Federal Trade Commission

Facsimile Transmittal Sheet

To:	Devorah Adler Fax number: 202-456-5557	Total number of pages sent (including this cover sheet): 3
From:	Karen Berg Congressional Relations Federal Trade Commission Washington, D.C. 20580 Telephone: (202) 326-~~2195~~ 2960 Facsimile: (202) 326-3585	Sending Organization Code: 0309 Date: 3/24 Time: 2:30
Subject:	Responses to AMA assertions re: HR 1304	
Note:	Per your request. Please let us know if you or Chris would like to discuss this further, or if you have any additional questions. thanks -K	

AMA Assertion: *The bill would not allow price fixing by health care professionals.*

FACT: **The bill clearly allows price fixing.** It would allow doctors and others to agree with their competitors on the prices they will accept from health plans. This is price fixing. The bill also permits competing providers to back up their price fixing with collective refusals to deal -- that is, they can agree that they will all refuse to contract with any health plan that does not agree to pay the fees demanded. This could leave patients having to pay out of pocket for needed medical services.

The AMA says "price fixing will still be illegal" because the bill would not allow health care professionals to set prices "outside of contract negotiations." That is like saying the bill does not allow price fixing because it does not immunize price fixing in all settings.

The AMA also suggests that price fixing would not be immunized because "fees would be determined through these negotiations between health care professionals and health plans – not by agreement among the health care professionals." That is the equivalent of suggesting that if all car dealers agreed to sell a Ford Taurus at a set price, they have not fixed prices because the consumer must still agree to pay the price.

AMA Assertion: *The FTC and DOJ would supervise negotiations under HR 1304.*

FACT: This claim is false. **The bill provides for no regulatory oversight.** The AMA later explains that the bill does not decrease the authority of the antitrust agencies over "*activities that are not allowed under HR 1304.*"

AMA Assertion: *FTC and DOJ opposition to HR 1304 is based on academic theory, not the real world.*

FACT: **The agencies' opposition is based on their experience** investigating and prosecuting cases in which health care providers have engaged in collective negotiations to raise the fees paid by health plans – precisely the type of conduct that HR 1304 would immunize.

AMA Assertion: *HR 1304 would promote competition by correcting the imbalance that currently exists in the marketplace between health care professionals and health plans.*

FACT: **The bill would permit doctor monopolies.** These monopolies could negotiate with health plans -- even those that the AMA would concede are not "dominant" purchasers. This does not "level the playing field," it tilts it entirely in favor of physician cartels.

AMA Assertion: *The argument that HR 1304 will drive up the cost of health care is a smokescreen thrown up by the insurance industry.*

FACT: **The federal antitrust agencies, economists, employer groups, the Consumer Federation of America, and the American Bar Association's Antitrust Section have all expressed their belief that the bill threatens to substantially increase health care costs.**

AMA Assertion: *Current antitrust enforcement policies are inadequate because the agencies have broad discretion to declare negotiating arrangements insufficient to pass antitrust muster.*

FACT: Antitrust law allows doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The agencies have issued health care policy statements and numerous advisory opinions that emphasize physicians' ability under the antitrust laws to organize networks and other joint arrangements to deal collectively with health plans.

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Quality Health-Care Coalition Act of 1999 (Introduced in the House)

HR 1304 IH

106th CONGRESS

1st Session

H. R. 1304

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.

IN THE HOUSE OF REPRESENTATIVES

March 25, 1999

Mr. CAMPBELL (for himself, Mr. CONYERS, Mr. MILLER of Florida, Mr. HOEFFEL, Mr. BAKER, Mr. LAFALCE, Mr. COOKSEY, Mr. PALLONE, Mr. NADLER, Mr. HORN, Mr. FROST, Mr. FILNER, Mr. BOUCHER, Mr. WEXLER, Mr. SCARBOROUGH, Ms. SCHAKOWSKY, Mr. SHOWS, Mr. SANDLIN, Mr. TOWNS, Mr. BLAGOJEVICH, Mr. BROWN of Ohio, Mr. PAUL, Mr. COBURN, Mr. GANSKE, Mr. DELAHUNT, Mr. ROHRABACHER, Mr. MCCOLLUM, and Mr. KLINK) introduced the following bill; which was referred to the Committee on the Judiciary

A BILL

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 1999'.

SEC. 2. FINDINGS.

Congress finds the following:

(1) A large number of Americans receive their health care coverage from managed health care plans. This represents a 10-fold increase over the last 20 years. Serious questions have been raised about the quality of care patients are receiving under these plans.

(2) Changes in the health care industry have led to an increased concentration of health care plans, including more than 162 mergers in the last 10 years.

(3) The McCarran-Ferguson Act has created an enhanced opportunity for market power of insurance companies in health care and has given such companies significant leverage over health care providers and patients.

(4) Permitting health care professionals to negotiate collectively with health care plans will create a more equal balance of negotiating power, will promote competition, and will enhance the quality of patient care.

(5) Allowing health care professionals to negotiate collectively with health care plans will not change the professionals' ethical duty to continue to provide medically necessary care to their patients.

SEC. 3. 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- The exemption provided in subsection (a) shall not confer any right to participate in any collective cessation of service to patients not otherwise permitted by law.

(d) 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, a health

insurance issuer that is offering health insurance coverage, a Medicare+Choice organization that is offering a Medicare+Choice plan, or a Medicaid managed care entity offering benefits under title XIX of the Social Security Act.

(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)).

(D) MEDICARE+CHOICE ORGANIZATION; MEDICARE+CHOICE PLAN- The terms `Medicare+Choice organization' and `Medicare+Choice plan' have the meanings given such terms in subsections (a)(1) and (b)(1) of section 1859 of the Social Security Act (42 U.S.C. 1395w-28).

(E) MEDICAID MANAGED CARE ENTITY- The term `Medicaid managed care entity' has the meaning given the term `managed care entity' under section 1932(a)(1)(B) of the Social Security Act (42 U.S.C. 1396u-2(a)(1)(B)).

(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.

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professionals will total $53 billion, and spending for prescription drugs and related items will be $59 billion.

TABLE 1. ESTIMATE OF THE BUDGETARY EFFECTS OF H.R. 1304, THE QUALITY HEALTH-CARE ACT

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
REVENUES											
On-Budget: Income and Medicare Payroll Taxes	0	-100	-260	-430	-620	-840	-950	-1,000	-1,060	-1,120	-1,190
Off-Budget: Social Security Payroll Taxes	0	-45	-110	-190	-280	-370	-420	-440	-470	-490	-520
Total	0	-145	-370	-620	-900	-1,210	-1,370	-1,440	-1,530	-1,610	-1,710
DIRECT SPENDING											
Federal Employee Health Benefits for Annuitants	0	5	10	20	25	35	40	40	45	50	50
Medicaid	0	150	330	550	805	1,110	1,220	1,340	1,475	1,620	1,780
SCHIP	0	10	20	40	60	75	75	80	85	90	100
Total	0	165	360	610	890	1,220	1,335	1,460	1,605	1,760	1,930
SPENDING SUBJECT TO APPROPRIATION ACTION											
Federal Employee Health Benefits for Active Workers	0	10	20	30	45	60	65	65	70	75	80
Indian Health Service	Not Yet Estimated										
Tricare (Department of Defense)	Not Yet Estimated										
Other Federal Health Programs	Not Yet Estimated										

NOTE: SCHIP = State Children's Health Insurance Program.

WASHINGTON COUNSEL, P.C.

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Chris Jennings	Robert M. Rozen
COMPANY:	DATE: March 22, 2000
FAX NUMBER: 456-5557	TOTAL NO. OF PAGES INCLUDING COVER: 5
PHONE NUMBER:	SENDER'S PHONE NUMBER: (202) 293-7474
RE:	SENDER'S FAX NUMBER: (202) 293-8811

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Chris:

As we discussed, attached is a list of our association in the coalition and a copy of the Consumer Federation letter. I am going to mail you an FTC document that summarizes the multitude of enforcement actions that the FTC has taken against health care professionals (mostly docs and pharmacists) over the last twenty years or so. There is a surprising amount of antitrust activity in this area; and of course, all of this anticompetitive behavior would be made legal under H.R. 1304.

1150 17TH STREET, N.W. SUITE 601 WASHINGTON, D.C. 20036

Antitrust Coalition for Consumer Choice in Health Care Association Members

Academy of Nurse Practitioners
American Association of Health Plans
American College of Nurse Midwives
American Hospital Association
American Optometric Association
American Nurses Association
Association of Private Pension and Welfare Plans
Employer Health Care Alliance (Ohio)
Employers Health Care Coalition of Los Angeles
Healthcare Leadership Council
Health Insurance Association of America
National Association of Health Underwriters
National Association of Manufacturers
National Association of Rehabilitation Agencies
National Business Coalitions on Health
National Childbearing Centers
National Federation of Independent Business
Private Practice Section of the American Physical Therapy Association
Savannah Business Group on Health Care Cost Management, Inc.
Southeast Missouri Business Group on Health
St. Louis Area Business Health Coalition
Texas Business Group on Health
The Community Healthcare Coalition, Inc. (Ohio)
The ERISA Industry Committee
United States Chamber of Commerce

Consumer Federation of America

February 24, 2000

The Honorable Henry J. Hyde
U.S House of Representatives
Washington, DC 20510

The Honorable John Conyers, Jr.
U.S. House of Representatives
Washington, DC 20510

Dear Representatives Hyde and Conyers:

The Consumer Federation of America (CFA) opposes H.R. 1304, which would grant a broad antitrust exemption to self-employed physicians, pharmacists and other health care professionals. CFA vigorously supports the enactment of significant reforms that would improve the quality-of-care offered by managed health care plans and allow health care providers to better advocate on behalf of their patients. However, this bill would likely do more harm than good for consumers.

Instead of hastily granting antitrust immunity to health care providers, Congress should convene a committee or working group representing all stakeholders to more closely examine the implications of this proposal and to arrive at a solution fair to providers, plans, and most importantly, those in need of health care. CFA also advocates the enactment of strong managed care patient protections, vigorous antitrust enforcement against plans and providers and, ultimately, a national health care program accountable to consumers.

H.R. 1304 could result in a number of problems that would take consumers who may already be unhappy with managed care "from the frying pan into the fire", including:

- increased health care costs for consumers, employers and federal and state health care programs;
- reductions in benefits to private plan enrollees and government plan beneficiaries;
- decreased access to health insurance coverage and to federal and state health care programs, such as Medicare and Medicaid, and
- overuse of some health care services and a decline in the coordination of patient care.

H.R. 1304 would authorize the creation of health care cartels, not unions. Current law already allows health care providers who are directly employed by insurance plans to unionize. The bill does not amend the federal labor laws to permit self-employed health care professionals to form a bona fide labor organization. The bill does not establish oversight of the collective bargaining process under the auspices of

the National Labor Relations Board, as is the case for all unions. Rather, the bill amends the federal antitrust laws to grant providers a blanket exemption in negotiating with health plans that covers not only health care quality issues, but also price. This allows the creation of a price-fixing cartel, like the Organization of Petroleum Exporting Countries (OPEC), rather than a union.

Congressional antitrust exemptions are typically accompanied by some type of regulatory oversight of the market. This is true, for example, with exemptions that pertain to collective labor negotiations, the sale of insurance and the creation of agricultural cooperatives. H.R. 1304 would, however, repeal antitrust laws that apply to health care providers without constructing a regulatory framework. This strips consumers of protection from price-fixing cartels without substituting any enforcement authority that can intervene on behalf of consumers who are victimized by unfair price increases or reduced access to health care.

Under H.R. 1304, the economic incentive to collude against consumer interests would be too great to resist for even the most well-intentioned providers, especially physicians. The bill would give physicians the power to collude on price, divide up markets and work in concert to drive competing nonphysician providers out of business, such as nurse midwives and chiropractors. This is not an academic concern. The Department of Justice and the Federal Trade Commission have successfully pursued a number of cases against physician practices for anti-competitive behavior. Moreover, in several of these cases, the physicians involved were not acting to improve quality of care—the motives were clearly related to economic rivalry with nonphysician providers.[1]

The Department of Justice and the Federal Trade Commission state that existing law, as interpreted under the agencies' "Statements of Antitrust Enforcement Policy in Health Care", allow physicians and other providers to work in concert to raise quality-of-

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[1] *Mesa County Physicians Independent Practice Association, FTC Dkt. No. 9284, 63 Fed. Reg. 9549 (Feb. 28, 1998) (Eighty-five percent of physicians in a county worked in concert to raise reimbursement rates with plans.)*

United States v. Federation of Certified Surgeons and Specialists, Inc., 64 Fed. Reg. 5831 (Feb 5, 1999), consent decree in No. 99-167-CIV-T-17F. (Price-fixing by Florida surgeions that performed 87% of general and vascular surgeries in five Tamp hospitals.)

Health Care Management Corp. 107 F.T.C. 285 (1986) (consent order) (Hospital medical staff agreed not to unreasonably restrict podiatrist from practicing at the hospital)

Nurse Midwifery Associates v. Hibbett, 918 F.2d 605 (finding illegal actions by a physician-owned medical malpractice company to cancel insurance of doctors who agreed to collaborate with nurse midwives)

Medical Staff of Memorial Med. Ctr., 110 F.T.C. 341 (1988) (Physician medical staff conspired to prevent nurse midwives from gaining hospital privileges).

Wilk v. American Med. Ass'n, 895 F.2d 352 (355 (7th Cir.), cert. denied (498 U.S. 982) (1990) (AMA boycott to prevent medical physicians from referring patients to or accepting patients from chiropractors).

care issues with insurance plans. To the extent that physicians have genuine concerns about their ability to discuss quality-of-care issues among themselves, they should seek clarification and further guidance from the antitrust agencies, not a blanket exemption unfocused on legitimate quality concerns.

Trade associations representing nurses, physical therapists and nurse midwives oppose H.R. 1304, even though it grants them the same antitrust immunity as physicians. They are understandably concerned that some physicians will use their immunity to collectively demand terms from health plans that would disadvantage competing providers. **This is not just a "turf war" among providers that has no effect on consumers. Nurse midwives, nurse anesthetists and nurse practitioners often provide care of high quality to patients in underserved areas that have been abandoned by physicians.**

CFA has serious concerns regarding health plan mergers and the increasing level of concentration among health insurers. In a number of parts of the country, market concentration among insurers is very high. For consumers, decreased plan competition means fewer choices, higher prices and less access to health care. In fact, health plan concentration may already be affecting the quality of care for consumers. We will continue to advocate vigorous antitrust enforcement by the Department of Justice and the Federal Trade Commission to prevent any accumulation of market power by plans and to prosecute abuse of market power by plans, whether such abuse is visited upon doctors, nurses or consumers.

We will also continue to raise serious concerns about the overall effect of managed care—America's dominant health care delivery model—on consumers and the American health care system. There are a number of bright spots in the delivery of managed care. However, a once-progressive idea for improving the quality and continuity of health care is now plagued by serious problems: an unconscionable preoccupation by many plans with profit over high-quality care ; financial incentives that encourage the provision of less care than may be necessary; nagging doubts about quality-of-care and the continued sharp growth in the number of uninsured Americans.

CFA strongly recommends several measures that could have a much more meaningful impact on problems with managed health care than H.R. 1304:

1. Congress should convene a committee or working group representing all major interests—especially health care consumers—to more closely examine the implications of an antitrust exemption for providers and to offer workable solutions to many of the concerns raised by proponents of this legislation.
2. The Federal Trade Commission and the Department of Justice should step up their efforts to detect and prosecute anti-competitive business practices by managed care organizations and health care providers and to examine more closely the proposed plan mergers with respect to their impact on consumers.

3. The Federal Trade Commission and the Department of Justice should ensure that their guidelines allow providers to easily work together to raise valid quality-of-care concerns with managed care plans.
4. Congress should create a system of national health care focused on quality and access that is accountable to health care consumers, not insurers or providers.

Sincerely,

Senator Howard M. Metzenbaum (Ret.)
Chairman

Travis B. Plunkett
Legislative Director

cc: The Honorable F. James Sensenbrenner, Jr.
The Honorable Bill McCollum
The Honorable George W. Gekas
The Honorable Howard Coble
The Honorable Lamar S. Smith
The Honorable Elton Gallegly
The Honorable Charles T. Canady
The Honorable Bob Goodlatte
The Honorable Ed Bryant
The Honorable Steve Chabot
The Honorable Bob Barr
The Honorable William L. Jenkins
The Honorable Asa Hutchinson
The Honorable Edward A. Pease
The Honorable Christopher Cannon
The Honorable James E. Rogan
The Honorable Lindsey Graham
The Honorable Mary Bono
The Honorable Spencer Bachus
The Honorable Barney Frank
The Honorable Howard L. Berman
The Honorable Rick Boucher
The Honorable Jerrold Nadler
The Honorable Bobby Scott
The Honorable Mel Watt
The Honorable Zoe Lofgren
The Honorable Sheila Jackson Lee
The Honorable Maxine Waters
The Honorable Marty Meehan
The Honorable William Delahunt
The Honorable Robert I.Wexler
The Honorable Steven R. Rothman
The Honorable Tammy Baldwin
The Honorable Anthony David Weiner

Prepared Statement
of
Federal Trade Commission

Presented by

Robert Pitofsky, Chairman
Federal Trade Commission

Before The
Committee on The Judiciary
United States House of Representatives

Concerning H.r. 4277 the "Quality Health-care Coalition Act of 1998"

July 29, 1998

INTRODUCTION

Mr. Chairman and Members of the Committee, I am pleased to appear before you today to present the testimony of the Federal Trade Commission concerning H.R. 4277, which would create an exemption from the antitrust laws to enable health care professionals to negotiate collectively with health plans over fees and other terms of dealing. The Commission believes that the interests of consumers would be harmed by such an exemption. The immunity that would be granted by H.R. 4277 is unnecessary to protect legitimate collaboration among competing health care providers. It would immunize anticompetitive activities that could diminish the effective functioning of health care markets. This, in turn, could harm consumers and raise health care costs, and would likely encourage those in other industries to seek similar special interest exemptions.

We are aware that some health care providers, as well as others, have expressed concerns about the effects that certain managed care arrangements may have on the quality of patient care. We do not question the sincerity of those raising concerns about the welfare of patients. However, we do not believe that granting a broad antitrust exemption to health care providers for anticompetitive collective activity is the best way to address those concerns.

Health care markets are undergoing rapid and far-reaching changes. The issue of how best to protect consumers in the changing health care system is a matter of fundamental national importance, and the subject of substantial public debate. As Members of this Committee are well aware, Congress is currently considering various legislative proposals designed to address concerns that consumers may lack adequate protections in dealing with the health care system. While the Commission is not now offering comments on the merits of these various proposals, it respectfully submits that an exemption such as the one before this Committee today would undermine efforts to address concerns about the current state of our health care system.

In this testimony, the Commission will first briefly discuss the role of antitrust law enforcement in the health care area, and then address the proposed legislation under consideration by the Committee. We understand that H.R. 4277 is intended to allow health care professionals to present a united front when negotiating with health plans over fees and other terms governing the plans' dealings with health care providers, and the Commission's testimony is based on its understanding of that intent.

I. THE ROLE OF ANTITRUST IN THE EVOLVING HEALTH CARE SYSTEM

A key focus of the Commission's efforts in the health care area has been to help assure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. The development of these new arrangements, which have helped substantially to slow the rate of increase in health care costs, depends on vigorous competition among market participants. To that end, the Commission, the Department of Justice, and state antitrust enforcers have challenged numerous practices that restrict competition among health care providers when those restraints have harmed consumers. These practices include price fixing, ethical restrictions on the dissemination of truthful information, restraints on physician participation in HMOs and other types of managed care organizations, and efforts by some health care providers to stifle cost-containment efforts.

In over 20 years of antitrust law enforcement in the health care area, the Federal Trade Commission has addressed numerous instances of collective activity by otherwise independent health care providers aimed at third-party payers whose policies or mere existence the providers found objectionable for one reason or another. A broad range of payers, including Blue Shield plans, health maintenance organizations (HMOs) and other managed care plans, dental insurers, and state Medicaid programs, at various times, have been the targets of such actions. Early cases involved instances of collective boycotts or similar activity by physicians and other health care providers to prevent HMOs from entering the market.(1) Subsequently, the vast majority of cases has involved collective action aimed solely or primarily at increasing (or preventing reductions in) payment levels to providers. This collective activity has involved joint agreement and/or collective negotiation on prices or reimbursement issues, often accompanied by actual or threatened coercive boycotts to pressure payers into accepting the terms demanded by the providers.(2)

Most of the Commission's past enforcement actions have been directed at health care providers' efforts to forestall the development of, or raise prices charged to, privately funded health plans. Yet for many citizens, private insurance is unavailable. Many states are currently developing forms of publicly-sponsored insurance to provide medical coverage for the otherwise uninsured. One of our most recent health care enforcement actions involved such a program.

The Commonwealth of Puerto Rico developed a program for providing health care coverage for the uninsured, known as the Reform, which currently covers about 30% of the population. In late 1996, the College of Physicians and Surgeons decided to take collective action in an attempt to raise their reimbursement level under the Reform, which would have raised the costs of health care to the citizens of Puerto Rico. The College ultimately called an eight-day strike, with physicians closing their offices and, in some cases, canceling elective surgery without notice. The potentially serious impact on patients of such anticompetitive behavior is obvious. The FTC and the Commonwealth of Puerto Rico jointly filed a complaint and obtained a consent agreement, under which the College and three large medical groups that contracted with the government paid $300,000 in restitution and agreed not to engage in future boycotts or unintegrated collective price fixing.(3)

We believe that sound antitrust enforcement in situations like the one in Puerto Rico has been a major factor in permitting the emergence of alternative health care arrangements that today vie for the patronage of consumers, private employers, and government purchasers. Although health care markets have changed dramatically over time, and continue to evolve, collective action by health care providers to block innovation and interfere with cost-conscious purchasing remains a significant threat to consumers. The prospect of effective antitrust enforcement therefore continues to be a crucial, positive influence on the marketplace which encourages better responses to consumer demands for high-quality and cost-effective health care.

While many of our cases have focused on health care providers' efforts to obstruct managed care plans, we wish to emphasize that the Commission does not favor any particular model of health care delivery -- whether it be fee-for-service, managed care, or some other type of arrangement. Our goal simply is to deter restraints that unduly limit the options available in the market or artificially raise prices, so that consumers will be free to choose the health care arrangements they prefer at competitive prices.

II. THE ANTITRUST EXEMPTION FOR HEALTH CARE PROFESSIONALS EMBODIED IN H.R. 4277 WOULD BE A RADICAL DEPARTURE FROM EXISTING LABOR LAW STANDARDS

As presently drafted, H.R. 4277 would create a broad antitrust exemption for price fixing and boycotts by physicians, dentists, and other health care professionals, by granting competing providers the same antitrust exemption that is accorded to employees who create legitimate labor organizations to negotiate with employers. The bill states that any group of health care professionals that negotiates with a "health insurance issuer," such as an HMO or commercial health insurer, is entitled to "the same treatment under the antitrust laws as that which is accorded to members of a bargaining unit recognized under the National Labor Relations Act." Workers in such bargaining units enjoy what is known as "the labor exemption" from the antitrust laws.(4) In essence, the labor exemption allows employees to unionize and use collective economic pressure against an employer to gain higher wages and more favorable working conditions. Thus, the bill would create a "collective bargaining" exemption to allow doctors and other health care professionals to exert economic pressure on health plans to gain higher fees and other, more favorable, terms of dealing. As was noted earlier in this testimony, challenges to such collective action have been and continue to be a central focus of antitrust enforcement in the health care sector because of the harm such activity inflicts on consumers.

It is important to recognize that the labor exemption already operates in the health care sector under the same standards that apply in other industries -- that is, where there is a "labor dispute" involving a bona fide labor organization. Thus, physicians who are employees are *already* covered by the labor exemption under current law. The exemption, however, is limited to the employer-employee context. An antitrust defendant must demonstrate that the dispute at hand grew out of an employer-employee relationship -- *i.e.*, a "labor dispute" -- to successfully invoke the labor exemption.(5) But when independent business people combine to enhance their entrepreneurial interests, rather than to affect some employer-employee relationship, the labor exemption does not apply.(6)

This distinction between employees and independent contractors is fundamental to the labor relations scheme established by Congress. NLRA Section 2(3) gives the right to bargain collectively only to "employees." The 1947 Taft-Hartley amendments to the NLRA included an amendment to Section 2(3) to provide expressly that the term "employee" does not include "any individual having the status of an independent contractor." 29 U.S.C. § 152(3). The House Report accompanying the amendment stated:

> In the law, there always has been a difference, and a big difference, between "employees" and "independent contractors." "Employees" work for wages or salaries under direct supervision. "Independent contractors" undertake to do a job for a price, decide how the work will be done, usually hire others to do the work, and *depend for their income not upon wages, but upon the difference between what they pay for goods, materials, and labor and what they receive for the end result, that is, upon profits.*

H.R. Rep. No. 245, 80th Cong., 1st Sess. 18 (1947) (emphasis supplied).

Some self-employed physicians have contended that they must contract with dominant purchasers, and that managed care health plans control their medical practices to such a degree that they are effectively "employees." To the extent that sufficient control in fact exists to create an employment relationship, no legislative exemption, such as that

proposed in H.R. 4277, is needed. Such physicians would be able under existing labor laws to function as a legitimate collective bargaining unit.

Typically, however, the relationship that self-employed physicians have with health plans differs in many ways from that of an employer-employee relationship. For example, recently a group of New Jersey physicians who contract with a large HMO in their area asserted that their relationship to the HMO met the requirements for the labor exemption. The NLRB Regional Director, in rejecting their argument, concluded that the physicians were independent contractors rather than true employees entitled to the labor exemption, citing numerous factors that distinguished the physicians from such employees.(7) The Director noted that:

- The physicians themselves make the fundamental decisions that determine the profitability of their practices. For example, they decide whether to be sole practitioners or join a group practice, have virtually total control over their expenses (such as the cost of their offices, equipment, and staff), and can vary their incomes by choosing to work more hours.

- The physicians spend only a minority of their time and derive only a minority of their incomes from services provided to the HMO's members. They treat patients who are members of other HMOs, are covered by other types of private health insurance or the Medicare program, or who pay directly for physicians' services.

- Many of the restrictions and procedures imposed on the physicians by the HMO's contracts were mandated by state law, either directly or by virtue of state law requiring certification by an accrediting organization whose standards require the procedures in question. Under labor law principles, restrictions and procedures imposed by governmental regulation do not amount to control by an employer.

In sum, H.R. 4277 is designed to confer the labor exemption on those whose situations are vastly different from those eligible for the exemption under long-standing and well-established principles of labor law. Moreover, the bill makes no provision for bringing these providers within the regulatory scheme of the labor laws that applies to others entitled to the labor exemption. Instead, it would merely grant them a broad immunity to present a "united front" when negotiating price and other terms of dealing with health plans, without any efficiency benefits for consumers or any regulatory oversight to safeguard the public interest. The Commission believes that enacting a labor exemption for health care providers who are not employees is not justified, and would seriously harm competition and consumers. In addition, providing such an exception to a requirement that applies to all other professionals -- that they must be employees in order to qualify for the labor exemption -- is likely to encourage others who do not meet that standard to seek such special treatment. H.R. 4277, therefore, would be the first step on a slippery slope.

III. THE PROPOSED EXEMPTION IS NOT NEEDED TO ALLOW PROVIDERS TO RAISE CONCERNS ABOUT MANAGED CARE QUALITY, OR TO OFFER THEIR OWN ALTERNATIVE PLANS TO CONSUMERS

The broad exemption from the antitrust laws that H.R. 4277 would create is unnecessary for health care providers to effectively express their concerns about the quality of managed care plans, or to offer to consumers what they believe to be a superior alternative. The antitrust laws already allow health care professionals to create joint ventures and to negotiate collectively with health plans where those ventures are likely to produce procompetitive benefits for consumers. Such negotiations are analyzed under the "rule of reason" if the group involves integration that may significantly enhance efficiency, and if the joint price setting is reasonably necessary to achieve that procompetitive goal. These arrangements will pass muster under the rule of reason unless their anticompetitive effects outweigh their contributions to consumer welfare.

As some Members of this Committee may recall, in 1996 the Federal Trade Commission and the Department of Justice revised their health care guidelines to emphasize that providers can organize network joint ventures in a variety of ways without raising antitrust problems.(8) The goal was to ensure that unwarranted fears about the antitrust laws did not discourage innovation by providers that would stimulate competition and benefit consumers. Those revised guidelines have been widely cited for reducing uncertainty and recognizing that a wide range of joint activities by health care providers potentially can be procompetitive and benefit consumers.(9) In addition, since issuing the revised guidelines the agencies have issued 15 advisory opinions and business review letters approving proposed provider networks (and disapproving none).

Thus, collaboration among providers in dealing with health plans and other purchasers, in circumstances where it is likely to benefit consumers through enhanced efficiency, already is permitted under the antitrust laws and has been encouraged by the Agencies' health care guidelines and advisory opinion programs. Provider networks can organize and contract directly with employers and other payers, and thereby compete with health plans that providers believe offer fees and other contractual terms that they consider unfair or potentially harmful to patients. Simply put, if health care providers believe that a health plan does not offer consumers good quality, those providers are free to establish and offer the public their own, better, product without fear of the antitrust laws. And if purchasers agree with the providers and prefer their approach, such plans should flourish in the marketplace. Congress has concurred in this approach by recently amending the Medicare program to allow physicians and other health care providers, through the establishment of "provider sponsored organizations," to offer alternatives to the Medicare HMOs currently available in the market.(10)

In addition, there are a variety of other ways in which health care providers can express their concerns about both price and quality issues relating to managed care. Current law permits collective efforts, such as standard setting and certification, by physicians and other health care providers to promote quality, provided that such efforts are properly circumscribed to achieve that purpose, and thus do not unreasonably injure competition. Such actions, and more generally the offering of a professional group's opinion on issues affecting quality, are unlikely to restrain, and in fact can improve, the ability of consumers to choose among competing alternatives. The value and lawfulness of providers giving information and views also is explicitly recognized in our health care guidelines.(11) What is forbidden under current antitrust law standards is for anyone -- including medical groups -- to enter agreements that coercively impose on the market their view of what choices should be available to consumers and what prices they should receive.

IV. THE EXEMPTION WOULD PERMIT CONDUCT THAT COULD INJURE CONSUMERS

The antitrust exemption language contained in H.R. 4277 is prefaced by a statement that the bill's purpose is "[t]o ensure and foster continued patient safety and quality of care." Yet the activities protected by the bill are not limited to conduct furthering those purposes; rather, the bill would authorize a broad range of anticompetitive joint conduct by physicians and other health care professionals that could seriously harm consumers and undermine efforts to make available and promote high quality, cost-effective health care for consumers. For example, the bill would permit otherwise competing health care providers to jointly agree to raise their prices and increase their payments from insurers and other payers, at the expense of consumers. Like the physicians in the Puerto Rico case discussed above, they could "strike" by refusing to provide services to patients covered by payers who did not accede to their payment and other demands.

Third-party payers, attempting to respond to the demands of their customers to control

costs, increasingly have sought to obtain lower fees from providers, and to develop ways to control what previously was the providers' virtually unrestricted ability to provide expensive health care services to patients, even when such services were unnecessary or inappropriate. Not surprisingly, at various times payers have faced concerted opposition to their cost-containment efforts from some health care providers, in an effort to thwart what the providers perceived as unwarranted intrusions into their professional practice autonomy.(12) Many of these instances involved assertions that the collective conduct was aimed, at least in part, at protecting consumers and assuring quality of care. For example, this was precisely the rationale used by the AMA to justify its ethical prohibition on its members providing their services on other than a fee-for-service basis, or affiliating with HMOs or other novel arrangements for delivering health care services.(13)

This is not to say that many of the issues raised by physicians and other health care providers regarding changes in the health care system are not motivated by genuine concerns about their patients' welfare. The Commission shares those concerns. But "quality-of-care" arguments also easily can be invoked as a justification for even the most egregious anticompetitive conduct. They have been advanced to support, among other things, broad restraints on almost any form of price competition,(14) policies that inhibited the development of managed care organizations,(15) and concerted refusals to deal with providers or organizations that represented a competitive threat to physicians.(16) Thus, even if the antitrust exemption in H.R. 4277 were limited to conduct aimed at protecting patient safety and quality, history nevertheless cautions that the exemption could be subject to abuse.

The bill could also make it harder to develop innovative approaches to health care delivery and financing. For example, small HMOs, facing the aggregated power of provider collective bargaining, could find it more difficult to enter or succeed in the market.(17) Ironically, this effect would undermine the purposes of H.R. 4277, since such thwarted market entrants could have been competitive alternatives to the larger health plans whose policies and operations health care providers seek to respond to under the bill's protection.

Allowing providers to enter agreements that restrict the price/quality mix of health care services available to consumers in the market, even if motivated in part by genuine quality-of-care concerns, removes that choice from consumers. Moreover, it could force many consumers to forgo health care coverage altogether because they would be unable to afford the only available arrangements that result from providers' jointly determined prices and other terms for the market.(18)

CONCLUSION

The health care system is a complex and dynamic sector of our economy. New arrangements and approaches to delivering and paying for care are continually emerging in the private sector, as well as in Medicare, Medicaid, and other government programs. Competition is the basic approach that our nation increasingly is relying upon to control costs and assure quality in the delivery of health care services, with resort to regulatory intervention only as needed to address specific problems that the market cannot cure. The result is a complex, difficult, and ongoing process. Different options are being tried. Some are successful, while others proving less so have been or will be abandoned. Problems that arise will need to be addressed one way or another -- either by making the market work better or, if that fails, by regulations designed to protect consumers. But in either case, the solution does not lie in eliminating competition and granting health care providers the right collectively to raise their prices and jointly agree on the terms and conditions under which their services will be available in the market.

The Commission believes that H.R. 4277 would do just that. It would allow health care providers to aggregate their market power and impose their collective will on consumers

and the marketplace. It would erase more than 20 years of effective effort to allow health care markets to function competitively so as to better meet the needs and wants of consumers. For the reasons discussed above, the Federal Trade Commission believes that H.R. 4277 would harm consumers, and for that reason respectfully opposes its enactment. Instead, we believe that it would be better to continue the approach we took two years ago when we and the Department of Justice revised the health care guidelines. This involves continued enforcement of the antitrust laws to ensure that consumers have choice in competitive health care markets, while at the same time making clear that the antitrust laws do not stand in the way of collaborative efforts by health care providers to offer alternatives to consumers that will lower costs and assure quality for their patients.

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1. *See, e.g., Forbes Health System Medical Staff*, 94 F.T.C. 1042 (1979) (consent order) (hospital medical staff, including physicians, dentists, and podiatrists, agreed not to discriminate against medical staff members who were associated with HMOs, and not to exclude applicants for hospital privileges simply because they provided services on other than a fee-for-service basis); *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976) (consent order) (physician-controlled Blue Shield plan and affiliated physicians' association agreed to cease conduct that discriminated against HMOs, or against physicians who practiced with an HMO or on other than a fee-for-service basis). *See also Physicians Group, Inc.*, 120 F.T.C. 567 (1995) (consent order); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988) (consent order); *Medical Staff of Doctors' Hospital of Prince George's County*, 110 F.T.C. 476 (1988) (consent order); *American Medical Association*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982).

2. *See, e.g., M.D. Physicians of Southwest Louisiana, Inc. (MDP)*, FTC File No. 941-0095, 63 Fed. Reg. 33423 (June 24, 1998) (proposed consent order); *Mesa County Physicians Independent Practice Association, Inc.*, Dkt. No. 9284, 63 Fed. Reg. 9549 (February 25, 1998) (proposed consent order); *FTC and Commonwealth of Puerto Rico v. College of Physicians-Surgeons of Puerto Rico*, FTC File No. 971-0011, Civil No. 97-2466-HL (D.P.R. October 2, 1997) (consent order); *Montana Associated Physicians, Inc./Billings Physician Hospital Alliance, Inc.*, C-3704, 62 Fed. Reg. 11,201 (March 11, 1997) (consent order); *Physicians Group, Inc.*, 120 F.T.C. 567 (1995) (consent order); *La Asociacion Medica de Puerto Rico*, 119 F.T.C. 772 (1995) (consent order); *McLean County Chiropractic Association*, 117 F.T.C. 396 (1994) (consent order); *Southbank IPA, Inc.*, 114 F.T.C. 783 (1991) (consent order); *Patrick S. O'Halloran, M.D.*, 111 F.T.C. 35 (1988) (consent order); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988) (consent order); *New York State Chiropractic Association*, 111 F.T.C. 331 (1988) (consent order); *Rochester Anesthesiologists, et al.*, 110 F.T.C. 175 (1988) (consent order); *Preferred Physicians, Inc.*, 110 F.T.C. 157 (1988) (consent order); *Michigan State Medical Society*, 101 F.T.C. 191 (1983); *Association of Independent Dentists*, 100 F.T.C. 518 (1982) (consent order).

3. *FTC and Commonwealth of Puerto Rico v. College of Physicians-Surgeons of Puerto Rico*, FTC File No. 971-0011, Civil No. 97-2466-HL (D.P.R. Oct. 2, 1997).

4. The labor exemption from the antitrust laws is derived from Sections 6 and 20 of the Clayton Act and Section 4 of the Norris-LaGuardia Act. The exemption has two branches: (1) the "statutory exemption," which is based on the express wording of the statutory provisions; and (2) the judicially created "nonstatutory exemption," which harmonizes the policies underlying the National Labor Relations Act of 1935 ("NLRA") with the antitrust laws.

5. *See, e.g., H.A. Artists & Assocs. v. Actors Equity Ass'n*, 451 U.S. 704, 717 n.20 (1981) ("a party seeking refuge in the statutory exemption must be a bona fide labor organization and not an independent contractor").

6. *Columbia River Packers Ass'n v. Hinton*, 315 U.S. 143 (1942). *Accord, Los Angeles Meat and Provision Drivers Union, Local 626 v. United States*, 371 U.S. 94 (1962); *United States v. National Ass'n of Real Estate Boards*, 339 U.S. 485 (1950); *United States v. Women's Sportswear Mfg. Ass'n*, 336 U.S. 460 (1949); *American Medical Ass'n v. United States*, 317 U.S. 519, 533-36 (1943) (rejecting assertions that the labor exemption to the antitrust laws applied to joint efforts by independent physicians and their professional associations to boycott an HMO in order to force it to cease operating).

7. Letter from Dorothy L. Moore-Duncan, Regional Director, Region Four, NLRB, to Robert F. O'Brien (January 8, 1998). The decision currently is on appeal to the full NLRB.

8. 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.

9. *See, e.g.,* Reardon, "Oral Statement of the American Medical Association to the Joint Venture Project of

the Federal Trade Commission in Collaboration with the United States Department of Justice, Re: Impact of Federal Antitrust Law and Enforcement Policy on Physician Network Joint Ventures," (July 1, 1997) (". . . we believe that they [the revised statements] have facilitated the formation of physician networks." *Id.* at 1-2; "The AMA believes that all three sets of statements of antitrust enforcement policy for health care issued by the agencies, including the 1993, 1994, and 1996 versions, have facilitated the formation of certain kinds of POs [physician organizations]." *Id.* at 7); Hirshfeld, "Key Changes in Federal Antitrust Enforcement Policy for Physician Joint Venture Networks," 10 *The Chronicle* 9 (Fall 1996) ("The AMA believes that the new guidelines provide a rich source of tools for physicians to form different kinds of networks, and that there are now many options open to physicians to meet the needs of their markets in a realistic and practical fashion." *Id.* at 12); Grady, "1996 Revised Antitrust Policy Statements: Building a Bridge to Network Competition," 24 *Health Law Digest* 3 (October 1996) ("The 1996 Statements provide a much better clarification of and insight into the Agencies' position on physician networks and multiprovider networks. . . . [They] should go a significant way to responding to claims by physicians and other providers that the Agencies are hostile to provider networks. . . . [T]he Agencies' 1996 Statements provide a welcome guide to appropriate antitrust analysis of provider networks." *Id.* at 11); Horoschak, "The Revised DOJ/FTC Health Care Enforcement Policy Statements: An Overview," 10 *The Chronicle* 2 (Fall 1996). *See, generally,* Hirshfeld, "Interpreting the 1996 Federal Antitrust Guidelines for Physician Network Joint Ventures," 6 *Ann. Health L.* 1 (1997); Miles, "Joint Venture Analysis and Provider-Controlled Health Care Networks," 66 *Antitrust L. J.* 127 (1997).

10. Section 4001 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, August 5, 1997.

11. *See, e.g.,*United States Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, issued August 28, 1996, *supra* n. 8, 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").

12. *See, e.g., Indiana Federation of Dentists*, 101 F.T.C. 57 (1983), *rev'd*, 745 F.2d 1124 (7th Cir. 1984), *rev'd* 476 U.S. 447 (1986); *Michigan State Medical Society*, 101 F.T.C. 191 (1983); *Texas Dental Association*, 100 F.T.C. 536 (1982) (consent order); *Indiana Dental Association*, 93 F.T.C. 392 (1979).

13. The AMA's ethical prohibitions on such purely price-related issues as physicians' being paid "on a basis other than the traditional fee-for-service norm," or on "contractual arrangements which affect the adequacy of fees, [or] involve underbidding" were justified by the AMA on quality grounds, since such payment methods were viewed as "terms or conditions which tend to interfere with or impair the free and complete exercise of . . . [a physician's] medical judgment and skill or tend to cause a deterioration of the quality of medical care." *American Medical Association*, 94 F.T.C. 701, 1011-12 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982).

14. *See American Medical Ass'n, supra.*

15. *Id.*

16. *E.g., State Volunteer Mutual Insurance Corp.*, 102 F.T.C. 1232 (1983) (consent order) (physician-owned malpractice insurance company agreed not to unreasonably discriminate against physicians who work with independent nurse midwives).

17. Even very large payers that are well-established in a local market may not have the ability to reject provider demands, however unreasonable, in the face of such concerted provider power.

18. On March 12, 1998, the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which included representatives from a broad range of interests involved with the health care system, issued its final report, entitled "Quality First: Better Health Care For All Americans." While addressing an array of issues, and offering numerous recommendations, the Commission nowhere suggested that reducing competition among health care providers and eliminating antitrust law enforcement in the health care sector were approaches likely to lead to better quality health care for consumers.

HIAA®

Health Insurance Association of America

UPDATED NATIONAL PROJECTIONS

THE COST OF PHYSICIAN ANTITRUST WAIVERS

Charles River Associates Inc.

March 3, 2000

555 13th Street, NW - Suite 600 East, Washington, D.C. 20004-1109 202/824-1600

PREFACE

In June 1999, the Health Insurance Association of America commissioned research by Charles River Associates, Inc. to determine the cost impact of federal legislation (H.R. 1304, the "Quality Health-Care Coalition Act of 1999") that would grant physicians and other health care professionals immunity from both state and federal antitrust laws that prohibit collective negotiation by independent competitors over fees and other contract terms.

The 1999 study found that the legislation would raise health care costs, financed by both the public and private sectors, considerably. For example, projections at that time were that total annual personal health care spending would rise between 3.1 and 7.1 percent, or by $34.5 billion to $80.0 billion annually. In addition, private health insurance premiums would increase annually by up to 11 percent.

The cost impact estimates from that earlier analysis have now been updated to reflect the most recent national health expenditure data, more recent estimates of managed care penetration, and the potential for greater variability in response to the legislation in certain markets.

Among the updated findings reflected in the attached tables are that annual private sector premium increases could climb as high as 13 percent, while increases in overall health spending range from $29.2 to $95.4 billion a year. Annual impacts toward the lower end of these ranges can be anticipated to result fairly quickly, while the longer-term impact could fall toward the upper end of the range.

March 3, 2000

Table 1 -- Federal

Federal Estimates of the Cost of Physician Antitrust Waivers (in Billions of Dollars)

	Parameter Values for Scenario:					
Parameter	**One**	**Two**	**Three**	**Four**	**Five**	**Six**
Provider Discounts	6.0%	10.0%	13.0%	15.0%	20.0%	25.0%
% Discount Lost	50.0%	60.0%	75.0%	75.0%	85.0%	100.0%
Spillover Price Effect	0.0%	5.0%	8.0%	10.0%	10.0%	10.0%
% Change in Utilization	3.0%	3.0%	4.4%	6.5%	8.0%	9.7%
Spillover Utilization Effect	0.0%	10.0%	20.0%	30.0%	40.0%	50.0%
Managed Care Pentetration	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

	Costs (Billions $)			
Source of Cost	**Private Insurance**	**All Private**	**Public**	**Total**
Scenario One				
Price Increases (direct)	3.9	4.8	0.6	5.4
Price Increases (spillover)	0.0	0.0	0.0	0.0
Total Price Effect	3.9	4.8	0.6	5.4
Utilization (direct)	9.8	12.6	3.5	16.2
Utilization (spillover)	0.0	0.0	0.0	0.0
Total Utilization Effect	9.8	12.6	3.5	16.2
Total (direct)	13.7	17.5	4.1	21.6
Total (spillover)	0.0	0.0	0.0	0.0
Total	**13.7**	**17.5**	**4.1**	**21.6**
Scenario Two				
Price Increases (direct)	7.8	9.6	1.2	10.8
Price Increases (spillover)	0.1	0.4	0.0	0.4
Total Price Effect	8.0	10.0	1.2	11.2
Utilization (direct)	9.8	12.6	3.5	16.2
Utilization (spillover)	0.2	0.7	1.1	1.8
Total Utilization Effect	10.0	13.3	4.7	18.0
Total (direct)	17.7	22.3	4.7	27.0
Total (spillover)	0.3	1.1	1.1	2.2
Total	**18.0**	**23.3**	**5.9**	**29.2**
Scenario Three				
Price Increases (direct)	12.7	15.7	1.9	17.6
Price Increases (spillover)	0.4	0.9	0.0	0.9
Total Price Effect	13.1	16.6	1.9	18.6

Utilization (direct)	14.4	18.5	5.2	23.7
Utilization (spillover)	0.5	2.0	3.4	5.4
Total Utilization Effect	14.9	20.6	8.5	29.1
Total (direct)	27.2	34.2	7.1	41.3
Total (spillover)	0.9	3.0	3.4	6.3
Total	**28.1**	**37.2**	**10.5**	**47.6**

Scenario Four

Price Increases (direct)	14.7	18.1	2.2	20.3
Price Increases (spillover)	0.6	1.4	0.0	1.4
Total Price Effect	15.3	19.4	2.2	21.7
Utilization (direct)	21.3	27.4	7.6	35.0
Utilization (spillover)	1.1	4.5	7.4	11.9
Total Utilization Effect	22.4	31.9	15.1	47.0
Total (direct)	36.0	45.5	9.9	55.3
Total (spillover)	1.7	5.8	7.4	13.3
Total	**37.7**	**51.3**	**17.3**	**68.6**

Scenario Five

Price Increases (direct)	22.2	27.3	3.4	30.7
Price Increases (spillover)	0.8	2.1	0.0	2.1
Total Price Effect	23.1	29.4	3.4	32.8
Utilization (direct)	26.2	33.7	9.4	43.1
Utilization (spillover)	1.9	7.4	12.2	19.6
Total Utilization Effect	28.1	41.1	21.6	62.7
Total (direct)	48.4	61.1	12.8	73.8
Total (spillover)	2.7	9.4	12.2	21.6
Total	**51.1**	**70.5**	**25.0**	**95.4**

Scenario Six

Price Increases (direct)	32.7	40.2	5.0	45.2
Price Increases (spillover)	1.2	3.0	0.0	3.0
Total Price Effect	33.9	43.2	5.0	48.2
Utilization (direct)	31.8	40.9	11.4	52.3
Utilization (spillover)	2.9	11.2	18.5	29.7
Total Utilization Effect	34.6	52.0	29.9	81.9
Total (direct)	64.4	81.1	16.3	97.4
Total (spillover)	4.1	14.2	18.5	32.7
Total	**68.5**	**95.3**	**34.9**	**130.1**

Table 2 -- Federal

Federal Estimates of the Cost of Physician Antitrust Waivers (as a Percentage of Total Expenditures by Payment Source)

Parameter	Parameter Values for Scenario: One	Two	Three	Four	Five	Six
Provider Discounts	6.0%	10.0%	13.0%	15.0%	20.0%	25.0%
% Discount Lost	50.0%	60.0%	75.0%	75.0%	85.0%	100.0%
Spillover Price Effect	0.0%	5.0%	8.0%	10.0%	10.0%	10.0%
% Change in Utilization	3.0%	3.0%	4.4%	6.5%	8.0%	9.7%
Spillover Utilization Effect	0.0%	10.0%	20.0%	30.0%	40.0%	50.0%
Managed Care Penetration	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Source of Cost	Costs as Percentage of Expenditure* Private Insurance	All Private	Public	Total
Scenario One				
Price Increases (direct)	1.0%	0.7%	0.1%	0.5%
Price Increases (spillover)	0.0%	0.0%	0.0%	0.0%
Total Price Effect	1.0%	0.7%	0.1%	0.5%
Utilization (direct)	2.5%	1.9%	0.7%	1.4%
Utilization (spillover)	0.0%	0.0%	0.0%	0.0%
Total Utilization Effect	2.5%	1.9%	0.7%	1.4%
Total (direct)	3.6%	2.7%	0.8%	1.9%
Total (spillover)	0.0%	0.0%	0.0%	0.0%
Total	**3.6%**	**2.7%**	**0.8%**	**1.9%**
Scenario Two				
Price Increases (direct)	2.0%	1.5%	0.2%	0.9%
Price Increases (spillover)	0.0%	0.1%	0.0%	0.0%
Total Price Effect	2.1%	1.5%	0.2%	1.0%
Utilization (direct)	2.5%	1.9%	0.7%	1.4%
Utilization (spillover)	0.0%	0.1%	0.2%	0.2%
Total Utilization Effect	2.6%	2.0%	0.9%	1.6%
Total (direct)	4.6%	3.4%	0.9%	2.3%
Total (spillover)	0.1%	0.2%	0.2%	0.2%
Total	**4.7%**	**3.6%**	**1.2%**	**2.5%**

Scenario Three

Price Increases (direct)	3.3%	2.4%	0.4%	1.5%
Price Increases (spillover)	0.1%	0.1%	0.0%	0.1%
Total Price Effect	3.4%	2.6%	0.4%	1.6%
Utilization (direct)	3.7%	2.8%	1.0%	2.1%
Utilization (spillover)	0.1%	0.3%	0.7%	0.5%
Total Utilization Effect	3.9%	3.2%	1.7%	2.5%
Total (direct)	7.0%	5.3%	1.4%	3.6%
Total (spillover)	0.2%	0.5%	0.7%	0.5%
Total	**7.3%**	**5.7%**	**2.1%**	**4.1%**

Scenario Four

Price Increases (direct)	3.8%	2.8%	0.4%	1.8%
Price Increases (spillover)	0.1%	0.2%	0.0%	0.1%
Total Price Effect	4.0%	3.0%	0.4%	1.9%
Utilization (direct)	5.5%	4.2%	1.5%	3.0%
Utilization (spillover)	0.3%	0.7%	1.5%	1.0%
Total Utilization Effect	5.8%	4.9%	3.0%	4.1%
Total (direct)	9.3%	7.0%	2.0%	4.8%
Total (spillover)	0.4%	0.9%	1.5%	1.2%
Total	**9.8%**	**7.9%**	**3.5%**	**6.0%**

Scenario Five

Price Increases (direct)	5.8%	4.2%	0.7%	2.7%
Price Increases (spillover)	0.2%	0.3%	0.0%	0.2%
Total Price Effect	6.0%	4.5%	0.7%	2.8%
Utilization (direct)	6.8%	5.2%	1.9%	3.7%
Utilization (spillover)	0.5%	1.1%	2.4%	1.7%
Total Utilization Effect	7.3%	6.3%	4.3%	5.4%
Total (direct)	12.5%	9.4%	2.6%	6.4%
Total (spillover)	0.7%	1.4%	2.4%	1.9%
Total	**13.2%**	**10.8%**	**5.0%**	**8.3%**

Scenario Six

Price Increases (direct)	8.5%	6.2%	1.0%	3.9%
Price Increases (spillover)	0.3%	0.5%	0.0%	0.3%
Total Price Effect	8.8%	6.6%	1.0%	4.2%
Utilization (direct)	8.2%	6.3%	2.3%	4.5%
Utilization (spillover)	0.7%	1.7%	3.7%	2.6%
Total Utilization Effect	9.0%	8.0%	6.0%	7.1%
Total (direct)	16.7%	12.4%	3.3%	8.5%
Total (spillover)	1.1%	2.2%	3.7%	2.8%
Total	**17.7%**	**14.6%**	**7.0%**	**11.3%**

* For instance the category entitled "private insurance" reports the increase in private insurance costs as a percentage of total expenditures on personal health care made by private insurance companies.

Monica G. Noether, the author of this study, leads the health economics practice at Charles River Associates and specializes in antitrust and strategic analyses of health care markets. She has published on competitive issues relating to health care markets and provided expert testimony in antitrust and reimbursement litigation and has assessed the competitive effects of a wide range of health care transactions. Before joining CRA, Dr. Noether was managing vice president at Abt Associates, where she researched and published on antitrust and reimbursement issues related to health care markets. She also served as deputy assistant director and staff economist at the Antitrust Division, Bureau of Economics, Federal Trade Commission.

HIAA®

Health Insurance Association of America

CALIFORNIA

THE COST OF PHYSICIAN ANTITRUST WAIVERS

Charles River Associates Inc.

Preliminary
March 3, 2000

555 13th Street, NW - Suite 600 East, Washington, D.C. 20004-1109 202/824-1600

California Costs of Antitrust Waivers for Physicians

- Attached tables present estimates of the increase in the cost of health care services provided to the residents of California if legislation is enacted that grants physicians and other health professionals a waiver from antitrust laws that otherwise forbid collective negotiations among competing providers.

- Legislation could be either federal (such as H.R. 1304 introduced by Representative Thomas Campbell) or state (such as the recently introduced California SB 2007 introduced by State Senator Speier).

- The impact on health care expenditures of such legislation would be substantial, particularly given the high proportion of privately and publicly insured California residents enrolled in a managed care plan:

  - Total personal health care expenditures could rise between $3.1 – $9.9 billion dollars, or 2.7 to 8.8 percent;

  - Total private health insurance premiums could increase by 4.6 to 13.2 percent;

  - Total public expenditures (both federal and state expenditures on publicly insured residents of California, given their current enrollments in managed care plans) could increase by $500 million – $2.2 billion, or 1.4 to 5.5 percent.

  - Medicare expenditures for the four million California Medicare enrollees could grow by $320 million – $1.1 billion, or 1.9 to 6.7 percent at current managed care enrollment levels, and would rise further with the anticipated growth in Medicare managed care enrollments;

  - Medicaid (both federal and state portions) expenditures for 4.9 million California beneficiaries could increase by $130 – 760 million, or .7 to 3.9 percent.

Table 1 -- California
California Estimates of the Costs of Physician Antitrust Waivers (in Billions of Dollars)

Parameter	Parameter Values for Scenario: One	Two	Three	Four	Five	Six
Provider Discounts	6.0%	10.0%	13.0%	15.0%	20.0%	25.0%
% Discount Lost	50.0%	60.0%	75.0%	75.0%	85.0%	100.0%
Spillover Price Effect	0.0%	5.0%	8.0%	10.0%	10.0%	10.0%
% Change in Utilization	3.0%	3.0%	4.4%	6.5%	8.0%	9.7%
Spillover Utilization Effect	0.0%	10.0%	20.0%	30.0%	40.0%	50.0%
Managed Care Pentetration	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Source of Cost	Costs (Billions $) Private Insurance	All Private	Public	Total
Scenario One				
Price Increases (direct)	0.4	0.5	0.1	0.6
Price Increases (spillover)	0.0	0.0	0.0	0.0
Total Price Effect	0.4	0.5	0.1	0.6
Utilization (direct)	1.0	1.4	0.3	1.7
Utilization (spillover)	0.0	0.0	0.0	0.0
Total Utilization Effect	1.0	1.4	0.3	1.7
Total (direct)	1.5	1.9	0.4	2.3
Total (spillover)	0.0	0.0	0.0	0.0
Total	**1.5**	**1.9**	**0.4**	**2.3**
Scenario Two				
Price Increases (direct)	0.8	1.0	0.1	1.2
Price Increases (spillover)	0.0	0.0	0.0	0.0
Total Price Effect	0.8	1.1	0.1	1.2
Utilization (direct)	1.0	1.4	0.3	1.7
Utilization (spillover)	0.0	0.1	0.1	0.2
Total Utilization Effect	1.1	1.5	0.4	1.9
Total (direct)	1.9	2.4	0.5	2.9
Total (spillover)	0.0	0.1	0.1	0.2
Total	**1.9**	**2.6**	**0.5**	**3.1**
Scenario Three				
Price Increases (direct)	1.3	1.7	0.2	1.9
Price Increases (spillover)	0.0	0.1	0.0	0.1
Total Price Effect	1.4	1.8	0.2	2.0
Utilization (direct)	1.5	2.0	0.5	2.5
Utilization (spillover)	0.1	0.2	0.3	0.5
Total Utilization Effect	1.6	2.3	0.7	3.0
Total (direct)	2.9	3.7	0.7	4.4

Total (spillover)	0.1	0.3	0.3	0.6
Total	**3.0**	**4.1**	**1.0**	**5.0**
Scenario Four				
Price Increases (direct)	1.6	2.0	0.3	2.2
Price Increases (spillover)	0.1	0.2	0.0	0.2
Total Price Effect	1.6	2.1	0.3	2.4
Utilization (direct)	2.3	3.0	0.7	3.7
Utilization (spillover)	0.1	0.5	0.6	1.1
Total Utilization Effect	2.4	3.5	1.3	4.8
Total (direct)	3.8	5.0	0.9	5.9
Total (spillover)	0.2	0.7	0.6	1.3
Total	**4.0**	**5.6**	**1.5**	**7.2**
Scenario Five				
Price Increases (direct)	2.4	3.0	0.4	3.4
Price Increases (spillover)	0.1	0.2	0.0	0.2
Total Price Effect	2.4	3.2	0.4	3.6
Utilization (direct)	2.8	3.7	0.8	4.5
Utilization (spillover)	0.2	0.9	0.9	1.8
Total Utilization Effect	3.0	4.5	1.8	6.3
Total (direct)	5.1	6.6	1.2	7.9
Total (spillover)	0.3	1.1	0.9	2.1
Total	**5.4**	**7.8**	**2.2**	**9.9**
Scenario Six				
Price Increases (direct)	3.5	4.4	0.6	5.0
Price Increases (spillover)	0.1	0.3	0.0	0.3
Total Price Effect	3.6	4.7	0.6	5.3
Utilization (direct)	3.4	4.5	1.0	5.5
Utilization (spillover)	0.3	1.3	1.4	2.8
Total Utilization Effect	3.7	5.8	2.4	8.2
Total (direct)	6.8	8.8	1.6	10.4
Total (spillover)	0.4	1.7	1.4	3.1
Total	**7.3**	**10.5**	**3.1**	**13.5**

Table 2 -- California
California Estimates of the Costs of Physician Antitrust Waivers (as a Percentage of Total Expenditures by Payment Source)

Parameter	Parameter Values for Scenario: One	Two	Three	Four	Five	Six
Provider Discounts	6.0%	10.0%	13.0%	15.0%	20.0%	25.0%
% Discount Lost	50.0%	60.0%	75.0%	75.0%	85.0%	100.0%
Spillover Price Effect	0.0%	5.0%	8.0%	10.0%	10.0%	10.0%
% Change in Utilization	3.0%	3.0%	4.4%	6.5%	8.0%	9.7%
Spillover Utilization Effect	0.0%	10.0%	20.0%	30.0%	40.0%	50.0%
Managed Care Pentetration	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Source of Cost	Costs as Percentage of Expenditure* Private Insurance	All Private	Public	Total
Scenario One				
Price Increases (direct)	1.0%	0.7%	0.2%	0.5%
Price Increases (spillover)	0.0%	0.0%	0.0%	0.0%
Total Price Effect	1.0%	0.7%	0.2%	0.5%
Utilization (direct)	2.5%	1.9%	0.8%	1.5%
Utilization (spillover)	0.0%	0.0%	0.0%	0.0%
Total Utilization Effect	2.5%	1.9%	0.8%	1.5%
Total (direct)	3.5%	2.6%	1.0%	2.0%
Total (spillover)	0.0%	0.0%	0.0%	0.0%
Total	**3.5%**	**2.6%**	**1.0%**	**2.0%**
Scenario Two				
Price Increases (direct)	2.0%	1.4%	0.4%	1.1%
Price Increases (spillover)	0.0%	0.1%	0.0%	0.0%
Total Price Effect	2.1%	1.5%	0.4%	1.1%
Utilization (direct)	2.5%	1.9%	0.8%	1.5%
Utilization (spillover)	0.0%	0.1%	0.2%	0.2%
Total Utilization Effect	2.6%	2.0%	1.0%	1.6%
Total (direct)	4.6%	3.3%	1.1%	2.5%
Total (spillover)	0.1%	0.2%	0.2%	0.2%
Total	**4.6%**	**3.5%**	**1.4%**	**2.7%**
Scenario Three				
Price Increases (direct)	3.3%	2.3%	0.6%	1.7%
Price Increases (spillover)	0.1%	0.1%	0.0%	0.1%
Total Price Effect	3.4%	2.5%	0.6%	1.8%

Utilization (direct)	3.7%	2.8%	1.1%	2.2%
Utilization (spillover)	0.1%	0.3%	0.7%	0.4%
Total Utilization Effect	3.9%	3.1%	1.8%	2.6%
Total (direct)	7.0%	5.1%	1.7%	3.9%
Total (spillover)	0.2%	0.5%	0.7%	0.5%
Total	**7.2%**	**5.6%**	**2.4%**	**4.4%**

Scenario Four

Price Increases (direct)	3.8%	2.7%	0.7%	2.0%
Price Increases (spillover)	0.1%	0.2%	0.0%	0.1%
Total Price Effect	3.9%	2.9%	0.7%	2.1%
Utilization (direct)	5.5%	4.1%	1.7%	3.2%
Utilization (spillover)	0.3%	0.7%	1.4%	1.0%
Total Utilization Effect	5.8%	4.8%	3.1%	4.2%
Total (direct)	9.3%	6.8%	2.4%	5.2%
Total (spillover)	0.5%	0.9%	1.4%	1.1%
Total	**9.7%**	**7.7%**	**3.8%**	**6.3%**

Scenario Five

Price Increases (direct)	5.7%	4.1%	1.0%	3.0%
Price Increases (spillover)	0.2%	0.3%	0.0%	0.2%
Total Price Effect	5.9%	4.4%	1.0%	3.2%
Utilization (direct)	6.8%	5.0%	2.1%	4.0%
Utilization (spillover)	0.5%	1.2%	2.4%	1.6%
Total Utilization Effect	7.3%	6.2%	4.4%	5.6%
Total (direct)	12.5%	9.1%	3.1%	7.0%
Total (spillover)	0.7%	1.5%	2.4%	1.8%
Total	**13.2%**	**10.6%**	**5.5%**	**8.8%**

Scenario Six

Price Increases (direct)	8.4%	6.0%	1.5%	4.4%
Price Increases (spillover)	0.3%	0.5%	0.0%	0.3%
Total Price Effect	8.7%	6.4%	1.5%	4.7%
Utilization (direct)	8.2%	6.1%	2.5%	4.8%
Utilization (spillover)	0.8%	1.8%	3.6%	2.4%
Total Utilization Effect	8.9%	7.9%	6.1%	7.3%
Total (direct)	16.6%	12.1%	4.0%	9.2%
Total (spillover)	1.1%	2.3%	3.6%	2.7%
Total	**17.7%**	**14.3%**	**7.6%**	**12.0%**

* For instance the category entitled "private insurance" reports the increase in private insurance costs as a percentage of total expenditures on personal health care made by private insurance companies.

Monica G. Noether, the author of this study, leads the health economics practice at Charles River Associates and specializes in antitrust and strategic analyses of health care markets. She has published on competitive issues relating to health care markets and provided expert testimony in antitrust and reimbursement litigation and has assessed the competitive effects of a wide range of health care transactions. Before joining CRA, Dr. Noether was managing vice president at Abt Associates, where she researched and published on antitrust and reimbursement issues related to health care markets. She also served as deputy assistant director and staff economist at the Antitrust Division, Bureau of Economics, Federal Trade Commission.

HIAA

STATEMENTS

Health Insurance Association of America

Statement of

DONALD A. YOUNG, M.D.,

Chief Operating Officer and Medical Director

HEALTH INSURANCE ASSOCIATION OF AMERICA

Before the

HOUSE JUDICIARY COMMITTEE

U.S. HOUSE OF REPRESENTATIVES

Antitrust Waivers for Physicians

June 22, 1999

Introduction

Good morning. Mr. Chairman, members of the committee, I am Don Young, chief operating officer and medical director of the Health Insurance Association of America. HIAA represents 269 member companies providing health, long-term care, disability income, and supplemental insurance coverage to over 115 million Americans. I am pleased to testify on H.R. 1304, the "Quality Health-Care Coalition Act of 1999."

Today, I want to focus on three specific issues that relate to the proposed granting of antitrust waivers to physicians and other health care providers under the provisions of H.R. 1304:

- we have a health care system that is in balance and intensely competitive but with a good balance between provider and managed care organization;
- this balance would be destroyed by granting the proposed antitrust waiver;
- costs to health care consumers and taxpayers would increase if the current market balance is destroyed, as it will be, if H.R. 1304 were to be enacted.

The Private Health Care System Is Balanced and Extremely Competitive

Today, we are finally operating under a health care system that is extremely competitive and becoming more efficient every day. During the late 1960s and 1970s, the rate of inflation for the cost of health care services far outpaced the general inflation rate. These cost increases were passed along to employers, government payers, and consumers in the form of higher insurance premiums and to taxpayers in the form of taxes. By the early 1980s, there were serious concerns over the escalating costs of health care insurance and the growing number of people who were uninsured.

Much of the cost increase stemmed from the nature of unrestricted fee-for-service (FFS) payment systems that rewarded physicians for providing more services, regardless of the impact on patient outcomes and the quality of care. The FFS system paid physician fees based on reasonable and customary charges, paid for in large part by health insurance plans. During this time, policy analysts repeatedly noted the need to instill competition and the discipline of the market place into reimbursement policies.

In the past decade, employers, who are the major purchasers of private health care coverage, began to bring competition to the health marketplace. The result was a movement to address this spending spiral, which became known as managed care, which has been successful in curtailing costs and improving quality. Double-digit inflation in excess of 20 percent in the late 1980s dropped dramatically to low single digit rates in the late 1990s, more in line with general consumer price index trends. For example, while insurance premiums increased by 10.9 percent between 1991 and 1992, the annualized rate of increase by 1996 was only one half of one percent.[1]

The decline in premium growth during the 1990s coincides with dramatic increases in market penetration of managed care. Enrollment in PPOs, HMOs, and other forms of managed care tripled during the past 10 years from 29 percent in 1988 to 86 percent in 1998.

Managed care stimulated healthy competition that not only held down the rate of inflation, but increased access and frequently improved the quality of care. It is estimated that the impact of lower insurance price increases attributable to this trend saved consumers somewhere between $24 billion and $37 billion in 1996. These savings are projected to grow to between $125 billion and $200 billion by the year 2000. In fact, without these savings, some employers would not have been able to afford to provide private insurance and would have been forced to discontinue coverage for their employees. Lower premiums resulting from managed care has reduced the number of uninsured by between three and five million people.[2]

The Costs and Consequences of Antitrust Waivers for Physicians and other Health Care Providers

To date, as managed care plans have enrolled an increasing proportion of private and publicly insured individuals, the positive effect on overall health care cost, access, and quality has become stronger. In reality, despite the name of the legislation (the "Quality Health-Care Coalition Act"), it is not about the quality of patient care, but rather it is largely about economics. Physicians do not need an exemption from the antitrust laws to collectively discuss issues concerning legitimate quality of care concerns with health

plans. In fact, federal antitrust guidelines issued jointly by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) specify that such discussions are lawful, so long as they do not involve boycotts or other collective actions that would harm consumers and patients.

Physician Income Continues to Rise Under Managed Care

Physicians are among the nation's highest paid professions, and, over the last decade as managed care has grown, their incomes have increased 77 percent, with a median net income in 1996 of $166,000. During this same period, the median income of the average worker increased by only 43 percent to $28,480 during the same period.[3] Data based on an American Medical Association study reveals that in 1997, the average physician net income reached a record high of $199,600, up slightly from 1996.[4] H.R. 1304 would effectively allow physicians to further increase their salaries using the threat of boycotting or by collectively refusing to provide any service to beneficiaries until their demands are met. These additional costs would be paid for by employers and consumers.

The Effect of Antitrust Waivers for Physicians

The "Quality Health-Care Coalition Act of 1999" would "cause the antitrust laws [to] apply to negotiations between groups of health care professionals,[5] 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."[6] It would grant physicians and other health care professionals immunity from both state and federal antitrust laws that generally prohibit collective negotiation by independent competitors over fees and other contract terms, such as work rules, which the case of health care providers would encompass utilization review and other management procedures.

H.R. 1304 would destroy this competition at the expense of American businesses, consumers, and taxpayers. The changes of the past decade have brought a balance to the relationship between managed care organizations, health insurers, and physicians. Prior to this time, physician incomes were directly related to the amount of services they provided and the fees they charged. Insurers and the employers and consumers they represented had little or no bargaining power, and there were no incentives to increase efficiency. To disrupt the healthy balance that has finally been achieved between health care providers and those who pay the bills for health care by enacting H.R. 1304 would constitute a rollback of the progress made by managed care on behalf of businesses and consumers. It would serve not only to increase costs, but also, the number of Americans without health insurance. Lessons from the past also suggest that quality of care would decline, rather than improve.

Few Barriers to Physician Consolidation Exist Under Current Law

H.R. 1304 is based on the premise that "permitting health care professionals to negotiate collectively with health plans will create a more equal balance of negotiating power, will promote competition, and will enhance the quality of patient care."[7] Advocates of this antitrust waiver for physician collective bargaining contend that health plans, as a result of consolidation, have secured such significant market power that they can negotiate payment rates that are so low that providers cannot deliver high quality services. Providers have alleged that they need this legislation to "level the playing field."

In fact, current law provides physicians legitimate procedures to discuss clinical and

quality of care issues, or other concerns they may have regarding the impact of managed care on the quality of care. Professionals may and do form competing delivery systems, provided that these organizations create value for their customers and do not pose a substantial threat to competition.

Approximately 60 percent of physicians belong to groups with three or more physicians, while many practice groups include several hundred members. Consolidation has ranged from direct mergers to joint ventures among providers or with hospitals. Although consolidation among health plans varies by geographic area and concentration of population, physicians and health care professionals have enhanced their bargaining leverage by various means of aggregation. These include increasing the size of group practices, forming independent practice associations, provider hospital organizations (PHOs), and provider service organizations (PSOs), as growth through mergers and acquisitions.

These types of successful alliances by providers are increasing. For example, it would be hard to suggest that groups such as the Hill Physicians Medical Group located in Oakland California—with 700 primary care physicians, over 1,800 specialists, and 325,000 enrollees—is at a competitive disadvantage when negotiating with health plans in the area. By purchasing Physician Reliance Network in 1998, American Oncology Resources increased its size to 700 physicians and over 325 oncologists in 44 cancer treatment centers in 24 states. Following the merger, this organization will treat approximately 13 percent of all new cancer cases and enjoy revenues in excess of $850 million.[8] As an entity operating in many states, the federal oversight currently provided by the FTC would not be replaced if H.R. 1304 were to be enacted.

H.R. 1304 Would Legitimize Anticompetitive Activity That Would be Harmful to Consumers

One of the problems with the proposed legislation is that it fails to distinguish between different types of markets. The proposed collective bargaining power that would be allowed to groups of otherwise unrelated physicians under H.R. 1304 could dramatically increase physician income and virtually eliminate all competition in many markets. Theoretically, providers in a geographic area could form a single unit and demand huge salary increases without fear of antitrust challenge. Or, all of the cardiac surgeons or eye surgeons, for example, could band together and refuse to provide services to enrollees of managed care organizations unless the MCOs agreed to meet their income demands.

H.R. 1304 would truly serve to benefit the few, at the expense of the American consumers and taxpayers. It would level a devastating blow to our nation's health care system and the success that finally has been achieved in limiting health care inflation.

Many of these organizations are large and sophisticated, enjoying leverage over prices and terms due to their size, reputation, and connection to their consumers. In fact, some physician groups have been scrutinized and prosecuted for boycotting and price-fixing that would be legal should this proposed legislation be enacted. This year, the DOJ alleged that a group of Florida surgeons were guilty of price-fixing, and joint negotiations resulting in average annual income increases exceeding $14,000 per surgeon. The DOJ eventually entered into a consent decree with the 29 surgeons that performed 87 percent of the vascular and general surgeries in five Tampa, Florida, hospitals.[9] Yet, under H.R. 1304, these actions would be legal, and could well become a standard practice in many areas of the country.

The assertion that physicians must be permitted to form unions to negotiate on more equal footing does not fit with basic economic theory or current market practice. In

fact, one of the reasons that a number of health plans curtailed their service areas or withdrew from the Medicare+Choice program last year was their inability to convince physicians to participate in their networks. Assuming it was even possible that health plans could have monopsony power over physicians, there is absolutely no reason to believe that permitting physicians to form a bargaining unit without any safeguards would lead to a better outcome for their patients, either clinically or financially. In fact, a strong case could be made for substantial adverse effects on patients.

Federal Trade Commission and Department of Justice Oversight

The FTC and the DOJ have issued guidelines in their "Statements of Antitrust Enforcement Policy in Health Care," updated in 1996, which describe the types of physician networks under which collective negotiation by physicians would not generally be challenged. These federal antitrust statements explain that "[t]he collective provision of non-fee-related information by competing health care providers to a purchaser in an effort to influence the terms upon which the purchaser deals with the provider does not necessarily raise antitrust concerns."[10] Moreover, the DOJ and FTC continue to issue guideline interpretations in the form of "business review letters" and "advisory opinions" to further reduce uncertainty surrounding the legality of these types of formations. Generally speaking, enforcement actions have only been brought against organizations whose conduct indicated that they posed a substantial threat to competition without any significant offsetting efficiency.

As an example, the FTC took action against Montana Associated Physicians, Inc. (MAPI), an organization of approximately 115 physician-shareholders that comprised 43 percent of all physicians in Billings, Montana, and over 80 percent of all independent physicians. MAPI agreed to settle allegations that it had acted as a group to delay the entry of managed care into Billings. Additionally, the group agreed to settle charges that, in response to a PPO request for fee information, they encouraged their members to submit prices higher than current prices with the goal of inflating the fee schedule.

The Impetus for H.R. 1304 Is Primarily Economic

It is clear that patient care is not the driving force behind this legislation. Under current law, physicians and health care professionals are not restricted from collaborating and sharing information with each other and the public regarding patient care issues. It is only where physician networks have acted as little more than cartel devices that continued antitrust enforcement in this area has been, and will continue to be, necessary.

Federal Trade Commission Chairman Robert Pitofsky has testified before this committee that legislation of this type simply goes too far. He has clarified that conferring a labor exemption on physicians "would merely grant [physicians] broad immunity to present a 'unified front' when negotiating price and other terms of dealing with health plans, without any efficiency benefits for consumers or any regulatory oversight to safeguard the public interest."[11] Organizations that are designed exclusively to raise prices—and hold little potential of efficiency—are not now shielded with antitrust protection and should not be in the future. H.R. 1304 would effectively do away with the prime objective of antitrust law: to promote consumer welfare by preserving and promoting competition.

NLRB Rejects Physicians' Petition to Be Granted Employee Status

A clear example of the fact that physicians are operating as independent contractors, and are not contemplated, nor do they fit within the intent of the current collective

bargaining labor exemption, is the case heard in May by the National Labor Relations Board, (NLRB). The NLRB in this case rejected a petition on behalf of 650 New Jersey doctors to grant them status as "employees" for antitrust purposes, concluding they were independent contractors and could not form a union. The NLRB's regional director was persuaded in part by the fact that the physicians ran their own practices, could contract with other health plans, and worked in their own facilities.

Economic Effects of Antitrust Waivers

HIAA recently commissioned a study, "Antitrust Waivers For Physicians: Costs and Consequences," which is the first to examine in detail both the quantitative and qualitative impact of this type of legislation. According to the study's author, Dr. Monica G. Noether, vice president of Charles River Associates and former staff economist of the Federal Trade Commission's Antitrust Division, passage of H.R. 1304 could result in up to an annual $80 billion increase to the nation's health care bill.[12] Giving physicians an antitrust exemption could increase private health care premiums from 6 to 11 percent, on top of currently projected medical inflation. Annual government health costs could rise by up to $24 billion. As a result of these increases, using the Congressional Budget Office assumptions, over two million more Americans could be added to the rolls of the uninsured each year.

Special treatment for physicians under the antitrust laws would raise the cost of our health care significantly. Legislation that immunizes physicians from antitrust scrutiny has the potential to raise costs by reducing providers' incentives to offer competitive prices and comply with utilization management processes. H.R. 1304 would protect price fixing, group boycotts, and conduct that would otherwise be *per se* illegal under the antitrust laws. Significantly, although physicians seek the same protections available under the labor exemptions for collective bargaining, the proposed legislation would not also concomitantly require physicians to be employees of a common employer, nor would these physician "bargaining units" be subject to the requirements of federal labor law.

Physicians would not have to achieve any of the efficiencies of integrating their practices, nor would they be subject to the jurisdiction of the NLRB. The physician exemption would cover more than wages and would include any matter that is subject to health plan negotiation. Yet, despite the expansion of the scope of the exemption, all regulatory oversight that applies to current labor bargaining would be removed at both the state and federal levels.

In addition to seeking collective bargaining power on price terms, H.R. 1304 would allow physicians and heath care professionals to collectively negotiate utilization management and other quality and administrative processes of managed care organizations. Curtailing the effectiveness of utilization management poses broader implications than the fee impact of an antitrust exemption for physicians. In addition to its indirect but real impact on costs, to the extent that H.R. 1304 would reduce managed care plans' ability to maintain health plan utilization management policies, (e.g., prior authorization for hospitalization, health plan guidelines, and protocols based on nationally recognized scientific evidence), its impact on the quality and utilization of all services could be substantial.

The study clearly demonstrates that antitrust waivers for physicians would increase costs for health care consumers and taxpayers. It examined the effect of the increase in physician and other health care provider fees if providers no longer have to be competitive and control fees. Historically, savings in physician fees achieved by the use of managed care have ranged from 6 to 25 percent. Estimates suggest that one-half to all of these savings would disappear if the proposed legislation were to take effect.

Ultimately, employers and consumers, as well as Medicare, Medicaid, and other government programs would pay the added costs. Annually, the costs of antitrust immunity in terms of higher provider fees would range from $16.6 to $25.6 billion. These figures indicate that total expenditures on health provider services will increase by 4.2 to 6.5 percent of total expenditures on health professionals, and by 1.5 to 2.3 percent of total health care expenditures and without any reason to expect that quality of care will improve.

Moreover, the study reveals that managed care plans are not the only entities to be affected by a physician antitrust exemption. Although managed care plans will absorb the majority of the impact, a spillover effect will occur as changes in fees and managed care practices are reflected in a rise in costs for indemnity plans and public fee-for-service programs. To the extent that physicians' utilization management and practice patterns change, the effects will permeate into fee-for-service. Projections of these increases range from $1.2 to $1.8 billion. Such increases would hurt government programs such as Medicare, Medicaid, and the Federal Employees Health Benefits Program that are increasingly relying upon managed care to contain costs and address quality issues. Out-of-pocket spending for the beneficiaries of these programs will also increase. Combining the effects in the managed care and FFS markets, estimated annual increases in expenditures for health care providers could range from $17.8 to $27.4 billion.

Overall, current antitrust policy grants significant latitude to physicians to form organizations that do not significantly jeopardize competition. Unfortunately, H.R. 1304 would provide no added value to consumers and would raise prices up to $80 billion a year.

Federal and State Scrutiny of Health Plan Consolidation

Consolidation among health plans and insurers has been subject to rigorous antitrust scrutiny at both the state and federal levels, despite the fact that under the McCarran-Ferguson Act the regulation of the "business of insurance" was delegated to the states. In fact, McCarran-Ferguson did not waive federal antitrust oversight for health plans. Recent health plan consolidations have received careful scrutiny from antitrust agencies to ensure that healthy competition would be maintained. A good example of this oversight would be the agreement by Aetna and U.S. Healthcare to accede to the concerns of the federal regulators regarding the effect of its acquisition of Prudential's health care business in Dallas, Texas. The health insurance industry continues to remain very competitive, making it improbable—if not impossible—for plans to be able to exercise significant market power in its negotiations with health care providers.

Antitrust Law Stimulates Competition in Health Care

Antitrust laws are intended to encourage innovation and flexibility in health care and promote competition in the marketplace. Such protections increase consumer choice by making sure that providers cannot collude to restrict the range of prices and services available and to ensure that providers compete for patients by offering a range of services at reasonable prices. Giving physicians an antitrust waiver would deny consumers choice, quality, and affordability. The justification for the proposed antitrust immunity overlooks three critical factors:

- this legislation would raise health care costs, financed by both the public and private sectors;
- legitimate antitrust mechanisms already exist under which providers can and do collaborate and negotiate with health plans; and
- consolidation among health plans is subject to rigorous antitrust scrutiny, at both

the state and federal levels.

Conclusion

The proposed legislation would tax the very persons it claims to help—American consumers—with a price tag of enormous proportion. H.R. 1304 would truly serve to benefit the few, at the expense of the American consumers and taxpayers. It would level a devastating blow to our nation's health care system and the success that finally has been achieved in limiting health care inflation. Health care premiums would increase by 6 to 11 percent, and total health expenditures in public entitlement programs would rise by as much as $24 billion. These added costs would be paid for by consumers, employers, and taxpayers, without any improvement in the quality of care. Perhaps most significantly, due to increased costs, the proposed legislation would push in excess of two million Americans a year into the growing ranks of the uninsured.

Mr. Chairman, that concludes my testimony. I would be happy to answer any questions that you may have.

P. Ginsburg & J. Pickreign, "Tracking Health Care Costs: An Update" *Health Affairs* 16, July/August 1997.

[2] Sheils, John F. and Haught, Randall A., *Managed Care Savings for Employers and Households: Impact on the Uninsured*, June 1997, The Lewin Group, Inc. for the American Association of Health Plans.

[3] Levitt L & Lundy J, *Trends and Indicators in the Changing Health Care Marketplace*, Henry J. Kaiser Family Foundation (Aug. 1998) p. 65.

[4] Mary Chris Jaklevic, *AMA: Docs Working less, Study shows physicians earn a little more, put in fewer hours*, *Modern Healthcare*, May. 24, 1999, at 2.

[5] The term "health care professional" is defined under H.R. 1304 to mean 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, possess specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.

[6] H.R. 1304, 106th Cong. (1999).

[7] H.R. 1304, 106th Cong. §2 (4) (1999).

[8] American Oncology Resources, Press Release (Dec. 14, 1998), available at www.aori.com.

[9] *United States v. Federation of Certified Surgeons and Specialists, Inc. and Pershing Yoakley & Associates, P.C.*, Case No. 99-167-CIV-T-17F (M.D. Fl. , filed Jan. 26, 1999). See Proposed Final Judgement, Stipulations, and Competitive Impact Statement. 64 Fed. Reg. 5831 (1999).

[10] Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care, § 4, *Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Providers' Collective Provision of Non-Fee-Related Information to Purchasers of Health Care Services*, at 14 (1996).

[11] H.R. 4277, "The Quality Health-Care Coalition Act of 1998": Hearing Before Committee on the Judiciary of the House of Representatives, 105th Cong. (July 29, 1998) (statement of Robert Pitofsky, Chairman, Federal Trade Commission).

[12] Charles Rivers Associates Study (Figures are based on a preliminary cost model which estimates a range of dollar impacts for each of four related effects, two price effects, and two utilization effects. Predictions under this model indicate the annual total dollar impact of the proposed legislation ranges from $35 billion to $80 billion in increased expenditures for personal health care services. These figures represent from about 3 percent to 7 percent of total personal health care expenditures predicted for the

year 2000 in the National Health Expenditures Projections, published by the Health Care Financing Administration. Projections are derived from year 2000 predictions of health care expenditures.)

Would this bill allow price fixing by health care professionals? Yes. The AMA fact sheet claims "HR 1304 would not allow health care professionals to get together outside of contract negotiations and set prices." Of course doctors won't need to do so, because they will legally be able to negotiate collectively, which would mean, for example, that all of the orthopedists in an area could join together, use one negotiator, and demand a higher fee, which is essentially price fixing. Plans would be unable to negotiate directly with individual doctors (they wouldn't be able to pick off some doctors) and would have to give in, or risk having no orthopedists on their panels. In sum, the bill would upset the competitive balance in the health care market, which is critical to holding down increases in health costs.

Do we really need HR 1304 if we get a strong Patients' Bill of Rights? No. Supporters of the bill claim this is about promoting quality care, and not about increasing physician fees. But it remains to be seen whether doctors will really use the power granted them under the legislation to increase the quality of care. DOJ Antitrust and FTC experience has shown that when doctors illegally band together for negotiating purposes, they are mainly concerned about fees, not about the ancillary contract issues they point to now in arguing for this bill.[1] The other issues the AMA mentions, such as restrictions on access to specialists and restrictive definitions of medically necessary care, are more appropriately dealt with in the context of the Patients' Bill of Rights, and do not justify upsetting the competitive balance in the health care market.

Would health care professionals be allowed to strike? The AMA and Rep. Campbell make much of the fact that the bill specifically prohibits "any collective cessation of patient care services." What would happen under the bill, however, is that doctors could collectively reject a health plan's offer, and then, while not refusing to see patients, they would just balance bill the patients. (This is what DOJ claimed happened in the Delaware orthopedists case).

What kinds of issues can be negotiated under H.R. 1304? Again, although, as the AMA claims, the legislation would allow doctors to jointly negotiate any contract issue, including quality issues, experience has shown that doctors will primarily use the power to bargain for higher fees.

Isn't this all about dollars? Perhaps not, but, as mentioned above, antitrust experience with physician joint negotiations thus far has shown that the main issue will be fees, and with the power to negotiate collectively, doctors will surely be able to extract higher fees.

Aren't the FTC and DOJ against HR 1304? Yes. Antitrust regulators argue that it is important to ensure that the health insurance and provider markets function competitively; that is, neither insurers nor providers should be able to obtain or exercise market power to distort the

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[1] In the two recent cases brought by the Department of Justice, the only issues physicians raised in their collective negotiations was fee levels – the alleged collective negotiations were not about non-fee quality of care issues. In the case currently in litigation, the Department is suing a union, the Federation of Physicians and Dentists, alleging that the union facilitated price fixing by all the orthopedic surgeons in Delaware and a boycott of Blue Cross. In that case, the Department alleges that the union facilitated united opposition to Blue Cross's attempts to reduce specialists' fees to bring them in line with the fees paid by insurers in surrounding areas.

competitive outcome. They contend that the legislation will upset that competitive balance, resulting in higher health care costs that will be passed on to consumers.

Aren't the DOC and FTC's current antitrust enforcement policies adequate? The AMA claims that antitrust regulators are not protecting patients and physicians from the big insurers. In response, Joel Klein, Assistant Attorney General for Antitrust, pointed to the Division's review of the Aetna/Prudential merger, the first merger, he said, 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 doctor's services. The Division required Aetna to divest some of its business in Dallas and Houston to eliminate the market power it otherwise could have gained from the merger. (The combined market share that would have resulted from the merger in Houston and Dallas was over 63 percent and 42 percent, respectively). [Chris: you asked what % would cause the problem – these were easy numbers, and I don't know how much lower the % could go and still raise concerns about market power]. As for the trend toward health plan consolidation, Joel Klein testified that

> "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."

Federal Trade Commission

Facsimile Transmittal Sheet

To:	Devorah Adler Fax number: 456-5557	Total number of pages sent (including this cover sheet): 23
From:	Karen Berg Congressional Relations Federal Trade Commission Washington, D.C. 20580 Telephone: (202) 326-~~2195~~ 2960 Facsimile: (202) 326-3585	Sending Organization Code: 0309 Date: 3/22 Time: 6:45
Subject:	Chairman Pitofsky's testimony on HR 1304	
Note:	Here is a copy of Chairman Pitofsky's statement on HR 1304. I have also asked the head of our health care shop to give you a call about the bill.	

Prepared Statement
of the
Federal Trade Commission

Presented by

Robert Pitofsky, Chairman [1]
Federal Trade Commission

Before The
Committee on the Judiciary
United States House of Representatives

Concerning H.R. 1304
the "Quality Health-Care Coalition Act of 1999"

June 22, 1999

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[1] This written statement represents the views of the Federal Trade Commission. Chairman Pitofsky's oral presentation and responses to questions are his own, and do not necessarily represent the views of the Commission or any other Commissioner.

Mr. Chairman, the Federal Trade Commission thanks you and the members of the Committee for inviting us again this year to present the Commission's views on a proposed antitrust exemption to allow physicians and other health care professionals to engage in collective bargaining with health plans. The basic effect of this year's bill is the same as last year's proposal: to grant independent health care practitioners the right to agree on the fees and other terms that they will accept from insurers, employers, and other third party payers, and to boycott payers who refuse to accept their demands. This year's version, however, makes clear that the immunity would apply not just to doctors, but also to pharmacists and others who supply health care products or services. The Commission continues to believe that such an exemption would be bad medicine for consumers. The issues that have been raised regarding patient protection are vitally important, but this proposal is not the way to address them.

H.R. 1304 would create a broad antitrust exemption that would, for example, allow all of the physicians in a particular medical specialty in an area to demand a 20% increase in fees and to refuse to contract with any insurer who refused to pay those rates. The example mentioned above is not a mere hypothetical. The Commission's staff currently has an investigation into just such conduct. Nor is this an isolated case. The Commission has brought numerous actions challenging similar activities.[2]

The bill, while appealing in its apparent simplicity, threatens to cause serious harm to consumers, to employers, and to federal, state, and local governments:

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[2] An appendix describing these cases in more detail will be provided under separate cover.

- **Doctors and other health care professionals could join together to demand substantially higher fees.**

- **Pharmacists could insist on higher payments for filling prescriptions. The bill apparently would permit even large chain pharmacies, such as CVS and Rite Aid, to get together and demand higher prices.**

- **Consumers and employers, including government employers, would face higher insurance premiums.**

- **Consumers would pay more out-of-pocket and could see their benefits reduced.**

- **Medicaid programs that provide services through managed care plans could be forced to increase their budgets or reduce services.**

- **The number of uninsured Americans, and the costs borne by state and local governments in providing for their care, could increase significantly.**

Supporters of the bill argue that giving this kind of unrestrained power to private competitors is needed because of concerns about the changes taking place in our nation's health care system. That significant changes are occurring is beyond dispute. Efforts by private employers and government health care programs to address rapidly increasing health care costs have transformed health service markets. Many doctors are concerned about their ability to care for their patients in the way they believe is best. Many patients are dissatisfied with the services they have received from their health plans; others are worried about the availability and quality of services should they become seriously ill. Press reports of apparent abusive practices by some health plans abound. But even though there are serious problems concerning the relationship of HMOs and other health plans to doctors and patients that deserve to be addressed, this proposal is the wrong approach.

What do we mean by this? An across-the-board antitrust exemption would allow all doctors in a community or all members of a particular specialty – for example, specialists already

compensated at $150,000 to $200,000 a year, not to mention pharmacists who work for large corporate pharmacies -- to band together and insist that they be paid an additional 10 or 20%. Although H.R. 1304 is presented as an extension of the antitrust immunity granted to labor organizations, the circumstances here are surely very different from the context in which the labor exemption was originally adopted by Congress.

The Commission's opposition to the proposed exemption is not based on any policy preference for HMOs over fee-for-service medicine, or on an assumption that the market, if left alone, will cure all problems. Nor does it reflect a lack of concern about the special characteristics of health care markets, or disregard for the strong sense of responsibility that medical practitioners feel for the welfare of their patients. Rather, our opposition is based on the Commission's experience investigating the impact on consumers of numerous instances of collective bargaining by independent health care practitioners.

The bill's stated purpose is to promote the quality of patient care. Collective bargaining by health care professionals, however, does not ensure better care for patients. Two broad-based commissions recently studied changes in the health care system and recommended numerous measures to protect consumers and promote quality. But neither suggested that antitrust immunity was appropriate or desirable.[3] The Commission believes that measures designed to increase the power of consumer choice will serve patients, and our nation as a whole, far better than giving providers the collective power to dictate what choices -- and, significantly, what

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[3] *See* President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Quality First: Better Health Care for All Americans (1998); California Managed Health Care Improvement Task Force, Improving Health Care in California (1998).

prices -- will be available in the marketplace. Government can play an important role in creating the conditions for effective competition in health care markets, and in addressing specific abuses through targeted regulation.

I. The Bill Would Grant Broad Antitrust Immunity For Price Fixing, Boycotts, And Other Anticompetitive Conduct

H.R. 1304, like the proposal before the Committee last year, would create a broad antitrust exemption for price fixing and boycotts by physicians, dentists, pharmacists, and other health care professionals. To understand the types of activity that this bill would legalize, one need only refer to the record of antitrust law enforcement over the past two decades. The Commission, the Department of Justice, and state attorneys general have brought numerous actions challenging price fixing and boycotts by health care professionals who sought to obtain higher fees or more favorable reimbursement terms from third party payers. For example, the Commission's early case against the Michigan State Medical Society[4] challenged the Society's formation of a "negotiating committee" that orchestrated boycotts of the state Blue Shield plan and the state Medicaid program in order to promote the reimbursement policies that the Society preferred. Among other things, the Society opposed vision and hearing care benefits plans negotiated by the United Auto Workers union, because these programs provided for different reimbursement levels for participating and nonparticipating providers.[5]

More recently, the Commission issued a consent order settling charges that a group of physicians in Danville, Virginia, agreed on reimbursement rates and other terms of dealing with

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[4] 101 F.T.C. 191 (1983).

[5] *Id.* at 234-35.

third-party payers, agreed to boycott payers that did not meet those terms, and thereby succeeded in obstructing the entry of new health care plans into its area.[6] One of the victims of the boycott was a health plan established by Virginia to cover state employees. The Commonwealth of Virginia jointly investigated the case with FTC staff, and collected $170,000 in penalties and damages for the increased costs it had to bear in providing health benefits to its employees.[7]

The Commission's most recent challenge to providers' collective negotiation with health plans involved a group of independent physicians that included between 70 and 80% of the doctors in the Lake Tahoe area. According to the complaint, the doctors negotiated collectively with all health plans in the area, and forced the plans to either accept rates much higher than those paid in other parts of California or Nevada, or abandon plans to contract with doctors in the area. The physicians asked Blue Shield of California to raise its premiums to fund increased payments to doctors, and concertedly terminated their participation agreements with Blue Shield when it did not comply with their demands.[8]

These are just a few examples of actions antitrust enforcers have blocked – actions that meant higher prices for consumers without any guarantee of improved patient care. There are many more.[9] The immediate effect of H.R. 1304 would be to allow such anticompetitive

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[6] Physicians Group, Inc., 120 F.T.C. 567 (1995) (consent order).

[7] Commonwealth of Virginia v. Physicians Group, Inc., 1995-2 Trade Cas. (CCH) ¶ 71,236 (W.D. Va. 1995) (consent decree).

[8] North Lake Tahoe Medical Group, Inc., FTC File No. 981-0261, 64 Fed. Reg. 14730 (Mar. 26, 1999) (proposed consent order).

[9] *See, e.g.*, Mesa County Physicians Independent Practice Association, Inc., Dkt. No. 9284 (May 4, 1999) (consent order); Asociacion de Farmacias Region de Arecibo, Dkt. No. C-3855 (March 2, 1999) (consent order); Ernesto L. Ramirez Torres, D.M.D., Dkt. No. C-3851

conduct to proceed unchallenged, and it may encourage health care professionals to undertake such actions.

The bill also could permit physicians to collectively demand terms from health plans that would disadvantage allied health care providers or other alternatives to prevailing modes of medical practice. The collective judgment of health care professionals concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace. The Commission has taken enforcement action in cases in which provider groups sought to impede practice by competing alternatives by, for example, denying, delaying, or limiting hospital privileges of non-physician providers[10] or physicians providing services through innovative arrangements, such as the Cleveland Clinic's integrated multi-specialty group

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(Feb. 5, 1999) (consent order); M.D. Physicians of Southwest Louisiana, Inc., Dkt. No. C-3824 (Aug. 31, 1998) (consent order); Institutional Pharmacy Network, Dkt. No. C-3822 (Aug. 11, 1998) (consent order); FTC and Commonwealth of Puerto Rico v. College of Physicians-Surgeons of Puerto Rico, FTC File No. 971-0011, Civil No. 97-2466-HL (D.P.R. October 2, 1997) (consent decree); Montana Associated Physicians, Inc./Billings Physician Hospital Alliance, Inc., 123 F.T.C. 62 (1997) (consent order); La Asociacion Medica de Puerto Rico, 119 F.T.C. 772 (1995) (consent order); McLean County Chiropractic Association, 117 F.T.C. 396 (1994) (consent order); Baltimore Metropolitan Pharmaceutical Association, Inc. and Maryland Pharmacists Association, 117 F.T.C. 95 (1994) (consent order); Southeast Colorado Pharmacal Association, 116 F.T.C. 51 (1993) (consent order); Peterson Drug Company, 115 F.T.C. 492 (1992); Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order); Patrick S. O'Halloran, M.D., 111 F.T.C. 35 (1988) (consent order); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order); New York State Chiropractic Association, 111 F.T.C. 331 (1988) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order); Preferred Physicians, Inc., 110 F.T.C. 157 (1988) (consent order); Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order).

[10] *See, e.g.*, Medical Staff of Memorial Medical Center, 110 F.T.C. 541 (1988) (consent order); North Carolina Orthopaedic Association, 108 F.T.C. 116 (1986) (consent order).

practice.[11] Other cases illustrate how groups of professionals have attempted to secure health plan payment policies that disadvantage their competitors.[12] Although it was suggested at last year's hearing that the legislation would not grant antitrust immunity to agreements between doctors and health plans that disadvantaged competing providers, but would protect only agreements among physicians on what terms they will accept from plans, it is not clear that the courts would interpret the law in that way.[13]

The differences between this year's bill and last year's do nothing to reduce the Commission's concerns about the potential harm to consumers. Indeed, the changes primarily broaden rather than limit the bill's scope. The current version includes an expansive definition of

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[11] *See* Medical Staff of Broward General Medical Center, 114 F.T.C. 542 (1991) (consent order); Medical Staff of Holy Cross Hospital, 114 F.T.C. 555 (1991) (consent order).

[12] The Commission challenged an alleged boycott of a health plan by physiatrists (doctors specializing in rehabilitative medicine) that demanded not only higher fees, but also that the plan pay for physical therapy services only if the patient was referred by a physiatrist (rather than a doctor in another specialty). La Asociacion Medica de Puerto Rico, 119 F.T.C. 772 (1995) (consent order). *See also* Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (physicians used their control of Blue Shield to impose payment policies that disadvantaged competing clinical psychologists).

[13] The courts have immunized certain agreements arising out of collective bargaining between employers and unions -- the so-called "nonstatutory" or "implicit" labor exemption -- precisely because it was necessary to effectuate the statutory exemption that protects the bargaining and related activities of unions and their members. *See* Brown v. Pro Football, Inc., 518 U.S. 231, 237 (1996). *See also* P. Areeda and H. Hovenkamp, IA Antitrust Law ¶ 255c at 173 (1997) ("There seems little warrant in labor law or policy for distinguishing most collective bargaining agreements from unilateral union activities to accomplish the same result."). Courts might well find similar logic supports immunizing many agreements arising from the collective bargaining protected by H.R. 1304, including not only agreements about wages, but also agreements that preserve the ability of physicians to work free from competition by nonphysicians.

"health care professional" that appears designed to encompass a sweeping array of individuals who provide health care products or services. This year's bill also makes clear that state, as well as federal, antitrust enforcement would be displaced. In addition, although the current bill excludes the "collective cessation of service to patients" from its protections, this limitation takes virtually nothing away from the coercive power the bill grants to providers. The bill continues to permit physicians and others to collectively refuse to deal with a health plan that refuses their demands for higher fees. If a plan failed to accede to those demands, and the group refused to contract, the plan could be forced from the market,[14] or patients would be left to pay their medical bills out of their own pockets.[15] Thus, although providers could not collectively refuse to treat patients, their collective refusal to contract with a plan could impose formidable financial obstacles to patients seeking care.

Although styled as a labor exemption, the antitrust immunity that H.R. 1304 would confer has little to do with established labor law and policy. The labor exemption *already* applies to health care professionals under the same standards that apply in other sectors of the economy; that is, physicians who are employees (for example, of hospitals) are already covered by the labor exemption under current law. The labor exemption, however, is limited to the

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[14] Some types of plans are required as a condition of licensure to maintain a network of providers adequate to provide services to their enrollees; thus, the inability to establish a satisfactory network would force such a plan to leave the market (or prevent it from entering).

[15] Enrollees of HMOs would have to pay out of pocket the full cost of services obtained from non-network providers. PPO enrollees who see non-network providers would have to pay any amount by which the providers' billed charges exceeded the plan's payment allowance. In addition, they likely would have to pay the full charge at the time of service, file a claim for payment, and wait to be reimbursed by the plan, instead of simply paying the copayment and relying on the doctor to collect the remainder of the fee directly from the insurance company.

employer-employee context, and it does not protect combinations of independent business people.[16] H.R. 1304 is designed to override the distinction Congress drew in the labor laws between employees and independent contractors, and to allow some independent contractors -- doctors and other health care professionals operating as independent businesses -- to collectively exert economic pressure on health plans to gain higher fees and other, more favorable, terms of dealing.[17] In addition, it grants the exemption without providing for any oversight of the collective bargaining process by the National Labor Relations Board.

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[16] Columbia River Packers Ass'n v. Hinton, 315 U.S. 143 (1942). *Accord*, Los Angeles Meat and Provision Drivers Union v. United States, 371 U.S. 94 (1962); United States v. National Ass'n of Real Estate Boards, 339 U.S. 485 (1950); United States v. Women's Sportswear Mfg. Ass'n, 336 U.S. 460 (1949); American Medical Ass'n v. United States, 317 U.S. 519, 533-36 (1943) (rejecting assertions that the labor exemption to the antitrust laws applied to joint efforts by independent physicians and their professional associations to boycott an HMO in order to force it to cease operating).

[17] This distinction between employees and independent contractors is fundamental to the labor relations scheme established by Congress. NLRA Section 2(3) gives the right to bargain collectively only to "employees." The 1947 Taft-Hartley amendments to the NLRA included a provision expressly stating that the term "employee" does not include "any individual having the status of an independent contractor." 29 U.S.C. § 152(3). The House Report accompanying the amendment stated:

> In the law, there always has been a difference, and a big difference, between "employees" and "independent contractors." "Employees" work for wages or salaries under direct supervision. "Independent contractors" undertake to do a job for a price, decide how the work will be done, usually hire others to do the work, and depend for their income not upon wages, but upon the difference between what they pay for goods, materials, and labor and what they receive for the end result, that is, upon profits.

H.R. Rep. No. 245, 80th Cong., 1st Sess. 18 (1947). Just last month, the NLRB Regional Director in Philadelphia decided, after having held 14 days of hearings, that network doctors of a New Jersey HMO were independent contractors rather than employees within the meaning of the NLRA. AmeriHealth Inc./AmeriHealth HMO and United Food and Commercial Workers Union, Case 4-RC-19260 (NLRB 4th Region, May 24, 1999).

Moreover, this extension of the labor exemption is being offered as a way to remedy matters that collective bargaining was never intended to address. The stated goal of this bill is to promote the quality of patient care. The labor exemption, however, was not created to solve issues regarding the ultimate quality of products or services that consumers receive. 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. The patient care issues raised by supporters of the bill deserve serious attention, but an ill-fitting labor exemption is the wrong approach.

II. The Exemption Would Harm Consumers

It is undisputed that the immediate effect of H.R. 1304 would be to permit all doctors in a community -- indeed, all health care professionals – to bargain collectively with all health plans that contract with independent health practitioners. It would permit those practitioners to demand much higher fees for their services, and to refuse collectively to contract with plans that did not meet those demands. What is disputed is the impact the bill would have on consumers.

At last year's hearing, there was much discussion about hypotheticals and theoretically-possible results. The Commission believes, however, that past experience is a more reliable guide to what is likely to happen when health care practitioners collectively bargain with health plans. That experience suggests that the proposed exemption presents substantial risks of harm to consumers, private and governmental purchasers of health care, and taxpayers who ultimately foot the bill for government-sponsored health care programs.

A. The Exemption Would Raise Costs And Threatens To Reduce Access To Care

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, however, would not simply be on the health plans and employers that are forced to pay higher prices to health care practitioners, but can be expected to extend to various parties, and in various ways, throughout the health care system:

- Consumers and employers would face higher prices for health insurance coverage.
- Consumers also would face higher out-of-pocket expenses as copayments and other unreimbursed expenses increased.
- Consumers might face a reduction in benefits as costs increased.
- Senior citizens participating in Medicare HMOs would face reduced benefits, because Medicare pays these HMOs a fixed amount per enrollee. Higher fees for professional services means health plans would have fewer dollars available to pay for prescription drug coverage and other benefits that are not available under traditional Medicare but currently are provided by many Medicare HMOs.
- The federal government would pay more for health coverage for its employees through the Federal Employees Health Benefits Program and military health programs.
- State and local governments would incur higher costs to provide health benefits to their employees.
- State Medicaid programs attempting to use managed care strategies to serve their beneficiaries could have to increase their budgets, cut optional benefits, or reduce the number of beneficiaries covered.
- State and local programs providing care for the uninsured would be further strained, because, by making health insurance coverage more costly, the bill threatens to increase the already sizable portion of the population that is uninsured.

These widespread effects are not simply theoretical possibilities. The record of antitrust law enforcement sets forth the impact of collective "negotiations" on the public. For example, as described in the Commission's complaints, collective bargaining by anesthesiologists in Rochester, New York, and by obstetricians in Jacksonville, Florida, forced health plans to raise their reimbursement, and the result was increased premiums for the HMOs' subscribers.[18] Other cases have challenged actions by associations of pharmacists who succeeded in forcing state and local governments to raise reimbursement levels paid under their employee prescription drug plans.[19] In one such case, an administrative law judge found that the collective fee demands of pharmacists cost the State of New York an estimated $7 million.[20]

By raising health care costs and making health insurance less affordable, the exemption threatens to increase the number of uninsured and thus reduce access to care. A 1997 report by the General Accounting Office concluded that a major reason for declining private health coverage is the rising cost of health insurance. Higher insurance costs affect employers' decisions whether to offer health benefits and employees' decisions whether to purchase coverage.[21] In a country where 43.4 million people did not have health insurance in 1997 (1.7

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[18] Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

[19] *See, e.g.*, Baltimore Metropolitan Pharmaceutical Association, Inc. and Maryland Pharmacists Association, 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).

[20] *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).

[21] United States General Accounting Office, "Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures" 2-3 (GAO/HEHS-97-122) (July 1997). A more recent study also concluded that the increase in the proportion of workers who are not covered by

million more than in 1996), any development that threatens to increase the proportion of the population that is uninsured is cause for serious concern.

B. There Is No Support For Claims That Consumer Costs Would Not Increase

In last year's hearing there was acknowledgment that passage of the bill could result in higher payments to health professionals. There has been a suggestion that fee increases imposed on health plans might not be passed on to consumers, but could simply reduce health plan profits. Such a result is unlikely. Fees for professional services account for almost one-half of private insurance payments for health services and supplies.[22] If these costs increase significantly, the most logical assumption is that costs to consumers would go up substantially. Relying on an assumption that higher costs will not be passed on to consumers puts consumers at risk of serious harm. Economic theory predicts that a significant industry-wide increase in input costs will

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private health insurance, from 15.1% in 1979 to 23.3% in 1995, was due in large part to per capita health care spending rising much more rapidly than personal income during the period. (Per capita health spending divided by median income rose from 4.5% in 1979 to 7.3% in 1995.) Kronick & Gilmer, "Explaining The Decline in Health Insurance Coverage, 1979-1995," 18:2 Health Affairs 30 (March/April 1999). Another study reported that in 1997, 2.5 million people refused to accept employer-sponsored health insurance coverage for which they were eligible, even though they had no other source of coverage. Sixty-eight percent of these employees reported that the high cost of health insurance was the reason they rejected the coverage. Thorpe & Florence, "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997," 18:2 Health Affairs 213 (March/April 1999). See also Findlay & Miller, "Down a Dangerous Path: The Erosion of Health Insurance Coverage in the United States" (May 1999).

[22] In 1997, private insurance paid $109.1 billion for physician services, and an additional $43.2 billion for dental and other professional services. This amounts to about 44 % of total private insurance payments, and about 49% of private insurance payments for health services and supplies. National Health Expenditures 1997, Table 3 (found at *www.hcfa.gov/stats/nhe-oact/tables/t11.htm*).

ordinarily raise the price of the final product.[23] Moreover, as noted above, our enforcement actions provide numerous examples in which health care professionals' collective demands for higher fees resulted in higher costs to consumers and to government purchasers.

Arguments that consumers would not be harmed by an antitrust exemption for collective bargaining by independent health care professionals appear to rest on assertions that the bill would balance the bargaining power between health care professionals and health plans. These assertions, however, are incorrect. The bill would permit doctors to create monopolies. On the health plan side of the ledger, the evidence does not support the suggestion that most (or even many) areas have only one or two health plans. A November 1998 letter to Chairman Hyde from Chairman Pitofsky discussed in greater length than is possible here the available information on the extent to which health plans have market power in individual geographic areas. That information indicates that health plan markets vary widely, and simply does not support suggestions that most markets have little or no health plan competition. For example, individual HMOs typically face considerable competition from other HMOs.[24] Data on HMO penetration published in June 1998 show that areas in which HMOs as a group have the largest collective market share tend to have a larger number of individual HMOs in operation and more

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[23] A study published last year concluded that, although health care costs and health insurance premiums did not increase at identical rates on a year-to-year basis in recent years, "over a slightly longer period, the dominant influence on premiums is underlying costs" of health care products and services. Ginsberg & Gabel, "Tracking Health Care Costs: What's New in 1998," 17:5 Health Affairs 141, 145 (Sept./Oct. 1998).

[24] Information on HMOs' market shares is most readily available.

competitive HMO markets.[25] Of course, HMOs also face competition from other types of health plans, such as preferred provider organizations ("PPOs").[26]

Nor does the recent number of highly publicized mergers among commercial health plans suggest that most markets are likely to have only one or two health plans in the future. The Commission and the Department of Justice review these transactions, and we have investigated those that appeared to raise competitive concerns. The Commission is committed to preserving competition in the market for health plans, as in all markets, and if a proposed transaction appeared likely to create market power, we would challenge it.

Arguments about equalizing bargaining power also rest on unsupported assertions that the McCarran-Ferguson Act gives insurance companies leverage in bargaining with health care professionals. Although McCarran-Ferguson protects certain types of activities by insurers (to the extent that such activity is regulated by state law), the Supreme Court has held an insurance company's agreements with providers on the fees they will be paid are not "the business of insurance" and thus are not covered by the McCarran-Ferguson immunity.[27] It seems clear, therefore, that collusion among insurers on such agreements likewise would not be protected by the Act. In fact, complaints about health plans wielding power over doctors appear to have

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[25] *See* The InterStudy Competitive Edge, *Regional Market Analysis 8.1* (June 1998).

[26] Indeed, in 1997 the percentage of workers in traditional HMOs fell from 33 to 30%, while the percentage enrolled in PPOs and point of service plans rose. *See* "Wall Street Verbatim; Wider Networks Need Not Drive New Cost Explosion," Medicine & Health (June 22, 1998).

[27] Group Life and Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979); *see also* Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982).

nothing to do with McCarran-Ferguson or with any statutorily-protected collusion among insurers. We know of no evidence of insurers colluding in setting fees or other terms of dealing with providers, and the Commission does not believe that McCarran would protect such conduct. Rather, the complaints revolve around the size and power of individual insurers relative to individual health professionals.

There is undoubtedly a bargaining imbalance between an individual physician in solo practice and an insurance company. Bargaining imbalances between parties to a commercial transaction are not uncommon in our economy. But the suggestion that this bill would not impose higher costs on consumers and others -- on the ground that the exemption would merely create a countervailing monopoly -- is premised on theoretical arguments about market conditions that do not describe most health care markets. These speculative arguments provide no assurance that the bill's effect would not be a dramatic inflation in health care costs.

C. No Antitrust Exemption Is Needed To Allow Professional Societies And Others To Discuss Their Concerns About Actions By Health Plans

In the debate over this proposed exemption, we frequently hear arguments that the antitrust laws prevent physicians from being effective advocates for their patients. Indeed, it is often suggested that any effort by physicians to talk among themselves or with plans about concerns regarding health plans' practices would violate the antitrust laws. That is simply not the case. Health care professionals can and do engage in collective advocacy, both to promote the interests of their patients and to express their opinions about other issues, such as payment delays, dispute resolution procedures, and other matters. Health care associations have traditionally played an active role in lobbying legislatures and regulatory bodies, such as state

insurance commissions, and presenting issues to the media and the public.

Moreover, the antitrust laws do not prohibit medical 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 data to support their views.[28] In fact, physician groups have presented their views on a number of issues to payers. For example, the American Medical Association has issued a Model Medical Services Agreement that explains its views on appropriate contract terms and on why other contract terms are inappropriate or harmful. Recent press reports indicate that Aetna U.S. Healthcare has altered some of its contract terms in response to communications from the American Medical Association concerning physician dissatisfaction with the contracts.[29]

The Commission has never brought a case based on physicians' collective advocacy with a health plan on an issue involving patient care. Our cases have addressed instances in which physician groups (1) negotiated collectively on fee levels or other price-related issues, or (2) collectively refused to contract with plans, either to gain acceptance of their price-related demands or to prevent or delay market entry by managed care plans generally. In all such cases, the Commission has been very careful to make sure that its orders do not interfere with the

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[28] The statements of antitrust enforcement policy issued by the Commission and the Department of Justice create an antitrust safety zone for health care providers' collective provision of non-fee-related information to health plans. *See* Statements of Antitrust Enforcement Policy in Health Care 40, 4 Trade Reg. Rep. (CCH) ¶13,151 (Aug.1996) (available at *www.ftc.gov*).

[29] "Aetna's U.S. Healthcare Unit Revamps Doctors' Contracts After AMA Criticism," Wall Street Journal B10 (Oct. 20, 1998).

legitimate exchange of information and views between health plans and health care practitioners. Indeed, in the Commission's first litigated case involving collective negotiations by physicians – Michigan State Medical Society – the opinion emphasized that the antitrust laws do not prohibit health care providers' collective provision of information and views to health plans.[30] Specific language was inserted in that order, and in subsequent orders, to make it clear that bans on anticompetitive agreements among competing providers do not prohibit the provision of information and views to health plans concerning any issue, including reimbursement.[31]

III. There Are Better Ways To Protect Consumers

For all the reasons set forth above, the Commission believes the proposed antitrust exemption is the wrong approach to solving concerns about patient care, and that it threatens serious harm to consumers. The Commission recognizes the serious concerns that have been raised regarding the current operation of health care markets. We do not suggest that the market is performing as well as it could, or that the market can or will cure all of the problems that concern this Committee. But recent efforts to examine health care markets, such as the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, have produced a variety of concrete proposals for reform. As antitrust enforcers, we do not seek to endorse any specific proposal. We note, however, that these studies recommend a number of ways to improve quality and protect consumers, and they do not recommend antitrust immunity or collective bargaining rights for providers.

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[30] 101 F.T.C. at 302-09.

[31] *Id.* at 314; *see also* Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

Proposals for reform include:

- **Increasing Consumers' Ability To Choose Their Health Plan.**

  A fundamental concern expressed by health policymakers -- and by members of this Committee at last year's hearing -- is that many consumers lack a choice among different types of health plans. Most consumers obtain health care coverage as a benefit of employment, and many employers offer only one plan. Consumers have different views about many aspects of health care service delivery, including the types of settings in which they want to receive health care, the kinds of services and health practitioners to which they want access, how much they are willing to pay for health insurance, and the value they attach to broader choices among providers.[32] Offering consumers a choice can help make health plans more responsive to consumer preferences. Consumer choice can be increased, for example, by regulatory changes making it easier for small employers to participate in purchasing pools that can offer individuals a choice of health plans.[33]

  Increased consumer choice among health plans also would be good for doctors. Patients who can choose among plans are less likely to have to switch doctors when the employer changes the health plan that is offered, with the result that doctors likely would feel less pressure to participate in a large number of plans in order to retain access to their patients.

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[32] For example, a survey conducted by the Center for Studying Health System Change found large differences in Americans' willingness to trade lower health care costs for limits on choice of providers available in the network, and that many people on both sides of the question had strongly held views. Data Bulletin Number 4 (Fall 1997).

[33] Other observers have urged actions to make it possible for much greater numbers of consumers to choose their health plans directly, rather than having their range of choice defined by their employer. The AMA, for example, has proposed moving from an employment-based system of health insurance to a system of individually selected and owned health insurance coverage, in order to permit individuals with varying needs and preferences to choose the plan that suits them best. As the AMA recognizes, such a system depends on competition among various plans on price, plan features, and quality, that will place pressure on plans to operate efficiently and to lower the price of insurance, as well as to be responsive to individual patients' concerns about quality. American Medical Association, "Expanding Access to Insurance Coverage for Health Expenses" (Nov. 1998); American Medical Association, "Rethinking Health Insurance" (Nov. 1998).

- **Improving Consumer Information.**

  Several proposals would require health plans to disclose various kinds of information, including limits on coverage, use of drug formularies, how procedures and drugs are deemed experimental, and the types and extent of dispute resolution procedures. In addition, work also is underway to develop ways of presenting consumers with comprehensive comparative quality and performance information about health plans, to better inform their decision-making.[34]

  The Commission's Bureau of Consumer Protection has been active in efforts to improve the information available to consumers through a federal interagency task force on health care quality (the Quality Interagency Coordinating Task Force). The consumer information committee of this group is working on ways to improve the information that federal health care plans disclose to consumers, and is considering the types of information that should be disclosed, the way the information should be communicated, and development of a common terminology.[35] The Commission's staff is considering other ways that the Commission can help improve the quantity and quality of information about health plans available to consumers.

- **Regulation of Plan Behavior.**

  Targeted regulation of certain aspects of health plan behavior may be appropriate in some cases to protect consumers. Numerous bills addressing such things as patients' access to appeal and review mechanisms are under consideration at both the state and federal levels.

The Commission appreciates the desire to avoid detailed federal regulation of health plan behavior and to rely instead on the market. However, the proposed exemption would not let the

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[34] The Presidential Commission concluded that more active involvement by public and private group purchasers and by consumers in demanding high quality services would increase the industry's ability and willingness to focus on quality improvement. To this end, it recommended development of core sets of quality measures for health plans, institutional providers, and individual practitioners, and making valid, reliable and comprehensive comparative quality information widely available. Quality First: Better Health Care For All Americans 3-4 (1998). Much work already is being done to develop and improve methods for measuring and communicating information about health plans' performance and the quality of services they provide.

[35] In addition, there are plans to use a government website as a gateway for consumers seeking information on health care quality.

market work. On the contrary, it would severely limit competition among health professionals and health plans, without any regulatory oversight or other mechanism to protect the public interest.

Conclusion

There are no easy solutions to the problems inherent in the simultaneous pursuit of cost effectiveness, high quality, and wider access to health care services. But allowing doctors and other health care practitioners to fix prices and other contract terms is not the answer. The Commission continues to believe that competition among health care providers and among health plans is an important tool for controlling costs, providing consumer choice, and promoting innovation and high quality. We counsel strongly against abandonment of competition as a mechanism for promoting a better health care system, and we urge that every effort be made to address concerns about quality and patient care while preserving and strengthening the benefits that competition can provide. The Commission stands ready to help in any way it can.

American Medical Association
Physicians dedicated to the health of America

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FAX TRANSMISSION SHEET

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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.