Testimony of David A. Balto

To the Committee on Commerce and Labor
Minnesota House of Representatives

Regarding HF 120: Health Care Cooperative Arrangement Oversight Established, Rural Area Health Care Service Access Increased, and Money Appropriated.

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I appreciate the opportunity to testify before you on these bills. I am the former Policy Director of the Federal Trade Commission and have practiced antitrust law for over 25 years, primarily as a government enforcer at the FTC and Justice Department. I am also a Senior Fellow at the Center for American Progress a public interest advocacy group, where my work focuses on healthcare reform. I am here to testify in response to the letter submitted by the staff of the Federal Trade Commission regarding the proposed legislation.

As my testimony sets forth, the criticisms of the FTC staff are misplaced and do not recognize the procompetitive benefits of the Minnesota Rural Health Cooperative over the past 14 years. This legislation is an appropriate and necessary step to protect the ability of healthcare cooperatives to exist and enable their members to provide access to high quality health care.

Let me start with two simple facts. But for the Minnesota Cooperative Health Care Act, and statutes like it in other states, the problems of rural health care would be far worse. As documented in numerous studies, rural health care markets suffer from chronic shortages of providers leading to even greater health care problems. If the Minnesota Rural Healthcare Act is not amended rural health care cooperatives will cease to exist, and health insurers will be able to force inadequate reimbursement on hospitals and providers on a "take it or leave it" basis. Residents of rural areas will lose access to both health insurance and providers. Although these residents may then travel long distances for crucial health care services, it is unlikely that they will do so for routine, preventative care, in which case their health may further deteriorate and the cost of caring for them would become substantially more expensive than had they received care earlier by a local provider.

Second, the cooperative legislation offers an important trade off between the theoretical potential for lower prices and greater access. Lower prices are not the

sole concern of the public interest, especially when health care is involved.[1] The Minnesota Legislature has chosen to permit firms to engage in collective activities on dozens of occasions by enacting legislation permitting the formation of cooperatives. There are over 800 cooperatives in the state in areas as varied as agriculture, insurance, banking and electricity.[2] Even if these entities result in somewhat higher prices, the state has wisely determined that access to care is a more important goal. And, in the long run, greater healthcare access actually saves money.

Certainly, one can envision that in the 1930s we could have heard the current arguments of the insurers against this legislation aimed at agriculture cooperatives. They would have said, "if these coops are formed farmers will get more and consumers will pay more." They might have said "we don't want to diminish the bargaining power of agricultural processors to drive down prices." They were wrong then and they are wrong now. If the state legislature had listened to those arguments in the 1930s the family farm would now be a distant memory and farming would be a weakened force in the Minnesota economy. Fortunately, the state legislature ignored those arguments and in farming there is some degree of a level playing field because farmers can band together in coops.

Now to the FTC letter. First, it is important to note that when Minnesota and other states responded to the chronic problems of rural health care shortages in

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[1] States frequently act to ensure access in healthcare markets even where it may result in higher costs. For example, this year the North Dakota state legislature refused to rescind a law that prevents corporations from owning pharmacies even though the proponents of repeal of the law argued that repeal would result in lower healthcare prices. North Dakota Century Code 43-15-35 (e). Implicitly, the decision of the state legislature was that access, particularly in rural markets, was more important than lower prices.

[2] The Minnesota legislature has enacted over a dozen separate pieces of legislation to provide for the formation of cooperatives in a variety of business sectors. *See* https://www.revisor.leg.state.mn.us/statutes/?topic=150562. Minnesota leads the country in the number of cooperative organizations with over 840 cooperatives representing over 44 business sectors, and over one million members. Cooperatives provide substantial benefits to businesses, their local communities, and consumers including support of infrastructure that helps to develop and grow locally owned business, support of cooperative purchasing alliances which can reduce costs, and providing access to services for consumers that are either unavailable or available only at a very high cost. *See* USDA, Measuring the Economic Impact of Cooperatives in Minnesota (December 2003), *available at* http://www.rurdev.usda.gov/rbs/pub/RR200.pdf.

the 1990s by proposing legislation to permit the formation of cooperatives and collective negotiation the FTC never objected.

Second, the proposed legislation does not create some new antitrust exemption as the FTC suggests. The antitrust exemption in the Minnesota cooperative statute has existed for 15 years. Healthcare cooperatives have acted under the statute for that period of time. This proposed legislation does not create a new exemption but simply strengthens the level of supervision of the negotiating process to both alleviate the concerns about unjustified higher prices that the FTC raises and to ensure protection against antitrust actions that could destroy all the benefits that healthcare cooperatives have provided to Minnesota's rural residents.

Third, the FTC fails to recognize that these cooperatives have brought significant procompetitive benefits to the market. The Minnesota Rural Healthcare Act was enacted to improve access to rural healthcare providers for rural healthcare consumers. At the time there was a serious shortage of healthcare providers, both hospitals and doctors in rural Minnesota. The marketplace was dominated by a single health insurance company which often refused to contract with rural healthcare providers. In response to the significant healthcare shortages, Minnesota, like many other states, adopted healthcare cooperative statutes to permit the formation of coops to improve the level of access in these communities.

As documented in both the letter attached to my testimony and submissions by the Minnesota Rural Health Cooperative, this legislation has been successful in numerous respects. Because of the activities of the MRHC, the level of competition in the insurance market has increased. Perhaps this is why the health plans object to this bill – they don't want to compete. Moreover, the cooperative has actively worked with providers to improve the quality of healthcare. In addition, the MRHC's efforts at negotiating on behalf of providers has helped stem the loss of providers in these typically underserved markets because, those providers can now obtain contracts to provide services.

These benefits were recognized by Congressmen Peterson and Walz in a letter to the FTC:

> The MRHC has improved the level of health care significantly for rural Minnesotans. It has enabled its members, including over 20 Critical Access Hospitals, numerous primary care physicians and several specialty care clinics, to enter into agreements with health care plans so that consumers can receive high quality local health care from his or her local health care

provider. The MRHC also seeks to improve the quality of care and the level of access by providing services that monitor and improve the quality of patient care, centralizing credentialing services that increase efficiency for both health plans and health care providers, and offering group purchasing opportunities and projects that save its members scarce financial resources.[3]

Let me respond to some of the specific concerns raised by the Federal Trade Commission:

- Would the proposed legislation harm consumers through higher prices? The FTC suggests that "the bills if enacted would harm Minnesota consumers through higher prices for healthcare services, higher insurance premiums, lower levels of insurance coverage, and lower wages." The FTC's logic has a fatal flaw however - it assumes that private insurance companies are perfect surrogates for the public interest. As this committee is all too aware that is simply not the case. Moreover, there is simply no evidence to support this claim that the proposed legislation would harm consumers. (Indeed, the FTC cites no evidence from Minnesota to support any of its claims.) Even though healthcare cooperatives in Minnesota have existed for 14 years and engaged in collective negotiations for that period of time the FTC letter cites no evidence from Minnesota to support these allegations. Instead they rely on two enforcement actions from other states -- one from 1988 and one from 1992 -- and some almost-decade-old Congressional studies regarding proposed nationwide antitrust exemptions. The best evidence of the impact of collective negotiations in rural areas is the actual experience in rural Minnesota over the past 14 years. If there was evidence of actual anticompetitive effects such as rural Minnesota consumers paying higher prices for healthcare services or higher insurance premiums one would expect the FTC to have presented that evidence in their letter. Rather, collective negotiations by the MRHC have led to greater access and greater information for consumers and not higher premiums.

- Are the bills unnecessary? The FTC suggests that the bills are not necessary because healthcare cooperatives can engage in certain types of joint contracting under the current standards applied by the FTC. We respectfully disagree. If that were true the legislature would not

[3] Letter from Congressmen Collin C. Peterson and Timothy J. Walz to the Honorable Deborah Platt Majoras, Jan. 9, 2008.

have enacted the original exemption. The FTC cites no examples of permitting similar arrangements in their letter. Recently, the FTC has permitted very limited forms of collective negotiations by healthcare groups which meet certain standards for a "clinical integration." In the past eight years they have only approved three of these arrangements and all of these approvals occurred in large urban areas. My understanding is that those arrangements were approved only after a lengthy FTC process that cost each of those healthcare groups over $100,000.00. And implementing the processes that the FTC demands to permit collective negotiations typically costs well over a million dollars. So while joint contracting may be possible in theory, it is not available in practice, and certainly not in the case of MRHC. Moreover, in order to meet the FTC's standards it was necessary for these groups to bring together several hundred healthcare providers, an arrangement that simply would be impossible in a rural healthcare environment. Simply, this legislation is necessary for healthcare cooperatives to continue to function and deliver the benefits it has over the last 14 years.

- Are the bills not likely to improve the quality of our access to care? The FTC alleges that the bills would reduce access to healthcare services. These allegations simply are not borne out by the Minnesota experience. Even if the collective negotiations by a cooperative did result in some level of higher reimbursement, that reimbursement may actually have improved access and the delivery of health care for patients in these underserved areas, as it facilitated the retention of providers in these underserved areas. By enabling the members of the cooperative to stay in business in rural areas, the MRHC improves the level of access and quality of care for consumers.

- Are the provisions in the proposed legislation adequate to protect the consumers? The FTC suggests that the provisions for state oversight "would not ensure that consumers are protected from the significant harm likely to occur as a result of state-sanctioned price fixing." The FTC appears to assume that the regulator currently would engage in only a limited or a superficial review. Indeed it questioned whether the reviewing officials would have the relevant expertise or the capability or resources to make the appropriate evaluation. Based on our discussions with the Minnesota Department of Health we are confident that the regulator is capable and competent. Legislation in

other states provides this type of review and the FTC has not objected to those statutes.

- More important, the proposed legislation was based on legislation previously adopted by the Minnesota Legislature. In a law review article, Judge Sarah Vance observed that the Minnesota legislation would be adequate to confer state action immunity.[4] Finally, if there is a question about the adequacy of review the Minnesota state regulators can identify the appropriate issues and act accordingly.

Finally, the FTC suggests that the proposed legislation would make it "more difficult to institute healthcare reform and expand healthcare coverage." The 14-year experience of the Minnesota Rural Health Cooperative shows there is simply no basis for that claim. In fact, precisely the opposite is true. The healthcare cooperative has provided significant assistance in promoting healthcare reform and expanding healthcare coverage through a variety of programs.

As a former FTC official myself who dedicated almost two decades to public antitrust enforcement, I have the greatest degree of respect for that agency. But here, the agency's comments have failed to recognize the unique challenges of rural healthcare markets and the actual procompetitive benefits of Minnesota cooperatives and their negotiations for cooperative members. Nor have they recognized the decision of the Minnesota state legislature to permit the formation of these cooperatives and permit collective negotiations. The decision to enact the cooperative statute has not harmed consumers, rather it has led to greater access to hospitals and providers, greater insurance competition, and improved healthcare. The cooperative statute should be amended so that this procompetitive conduct can continue.

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[4] Sarah Vance, *Immunity for State-Sanctioned Provider Collaboration After Ticor*, 62 ANTITRUST L.J. 409, 420 (Winter 1994).