Approved: February 23, 1994
Date FM

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on February 16, 1994 in Room 423-S of the Capitol.

All members were present except:

Committee staff present:
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Rep. Gatlin
Rep. Dennis McKinney
Tom Bell, Kansas Hospital Association
Chip Wheelen, Kansas Medical Society
Harold Riehm, Kansas Association of Osteopathic Medicine

Others attending: See attached list

Chair called the meeting to order and welcomed all the visitors to the meeting today.

Chair called attention to the agenda and requested a staff briefing on **HB 2709**

HB 2709

Dr. Wolff gave a comprehensive explanation of **HB 2790,** noting this legislation is the result of discussions held in the Joint Committee on Health Care Decisions of the 1990s. He drew attention to language regarding cooperative agreements requiring health care providers to collaborate on the provision of services thereby raising the issue of anti-trust effects. Regulatory oversight of cooperative agreements is necessary to insure that the benefits outweigh any disadvantages attributable to the reduction in competition.

He drew attention to policy issues; new language; and exclusions, terms of cooperative agreements; definitions of health care providers. The Secretary of Health and Environment is the authority that will review the cooperative agreements. Mr. Wolff continued, detailing the bill section by section. It was noted an Advisory Committee is to be appointed by the Secretary. He answered numerous questions.

Rep. Gatlin, Chairman of the Joint Committee on Health Care Decisions for the 1990s spoke in support of **HB 2709.** He offered hand-out (Attachment No. 1). He noted savings for health care can be attained by agreement of competing parties to provide a single service, but each is potentially subject to Federal anti-trust law violations. He stated **HB 2709** sets up a mechanism for a system by which the state can review cooperative acts and provide for some protection from anti-trust laws. Economics of the times dictate that we look favorably on cooperation between health care providers. No questions.

Rep. Dennis McKinney offered hand-out (Attachment No.2). He stated, this legislation would open doors for rural hospitals. The industry is changing as the medical industry, doctors in rural communities usually no longer own the clinic facilities. Doctors are quite often hired by hospital management on a productivity contract after being given large first year guarantees. With the difficulty in hiring doctors in rural areas, there is more discussion regarding Multi-County Family Practice Corporations. The purpose of legislation to facilitate cooperative agreements is to remove obstacles to local efforts to help ourselves. There are challenges, but there is optimism that high quality affordable and accessible rural health care can be obtained.

Tom Bell, Kansaas Hospital Association (Attachment No.3) stated support **HB 2709** because it could be beneficial in promoting more collaboration among health care providers. He noted anti-trust laws were not intended to prevent or inhibit vital health care services from being provided to communities. Yet, laws create obstacles to collaborative efforts. Activities health care providers could engage in independently, may be subject to anti-trust scrutiny if engaged in with others. He highlighted some examples. It was noted the health care providers have received mixed signals from the federal government, i.e., on one hand they are asked by the Department of Health/Human Services to cooperate and increase their efficiency, and on the other hand the Federal Trade Commission and the Department of Justice tells the provider that what they want to do is problematic. He noted, the ultimate solution to the problems related to the anti-trust, lie at the federal level. If appropriate federal policies can be developed, it would render legislation such as **HB 2709** unnecessary. He answered numerous questions.

Chip Wheelen, Kansas Medical Society offered hand-out (Attachment No. 4). He stated, if possible, the Medical Society would prefer amendments to federal laws which would allow collaboration between health care providers, but short of that they do support the provision in **HB 2709**. In some situations in the health care market, cooperation may be more efficient than competition. **HB 2709** is really about just that. For physicians, the relief from constraints of the anti-trust would allow meaningful discussions with insurance plans regarding credentialing issues, policies affecting care of patients, utilization review procedures, and payment issues. He noted their Industry continues to lobby Congress for anti-trust relief. In the meantime, they do support **HB 2709**.

Harold Riehm, Kansas Association Osteopathic Medicine offered hand-out (see Attachment No.5). He noted as those in his Association number in the minority of physician groups in Kansas, the Osteopathic physicians are always concerned about agreements among providers that may lead to the exclusion of Doctor's of Osteopathy (DO) in patterns of health care delivery, and ultimately in the loss of physician choice by patients. He noted it is assumed that high on the state's list of required characteristics of such agreements would be efforts to protect and maintain a competitive environment that encourages provider access as well as protects patient choice of physician. At a very rapid pace, hospitals are buying up physician's practices. It is still an unknown as to how this will eventually impact consumers. Added to this, a mechanism that permits the type of cooperation which is subject to waiver of anti-trust provision, it gives the Osteopathic Medicine community a feeling of uneasiness. However, the support they state for **HB 2709** for the establishment of a mechanism with a large number of built in safety checks, (shown on page 3 of the bill). Their organization would prefer to see the waivers to anti-trust competition resolved on the state level rather than the federal level because of the numbers in the profession of Osteopathic medicine. With these safeguards in place, they support **HB 2709.** He answered numerous questions.

HEARINGS CLOSED ON **HB 2709.**

Chair made announcements. Ms. Correll is still quite ill, and wished the best for quick recovery.

Chair announced the Sub-Committee on **HB 2581** will meet on adjournment of the regular Committee meeting.

Business concluded, Chair adjourned the meeting at 2:30 p.m.

The next meeting is scheduled for February 17, 1994.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-16-94

NAME	ORGANIZATION	ADDRESS
Marilyn Bradt	KCOA	Lawrence
Elizabeth Middleton	NC-EH AAA	MANHATTAN
Jan Howell	Children's Mercy Hosp.	OP, KS
Genny Nicholas	Children's Mercy	KC, MO
Rich Guthrie	Health Midwest	KC
Tina Munroe	Johnson Co. Human Services + Aging	Merriam, KS
Sherry Hannon	Jo Cty HS & A	Olathe Kansas
Angela Pelger	Johnson County Human Services Aging	~~Ot~~ Merriam, KS
Cherise Stull	Jo Cty Human Svcs/aging	Olathe, KS
Jessica Carter	Jo County Human Services & Aging	Olathe KS
Joe Turjanic	KCA	Topeka
KEITH R LANDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS	TOPEKA
Annette Sibert	KAHA	Topeka
Martha Hodgesmith	KARF	Topeka
Dee Cannon	Comes Johnson City on aging & KAHA	Shawnee KS
Donna Elliott	Comes " " JCOA	Shawnee KS.
Lillian A. Drake	Jo Cty AAA	O.V., Ks.
R. J. Drake	Jo Cty AAA	P.V. KS
Josie Torrez	Families Together, Inc	Topeka
John J Federico	McGill + Assoc.	"
Geraldine J Anderson	Jo Co AAA	Lenexa
Daniel + Gladys Cairns	Jo Co AAA	"
Chip Wheelen	Ks Med Soc	Topeka

STATE OF KANSAS

FRED GATLIN
REPRESENTATIVE, 120TH DISTRICT
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: AGRICULTURE
APPROPRIATIONS
ENERGY AND NATURAL RESOURCES
JOINT COMMITTEE ON HEALTH
CARE DECISIONS FOR 90's

TO : House Public Health and Welfare Committee

FROM: Representative Fred Gatlin FG

SUBJ: HB-2709

DATE: February 16, 1994

Chairman Flower and members of the Committee it is my pleasure as Chairman of the Joint Committee on Health Care Decisions for the 1990s to appear in support of HB-2709.

HB-2709 is the outgrowth of a bill from last year that was referred for interim study to the Joint Committee on Health Care Decisions for the 1990's. The genesis for it is a catch 22 situation that has developed within the health care industry. One of the ways that savings can be attained is by agreement of competing parties to provide a single service rather than each party in a given locality providing that service. This can take a multitude of different forms but each and everyone potentially is subject to Federal anti-trust law violation.

There is at present case law which has been developed that says, "for the public good the state can regulate cooperative acts that may

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reduce competition but provide a greater public good by that reduction in competition." I am sure other conferees can tell you more about this than I.

This bill sets up a mechanism for a system by which the state can review cooperative acts and provide for some protection from anti-trust laws. This is an area where a need is certain, regardless of what form federal or state discussions/plans of health care reform take. The economics of the times dictate that we would look favorably on cooperation between health care providers. This legislation facilitates a legal mechanism for that desired cooperation.

Thank you for allowing me to appear today. I will be glad to answer any questions.

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Attch #1-2
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ENERGY & NATURAL RESOURCES
TAXATION
TRANSPORTATION

February 16, 1994

Testimony to House Public Health & Welfare Committee

Thank you for the opportunity to testify on HB2709 regarding hospital cooperative agreements. Naturally I am interested in this legislation because of the doors I believe it would open for rural hospitals.

As I understand current federal law, some antitrust protection is already afforded to public hospitals. And most rural hospitals are publicly owned.

However, rural hospitals are not only cooperating more among themselves, but they are linking up with larger "tertiary care centers" which are usually privately owned. The most exciting new development in this area is the extension of interactive video which now exists in most rural Kansas communities. Interactie video will allow rural hospitals to keep patients in their "home" hospital and access specialists through the interactive video link to the larger urban hospital.

In addition, rural hospitals are getting into areas once thought to be the domain of private enterprise. Because of changes in the medical industry doctors in rural communities usually no longer own the clinic facilities. These are now usually owned by the cities or counties and managed by the hospital management. The doctors are hired quite often by the hospital management on a productivity contract after being given large first year guarantees and other major benefits.

Still further, because of the difficulty in hiring doctors in rural areas we are starting to discuss setting up multi-county family practice

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corporations. These could allow greater sharing of doctors and health care professionals and more ability to locate and recruit professionals.

Attached is a copy of a Wall Street Journal article discussing problems posed under current federal law.

The purpose of legislation to facilitate cooperative agreements is to remove obstacles to local efforts to help ourselves. While we are facing great challenges, there is optimism in my area that we can adapt and overcome the threats to high quality affordable and accessible rural health care.

Thank you very much for your time and attention.

KETPLACE

Advertising: *Racy 'NYPD Blue' looks to be a tough sell for ABC* **Page B5.**

Medicine: *Study links breast cancer treatment to lung disease risk* **Page B8.**

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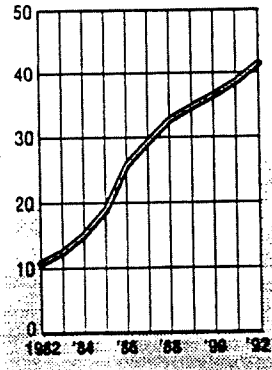
MEDICINE

Disputes Pit HMOs Against Doctors

HMOs Gain Ground...
HMO membership in millions



Sources: Health Affairs and Group Health Association of America

But Clash With M.D.s
Recent cases and outcomes

- **U.S. VS. AARON LANOY ALSTON, ET AL.:** Arizona dentists were accused of conspiring to fix prices; lead defendant pleaded no contest in January 1993.
- **U.S. VS. MASSACHUSETTS ALLERGY SOCIETY:** Society was accused of conspiring to fix prices paid by HMO; it settled case in 1992 by accepting limits on its negotiation tactics.
- **IN RE: SOUTHBANK IPA:** Jacksonville, Fla., obstetricians were investigated by FTC on charges of anticompetitive behavior; they settled case in 1991 and agreed to disband joint marketing group.

clearing the way for managed-care plans to operate in the face of doctors' opposition. He added: "Continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care reform."

HMOs portray themselves as the vulnerable ones, needing federal antitrust support. "What's disturbing to me is a push by providers to band together and exclude managed care," says David Simon, general counsel of U.S. Healthcare Corp., an HMO based in Blue Bell, Pa.

"I believe the Justice Department is getting more aggressive in trying to find out about these issues and pursue them," Mr. Simon says. But he contends that it's difficult to catch doctors in the midst of anticompetitive plotting. "Nothing is done overtly," Mr. Simon asserts. "It's done quietly, in hospital cafeterias."

Doctors and their lawyers contend that the balance of price-negotiating power has shifted too far toward HMOs. "We want an ability for physicians to have viable collective negotiations [with HMOs], so we can have a level playing field," says Kirk Johnson, chief legal counsel for the American Medical Association. "We aren't talking about an ability for doctors to boycott, or engage in price fixing. We're just talking about fairness.

"Health plans now are able to speak for hundreds of thousands of people," Mr. Johnson says. "Maybe professionals ought to be able to respond to that in a collective way." The current disparity, in which health plans can use their market clout but doctors can't, is "very disturbing," he says.

Antitrust cases so far provide some support for both sides. In at least five instances since 1990, the Justice Department or the FTC has won either court verdicts or settlements that have barred doctor groups from anticompetitive practices. The cases range from alleged price fixing by Massachusetts allergists to an alleged boycott of an unpopular HMO by Florida obstetricians.

But several cases also protect doc-

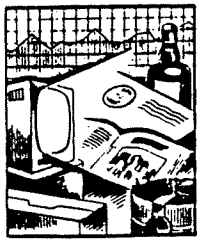
Please Turn to Page B9, Column 1

New Rules Let Hospitals Start Joint Ventures

By EDWARD FELSENTHAL
Staff Reporter of THE WALL STREET JOURNAL

Hospital executives in five states are doing something that only a few years ago would have been unthinkable, and possibly illegal. They're talking to one another.

Despite concerns about inhibiting competition, more states are allowing hospitals to negotiate joint ventures that could help reduce empty beds and underused services. Just talking about such ventures might once have violated antitrust laws, which are designed to promote competition by preventing collusion and price fixing. But under newly enacted legislation in Maine, Minnesota, Ohio, Wisconsin and Washington, hospitals pursuing many kinds of cooperative projects can get protection from antitrust enforcement. Similar laws are pending in six other states and in Congress.



"Before this law was passed, if you got two hospitals together, somebody in the room was going to say, 'Wait a minute, antitrust, everybody clam up,' " says Donald McDowell, president of Maine Medical Center in Portland, the state's largest hospital.

Courts will allow a state to grant exemptions from federal antitrust scrutiny, as long as the state actively supervises any anticompetitive ventures. Wisconsin's reform, for instance, sets up a screening process through which hospitals and other health-care facilities can petition state

Please Turn to Page B5, Column 5

ENTERTAINMENT

LAW

New Rules Are Allowing Hospitals To Engage in Some Joint Ventures

Continued From Page B1

officials for authorization to share personnel, patients or services. The officials are to issue their approval if they decide the benefits of a proposed venture substantially outweigh the disadvantages of any reduction in competition. Authorization can be revoked later if the officials monitoring the venture change their minds.

The first state to change the rules on hospital cooperation was Maine, which enacted its law last year. Almost immediately, hospitals all over the state leapt into negotiations. In September, Northern Cumberland Memorial Hospital, a 40-bed hospital in Bridgton that hadn't been able to recruit a pediatrician, formed a joint venture with a 50-bed hospital 20 miles away. The venture established a pediatric practice to serve all of western Maine. Meanwhile, 10 Maine hospitals are considering collectively expanding their mental-health services. And three Portland facilities have discussed creating a joint laboratory.

By relaxing antitrust scrutiny and promoting cooperation, the five states have challenged a tenet of faith in current efforts to control health costs: the idea that more-intense competition will reduce prices. The states' actions also could collide with proposals by President Clinton's health-care task force, which is expected to recommend introducing new competition to the medical market.

But many supporters of the antitrust reforms contend that competition is part of the problem, and not the solution. Competition, they argue, has led to a kind of medical arms race in which even small hospitals try to offer patients all the latest technology. The hospitals then have to raise prices to cover the high costs of the technology. "Competition has had a long time to work," says Mr. McDowell. "The more we've competed, the more we've driven up the costs."

Even if more states pass antitrust exemptions, hospitals in many areas may choose not to cooperate with one another. Most of the states that already have passed reforms have an abundance of small rural hospitals struggling to stay afloat. In big cities teeming with prospective patients, large hospitals could find the need for collaboration less urgent.

Big-city hospitals often are "committed to a kamikaze survival instinct," says Mr. McDowell. "If I have a long-range strategic plan that says I'm going to steal your market share, it's very hard for me to sit down and talk with you about cooperation."

Some supporters of hospital antitrust exemptions believe that encouraging more cooperation in health care actually will promote competition in the long run. "It isn't a question of competition not working," says Thomas Campbell, an antitrust specialist at law firm Gardner, Carton & Douglas in Chicago. "It's a question of whose brand of competition we're talking about." Mr. Campbell contends that joint ventures and mergers make hospitals more efficient and therefore better able to compete for patients by offering cheaper care.

Federal officials responsible for antitrust enforcement remain wary of hospitals' intentions and warn that some facilities, if unwatched, may collaborate in ways that harm consumers. They also insist that broad antitrust exemptions aren't necessary because the government has challenged only five of the more than 200 hospital mergers that took place between 1987 and 1991. "Government action has been very precise," says Mary Lou Steptoe, acting director of the Federal Trade Commission's Bureau of Competition. "It's been a scalpel and not a bludgeon, and yet the talk out there is as if we are running out there with a bludgeon and stopping every hospital merger."

But antitrust lawyers and hospital executives say the government's five prosecutions have been vigorous enough to frighten many hospitals from talking about cooperative ventures. "It's a little disingenuous to say we've only gotten away with robbing five banks," says Mr. Campbell. Once word gets out, he says, "everyone locks their windows."

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Antitrust

Colo., Texas laws offer relief

Colorado and Texas are the latest two states to pass laws extending antitrust relief to hospitals that engage in collaborative ventures.

With last month's passage of the laws, at least seven states now offer hospitals similar antitrust protection. The others are Maine, Minnesota, Ohio, Washington and Wisconsin. Similar bills are pending in a number of other states.

The hospital industry, led by the American Hospital Association, has argued that antitrust laws and enforcement policies have barred and inhibited beneficial collaborative arrangements among hospitals. However, recent business activity and statements by AHA executives indicate that collaborative ventures among hospitals and between hospitals and other providers are flourishing despite the antitrust laws and enforcement policies (Oct. 12, 1992, p. 26).

Regardless, the industry has been lobbying for antitrust relief at both the federal and state levels. While some skepticism remains among federal officials, state lawmakers appear sympathetic to hospitals' cause and are passing hospital antitrust protection measures.

In Colorado, the Hospital Efficiency and Cooperation Act took effect on July 1. The state House of Representatives passed the bill on May 11 by a 58-4 vote; the state Senate passed the bill on April 15 by a 28-3 vote. Colorado Gov. Roy Romer signed the bill into law on June 8.

The new law, written by and introduced on behalf of the Colorado Hospital Association, creates an 11-member "healthcare agreements board" to review applications from any of Colorado's 76 hospitals seeking collaborative arrangements.

The board can approve applications from hospitals whose ventures are deemed to provide certain benefits, such as improving access or quality, reducing costs or increasing efficiency. Approved ventures would be exempt from state antitrust laws. The board also will review annual reports from hospitals and can terminate agreements that aren't meeting their promised goals.

The law achieves a number of objectives aside from offering hospitals legal safety, said Larry Wall, president of the Colorado Hospital Association.

The objectives include sending a message to hospitals that they should consider collaboration rather than competition, said Mr. Wall, who added, "This precludes hospitals from using antitrust as a reason not to work together."

Mr. Wall

The new law, however, doesn't specifically mention mergers or acquisitions as types of protected activity. Mergers and acquisitions were included in the CHA's original bill but were dropped during the legislative negotiations.

"We would have liked to keep mergers in, but we're comfortable with the change because many mergers would need to be reviewed by the Justice Department anyway," Mr. Wall said.

Meanwhile, Texas Gov. Ann Richards signed legislation on June 12 that tries to insulate hospitals from federal antitrust law by creating a way to certify that the benefits of collaboration outweigh any anti-competitive risks.

The measure passed the state Senate on May 26 by a voice vote; it passed the state House on May 28, also by a voice vote. The new law will take effect on Sept. 1.

Under the law, any of Texas' 511 hospitals can apply for a "certificate of public advantage" from the state health department. To obtain a certificate, hospitals will have to demonstrate by "clear and convincing evidence" that their proposed ventures do such things as improve access and quality, improve hospitals' cost efficiency and avoid duplication of hospital resources.

Like Colorado's law, the new Texa statute doesn't apply to hospital merg ers or acquisitions.

The state attorney general's office wi conduct a simultaneous review of th ventures to determine whether th anti-competitive risks of the deals ou weigh the community benefits. The a torney general can advise the health d partment against granting certificat or, if certificates are granted, can sue th hospitals anyway.

The law is intended to insulate hosp tals from federal antitrust scrutiny u der the legal doctrine of "state action i munity." Under the doctrine, activiti mandated by the state and actively s pervised by the state are immune fr federal antitrust laws.

Under the Texas law, the health partment and attorney general have t authority to terminate a hospital's c tificate of public advantage if a vent isn't living up to its promises.

The Texas Hospital Association hel draft and lobbied for the legislati

—David Burda

Iowa hospitals submi additional merger dat

Attorneys for two merging Iowa ho tals are scheduled to meet with Jus Department antitrust investiga this week to discuss the competitiv fects of the hospitals' consolidation.

The July 9 meeting in Washin follows the completion last week o submission of additional financial utilization documents to the Ju Department by the two Des Mc hospitals, 710-bed Iowa Meth Medical Center and 319-bed Iow theran Hospital.

The hospitals announced merger in February and filed th quired pre-merger notification ments with the government in Ap May, the Justice Department iss "second request" for information the two hospitals regarding transaction.

A second request for informatio cally signals that a proposed mer acquisition is undergoing a thorou amination for anti-competitive eff

Spokesmen for the hospitals, merger will give them control of the nearly 2,000 staffed hospita in Des Moines, have expressed dence the government will gi hospitals antitrust clearance 24, p. 13).

Shalala OKs 'safe harbors' volume 2

HHS Secretary Donna Shalala signed off on the long-awaited second set of Medicare "safe harbor" regulations last week, forwarding them to the White House Office of Management and Budget for a final review, said a spokeswoman for HHS' inspector general's office.

In January, the Clinton administration withdrew the regulations days before their expected publication along with all non-emergency federal regulations (Feb. 1, p. 10).

The regulations are expected to insulate certain hospital physician recruitment activities from the anti-kickback provisions of the Medicare and Medicaid fraud and abuse statutes.

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

Date: February 16, 1994

To: House Public Health & Welfare Committee

From: Kansas Hospital Association

Re: **Health Care Provider Cooperation Legislation; HB 2709**

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of HB 2709. We support such legislation because it could be beneficial in promoting more collaboration among health care providers in our state.

At the heart of this discussion are the antitrust laws and their effect on collaborative efforts among health care providers. The Sherman Act (15 U.S.C. § 1), a federal law, prohibits joint action that unreasonably restrains trade. The Act also prohibits monopolization and attempted monopolization. Another federal law, the Clayton Act (15 U.S.C. § 13), prohibits, among other things, mergers or joint ventures that may lessen competition or create monopolies. These laws are enforced by the Federal Trade Commission and the Department of Justice. In addition, state attorneys general have standing to enforce the federal antitrust laws under the Clayton Act.

Most advocates of some type of health care reform agree on at least one point: increased cooperation among health care providers is vital for improving cost efficiency and patient access. Despite this agreement, health care providers are receiving mixed messages from the federal government. The Department of Health and Human Services (HHS) encourages providers to increase efficiency, avoid duplication, and reduce costs--goals that can be achieved through greater provider collaboration. At the same time, the Department of Justice (DOJ) and Federal Trade Commission (FTC) indicate that activities designed to achieve these goals may be at risk under the federal antitrust laws. Many arrangements which common sense indicates are appropriate from a health care perspective may be prohibited by the antitrust laws.

The antitrust laws were not intended to prevent, or even inhibit, vital health care services from being provided to a community. Yet, the laws create obstacles to

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collaborative efforts. Intended to prevent anticompetitive behavior, the antitrust laws scrutinize joint conduct more closely than unilateral conduct. Therefore, activities health care providers could legitimately engage in independently may be subject to antitrust scrutiny if engaged in with others.

Some examples of beneficial arrangements help illustrate the barriers faced. Under current law, hospitals cannot agree to allocate services among themselves based on location or the type of services provided, even if the allocation is recognized as beneficial by consumers--including the business community, one of the largest purchasers of health care. Thus, two hospitals cannot agree that one will purchase an MRI and the other will purchase a lithotripter, instead of each purchasing both pieces of equipment. Such an agreement would be considered "market division," a violation of the antitrust laws.

Other examples of arrangements that risk antitrust liability include agreements to create health care "centers of excellence" and joint ventures to provide high technology services, even where such arrangements enhance the quality of care and eliminate the unnecessary duplication of services.

Even where the antitrust laws may not pose an actual threat, other factors create a "chilling effect" on health care providers' efforts to work together. Inadequate guidance from the federal government, the potential for treble damages and/or criminal prosecution, and the time and expense associated with challenges by enforcement agencies combine to inhibit hospital initiatives. In order to successfully cooperate and conserve costly resources, health care providers need to discuss and assess the needs of their communities. Yet, even these discussions may implicate the antitrust laws. A *Hospitals* magazine poll indicated that almost half of surveyed hospital CEOs agreed that antitrust concerns have slowed down or inhibited hospitals' collaborative efforts.

Given the lack of any clear direction on the federal level thus far, some states have passed laws to encourage collaboration on the part of health care providers. These laws are based on the doctrine of "state action immunity", a legal concept that exempts certain activities from federal antitrust prosecution if the state actively promotes and oversees them. To qualify for this state action immunity, the actions in question must be (1) pursuant to a "clearly articulated and affirmatively expressed state policy", and (2) "actively supervised" by the state.

These state laws, beginning with one adopted by the Maine legislature, typically provide that, pursuant to a clear legislative policy, hospitals and other health care

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providers can apply for a "certificate of public advantage" from the state. If the application is approved, the state agency certifies that the benefits of the collaborative agreement outweigh the disadvantages. The state then continues to oversee the arrangement. In this way, both parts of the legal test are met.

Clearly, the ultimate solution to this problem lies at the federal level. There is now increasing evidence that federal policymakers intend to deal with antitrust issues. For example, the Department of Justice (DOJ) and the FTC have recently issued clarifying guidelines applicable to questionable health care activity. President Clinton's proposal contains some antitrust exemptions, and Senator Hatch has introduced legislation creating safe harbors for cooperative activities of providers. If appropriate federal policies can be developed, it would render legislation such as HB 2709 unnecessary.

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WATS 800-332-0156 FAX 913-235-5114

February 16, 1994

To: House Public Health and Welfare Committee

From: Chip Wheelen, KMS Director of Public Affairs

Subject: House Bill 2709;
Cooperative Agreements Among Health Care Providers

The Kansas Medical Society supports the intent of HB2709 because it recognizes the need to allow health care providers to collaborate in an effort to provide cost-effective health care services. We would prefer, if possible, amendments to federal laws which would allow such collaboration but, short of that, we support the provisions of HB2709.

The current provisions of federal anti-trust laws are based on the premise that monopolistic or other anti-competitive activity is not in the best interests of the public. These laws assume that competition in the marketplace will provide consumer access to the lowest priced products and services, and that supply will meet or exceed demand. While this may be true under normal economic circumstances, there are occasions when the health care market does not reflect theoretical economic models. In some situations, cooperation may be more efficient than competition.

For physicians, relief from the constraints of federal anti-trust laws would allow meaningful discussions with insurance plans regarding credentialing issues, policies affecting care of patients, utilization review procedures, and payment issues. Under current proscriptions, we are reminded frequently by our attorneys to avoid discussions that might imply a collective effort to affect the health care marketplace.

We continue to lobby Congress through the American Medical Association for anti-trust relief. In the meantime, we respectfully request your favorable recommendation for passage of HB2709. Thank you for considering our position on this matter.

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Ka .s Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

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(913) 234-5564 Fax

February 16, 1994

To: Chairperson Flower and Members, House Public Health Committee

From: Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine

TESTIMONY ON HOUSE BILL 2709 - 02/16/94

Thank you for this opportunity to testify on H.B. 2709. I appear today in qualified support of this Bill.

As a distinct minority physician group in Kansas, osteopathic physicians are always concerned about agreements among providers that may lead to the exclusion of D.O.s in patterns of health care delivery, and, ultimately, in the loss of physician choice by patients. We are, thus, concerned about some changes now occurring in Kansas, and about others that might occur should cooperative agreements, in the name of "health care reform", be initiated that are essentially anti-competitive in nature.

The many procedural safeguards that appear in this Bill appear to offer a means for the State, specifically the Department of Health and Environment and its Secretary, to carefully observe and evaluate the types of agreements that might be proposed among health care providers. We assume that high on the State's list of required characteristics of such agreements, would be efforts to protect and maintain a competitive environment that encourages provider access as well as protects patient choice of physician.

With these safeguards in the Bill, we support passage of 2709.

I will be pleased to respond to questions you may have.

PH&W
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