Office of Policy Planning
Bureau of Economics
Bureau of Competition

January 30, 2008

Antonio Silva Delgado, President
Treasury and Financial Affairs Commission
Comisión de Hacienda y Asuntos Financieros
Cámara de Representantes de Puerto Rico

Dear Mr. Delgado:

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 that we review and comment on the likely competitive effects of Senate Bill 2190 (S.B. 2190 or the Bill),[2] which would permit collective bargaining for health care providers in Puerto Rico. The Bill would provide for collective bargaining, on behalf of diverse individual and corporate health care service providers, on fees and other matters. In our judgment, such collective bargaining may raise prices for, and thereby reduce access to, health care services, without ensuring better quality care as a countervailing benefit for health care consumers. For those reasons, the Commission has enforced the antitrust laws when certain private groups of health care providers have colluded to fix prices, and the Commission consistently has opposed legislative proposals to exempt from antitrust scrutiny various categories of health care providers. In fact, S.B. 2190 would appear to authorize private parties to engage in actions that normally would be deemed *per se* violations of federal antitrust law, including price-fixing between competitors,

that impede competition without offering countervailing benefits to consumers. For several decades, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[4] The FTC and its staff have issued studies and reports regarding various aspects of the health care industry,[5] and the Commission has brought numerous enforcement actions against entities in the industry that have violated federal antitrust laws.[6] In addition, the FTC and its staff have analyzed competition issues raised by proposed state and federal regulation of health care markets.[7]

More specifically, the FTC has fo

following: competition, regulation, and market entry issues for hospitals, diverse health care professionals and para-professionals; unionization issues for health care service providers; professional vertical and horizontal integration issues; and Medicaid and Medicare issues.[10] In 2004, the FTC and DOJ issued a report based on the hearings, a 2002 FTC-sponsored workshop, and independent research.[11]

Recent law enforcement matters in the Commonwealth of Puerto Rico are illustrative of the FTC's concerns in this area. The Commission recently approved a consent order against an association representing all optometrists in Puerto Rico, along with two of its leaders.[12] The complaint charged the respondents with violating the FTC Act by orchestrating and carrying out agreements among the association's members to refuse, and to threaten to refuse, to deal with payors, unless the payors raised the fees paid to the optometrists. More specifically, the complaint alleged that the Colegio de Optometras, a not-for-profit association of all 500 optometrists licensed to practice in Puerto Rico, led by Dr. Rivera (its president-elect) and Dr. Dávila (its treasurer), joined in a collective effort to force a particular vision plan to increase its reimbursement rates. Among other things, the FTC challenged Dr. Rivera's informing the plan that he had the authority to ne

other matters.[15] Under the Bill, "providers" include individual and corporate providers of health care services, including "all doctors, hospitals, primary care facilities, diagnostic and treatment centers, dentists, laboratories, pharmacies, emergency medical services, pre-hospital services, or any other person authorized in Puerto Rico to provide health care services, whether to groups or individuals, which under contract with a health services organization provides health care services to subscribers or beneficiaries of a health care plan."[16] Under the most-recent Senate draft of the Bill, the size and scope of provider groups that would be permitted to engage in such collective bargaining is limited.[17] S.B. 2190 also stipulates that parties should submit to arbitration certain disputes or impasses that may arise, and it appears to restrict the ability of providers to strike.[18]

B. The Contemplated Collective Bargaining Could Be Anticompetitive and Detrimental to Health Care Consumers.

Since the advent of active antitrust enforcement in health care services markets, health care providers have sought antitrust exemptions in state and federal legislatures. Although varied in certain regards, such proposals have all, at bottom, sought protection from antitrust scrutiny for anti-competitive conduct that would tend to raise the prices of health care services without conferring countervailing benefits on health care consumers. Recognizing that many Americans face difficult health care choices in the market already, the FTC consistently has opposed such proposals. The Commission has enforced the antitrust laws when certain private groups of health care providers have colluded to fix prices,[19] and the Commission has opposed legislative proposals to exempt from antitrust scrutiny various categories of health care providers.[20]

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[15] *See* Draft Article 31.030 (Authorized Collective Bargaining).

[16] *Id.* at Article 31.020.

[17] "Groups or corporations authorized to bargain collectively shall not exceed twenty individuals, or 20% of the providers for that specialty or service in that geographic area, whichever is less." *Id.* at Article 31.030.

[18] *See id.* at Article 31.040 (Method for Resolving Disputes or Impasses in Bargaining) and 31.060 (Prohibition of Specific Joint Actions). In particular, the Bill states that it should not be interpreted as authorizing coordinated stoppages of services and that such stoppages may be subject to federal or state antitrust actions as may be applicable independent of the Bill. *Id.* at 31.060. The Bill also states that the Office of Monopolistic Affairs shall in some fashion supervise the bargaining the Bill seeks to authorize, although it does not specify the criteria under which such bargaining would be evaluated.

[19] *See, e.g.*, In the Matter of Colegio de Optometras de Puerto Rico, *supra* note 6 (price fixing and concerted refusal to deal with vision and health plans by optometrists); In the Matter of Advocate Health Partners, et al., *supra* note 6 (horizontal agreements to fix prices, engage in collective bargaining, and refuse to deal individually with health plans by competing independent physicians and physician practice groups accounting for over 2,900 physicians in Chicago metropolitan area).

[20] *See, e.g.*, Letter from Federal Trade Commission Staff to the Hon. Dennis Stapleton, Ohio House of Representatives (Oct. 164.5(h)3 -1.14gletonpi(d-p30-8.5(h)3028 Tw[0oTf36)3.7(.5t.7(e)8(bl0oTf8l4.2at)6.9(0oTf8l4.-0tc(19)9.

In the FTC staff's judgment, S.B. 2190 raises the same sorts of competition concerns as have those cases and legislative proposals. As the Commission explained in recent testimony before Congress,[21]

> The Commission's experience indicates that the conduct that the proposed exemption would allow could impose significant costs on consumers, private and governmental purchasers, and taxpayers, who ultimately foot the bill for government-sponsored health care programs. Past antitrust challenges to collective negotiations by health care professionals show that groups have often sought fee increases of 20 percent or more.[22] For example, in 1998, an association of approximately 125 pharmacies in northern Puerto Rico settled FTC charges that the association fixed prices and other terms of dealing with third-party payers, and threatened to withhold services from Puerto Rico's program to provide health care services for indigent patients.[23] According to the complaint, the association demanded a 22 percent increase in fees, threatened that its members would collectively refuse to participate in the indigent care program unless its demands were met, and thereby succeeded in securing the higher prices it sought.

In other cases, the Commission has accepted consent orders settling charges that physician collective bargaining forced health plans to raise their reimbursement rates[24] – with the attendant risk of increases in premiums for policy holders.

1999), *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm (regarding federal legislation that would have exempted all health care workers from antitrust scrutiny).

[21] *See* Prepared Statement of the Federal Trade Commission Before the Antitrust Task Force of the H. Comm. the Judiciary, Concerning H.R. 971, *supra* note 7, at 9-10.

[22] *See, e.g.*, Asociacion de Farmacias Region de Arecibo, 127 F.T.C. 266 (1999) (consent order) (22

Although the magnitude of consumer harm can vary according to the particulars of each market, the competition analysis is consistent across different types of health care service providers.[25] Just this year the Antitrust Modernization Commission (AMC) – the body created by Congress to evaluate the application of our nation's antitrust laws – addressed the subject of antitrust exemptions. The AMC urged Congress to exercise caution when considering proposals for new antitrust exemptions, because such exemptions typically "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."[26]

The stated purpose of S.B. 2190 is to "create a competitive equilibrium in contracting health services."[27] In staff's judgment, such attempts at market intervention are unlikely to further competition. In spite of the significant consumer harms that can flow from provider collective bargaining, proponents of collective bargaining exemptions frequently argue that they are necessary to "level the playing field" between, e.g., physicians and health plans. This argument, however, presupposes that providers are at the mercy of monopsony health plans. Even if that were the case – an assumption that has not been demonstrated to be true across the diverse markets at issue here – attempts to counterbalance such monopsony power with a provider cartel would *not* be likely to benefit consumers. If a health plan did possess significant market power, health care consumers could be doubly harmed by provider collective bargaining, as consumers could be forced to bear the brunt of the elevated fees charged by the provider cartel *on top of* any markup already charged by that health plan because of its market power. Without antitrust enforcement to block such price fixing, prices for health care services could rise substantially.

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Antitrust law and the enforcement agencies recognize the risks that can attend undue buyer power, which is known as "monopsony power."[28] In principle, monopsony power enables buyers to depress prices below competitive levels. In response to reduced prices, sellers or providers of goods or services may reduce output, ultimately leading to higher consumer prices, lower quality, or the substitution of less efficient alternative products and services. It is important, however, to distinguish between this potential type of buyer power, which can harm competition and

[25] That is, the competition concerns are analogous across these various markets. The magnitude of potential consumer harm is difficult to predict without detailed analysis of, e.g., market size, market power, conduct, and other factors for particular service provider markets. In addition, it is difficult to estimate the extent to which consumer harm might be mitigated by the Bill's apparent no-strike provision, limitations on the scope or size of bargaining units, or the stipulation of government ovfe B2 Tm.00n 06(f)8of k5i112

This combination – collective negotiation over price and no significant efficiency-enhancing integration – means that the agreement to bargain "will be treated as *per se* illegal price fixing."[33]

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providers to engage in conduct that could expose them to liability under the federal antitrust laws. The state action doctrine – first articulated by the Supreme Court in *Parker v. Brown*[45] – shields certain anticompetitive conduct by the states from federal antitrust scrutiny. Although a legal analysis of the state action doctrine, and its application to S.B. 2190 and private conduct related to the Bill, is beyond the scope of this letter, we note that it is settled law that states cannot immunize private anticompetitive conduct merely by stipulating the application of state action immunity.[46]

Parker represents the Court's reading of the preemptive reach of the Sherman Act,

parties, moreover, are not insulated from antitrust scrutiny merely because a state legislature stipulates their immunity.[54] When a state expresses a policy to displace competition in favor of regulation, but delegates to private parties the implementation of that policy, *Parker* immunity requires establishing that the anticompetitive conduct is sufficiently "the state's own."[55] Two tests are required for that purpose: "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the State itself."[56] Because various health care providers under the Bill are not State employees, collective bargaining by them or their privately elected representatives cannot be immune unless it passes both of these tests. For example, in *California Retail Liquor Dealers Association v. Midcal Aluminum,*[57] California's system for wine pricing was not immune from antitrust scrutiny because the legislature itself did not establish prices, review the reasonableness of price schedules, or engage in any "pointed reexamination" of the program – hence, failing the active supervision test.[58] Although S.B. 2190 states that the Office of Monopolistic Affairs will "supervise and look into" the contemplated bargaining, the Bill specifies neither the process of such supervision nor the criteria under which anticompetitive conduct would be evaluated for possible approval.[59]

Conclusions

providers tends to work to the substantial detriment of health care consumers and is inconsistent with federal antitrust law and policy. The staff is concerned, therefore, that the proposed legislation may raise prices for – and thereby reduce access to – vital

Respectfully submitted,

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