Physician Unionization: The Quality Health Care Coalition Act

Q: Do you support the Quality Health Care Coalition Act, which would give physicians an antitrust exemption so they could unionize?

A: I think we need to look at it. Physicians have raised serious and valid concerns about the increasing concentration of the health insurance market. We've seen an unprecedented number of insurance company mergers, and now a few large insurers dominate the market. Physicians are rightly concerned that HMO's will use this market power to interfere with the doctor-patient relationship and restrict patient access to medically necessary care. That's why I'm fighting so hard for a patients' bill of rights, which would help address managed care abuses. I am a strong supporter of unions and think we need to look at how we can ensure that large insurers do not have unfair leverage over physicians – we need to make sure physicians face a level playing field.

Doctors Taking Control

NYT 10/6/99

The growth of managed-care health plans since the mid-1990's brought the explosive rise of health-care costs to at least a temporary halt. But cost control antagonized both physicians and patients. Physicians choked on constraints that insurance companies slapped on their income and professional autonomy. Patients complained that denials by H.M.O.'s of treatments recommended by physicians amounted to profit-driven betrayal.

But now comes evidence that managed-care systems are bending to satisfy both patients and doctors with modifications in at least one key area, payments to physicians. The modifications have come from some of the more venturesome Independent Practice Associations, known as I.P.A.'s, which are groups of doctors that sign contracts with H.M.O.'s to treat enrollees. In many Western states such groups treat most of the enrollees in H.M.O.'s, and they are growing everywhere else, including New York City.

The physicians who join such an association remain in solo or small-group practice and in charge of running their own offices. Insurance companies like Aetna pay the I.P.A.'s a fixed fee to treat each enrollee who chooses a primary-care physician from the I.P.A. The I.P.A., in turn, pays its physicians and performs tasks like processing claims.

An I.P.A. controls costs by monitoring its physicians' practices and denying requests for unnecessary procedures. But in this case, physicians are told no by members of their physician group, not by a nurse or medical director from a faraway insurance company. I.P.A.'s, then, can reduce intrusive interference by insurance companies, the source of much antagonism of patients and doctors.

The best I.P.A.'s also oversee quality. For example, specialists at a San Francisco Bay Area association meet regularly to develop ways to treat patients and intervene when physicians fail to uphold agreed-upon standards.

Some I.P.A.'s have paid physicians a fee for every procedure they provide, which motivates doctors to attend to patients' every need but does a poor job controlling costs. Others have paid a fixed monthly rate per patient, a practice called capitation, which creates an agonizing conflict of interest because the less doctors do for their patients, the more income they keep. Neither pure fee-for-service nor pure capitation works well.

But now, according to an article by Prof. James C. Robinson of the University of California at Berkeley in a recent issue of the Journal of the American Medical Association, I.P.A.'s are developing "blended" methods that combine the best features of fee-for-service and capitation. For example, a California I.P.A. pays primary-care physicians a fixed monthly rate per enrollee to cover basic services. But it also pays them extra fees to cover services that the I.P.A. wants to encourage: mammograms, visits to patients in nursing homes and office procedures, like screening for colon cancer, that the primary-care physicians might otherwise refer to an expensive specialist.

When enrollees in Aetna or Cigna pick a primary-care physician, they may not know they are joining an I.P.A. But the best I.P.A.'s, Professor Robinson points out, can offer the patient the "feel of fee-for-service," with physicians offering evening office hours and procedures with less grumbling about second-guessing by insurance bureaucrats.

I.P.A.'s may not solve the nation's health-care problems. But doctors, by this means or another, must take responsibility for controlling costs, because they and their patients will surely resist if anyone else tries. Markets are supposed to respond to consumer complaints. Professor Robinson's study shows the process is gathering momentum.

March 30, 2000

Six HMOs To Form Online Partnership

A.P. INDEXES: TOP STORIES | NEWS | SPORTS | BUSINESS | TECHNOLOGY | ENTERTAINMENT

Filed at 5:20 p.m. EST

By The Associated Press

NEW YORK (AP) -- Six large health maintenance organizations are developing their own Internet venture in an effort to reduce administrative hassles for doctors and patients.

The consortium would compete with Internet health giant Healtheon/WebMD which is trying to shift all the paperwork used in health care transactions to the World Wide Web. Those transactions include processing claims, patient referrals and handling prescriptions.

Shares of Healtheon, which went public last year and grew rapidly through a series of mergers in the past six months, lost nearly 16 percent Thursday because of concerns the alliance would deprive it of millions in potential revenue. Atlanta-based Healtheon fell $4.86 to $25.83 on the Nasdaq stock market.

The six health insurers seeking to put together the online project called MedUnited are Aetna, Cigna, Wellpoint Health Networks, Oxford Health Plans, Foundation Health Systems and Pacificare Health Systems, sources from three of the HMOs say. The health plans are working with IBM and Oracle.

It is still unsure whether the consortium will be created and exactly what its strategy would be.

But the effort is striking because the companies are fierce rivals in many major cities around the country.

"They are sending a shot over the bow that they do not want

Healtheon to be the answer for us and they are willing to construct an Internet platform themselves,'' said Claudine Singer, an analyst with Internet research firm Jupiter Communications.

But Singer warns the consortium faces many hurdles. For instance, the companies may find it difficult to share information and doctors are less likely to trust a venture formed by HMOs that have cut their income.

The lack of a standard system to handle physician claims and other paperwork in the health care system is what led to the creation of Healtheon.

The HMOs need to work together on such an Internet transaction system because if only one of them did it would have little impact on physician offices, which routinely accept members from several major insurers.

Most of the HMOs in the consortium have already begun integrating the Internet into their operations. For example, Aetna's Web site now allows consumers to enroll, search for a doctor and check benefits.

''We are interested in the commonality, in terms of getting the administrative burden out of the system,'' said Aetna spokeswoman Joyce Oberdorf. She said the consortium is one of several Internet opportunities the company is exploring.

Internet analysts say the move is likely to be the first of several ventures that are formed with the intent of competing with Healtheon.

Related Information From Hoover's Inc.
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House Judiciary OKs Bill To Let Doctors Bargain With Health Plans

By Michael Posner
National Journal News Service

House Judiciary

H.R. 1304

WASHINGTON (March 30, 2000) -- The House Judiciary Committee approved a controversial bill Thursday to waive antitrust laws and permit doctors to band together and bargain with health care plans.

The bill (H.R. 1304) was approved on a 26-2 roll call [Vote 2] and goes to the full House for action.

Rep. Tom Campbell, R-Calif., sponsored the bill, which has been backed by doctors' groups and opposed by health insurance plans. It would give doctors power to negotiate fees and services with health care organizations which have come under criticism for dictating medical practices which doctors say they should decide.

An amendment by Rep. John Conyers, D-Mich., which was adopted by voice vote, would exempt federal health care programs from requirements to bargain, a move he said would keep the measure out of the hands of other committees. Committee Chairman Henry Hyde, R-Ill., said health care plans opposed to the bill wanted to stall the measure by having it referred to other committees, such as Ways and Means and Commerce. Medicare and Medicaid programs, which fall within the jurisdiction of the other committees, were exempted during an earlier drafting session.

Rep. Edward Pease, R-Ind., offered an amendment that would require doctors groups to get permission from the Federal Trade Commission or Justice Department before they could bargain, a move the bill's backers said would kill the measure. Rep. Bob Goodlatte, R-Va., responded by trying to amend Pease's amendment, proposing to exempt small doctors' groups from having to obtain prior approval from the government.

The committee voted 17-13 [Vote1] to approve the Goodlatte amendment, but then Pease withdrew his underlying amendment, saying he would rework it, presumably for the House floor.

Recorded Votes

Bill: H.R. 1304 Vote: 1

Goodlatte amendment to the Pease amendment, exempting small doctors' groups from having to obtain prior government approval.

Tally: 17 Yes, 13 No, 7 Not Voting

Republicans (21)
N Hyde (R-Ill.)
Y Sensenbrenner (R-Wis.)
Y McCollum (R-Fla.)
Y Gekas (R-Pa.)
Y Coble (R-N.C.)
Y Smith (R-Texas)
Y Gallegly (R-Calif.)
Y Canady (R-Fla.)
Y Goodlatte (R-Va.)
NV Chabot (R-Ohio)
N Barr (R-Ga.)
Y Jenkins (R-Tenn.)
Y Hutchinson (R-Ark.)
Y Pease (R-Ind.)
Y Cannon (R-)
Y Rogan (R-Calif.)
N Graham (R-S.C.)
NV Bono (R-Calif.)
NV Bachus (R-Ala.)
NV Scarborough (R-Fla.)
Y Vitter (R-La.)

Democrats (16)
N Conyers (D-Mich.)
NV Frank (D-Mass.)
N Berman (D-Calif.)
Y Boucher (D-Va.)
N Nadler (D-N.Y.)
Y Scott (D-Va.)
Y Watt (D-N.C.)
NV Lofgren (D-Calif.)
N Jackson Lee (D-Texas)
N Waters (D-Calif.)
N Meehan (D-Mass.)
NV Delahunt (D-Mass.)
N Wexler (D-Fla.)
N Rothman (D-N.J.)
N Baldwin (D-Wis.)
N Weiner (D-N.Y.)

Bill: H.R. 1304 Vote: 2

Vote on final approval.

Tally: 26 Yes, 2 No, 1 Present, 8 Not Voting

Republicans (21)
Y Hyde (R-Ill.)
N Sensenbrenner (R-Wis.)
Y McCollum (R-Fla.)
N Gekas (R-Pa.)
Y Coble (R-N.C.)
Y Smith (R-Texas)
Y Gallegly (R-Calif.)

Y Canady (R-Fla.)
Y Goodlatte (R-Va.)
NV Chabot (R-Ohio)
Y Barr (R-Ga.)
Y Jenkins (R-Tenn.)
Y Hutchinson (R-Ark.)
NV Pease (R-Ind.)
NV Cannon (R-)
NV Rogan (R-Calif.)
Y Graham (R-S.C.)
NV Bono (R-Calif.)
NV Bachus (R-Ala.)
Y Scarborough (R-Fla.)
Y Vitter (R-La.)

Democrats (16)
Y Conyers (D-Mich.)
NV Frank (D-Mass.)
P Berman (D-Calif.)
Y Boucher (D-Va.)
Y Nadler (D-N.Y.)
Y Scott (D-Va.)
Y Watt (D-N.C.)
Y Lofgren (D-Calif.)
Y Jackson Lee (D-Texas)
Y Waters (D-Calif.)
Y Meehan (D-Mass.)
NV Delahunt (D-Mass.)
Y Wexler (D-Fla.)
Y Rothman (D-N.J.)
Y Baldwin (D-Wis.)
Y Weiner (D-N.Y.)

Q&A: HR 1304, the "Quality Health Care Coalition Act of 1999"

AMA February 2000

What does HR 1304 do?

HR 1304 would modify the antitrust laws to foster quality health care for patients by allowing health care professionals to jointly negotiate the terms of their contracts with health care plans.

Why do patients and health care professionals need this bill?

In the last few years, an unprecedented number of health insurance companies have merged. A few large insurers now dominate the marketplace and nearly 80% of Americans receive their health care coverage from a managed care plan. Serious questions have been raised about the ability of patients to receive medically necessary care from these plans. Furthermore, the ability of health care professionals to make decisions for their patients has been compromised to the detriment of the doctor-patient relationship. HR 1304 would ensure that physicians are able to act as effective patient advocates.

Would this bill repeal the antitrust laws that apply to health care professionals?

No. HR 1304 would modify the antitrust laws and would only apply to conduct in conjunction with good faith negotiations with a health plan. All other conduct would continue to be subject to antitrust enforcement.

Would this bill allow price fixing by health care professionals?

No. Price fixing will still be illegal. Price fixing is an antitrust term that refers to the ability of competitors in a market to get together and agree to charge the same price for their products or services. HR 1304 would not allow health care professionals to get together outside of contract negotiations and set prices. They would only be able to negotiate in good faith over contract terms such as referrals to specialists, gag clauses and reimbursement issues. Fees would be determined through these negotiations between health care professionals and health plans – not by agreement among the health care professionals. Under HR 1304, price fixing would remain illegal and would be subject to enforcement measures by the Department of Justice and the Federal Trade Commission.

How many co-sponsors are there? What's the breakdown of Republicans and Democrats?

There are currently 207 co-sponsors, about half Democrats and half Republicans. 20 (8 Republicans and 12 Democrats) of the co-sponsors are members of the Judiciary Committee which has jurisdiction over the bill. It's a truly bipartisan effort. This bill has been gaining incredible momentum, as Congress has become aware of the urgent need to level the playing field with dominant health insurers.

Do we really need HR 1304 if we get a strong Patients' Bill of Rights passed into law at the Federal level?

Yes. The Patients' Bill of Rights is one of AMA's top priorities, but it is not yet the law. In addition, a Patients' Bill of Rights would provide essential protections for all Americans, but it would not cover everything – and there's no way to predict what kind of quality issues will arise in the future. HR 1304 would enable physicians to address managed care abuses and other patient care issues as they arise through contract negotiations.

What does the National Labor Relations Act (NLRA) do?

The NLRA modified the antitrust laws to allow employees to negotiate with their employers.

Does HR 1304 come under the National Labor Relations Act?

No. HR 1304 modifies the antitrust laws (the Sherman Act, the Clayton Act and the Federal Trade Commission Act). The National Labor Relations Act (NLRA) is a labor law that only applies to labor (employer-employee) relations.

Would the National Labor Relations Board supervise negotiations under HR 1304?

No. The National Labor Relations Board was created as part of the NLRA which only governs employer-employee relations.

Would there be any supervision over negotiations under HR 1304?

Yes. The oversight currently exercised by the Department of Justice and the Federal Trade Commission will remain intact. HR 1304 does not repeal the jurisdiction those agencies have over activities of health care professionals. It would not decrease their authority to prosecute health care professionals for activities that are not allowed under HR 1304, such as price-fixing or exclusive dealing (e.g., insisting upon agreements that prevent the health plan from doing business with other classes of health care professionals).

Would health care professionals need to join unions under HR 1304?

No. The legislation simply allows health care professionals to join together in order to negotiate with health plans, whether it be on their own, through the local medical society, an association or organization that represents physicians, an attorney, an established medical group or IPA.

Would health care professionals be allowed to strike?

No. The bill specifically prohibits any collective cessation of patient care services. Physicians currently have ethical and legal duties that require them to provide medically necessary care to their patients once the doctor-patient relationship has commenced. In addition, the AMA has policy against the use of strikes as a negotiation tactic.

What kinds of issues can be negotiated under HR 1304?

Under HR 1304, physicians can negotiate in good faith on most any contract issue – gag clauses, patient privacy issues, referral to specialists, drug formularies, payment, patient convenience issues, etc.

For example, as a convenience to her patients, a Texas pediatrician recently agreed to draw blood for blood tests in her office. Her patients had requested this service because they did not want to make separate trips to the lab the health-plan required that was across town. The pediatrician charged a nominal fee to cover the cost of the needles. She was later reprimanded by the health plan and told to stop drawing blood in her office. These kinds of issues could be negotiated under HR 1304.

Isn't this all about dollars?

HR 1304 is about quality care. Physicians and other health care professionals are concerned about egregious contract provisions that impede their ability to provide high quality care to patients.

The reality is that payment issues can very clearly be patient care issues as well. It is not always possible to separate cost from quality.

In Texas, for example, physicians were being forced to pay out of pocket for the cost of prescription drugs their patients required if the cost exceeded $9000 per patient. This means caring for any patient with AIDS is a money-losing prospect. Unfortunately, these are very sick patients who need care.

The California Medical Association gathered data showing that some pediatricians receive as little as $10 per month for each patient, while the average cost of child care in the state is $24.10 per month. The national average is calculated to be $47 a month. (Towers Perrin) So California physicians are losing anywhere from $444 to $271 per year for each child in their care. How can a physician take the time to provide quality care for a child when he or she is losing money?

If physicians are not able to negotiate for adequate contract terms, including appropriate payments, quality care will continue to suffer. As a matter of fact, a 1999 Price Waterhouse Coopers study revealed that physician practices in California are filing for bankruptcy at an alarming rate. The California Medical Association predicts that 10 million patients risk delayed or interrupted care as a result. If history proves accurate, California will set a trend for the nation.

Isn't it true that physicians can negotiate on patient care issues now?

Physicians as individuals can **try** to negotiate with a health plan over any terms. But an individual physician has little chance for true negotiations with a health plan like Aetna, for example, that has 24 million lives under contract. **The individual patient and the individual physician are essentially irrelevant to a massive health plan.** Independent physicians can only jointly **present** information to health plans regarding patient care issues now. They have no ability to jointly **negotiate** over these terms. Health plans are not required to act upon the information presented. If physicians jointly refuse to contract with the health plan because the health plan won't listen, they risk allegations of an antitrust violation and stiff penalties. Even if physicians independently refuse the contract, they risk allegations of illegal joint activity under the antitrust laws and the same stiff penalties.

For example, in Florida, the medical association sent a letter to a health plan outlining issues to discuss regarding numerous contract terms physicians deemed to be unfair. The health plan responded in a letter that they would not discuss the issues with the association and stated that the association's letter violated antitrust laws. In Texas, a physician IPA had a dispute with a health plan over several issues related to both quality care and fees. The IPA ultimately decided to terminate the plan's HMO contract. After a majority of the physicians refused to re-contract independently with the health plan, the IPA received a threatening letter from the plan's attorney alleging an antitrust violation.

Aren't the FTC and the DOJ against HR 1304?

The FTC and DOJ oppose any attempts to modify the antitrust laws. Their opposition to HR 1304 is based on academic theory, not the real world. The agencies are afraid the bill would give health care professionals too much power. In the current health care marketplace, health plans have all the power. Even though the antitrust laws were designed to protect the little guys from the big guys, nothing currently protects the individual patient or the individual physician from the big insurers. The DOJ did not challenge a single merger in the last decade - while the 18 largest health plans merged into just 6 – until the AMA intervened. The DOJ looked into the Aetna/Prudential merger and ultimately approved it with only minor modifications.

Has Congress previously enacted modifications to the antitrust laws for other industries?

Yes. Some examples include: insurance, labor unions, baseball, sports broadcasting networks, newspapers, motor rail carriers, interstate water carriers, research and development joint ventures, banks, agriculture cooperatives, securities, air carriers and export trade associations. Throughout the history of the antitrust laws, both the courts and Congress have responded to ensure that the marketplace remains competitive, including creating or eliminating exemptions to the antitrust laws. The anticompetitive nature of the current health care market place demands that Congress address this problem now.

Won't this drive up the cost of healthcare and increase the number of uninsured?

This argument is a smokescreen. Every time the physicians try to do something to protect patients the response from the insurers is the same: protections will drive up costs and increase the number of uninsured. For insurers, when it means more dollars for profits – it's ok to raise premiums and risk increasing the number of uninsured – but when it comes to patient protections – suddenly they are worried about the cost and the uninsured. It is especially disingenuous to make this claim when health plans' share of premiums for "overhead" are often as much as 20 to 25 percent despite the fact that they pass on some or all of the risk to physicians. This bill is about improving the quality of care for patients.

Many say physicians can already negotiate collectively using the messenger model. Isn't that true?

No. The messenger model does not allow joint negotiations with health plans. Instead, it is a process whereby each physician arrives at an individual agreement with a health plan through a common messenger. The messenger communicates with each physician individually about what terms the physician is willing to accept and then communicates this information to the health plan so it can offer a contract to all of the physicians at once. However, the messenger may *not* share information with the physicians. The process actually gives more information to the health plan while the physicians remain in the dark.

It is costly, cumbersome, time consuming, ineffective and it does not guarantee protection from antitrust enforcement actions by the FTC. As a matter of fact, use of this process is too risky because it can actually trigger an antitrust challenge. If enough physicians using the process end up rejecting the contract the health plan offers it can appear as if the messenger or the physicians illegally shared information.

Aren't the DOJ and FTC's current antitrust enforcement policies adequate?

No. Most physicians are independent contractors. Under the current FTC/DOJ guidelines these physicians must be in business together in order to negotiate jointly with a health plan. This requires either sharing "substantial financial risk" or integrating business operations, which is not always feasible. Forming, managing and operating networks or group practices is a very expensive and time consuming undertaking. Physicians are understandably reluctant to do this because it requires substantial capital, forces them to practice in a setting they may not prefer, and may not even provide antitrust protection because the guidelines are not entirely clear as to what constitutes an appropriate level of integration.

Even if physicians receive a letter from the FTC *approving* an arrangement, they cannot rely on it as a guarantee against an antitrust challenge. Each determination under the antitrust laws is dependent on specific facts of the situation. If *any* facts or circumstances change, such as *one* new physician entering the market, the agencies may investigate and prosecute. In addition, nothing prevents a health plan from filing a private antitrust action. The DOJ and FTC have broad discretion to simply decide that a particular integration or risk sharing arrangement is insufficient (for example, FTC Letter to Paul W. McVay (1994), Mesa County IPA,

Colorado (1999)) and challenge physicians at any time. With the prospects of prison and/or stiff monetary penalties, there is a strong deterrent for physicians to integrate absent a clear understanding of the rules.

Isn't this really a bill to protect health care professionals' fees?

No. This bill is about giving health care professionals the power to negotiate *all* contract terms and conditions *to promote quality health care for their patients*. Many physicians are currently presented with contracts that contain provisions that may be detrimental to patient care. Examples include:

- Prohibiting physicians from discussing all treatment options (i.e. "gag clauses") with their patients
- Restrictions on access to specialty care
- Payment schemes which encourage the limitation of medically necessary care
- Restrictive definitions of what constitutes medically necessary care
- De-selection of physicians who provide "too much care"
- Unreasonable administrative burdens
- Requirements that physicians must participate in all of the insurer's plans or none of them
- Requiring physicians who decide to stop taking new patients from the health plan to also stop taking patients from any other health plan

All of these terms under which physicians must practice directly affect their patients and the care they are able to receive. HR 1304 would therefore restore the ability of physicians to advocate on behalf of their patients through their contract negotiations.

How would the bill affect health care competition?

This bill would promote competition by correcting the imbalance that currently exists in the marketplace between health care professionals and health plans due to the increasing power of consolidated health plans. Because the insurance industry has a special exemption under the antitrust laws (the McCarran-Ferguson Act), health plans are able to share actuarial and price information with their competitors (something physicians cannot do). In addition, health plans have the ability to exert significant market power over physicians and patients. Health plans can use their leverage to impose supra-competitive prices to patients and require physicians to accept "take it or leave it" contracts that are detrimental to patient care. HR 1304 would level the playing field so physicians can negotiate contracts that ensure that patients continue to receive high quality care.

How does the law that recently passed in Texas differ from HR 1304?

HR 1304 would allow all independently practicing health care professionals to jointly negotiate with health plans by amending the federal antitrust laws that prohibit this type of activity. It is one way of addressing the imbalance of power created by large health plans. Another way is for a state to enact its own antitrust exemption under the State Action Doctrine. The Texas bill falls under the State Action Doctrine. This is a judicially created doctrine that allows States to pass legislation allowing an activity that is prohibited by federal antitrust laws in the State only if the State regulates and actively supervises the particular activity.

However, the State Action Doctrine is limited in two ways. The amount of government bureaucracy in health care would increase because negotiations *must be regulated and actively supervised by the State*. In addition, only physicians in the State where the law is passed would be able to jointly negotiate. Because so many health plans are national or regional in scope, and the antitrust laws are federal laws, the imbalance in the health care industry must be corrected at the federal level to adequately address the problem. Under the State Action Doctrine, all fifty States would need to pass their own laws which would not be uniform across states.

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Bill 4 of 4
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Quality Health-Care Coalition Act of 2000 (Referred in Senate)

HR 1304 RFS

106th CONGRESS

2d Session

H. R. 1304

IN THE SENATE OF THE UNITED STATES

June 30, 2000

Received

July 27, 2000

Read twice and referred to the Committee on Health, Education, Labor, and Pensions

AN ACT

To ensure and foster continued patient safety and quality of care by making the antitrust laws apply to negotiations between groups of health care professionals and health plans and health insurance issuers in the same manner as such laws apply to collective bargaining by labor organizations under the National Labor Relations Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Quality Health-Care Coalition Act of 2000'.

SEC. 2. APPLICATION OF THE ANTITRUST LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING WITH HEALTH PLANS.

(a) IN GENERAL- Any health care professionals who are engaged in negotiations with a health

plan regarding the terms of any contract under which the professionals provide health care items or services for which benefits are provided under such plan shall, in connection with such negotiations, be entitled to the same treatment under the antitrust laws as the treatment to which bargaining units which are recognized under the National Labor Relations Act are entitled in connection with such collective bargaining. Such a professional shall, only in connection with such negotiations, be treated as an employee engaged in concerted activities and shall not be regarded as having the status of an employer, independent contractor, managerial employee, or supervisor.

(b) PROTECTION FOR GOOD FAITH ACTIONS- Actions taken in good faith reliance on subsection (a) shall not be the subject under the antitrust laws of criminal sanctions nor of any civil damages, fees, or penalties beyond actual damages incurred.

(c) LIMITATION-

(1) NO NEW RIGHT FOR COLLECTIVE CESSATION OF SERVICE- The exemption provided in subsection (a) shall not confer any new right to participate in any collective cessation of service to patients not already permitted by existing law.

(2) NO CHANGE IN NATIONAL LABOR RELATIONS ACT- This section applies only to health care professionals excluded from the National Labor Relations Act. Nothing in this section shall be construed as changing or amending any provision of the National Labor Relations Act, or as affecting the status of any group of persons under that Act.

(d) 3-YEAR SUNSET- The exemption provided in subsection (a) shall only apply to conduct occurring during the 3-year period beginning on the date of the enactment of this Act and shall continue to apply for 1 year after the end of such period to contracts entered into before the end of such period.

(e) LIMITATION ON EXEMPTION- Nothing in this section shall exempt from the application of the antitrust laws any agreement or otherwise unlawful conspiracy that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care professional or group of health care professionals with respect to the performance of services that are within their scope of practice as defined or permitted by relevant law or regulation.

(f) NO EFFECT ON TITLE VI OF CIVIL RIGHTS ACT OF 1964- Nothing in this section shall be construed to affect the application of title VI of the Civil Rights Act of 1964.

(g) NO APPLICATION TO FEDERAL PROGRAMS- Nothing in this section shall apply to negotiations between health care professionals and health plans pertaining to benefits provided under any of the following:

(1) The Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) The Medicaid Program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) The SCHIP program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(4) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

(5) Chapter 17 of title 38, United States Code (relating to Veterans' medical care).

(6) Chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

(7) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(h) EXEMPTION OF ABORTION AND ABORTION SERVICES- Nothing in this section shall apply to negotiations specifically relating to requiring a health plan to cover abortion or abortion services.

(i) GENERAL ACCOUNTING OFFICE STUDY AND REPORT- The Comptroller General of the United States shall conduct a study on the impact of enactment of this section during the 6-month period beginning with the third year of the 3-year period described in subsection (d). Not later than the end of such 6-month period the Comptroller General shall submit to Congress a report on such study and shall include in the report such recommendations on the extension of this section (and changes that should be made in making such extension) as the Comptroller General deems appropriate.

(j) DEFINITIONS- For purposes of this section:

(1) ANTITRUST LAWS- The term `antitrust laws'--

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section 5 applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) HEALTH PLAN AND RELATED TERMS-

(A) IN GENERAL- The term `health plan' means a group health plan or a health insurance issuer that is offering health insurance coverage.

(B) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER- The terms `health insurance coverage' and `health insurance issuer' have the meanings given such terms under paragraphs (1) and (2), respectively, of section 733(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)).

(C) GROUP HEALTH PLAN- The term `group health plan' has the meaning given that term in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)).

(3) HEALTH CARE PROFESSIONAL- The term `health care professional' means an individual who provides health care items or services, treatment, assistance with activities of daily living, or medications to patients and who, to the extent required by State or Federal law, possesses specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.

(k) SENSE OF THE CONGRESS- It is the sense of the Congress that decisions regarding medical care and treatment should be made by the physician or health care professional in consultation with the patient.

Passed the House of Representatives June 30 (legislative day, June 29), 2000.

Attest:

JEFF TRANDAHL,

Clerk.

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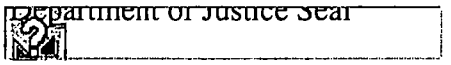

H.R. 1304
The Quality Health-Care Coalition Act Of 1999

Statement by

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U.S. Department of Justice

Before the
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Introduction

Chairman Hyde, Ranking Member Conyers and members of the Committee, I am pleased to be invited here to present the views of the Antitrust Division on H.R. 1304, the Quality Health- Care Coalition Act of 1999. I would like to start by briefly summarizing the importance of competition to the economy. Then I will turn to the specifics of the bill. In brief, the Division strongly opposes H.R. 1304. We believe it takes the wrong approach to problems raised by managed care, an approach that will harm consumers of health care in the future.

For over a century, the United States has committed itself to protecting competition in the vast majority of markets in the economy. Free-market competition is the engine that has made the American economy the envy of the world. The Sherman

Act, passed in 1890, has been called the Magna Carta of free enterprise. In general, the United States operates a free-market economy that allows free and unfettered competition, subject to the antitrust laws. Time and again, relying on free-market competition has allowed consumers numerous benefits, including more innovation, more choice and lower prices than that of economies where free competition has been limited.

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H.R. 1304 would change, for the health-care industry, the competitive system applicable to the rest of the American economy. It would uniquely authorize health care professionals who are not employed by health insurance plans, and thus not exempt from antitrust scrutiny under existing law, to negotiate collectively with any health plan over fees and collectively to refuse to deal with any plan that did not accede to their demands. Current law already provides an exemption from the antitrust laws for doctors and other health care professionals in an employee-employer context. Like other employees, employed doctors and other health care professional employees may collectively bargain with their employer without antitrust scrutiny. But, like all who are not employees, independent-contractor doctors and other health care professionals in private practice must satisfy the antitrust laws when negotiating with those that purchase their services.

This bill would allow non-employee, health care professionals collectively to raise their fees to health insurers without fear of antitrust liability and without regard to competitive market forces fostered by the antitrust laws. This increased cost ultimately will be borne by consumers. There is no justification to accord special status to health care professionals under the antitrust laws, differentiating them from other professionals and independent contractors such as architects, engineers, or lawyers. It would be both unwise and harmful to consumers to grant them a special exemption. We want to be clear, however, that we have and will continue to enforce the antitrust laws in this area, and will rigorously pursue evidence of collusion regardless of whether providers or insurers are involved.

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As in other markets, the goal for health care markets should be to ensure that consumers benefit from a competitive marketplace where neither the buyers nor sellers unlawfully exercise market power. Policy should focus on ensuring that there is a competitive marketplace where neither health insurance plans nor health care professionals are able to obtain or exercise market power to distort the competitive outcome. Any other result inevitably will lead to governmental regulation of the health care market -- an outcome that is not likely to produce desirable results for consumers. We have learned this lesson over time from other industries and we should be sure we continue to apply it to health care markets as well. The injection of competition into health care markets over the past decade has helped hold down

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The preference for market competition over regulation, of course, is dependent on the assurance that the enforcement of the antitrust laws will prevent all participants in a market from obtaining or exercising market power through anticompetitive means. Thus, federal antitrust enforcement must ensure that neither health insurance plans nor health care professionals utilize anticompetitive means to distort the competitive outcome in the health care industry. The Antitrust Division has been active in pursuing that important role.

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The McCarran-Ferguson Act Does Not Give Insurers Leverage

The bill's "Findings" assert that increasing concentration among health care plans, enhanced by the McCarran-Ferguson Act, gives insurance companies significant leverage over health care providers and patients and, therefore, warrants permitting health care professionals to negotiate collectively with health plans to create more equal negotiating power, which will promote competition and enhance the quality of patient care. The claim that the McCarran- Ferguson Act ("McCarran"), 15 U.S.C. §§ 1011-1015, has given insurers significant market leverage over health care providers and patients appears to reflect a widely held misperception.

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To the extent that there is a concern that mergers will increase the bargaining power of health insurance plans, our enforcement in the Aetna case should convincingly establish that antitrust enforcers will not allow anticompetitive mergers that will produce market power by health insurance plans in the market for purchasing provider services.

Quality Concerns Do Not Justify The Antitrust Exemption

The proposed bill makes no attempt to distinguish between joint negotiations by health care professionals that are designed to enhance efficiency, reduce costs and improve quality of care and those designed simply to increase the providers' income. The American Medical Association, in its written testimony submitted to this committee last year in support of the predecessor to H.R. 1304, acknowledged that "[m]ost studies comparing the quality of care in managed care plans and traditional indemnity plans have found the quality of care to be comparable." This is not to say that there may not be problems concerning the quality or scope of services under managed care that require correction; just that problems of poor-quality care are not endemic to managed care.

The concern relevant to this bill, however, is whether doctors will use the power granted them by an antitrust exemption to increase the quality of patient care. Our history of investigations, including our recent cases against two federations of competing doctors involving group boycotts and price-fixing conspiracies, leads us to have concerns because the proposed bill provides no assurance that health care professionals would direct their collective negotiating efforts to improving quality of care, rather than their own financial circumstances.

In our Federation of Certified Surgeons and Specialists case, twenty-nine otherwise competing surgeons who made up the vast majority of general and vascular surgeons with operating privileges at five hospitals in Tampa formed a corporation solely for the purpose of negotiating jointly with managed care plans to obtain higher fees. Their strategy was a success. Each of the twenty-nine surgeons gained, on average, over $14,000 in annual revenues in just the few months of joint negotiations before they learned that the Division was investigating the conduct. The participants in that scheme did not take any collective action that improved quality of care.

In the Federation of Physicians and Dentists case, we allege that most of the orthopedic surgeons in Delaware agreed among themselves to boycott Blue Cross Blue Shield of Delaware after Blue Cross announced it was going to reduce fees paid to orthopedic surgeons and other physicians. Blue Cross is one of four major private insurance plans operating in Delaware, and a number of smaller plans operate there also. Blue Cross's proposed fees, however, were still higher than those paid to orthopedic surgeons in Philadelphia, a nearby major medical center recognized for quality care, and in line with fees paid to other types of specialists in

Delaware. Although the defendant organization claimed quality-of-care concerns in directing its member surgeons' collective opposition to Blue Cross's proposed fee reductions, the surgeons themselves conceded that they provide the same high quality of care to their patients regardless of the payment level. Indeed, there is no evidence that any of the orthopedic surgeons participating in the alleged conspiracy even sought to evaluate the impact that Blue Cross' proposed fee reduction would have on their cost structure or on their ability to provide quality care.

Both of these cases, as well as many other cases brought by both the Division and FTC, illustrate the serious harm to consumers that would result from passage of the proposed bill, with very limited, if any, concomitant improvement in quality of patient care.

The Bill is Likely to Raise Costs Substantially to Consumers and Taxpayers

The bill's potential adverse economic impact on consumers is large. Our investigations reveal that when health care professionals jointly negotiate with health insurers, without regard to antitrust laws, they typically seek to significantly increase their fees, sometimes by as much as 20- 40%. For example, in our recent Tampa case discussed above, the otherwise competing surgeons, through joint negotiations with health plans, had succeeded in raising their fees 20-30% prior to learning of our investigation. Exempting such joint activity through enactment of H.R. 1304 would permit health care professionals to negotiate and effectuate such increases in countless markets throughout the country. In view of the size of expenditures for health care services and the large number of patients receiving care, the potential anticompetitive costs that would be borne by consumers are large.

There appears to be no dispute that the bill will result in health plans paying higher fees to health care professionals. At a hearing of this Committee last year on a precursor bill, Representative Campbell acknowledged that the bill would enable health care professionals to obtain higher fees from health care insurers but maintained that such cost increases would be absorbed by managed care plans, rather than passed on to consumers. See Transcript of the July 29, 1998 Hearing before the U.S. House of Representatives Committee on the Judiciary on H.R. 4277 at 12, 27, 38-40. Conventional economic theory and business realities lead, however, to the opposite conclusion. Health insurers will pass on to consumers most, if not all, cost increases that they would incur in collective negotiations under H.R. 1304.

Economic theory predicts that an increase in the cost of an input in nearly every instance translates into a higher output price. Only in those rare cases where a different input can be used as a perfect substitute will an increase in the cost of an input not give rise to a price increase to the consumer. But, because of both licensing requirements and the nature of services provided, there are no good substitutes for physicians, pharmacists, therapists, dentists, or other health professionals. Consequently, health insurers are virtually certain over time to pass through to consumers and taxpayers most, if not all, of the increase in costs for any covered services provided by health care professionals. See, e.g., Wholey, Feldman, and Christianson, "The Effect of Market Structure on HMO Premiums," 14 J. Health

Economics 81, 89, 100 (1995) (finding that increases in provider costs increase health plan premiums); M. Pauly, "Managed Care, Market Power, and Monopsony," 33:5 Health Services Research 1439, 1450 (Dec. 1998, Part II) ("In virtually any model of profit-seeking firms, an increase in marginal cost of an input translates into a higher equilibrium output price.").

The realities of the health insurance business also contribute to our conclusion that health insurers will pass on most of any cost increases for professional services resulting from H.R. 1304, services that ordinarily constitute about 40-50 percent of a health plan's total costs. For the last few years, premiums closely reflected insurers' costs, and a leading health care policy "think- tank" predicts that "over the longer term, the underlying cost of health care remains the dominant influence on the direction of premium trends." See Center for Health System Change, "Despite Fears, Costs Rise Modestly in 1998," Data Bulletin No. 13 (Fall 1998) at 2.

Increases in the cost of services provided by health care professionals resulting from enactment of H.R. 1304 will undoubtedly have a direct and predictable effect on consumers and taxpayers, resulting in the transfer of funds to providers and making health care insurance coverage increasingly unaffordable for many. Medicare and Medicaid programs, for example, will incur substantial additional costs to meet increased premiums from managed care plans. Alternatively, managed care plans will cease serving Medicare and Medicaid beneficiaries in high- cost areas or reduce non-mandatory benefits.

Employers and employees in the private sector also will be confronted with increased costs of health insurance as a result of this bill. The inevitable increase in premiums would lead to more consumers either losing or foregoing their health care coverage and likely would increase the ranks of our nation's uninsured. Faced with substantial increases in premiums, more employers may stop offering their employees health insurance or will decrease benefits, and more workers who are eligible for employer-sponsored insurance may nevertheless reject coverage as their shared costs increase. Such trends also will translate into additional Medicare and Medicaid costs.

There Is a Better Approach to Deal with Problems Raised by Managed Care

The stated objective of the proposed bill is to "enhance the quality of patient care" and implicitly to resolve some of the problems attributed to managed care. One of the ways is to pass a Patients' Bill of Rights that provides critical patient protections, such as guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; access to a fair, unbiased and timely internal and independent external appeals process to address health plan grievances; and an enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions. The Administration continues to urge the Congress to pass a strong, enforceable Patients' Bill of Rights in this legislative session. Some of these quality of care issues and other problems frequently associated with managed care, however, may be resolved without any legislation since there are already legitimate ways for physicians and other health care professionals jointly to influence or make recommendations on quality of care

issues. See, e.g., United States Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, issued August 28, 1996, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at Statement 4 ("Providers' Collective Provision of Non-Fee- Related Information to Purchasers of Health Care Services") and Statement 5 ("Providers' Collective Provision of Fee-Related Information to Purchasers of Health Care Services").

For example, the American College of Physicians-American Society of Internal Medicine and 21 other physician groups recently wrote letters to national managed care organizations urging them not to adopt mandatory hospitalist programs, that is, programs requiring primary- care physicians to turn over care of their patients to hospital-based physicians when a patient needs hospital care. In response, the health plans clarified that their hospitalist programs were voluntary.

Legislation should not, as would H.R. 1304, injure the public by eliminating competition in health care provider markets in the hope that it will indirectly solve the problems of managed care facing consumers. Providers have their own self interests, and our enforcement actions and other experience suggest that their actions may not be congruent with the interests of consumers.

Conclusion

We oppose this legislation which would immunize independent-contractor doctors and other health care professionals in private practice from antitrust prohibitions. This bill is the wrong way to deal with problems identified with managed care and will harm consumers of health care in the future. The bill would hurt consumers and taxpayers by raising the costs of both private health insurance and governmental programs with no assurance that quality of care would be improved. The better approach is to empower consumers by encouraging price competition, opening the flow of accurate, meaningful information to consumers, and ensuring effective antitrust enforcement both with regard to buyers (health insurance plans) and sellers (health care professionals) of provider services. Competitive issues are best dealt with in a manner which promotes competition, not retards competition, as this bill would do if enacted.

Department of Justice Seal

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The Bill is Likely to Raise Costs Substantially to Consumers and Taxpayers

The bill's potential adverse economic impact on consumers is large. Our investigations reveal that when health care professionals jointly negotiate with health insurers, without regard to antitrust laws, they typically seek to significantly increase their fees, sometimes by as much as 20- 40%. For example, in our recent Tampa case discussed above, the otherwise competing surgeons, through joint negotiations with health plans, had succeeded in raising their fees 20-30% prior to learning of our investigation. Exempting such joint activity through enactment of H.R. 1304 would permit health care professionals to negotiate and effectuate such increases in countless markets throughout the country. In view of the size of expenditures for health care services and the large number of patients receiving care, the potential anticompetitive costs that would be borne by consumers are large.

There appears to be no dispute that the bill will result in health plans paying higher fees to health care professionals. At a hearing of this Committee last year on a precursor bill, Representative Campbell acknowledged that the bill would enable health care professionals to obtain higher fees from health care insurers but maintained that such cost increases would be absorbed by managed care plans, rather than passed on to consumers. See Transcript of the July 29, 1998 Hearing before the U.S. House of Representatives Committee on the Judiciary on H.R. 4277 at 12, 27, 38-40. Conventional economic theory and business realities lead, however, to the opposite conclusion. Health insurers will pass on to consumers most, if not all, cost increases that they would incur in collective negotiations under H.R. 1304.

Economic theory predicts that an increase in the cost of an input in nearly every instance translates into a higher output price. Only in those rare cases where a different input can be used as a perfect substitute will an increase in the cost of an input not give rise to a price increase to the consumer. But, because of both licensing requirements and the nature of services provided, there are no good substitutes for physicians, pharmacists, therapists, dentists, or other health professionals. Consequently, health insurers are virtually certain over time to pass through to consumers and taxpayers most, if not all, of the increase in costs for any covered services provided by health care professionals. See, e.g., Wholey, Feldman, and Christianson, "The Effect of Market Structure on HMO Premiums," 14 J. Health

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The realities of the health insurance business also contribute to our conclusion that health insurers will pass on most of any cost increases for professional services resulting from H.R. 1304, services that ordinarily constitute about 40-50 percent of a health plan's total costs. For the last few years, premiums closely reflected insurers' costs, and a leading health care policy "think- tank" predicts that "over the longer term, the underlying cost of health care remains the dominant influence on the direction of premium trends." See Center for Health System Change, "Despite Fears, Costs Rise Modestly in 1998," Data Bulletin No. 13 (Fall 1998) at 2.

Increases in the cost of services provided by health care professionals resulting from enactment of H.R. 1304 will undoubtedly have a direct and predictable effect on consumers and taxpayers, resulting in the transfer of funds to providers and making health care insurance coverage increasingly unaffordable for many. Medicare and Medicaid programs, for example, will incur substantial additional costs to meet increased premiums from managed care plans. Alternatively, managed care plans will cease serving Medicare and Medicaid beneficiaries in high- cost areas or reduce non-mandatory benefits.

Employers and employees in the private sector also will be confronted with increased costs of health insurance as a result of this bill. The inevitable increase in premiums would lead to more consumers either losing or foregoing their health care coverage and likely would increase the ranks of our nation's uninsured. Faced with substantial increases in premiums, more employers may stop offering their employees health insurance or will decrease benefits, and more workers who are eligible for employer-sponsored insurance may nevertheless reject coverage as their shared costs increase. Such trends also will translate into additional Medicare and Medicaid costs.

There Is a Better Approach to Deal with Problems Raised by Managed Care

The stated objective of the proposed bill is to "enhance the quality of patient care" and implicitly to resolve some of the problems attributed to managed care. One of the ways is to pass a Patients' Bill of Rights that provides critical patient protections, such as guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; access to a fair, unbiased and timely internal and independent external appeals process to address health plan grievances; and an enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions. The Administration continues to urge the Congress to pass a strong, enforceable Patients' Bill of Rights in this legislative session. Some of these quality of care issues and other problems frequently associated with managed care, however, may be resolved without any legislation since there are already legitimate ways for physicians and other health care professionals jointly to influence or make recommendations on quality of care

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For example, the American College of Physicians-American Society of Internal Medicine and 21 other physician groups recently wrote letters to national managed care organizations urging them not to adopt mandatory hospitalist programs, that is, programs requiring primary- care physicians to turn over care of their patients to hospital-based physicians when a patient needs hospital care. In response, the health plans clarified that their hospitalist programs were voluntary.

Legislation should not, as would H.R. 1304, injure the public by eliminating competition in health care provider markets in the hope that it will indirectly solve the problems of managed care facing consumers. Providers have their own self interests, and our enforcement actions and other experience suggest that their actions may not be congruent with the interests of consumers.

Conclusion

We oppose this legislation which would immunize independent-contractor doctors and other health care professionals in private practice from antitrust prohibitions. This bill is the wrong way to deal with problems identified with managed care and will harm consumers of health care in the future. The bill would hurt consumers and taxpayers by raising the costs of both private health insurance and governmental programs with no assurance that quality of care would be improved. The better approach is to empower consumers by encouraging price competition, opening the flow of accurate, meaningful information to consumers, and ensuring effective antitrust enforcement both with regard to buyers (health insurance plans) and sellers (health care professionals) of provider services. Competitive issues are best dealt with in a manner which promotes competition, not retards competition, as this bill would do if enacted.

Department of Justice Seal

H.R. 1304
The Quality Health-Care Coalition Act Of 1999

Statement by

JOEL I. KLEIN

Assistant Attorney General
Antitrust Division
U.S. Department of Justice

Before the
House Judiciary Committee

Washington, D.C.

June 22, 1999

Introduction

Chairman Hyde, Ranking Member Conyers and members of the Committee, I am pleased to be invited here to present the views of the Antitrust Division on H.R. 1304, the Quality Health- Care Coalition Act of 1999. I would like to start by briefly summarizing the importance of competition to the economy. Then I will turn to the specifics of the bill. In brief, the Division strongly opposes H.R. 1304. We believe it takes the wrong approach to problems raised by managed care, an approach that will harm consumers of health care in the future.

For over a century, the United States has committed itself to protecting competition in the vast majority of markets in the economy. Free-market competition is the engine that has made the American economy the envy of the world. The Sherman

Act, passed in 1890, has been called the Magna Carta of free enterprise. In general, the United States operates a free-market economy that allows free and unfettered competition, subject to the antitrust laws. Time and again, relying on free-market competition has allowed consumers numerous benefits, including more innovation, more choice and lower prices than that of economies where free competition has been limited.

In particular, our nation's economic vitality depends upon the competitive structure of the health care industry. In 1997, the latest year for which data are available, annual revenues of health care professionals covered by the Sherman Act ranged between $300-400 billion, about 4- 5% of the GDP.

H.R. 1304 would change, for the health-care industry, the competitive system applicable to the rest of the American economy. It would uniquely authorize health care professionals who are not employed by health insurance plans, and thus not exempt from antitrust scrutiny under existing law, to negotiate collectively with any health plan over fees and collectively to refuse to deal with any plan that did not accede to their demands. Current law already provides an exemption from the antitrust laws for doctors and other health care professionals in an employee-employer context. Like other employees, employed doctors and other health care professional employees may collectively bargain with their employer without antitrust scrutiny. But, like all who are not employees, independent-contractor doctors and other health care professionals in private practice must satisfy the antitrust laws when negotiating with those that purchase their services.

This bill would allow non-employee, health care professionals collectively to raise their fees to health insurers without fear of antitrust liability and without regard to competitive market forces fostered by the antitrust laws. This increased cost ultimately will be borne by consumers. There is no justification to accord special status to health care professionals under the antitrust laws, differentiating them from other professionals and independent contractors such as architects, engineers, or lawyers. It would be both unwise and harmful to consumers to grant them a special exemption. We want to be clear, however, that we have and will continue to enforce the antitrust laws in this area, and will rigorously pursue evidence of collusion regardless of whether providers or insurers are involved.

Competition in Health Care: Both Health Insurance and Provider Markets Need to Function Competitively

As in other markets, the goal for health care markets should be to ensure that consumers benefit from a competitive marketplace where neither the buyers nor sellers unlawfully exercise market power. Policy should focus on ensuring that there is a competitive marketplace where neither health insurance plans nor health care professionals are able to obtain or exercise market power to distort the competitive outcome. Any other result inevitably will lead to governmental regulation of the health care market -- an outcome that is not likely to produce desirable results for consumers. We have learned this lesson over time from other industries and we should be sure we continue to apply it to health care markets as well. The injection of competition into health care markets over the past decade has helped hold down

increases in health care costs.

The preference for market competition over regulation, of course, is dependent on the assurance that the enforcement of the antitrust laws will prevent all participants in a market from obtaining or exercising market power through anticompetitive means. Thus, federal antitrust enforcement must ensure that neither health insurance plans nor health care professionals utilize anticompetitive means to distort the competitive outcome in the health care industry. The Antitrust Division has been active in pursuing that important role.

To keep health insurance markets competitive, the Division carefully scrutinizes mergers and other activities among health insurance plans that may harm consumers by raising prices or limiting the scope or quality of care. For example, last year the Division investigated the proposed acquisition of Humana by United Health Care. The parties abandoned the transaction during the course of the review. This week the Division concluded that Aetna's proposed acquisition of Prudential's health care business would violate the antitrust laws unless Aetna undertook substantial divestitures in Dallas and Houston to eliminate the market power it otherwise would have gained from the merger.

The Aetna case is an extremely important precedent in this regard. The Division, after a thorough investigation, determined that the merger of these health plans was anticompetitive in two separate ways. First, we believed the merger would lead to market power in the sale by Aetna of health maintenance organization services in certain markets. The combined market share which would have resulted from the merger in Houston and Dallas were over 63 percent and 42 percent, respectively. We believed this would give Aetna the ability in those markets to increase its price or lower its quality of service for its HMO customers. Second, we believed that the merger would lead to market power in the purchase of doctors' services by Aetna. The divestiture which we accepted addressed both of these concerns. This was the first merger case in which the Division was faced with a concern that a combination of health plans would give the resulting plan market power in the purchase of doctors' services. It clearly establishes the precedent that unacceptable aggregations of market power by health plans will not be allowed to the detriment of consumers and health care professionals.

At the same time, we also have pursued anticompetitive actions by health care professionals, who have sought to use market power to demand anticompetitive concessions from health plans. In both our Federation of Physicians and Dentists and our Federation of Certified Surgeons and Specialists cases (discussed below), we established that competing doctors took joint action contrary to the antitrust laws to increase their reimbursement rates at the expense of consumers' pocketbooks.

Our ultimate goal is the preservation of competition at all levels of the health care industry. It has become clear over the years that consumer welfare and patient choice are best preserved by relying on antitrust principles to assure the proper operation of health care markets just as they are in other markets. Permitting providers to form bargaining groups in response to perceived bargaining leverage by insurers will not decrease the cost of health care or increase the quality of patient care.

The Rationales for the Bill Support Neither the Need nor the Desirability of an Antitrust Exemption

There are various arguments that supporters of bills like this one have used to argue their case. On closer inspection, those arguments often are not aligned with the competitive realities of the marketplace and do not support the adoption of an antitrust exemption. Supporters often argue that the McCarran-Ferguson antitrust exemption lets insurers collude, so doctors should be allowed to collude as well; that health plans have all the bargaining power and tremendous market share; that doctors will only use their power to increase the quality of care; and that the bill will protect doctors and not increase costs to consumers, just affect the health plans' profits. Let me address each of these briefly.

The McCarran-Ferguson Act Does Not Give Insurers Leverage

The bill's "Findings" assert that increasing concentration among health care plans, enhanced by the McCarran-Ferguson Act, gives insurance companies significant leverage over health care providers and patients and, therefore, warrants permitting health care professionals to negotiate collectively with health plans to create more equal negotiating power, which will promote competition and enhance the quality of patient care. The claim that the McCarran- Ferguson Act ("McCarran"), 15 U.S.C. §§ 1011-1015, has given insurers significant market leverage over health care providers and patients appears to reflect a widely held misperception.

McCarran provides insurers with a limited exemption from the antitrust laws, but twenty years ago the Supreme Court in Group Life and Health Co. v. Royal Drug, 440 U.S. 205 (1979), clearly held that McCarran does not exempt insurers' dealings with health care providers from antitrust scrutiny. To the extent insurers' dealings with health care professionals are in violation of the antitrust laws, McCarran provides no obstacle to prosecution of such claims either by the affected providers or by state or federal enforcement agencies. When the Division learns about exclusionary or collusive activities among health plans, it carefully reviews them, and if necessary, takes appropriate action. In the past few years alone, the Division aggressively challenged contractual provisions imposed by payers on Rhode Island dentists, U.S. v. Delta Dental of Rhode Island, and Cleveland area hospitals, U.S. v. Medical Mutual of Ohio, Inc., when it determined that those provisions were resulting in higher costs and diminished choices for health care consumers.

Thus, the claim that McCarran gives insurers leverage in their dealings with health care providers is illusory and should not support passage of this bill or increasing the bargaining leverage of health care providers.

Health Plan Bargaining Power

The relative bargaining power of plans and providers varies tremendously among markets. Although there have been several mergers of health plans over the last few years, in our view there still exists a significant number of competing health insurance plans, none of which dominates, and there has been new entry into various

local markets. Between 1994 and 1997 over 150 new HMOs were licensed across the country. Moreover, over the last decade, as enrollment in managed care plans has grown, the market shares of many once-dominant Blue Cross and Blue Shield plans has eroded, resulting in decreasing, rather than increasing, concentration among health insurers in certain markets.

To the extent that there is a concern that mergers will increase the bargaining power of health insurance plans, our enforcement in the Aetna case should convincingly establish that antitrust enforcers will not allow anticompetitive mergers that will produce market power by health insurance plans in the market for purchasing provider services.

Quality Concerns Do Not Justify The Antitrust Exemption

The proposed bill makes no attempt to distinguish between joint negotiations by health care professionals that are designed to enhance efficiency, reduce costs and improve quality of care and those designed simply to increase the providers' income. The American Medical Association, in its written testimony submitted to this committee last year in support of the predecessor to H.R. 1304, acknowledged that "[m]ost studies comparing the quality of care in managed care plans and traditional indemnity plans have found the quality of care to be comparable." This is not to say that there may not be problems concerning the quality or scope of services under managed care that require correction; just that problems of poor-quality care are not endemic to managed care.

The concern relevant to this bill, however, is whether doctors will use the power granted them by an antitrust exemption to increase the quality of patient care. Our history of investigations, including our recent cases against two federations of competing doctors involving group boycotts and price-fixing conspiracies, leads us to have concerns because the proposed bill provides no assurance that health care professionals would direct their collective negotiating efforts to improving quality of care, rather than their own financial circumstances.

In our Federation of Certified Surgeons and Specialists case, twenty-nine otherwise competing surgeons who made up the vast majority of general and vascular surgeons with operating privileges at five hospitals in Tampa formed a corporation solely for the purpose of negotiating jointly with managed care plans to obtain higher fees. Their strategy was a success. Each of the twenty-nine surgeons gained, on average, over $14,000 in annual revenues in just the few months of joint negotiations before they learned that the Division was investigating the conduct. The participants in that scheme did not take any collective action that improved quality of care.

In the Federation of Physicians and Dentists case, we allege that most of the orthopedic surgeons in Delaware agreed among themselves to boycott Blue Cross Blue Shield of Delaware after Blue Cross announced it was going to reduce fees paid to orthopedic surgeons and other physicians. Blue Cross is one of four major private insurance plans operating in Delaware, and a number of smaller plans operate there also. Blue Cross's proposed fees, however, were still higher than those paid to orthopedic surgeons in Philadelphia, a nearby major medical center recognized for quality care, and in line with fees paid to other types of specialists in

Delaware. Although the defendant organization claimed quality-of-care concerns in directing its member surgeons' collective opposition to Blue Cross's proposed fee reductions, the surgeons themselves conceded that they provide the same high quality of care to their patients regardless of the payment level. Indeed, there is no evidence that any of the orthopedic surgeons participating in the alleged conspiracy even sought to evaluate the impact that Blue Cross' proposed fee reduction would have on their cost structure or on their ability to provide quality care.

Both of these cases, as well as many other cases brought by both the Division and FTC, illustrate the serious harm to consumers that would result from passage of the proposed bill, with very limited, if any, concomitant improvement in quality of patient care.

The Bill is Likely to Raise Costs Substantially to Consumers and Taxpayers

The bill's potential adverse economic impact on consumers is large. Our investigations reveal that when health care professionals jointly negotiate with health insurers, without regard to antitrust laws, they typically seek to significantly increase their fees, sometimes by as much as 20- 40%. For example, in our recent Tampa case discussed above, the otherwise competing surgeons, through joint negotiations with health plans, had succeeded in raising their fees 20-30% prior to learning of our investigation. Exempting such joint activity through enactment of H.R. 1304 would permit health care professionals to negotiate and effectuate such increases in countless markets throughout the country. In view of the size of expenditures for health care services and the large number of patients receiving care, the potential anticompetitive costs that would be borne by consumers are large.

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The realities of the health insurance business also contribute to our conclusion that health insurers will pass on most of any cost increases for professional services resulting from H.R. 1304, services that ordinarily constitute about 40-50 percent of a health plan's total costs. For the last few years, premiums closely reflected insurers' costs, and a leading health care policy "think- tank" predicts that "over the longer term, the underlying cost of health care remains the dominant influence on the direction of premium trends." See Center for Health System Change, "Despite Fears, Costs Rise Modestly in 1998," Data Bulletin No. 13 (Fall 1998) at 2.

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There Is a Better Approach to Deal with Problems Raised by Managed Care

The stated objective of the proposed bill is to "enhance the quality of patient care" and implicitly to resolve some of the problems attributed to managed care. One of the ways is to pass a Patients' Bill of Rights that provides critical patient protections, such as guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; access to a fair, unbiased and timely internal and independent external appeals process to address health plan grievances; and an enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions. The Administration continues to urge the Congress to pass a strong, enforceable Patients' Bill of Rights in this legislative session. Some of these quality of care issues and other problems frequently associated with managed care, however, may be resolved without any legislation since there are already legitimate ways for physicians and other health care professionals jointly to influence or make recommendations on quality of care

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March 22, 2000

Panel Mulls Doctor Bargaining Rights

Filed at 1:55 p.m. EST

By The Associated Press

WASHINGTON (AP) -- Doctors would gain new rights to bargain collectively with health maintenance organizations under legislation considered Wednesday by the House Judiciary Committee. Critics say the move could drive up costs, but supporters see it as a way to protect patients from HMO abuses.

The legislation amends antitrust laws to give health care professionals the same rights to bargain collectively as union workers when they negotiate with health plans over fees and other contract terms.

Rep. Tom Campbell, R-Calif., the author of the legislation, said it would allow health care professionals to join together to fight gag rules, limits on testing and other restrictions imposed by HMOs.

He said he has 207 co-sponsors, nearly half the House membership, and the backing of groups such as the American Medical Association, the American Dental Association and the National Association of Community Pharmacists.

The bill also faces strong opposition from a coalition of health insurance, HMO, hospital and business groups. They contend the bill would lead to anti-competitive practices by doctors, driving up private health insurance premiums by more than 10 percent and adding to the ranks of the uninsured.

''Doctor cartels are bad medicine for patients,'' the Antitrust Coalition for Consumer Choice in Health Care writes in ads running in Capitol Hill publications.

The Congressional Budget Office last week came out with a report predicting employers would pass on higher health insurance premiums to their employees and that the bill would result in nearly $11 billion in lost tax revenues over 10 years as employers reduce taxable benefits.

Campbell disputed the findings and argued that his bill actually could produce savings if doctors work to improve HMO service and more Americans turn to HMOs, which generally offer medical service at lower cost.

Dr. Donald Palmisano, a New Orleans surgeon and trustee for the American Medical Association, said there was no valid evidence the legislation would raise health care costs. He said the main purpose of bargaining rights would be to make physicians better advocates for their patients and stop HMOs from imposing contract provisions that interfere with patient-physician relationships.

About 180 million Americans are in managed care plans that are dedicated to turning a profit for their investors, Palmisano told Congress recently. ''There must be a counterbalance that emphasizes quality care. And physicians are in the best position to act as that counterbalance.''

Campbell's bill makes clear that the new bargaining power does not give doctors the right to strike and takes out references to Medicare and Medicaid as subjects for bargaining. It also limits the life of the bill to three years, so that the effects of the bill on health care costs can be evaluated.

Currently, most of the nation's 650,000 doctors are ineligible to join a union because they are self-employed and antitrust laws ban collective bargaining by the self-employed.

Doctors who are employed by a hospital or municipality may unionize. The AMA says that as of last year about 40,000 doctors belonged to a labor organization.

The bill number is H.R. 1304.