'n & U.S. Dep't of Justice, *Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating In the Medicare Shared Savings Program*, *available at* http://www.ftc.gov/opp/aco/index.shtml.

[20] For information about the Federal Trade Commission's advisory opinion process, *see Guidance From Staff of the Bureau of Competition's Health Care Division on Requesting and Obtaining an Advisory Opinion, available at* http://www.ftc.gov/bc/healthcare/industryguide/advop-health.pdf.

[21] The 1996 *Statements of Antitrust Enforcement Policy In Health Care* issued by the Commission and the Department of Justice explain the ways in which antitrust law permits health care providers to collectively provide both fee and non-fee related information to health plans. DOJ/FTC, *1996 Health Care Statements*, *supra* note 19. *See also* Letter to Gregory G. Binford (Feb. 6, 2003) (advisory opinion explaining that physicians' proposed formation of advocacy group to collect and disseminate information about health plan policies and procedures, including fees paid to local physicians compared to fees paid in other areas, did not appear likely to have anticompetitive effects); American Medical Assn., Model Managed Care Contract (4th Ed. 2005), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/368/mmcc_4th_ed.pdf.

[22] There are some studies demonstrating that consolidation among health plans may result in lower prices to consumers for healthcare services. *See, e.g.*, Glenn A. Melnick, Yu-Chu Shen & Vivian Yaling Wu, *The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices*, 30 HEALTH AFFAIRS 1728 (2011), *available at* http://content.healthaffairs.org/content/30/9/1728.full.html. There is, however, no reasonable basis for the assertion that consolidation among health care providers (either physicians or hospitals) would benefit consumers in the form of lower prices. *See, e.g.*, Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power,* Center for Studying Health System Change, Research Brief No. 16 (Nov. 2010), *available at* http://www.hschange.com/CONTENT/1162/; Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFFAIRS 699 (2010), *available at* http://content.healthaffairs.org/content/29/4/699.full; William B. Vogt & Robert Town, *How has hospital consolidation affected the price and quality of hospital care?*, Robert Wood Johnson Found. Synthesis Project, Research Synthesis Rep. No. 9 (Feb. 2006), *available at* http://www.rwjf.org/files/research/no9researchreport.pdf; Cory Capps & David Dranove, *Hospital Consolidation & Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175 (2004), *available at* http://content.healthaffairs.org/content/23/2/175.full.

[23] *See* FTC Health Care Overview, *supra* note 3, at 21-52.

[24] Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999," June 22, 1999, *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm. It is well-recognized that antitrust exemptions routinely threaten broad consumer harm for the benefit of a few. The bipartisan Antitrust Modernization Committee 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." ANTITRUST MODERNIZATION COMMISSION, REPORT AND RECOMMENDATIONS (April 2007) at 335, *available at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[25] Antitrust jurisprudence recognizes a party's long-established right to exercise discretion over with whom it deals. *See* United States v. Colgate & Co., 250 U.S. 300, 307 (1919).

[26] *See* FTC/DOJ, A DOSE OF COMPETITION, *supra* note 5, at 11-12:

> [Managed Care Organizations, hereinafter MCOs] historically relied on three strategies to control costs and enhance quality of care. One is selective contracting with providers that must meet certain criteria to be included in the MCO's provider network. Selective contracting can intensify price competition and allow MCOs to negotiate volume discounts and choose providers based on a range of discounts. When MCOs and other insurers have a credible threat to exclude providers from their networks and send patients elsewhere, providers have a powerful incentive to bid aggressively to be included in the network. Without such credible threats, providers have less incentive to bid aggressively, and even MCOs with large market shares may have less ability to obtain lower prices.

[27] S.B. 3186§ 4925(1) (N.Y. 2011).

[28] The FTC has taken numerous enforcement actions to address situations in which health care providers collectively negotiated prices and other competitively significant terms with health plans and refused to negotiate individually with health plans. In using these tactics, health care providers often were able to extract higher fees and other favorable terms from health plans, thereby raising the costs of and restricting access to health care services for consumers. *See, e.g.,* Southwest Health Alliances, Inc., Dkt. No. C-4327 (F.T.C. Jul. 15, 2011); Minnesota Rural Health Cooperative, Dkt. No. C-4311 (F.T.C. Dec. 28, 2010); Roaring Fork Valley Physicians IPA, Inc., Dkt. No. C-4288 (F.T.C. April 5, 2010); Michigan State Medical Society, 101 F.T.C. 191, 296 n. 32 (1983) ("the bargaining process itself carries the implication of adverse

consequences if a satisfactory agreement cannot be obtained"); Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations). For descriptions of all FTC enforcement actions taken prior to March 2011 that relate to agreements on price or price-related terms in the health care industry, as well as docket links, *see* FTC Health Care Overview, *supra* note 3, at 21-52.

[29] S.B. 3186 § 4922 (N.Y. 2011). The Bill states that "substantial market share in a business line" exists if a health care plan's market share of a business line within a service area exceeds either ten percent of the total number of covered lives in that service area or 25,000 lives, or the New York Attorney General determines that the health plan's market share significantly exceeds the countervailing market share of individual health care providers. S.B. 3186 § 4920.5 (N.Y. 2011).

[30] S.B. 3186 § 4923(2) (N.Y. 2011). The Bill limits the size of health care provider negotiating groups to 30 percent in situations where health plans have less than 5 percent of the market.

[31] Proper market definition allows market participants to be identified, which facilitates the calculation of market shares and market concentration levels. These calculations may be informative of the likely competitive effects of a merger, collaboration, or other type of conduct by market participants, especially in situations where market power is thought to exist. *See, e.g.*, U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 4 (2010), *available at* http://www.ftc.gov/os/2010/08/100819hmg.pdf.

By setting the thresholds at a 10 percent and 5 percent market share, respectively, the Bill would authorize anticompetitive behavior by health care providers in many situations in which the health plan would not actually possess market power. Although the federal courts have not identified a precise market share figure that constitutes market power, the guidance they have provided strongly suggests that 10 percent is not sufficient. *See, e.g., Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984) (rejecting the possibility that a hospital had market power in spite of the fact that it serviced roughly 30 percent of the relevant market); *United States v. Eastman Kodak Co.*, 63 F.3d 95 (2nd Cir. 1995) (finding that 30 percent share of the relevant market was too small to give rise to inference of market power); *New York v. Anheuser-Busch, Inc.*, 811 F. Supp. 848 (E.D.N.Y. 1993) (finding that 40 percent market share was insufficient to show market power in light of low barriers to entry); *Manufacturer's Supply Co. v. Minnesota Mining & Manufacturing Co.*, 688 F. Supp. 303 (W.D. Mich. 1988) (finding that 25.8 percent market share was insufficient to show market power).

[32] For example, health care providers would be allowed to collectively negotiate a number of non-fee terms, including coverage provisions, health care benefits, benefit maximums/limitations, exclusions of coverage, as well as the formulation and application of health care provider reimbursement procedures. S.B. 3186 § 4921(1) (N.Y. 2011).

[33] *Parker v. Brown,* 317 U.S. 341, 351 (1943); *see also Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

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

[35] 486 U.S. 94, 101 (1988).

[36] S.B. 3186 § 4924.5 (N.Y. 2011).

[37] S.B 3186 § 4924.9 (N.Y. 2011).

[38] Based on the experience of FTC staff, investigating physician conduct matters is time- and resource-intensive.

[39] S.B. 3186 § 4926 (N.Y. 2011).

[40] In addition, according to the Bill, the Attorney General must monitor any agreements between health care providers and health plans that are approved under the Bill, and "may revoke an approval upon a finding that the agreement is not in substantial compliance with the terms of the application or the conditions of approval." S.B. 3186 § 4927 (N.Y. 2011). The Bill is silent, however, on what actions the Attorney General might take to remedy anticompetitive effects that have *already* resulted from such an agreement.