TO: **MSSNY's Officers, Councilors and Trustees**

FROM: **MSSNY Legislative & Physician Advocacy Committee**

DATE: **November 7, 2019**

RE: **Resolution 72 – 2019 House of Delegates**
Introduced by the New York County Medical Society

The following resolution was referred to the Council by the House of Delegates. The resolution was forwarded to the Legislative and Physician Advocacy Committee for further study and recommendation for the Council's consideration.

RESOLVED, That the Medical Society of the State of New York should seek legislation to adopt legislation that would be similar to the Minnesota Healthcare Cooperative Act but designed for the New York healthcare marketplace

At the House of Delegates, the reference committee heard some testimony in support of this resolution, but also indicated in its report that more study was necessary. The report noted that, according to the Minnesota Medical Association, there appears to be only one cooperative in existence under the Minnesota law, which was enacted in the 1990s. Apparently, Minnesota's healthcare cooperative was sued by the FTC for alleged anticompetitive behavior, including lack of appropriate "state action" oversight, and reached a settlement in 2011. According to MMA, it has contracting relationships with America's PPO, CorVel Corporation, HealthPartners, Humana, Medica, MultiPlan, Great West Health, PreferredOne, PrimeWest MA, Sanford Health Plan of Minnesota, South Country Health Alliance, and U Care. There was also recently established in Minnesota a health insurance cooperative for rural portions of the state.

While the Reference Committee believed that such an approach could hold promise for creating the opportunity for physicians to jointly negotiate, it was unclear how this approach would be different or less difficult to achieve than MSSNY's efforts in support of legislation (A.2393, Gottfried/S.3462, Rivera) that would permit independently practicing physicians to collectively negotiate with market dominant insurers under close state supervision. Therefore, the Reference Committee recommended that this resolution be referred to Council.

After review, it appears that the Minnesota Rural Healthcare Cooperative (MRHC) is one version of a collective entity that has authorized to negotiate with payers under the "State Action" exception to federal antitrust laws. The MRHC contained over 20 hospital members and 114 physician members (who practiced in 47 sites) in southwestern Minnesota. According to one summary, the flexibility of the cooperative model was an appeal for the rural providers who comprise the MRHC. However, the lack of a clear statutory definition of what exactly a cooperative is caused uncertainty to groups of physicians looking to form cooperatives, and led to disagreements between cooperatives and regulators as to the scope of terms that could be negotiated. While the statute required that payments in contracts between cooperatives and health insurers be "substantially capitated or similar risk sharing basis", the level of risk-sharing was not defined (by comparison, the collective negotiation legislation in New York does not define how payment is to be made, only that it could be a criteria for negotiations in certain circumstances).

The FTC initiated an investigation against the Minnesota cooperative charged that competing hospitals, physicians, and pharmacies in rural southwestern Minnesota agreed to fix prices and collectively negotiate contracts with third-party payers in Minnesota through the MRHC; and that MRHC had undertaken no efficiency-enhancing integration that could justify this conduct. The complaint charged that, since 1996, MRHC negotiated prices and other competitively significant terms with payers in Minnesota, and. MRHC members refused to negotiate individually with payers. It was also alleged that MRHC also threatened to terminate contracts with payers to

pressure them to increase reimbursement rates for MRHC physicians and hospitals. The complaint charged that, through its collective negotiations and coercive tactics, MRHC extracted higher payments and other favorable price-related terms from payers.

The FTC settlement prohibited the MRHC from entering into agreements between or among physicians, hospitals, or pharmacies: (1) to refuse, or threaten to refuse, to deal with any payer regarding the terms, conditions, or requirements upon which any physician deals, or is willing to deal, with any payer (including fees); or (2) to not deal individually with any payer, or to not deal with any payer through any arrangement other than one involving MRHC. The order also prohibited the MRHC from submitting to the Minnesota Department of Health for approval any agreement with any payer if MRHC or any of its officers, directors, members, or employees engaged in any acts of coercion, intimidation, or boycott of, or any concerted refusal to deal with, any payer seeking to contract with MRHC.

In May 2009, while the FTC was investigating the activities of the MRHC, the Minnesota legislature passed an amendment to the existing health cooperatives law requiring that the state commissioner of health "review and authorize" contracts entered into by health care cooperatives. The new legislation appears to have been directly aimed at shielding contracts submitted for state review from liability under the federal antitrust laws. New York's collective negotiation legislation contains a similar provision as necessary to meet the "state action" exception to antitrust laws.

While the FTC significantly limited the scope of what could be negotiated through the settlement, the resulting consent order continues to allow for collective negotiations by the MRHC on behalf of its members. It should be further noted that the FTC has also criticized New York's existing collective negotiation legislation, noting that it "will likely lead to increased costs, reduced innovation, and decreased access to health care for New York consumers, without countervailing benefits." Therefore, MSSNY should continue to examine the legal and political feasibility of creating a similar structure in New York, recognizing at the same time that the FTC would be closely scrutinizing any type of similar structure that could be attempted to be created in New York State. Again, the MHRC appears to be one form of a collective negotiation entity that could be authorized under legislation that is being sought by MSSNY.

At the October Committee meeting, it was discussed that, because the Minnesota statute only permits compensation to the cooperative to be on a "substantially capitated" basis, it was discussed that the policy should not refer specifically to the Minnesota law but only reference the concept of a healthcare cooperative. Questions were also raised regarding whether advocating for a different collective negotiation bill could adversely impact our success on the long-standing bill, but it was noted that both concepts would face strong opposition from the business and insurer community.

RECOMMENDATION: That the MSSNY Council adopt the following resolution in lieu of the original resolution:

RESOLVED, that the Medical Society of the State of New York seek legislation to create a physician-led healthcare cooperative in New York as one pathway for achieving legally permissible state supervised collective negotiation rights for physicians.