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

II. Physician Collective Bargaining

The Commission's opposition to legislation intended to create an antitrust exemption for physician collective bargaining has historically focused on two fundamental points, both of

level. If a health plan possessed actual market power, health care consumers could be doubly harmed by physician collective bargaining, because they could be forced to pay the health care plan's monopoly mark-up on top of the elevated fees charged by the physicians.

B. Quality of Care

Proponents of antitrust exemptions for physicians often suggest that greater physician bargaining power against health plans would result in increased quality of care fo

language was inserted in that order, and in subsequent orders, to make it clear that bans on anticompetitive agreements among competing providers do not prohibit the provision of information and views to health plans concerning any issue, including reimbursement. .(15)

Accordingly, blanket antitrust immunity for physician price-fixing is not necessary to protect patient welfare.

III. The Alaska Bill

Nonetheless, Senate Bill 37, like its federal and state counterparts, seeks to confer antitrust immunity with respect to collective physician conduct. To be sure, Senate Bill 37 also contains a number of provisions designed to protect consumers from the potential harms arising from a physician collective bargaining exemption. In some respects, these provisions resemble protections contained in physician collective bargaining bills introduced in Texas and the District of Columbia, on which the Commission staff also has commented.(16) As with the protections in the Texas and District of Columbia bills, these provisions - addressing a health plan's market power, the size of the physician bargaining group, and potential boycott conduct - do not alleviate the risk of substantial consumer harm resulting from a collective bargaining exemption.

A. Minimum Threshold for Health Plan Market Power

Section (d)(1) of Senate Bill 37 states that physicians may "collectively negotiate with a health benefit plan the items described in (b)" - including fees or prices - provided that the health benefit plan has "substantial market power." "Substantial market power" is defined as "more than 15 percent of the market share." Id. at § (s)(4). Alternative formulas by which market power may be measured are set forth in Sections (f)(1) and (f)(2).

This market power screen is unlikely to guard against consumer harm.

First, the screen does not apply to all collective bargaining by physicians, or even to all price-related bargaining. Rather, it applies only to certain kinds of price-related matters. For example, the market share screen does not apply to negotiations concerning the formulation and application of reimbursement methodology. Id. at § (a)(6). The method a health plan uses to calculate its payments to providers for particular services, however, can have a direct and significant impact on the ultimate price that providers receive for their services, and thus such matters are also "price" terms. Moreover, even 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.

Second, there are significant problems with the concept of health plan market power as defined in the bill. As the Commission staff noted in its comment on the District of Columbia bill:

Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only if based upon a properly defined market. Even if the bill's categories correctly

identified relevant markets, a 15% market share…is not a level ordinarily assumed to constitute market power.(17)

addition, Section (g)(7) authorizes the Attorney General to limit the percentage of practicing physicians represented by an authorized third party. However, the Attorney General may not impose a limit of "less than 30 percent of the market of practicing physicians" and may not impose any limit at all if "the market of practicing physicians…consists of 40 or fewer individuals." Id.

Senate Bill 37 faces severe difficulties under the "active supervision" prong of that test. In order for state supervision to be adequate for state action purposes, state officials must "have and exercise ultimate authority over the challenged anticompetitive conduct."(22) Senate Bill 37 falls far short of providing the "pointed reexamination"(23) of private anticompetitive conduct necessary to confer antitrust immunity.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own."(24) Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties."(25) In this instance, the bill does not appear to provide the Attorney General with the means to exercise sufficient independent judgment and control.

Lack of Active Supervision

The regulatory scheme established by Senate Bill 37 endeavors to provide state supervision of physician collective bargaining by authorizing the Attorney General to approve or disapprove: (1) the composition of a physician collective bargaining group, (2) a brief report on any proposed collective negotiations, and (3) a contract that was the subject of collective bargaining. The Attorney General's role is limited in significant respects, however, making it unlikely that the regulatory scheme would be found to provide the level of active supervision required to confer antitrust immunity.

1. Review of Composition of Physician Groups

The power to approve or disapprove the composition of a physician collective bargaining group is provided by Section (g)(7). This provision states that the Attorney General may limit the percentage of physicians represented by an authorized third party, but that the limitation "may not be less than 30 percent of the market." Furthermore, the Attorney General "shall" consider the potential competitive benefits and anticompetitive effects described in Sections (k) and (l). The Attorney General has no power to impose such limitations when the market of practicing physicians consists of "40 or fewer individuals."

The Supreme Court has emphasized that active supervision requires that state officials "have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy."(26) The Attorney General's limited review of bargaining groups at the formation stage, under Section (g)(7), would not amount to active supervision of "particular anticompetitive acts." Indeed, in a market of "40 or fewer individuals," the Attorney General has no authority whatsoever to review the composition of physician groups. This loophole may be particularly significant in a state like Alaska which, due to its population and its large geographic area, may have a large number of physician specialty markets consisting of 40 or fewer providers.

2. Review of "Brief Report" on Proposed Negotiations

The power to approve or disapprove a "brief report" on any proposed collective negotiations is provided by Section (h)(1)(B). This provision appears to provide the Attorney General with authority to disapprove proposed negotiations if the physician group is found to be "not appropriate to represent the interests involved in the proposed negotiations."(27) It is unclear, however, what authority this actually would confer, or how the Attorney General could make such an assessment on the basis of the limited information that the third party representative is

physicians - would, of course, be better able to make appropriate determinations. An equally troubling omission from the process is any mechanism by which to receive input from other physicians, affected health benefit plans, or patients. Indeed, the process provides no notice to any of these groups, and so no means for them even to be aware of the potential value of their input.

To attempt to ascertain credibly whether "the competitive and other benefits of the contract terms outweigh any anticompetitive effects" - the core stated criterion of the Attorney General's review - without sufficient data, or adequate input from other parties, would be extremely difficult. Making judgments about competitive effects is the Commission's core function. To carry out this function, the Commission employs a large staff of lawyers and economists, who rely on information gathered from the careful review of a complete documentary record and interviews of numerous key witnesses. "Active supervision" need not necessarily entail the same exhaustive examination but, at the very least, it should constitute a pointed and meaningful review.

In addition, Section (h)(3) requires an authorized third party to provide the Atto paawt2(o pa)E(0(g)p")10( )]T2v

5. *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).

6. Docket No. C-4007, 2001 WL 443471 (F.T.C. April 25, 2001) (consent order).

7. Docket No. C-3824, 1998 WL 566834 (F.T.C. August 31, 1998) (consent order).

8. FTC Testimony on H.R. 1304, supra note 2, at 6-7.

9. FTC Testimony on H.R. 1304, supra note 2, at 10.

10. *See* Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (Aug. 1996) ("Health Care Guidelines") available at <http://www.ftc.gov/reports/hlth3s.pdf>. The Health Care Guidelines discuss "messenger model" arrangements designed to minimize the costs associated with the contracting process.

11. *See, e.g.*, Schachar v. American Academy of Ophthalmology, 870 F.2d 397 (7th Cir. 1989); Statements 4-5 of Health Care Guidelines, *supra* note 10.

12. FTC Testimony on H.R. 1304, *supra* note 2, at 7-8 (footnotes 13-15 in original).

13. [The Health Care Guidelines] create an antitrust safety zone for health care providers' collective provision of non-fee-related information to health plans. . . . [See Statement 4 of Health Care Guidelines, *supra* note 10.]

14. 101 F.T.C. [191,] at 302-09 [(1983)].

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

16. Letter to the Texas Legislature on Senate Bill 1468 (May 13, 1999) available at < http://www.ftc. gov/be/v990009.shtm > (Attachment B); Letter to the District of Columbia Office of Corporation Counsel on Bill No. 13-333 (Oct. 29, 1999) ("District of Columbia Letter") available at < http://www.ftc. gov/be/rigsby.shtm > (Attachment C).

17. District of Columbia Letter, *supra* note 16, at 3-4.

of low barriers to entry); Manufacturer's Supply Co. v. Minnesota Mining & Manufacturing Co., 688 F. Supp. 303 (W.D. Mich. 1988) (25.8 percent market share insufficient to show market power).

19. *See* Alaska Healthcare Network, Inc., Docket No. C-4007, 2001 WL 443471 (F.T.C. Apr. 25,

Metro Line Services v. Southwestern Bell Telephone, 988 F.2d 601, 606-