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RE: AN ACT to amend the public health law, in relation to requirement for collective negotiations by health care providers with certain health benefit plans

A. 2474 (Canestrari)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The Blue Cross and Blue Shield Plans of New York strongly oppose enactment of this bill, which would provide for "collective negotiation" by physicians and other health care providers. Although this legislation purports to create new authority to permit physicians to collectively negotiate with payers, it is actually a transparent attempt to exempt physicians from the New York's anti-trust laws and unfairly empower physicians in negotiating with health plans. Last year's iteration of this bill at least provided for some measure of oversight and monitoring of these negotiations by the Attorney General. The current version of the bill deletes that requirement, further exacerbating the potential for abuse by physicians seeking to enhance their compensation through collective negotiation.

1. ESSENTIAL CONSUMER PROTECTION DEVICES ARE MISSING FROM THIS BILL.

This bill would eviscerate current antitrust laws that are designed to protect consumers from unfair collaboration between health care providers. For example:

No quality control. Under existing antitrust law, physicians may bargain collectively if there is sufficient "clinical integration" – which can take the form of uniform quality improvement controls or a single quality assurance program. This bill includes no such restriction, permitting physicians to collaborate for one purpose: increasing their revenue.

No controls over price-fixing. Essentially, this bill would permit physicians and health care providers to determine their own levels of reimbursement, as a health plan faced with a multi-discipline negotiating coalition would have little choice but to accept the coalition's terms. This bill provides no protection against exorbitant price-setting by providers.

No protection against anti-competitive "spillover". Existing antitrust law prohibits communication between competitors regarding prices. This bill would alter such protections, permitting competing health care providers to communicate freely with each other regarding reimbursement matters. In the event that an agreement between the providers is disapproved, there is no way of "undoing" the anti-competitive impact of these communications.

2. THE NEW YORK STATE ATTORNEY GENERAL HAS ALREADY OPINED THAT THIS BILL WOULD VIOLATE FEDERAL ANTITRUST LAW.

The Attorney General, writing in opposition to this legislation on June 14, 2000, opined that a State may only displace federal antitrust law where a two-pronged test articulated by the U.S. Supreme court is satisfied. The test, known as the state action doctrine, requires (1) a clear and express articulation by the State of the intent to displace competition with regulation; and (2) active supervision by the State of the regulatory scheme. The opinion offered by the Attorney General's Office is that this proposed legislation fails **both** prongs of this test. (See letter to Assemblyman Canestrari from Assistant Attorney General Kathy Bennett, Bureau Chief Legislative Bureau, dated June 14, 2000).

Under the provisions of this bill, two things are clear: (1) The bill is designed mainly to serve the financial interests of providers; and (2) there are no specific provisions of the bill which would afford state officials the ability to have or exercise the power to review **particular anticompetitive acts** that would rise to the level of "active supervision" as defined by the Supreme Court in Patrick.

Likewise, in F.T.C. v. Indiana Federation of Dentists, 476 U.S.447 (1986), the Supreme Court stated "Anticompetitive collusion among private actors, even when the goal is consistent with state policy, acquires antitrust immunity only when it is actively supervised by the state." Under this bill, the Commissioner of Health has only the power to disapprove a report identifying the subject of the negotiations and the benefits to be received, which is simply not sufficient regulatory involvement to satisfy the Supreme Court.

This bill does not establish a regulatory scheme requiring negotiation and prescribing limitations. Instead, it provides a broad outline of what can be collectively negotiated and simple reporting requirements leaving the state's already troubled health care system subject to dangerous restraints on competition. Clearly, this loose system of regulation and oversight is not what the Supreme Court intended to suffice for the state-action doctrine as elucidated in the aforementioned cases.

3. THIS BILL DEPARTS FROM GENERALLY ACCEPTED PRINCIPLES OF ANTITRUST LAW AND THE JOINT RECOMMENDATION OF THE FEDERAL TRADE COMMISSION AND THE DEPARTMENT OF JUSTICE.

This legislation is completely contrary to a July 2004 report issued by the Federal Trade Commission and the Department of Justice. In that report, the agencies state that "[g]overnments should not enact legislation to permit independent physicians to bargain collectively.: *See* Improving Health Care: A Dose of Competition, A Report by the Federal Trade Commission and the Department of Justice,

July 2004, Executive Summary at 23. They predict that "physician collective bargaining will harm consumers financially and is unlikely to result in quality improvements." *Id.* Finally, it explains how competition can lead to lower prices and higher quality, but that regulation interferes with obtaining these desirable results. *See id.* at 5. Consequently, this proposed legislation is inconsistent with generally accepted antitrust principles and ignores the recommendations of a recent Federal Trade Commission and Department of Justice report.

4. THIS BILL IS UNNECESSARY IN LIGHT OF EXISTING NEW YORK AND FEDERAL ANTITRUST LAW.

Existing law permits health care providers of all professions to form an organization for many purposes including collective negotiation with insurers, health maintenance organizations, and other payors. These organizations are commonly known as independent practice associations, or IPAs. IPAs can negotiate collectively with payors on behalf of all members, and can also negotiate to perform certain administrative functions on behalf of the payor such as claims processing or credentialing. In cases where IPA models are not permitted (for example, contractual arrangements with indemnity insurers), a "messenger model" could be used to negotiate essential elements of the contract, or the providers could form a joint venture in which there is sufficient clinical and financial integration to justify collaboration on fees.

There is no need for additional legislation for providers to be able to bargain collectively because they are already able to do so under the existing law. Moreover, the existing models for collective bargaining include all of the consumer protection provisions that this bill would sweep away.

5. SIMILAR RELAXATIONS OF FEDERAL ANTITRUST LAWS IN OTHER STATES HAVE PROVEN HARMFUL TO CONSUMERS

The Federal Trade Commission (FTC) has intervened numerous times in situations where independent contractor physicians practiced collective negotiation tactics similar to those proposed by this legislation in order to curb the dangerous effect that they had on the surrounding health care community. The most recent edition of a report by the Federal Trade Commission Bureau of Competition, Overview of FTC Antitrust Actions In Health Care Services and Products, (Mar. 2010), details dozens of examples of such activity and identifies significant increases in health care costs as a result. For example, in the case of Southeastern New Mexico Physician's IPA (138 F.T.C. 281 – 2003), the FTC found that physician reimbursement in New Mexico for various services was typically between 120% and 140% of Medicare's Resource Based Relative Value System (RBRVS). However, due to the price fixing tactics employed by the groups in question, which are precisely what this bill would permit, rates in this particular part of New Mexico were typically over 200% RBRVS and at times topped 250% RBRVS. The FTC found the group's "joint negotiation of fees and other competitively significant contract terms has not been, and is not, reasonably related to any efficiency-enhancing integration" and therefore is unjustified. The FTC takes a similar position over and over with respect to price-fixing for no purpose other than to increase physicians' reimbursement rates at the detriment of consumers.

6. THIS BILL WILL RAISE HEALTH CARE COSTS, RESULTING IN HIGHER PREMIUMS AND AN INCREASE IN THE NUMBER OF UNINSURED NEW YORKERS.

A study performed by the Health Insurers Association of America analyzed similar federal physician collective bargaining legislation and determined that it would raise premiums by 6% to 11%. These costs, like any other costs, would be paid for by purchasers of health insurance coverage. From 2001-2005 there has been a steady decline in employment-based health coverage throughout the state. In upstate New York, there was a 2.2% drop in employment based coverage between 2001-2005 and a 1.3% drop statewide as a result of rising premiums. Doing away with the Federal antitrust restriction on providers would have a devastating effect on the already falling percentage of employer-based coverage in the state. Collective bargaining by providers would lead to sharp increases in premiums forcing many employers to increase employee contributions or being forced to eliminate their employee coverage altogether. Employees would have to choose between paying the substantial increases in health care premiums or joining the millions of New Yorkers' that are uninsured.

In a letter to the American Association of Health Plans, John Sheils, Vice President of the Lewin Group, explained:

> Various studies have shown that employer coverage is sensitive to the price of insurance. The available literature indicates that an increase in the price of insurance is typically associated with a reduction in the proportion of workers who have coverage. . . . Thus, in our estimates, each one-percent increase in private insurance premiums will be associated [nationally] with an increase in the number of persons without insurance of about 400,000 persons.

In New York, the number of uninsured has reached crisis levels. A February 2000 study by the Commonwealth Fund found that more than one in four (28%) New York City residents are uninsured, a rate that is 50% higher than the national average. Statewide, the uninsured rate has reached 19.8% for adults aged 18-64 (U.S. Census Bureau, 2005). Tellingly, a 1996 study (Donelan) showed that 64% percent of the uninsured cite high costs as the reason for having no insurance coverage.

By driving up health care costs, this bill will contribute to the growing number of uninsured New Yorkers. Physicians who earn, on average, nearly $200,000 a year should not be given additional leverage to increase their income at the expense of working people. Legislative efforts should be directed at reducing, not increasing, the number of uninsured.

For these reasons, we strongly oppose enactment of this bill.

Respectfully submitted,

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