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:

Health care competition is critically important to the economy and consumer

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

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) The Bill Poses a Substantial Risk of Consumer Harm

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.

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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Office of Policy Planning

Joseph Farrell, Director
Bureau of Economics

Richard A. Feinstein, Director
Bureau of Competition

[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

[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

[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

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 situati

[40] In addition, a