

DESPERATE DOCTORS AND ANTITRUST LAWS: THE BEST WAYS FOR LAWMAKERS TO SIMULATE PHYSICIAN COLLECTIVE BARGAINING

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I. INTRODUCTION

Not only do rising health insurance premiums make us cringe¹—so do the mistakes of overworked doctors who are trying to make ends meet in the face of a broken healthcare financing system. The unfairness in healthcare financing—that is, the stranglehold that a few powerful insurance companies often wield over doctors’ reimbursements—has prompted some creative solutions, including two recent bills in the California Legislature² and one in the New York Assembly.³ The bills aimed to loosen healthcare antitrust laws and give physicians greater bargaining power against insurance companies.

Currently, physicians cannot collectively bargain, so their legal choices for improving profits⁴ include: garnering better contract terms through personal negotiation, banding together to use federally approved methods,⁵ or squeezing in more patients per day.

The prospect of doctors over-scheduling to see more patients each day has lawmakers worried. In a recent example of why that worry is justified, “assem-

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¹ Healthcare spending made up 16 percent of the gross domestic product of the United States in 2006, and the U.S. government expects that ratio to increase to 19.5 percent in 2017—at a cost of \$4.3 trillion per year. OFFICE OF THE ACTUARY, CENTERS FOR MEDICARE & MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURE PROJECTIONS 2007-2017 1 (2008).

² Assem. 2839, 2007-08 Leg., Reg. Sess. (Cal. 2008); S. 1300, 2008 Leg. (Cal. 2008).

³ Assem. A04301A, 2009-10 Leg., Reg. Sess. (N.Y. 2009).

⁴ Physicians are driven to increase profits because of unsatisfactory reimbursement rates from insurance companies. *See, e.g.*, THE PHYSICIANS’ FOUNDATION, THE PHYSICIAN’S PERSPECTIVE: MEDICAL PRACTICE IN 2008, at 3 (2008), available at http://www.mcms.org/downloads/PF_Report_Final.pdf.

⁵ See ABA SECTION OF ANTITRUST LAW, ANTITRUST IMMUNITY LEGISLATION FOR HEALTH CARE PROVIDERS 7 (2000) for a summary of how individual physicians may use joint ventures or mergers, as long as they do not lead to antitrust violations such as “price fixing, group boycotts, market division, [and] monopolization.”

bly-line,”⁶ cost-cutting practices at a Las Vegas endoscopy clinic led practitioners to infect six patients with hepatitis C.⁷ The six hepatitis C cases represented a substantial increase from the normal amount of such cases reported in Clark County—about two per year.⁸ Clinic staffers dipped dirty syringes into vials of medicine, contaminating the medicine, and then administered the contaminated medicine to patients.⁹ Using those unsafe practices for four years, the clinic rushed through fifty to sixty colonoscopies or endoscopies per day, five days a week.¹⁰ As a result of these actions, all patients at the Endoscopy Center of Southern Nevada between March 2004 and January 2008 were urged to undergo hepatitis tests.¹¹

Recognizing the importance of sound healthcare—but wary about upsetting the competitive markets—this country has made efforts in the past ten years to adjust or work around the antitrust doctrines governing doctors.¹² More recently, in 2008, California lawmakers suggested that the state prohibit the confidentiality clauses that insurance companies attach to the provider reimbursement contracts.¹³ Generally, those confidentiality clauses keep doctors from sharing their reimbursement arrangement with other doctors. In 2009, a New York bill aimed for a different approach: to straightforwardly allow physician collective bargaining on reimbursement rates.¹⁴ However, the New York proposal restricted collective bargaining to situations where a single insurance company had a “substantial market share,” in which case the proposal allowed the state to “actively monitor” the agreement.¹⁵

These bills seemed heaven-sent in the eyes of struggling doctors because bargaining power would lead to higher reimbursement rates from insurance companies.¹⁶ The state intrusion into insurance-provider contracts had legal precedent, too.¹⁷ Furthermore, the proposals espoused a concept that supports the free market, and benefits consumers overall, rather than pandering only to

⁶ See Marshall Allen, *Assembly-line Colonoscopies at Clinic Described*, LAS VEGAS SUN, March 9, 2008, at 1, available at <http://www.lasvegassun.com/news/2008/mar/09/assembly-line-colonosopies-clinic-described>.

⁷ *Id.*

⁸ SOUTHERN NEVADA HEALTH DISTRICT, *OUTBREAK OF HEPATITIS C AT OUTPATIENT SURGICAL CENTERS* 130 (2009), <http://www.southernnevadahealthdistrict.org/download/outbreaks/final-hepc-investigation-report.pdf>.

⁹ See *id.*

¹⁰ Centers for Disease Control and Prevention, Department of Health and Human Services, *Acute Hepatitis C Virus Infections Attributed to Unsafe Injection Practices at an Endoscopy Clinic—Nevada, 2007*, 57 MORBIDITY & MORTALITY WKLY. REP. 513, 515 (2008), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5719a2.htm>.

¹¹ *Id.*

¹² See *infra* Part II.D.

¹³ S. 1300, 2008 Leg. § 1 (Cal. 2008).

¹⁴ See Assem. A04301A, 2009-10 Leg., Reg. Sess. (N.Y. 2009).

¹⁵ *Id.*

¹⁶ See, e.g., Cristina Rodriguez, *Greater Health Care Transparency on the Horizon*, IN BUSINESS LAS VEGAS, March 23-29, 2007, at 9; Healthcare Financial Management, *Provider Views and Strategies for Price Transparency*, May 2007.

¹⁷ See *infra* text accompanying notes 124-126 for the background on a different kind of “gag clause” that was prohibited from doctor-insurer contracts.

doctors. In situations where *insurance companies* have weak bargaining power in a market, greater price transparency could help them instead.¹⁸

However, the Federal Trade Commission (“FTC”) has been critical of several previous incarnations of state plans to loosen anticompetitive rules.¹⁹ A common theme in the FTC’s disapproval has been that the proposals conflict with an antitrust principle in healthcare known as the “state action doctrine.”²⁰

With careful attention to the state action doctrine, a state could successfully shift the bargaining power in health insurance markets. This Note will examine the legality of bills that open up physician collective bargaining—and what kind of provisions lawmakers should include to ensure legality and good policy. Given the current economic downturn, states must look for ways to make health insurance more affordable; a low-cost adjustment of collective bargaining rules may be a good solution. Such an adjustment would not be the only, or necessarily the best, solution to the healthcare cost crisis that exists in America, but it would be worthwhile for legislators to consider. Furthermore, if lawmakers craft legislation that puts state governments in charge of actively supervising these policies, the policies can comport with the existing state-action doctrine and avoid federal antitrust rules that govern healthcare.

Part II of this Note describes the history of the issues involved in physician collective bargaining, including the antitrust laws that apply to the healthcare industry. Part III looks at the specific bills that recently made their way into the California and New York legislatures. Part IV analyzes the main elements of those bills against the state-action doctrine, an exception to antitrust laws that applies when states have a purpose that benefits the public welfare and actively supervise how parties bypass antitrust rules. Part IV also offers recommendations for creating legislation that comports with the state-action doctrine.

II. HEALTHCARE FINANCING ARRANGEMENTS HARM THE INDUSTRY BECAUSE OF THE HEAVY-HANDEDNESS OF LARGE INSURANCE COMPANIES

A. *An Overview of Doctor Reimbursement*

The face of the American doctor today is worn-out, harried, and regretful. Though doctors are highly respected, they face struggles that merit our sympa-

¹⁸ “Conversely, if a health plan learned that a hospital had granted steeper discounts to competing insurers, it might ask for the same discount. Whether providers or health plans would prevail in this scenario would depend on which had the greater bargaining power.” MARK MERLIS, NATIONAL HEALTH POLICY FORUM, HEALTH CARE PRICE TRANSPARENCY AND PRICE COMPETITION 19 (2007), http://www.nhpf.org/library/background-papers/BP_PriceTransparency_03-28-07.pdf.

¹⁹ See, e.g., Press Release, Federal Trade Commission, FTC Staff Opposes Ohio Bill to Allow Physician Collective Bargaining (Oct. 21, 2002), *available at* <http://www.ftc.gov/opa/2002/10/physicians.shtm>; Press Release, Federal Trade Commission, FTC Staff Opposes Washington State Proposal to Allow Physician Collective Bargaining (Feb. 14, 2002), *available at* <http://www.ftc.gov/opa/2002/02/washphys.shtm>; Press Release, Federal Trade Commission, FTC Staff Opposes Alaska Proposal to Allow Physician Collective Bargaining (Jan. 31, 2002), *available at* <http://www.ftc.gov/opa/2002/01/alaskaphysicians.shtm>.

²⁰ See *infra* text accompanying notes 78-85.

thy. The main culprits, according to a 2008 survey of 12,000 physicians,²¹ are “declining reimbursement,” followed by “demands on physician time,” the latter clearly a result of trying to make up for “declining reimbursement.”²² The survey emphasizes that only 17 percent of physicians said that finances of their practices are “healthy and profitable,” and 60 percent of doctors said that they would not recommend medicine as a career for the nation’s youth.²³

Healthcare struggles have also stretched into the national conscience due to rising insurance premiums. The cost and quality of healthcare were two of the foremost issues in the 2008 presidential election.²⁴ President Barack Obama resounded with voters by calling healthcare a right, not a privilege.²⁵

Of course, many factors contribute to America’s healthcare crisis. One specific factor involves reimbursement. Physicians who feel slighted by reimbursement-rate offers blame their problems on the rise of “managed care” systems in the early 1990s.²⁶ Through this system, employers abandoned the more expensive “fee-for-service” insurance system by which insurance companies passively paid for doctor bills. Instead, through managed care, employers began to negotiate healthcare arrangements through insurance companies, leaving doctors entirely out of the negotiation process.²⁷

B. Doctor Pushback Against Managed-Care Insurance

Significantly, as the years of managed-care power have ensued, a number of physicians have sidestepped the law to resolve their frustrations and garner better reimbursement rates from insurance companies. From 1996 through 2006, forty-six antitrust cases involving doctors—most of which were blatant violations of horizontal price-fixing rules—were prosecuted by the FTC and the Department of Justice.²⁸ In contrast, these federal agencies prosecuted about the same amount of cases in the preceding twenty years, from 1976 through 1996; however, most of those situations were much more benign.²⁹

²¹ See THE PHYSICIANS’ FOUNDATION, *supra* note 4, at 2.

²² Medicaid and Medicare reimbursement were specifically highlighted as contributing to this issue. *Id.* at 3.

²³ *Id.* at 2-3.

²⁴ “Two-thirds of voters said they’re worried about being able to afford the health care they need.” Associated Press, Survey: 6 in 10 Say Economy Most Important Issue, THE MONITOR, Nov. 4, 2008, available at <http://www.themonitor.com/news/voters-19505-one-half.html>; see also THE HENRY J. KAISER FAMILY FOUNDATION, HEALTH CARE AND THE 2008 ELECTIONS 1, available at <http://www.kff.org/insurance/upload/7828.pdf> (finding the 2008 economic downturn created worry about health-insurance costs).

²⁵ “I think [healthcare] should be a right for every American.” Transcript of the Second McCain, Obama Debate, (October 7, 2008), <http://www.cnn.com/2008/POLITICS/10/07/presidential.debate.transcript/>.

²⁶ See Thomas (Tim) Greaney, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels*, 7 Hous. J. Health L. & Pol’y 189, 197 (2007).

²⁷ Charles S. Ofstein, Comment, *Destination Unknown: Illinois’ Search for a Solution to the Physician Collective Bargaining Problem*, 33 Loy. U. Chi. L.J. 443, 446-47 (2002).

²⁸ See Greaney, *supra* note 26, at 194.

²⁹ “Reflecting the fact that these cases were doctrinally uncontroversial, virtually all were settled without administrative or judicial hearings.” *Id.* at 193.

Illegal collective bargaining among physicians arises in the same ways, according to a survey of recent consent orders from the FTC.³⁰ A 2007 consent order, *Advocate Health Partners et al.*, involved a large physician-hospital organization in the Chicago metropolitan area that represented almost 3000 physicians.³¹ When a health plan would not raise the reimbursement fees for physicians, this organization cancelled its members' contracts with that health plan.³² The health plan then agreed to fees that were between twenty and thirty percent higher than stated in its previous contracts.³³ That rate increase was short-lived, though. The FTC prohibited the 3000-strong doctors' group from negotiating collectively for the doctors.³⁴

In 2006, Kansas City doctors caught the eye of the FTC in *New Century Health Quality Alliance Inc.*³⁵ In this case, only 127 physicians were members of Independent Physician Association groups that worked together to collectively bargain.³⁶ Members refused to deal with health plans directly. After the FTC prosecuted the group for antitrust violations, it issued a consent order prohibiting the group from negotiating on behalf of the physicians.³⁷

Professor Tim Greaney, in a 2007 article, stated that the recent violations of the antitrust rules were significant and suggested two sources of the disobedience.³⁸ First, Professor Greaney observed that government officials did not strongly enforce antitrust rules, resulting in irresistible possibilities for doctors' groups to test the boundaries of legal enforcement.³⁹ Second, Professor Greaney hypothesized that too much uncertainty exists regarding antitrust laws in the healthcare realm.⁴⁰

C. *Antitrust Laws over Doctors*

The broad laws that cover physicians and healthcare include the Sherman Antitrust Act,⁴¹ sections 2, 3, and 7 of the Clayton Act,⁴² section 5 of the Federal Trade Commission Act,⁴³ and state-law counterparts of these laws.⁴⁴

³⁰ The Federal Trade Commission's 2008 report on its recent antitrust prosecutions includes thirty pages summarizing administrative decisions regarding illegal price-fixing coalitions, starting with a 1976 case and showing a marked increase of cases in the 1990s and 2000s. BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION HEALTH CARE SERVICES AND PRODUCTS DIVISION, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS 10-40 (2008), available at <http://www.ftc.gov/bc/0608hcupdate.pdf>.

³¹ *Id.* at 10-11.

³² *Id.* at 11.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ Greaney, *supra* note 26, at 195.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ 15 U.S.C. §§ 1, 2 (2006) (prohibits conspiracies and monopolies), cited in ABA SECTION OF ANTITRUST LAW, ANTITRUST HEALTH CARE HANDBOOK 2 (2004).

⁴² *Id.* §§ 13, 14, 18.

⁴³ *Id.* § 45(a) (prohibits "unfair methods of competition"). There is no evidence of a state counterpart within this cite. The United States Code is obviously federal.

⁴⁴ See ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 6.

Congress has authority to regulate insurance through the Commerce Clause, even though insurance is traditionally a state issue.⁴⁵ In the 1970s, the FTC's Bureau of Competition created the Health Care Services and Products Division, whose sole responsibility was to investigate healthcare-related antitrust violations.⁴⁶

Antitrust laws treat the insurance industry differently than other industries. Insurers are exempt from some antitrust laws via the McCarran-Ferguson Act, enacted in 1945,⁴⁷ though any organization in the "business of insurance" cannot engage in agreements that "boycott, coerce, or intimidate," according to the Sherman Act.⁴⁸ Congress adopted the McCarran-Ferguson Act to ensure "that regulation of the insurance industry be left to the individual states,"⁴⁹ for tax and other Commerce-Clause purposes.⁵⁰ However, a report from the House Committee on the Judiciary stated that the 1979 Supreme Court decision in *Group Life and Health Co. v. Royal Drug* "clearly held that McCarran does not exempt insurers' dealings with health care providers from antitrust scrutiny."⁵¹ It is the federal government's responsibility to investigate and prosecute "exclusionary or collusive activities among health plans."⁵²

Physicians, on the other hand, have repeatedly failed in their attempts to exempt themselves directly from antitrust laws. In the 1975 decision, *Goldfarb v. Virginia State Bar*,⁵³ the Supreme Court decided that "learned professions" were not exempt from antitrust laws.⁵⁴ That classification included doctors and was an "affirm[ation] that antitrust laws apply to the healthcare industry."⁵⁵

Also, physicians are not "employees" as defined by the National Labor Relations Act,⁵⁶ which governs labor unions. Most doctors are independent contractors with rights at hospitals. Physicians who are employed by hospitals or by health-maintenance organizations are more likely to be seen as "employ-

⁴⁵ *Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738, 745-46 (1976); see also ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 2.

⁴⁶ BUREAU OF COMPETITION, *supra* note 30, at 1. In the 1990s, coinciding with "major transitions in the delivery and financing of health care," the Department of Justice and the FTC issued policy papers detailing how antitrust principles applied to modern healthcare. Jeffrey L. Harrison, *The Messenger Model: Don't Ask, Don't Tell?*, 71 ANTITRUST L.J. 1017, 1017 (2004). Among those policy papers was the U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 1996, available at <http://www.usdoj.gov/atr/public/guidelines/1791.pdf>.

⁴⁷ 15 U.S.C. §§ 1011-15. For more information, see U.S. DEPARTMENT OF JUSTICE, ANTI-TRUST DIVISION MANUAL ch. 2 (4th ed. 2008), available at <http://www.justice.gov/atr/public/divisionmanual/atrdvman.pdf>.

⁴⁸ 15 U.S.C. § 1013.

⁴⁹ See, e.g., *Levy v. Lewis*, 635 F.2d 960, 963 (2d Cir. 1980).

⁵⁰ See, e.g., *Metropolitan Life Ins. Co. v. Ward*, 470 U.S. 869, 880 (1985).

⁵¹ H.R. REP. NO. 106-625, at 44 (2000). The Department of Justice argued that existing antitrust laws were suitable to ensure competitive behavior between insurance companies and healthcare providers. This argument urged the U.S. House to shoot down a bill that would have allowed physicians to collectively bargain like they were in unions. *Id.*

⁵² *Id.*

⁵³ *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975).

⁵⁴ *Id.* at 787; see also ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 1.

⁵⁵ See ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 5.

⁵⁶ *Id.* at 33.

ees” within the National Labor Relations Board definitions.⁵⁷ However, some theories suggest that physicians have lost their autonomy typical of an independent contractor with the rise of managed care, turning them more into manageable “employees.”⁵⁸ This theory has not yet prevailed to give physicians the right to organize⁵⁹ that nurses and other hospital workers retain.⁶⁰

D. Attempts to Allow Doctors to Share Reimbursement Data

Advocates of collective bargaining for physicians have tried at both federal and state levels to attain antitrust exceptions for doctors. One failed attempt at the federal level occurred in 2000, when the Quality Health-Care Coalition Act of 2000 stalled in a Senate committee.⁶¹ The bill, introduced by U.S. Representative Tom Campbell, came to be known as the Campbell Bill. The simple, stated purpose of the bill, according to the version sent to the Senate committee, was, “To ensure and foster continued patient safety and quality of care.”⁶²

The Campbell Bill induced much controversy, mainly because it would set physicians free of the competitive economic pressures⁶³ that Americans trust to regulate markets. The bill would have given physicians and other healthcare professionals “engaged in negotiations with a health plan” the same status as contract-negotiating labor unions recognized by the National Labor Relations Act.⁶⁴ The bill also precluded criminal prosecution for good-faith efforts to comply with the new law.⁶⁵

Support and opposition to the Campbell Bill in 2000 illustrate this nation’s feelings of sympathy and fear regarding healthcare pricing. There was—and nine years later still is—sympathy for physicians who have been humbled in the negotiating game. However, there is fear that upsetting competitive markets would only create higher healthcare prices and harm innocent patients. Supporters of the bill saw independent doctors as defenseless victims: According to one of the bill’s 220 co-sponsors, U.S. Representative John Conyers, Jr.: “It is unrealistic to expect a local doctor to have anywhere near the financial capacity or legal wherewithal to negotiate fair or reasonable contract terms with a multibillion dollar health insurer.”⁶⁶ Shifting the balance of power would, in

⁵⁷ *Id.* at 33 n.103.

⁵⁸ *Id.* at 34-35.

⁵⁹ *Id.* at 37.

⁶⁰ Serv. Employers Int’l. Union, Fast Facts, <http://www.seiu.org/a/ourunion/fast-facts.php> (last visited Mar. 13, 2010) (Service Employees International Union membership includes “over 1 million members in the field, including nurses, LPNs, doctors, lab technicians, nursing home workers, home care workers.”).

⁶¹ Quality Health-Care Coalition Act of 2000, H.R. 1304, 106th Cong. (2000) (Thomas.loc.gov states that its last action was referred to the Senate Committee on Health, Education, Labor and Pensions.).

⁶² *Id.*

⁶³ ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 42.

⁶⁴ H.R. 1304 § 2(a).

⁶⁵ *Id.* § 2(b).

⁶⁶ H.R. REP. NO. 106-625, at 54 (2000).

Conyers' view, "maximize consumer choice,"⁶⁷ because doctors would be expected to adjust their contracts to provide better care for their patients.⁶⁸

By contrast, the federal antitrust agencies—the FTC and the Department of Justice—were fearful of the Campbell Bill.⁶⁹ The FTC predicted that "prices for health care services [would] rise substantially," and noted that insurance premiums and prescription drug prices would affect companies, insured individuals and the uninsured.⁷⁰ The unpredictable impact on competitive market forces was an apparent concern for Congress; the House Committee on the Judiciary, which handled the bill, inserted a sunset provision that would have disintegrated the policy after three years if a General Accounting Office analysis proved unsatisfactory.⁷¹

Besides a fear of increased healthcare prices, opponents also disliked how the Campbell Bill would have trampled on the competitive values that had given doctors some leeway to band together.⁷² Under existing law, healthcare providers may combine in joint ventures if they wish to "sell a new product or service in the market."⁷³ Instead of seeing this combination as horizontal price-fixing, the federal government recognizes it as a risk-sharing structure in which members compel themselves to operate efficiently.⁷⁴ The Campbell Bill would have allowed large groups to form for the sole purpose of negotiating costs, without regard for how efficiently members of the group operated.⁷⁵ In other words, the bill "would [have] substantially eliminate[d] the normal incentives for health care professionals to consolidate only to achieve efficiencies which enhance their ability to compete, and thereby benefit consumers."⁷⁶

Although the Campbell Bill of 2000 failed, states have been more successful in using antitrust laws to benefit doctors in insurance reimbursement negotiations. States can create antitrust immunity under limited circumstances under the "state-action doctrine." This exemption applies when two elements exist: (1) when there is a clear, expressly stated state policy for the antitrust immunity; and (2) when the antitrust immunity is "actively supervised" by the state itself.⁷⁷

The second prong of the state-action doctrine makes the state a party in contract negotiations, and the Supreme Court has demanded that the state's role be substantial.⁷⁸ The state seeking to use that exception should take "ultimate control over the challenged anticompetitive conduct."⁷⁹

Using the state-action doctrine, Texas was the first state to adopt the American Medical Association's Model State Legislation, which was modeled

⁶⁷ *Id.* at 55.

⁶⁸ *Id.* at 54.

⁶⁹ *Id.* at 29-30, 41.

⁷⁰ *Id.* at 35.

⁷¹ *Id.* at 4.

⁷² ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 42.

⁷³ *Id.* at 8.

⁷⁴ *Id.*

⁷⁵ *Id.* at 42-43.

⁷⁶ *Id.*

⁷⁷ *Id.* at 54.

⁷⁸ *Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105-06 (1980).

⁷⁹ *Patrick v. Burget*, 486 U.S. 94, 101 (1988).

after 1995 legislation adopted in Washington State.⁸⁰ While the Texas Managed Care Freedom of Choice Act did not allow physicians to collectively bargain for reimbursement rates, it did allow them to collectively bargain on contract terms,⁸¹ including practices and procedures relating to children's care, methods to decrease costs in managing diabetes, asthma and cardiovascular disease, and procedures to curb fraud.⁸²

The Texas act derived from model legislation by the American Medical Association, which, in turn, was based on a Washington State act from 1995.⁸³ Washington State lawmakers attempted in 2002 to expand physician collective bargaining to include fee negotiations, but the FTC actively opposed that attempt.⁸⁴ Specifically, the FTC found that the 2002 Washington bill may not have "provide[d] the supervisory agencies with the necessary tools to exercise 'independent judgment and control' over collective provider conduct."⁸⁵

Another method that physicians may use to approach negotiations as a group, though not directly collectively bargain, is called the "messenger model." This system was authorized in the policy statements issued by the FTC and the Department of Justice in the 1990s.⁸⁶ The messenger model allows an independent agent to gather acceptable contract terms from individual providers, and then to share the aggregate data with an insurer. In this system, a healthcare provider gets a picture of what physicians are generally willing to accept, then makes contract offers based on that information.⁸⁷

The messenger model has drawn criticism for several reasons. One reason is that it is "cumbersome and administratively unwieldy" to have a third party shuttle back and forth with information, even with newer rules that allow messengers to accept contract terms.⁸⁸ Another criticism is that the messenger model prompts dishonest behavior by messengers who, not surprisingly, become much more efficient when they collectively bargain on behalf of their customers.⁸⁹ Collusion is especially tempting "in markets in which the number of competitors is small enough to permit collusion."⁹⁰

⁸⁰ TEX. INS. CODE ANN. § 29.01 (Vernon 2003), *reprinted in* ABA Section of Antitrust Law, *supra* note 5, at 77.

⁸¹ ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 62-63.

⁸² TEX. INS. CODE ANN. § 29.04, *reprinted in* ABA Section of Antitrust Law, *supra* note 5, at 79.

⁸³ Christopher Guadagnino, *Physicians Seek Antitrust Waiver: Legislative Initiatives*, PHYSICIAN'S NEWS DIG., June 1999, available at <http://www.physiciansnews.com/cover/699.html>.

⁸⁴ See Press Release, Federal Trade Commission, FTC Staff Opposes Washington Proposal to Allow Physician Collective Bargaining (Feb. 14, 2002), <http://www.ftc.gov/opa/2002/02/washphys.shtm>.

⁸⁵ *Id.*

⁸⁶ See, e.g., U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *supra* note 46, at 126-27.

⁸⁷ Harrison, *supra* note 46, at 1018.

⁸⁸ ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 21.

⁸⁹ See Harrison, *supra* note 47, at 1022.

⁹⁰ *Id.* at 1030.

III. RECENT STATE PROPOSALS TO LOOSEN PHYSICIAN COLLECTIVE
BARGAINING RESTRICTIONS MAY COMPORT WITH
FEDERAL ANTITRUST REQUIREMENTS

A. *Recent Proposals in California and New York*

Some states have introduced bills to give physicians and other healthcare professionals who negotiate with insurance companies the opportunity to move closer to collective bargaining. One bill in California's 2008 legislative session attempted to make public the contracts between individual physicians and insurance companies, opening them up to government and market scrutiny.⁹¹ A second bill in California that year would have prohibited insurers from executing any "unfair and unreasonable agreement as a condition of entering into contract negotiations"⁹² One bill in New York's 2009 Assembly aimed to give state authorities the power to allow or disallow collective bargaining, depending on whether an imbalance of power existed in the health insurance market.⁹³

The first piece of legislation that this Note will analyze is Senate Bill 1300, introduced by California State Senator Ellen Corbett. This bill passed through the State Assembly's Appropriations Committee, but the amendments created in that Committee did not pass muster with the State Senate.⁹⁴ Corbett's bill would have prohibited confidentiality clauses in reimbursement-rate contracts between physicians and insurance companies.⁹⁵ Existing law in California required that hospital "chargemasters," which are scales listing how much money hospitals are paid by insurers for certain procedures, be made public; however, the law had not extended to physicians.⁹⁶ The public release of the hospital chargemasters was consistent with a move toward healthcare pricing transparency, a policy aimed at providing cost information to consumers.⁹⁷ For reasons discussed below, many experts doubt that consumers are sophisticated enough to interpret complex healthcare pricing data. However, supporters of Senate Bill 1300 only articulated concern for consumers, not for physicians who want to gain bargaining power in contract negotiations.⁹⁸

⁹¹ S. 1300, 2008 Leg. § 1 (Cal. 2008) (The bill would have prohibited any "provision that restricts the ability of the provider to furnish health care pricing . . . to subscribers or enrollees of the plan or individuals insured by the insurer.").

⁹² See Assem. 2839, 2007-08 Leg., Reg. Sess. (Cal. 2008).

⁹³ Assem. A04301A, 2009-10 Leg., Reg. Sess. § 3 (N.Y. 2009).

⁹⁴ S. 1300, 2008 Leg. (Cal. 2007), *Current Bill Status*, http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_1251-1300/sb_1300_bill_20090204_status.html (last visited Mar. 8, 2010).

⁹⁵ After 2009, such a contract "shall not contain a provision that restricts the ability of a health care service plan to furnish information on the cost of procedures or health care quality information to subscribers or enrollees of the plan." S. 1300, 2008 Leg. § 1 (Cal. 2008).

⁹⁶ The California Senate's Health Committee analyzed the issue during debate of S. 1300 in March 2008. S. 1300, Senate Bill Analysis, http://info.sen.ca.gov/pub/07-08/bill/sen/sb_1251-1300/sb_1300_cfa_20080325_100427_sen_comm.html (last visited Mar. 8, 2010).

⁹⁷ *Id.* Besides pricing information, some healthcare quality statistics have recently become available to the public in California. *Id.*

⁹⁸ *Id.* (See the "arguments in support" section of the Senate Health Committee Analysis, where arguments relate only to consumers).

The second recent California bill analyzed here is Assembly Bill 2839, the so-called Health Care Providers' Bill of Rights,⁹⁹ which stalled in the State Assembly's Appropriations Committee. That bill would have authorized the State's Department of Managed Health Care and its Office of the Insurance Commissioner to inspect insurer-provider negotiations and contracts to see if they were "unfair or unreasonable." The penalties for such a situation, found only after notice and a hearing to the suspect company, would have included suspension or revocation of a state insurance license or administrative penalties. The bill listed elements that would be found unreasonable, including: "[A]uthority for the plan to change a material term of the contract," without provider agreement, provisions that force a provider to accept more patients than the provider deems is safe, requirements that providers comply with quality plans without first receiving notice of those plans, and language that discourages a provider from using an attorney or consultant during contract negotiations.¹⁰⁰ The State Assembly's Appropriations Committee estimated that the state would spend \$200,000 a year reviewing contracts and confidentiality agreements pursuant to Assembly Bill 2839.¹⁰¹ The committee also predicted greater costs to California healthcare consumers, stating: "[T]his bill weakens contracting confidentiality and leads to higher pricing in the health care market."¹⁰²

The purpose of the bill, introduced by Assemblymember Jared Huffman, was to codify a November 2007 order by the state's Department of Managed Health Care against practices run by Blue Cross of California, a health plan. The state department prohibited "pre-negotiation" confidentiality agreements, which Blue Cross of California used to keep consultants from representing more than one healthcare provider in contract negotiations. Without those confidentiality agreements, consultants could have used their knowledge of existing provider reimbursement agreements when negotiating new provider contracts. On the other hand, the state found relevant that insurance companies had enough resources to employ many "contract specialists, actuaries, financial analysts and outside attorneys," creating an imbalance in power when negotiations started.¹⁰³

Opponents to Assembly Bill 2839 said that eliminating the pre-negotiation confidentiality agreements would result in illegal price-fixing in violation of antitrust laws.¹⁰⁴ Those against the bill stated that insurers were subject to the same types of confidentiality agreements in that they could not share their rates with other insurance companies. Furthermore, opponents said that the terms "unfair" and "unreasonable" would require state agencies to enforce overbroad standards. This would have led to uncertainty in future contract negotiations.

⁹⁹ Assem. 2839, 2007-08 Leg., Reg. Sess. (Cal. 2008).

¹⁰⁰ *Id.* § 1.

¹⁰¹ Assem. 2839, 2007-08 Leg., Reg. Sess. (Cal. 2008), *Bill Analysis* at 1, http://www.leg.info.ca.gov/pub/07-08/bill/asm/ab_2801-2850/ab_2839_cfa_20080506_154934_asm_comm.html (last visited Mar. 8, 2010).

¹⁰² *Id.*

¹⁰³ Assem. 2839, 2007-08 Leg., Reg. Sess. (Cal. 2008), *Bill Analysis* at 5, [http://www.leg.info.ca.gov/pub/07-08/bill/asm/ab_2801-2850/ab_2839_cfa\)20080328_180532_asm_comm.html](http://www.leg.info.ca.gov/pub/07-08/bill/asm/ab_2801-2850/ab_2839_cfa)20080328_180532_asm_comm.html) (last viewed Mar. 12, 2010).

¹⁰⁴ *Id.*

The New York bill was introduced in 2000, kept alive until 2004, and revived in 2007 and 2009.¹⁰⁵ Assemblymember Ron Canestrari sponsored the bill in the 2009 session,¹⁰⁶ hoping that fellow lawmakers would subscribe to the bill's statement of policy: "[T]he legislature finds it appropriate and necessary to authorize collective negotiations on patient care issues and on fee-related and other issues where it determines that health plans have an undue advantage negotiating the terms of contracts with health care providers."¹⁰⁷ Substantively, the bill allows doctors to collectively bargain with insurance companies over *fees* only "[W]hen an individual managed care plan controls a substantial share of the managed care market," a conclusion that would likely be reached by New York state officials.¹⁰⁸ The bill would not affect existing laws banning physician strikes or boycotts of health-insurance plans.¹⁰⁹

B. Future Use of the California and New York Bills

This Note takes a limited look at two failed California bills and the 2009 New York bill, though the topic of healthcare reform is much broader than the issues presented herein. Specifically, this Note seeks to analyze the legality of the provisions in those three bills. It will show how legislation that incorporates the best provisions of the above bills could pass legal muster.

Importantly, this Note does not reach a conclusion as to whether price transparency in the healthcare industry will improve choices or long-term prices for patients. Such a theory is relevant to the confidentiality agreement prohibitions¹¹⁰—proving its validity would take into consideration too many parts for the scope of this Note.¹¹¹

Consequently, this Note does not attempt to characterize the aforementioned California bills or the New York bill as the *best* solution to the healthcare finance problem. This Note will focus on the pieces to the puzzle that comprises America's healthcare crisis. In particular, this Note asks: Do strate-

¹⁰⁵ Assem. A04301A, 2007-08 Leg. Reg. Sess. (N.Y. 2009), A04301 Memo, http://assembly.state.ny.us/leg/?default_fld=&bn=A04301%09%09&Memo=Y.

¹⁰⁶ Assem. A04301A, 2007-08 Leg. Reg. Sess. (N.Y. 2009), *available at* http://assembly.state.ny.us/leg/?default_fld=&bn=A04301%09%09&Text=Y.

¹⁰⁷ A04301 Memo, *supra* note 105.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ "[P]atients pay an unconscionable price because of these practices through reductions in patient autonomy and quality of care." Kristin L. Jensen, *Releasing Managed Care's Chokehold on Healthcare Providers*, 16 ANNALS HEALTH L., Winter 2007, at 141, 141.

¹¹¹ Becky Sutherland Cornett published a clear and concise summary of the price transparency theory; among other issues she noted that, "'Informed choice' isn't particularly relevant in our present health care system because traditional market forces do not apply to health care services." Becky Sutherland Cornett, *Transparency in Health Care: Through a Glass, Dimly*, 9 J. HEALTH CARE COMPLIANCE, Sep.-Oct. 2007, at 47, 48. One simple explanation is because healthcare consumers make financial decisions without knowing the extent of their future obligations: Will they need more medical care, for instance? Will the treatment work? These so-called episode costs cannot be calculated through dry charts of reimbursement rates toward physicians. This was noted in a report of the advocacy group, the National Health Policy Forum. MARK MERLIS, NATIONAL HEALTH POLICY FORUM, HEALTH CARE PRICE TRANSPARENCY AND PRICE COMPETITION *passim* (2007), *available at* http://www.nhpf.org/library/background-papers/BP_PriceTransparency_03-28-07.pdf.

gies employed through those bills have the potential to improve healthcare quality and costs? If so, do those strategies fit with the federal government's current antitrust policy and rules?

IV. WITH ATTENTION TO STATE SUPERVISION, COST AND ATTRACTIVENESS
TO PHYSICIANS, RECENT BILLS ANGLING FOR PHYSICIAN
COLLECTIVE BARGAINING WOULD BE
GOOD TO RE-CONSIDER

Policymakers should seriously consider the provisions of the two failed California bills and the current New York bill. This Note will first analyze why collective bargaining remains ripe for discussion among state lawmakers despite being repeatedly rejected in the past. There is clear physician demand for a creative solution: Physicians are using legal debate as well as criminal disregard of antitrust laws to reach for a solution. Furthermore, although Americans value competition, this nation has repeatedly made exceptions for the healthcare industry; public sentiment would allow an exception for over-worked physicians.

Secondly, this Note will pick through the provisions embodied in the three bills, and others, judging which provisions should be presented to state law-making bodies and which would raise the disapproval of the FTC. In other words, this Note will show how physician collective bargaining legislation can comport with the state-action doctrine exception to federal prohibitions on collective bargaining. In addition, the analysis will look at the most cost-efficient ways to implement this policy, given the financial straits of state governments.

A. *Lawmakers May Draw Power from Public Outrage*

As stated earlier, the changing landscape of insurer-physician reimbursement rates has done more than annoy doctors. It has made physicians want to leave the profession,¹¹² has effectively cut spending on staff and equipment, and has limited time that doctors spend spent with patients.¹¹³ The issues seem to be as imminent, if not more so, as when Congress considered the Quality Health-Care Coalition Act of 2000 (the Campbell Bill). The demand for collective bargaining is growing in more than rhetorical terms: Physicians and other healthcare providers are being prosecuted by the Department of Justice at an increasing rate.¹¹⁴

Supporters of the failed California bills unwisely pushed their agenda by focusing on price transparency—a tenuous policy goal, easily attacked by the managed care lobby—rather than the livelihood of struggling physicians, a more tangible, provable concern. That specific political problem could be easily avoided, especially if policy anglers use situations like the Las Vegas endoscopy clinic hepatitis issue to compel public sympathy.¹¹⁵

¹¹² See THE PHYSICIANS' FOUNDATION, *supra* note 4, at 8.

¹¹³ See *id.* at 10.

¹¹⁴ See *supra* notes 30-40 and accompanying text.

¹¹⁵ See *supra* notes 7-11 and accompanying text.

Furthermore, lawmakers must recognize that trying to establish physician collective bargaining is a fair and legally warranted recognition that this nation has granted regulatory exceptions to players in the healthcare field. The U.S. Department of Justice and the FTC operate under the policy that competition, “[W]ill generally allocate resources efficiently toward users who value them most.”¹¹⁶ In the mind of the U.S. government, markets work best without government interference, but the government should interfere when it sees price fixing or large horizontal mergers.¹¹⁷

Despite this mentality, the government is quick to exempt certain industries from federal antitrust laws. Professor Maurice E. Stucke, a former Department of Justice antitrust prosecutor, noted that his former employer makes exemptions for “agriculture, export activities, insurance, labor, fishing, defense preparedness, newspapers, professional sports, small-business joint ventures, and local governments.”¹¹⁸ Professor Stucke argued that the government should take a closer look at “what they mean by competition.”¹¹⁹

Therefore, the traditional arguments put forth by insurance companies that price fixing should not occur among doctors should be viewed with scrutiny. If there are exceptions for industries such as agriculture, then the healthcare industry should also have a similar chance at being subject to exceptions to antitrust rules.

In fact, the healthcare industry, and its contracts in particular, have already been subjected to government rules that give doctors greater bargaining power. As mentioned earlier, doctors may band together in joint partnerships if they share risks and market a product or a service.¹²⁰ Also, a form of price negotiating exists already in the messenger model, and its relation to illegal collective bargaining becomes clear when the third-party messengers do not fulfill their duties honestly.¹²¹

In addition, states across the nation have required insurance companies—which are licensed within individual states—to release reimbursement-rate information from contracts covering hospitals, medical-device suppliers, and pharmacy outlets. The National Conference for State Legislatures has compiled an extensive list of this type of legislation.¹²² Also telling is the fact that price transparency for these groups (but not for individual physicians, yet) has been a federal policy under the Bush Administration.¹²³

¹¹⁶ Maurice E. Stucke, *Better Competition Advocacy*, 82 ST. JOHN'S L. REV. 951, 957 (2008).

¹¹⁷ *Id.* at 957-58.

¹¹⁸ *Id.* at 961-62.

¹¹⁹ *Id.* at 1036.

¹²⁰ *Supra* notes 73-74 and accompanying text.

¹²¹ *Supra* notes 87-90 and accompanying text.

¹²² NATIONAL CONFERENCE FOR STATE LEGISLATURES, STATE LEGISLATION RELATING TO TRANSPARENCY AND DISCLOSURE OF HEALTH AND HOSPITAL CHARGES *passim* (2010), available at <http://www.ncsl.org/default.aspx?tabid=14512>.

¹²³ Press Release, Office of the Press Sec'y, Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs (Aug. 22, 2006), <http://georgewbush-whitehouse.archives.gov/news/releases/2006/08/20060822-2.html>.

Furthermore, states have previously interfered in a similar manner with insurance contracts when they banned another type of “gag clause” in the 1990s.¹²⁴ This type of gag clause had a direct effect on patients’ options for healthcare—and it was not a positive effect. In contracting with a certain insurance company, for example, a doctor had to promise to keep patients unaware about any treatment options that were not covered by that insurance company. Managed-care organizations said these clauses were merely protections of proprietary information and other trade secrets. The managed-care plans said these clauses were essential for maintaining a competitive managed-care market.¹²⁵ Federal laws against the practice of including those “gag clauses” were attempted but failed; however most states had anti-gag clause laws well before the end of the decade.¹²⁶

Based on the history of antitrust exemptions for sympathetic industries, the proposals to further break down competition among healthcare providers do not seem inappropriate on their face. Indeed, the national policy to promote competition is not ironclad. The banning of another type of confidentiality agreement in the 1990s—those that prohibited a physician from suggesting treatment not covered by insurance—signifies that public interest may override a fondness of our lawmakers and policymakers for market forces.

History also shows that strong opposition to anticompetitive measures does not always prevail. Regarding the treatment-option gag clauses, insurance companies denied that they existed or argued that the clauses merely protected what was rightfully theirs, i.e., a proprietary system for treating patients. The resulting outcry and state legislation showed that the public interest may interfere with proprietary business strategies, even to the point of interfering with contractual agreements.

B. Best Strategies for Creating Bills to Loosen Physician Collective Bargaining Rules

If written carefully, legislation that loosens physician collective bargaining rules could fit within the state-action doctrine, an exemption to antitrust laws that recognizes the sovereignty of states. The exemption requires two elements: (1) a clear, expressly stated policy by the state government for the antitrust immunity must exist; and (2) the state itself must “actively supervise” the program.¹²⁷ The doctrine derives from a 1943 Supreme Court case, *Parker v. Brown*,¹²⁸ which allowed California to restrict competition among raisin growers to stabilize prices.¹²⁹

The first prong within the state-action doctrine, that the state has a clearly articulated policy for an antitrust exemption, exists so that any immunity provision has the obvious—not accidental—support of the state government.¹³⁰ Therefore, this standard does not require that a state compel anticompetitive

¹²⁴ Jensen, *supra* note 110, at 152.

¹²⁵ *Id.* at 150-51.

¹²⁶ *Id.* at 152.

¹²⁷ ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 54.

¹²⁸ *Parker v. Brown*, 317 U.S. 341 (1943).

¹²⁹ *Id.* at 352; *see also* ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 53.

¹³⁰ ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 55.

measures; rather, allowing an exception to competition is adequate for a policy to fit under the state-action doctrine.¹³¹

The second state-action doctrine prong is, as it would seem, the harder test to meet. A state must actively supervise an anticompetitive policy, again to ensure that unintended effects—that is, those that do not stem from state policy—do not occur.¹³² One example of insufficient state supervision was enumerated in 1988, when the Supreme Court rejected an argument that the *possibility* of state-agency administrative review qualified as active state supervision.¹³³ In *Patrick v. Burget*, the doctors in a small town blacklisted an Oregon surgeon because the surgeon chose to compete with them. When the surgeon sued, the remaining doctors said that they had an antitrust exemption: They had a peer-review committee for such problems, and the peer-review committee was established by the state. Though the doctors tried to establish that the state “oversaw” the committee, the Supreme Court found no evidence of active supervision.¹³⁴

The line separating sufficient from insufficient state supervision remains undrawn. Therefore, state lawmakers that have considered or pursued proposals that would allow greater physician collective bargaining often proceed without legal certainty. In 2002, a legal article by Charles S. Ofstein picked apart an Illinois statute that would have allowed physician collective bargaining: Ofstein stated the bill would have failed to meet the second prong of the state-action doctrine.¹³⁵ The Illinois bill would have implemented a negative-option scheme,¹³⁶ by which the state’s attorney general had twenty days to disapprove of plans as violating antitrust laws. The author speculated that this loose control over policy would not fit within the “active supervision” prong of the state-action doctrine.¹³⁷

Both prongs of the state-action doctrine—(1) clear articulation of purpose and (2) active state supervision of the policy—can be fulfilled through carefully written legislation. This Note will now address several provisions common to these bills, including (1) prohibiting confidentiality clauses regarding reimbursement fees in physician-health insurer contracts, as the recent California bills would have done, and (2) pre-approving groups that may collectively bargain, using a formula that looks at the market control of each party, as the New York bill would accomplish.

1. Eliminating Confidentiality Clauses in Physician-Insurance Company Contracts

Legislation that eliminates reimbursement-related confidentiality clauses might be the simplest, most effective way to achieve greater balance in health insurance financing. Additionally, there is a good chance that courts would

¹³¹ *Id.* at 55-56.

¹³² *Id.* at 57.

¹³³ See *Patrick v. Burget*, 486 U.S. 94, 100 (1988). For a discussion of this case, see ABA SECTION OF ANTITRUST LAW, *supra* note 5, at 57-58.

¹³⁴ *Id.* at 101.

¹³⁵ Ofstein, *supra* note 27, at 472-73.

¹³⁶ *Id.* at 472.

¹³⁷ *Id.* at 472-73.

find that this solution fits into the state-action doctrine. First, state policymakers would find it easy to articulate a purpose, provided that it aimed to: (a) give physicians more bargaining power, (b) reveal price information to the health-care consumers—that is, everybody—in the state, (c) improve working conditions at medical clinics trying to make profits out of quantity of patients seen rather than quality of care or (d) any other purpose. Because opponents of these plans will attack the usefulness of providing complex pricing schedules to bewildered patients, who are stressed and untrained in analyzing medical pricing, the first and third goals would best articulate achievable goals by a state. Whichever goal a state chooses should suffice. The “clear articulation” prong is more of a retrospective test than a prospective one, so the important test lies in the second prong.

The state-action doctrine’s latter test requires active state supervision of a program that grants immunity to federal antitrust laws. Of the aforementioned California bills, the second—Assembly Bill 2839, the so-called bill of rights for providers—has the better chance of meeting the state-action doctrine test. Although California would have to spend \$200,000 per year analyzing the fairness of insurer-provided contracts, its act of enabling the state managed-care office to oversee contracts directly would qualify as active state supervision. Other methods could be enlisted to oversee fairness, including actions that interrupt the contract negotiation process; however, a review of completed contracts likely will be the most cost-efficient way to implement this procedure.

The first California bill mentioned above, Senate Bill 1300, did not contain the active supervision required by the state-action doctrine. Instead, the bill merely outlawed confidentiality clauses. Of course, this deficiency could be solved by more careful drafting: Like Assembly Bill 2839 stated, this method could have required a state agency to pick through contracts. A more directed approach would be to make a state agency verify whether the pricing schedules are correct, or that the reimbursement rates are presented on a user-friendly web site. However, the cost-intensive options—while they would easily satisfy the “active supervision” prong—seem too wasteful. Considering that physicians want pricing information available, policymakers must assume that physicians would know how to use it. If the state policy is to give health-care providers a boost in negotiating power, rather than to help consumers choose the best-valued doctor, the state could not in good conscience overspend resources on categorizing price data.

Consequently, legislatures that want to invalidate pricing confidentiality clauses in insurer-provider contracts could do so without violating the federal antitrust scheme. Using the state-action doctrine, a state would only have to ensure that it actively supervised the situation, which could occur under either of the ideas embodied in the failed California bills.

Such a regulation is so specific and, essentially, mathematical, that it would not lead to costly legal battles among negotiating parties and therefore would likely seem attractive to participants.¹³⁸ A problem will arise if participants find loopholes, but rather than forcing the supervising agency to adapt to loopholes, a state legislature should take on those challenges, knowing that leg-

¹³⁸ See *infra* Part IV.B.2.

islatures meet often and that contracts always have expiration dates. However, it is important to note that, because of the length of contracts and the ability of legislatures to react, there likely would be years between the enactment of this legislation and the beneficial results of collective bargaining. By the time the results would benefit healthcare consumers, states may have a number of other problems that confuse the results from a simple ban on confidentiality clauses. Therefore, politicians who support the provision in the California bills would need strong political will to declare that collective bargaining tools are important, despite the ongoing presence of other medical issues that evoke more public sympathy.

2. *A State's Pre-approval of Doctors' Groups*

New York Assembly Bill A04301 from the 2009 session may fulfill the “active supervision” requirement of the state-action doctrine, importantly with a mechanism to lower the state’s cost, as long as specific guidelines direct the decisions of the state agency tasked with pre-approving physician collective bargaining sessions. As with the previous California bills, a bill containing this language must articulate a clear purpose; the actual New York bill does this with its statement of intent, reading that it aims to correct a situation where “health plans dominate the market to such a degree that fair and adequate negotiations between health care providers and the plans are adversely affected”¹³⁹

The bill would lower New York’s “state supervision” cost by charging a fee—to be determined by the state agency responsible for oversight—to parties that wish to use the bill to collectively bargain.¹⁴⁰ The fee would return to the state’s general fund rather than directly to the department responsible for oversight. Importantly, the fee would not have a direct correlation with the agency’s activities, and it seems clear that the agency would end up costing the state much more than the legislators may expect. Because fee reimbursement contracts represent such an important element of the business model for both physicians and managed care providers, policymakers should expect that each side would hire consultants, lawyers and anybody else to take fullest advantage of the state’s new allowance for collective bargaining.¹⁴¹ The state agency aims to do more than make an initial pre-approval; it aims to receive and analyze periodic updates if situations change.¹⁴²

The New York agency—or the agency of any state—responsible for pre-approving physician collective bargaining would have to operate under specific guidelines, according to the FTC’s 2002 letter against a Washington bill that would have loosened collective bargaining rules for doctors.¹⁴³ The FTC criti-

¹³⁹ Assem. A04301A, 2007-08 Leg. Reg. Sess. § 3 (N.Y. 2009), available at http://assembly.state.ny.us/leg/?default_fld=&bn=A04301%09%09&Text=Y.

¹⁴⁰ *Id.*

¹⁴¹ See, e.g., Physician’s Computer Company, *Seven Steps to Successful Insurance Contract Negotiations*, <http://www.pcc.com/practmgmt/business/7step.php> (last visited Mar. 8, 2010) (demonstrating consultant groups that physicians’ groups might hire).

¹⁴² N.Y. Assem. A04301A § 3.

¹⁴³ Letter from Federal Trade Commission to Washington lawmakers (Feb. 8, 2002), <http://www.ftc.gov/be/v020009.pdf>.

cized the Washington bill for allowing physician collective bargaining to occur after informal reviews, by two agencies, of documents prepared by the parties seeking to enter negotiations.¹⁴⁴ The FTC also found inappropriate that the Washington bill would not have allowed the agencies to take in public comment—a vital tool in gathering information that self-interested parties would not have provided.

Although the 2009 New York bill would require ongoing supervision, it still relies on voluntary input from the parties involved. Therefore, as written, the provision likely would not meet the FTC's approval as complying with the state-action doctrine. A better provision would allow for public comment and autonomous, constant supervision of negotiations by the state agencies. However, both of these additions, while they would help the state comply with federal antitrust law, would cost the state more money.

A simple solution to the cost dilemma would be to raise fees on the physicians groups that seek to participate. However, creating a policy that is unattractive to participants could backfire, as Washington State lawmakers witnessed following a measure enacted in 1995. There, the state allowed physicians to negotiate collectively with insurance companies on elements of contracts excluding fees. However, the program attracted so few physicians that it, "[F]ailed to create a critical mass large enough to induce health plans to engage in any negotiations with the (Washington State Medical Association) negotiation service . . ."¹⁴⁵ In the end, consumer and interest group outrage regarding HMO contract practices led to what the 1995 Washington legislation was designed to achieve.¹⁴⁶

Therefore, a better-worded provision to pre-approve and monitor contracting groups would meet state-action doctrine requirements; however, such legislation might be undesirable because of cost to the state. Again, the collective bargaining solution is good to try, but during an economic downturn, it is not worth consideration if the economic benefits seem tenuous or even unlikely.

V. CONCLUSION

Countless ideas exist to solve the healthcare crisis, and many touch on antitrust issues. Policymakers should keep their minds open to all possibilities that do not immediately violate the federal antitrust laws that are enforced by the FTC or the Department of Justice.

That said, the ideas embodied in two recent California bills—though the bills have since failed—and the current New York bill deserve the attention of experts aiming to solve this country's healthcare crisis. In the 2007-2008 legislative session, Senate Bill 1300 and Assembly Bill 2839 both aimed to ban confidentiality agreements in reimbursement-rate contracts between insurers and healthcare providers. These confidentiality agreements came either before or after negotiations, and both seemed to give unfair benefit to large insurance

¹⁴⁴ "Both are written documents prepared unilaterally by providers," the letter complained. *Id.*

¹⁴⁵ Guadagnino, *supra* note 83.

¹⁴⁶ *Id.*

companies, especially in comparison to solo-practice doctors. In 2009, New York Assembly Bill A04301 would have allowed physician collective bargaining over fees, provided that the potential participants receive pre-approval from a New York agency.

Because of the importance of healthcare, and the recent shifts in medical financing, this idea is ripe for analysis among policymakers. Furthermore, breaking open the aforementioned confidentiality clauses does not seem obviously violative of federal antitrust laws. Specifically, legislation could be written to comport with the state-action doctrine that allows states to give antitrust exemptions if the state actively ensures that the exemption results in the achievement of state goals.

The important element for policymakers to remember is to try to create laws that fit within the state-action doctrine—which requires heavy supervision by a state—without spending too much money and without making the new program too unattractive for physicians to participate. Also, policymakers should articulate the right reasons for making this change. Their constituents are likely unsympathetic to skirting antitrust laws, especially in an era when large financial institutions damaged this nation's economy, and especially if an insurance lobby can easily attack lawmakers' policies. The best policy argument would be the following: Loosening physician collective-bargaining rules should not be expected to solve the healthcare financing dilemma, but rather should be seen as a low-cost, legal solution that chips away at the problems that physicians and their patients face regarding high-cost health insurance.