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Opinion No. 00-089

"Health Care Provider Joint Negotiations Act" As Exemption from Antitrust Laws

QUESTIONS

1. Is SB 2672 (HB 2936), the "Health Care Provider Joint Negotiations Act" as currently drafted in violation of state or federal antitrust laws?

2. If SB 2672 (HB 2936) as drafted arguably violates state or federal antitrust laws, can the provisions of the draft Act be amended to bring collective bargaining by health care providers within current state and federal statute and case law under the state action immunity doctrine?

3. If SB 2672 (HB 2936) cannot be amended so as to allow the state action immunity doctrine to apply, what statutes or case law regulate insurance companies and prohibit them from engaging in unfair and anticompetitive conduct in their dealings with health care providers?

OPINIONS

1. While a determination whether conduct violates either state or federal antitrust law is, above all, dependent on an intensive factual and economic analysis of that conduct, the provisions of SB 2672 (HB 2936) do not meet the strict requirements of the state action immunity doctrine as articulated in the United States Supreme Court in numerous cases and, accordingly, the anticompetitive conduct authorized by the legislation would be vulnerable to attack under the antitrust laws.

2. Any legislation seeking to immunize private conduct from scrutiny under federal antitrust law using the "state action" doctrine must first meet the rigorous standards established by the United States Supreme Court. First, the legislation must state unequivocally the policy of the state to substitute regulation by the state for the competitive forces of the marketplace. Second, the state must "actively supervise" the private anticompetitive conduct it seeks to immunize. It is highly doubtful whether SB 2672 (HB 2936) meets both these requirements.

3. The McCarran-Ferguson Act, although granting limited immunity from the antitrust laws to the insurance industry, does not protect health care insurers from *all* otherwise anticompetitive conduct. Except for those limited circumstances outlined in McCarran-Ferguson and as narrowly interpreted by the United States Supreme Court, the same state and federal antitrust laws that apply to other industries apply to health care insurers.

ANALYSIS

Summary of SB 2672

SB 2672 would allow competing health care providers to engage in joint negotiation and "engage in related joint activity" with health care insurers. In doing so, the bill would grant immunity to *all* licensed health care providers[1] in the State of Tennessee from liability under state antitrust law and purports to do so under federal antitrust law.[2] The grant of immunity is bolstered through use of the so-called "state action doctrine," a recognized exception to the antitrust laws for more than 60 years.

The legislation establishes two categories of matters regarding which independent health care providers are allowed to jointly negotiate with health care insurers: 1) nonfee-related matters, and, 2) fee-related matters. Section 5 of the bill sets forth 13 subjects[3] characterized as nonfee-related and about which health care providers may negotiate with any health care insurer. These include such

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[1] Section 4(6) of the bill defines health care provider as "a licensed hospital or health care facility, medical equipment supplier or person who is licensed or certified or otherwise regulated to provide health care services under the laws of this state, including but not limited to, physician, dentist, podiatrist, optometrist, pharmacist, osteopath, psychologist, chiropractor, physical therapist, certified nurse practitioner or nurse midwife."

[2] These statutes include the Sherman Act, 15 U.S.C. §§ 1-7; the Clayton Act, 15 U.S.C. §§ 12-27; the Federal Trade Commission Act, 15 U.S.C. §§ 41-51, and the Tennessee Trade Practices Act, Tenn. Code Ann. 47-25-101 *et seq.*

[3] The nonfee-related matters that may be negotiated under Section 5 of the legislation include, *but are not limited to*, the following:

(1) The definition of medical necessity and other conditions of coverage.
(2) Utilization review criteria and procedures.
(3) Clinical practice guidelines.
(4) Preventive care and other medical management policies.
(5) Patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals.
(6) Drug formularies and standards and procedures for prescribing off-formulary drugs.
(7) Quality assurance programs.
(8) Respective health care provider and health care insurer liability for the treatment or lack of treatment of plan enrollees.
(9) The methods and timing of payments, including, but not limited to, interest and penalties for late payments.
(10) Other administrative procedures, including, but not limited to, enrollee eligibility verification systems and claim documentation requirements.
(11) Credentialing standards and procedures for the selection, retention and termination of participating health care providers.
(12) Mechanisms for resolving disputes between the health care insurer and health care providers, including, but not limited to, the appeals process for utilization review and credentialing determination.
(13) The health insurance plans sold or administered by the insurer in which the health care providers are required to participate.

matters as the definition of medical necessity, utilization review and clinical practice guidelines. The fee-related matters[4] would allow health care providers to negotiate collectively and "engage in related joint activity" with health care insurers "with substantial market power"[5] regarding such items as including the amount of payment and its methodology, the amount of discount and the like.[6] In order to determine which health care insurers enjoy "substantial market power" the Commissioner of the Department of Commerce and Insurance each year must calculate "the number of covered lives of each health care insurer and its affiliates."[7]

In both instances, i.e., nonfee-related and fee-related matters, the legislation requires a petition to and approval from the Attorney General before any negotiations between health care providers and health care insurers may take place. The petition filed with the Attorney General must contain certain basic information, including "a statement of procompetitive and other benefits" of the negotiations. The Attorney General must approve or disapprove the petition within 60 days of the filing, which, if disapproved, must include "a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies may be corrected."[8] Additionally, any contract between health care providers and health care insurers negotiated under SB 2672 also must

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[4] Section 6 of the bill provides that the following fee-related matters may be subject to joint negotiation:

> (1) The amount of payment or the methodology for determining the payment for a health care service.
> (2) The conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care services.
> (3) The amount of any discount on the price of a health care service.
> (4) The procedure code or other description of the health care service or services covered by a payment.
> (5) The amount of a bonus related to the provision of health care services or a withhold from the payment due for a health care service.
> (6) The amount of any other component of the reimbursement methodology for a health care service.

This is not an all-inclusive list, however, since the bill utilizes the familiar "but not limited to" language.

[5] Section 7 of the bill provides that a health care insurer possesses substantial market power over health care providers when:

> (1) the insurer's market share in the comprehensive health care financing market or a relevant segment of that market, alone or in combination with the market shares of affiliates, exceeds either fifteen percent (15%) of the covered lives in the geographic service area of the providers seeking to jointly negotiate or twenty-five thousand (25,000) covered lives; or
> (2) the attorney general determines that the market power of the insurer in the relevant product and geographic markets for the services of the providers seeking to jointly negotiate significantly exceeds the countervailing market power of the providers acting individually.

[6] The legislation imposes neither a minimum nor a maximum number of physicians who may engage in joint negotiations.

[7] Section 7(d).

[8] SB 2672, Section 10(a).

be approved by the Attorney General following the filing of a separate petition by the health care providers and the health care insurers, and such approval or disapproval must occur within 60 days.[9] With certain exceptions, the Attorney General must follow the provisions of the Uniform Administrative Procedures Act.[10]

SB 2672, the Sherman Act and the Federal Trade Commission Act

Based on our review of the SB 2672 and of the current state of antitrust law under the state action doctrine, we do not believe that the provisions of this legislation provide health care providers with the desired immunity from enforcement action under federal antitrust law. Current law, both statutory and case law, does not prohibit health care providers, including physicians, from negotiating with health care insurers in those situations in which there exists a demonstrable benefit to consumers.

In 1993, 1994 and 1996, the two federal agencies charged with enforcement of federal antitrust laws, the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ") issued a series of Statements of Antitrust Enforcement in Health Care.[11] These Statements initially addressed six areas of mergers and other joint activities affecting the health care industry in light of the evolution then occurring under managed care. The Statements have been expanded to a total of nine and each includes so-called "antitrust safety zones" and a DOJ/FTC analysis of the Statement.[12] SB 2672 authorizes conduct well outside the scope of that permitted by the Statements and case law, and by

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[9] SB 2672, Section 10.

[10] Tenn.CodeAnn. Title 4, Chapter 5.

[11] *See* Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,151.

[12] Statement 4 allows competing health care providers to provide non-fee-related information to purchasers with the purpose of influencing "the terms upon which the purchaser deals with the providers." The Statements establish an "antitrust safety zone" for this collective activity where the intent is to resolve "issues relating to the mode, *quality*, or efficiency of treatment." (Emphasis added). Likewise, Statement 5 allows competing health care providers to provide "factual information concerning the fees charged currently or in the past for the providers' services, and other factual information concerning the amounts, levels, or methods of fees or reimbursement." Statement 5 establishes an antitrust safety zone for fee-related information similar to that established in Statement 4 for non-fee-related information.

Statement 5 also provides guidance as to the type of collective activity DOJ and the FTC believe falls *outside* the zone of protected activity.

> "The safety zone set forth in this policy statement does not apply to collective negotiations between *unintegrated* providers and purchasers in contemplation or in furtherance of any agreement among the providers on fees or other terms or aspects of reimbursement, or to any agreement among *unintegrated* providers to deal with purchasers only on agreed terms. Providers also may not collectively threaten, implicitly or explicitly, to engage in a boycott or conduct, to coerce any purchaser to accept collectively-determined fees or other terms or aspects of reimbursement. *These types of conduct likely would violate the antitrust laws and, in many instances, might be per se illegal.* (Emphasis added). (Footnote omitted).

its terms seeks to immunize conduct that would allow price fixing, collusion, boycotts and other concerted activities that we believe constitute violations of federal antitrust law. These activities fall within the scope of conduct prohibited by §§ 1 and 2 of the Sherman Act and § 5 of the FTC Act, to which both civil and criminal liability attach.

Market Share As Sole Indicator of "Substantial Market Power"

Nonfee-Related Matters

The legislation limits joint negotiation regarding fee-related matters to those health care insurers with "substantial market power." This limitation, however, does not allay our concerns regarding the scope of those matters the legislation defines as nonfee-related. A number of the items that health care providers may negotiate pursuant to Section 5 of the legislation relate, either directly or indirectly, to the cost of providing health care services and, accordingly, may increase that cost to the health care insurers who in turn will pass those additional costs on to the individual patient through higher premiums, higher co-pay or less reimbursement.

For instance, in Section 5 health care providers are authorized to negotiate jointly with health care insurers regarding "drug formularies and standards and procedures for prescribing off-formulary drugs." One way health care insurers typically attempt to contain their overall costs is to limit their drug costs through restrictions placed on the drugs physicians are allowed to prescribe. This limitation is manifested through the publication of an insurer's "formulary" or list of drugs it permits its member physicians to prescribe. Naturally, a health care insurer will permit only the lowest cost drugs to be a part of its formulary. While all these drugs first require approval from the United States Food and Drug Administration ("FDA"), legitimate medical differences may arise between insurer and physician as to whether a certain drug or class of drugs is the therapeutic equivalent of another.

Fee-Related Matters

Although the legislation further attempts to limit joint negotiations by requiring a health care insurer to possess "substantial market power" before health care providers may jointly negotiate fee-related matters with health care insurers, doing so does not diminish our concern about the risk to which this provision exposes consumers, i.e., that prices would increase without a demonstrable corresponding increase in efficiency or quality of care.

Under traditional antitrust analysis, economists and antitrust enforcement officials use a two-step process to determine whether a particular group of sellers or buyers possesses market power. As with all antitrust analysis, these determinations are extremely fact specific. First, one defines the *product* market, that is to say, delineates the products that genuinely compete against one another. For instance, in attempting to determine whether a certain automobile manufacturer possessed market power, most analysts would probably not consider a Yugo and a Lincoln Continental to be competing products since most buyers do not consider these two products to be substitutable. In the case of SB 2672, the product market is defined as the "comprehensive health care financing market

or a relevant segment of that market."[13] While under some fact scenarios this definition may accurately describe the product market in the health care insurance industry when describing the product market, case law does not arbitrarily allow such expansive definitions. *See*, e.g., *Ball Memorial Hospital v. Mutual Hospital Insurance Co.*, 784 F.2d 1325 (7th Cir.1986); *Reazin v. Blue Cross & Blue Shield of Kansas, Inc.*, 899 F.2d 951 (10th Cir.1990), cert denied 497 U.S. 1005 (1990), and *U.S. Healthcare v. Healthsource*, 986 F.2d 589 (1st Cir.1993).

The second step is to define the *geographic* market in which the firm conducts business. The purpose in doing so is to determine as accurately as possible the extent to which a firm with a defined product is able to control the sale or purchase of that product before the consumer either will substitute the product with another (in the case of health care, often an impossibility) or travel outside the geographic region to purchase the product at a lower price. The distance a consumer is willing to travel to obtain the same or identical product at the same or lower price in effect defines the geographic market for that product. Traditionally, case law has required substantially more than a 15% market share in order for a court to conclude that the firm is able to exercise market power. [14]

The bill's use of "substantial market power" and its definition do not comport with the traditional concepts of market power, either in the legal or economic sense. In the case of SB 2672, the product market is arbitrarily defined as the "comprehensive health care financing market or a relevant segment of that market" together with "fifteen percent (15%) of the covered lives in the geographic service area of the providers seeking to jointly negotiate or twenty-five thousand (25,000) covered lives . . ."[15] Only if the foregoing criterion is not met is the Attorney General permitted to determine whether or not a health care insurer has substantial market power.

As has been recently noted by the FTC when asked to comment on very similar legislation in the District of Columbia,

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[13] Section 7(a)(1) . This definition constitutes the broadest possible definition of the health care financing market. For obvious reasons, in antitrust enforcement, the target industry or business always seeks the broadest definition of product market as possible, while antitrust enforcement officials attempt to narrow the product market definition.

[14] For an economic discussion of market power in the context of monopolization, *see* Sullivan and Hovenkamp, ANTITRUST LAW, POLICY AND PROCEDURE (3d Ed.), The Michie Company (1994), Ch. 6(II)(A.). For one of the United States Supreme Court's most significant statements regarding the economic underpinnings of market power, *see United States v. E.I. du Pont de Nemours & Co.* (*"Cellophane"*), 351 U.S. 377 (1956).

[15] Section 7 (a) (1)

> [m]arket 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.[16]

We do not believe the attempt in SB 2672 to define "substantial market power" takes into account the many factors used by economists, antitrust enforcement officials and the courts to determine whether or not a particular firm has market power as that term is traditionally used. Accordingly, we believe this legislation would not be accorded the deference it seeks from federal antitrust enforcement officials in order to immunize physicians and other health care providers from antitrust scrutiny.

SB 2672 and the State Action Doctrine

This legislation further seeks to protect physicians and other health care providers from antitrust liability through use of the so-called "state action immunity" doctrine. This court-created rule first arose almost 60 years ago when the United States Supreme Court in *Parker v. Brown*[17] held that a state is permitted to decide as a policy matter that regulation is better than competition and that it may supplant the competitive forces of the marketplace with a regulatory structure.

The Court had under consideration a California marketing plan for raisins that directed the use to which raisin farmers could make of their crops. This, in effect, resulted in a scheme of price-fixing. The Court found that based on the principles of federalism and the lack of language in the Sherman Act restricting state activity, the Sherman Act allows a state, its officers and its agents to engage in "activities directed by its legislature",[18] even though such activities would violate the antitrust laws if engaged in by private parties.

Later cases have established two criteria that must be met before a state is allowed to override the antitrust laws. First, the legislature or other governing body must clearly articulate a policy to replace competition with regulation. Second, state officials must "actively supervise" the private anticompetitive conduct.[19] It is the requirement of "active supervision" that has resulted in the most discussion by the Supreme Court and the one which we find most lacking in SB 2672.

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[16] *United States v. E.I. du Pont de Nemours & Co.*, *supra* note 13. Letter dated October 29, 1999, from Richard A. Feinstein, Assistant Director, Bureau of Competition, Federal Trade Commission to Robert R. Rigsby, Interim Corporation Counsel, Government of the District of Columbia.

[17] 317 U.S. 341 (1943).

[18] *Parker*, *supra* at 317 U.S. 350-51.

[19] *See California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 92 (1980), *Patrick v. Burget*, 486 U.S. 94 (1988) and *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S. 621 (1992).

As the F.T.C. recently noted in commenting on similar legislation pending in the District of Columbia:

> 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." It is not met where the reviewing state official does not evaluate the substantive merits of the private action. Thus, the Court has held that a state did not actively supervise price arrangements when it did not establish the prices, review the reasonableness of prices, monitor market conditions, or engage in any "pointed reexamination" of the program. 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."[20]

We do not believe that the duties imposed on the Commissioner of Commerce and Insurance to determine those health care insurers with market power, which duties are essentially ministerial in nature, or the duties imposed on the Attorney General in SB 2672 meet those standards articulated above or the standards set forth by the Supreme Court in its most recent pronouncements on the subject. The reasons we find the required "active supervision" lacking are as follows.

First, Sections 9(a) and (b) of the legislation limit the information provided to the Attorney General to nine specific items, leaving it to the physicians or other health care providers to decide how much information to provide the Attorney General in their petition to engage in joint negotiations.[21] The legislation does not grant the Attorney General the authority to seek additional information. Second, the legislation allows the physicians or other health care providers to establish the criteria under which the Attorney General must either approve or disapprove the petition.[22] Third, rather than allowing the Attorney General to engage in traditional forms of factual and economic analysis, the legislation permits the physicians or other health care providers to establish the product and geographic markets and to determine whether or not a health care insurer has substantial market power .[23]

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[20] Letter from Richard A. Feinstein, *supra* note 15. *Patrick*, *supra* note 18 at 106; *Midcal*, *supra* note 18 at 105-106, *Ticor*, *supra* note 18 at 634-635.

[21] Section 9(a)(9) of the bill provides that those wishing to engage in joint negotiations submit "[S]uch other data, information and documents that the *petitioners* desire to submit in support of their petition." (Emphasis added).

[22] Section 9(a)(5) provides that the petitioners include "[t]he proportionate relationship of the health care providers to the total population of health care providers in the relevant geographic service area of the providers by providers by provider type and specialty."

[23] As we have discussed previously, we do not believe that SB 2672 properly articulates the standards for determining either the product market or the geographic market. As a result, the resulting conclusions regarding whether a health care insurer has market power is suspect. Section 9(a)(6) of the bill provides that where the joint negotiations

Following the Attorney General's approval for physicians and other health care providers to engage in joint negotiations, the Attorney General next must review the terms of any contract resulting from these joint negotiations.[24] The standards under which the Attorney General must review such a contract consist of criteria established for anticompetitive conduct historically utilized for "rule of reason" cases, when in fact the physicians or other health care providers have clearly engaged in conduct that would otherwise constitute *per se* violations of the antitrust laws. The inadequacy on its face of any genuine oversight and review by the Attorney General or other state official makes it highly unlikely that the nominal review process set forth in SB 2672 meets the stringent "active supervision" test set out in *Parker* and its progeny. By the terms of the legislation the Attorney General is presented with a previously-negotiated contract and asked to either approve or disapprove it. No provision exists in the legislation for the Attorney General or other state official to establish prices for health care services, review the reasonableness of those prices, monitor market conditions or otherwise engage in the "pointed reexamination" of the contract contemplated in *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 92 (1980). Throughout the Attorney General's review process, there exists no independent judgment and control over the terms of any jointly-negotiated contract between providers and insurers that would establishes that rates, prices or other contractual terms are the product of deliberate state intervention.

Those who seek immunity from antitrust scrutiny based on the state action doctrine bear the burden of showing that they are entitled to that immunity. We believe that this legislation does not establish an adequate regulatory scheme actively supervised by the Attorney General or other state official to meet the requirements the Supreme Court has established. Physicians and other health care providers who rely on the provisions of this bill to provide them with antitrust immunity, were SB 2672 to become law undoubtedly would expose themselves to the potential of substantial financial and criminal liability for their actions.

Health Care Insurers and the Antitrust Laws

In any discussion involving the perceived imbalance between and among health care insurers, physicians and other health care providers, there arises the issue of the insurance industry's "exemption" from antitrust laws as a result of the McCarran-Ferguson Act.[25] This imbalance, if it exists at all, does not exist as a result of McCarran-Ferguson, but the widely-held misconception

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contemplate discussions regarding fee-related terms the petition to the Attorney General shall include "a statement of the reasons why the health care insurer has substantial market power over the health care providers."

[24] Section 9(c) provides that "[n]o provider contract terms negotiated under this act shall be effective until the terms are approved by the attorney general." Of significance for purposes of state action analysis, the Attorney General does not participate in these negotiations.

[25] 15 U.S.C. §§ 1011-1015.

nonetheless exists that the insurance industry does indeed enjoy such an exemption. As a leading health law treatise notes in discussing McCarran-Ferguson:

> This statutory exemption provides that the Sherman, Clayton and FTC Acts are only "applicable to the business of insurance to the extent that such business is not regulated by State law. Thus as long as an activity that would otherwise violate the antitrust laws (e.g. price fixing) is part of the "business of insurance" and authorized and regulated by the state, it is immune from attack. The Supreme Court has interpreted the "business of insurance" requirement strictly, holding that insurers' provider contracts that did not involve "spreading and underwriting of a policyholder's risk" were not exempt. The exemption does not apply to acts of "boycott, coercion, or intimidation."[26]

Despite this limited exemption, the United States Supreme Court has held that McCarran- Ferguson does not exempt all insurers' dealings with health care providers. For instance, McCarran-Ferguson does not provide immunity from antitrust scrutiny for provider agreements,[27] peer review[28] and exclusion of non-physician providers.[29]

More recently, the Antitrust Division of the Department of Justice has challenged contractual provisions imposed on dentists in Rhode Island[30] and certain hospitals in the Cleveland, Ohio, area.[31] Only last month the FTC challenged the conduct of an independent practice association ("IPA") in Texas which had collectively refused to deal with health plans, resulting in increased surgical fees of more than $1,000,000.[32] The federal government took these actions based on its determination that the challenged practices were resulting in higher costs and fewer choices for consumers of health care services.

In summary, except for those limited circumstances outlined in McCarran-Ferguson as narrowly interpreted by the United States Supreme Court, the same state and federal antitrust laws that apply to other industries apply to health care insurers.

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[26] Furrow, Greaney *et al.* HEALTH LAW, Vol. 1 § 10-2d, West Publishing 1995. (Footnotes omitted).

[27] *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

[28] *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982).

[29] *Hartford Fire Insurance Co. v. California*, 504 U.S. 764, 113 S.Ct. 2891 (1993).

[30] *U.S. v. Delta Dental of Rhode Island*, 943 F.Supp. 172 (D. Rhode Island 1996).

[31] *U.S. v. Medical Mutual of Ohio, Inc.*, No. 1:98-CV-2172, (N.D. Ohio 2000).

[32] *In the Matter of Texas Surgeons, P.A., et al.*, F.T.C. Docket No. _____, (available at www.ftc.gov/os/2000/04/texasd&o.htm.

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