UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

October 16, 2002

Via Facsimile and First Class Mail

The Honorable Dennis Stapleton
Chairman, Insurance Committee
Ohio House of Representatives
77 South High Street, 13th Floor
Columbus, OH 43266-0603

Re: *Ohio House Bill 325*

Dear Representative Stapleton:

This letter[(1)] responds to your request for comment on House Bill 325,[(2)] a bill to permit competing health care providers to engage in collective bargaining with health plans over fees and other contract terms. The Commission has opposed federal legislation that would create an antitrust exemption for physician collective bargaining,[(3)] and the Commission staff has expressed concerns about similar bills before state legislatures.[(4)] Such an exemption, the Commission has stated, likely will raise health care costs and reduce access to care, without ensuring better care for patients. In our judgment, House Bill 325 raises similar concerns.

In addition, it is unlikely that House Bill 325 would immunize health care providers from liability for conduct that violates the federal antitrust laws. State economic regulation can immunize private parties from federal antitrust liability, but only where it satisfies the requirements of the "state action" doctrine. In this case, the level of governmental involvement called for in the bill falls far short of the "active state supervision" that the Supreme Court has required to displace federal antitrust law. Although the bill provides for review of both collective negotiations and collectively-negotiated contracts by the state Attorney General, it does not provide the Attorney General with sufficient information, sufficiently clear standards, or sufficient time to exercise "independent judgment and control" over physician collective bargaining matters. Furthermore, the bill requires a written opinion only when the Attorney General denies a petition to negotiate or adopt collectively negotiated terms in spite of the fact that, from the perspective of most consumers, this may well be a less troubling result than approval of a petition, which constitutes authorization to depart from competitive market forces.

I. An Antitrust Exemption for Health Care Provider Collective Bargaining Would Harm Consumers

The opposition of the Commission to antitrust exemptions for physician collective bargaining is based on two core concerns. First, an antitrust exemption will authorize physician price fixing, which is likely to raise costs and reduce consumer access to care. Second, an antitrust exemption is *not* likely to improve the quality of care. Other approaches are available that would improve quality and protect consumers, without sacrificing benefits of competition.[(5)]

A. An Exemption Will Likely Raise Costs and Reduce Access

On its face, House Bill 325 authorizes collective physician conduct that would constitute *per se* price fixing under the federal antitrust laws. The Health Care Statements issued by the Federal Trade

Commission and the U.S. Department of Justice address this issue directly.[(6)] In Example 3 of Statement 8, competing physicians form a hypothetical independent practice association ("IPA") to "combat the power" of managed care plans by negotiating with them collectively rather than individually. The IPA involves no integration that is likely to result in significant efficiencies (such as financial risk-sharing or clinical integration). This combination - collective negotiation over price and no significant efficiency-enhancing integration - means that "the physicians' agreement to bargain through the joint venture will be treated as *per se* illegal price fixing."[(7)]

There is widespread agreement among antitrust authorities that this type of naked horizontal price-fixing is among the most serious of competitive concerns, as such conduct predictably and consistently results in substantial consumer harm. As the Commission observed in its testimony before Congress opposing a federal exemption for physician collective bargaining:

Without antitrust enforcement to block price fixing and boycotts designed to increase health plan payments to health care professionals, we can expect prices for health care services to rise substantially. Health plans would have few alternatives to accepting the collective demands of health care providers for higher fees. The effect of the bill . . . can be expected to extend to various parties, and in various ways, throughout the health care system.[(8)]

The affected parties would likely include consumers, who would be faced with higher insurance premiums and co-payments, as well as their employers. They also likely would include federal, state, and local governments, which would be forced to increase their health care budgets, cut benefits, or reduce the number of beneficiaries covered. Finally the affected parties would likely include the uninsured. Increases in health care costs likely resulting from physician collective bargaining would be expected to increase the number of individuals in this category and strain the resources of both the public and private entities that currently provide for their needs.

The consumer harm likely to result from physician collective bargaining is not merely a hypothetical concern. The Commission's experience investigating numerous cases of collective bargaining by competing health care providers has demonstrated that, in practice, such conduct can have a substantial negative impact on the public. For example, collective fee demands by pharmacists in the State of New York cost the state an estimated $7 million in increased health benefits expenditures for state employees.[(9)] In other cases, the Commission accepted consent orders settling charges that physician collective bargaining forced health plans to raise their reimbursement rates[(10)] - with the attendant risk of increases in premiums for policy holders - and state and local governments to raise the reimbursement levels paid under their employee prescription drug plans.[(11)]

In spite of these significant consumer harms, proponents of physician collective bargaining exemptions frequently argue that they are necessary to "level the playing field" between physicians and health plans. This argument, however, presupposes that physicians are at the mercy of monopsony health plans. Even were it the case that physicians were faced with monopsony health plans,[(12)] attempts to counterbalance that monopsony power with a physician cartel would *not* be likely to benefit consumers. If a health plan did, in fact, possess market power, health care consumers would be doubly harmed by physician collective bargaining, as they would be forced to pay any monopoly mark-up charged by that health plan *on top of* the elevated fees charged by the physician cartel. Without antitrust enforcement to block such price fixing, prices for health care services can be expected to rise substantially. Raising health care costs and making health insurance less affordable would threaten to increase the already substantial uninsured population, and thereby reduce access to health care services.

B. An Exemption Will Not Improve the Quality of Care

Even if physician collective bargaining exemptions are likely to raise costs, proponents of such exemptions argue that increased costs are nevertheless justified. These costs, they argue, are a small price to pay for improvements in the quality of care that may result from the types of communications that

simply would not be possible in the absence of an antitrust exemption. This argument is unpersuasive for two reasons.

First, discussions between physician groups and health plans are not illegal. Current antitrust law permits doctors to negotiate collectively with health plans in various circumstances in which consumers are likely to benefit. The Health Care Statements, for example, describe multiple, antitrust-compliant methods by which physicians may organize networks, and other joint arrangements, to deal collectively with health plans and other physicians.[(13)] These methods include physicians' use of professional societies and other groups jointly to provide information and express opinions to health plans.[(14)] As the Commission explained in its testimony before Congress:

[T]he antitrust laws do not prohibit medicals societies and other groups from engaging in collective discussions with health plans regarding issues of patient care. Among other things, physicians may collectively explain to a health plan why they think a particular policy or practice is medically unsound, and may present medical or scientific date to support their views.[(15)]

Second, in practice, physician collective bargaining has historically focused on physician *compensation*, rather than quality of care issues. This focus suggests that immunizing collective bargaining will impose costs without guaranteeing that patients' interests in quality care would be served. The Commission addressed this issue squarely in its congressional testimony as well, stating that:

Collective bargaining rights are designed to raise the incomes and improve working conditions of union members. The law protects the United Auto Workers' right to bargain for higher wages and better working conditions, but we do not rely on the UAW to bargain for safer cars. Congress addressed those concerns in other ways.[(16)]

Accordingly, blanket antitrust immunity for physician price fixing is not necessary to protect patient welfare.

II. House Bill 325

Like the other physician collective bargaining bills on which the Commission and Commission staff have commented, House Bill 325 would confer a broad authorization on competing health care providers to agree on the prices and other terms they will accept from health plans and to bargain jointly with plans to obtain these collectively-determined contract terms. While House Bill 325 differs from these bills in some respects, these differences do not eliminate the likelihood of substantial harm to consumers.

A. Minimum Threshold for Health Plan Market Power

House Bill 325 does not authorize physician collective bargaining in every instance, but rather limits bargaining over fees and fee-related matters to instances in which a health plan has "substantial market power over providers."[(17)] This market power screen, however, is unlikely to offer adequate protection to Ohio's health care consumers.[(18)]

The principal problem is that the concept of substantial market power used in the bill would perform no meaningful screening function. House Bill 325 provides that physicians may only engage in collective bargaining with a health plan regarding fees and fee-related matters after first demonstrating that the plan has "substantial market power." The bill further provides that a health plan has "substantial market power" if: (1) its market share exceeds 15 percent of health plan enrollees or 25,000 covered lives; or (2) the Attorney General determines that the plan's market power in the relevant area "significantly exceeds the countervailing market power of the providers acting individually." Neither definition represents "substantial market power" in the accepted legal or economic sense.

Market share can indicate market power if based upon a properly defined market, but even if the bill's categories correctly identified relevant markets, a 15 percent market share is not a level ordinarily presumed to constitute market power. Using 25,000 covered lives as the threshold is also problematic as, depending on the size of the market in question, this figure could represent substantially less than a 15 percent share. Furthermore, that a health plan will be deemed to have market power whenever its negotiating power significantly exceeds that of any given individual provider would make the limitation even less connected to any economically meaningful concept of market power. Indeed, it is likely that this provision could be used to justify collective fee setting in virtually all cases. As a result, although it purports to do otherwise, House Bill 325 would, in effect, authorize competing providers collectively to negotiate fees with health plans that lack market power.

B. Pre-Negotiation Physician Communications

House Bill 325 also attempts to shield consumers from the competitive harms resulting from physician collective bargaining by providing the state Attorney General with oversight of the negotiating process and collectively-bargained contract terms. The extent of this oversight is central to the state action analysis, and is discussed in further detail below.

As in the case of the market share screen, however, an initial problem with this protective mechanism is that it does not cover *all* conduct that requires oversight. Most notably, House Bill 325 allows physicians to agree on the fees that they will accept in their negotiations *before* they obtain the Attorney General's approval to undertake actual negotiations.[(19)] As a result, even if the health plan ultimately were deemed to lack substantial market power (making collective fee negotiations improper under the bill), the physicians already will have agreed on acceptable price terms. The likelihood that such an agreement on fees would spill over into individual negotiations on price terms is substantial.

C. Health Plan Opt-Out Power

Finally, House Bill 325 attempts to limit the anticompetitive impact of physician collective bargaining by preserving a health plan's power to opt-out of collective negotiations or collectively-negotiated terms. Nothing in the bill *requires* a health plan to participate in collective bargaining. A health plan may refuse to negotiate with a physician collective bargaining group and attempt to negotiate with its members individually. Also, the petition to the state Attorney General for approval of collectively-negotiated terms must be submitted jointly by the health plan and the physicians that are party to the contract.[(20)]

Once again, however, these provisions are not likely to offer substantial protection to Ohio's health care consumers. Although a health plan is not *required* to negotiate with a physician collective bargaining group, the economic pressure to do so is likely to be substantial. As the Commission has previously observed, collective negotiations can by their very nature convey an implicit threat that, if the health plan does not agree to terms acceptable to the physician group as a whole, it will be prevented from successfully negotiating agreements with the members of the group separately.[(21)] Furthermore, by immunizing agreements among competing physicians on the fees and other terms they will accept from health plans, the bill facilitates coordinated conduct - such as collusive refusals to deal - that, even though not immune, would be difficult to detect and prosecute. Notably, the bill does not address these concerns, as it only requires that the petition to the Attorney General for approval of collectively-bargained terms - a petition that will be filed *after* the physician group has had an opportunity to pressure the health plan - to be filed jointly. The petition to the Attorney General for permission to bargain collectively with a health plan in the first instance, in contrast, may be submitted by the physicians alone.[(22)]

III. State Action Immunity

The antitrust immunity that House Bill 325 is intended to confer can be effective only if there is adequate state supervision of the collective bargaining activities authorized by the statute. Under the judicially-created "state action" doctrine, states may override the national policy favoring competition and provide

that aspects of their economies will be governed by state regulation rather than market forces. States, however, may not simply authorize private parties to violate the antitrust laws.[(23)] Instead, a state must substitute its own control for that of the market. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct.[(24)] In House Bill 325, the Ohio legislature has articulated an intent to displace federal antitrust enforcement. The critical question is whether the bill establishes a regulatory scheme with sufficient state supervision to satisfy the second prong of the state action test.

In order for state supervision to be adequate for state action purposes, state officials must exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties."[(25)] Our review of the bill indicates that its proposed regulatory scheme is not adequate to confer antitrust immunity.

A. Attorney General Approval of Negotiations and Contract Terms

Although House Bill 325 provides that the Attorney General must approve bargaining groups before they commence negotiations and must approve contract terms, these provisions do not appear to confer the kind of authority needed to confer state action immunity. In assessing whether there is adequate state supervision of a price setting scheme, the question is whether the state has exercised sufficient "independent judgment and control" such that "the details of the rates or prices" can properly be attributed to the state rather than private parties.[(26)] Thus, the Supreme Court has held that where, as in the case of the procedure authorized by House Bill 325, "prices or rates are set as an initial matter by private parties, subject only to veto if the State chooses to exercise it, the party claiming immunity must show that state officials have undertaken the necessary steps to determine the specifics of the ratesetting scheme."[(27)]

1. *Lack of Clear Standards*

House Bill 325 does not provide the Attorney General with the means to exercise independent judgment and control over the details of price setting. For example, the bill fails to provide the Attorney General with clear standards to guide its decision to approve, or disapprove, a petition to negotiate or to adopt collectively-negotiated terms. The very nature and extent of the Attorney General's power under the bill to make such determination remains unclear. The Supreme Court has emphasized that active state supervision requires that state officials "have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy."[(28)] The bill sets no clear standard for the Attorney General's review of physician petitions. It provides only that the Attorney General shall not approve negotiations, or contract terms, that "prohibit or restrict the performance of health care services by the providers that are parties to the contract, which health care services are within the recognized scope of practice of that category of provider."[(29)] It is not clear what this provision is intended to mean, but it is the only standard contained in the bill.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that a private party's anticompetitive action is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own."[(30)] In view of the highly limited examination of privately-set prices that the bill would authorize, it is unlikely that it would establish a sufficiently rigorous regulatory scheme to confer state action immunity.

2. *Limitations on Review*

In addition to failing to provide the Attorney General with sufficiently clear standards, House Bill 325 places strict limitations on the scope of the review, which further limit the Attorney General's ability to exercise independent judgment and control over the details of the physicians' private price setting.

a. Insufficient Information

For example, physicians petitioning for the permission to bargain collectively, or for approval of contract terms, are required to submit only basic identification and market share information, plus "such other data, information, and documents that the [petitioners] choose to submit."[(31)] In contrast, no provision grants the Attorney General the power independently to gather evidence or conduct hearings concerning the prices that result from the collective bargaining process, nor is there any mechanism by which to receive input from other physicians, affected health plans, or patients.

The limited nature of the state review is significant, because courts have rejected claims for state action immunity where state officials lacked the information necessary for a meaningful examination of rates.[(32)] In contrast, courts have found active state supervision of price setting arrangements where state officials' review included conducting hearings and providing a mechanism for complaining parties to challenge rates.[(33)]

b. Insufficient Time

House Bill 325 also imposes strict time limitations, allowing only 30 days for the Attorney General to review the facts and render a decision on a petition to negotiate or to adopt collectively-negotiated contract terms.[(34)] The time period is mandatory ("[t]he attorney general shall either approve or disapprove a petition . . . within thirty days") and there is no provision for extension. It is by no means clear that the Attorney General could complete the "pointed reexamination" required to immunize the underlying physician conduct in such a short time.

IV. Transparency

Finally, House Bill 325 requires a written explanation only when the Attorney General *denies* a petition to bargain collectively or disapproves collectively negotiated contract terms.[(35)] Notably, the bill contains no complementary provision requiring a written decision to *approve* a proposed contract. A written decision, expressly considering the potentially anticompetitive implications of a proposed contract and attempting to quantify the consumer impact and expected effect on consumer prices, would serve a number of salutary purposes. First, it would inform affected parties of the levels at which prices were being fixed, and so provide an opportunity for comment or challenge as to the appropriateness of those levels. Second, it would help inform the public of the likely impact of the proposed contract on their health care costs.

By requiring a written explanation only when permission is denied, House Bill 325 accomplishes neither of these objectives. In fact, from the perspective of most consumers, disapproval of these arrangements is likely to be the less troubling result. Disapproval indicates that market forces will continue to govern, whereas approval indicates that they will be temporarily suspended, with a potentially adverse impact on price and access. It is the latter situation - one that seeks to depart from the national policy favoring competition, rather than collaboration and price fixing among rivals - that more clearly warrants a written decision and is more properly subject to consumer scrutiny.

* * *

In summary, House Bill 325 poses a substantial risk of harm to Ohio citizens. By authorizing price fixing by health care providers, the bill is likely to increase costs and reduce access to care, without any assurance that the state's interest in promoting quality health care would be furthered. Moreover, the bill is unlikely to achieve its stated purpose of conferring state action immunity on provider collective bargaining, because the regulatory oversight provided is insufficient.

Parties claiming immunity under the state action doctrine bear the burden of establishing that they are entitled to such immunity. Thus, should the Ohio Legislature proceed with a collective bargaining bill, it will be important to ensure that the bill establishes a regulatory procedure that meets the rigorous requirements that the Supreme Court has established. Otherwise, providers relying on the bill's provisions

to provide antitrust immunity would risk exposure to potentially significant financial liability for their actions.

I hope you find these comments helpful. Should you have any additional questions, feel free to contact Jeffrey W. Brennan, Assistant Director for Health Care Products and Services, at 202-326-3688.

Sincerely,

Joseph J. Simons, Director
Jeffrey W. Brennan, Assistant Director
Bureau of Competition

R. Ted Cruz, Director
John T. Delacourt, Attorney
Office of Policy Planning

Endnotes:

1. This letter represents the views of the Federal Trade Commission's Bureau of Competition and Office of Policy Planning. It does not necessarily represent the views of the Commission or any individual Commissioner. The Commission, however, has voted to authorize the Bureau of Competition and the Office of Policy Planning to submit these comments.

2. H.B. 325, 124th Gen. Assem., Reg. Sess. (Ohio 2002) ("H.B. 325").

3. *See* Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 22, 1999) ("FTC Testimony on H.R. 1304"), *available at* <http://www.ftc.gov/os/1999/9906/healthcaretestimony.htm> (Attachment 1).

4. *See, e.g.,* Letter to the Washington House of Representatives on House Bill 2360 (Feb. 8, 2002), *available at* <http://www.ftc.gov/be/v020009.pdf> (Attachment 2); Letter to the Alaska House of Representatives on Senate Bill 37 (Jan. 18, 2002), *available at* <http://www.ftc.gov/be/v020003.htm> (Attachment 3); Letter to the District of Columbia Office of Corporation Counsel on Bill No. 13-333 (Oct. 29, 1999), *available at* <http://www.ftc. gov/be/rigsby.htm>; Letter to the Texas Legislature on Senate Bill 1468 (May 13, 1999), *available at* <http://www.ftc.gov/be/v990009.htm>.

5. *See* Staff Advisory Opinion Re MedSouth, Inc., reflected in letter dated February 19, 2002, from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, to John J. Miles, Ober, Kaler, Grimes & Shriver, *available at* <http://www.ftc.gov/bc/adops/medsouth.htm>.

6. Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (Aug. 1996) ("Health Care Statements"), *available at* <http://www.ftc.gov/ reports/ hlth3s.htm>.

7. *Id.* at Statement 8, Example 3.

8. FTC Testimony on H.R. 1304, *supra* note 3, at 5-6.

9. *See Peterson Drug Company*, 115 F.T.C. 492, 540 (1992). *See also Pharmaceutical Society of the State of New York, Inc.*, 113 F.T.C. 661 (1990) (consent order).

10. *See, e.g., R.T. Welter & Assocs., Inc. (Professionals in Women's Care),* Dkt. No. C-4063 (Oct. 8, 2002) (consent order), *available at* <http://www.ftc.gov/os/2002/10/piwcdo.pdf>; *System Health Providers,* File No. 011 0196 (Aug. 20, 2002) (proposed consent order accepted for placement on public record for comment), *available at* <http://www.ftc.gov/os/2002/08/shpdo.pdf>; *Aurora Associated Primary Care Physicians, L.L.C.,* Dkt. No. C-4055 (July 16, 2002) (consent order), *available at* <http://www.ftc.gov/os/2002/07/aurorado.pdf>; *Physician Integrated Services of Denver, Inc.,* Dkt. No. C-4054 (July 16, 2002) (consent order), *available at* <http://www.ftc.gov/os/2002/07/pisddo.pdf>; *Rochester Anesthesiologists*, 110 F.T.C. 175 (1988) (consent order).

11. *See, e.g., Baltimore Metropolitan Pharmaceutical Assoc., Inc. and Maryland Pharmacists Assoc.*, 117 F.T.C. 95 (1994) (consent order); *Pharmaceutical Society of the State of New York, Inc.*, 113 F.T.C. 661 (1990) (consent order).

12. *See also* FTC Testimony on H.R. 1304, *supra* note 3, at 7 (noting that available information covering the entire U.S. "does not support the suggestion that most (or even many) areas have only one or two health plans"). Furthermore, a health plan's ability to acquire and use monopoly power against providers is constrained by the antitrust laws. *See, e.g., Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); and *United States v. Aetna, Inc.*, Civ. No. 3-99CV 1398-H (N. D. Tex. Dec. 7, 1999) (acquisition by a worldwide provider of

health, retirement, and financial services benefits of the health care business of a competing company allowed to proceed only after the acquirer agreed to divest its health maintenance organization businesses in Houston and Dallas-Forth Worth, Texas).

13. *See generally* Health Care Statements, *supra* note 6.

14. *See , e.g., Schachar v. American Academy of Opthalmology*, 870 F.2d 397 (7th Cir. 1989). *See also* Health Care Statements, *supra* note 6, at Statements 4-5.

15. FTC Testimony on H.R. 1304, *supra* note 3, at 7. *See also* Health Care Statements, *supra* note 6, at Statement 4 (creating an antitrust safety zone for health care providers' collective provision of non-fee-related information to health plans).

16. FTC Testimony on H.R. 1304, *supra* note 3, at 10.

17. H.B. 325 at § 1751.133(B).

18. An initial problem with this screening mechanism is that it does not apply to *all* price-related collective bargaining. For example, the bill does not require physicians to demonstrate "substantial" health plan market power before collectively negotiating "[t]he methods and timing of payments, including, but not limited to, interest and penalties for late payments." *Id.* at § 1751.132(I). Interest charges and penalties have a direct and significant impact on the ultimate price that providers receive for their services. Moreover, even collective bargaining over other, more clearly "non-price" terms can have a substantial effect on the ultimate price paid by consumers.

19. *Id.* at § 1751.135(C)-(D).

20. *Id.* at §§ 1751.137(A) and 3923.356(A).

21. *See Alaska Healthcare Network, Inc.*, Dkt. No. C-4007, (Apr. 25, 2001) (consent order) (In its complaint, the Commission alleged that "[p]ayors believed that they could not go around [Alaska Healthcare Network] to contract individually with physicians in Fairbanks, and thus that they had no alternative but to reach agreement with AHN or to give up their planned entry into Fairbanks."). *See also Michigan State Medical Society*, 101 F.T.C. 191, 296 n.32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); *Preferred Physicians Inc.*, 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations).

22. H.B. 325 at §§ 1751.136(A) and 3923.355(A).

23. *Parker v. Brown*, 317 U.S. 341, 351 (1943) ("[A] state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or declaring that their action is lawful.").

24. *See California Retail Liquor Dealers Assn v. Midcal Aluminum, Inc.,* 445 U.S. 92 (1980). Although there are certain, limited exceptions to the active supervision requirement - *see Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 46 (1985) (holding that the active supervision prong of *Midcal* does not apply to municipalities) - no such exception is applicable here.

25. *Federal Trade Commission v. Ticor Title Insurance Co.,* 504 U.S. 621, 634-35 (1992).

26. *Id.* at 634-35.

27. *Id.* at 638.

28. *Patrick v. Burget,* 486 U.S. 94, 100-101 (1988).

29. H.B. 325 at § 1751.137(B).

30. *Patrick*, 486 U.S. at 106.

31. H.B. 325 at §§ 1751.136(A)(9), 1751.137(A)(4), 3923.355(A)(9), and 3923.356(A)(4).

32. *See, e.g., Ticor Title Insurance Co. v. FTC*, 998 F.2d 1129, 1140 (3d Cir. 1993) (finding lack of state supervision where Connecticut never obtained necessary information that would have enabled it to assess the appropriateness of filed rates).

33. *See, e.g., TEC Cogeneration Inc. v. Florida Power & Light* Co., 76 F.3d 1560 (11th Cir. 1996), *amended in part,* 86 F.3d 1028 (11th Cir. 1996) (rates determined by Public Service Commission rulemaking and subject to extensive agency proceedings); DFW *Metro Line Services v. Southwestern Bell Telephone*, 988 F.2d 601, 606-607 (5th Cir. 1993) (Public Utility Commission conducted both broad-based ratemaking

proceedings and adjudications of specific complaints about the reasonableness of rates); *Lease Lights, Inc. v. Public Serv. Co.*, 849 F.2d 1330, 1334-35 (10th Cir 1988) (state held public hearings to assess the reasonableness of rates).

34. *See* H.B. 325 at §§ 1751.136(C), 1751.137(B), 3923.355(C), and 3923.356(B) ("The attorney general shall either approve or disapprove a petition . . . within thirty days.").

35. *Id.* at §§ 1751.136(C), 1751.137(C), 3923.355(C), and 3923.356(C).