SB

256

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 2/24/00

REPORTED OUT OF SFC 4/7/00

FURTHER:

DATE TURNED IN TO OFFICE: 7 April 00

Finance Committee considered SENATE BILL NO. 256

"An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health care insurer that has substantial market power."

and recommends:

[✓] be **replaced** with ____ CS SB 256 (FIN)

[ ] adopt **previous** ____ CS ____ (____)

[ ] attached amendment(s) CS forthcoming

[ ] adopt Letter of Intent by ____

[ ] further referral to the ____ Committee

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR#____

SIGNING DO PASS	*DP*	*OTHER RECOMMENDATIONS*	*NR*	*DNP*	*AM*
Kelly Ellis	✓				
Pete Kelly	✓	Gary Wilken	✓		
		Drew D. Thomas	—		
		Wes Gyldenzy	✓	✓	
		Lyda Green	✓		
Co-Chair:		*Co-Chair:* Loren Leman	✓		
Co-Chair: Jean Parnell	✓	*Co-Chair*			

NEW FISCAL NOTE(S):

Departme:		:ro	Fiscal
	forthcoming f/n's		-
____	Admin		
____	✓Law		
____	Div. Insrance		

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

[ ] **APPROPRIATION -- no fiscal note**

***include fiscal notes accompanying Governor's bill**

REPORTED OUT OF SFC 4/7/00

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSSB 256 (FIN)

Revision Date/Time (Note if correction) _____ Dept. Affected Law
Title "An Act relating to allowing physicians to collectively negotiate with a health benefit plan ..." BRU Civil Division
Component Fair Business Practices
Sponsor Senator Pete Kelly
Requester Senate Finance Committee Component No. 2206

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services	190.0	190.0	190.0	190.0	190.0	
Travel	5.8	5.8	5.8	5.8	5.8	
Contractual	135.6	135.6	135.6	135.6	135.6	
Supplies	3.1	3.1	3.1	3.1	3.1	
Equipment	13.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**347.5**	**334.5**	**334.5**	**334.5**	**334.5**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )		**334.5**	**334.5**	**334.5**	**334.5**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	243.3					
1005 GF/Program Receipts	104.3	334.5	334.5	334.5	334.5	
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**347.5**	**334.5**	**334.5**	**334.5**	**334.5**	**0.0**

Estimate of any current year (FY2000) cost: _____

POSITIONS

Full-time	2	2	2	2	2	
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

CSSB 256 (FIN) provides a method for physicians to collectively negotiate certain terms and conditions of contracts with a health benefit plan. If an authorized third party negotiates with the health benefit plan, the subject matter of the negotiations must be reviewed and approved by the attorney general, who then receives various reports on the progress of the negotiations. Once a negotiated contract proposal is reached, it is to be reviewed and approved by the attorney general, using specific criteria, within thirty days. The bill provides that registration fees for authorized third parties will be established to approximately equal the regulatory costs for the attorney general's oversight of joint negotiations between physicians and health benefit plans. The bill further contains a sunset provision, repealing the new program on July 1, 2005.

Prepared by: Joan M. Kasson Joan M Kasson Phone 465-5370
Division Attorney General's Office Date/Time 4/10/00, 8:54 AM
Approved by Commissioner for Bruce M. Botelho, Attorney General Date 4/10/00
Agency Department of Law

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information, call the Governor's Legislative Office

ANALYSIS CONTINUATION

If enacted, this legislation places substantial responsibilities on the attorney general to approve proposed negotiations, monitor reports of on-going negotiations, and to make a very fact intensive determination whether to approve or not approve a proposed negotiated contract within a very short time frame. The economic and patient care detriment or benefit criteria the Attorney General is directed to base approval or disapproval on will require significant analysis by expert health care economic assistance, as well as additional legal resources.

Under this bill, competing physicians within the service area of a health benefit plan can collectively negotiate certain defined terms and conditions of contracts with the health benefit plan. Negotiations can include fee and price related terms and conditions when the health benefit plan has a market share greater than 15 percent in the geographic service area of the negotiating physicians.

It is difficult to predict how many contracts and reports during a given year that the attorney general's office will have to review and approve. There are 2,287 licensed physicians and 47 separate medical specialties currently in the State of Alaska, and we conservatively estimate more than 7,000 health benefit plans will be potentially subject to this bill. Given these numbers, we would anticipate the volume of collective negotiations under the bill to be significant enough that we will need additional resources to complete the required reviews and approvals.

The Department of Law anticipates a minimum of one new full-time equivalent attorney position and one full-time equivalent paraprofessional position will be needed to handle this new workload. Extensive regulation development will be necessary to implement the legislation by defining terms and setting forth the reporting requirements that authorized third parties will be required to submit in order to reduce, or preferably eliminate, investigation time during the 30 day review period. Once regulations are complete, these positions will perform the necessary investigation, review, and antitrust analyses on the collective bargaining reports submitted by the authorized third party, and represent the state when decisions of the attorney general are challenged.

Requests for approval of proposed negotiations and review of negotiated contracts by the attorney general are unlikely to be spread evenly throughout the course of a year. Instead, they may come at any time, and in any volume. Thus, we assume it will be more efficient to hire expert health care economic assistance by contract on an as needed basis. $100,000 is included for outside expert costs (500 hours at an estimated average cost of $200/hour).

In-house estimates are based on the department's FY 2001 standard full-time equivalent attorney and paraprofessional schedules, which include clerical support, communications, space, supplies, data processing, and other normal overhead expenses. (FTE attorney: $134,712, FTE paraprofessional: $89,837). Each position estimate also includes an additional $6,500 for one-time equipment purchases and $5,000 for direct case costs, costs that cannot be included in the rate as overhead.

The bill assumes fees for the registration of authorized third parties will be established to cover the cost of the program upon implementation. In the first year, it will take several months to establish the regulatory framework. During this time, no fees will be generated. General funds are necessary for the first year to implement the program, at which point, the fees will be set to cover all program costs. The Department of Law estimates, based on Texas' experience, that at least nine months will be required to get regulations in place. Accordingly, funds are split 70/30 general fund and general fund program receipts in FY 2001.

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSSB 256 (FIN)

Revision Date/Time (Note if correction) 04/11/00
Dept. Affected Community & Economic Development
Title An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health care...
BRU Insurance
Component Insurance
Sponsor Senator Pete Kelly
Requester S. (FIN)
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services	$23.10	23.6	24.1	24.6	25.1	25.6
Travel						
Contractual						
Supplies	1.5	1.5	1.5	1.5	1.5	1.5
Equipment	5.0	0.0	0.0	0.0	0.0	0.0
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**29.6**	**25.1**	**25.6**	**26.1**	**26.6**	**27.1**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	29.6					
1005 GF/Program Receipts		25.1	25.6	26.1	26.6	27.1
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**29.6**	**25.1**	**25.6**	**26.1**	**26.6**	**27.1**

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

Full-time						
Part-time	1	1	1	1		1
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

A part-time administrative clerk IIII position is needed in order to gather and report the health benefit plan market share information required under Sec. 23.50.020(e)(6), page 4, line 13. This position would be responsible for developing and sending out surveys requesting data from over 18,000 employers in the state and for performing reasonableness checks on the data submitted, entering the data into a spreadsheet, and developing the required market share reports. Since the Division of Insurance does not have regulatory authority over health benefit plans (employers), it is anticipated that employers will be reluctant to respond to the survey (about 30% response rate). Therefore, a significant amount of this employee's time is anticipated to be spent following up with the employers who do not respond to the survey.

Prepared by: Robert A. Lohr
Phone 269-7900
Division Insurance
Date/Time 4-11-00 12:29 PM
Approved by Commissioner Deborah B. Sedwick
Date 4/11/00
Agency Community & Economic Development

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

For further distribution information, call the Governor's Legislative Office

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

REPORTED OUT OF SFC 4/7/00

BILL NO. CS SB 256 (RLS)

Revision Date/Time	4/20/00	Dept. Affected	Administration
Title	An act relating to regulation of managed	BRU	Centralized Administrative Services
	health care and allowing physicians to collectively...	Component	Retirement and Benefits
Sponsor	Senator Pete Kelly		
Requester	Senate Finance	Component No.	64

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	*	*	*	*	*	*
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	*	*	*	*	*	*

Estimate of any current year (FY2000) cost: *

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill would compromise the State's ability to manage health care costs. Analyses of similar legislation at the federal level estimate health care increases of 5-13% when this type of legislation is enacted. That represents a potential increase to the State's plan of $3.5 - 9.1 million.

Prepared by: Guy Bell, Director — Phone 465-4471
Division: Retirement and Benefits — Date/Time
Approved by Commissioner: Robert Poe Jr. — Date: 4/20/00
Agency: Department of Administration

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

For further distribution information, call the Governor's Legislative Office

1-LS1291\I
Ford
3/27/00
adopted

CS FOR SENATE BILL NO. 256( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR PETE KELLY

A BILL

FOR AN ACT ENTITLED

"An Act relating to allowing physicians to collectively negotiate with a health benefit plan that has substantial market power."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 23 is amended by adding a new chapter to read:

Chapter 50. Collective Negotiation by Physicians.

Sec. 23.50.010. Legislative findings. (a) The legislature finds that permitting competing physicians to engage in collective negotiation of certain terms and conditions of contracts with a health benefit plan will benefit competition, so long as the physicians do not engage in an express or implied threat of retaliatory collective action, including boycotts or strikes.

(b) The legislature finds that permitting physicians to engage in collective negotiations over fee-related terms may, in some circumstances, yield anti-competitive effects. There are, however, instances in which a health benefit plan dominates the market to the degree that fair negotiations between physicians and the health benefit

plan are not possible in the absence of joint action on behalf of the physicians. In those circumstances, the health benefit plan can virtually dictate the terms of the contracts that it offers to physicians.

(c) The legislature finds that it is appropriate and necessary to authorize collective negotiations between competing physicians and health benefit plans on fee-related and other issues when the imbalances in bargaining capacity described in this section exist.

Sec. 23.50.020. Collective action by physicians. (a) Competing physicians may meet and communicate in order to collectively negotiate with the health benefit plan concerning any of the contract terms and conditions described in this subsection. Competing physicians may not engage in a boycott related to these terms and conditions. Competing physicians may meet and communicate concerning

(1) clinical practice guidelines and coverage criteria;

(2) the respective liability of physicians and the health benefit plan for the treatment or lack of treatment of insured or enrolled persons;

(3) administrative procedures, including methods and timing of the payment of services to physicians;

(4) procedures for the resolution of disputes between the health benefit plan and physicians;

(5) patient referral procedures;

(6) the formulation and application of reimbursement methodology;

(7) quality assurance programs;

(8) health service utilization review procedures; and

(9) criteria to be used by health benefit plans for the selection and termination of physicians, including whether to engage in selective contracting.

(b) Except as provided in (c) of this section, competing physicians may not meet and communicate for the purpose of collectively negotiating the following terms and conditions with a health benefit plan:

(1) the fees or prices for services, including fees or prices arrived at by applying any reimbursement methodology procedures;

(2) the conversion factor in a resource-based relative value scale

reimbursement methodology or similar methodologies;

(3) the amount of any discount on the price of services to be rendered by the physicians;

(4) the dollar amount for capitation or fixed payment for each person covered by the health benefit plan for health services rendered by physicians to a health benefit plan's insureds, beneficiaries, or enrollees; or

(5) the inclusion or alteration of terms and conditions to the extent that they are prohibited or required by law; however, this paragraph does not limit physician rights to collectively petition the government for a change in the law.

(c) Competing physicians within the geographic service area of a health benefit plan may collectively negotiate the terms and conditions of contracts described in (b) of this section if the health benefit plan has substantial market power. If the attorney general receives notice under (f) of this section that an authorized third party intends to negotiate with a health benefit plan, the attorney general shall provide written notice of the intended negotiation to the health benefit plan. A health benefit plan is rebuttably presumed to have substantial market power.

(d) A health benefit plan may rebut the presumption of substantial market power described under (c) of this section by providing proof satisfactory to the attorney general that the health benefit plan's market share does not exceed 15 percent

(1) as measured by the number of covered lives at the end of the most recently completed calendar year or by the actual number of consumers of prepaid comprehensive health services at the end of the most recently completed calendar quarter divided by the total population of the geographic service area as of the most recent census; or

(2) within a particular geographic service area when its market segments are added together for all types of health insurance insureds, beneficiaries, or enrollees and for Medicare and Medicaid beneficiaries.

(e) In exercising the collective rights granted by (a) and (c) of this section,

(1) physicians may communicate with each other with respect to the contractual terms and conditions to be negotiated with a health benefit plan;

(2) physicians may communicate with an authorized third party

regarding the terms and conditions of contracts allowed under this section;

(3) the authorized third party is the sole party authorized to negotiate with a health benefit plan on behalf of a defined group of physicians;

(4) physicians can be bound by the terms and conditions negotiated by the authorized third party that represents their interests;

(5) a health benefit plan communicating or negotiating with the authorized third party may contract with, or offer different contract terms and conditions to, individual competing physicians;

(6) an authorized third party may not represent more than 30 percent of the market of practicing physicians for the provision of services, or a particular physician type or specialty in the geographic service area or proposed geographic service area, if the health benefit plan has less than a five percent market share as determined by the number of covered lives as reported by the director of insurance for the most recently completed calendar year or by the actual number of consumers of prepaid comprehensive health services; and

(7) the authorized third party shall comply with the provisions of (f) of this section.

(f) A person acting or proposing to act as an authorized third party under this section shall,

(1) before engaging in collective negotiations with a health benefit plan,

(A) file with the attorney general the information that identifies the authorized third party, the authorized third party's plan of operation, and the authorized third party's procedures to ensure compliance with this section;

(B) furnish to the attorney general, for the attorney general's approval, a brief report that identifies the proposed subject matter of the negotiations or discussions with a health benefit plan and that contains an explanation of the efficiencies or benefits that are expected to be achieved through the collective negotiations; the attorney general may not approve the report if the proposed negotiations exceed the authority granted in this chapter and, if they do, shall enter an order prohibiting the collective negotiations from proceeding; the authorized third party shall provide supplemental information

to the attorney general as new information becomes available that indicates that the subject matter of negotiations with the health benefit plan has changed or will change;

(2) within 14 days after receiving a health benefit plan's decision to decline to negotiate or to te minate negotiations, or within 14 days after requesting negotiations with a health benefit plan who fails to respond within that time, report to the attorney general that negotiations have ended or have been declined;

(3) before reporting the results of negotiations with a health benefit plan and before giving physicians an evaluation of any offer made by a health benefit plan, provide to the attorney general, for the attorney general's approval, a copy of all communications to be made to physicians related to the negotiations, discussions, and health benefit plan offers.

(g) The attorney general shall either approve or disapprove the contract that was the subject of the collective negotiation within 30 days after receiving the reports required under (f) of this section. If the contract is disapproved, the attorney general shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures that would correct any identified deficiencies. An authorized third party who fails to obtain the attorney general's approval is considered to be acting outside the authority of this section.

(h) The attorney general shall approve a collective negotiation if

(1) the competitive and other benefits of the contract terms outweigh any anticompetitive effects; and

(2) the contract terms are consistent with other applicable laws and regulations.

(i) The competitive and other benefits of joint negotiations or negotiated provider contract terms may include

(1) restoration of the competitive balance in the market for health care services;

(2) protections for access to quality patient care;

(3) promotion of health care infrastructure and medical advancement; or

(4) improved communications between health care providers and health care insurers.

(j) When weighing the anticompetitive effects of contract terms, the attorney general may consider whether the terms

(1) provide for excessive payments; or

(2) contribute to the escalation of the cost of providing health care services.

(k) This section does not authorize competing physicians to act in concert in response to a report issued by an authorized third party related to the authorized third party's discussion or negotiations with a health benefit plan. The authorized third party shall advise the physicians of the provisions of this subsection and shall warn them of the potential for legal action against those who violate state or federal anti-trust laws by exceeding the authority granted under this section.

(l) A contract allowed under this section may not exceed a term of five years.

(m) The documents relating to a collective negotiation described under this section that are in the possession of the Department of Law are confidential and not open to public inspection.

Sec. 23.50.030. Fee for registration of authorized third parties. (a) The attorney general shall adopt regulations that establish the amount and manner of payment of a registration fee for authorized third parties. The attorney general shall establish the fee level so that the total amount of fees collected from authorized third parties approximately equals the actual regulatory costs for the oversight of joint negotiations between physicians and health benefit plans. The attorney general shall annually review the fee level to determine whether the regulatory costs are approximately equal to fee collections. If the review indicates that the fee collections and regulatory costs are not approximately equal, the attorney general shall calculate fee adjustments and adopt regulations under this subsection to implement the adjustments. In January of each year, the attorney general shall report on the fee level and revisions for the previous year under this subsection to the office of management and budget.

(b) In this section, "regulatory costs" means costs of the Department of Law

that are attributable to oversight of joint negotiations between physicians and health benefit plans.

Sec. 23.50.040. Regulations. The attorney general may adopt regulations necessary to implement this chapter.

Sec. 23.50.099. Definitions. In this chapter,

(1) "authorized third party" means a person authorized by the physicians to negotiate on their behalf with a health benefit plan under this chapter;

(2) "covered lives" means the total number of individuals who are entitled to benefits under the health benefit plan;

(3) "geographic service area" means the geographic area of the physicians seeking to jointly negotiate;

(4) "health benefit plan" has the meaning given in AS 21.54.500.

*** Sec. 2.** AS 45.50.572 is amended by adding a new subsection to read:

(k) AS 45.50.562 - 45.50.596 do not forbid the existence or operation of organizations of physicians acting in accordance with AS 23.50, or forbid or restrain members of those organizations from lawfully carrying out the legitimate objectives of them; nor are these organizations or members illegal combinations or conspiracies in restraint of trade under the provisions of AS 45.50.562 - 45.50.596.

*** Sec. 3.** AS 23.50.010, 23.50.020, 23.50.030, 23.50.040, 23.50.099; and AS 45.50.572(k) are repealed July 1, 2005.

SENATE FINANCE COMMITTEE
Amendment Number: #1 1-LS1291\H.1
Bill Number: SB 256 Ford
Sponsor: Torgerson Date: 3/27/00 2/29/00
Logged In By: Mindy

A M E N D M E N T

OFFERED IN THE SENATE

TO: CSSB 256(HES)

Page 1, line 1, following "**Act**":

Insert "**relating to unfair discrimination under group health insurance;**"

Page 1, line 7:

Delete "SECTION 2"

Insert "SECTION 3"

Page 1, line 10:

Delete "sec. 2"

Insert "sec. 3"

Page 2, line 3:

Delete "sec. 2"

Insert "sec. 3"

Page 2, following line 5:

Insert a new bill section to read:

"* **Sec. 2.** AS 21.36.090(d) is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, **physician assistant,** dentist, osteopath, optometrist, chiropractor, nurse

midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, or licensed clinical social worker, or certified direct-entry midwife."

Renumber the following bill sections accordingly.

1-LS1291\H.6
Ford
3/24/00

SENATE FINANCE COMMITTEE
Amendment Number: #2
Bill Number: SB 256
Sponsor: P. Kelly Date: 3/27/00
Logged In By: C Grindle

AMENDMENT

OFFERED IN THE SENATE BY SENATOR PETE KELLY

TO: CSSB 256(HES)

Page 10, lines 8 - 10:

Delete all material.

Page 10, line 11:

Delete "Sec. 23.50.050"

Insert "Sec. 23.50.040"

SENATE FINANCE
COMMITTEE
Amendment Number: #3
Bill Number: SB 256
Sponsor: P. Kelly Date: 3/27/00
AMENDMENT By: J Mindy

1-LS1291\H.7
Ford
3/25/00

OFFERED IN THE SENATE BY SENATOR PETE KELLY

TO: CSSB 256(HES)

Page 7, line 3, following "the":
Insert "geographic"

Page 7, line 11, following "power":
Insert "within the geographic service area"

Page 7, lines 16 - 17:
Delete "as reported by the director of insurance for"
Insert "at the end of"

Page 7, line 18, following "services":
Insert "at the end of the most recently completed calendar quarter divided by the total population of the geographic service area as of the most recent census"

Page 7, line 19, following "particular":
Insert "geographic"

Page 8, line 5:
Delete "service area or proposed service area"
Insert "geographic service area or proposed geographic service area"

Page 9, line 8, following "disapprove the":
Insert "contract that was the subject of the"

Page 10, following line 17:

Insert a new paragraph to read:

"(3) "covered lives" means the total number of individuals who are entitled to benefits under the health benefit plan;

(4) "geographic service area" means the geographic area of the physicians seeking to jointly negotiate;"

Renumber the following paragraph accordingly.

SENATE FINANCE
COMMITTEE
Amendment Number: #4
Bill Number: SB 256
Sponsor: P. Kelly Date: 3/27/00
Logged In By: J Mindy

1-LS1291\H.9
Ford
3/25/00

AMENDMENT

OFFERED IN THE SENATE BY SENATOR PETE KELLY

TO: CSSB 256(HES)

Page 7, line 5:
Delete "commissioner"
Insert "attorney general"

Page 7, line 7:
Delete "commissioner"
Insert "attorney general"

Page 7, line 15:
Delete "commissioner"
Insert "attorney general"

Page 8, line 15:
Delete "commissioner"
Insert "attorney general"

Page 8, line 18:
Delete "commissioner, for the commissioner's"
Insert "attorney general, for the attorney general's"

Page 8, line 22:
Delete "commissioner"
Insert "attorney general"

Page 8, line 26:

Delete "commissioner"

Insert "attorney general"

Page 9, line 1:

Delete "commissioner"

Insert "attorney general"

Page 9, line 4:

Delete "commissioner, for the commissioner's"

Insert "attorney general, for the attorney general's"

Page 9, line 7:

Delete "With the advice of the attorney general, the commissioner"

Insert "The attorney general"

Page 9, line 10:

Delete "commissioner"

Insert "attorney general"

Page 9, line 12:

Delete "commissioner's"

Insert "attorney general's"

Page 9, following line 13:

Insert new subsections to read:

"(h) The attorney general shall approve a collective negotiation if

(1) the competitive and other benefits of the contract terms outweigh any anticompetitive effects; and

(2) the contract terms are consistent with other applicable laws and regulations.

(i) The competitive and other benefits of joint negotiations or negotiated provider contract terms may include

(1) restoration of the competitive balance in the market for health care services;

(2) protections for access to quality patient care;

(3) promotion of health care infrastructure and medical advancement; or

(4) improved communications between health care providers and health care insurers.

(j) When weighing the anticompetitive effects of contract terms, the attorney general may consider whether the terms

(1) provide for excessive payments; or

(2) contribute to the escalation of the cost of providing health care services."

Reletter the following subsections accordingly.

Page 9, line 25:

Delete "commissioner"

Insert "attorney general"

Page 9, line 26:

Delete "commissioner"

Insert "attorney general"

Page 9, line 29:

Delete "commissioner"

Insert "attorney general"

Page 10, line 1:

Delete "commissioner"

Insert "attorney general"

Page 10, line 3:

Delete "commissioner"

Insert "attorney general"

Page 10, line 11:

Delete "commissioner"

Insert "attorney general"

Page 10, lines 16 - 17:

Delete all material.

Renumber the following paragraph accordingly.

SENATE FINANCE
COMMITTEE
Amendment Number: #5
Bill Number: SB 256
Sponsor: P Kelly Date: 3/27/00
Logged In By: Mindy

AMENDMENT

OFFERED IN THE SENATE BY SENATOR PETE KELLY
TO: CSSB 256 (HES)

Page 7, lines 10 – 12
Delete all material

SENATE FINANCE
COMMITTEE
Amendment Number: #6
Bill Number: SB 256
Sponsor: Kelly Date: 4/4/00
Logged In By: C Mindy

AMENDMENT

OFFERED IN THE SENATE BY SENATOR PETE KELLY
TO: CS SB 256 (FIN)

Page 3, line10
Delete "geographic" in front of "service"

SENATE FINANCE COMMITTEE

2000 COMMITTEE ACTION

Bill Number	SB 256
Amendment	#6
Motion	adopt
Motion by	K
Objection	
Objection by	none
Removed	
Second Objection by	

Committee Member	Y	***Vote***	N
Senator Al Adams			
Senator Gary Wilken			
Senator Pete Kelly			
Senator Lyda Green			
Senator Randy Phillips			
Senator Dave Donley			
Senator Loren Leman			
Co-Chair Sean Parnell			
Co-Chair John Torgerson			
Tally			
Yea		0	
Nay		0	
Absent		0	
MOTION		Passed	

American Medical Association
Physicians dedicated to the health of America

FOR IMMEDIATE RELEASE March 15, 2000

CAMPBELL BILL WILL GIVE POWER TO PATIENTS WITH LITTLE OR NO COST TO SOCIETY

Three-year sunset provision provides real world test of cost vs. benefits

A new cost analysis of the Campbell Bill (H.R. 1304), conducted by a Pennsylvania State University health policy economist finds the potential costs of the Campbell Bill are a tiny fraction of costs estimated by an earlier study promoted by the Health Insurance Industry of America (HIAA). In fact, the new study shows that when the benefits to society are weighed against potential costs – H.R. 1304 may cost nothing at all.

The Penn State study found that an earlier insurance-sponsored study used "questionable assumptions" and relied heavily on opinion, not empirical evidence.

"There is no definitive evidence to predict whether or not the Campbell Bill will present a cost to society, however, we do know there will be important benefits," said AMA Trustee Donald Palmisano, MD.

"We know for certain that patients are suffering under the current system that gives too much power to health plans, at the expense of individual patients. The Campbell Bill will change that. It will level the playing field so individuals have a fighting chance against enormous and powerful health plan bureaucracies."

"We propose that Congress fix the problem we know we have, and put the Campbell Bill to a real-life test. The key is this: the AMA supports a three-year sunset provision, which allows actual outcomes to replace educated guesses."

"With a three-year sunset, there's nothing to lose. If costs increase significantly, Congress is free to reevaluate." Dr. Palmisano said. "However, we predict the Campbell Bill will give power back to the patient at little or no cost to society – and that's an outcome we can all live with."

#

For more information
or a copy of the Penn State study, please call: Brenda L. Craine
202/789-7447

SUMMARY
Foreman Cost Analysis of
H. R. 1304, the "Quality Health care Coalition Act of 1999"

AMA March 9, 2000

In a new study by Stephen Foreman, J.D., Ph.D., M.P.A. from Pennsylvania State University, potential costs of H.R. 1304 are estimated to range from $71 to $814 million – only 0.005% to 0.06% of national health expenditures based on HCFA projections for 2000. The potential benefits, which are completely ignored by the opponents' estimate, could balance or outweigh the costs.

Opponents of H.R. 1304 cite a single study to support their claim that the bill would raise health care costs by $29.2 to $95 billion annually (the "Charles River estimate"). However, the Charles River estimate is replete with unwarranted assumptions and questionable methodology that leads to cost figures that are overstated and deeply flawed.

The fundamental premise of the Charles River estimate is that managed care has achieved large savings and that all health care professionals will negotiate back most or all of these savings from health plans. The estimate is based on flawed assumptions and uses the highest available savings estimates and other savings estimates that are not supported by any empirical evidence, while ignoring lower savings estimates published in a number of other studies.

A few examples include:

- Charles River uses an estimate based on a study of discounts achieved by a single plan (Aetna) in a single year (1992). However, Aetna is a large national plan with a reputation for achieving aggressive discounts and in 1992 there was substantially lower managed care penetration so health providers offered larger discounts.
- Four separate categories of savings substantially over-count savings, i.e., independent calculation of "direct price effects" and "utilization management effects" and "utilization review effects".
- The range of managed care savings (6%, 13%, 20% and 25%) is unrealistic. There is no empirical evidence that managed care has produced cost savings of 20% to 25%. In addition, Charles River uses a Barents 13% figure that was an average for only some HMOs, **not** for all managed care.
- Both Barents and Lewin estimates used by Charles River include discounts from hospital services that should not be included in an evaluation of potential costs of H.R. 1304. This is particularly misleading because many studies have found that managed care substantially reduced large levels of inefficiency in hospital costs.
- Barents uses a panel of experts to conclude that 60% to 90% of utilization savings will be lost upon the enactment of negotiating legislation. These estimates are not based on any empirical evidence - only opinion.
- The assumption that all cost discounts have been passed on in the form of reduced premiums is inaccurate. Premium dollars are also used for increasing profit structures, due in part to pressure from investors, substantial costs associated with mergers and acquisitions, and for increasing costs of technology and pharmaceuticals to name a few examples.

The Foreman estimate uses the same approach as Charles River, but with a more specific calculation of managed care savings and more realistic assumptions. To assess managed care

cost savings, Foreman uses "time series" analyses. Applying the results of his models to projections of expenditures in 2000, managed care would be expected to produce savings of 5.9 % with respect to services provided by health care professionals. The 5.9 % estimate of managed care savings is consistent with the low end of the range of savings estimates used by Charles River (6%) and is close to the low end of the Lewin estimate (7.5%).

As opposed to the Charles River assumption that health plans would "give-back" most to all of the savings from managed care as a result of negotiations under H. R. 1304, Foreman uses a more realistic, yet generous assumption. Foreman assumes that give-backs, if any, will range from 10% to 25% of managed care savings. This assumption is supported by the fact that most local markets have one or more dominant health plans that drive costs down. In fact, 82% of Standard Metropolitan Statistical Areas have at least one "dominant" HMO. 40 markets have two dominant HMOs, making them highly concentrated according to levels used by the Department of Justice to evaluate market concentration. **Almost half of the local markets have an HMO with a market share of 50% or more which is extremely concentrated.** (InterStudy1999)

In addition, only seven health plans (Aetna, Cigna, United, Foundation, Pacificare, Wellpoint and Humana) account for nearly 68 million patients and a large number of shareholders. The national Blue Cross and Blue Shield Association claims that Blues' plans have 50.5 million members nationwide. The assumption that these large powerful plans, with intense pressure to hold the line on costs, would yield back most or all managed care cost savings is certainly not a logical assumption and is not supported by experience or empirical evidence.

Foreman uses a more realistic assumption of the number of physicians that would join negotiating units under H. R. 1304 - 5% to 23%. This is due to several factors, most notably, independently practicing physicians account for 52.4% of all patient care physicians, and roughly 9.5% to 43.8% of workers who are already eligible to join negotiating units elect to do so (Bureau of Labor Statistics, 1999). To conclude, as does Charles River, that 100% of all patient care physicians would participate in negotiating units under H. R. 1304 simply ignores the facts.

Based on managed care savings of 5.9%, negotiation unit participation of 5.0% to 22.9% of all patient care physicians, and a generous give-back range of 10% to 25%, Foreman's projected cost estimate of $71 to $814 million is clearly reasonable.

Foreman believes that H.R. 1304 would also result in many benefits. For instance, improved physician contracts would lead to a greater number of physicians willing to join managed care provider networks, thereby improving the quality of the networks and reducing patient incentives to go "out of network," thereby reducing their out of pocket costs. While these types of benefits might be hard to quantify in dollars, there are other benefits related to pricing for physician services that can be estimated. The Foreman study therefore evaluates the beneficial impact of the Campbell bill strictly in terms of fees. The elimination of below market pricing of physician services will likely yield savings of $1.0 to $1.9 billion in the form of reduced "welfare losses" to society. Some examples include reduced access to services as a result of physician bankruptcies or strains on safety net services. Thus, Foreman believes the potential benefits of H.R. 1304 could likely outweighed potential costs.

PENNSTATE

1855

A Cost Analysis of Health Care Professional Negotiating Legislation

March 1, 2000

Stephen Foreman, J.D., Ph.D., M.P.A.
Assistant Professor
The Pennsylvania State University

A Cost Analysis of Health Care Professional Negotiating Legislation

March 1, 2000

Stephen Foreman, J.D., Ph.D., M.P.A.*

Introduction

On March 25, 1999, Congressman Thomas Campbell introduced legislation that would permit health care professionals to negotiate collectively with managed care plans (House of Representatives, 1999). Entitled the Quality Health-Care Coalition Act of 1999, the bill would give health care professionals immunity from antitrust laws when they negotiate as a group with HMOs and other large health plans. Proponents of the legislation are concerned about growing market power of large managed care firms and health plans. These firms purchase medical care services from health care professionals for resale to employers. Many of these entities have become so large that they can dictate contract terms to health care professionals, including price and quality. Their growing market dominance, proponents say, is a problem that requires legislation to "level the playing field." A countervailing power response is necessary to permit providers to negotiate contract terms relating to better quality and more appropriate price for medical care services.

Opponents contend that the legislation is not needed because existing legal mechanisms allow professionals to negotiate collectively (Noether, 1999). In addition, they believe, consolidation in the health insurance market is not a problem. Despite well-publicized mergers and acquisitions, they argue that the industry is "very competitive" making it "improbable if not impossible, [for large players] ... to exert significant market power in ... negotiations with health care providers" (Noether, 1999). Finally and most important, they contend that the proposed legislation will raise health care costs by a large amount (Reinhardt, 1999; Noether, 1999). The single empirical study of the potential impact of the negotiating legislation cited by opponents (the "Charles River Study") concludes that such a law would raise health care costs by $35 to $80 billion annually. This would come about because all physicians would join negotiating groups - and the negotiating groups would compel managed care firms and health insurers to give-

---

[1] Never defined by the Charles River study. Using the terms as described by the Health Care Financing Administration they include registered and practical nurses in private duty, podiatrists, optometrists, physical therapists, clinical psychologists, chiropractors, naturopaths and Christian Science practitioners. Many of these professionals are not paid by managed care firms.

* Assistant Professor, The Pennsylvania State University

back half to all of the savings that opponents estimate managed care has produced over the past fifteen years.

Proponents of this bill cite quality concerns as the primary need for the bill. However, it is not always possible to separate quality from cost. Legislation that provides quality improvements at an excessive cost is not an effective policy intervention. Accordingly, this study addresses the concerns raised by the opponents - with particular emphasis on the potential cost of the legislation. The first part reviews the findings and conclusions of the Charles River Study. Many of the assumptions on which the Charles River Study is based are questionable. The methodology used to reach findings and conclusions could be improved.

The second part of the study contains a more reasoned approach to estimation of the costs and benefits of the Campbell Bill. Included is a more specific calculation of costs based on a time series estimation of managed care cost savings and a more reasonable consideration of the physicians that would join negotiating units under the Campbell bill. Using these refinements, the increased costs of the proposed legislation attributable to physician fees would be $71 to $814 million. The increase in fees paid to other professionals would not be substantial.

Part three of the study considers several of the legal and economic concerns raised by the Charles River Study including adequacy of current collective negotiating laws and the competitive level of managed care markets. The proposed legislation is needed because existing laws are not adequate to "level the playing field" when providers attempt to negotiate with large managed care firms. Consolidation in the health insurance industry has produced dominant firms in many markets. These dominant firms currently dictate quality and price to health care providers. In these markets entry is neither easy nor effective to generate competition for the purchase of provider services.

Part four contains an analysis of the potential benefits of the Campbell Bill. The benefits of the legislation have been largely ignored by opponents. In addition to other benefits, the legislation has the potential to achieve efficiency gains through the reduction of inappropriate pricing of provider services. Part four discusses the potential magnitude of such gains.

Projection of the potential cost of the legislation is, like any forecast, subject to a host of unknown factors and the accuracy of a range of assumptions. Obviously, only actual experience with the effect of this type of legislation will yield accurate cost effects. For this reason, a number of advocates of the legislation have recommended use of a "sunset" provision that would permit Congress to consider the full cost impact of the legislation before reauthorizing it. A well considered sunset provision that permitted collection of information about the cost and quality impact of the legislation prior to its reconsideration could address a number of concerns that attach to the adoption of this legislation based on complex economic cost forecasts.

1. The Charles River Study

The Charles River Study estimates that the Campbell Bill will increase provider costs by $35 to $85 billion annually and that health care premiums could increase by six percent to 11%. The basis for the estimate is a so-called "price effect" and a "utilization effect."

a. Price effect-managed care savings.

The fundamental premise of the Charles River Study is that large savings have been achieved by managed care. One portion of these savings is said to be "direct" in that it is attributable to managed care plans' provider payment discounts. The amount of the "direct savings" that Charles River concludes will be lost upon enactment of the Campbell Bill is $17.8 to $27.4 billion. The Charles River Study managed care discount assumptions are based on a review by the Barents Group of prior studies of managed care cost savings (Barents Group, 1998). Barents estimated that managed care fee and price discounts ranged from six percent to 15% with an "all HMO" average of 13%. Based on this, the Charles River analysis considered a range of managed care cost savings: six percent, 13%, 20% and 25%. For a number of reasons the assumptions regarding managed care savings are deeply flawed and introduce major problems into the Charles River Study.

First, the Charles River managed care savings figure is based on an estimate (by Lewin-VHI in 1992) contained in another estimate (by Barents). The resulting joint estimation error can be expected to be quite large. Further, The Lewin-VHI estimate is based on the study of discounts achieved by a single plan (Aetna) in a single year (1992). Neither the Barents Report nor the Charles River Study attempts to explain why Aetna is a representative plan or why 1992 is a representative year for managed care cost savings. To the contrary, Aetna is a large national plan and 1992 may be a year in which managed care accomplished large discounts.[2] Other plans may well have had lower levels of savings and 1992 discount levels may have eroded over time. In short, the uncritical use by Charles River of the Barents Report for its managed care cost savings produces major questions regarding the Study's validity.

Second, there appears to be little basis for Charles River's use of the 20% and 25% ranges for managed care cost savings. The Charles River Study states that more tightly managed plans produce this level of discounts but provides no citation for the statement.[3] There is no empirical evidence that managed care has produced cost savings in this range. Indeed, Congressional Budget Office studies (reviewed by Barents but ignored by Charles River) estimated that cost savings of 15% might be available for

---

[2] Indeed, most of the studies finding large managed care discounts were conducted at a time of substantially lower managed care penetration. Providers were much more likely to offer larger discounts when managed care penetration was lower than they are in mature managed care markets.

[3] The Barents Report relied on heavily by the Charles River Study found discounts of six percent for POS and PPO plans, 15% for IPAs and eight percent for group and staff model HMOs (Barents Group, 1998). The 25% figure appears to have been derived from RAND studies in the mid-1980s. The RAND study was an experiment. Not only has it been criticized, but it is now dated. More reliable cost savings figures are available.

traditional health insurance and Medicare as well as cost savings of 7.5% for Medicaid (Emmons, 1995).

Third, the 13% discount figure used by the Charles River Study is attributable to Barents' "all HMO" average discount. This figure was derived by Barents as an average for IPA and staff HMOs, **not** for all managed care as assumed by the Charles River Study. Indeed discount figures used by Barents for POS and PPO plans are available and the Charles River study could have generated a weighted average based on relative enrollments given that it did so for the utilization effect (discussed below). Barents estimated them to be six percent. Charles River could have weighted the six percent and 13% figures for managed care enrollment to develop a more realistic estimate of managed care cost savings but failed to do so.

Fourth, the Charles River Study assumes that all cost discounts have been passed on to employers and consumers in the form of premium and charge savings so that managed care cost reductions produce a one-to-one reduction in national health expenditures. This assumption is also flawed. Not all provider discounts have been passed through by health plans. The high costs of utilization review and management have increased administrative costs of many managed care firms relative to fee for service. Some firms retain the advantages of deep provider discounts by increasing their profit structures, due in part to pressure from investors in the stock market. For example, in 1998 Keystone Health Plan East reported net income (after taxes) of $62.9 million (Hospital and Health System Association of Pennsylvania, 1999). Over the past eight years Keystone East's profit structure has steadily improved. Moreover, there has been a well-reported wave of merger and acquisition activity by managed care plans. As an example, Aetna has acquired U.S. Healthcare and Aetna-U.S. has acquired Prudential. The costs associated with the mergers and acquisitions have been substantial and in many cases have offset the cost savings attributable to provider discounts.[4] A portion of the cost discounts may have been used to pay for increased technology costs. For example, a wave of expensive newer drugs has permitted physicians to deal with a range of conditions including mental health, cholesterol, allergies and arthritis. The payments associated with these drugs have increased the cost structures of managed care firms.

Fifth, the Charles River Study also assumes a static world where quantity and quality do not respond to price. However, a substantial number of health economics studies show that the quantity and quality are indeed responsive to price change (Phelps, 1997). Again, the distorted assumptions in the Charles River Study undermine its conclusions.

Sixth, the Charles River Study includes what it considers to be a small "spillover" effect.[5] However, the effect is quite substantial, $1.2 to $1.8 billion. Charles River assumes that increases in amounts paid by managed care plans will also increase fees paid by fee for service plans in the range of zero to ten percent. Actually, since the range used by Charles River is $1.2 to $1.8 billion, it could not have used a zero percent spillover percentage. The basis for calculation of the spillover effect is not explained in

---

[4] Indeed, there has been a substantial amount of international merger and acquisition activity that has served to remove capital from the U.S. health system.

[5] Increases in fee for service fees associated with increases in managed care payments.

the study. However, the Barents Report totally discounted the existence of a spillover effect based on the finding that empirical "estimates are wide-ranging and many of the empirical estimates are small" and that estimates were based on past HMO penetration rates.[6] Moreover, it is possible that many providers increased fees in response to managed care discounts so that an increase in amounts paid by managed care firms might actually reduce fee levels for traditional indemnity patients. In essence, inclusion of any "spillover" effect in the Charles River calculations is questionable at best.

Finally, while the Barents Report considers a number of studies of reported managed care cost savings, most of the research reviewed related primarily to **hospital** payment discounts, not physician and other provider discounts. The study of Aetna price discounts by Lewin-VHI included hospital costs. Many studies of the impact of managed care found large levels of inefficiency in the use of hospital services prior to the growth of managed care over the past 15 years - and that managed care was able to make substantial reductions in the price and use of hospital services (Luft, 1981). There are no studies that find equivalent inefficiencies for physician and other professional services. Indeed, reduced hospital use under managed care may also be associated with increased use (and higher prices) for outpatient services (including physician visits). Thus, while there may be hospital cost discounts in the range reported by Barents, physician and provider discount levels may well be substantially lower. Use of a universal cost discount figure by Charles River may well overstate the level of discounts attributable to services provided by physicians and other providers.

In short, the managed care cost savings assumptions on which the entire Charles River Study is based are overstated and flawed.[7]

b. Utilization effect - managed care reductions

In addition to the "direct" price effect, the Charles River Study estimates large managed care savings (eight percent to 22%) attributable to "utilization" effects. This includes a weighted average savings of 6.8% attributable to utilization management and an across the board estimate of four percent for utilization review.[8] Using the Barents estimate that 60% to 90% of utilization savings would be lost if the proposed legislation were enacted, the Charles River Study estimates that the cost of the Campbell Bill attributable to reduced utilization review and management will be $14.8 to $32 billion, three percent to 9.7 % of total personal health care expenditures. The Charles River Study's utilization cost estimates are even more flawed than its estimate of direct discount savings loss.

First, the utilization effect figures contained in the Barents Report "pick and choose" among figures contained in the Lewin-VHI study of Aetna, Congressional Budget Office studies and a 1997 PPO study. The Barents Report includes both cost

---

[6] At a minimum, the Charles River Study picks and chooses from the Barents Report in an unscientific manner. Where discounts contained in Barents are high the Charles River Study adopts them. Where the discounts are low the Charles River Study ignores them or uses other figures.

[7] Indeed, the Charles River Study totally ignores figures contained in a report by The Lewin Group that show total 1996 managed care savings of $23.8 to $37.4 billion, 7.5% to 11.7% of private insurance costs (Shiels, 1997).

[8] Managed care firms' ability to reduce medical care use.

savings attributable to utilization management and across the board cost savings attributable to utilization review. The Barents Report findings are not based on a systematic empirical study of savings attributable to reductions in utilization. Uncritical use of the Barents findings by Charles River produces substantial distortions in study results.

Second, the Barents findings incorporate a four percent across the board utilization review reduction based on studies that show managed fee for service (based on utilization review) reduces costs over traditional indemnity by four percent. Barents then estimates reduced managed care use of four percent (for PPOs and POSs) to 18% (for group / staff HMOs) with a weighted average (based on use) of 6.8%. However, adding the 6.8% and 4.0% may well "double count" reduced utilization attributable to managed care activities.[9] Once again Charles River incorporates these figures in its study without critical analysis.

Third, the Barents study concludes that utilization cost savings apply across the board to all types of health plans including Medicare and Medicaid plans. This may well be unrealistic since utilization reduction incentives under Medicare and Medicaid may be quite different. The Charles River Study fails to evaluate the reasonableness of this assumption.

Fourth, the Barents Report uses a panel of experts to conclude that 60% to 90% of utilization savings will be lost upon the enactment of negotiating legislation. These estimates are not based on any empirical evidence - only on opinion. Moreover, they assume that almost all providers will join negotiating groups and that such groups will be totally successful in negotiating with large managed care plans. As discussed below, the reasonableness of this assumption is open to question.

Fifth, the Charles River Study assumes that the average utilization reductions contained in the Barents Report apply to all professional services including physicians, dentists and other professionals. In actuality, as with direct savings, utilization reductions may have been much greater for hospitals than for physicians, dentists and other professionals. Use of an average utilization reduction may provide substantial distortions in cost estimations of the effect of negotiating legislation on physicians.

In short, as was the case with "price effect" cost savings, the Charles River Study's findings that lost utilization effect cost savings will be attributable to provider negotiation legislation are based on unquestioned and unwarranted assumptions. Recently United Health Care dropped its use of utilization review controls, stating that their cost did not justify any savings produced by use of this device (Fong, 1999). If, as Charles River assumes, utilization review produces a four percent cost savings it is unlikely that United would have discontinued this practice. To give its competitors a four percent cost advantage would be self-defeating. There could be no more effective rebuttal of the Charles River Study assumptions regarding managed care cost savings from utilization review and management. Use of such assumptions clearly distorts study results.

---

[9] Indeed, plans with rigid utilization review may not produce as much in the way of utilization savings as plans without strict UR.

c. Double-counting

The Charles River study independently computes a managed care discount "price effect" and a managed care "utilization effect." Such methodology may well overstate the impact of both discounts and utilization review and management. Price and quantity are obviously interrelated. The Charles River Study fails to consider the interrelationship, particularly the direction and level. For example, improvements in utilization review procedures may reduce the amount of provider time spent in dealing with payment matters. This may reduce the price of professional services rather than (as assumed by Charles River) increasing them. Increased provider prices may increase the amount of services that professionals are willing to offer. This may increase access to health care by the uninsured and by the under-insured. The simplistic method of computing managed care cost savings contained in the Charles River Study suggest the existence of a range of problems that the Study fails to recognize or correct.

d. Professionals' participation in negotiating units

The Charles River Study calculates a managed care savings percentage attributable to provider discounts and a percentage attributable to utilization reductions. The study then concludes that half to all of the discounts and 60% to 90% of the utilization savings will be "given back" in provider negotiations with managed care firms. This assumes that all health care professionals will join negotiating units and that these units will break even or prevail in negotiations with large managed care firms and health care insurers. Both of these assumptions are questionable.

As an initial matter, it is very unlikely that most health care professionals will join negotiating units. The Bureau of Labor Statistics reports that 13.9% of all wage and salary workers and 9.5% of private industry workers were members of unions in 1998 (Bureau of Labor Statistics, 1999). Some 37.5% of government workers belonged to unions in 1999, far less than all employees. As discussed in part two, substantial portions of physicians engaged in patient care are employees, thus they would not join negotiating units under the Campbell bill. Physicians engaged in graduate medical education (interns and residents), those employed by the federal, state and local government (including the Department of Defense and the Veterans Administration), professionals employed by medical schools, staff members of HMOs and professionals employed in the practices of other professionals would not join negotiating units under the Campbell bill. Further, given the individualistic orientation of most physicians, even among private practitioners, substantial negotiation unit membership is unlikely.

The Charles River Study's implicit assumption that all physicians engaged in patient care will join negotiation units if the Campbell bill is enacted is particularly misplaced.

e. Savings "give-backs"

The assumption that half to all of managed care cost savings will be "given back" in negotiations with managed care plans is equally misplaced. The provider negotiating units that are at the core of the Campbell Bill will be faced with the task of negotiating with large national and local managed care firms. For example, the merged Aetna-U.S.-

Prudential entity will have more than 22 million members (Anderson, 1999).[10] As shown in Table 1, seven large for profit (generally publicly traded) managed care firms (Aetna, Cigna, United, Foundation, Pacificare, Wellpoint and Humana) have nearly 68 million members. These firms have large numbers of shareholders. The shareholders and the stock market track firm operations closely. Even small changes in firm operating results such as medical loss ratios result in large changes in stock value. For such a firm to "give-back" even a small portion of managed care cost savings would seriously depress stock values which could well produce significant changes in management.[11] Given these incentives it is unlikely that publicly traded HMOs would yield much in negotiations with providers, even if they were organized.

Table 1
1998 Membership of Large National Managed Care Firms

HMO/ Insurer	*Members (millions)*
Aetna-U.S.-Prudential	22.4
Cigna	12.7
United Health Care	7.0
Wellpoint	6.9
Humana	6.0
Foundation Health Plans	3.0
Pacificare	3.7
Horizon	1.7
Oxford	1.7
NYLife	1.2
One Health	0.8
HlthAmerica	0.5
Maxicare	0.5
Total	68.1

Source: Corporate Internet Web Sites, January 2000 and InterStudy (1999)

[10] As used in this context, members are synonymous with covered lives.
[11] For example, the 1999 change in management of Humana as a result of stock price reductions.

Table 2
1998 Membership of Blue Cross Plans

Plan	*Members*	*Plan*	*Members*
Independence	3.9		
HMO Blue (IL)	2.9	HMO Blue	1.0
CareFirst	2.3	Blue Advantage	0.7
Alliance	2.2	Blue Choice	0.7
CA Blue Shield	2.0	Anthem	0.6
NC Blue	1.6	Blue Care (MI)	0.6
Tenn Blue	1.4	Regence	0.6
Highmark	1.1	NE PA	0.6
Capital	1.0	Blue Care	0.6
HMO Blue (Tx)	1.0	Blue Choice (NY)	0.5
		Total	25.3

Members in millions. Source: Plans' Internet Web pages and InterStudy (1999)

Large regional (often nonprofit) insurers have substantial numbers of members and market power as well. The national Blue Cross and Blue Shield Association claims that Blues' plans have 50.5 million members nationwide (Blue Cross and Blue Shield Association, 2000). Twenty of the largest Blue Cross plans (excluding Wellpoint's California and Georgia operations), each with more than 500,000 members, have a total enrollment of 25.3 million. See Table 2. Most of these firms would provide strong negotiating resistance to physician negotiating units. Other large nonprofit managed care firms can be expected to offer substantial resistance as well. For example, Kaiser Permanente has more than 8 million members. See Table 3. Collectively, more than 108 million Americans are members of large health plans. These plans have strong incentives to regain and extend any managed care discounts that they have obtained from providers. The assumption that these large firms would yield back most or all of any managed care cost savings has no basis in experience, empirical evidence or inference.

Table 3
1998 Membership of Large Nonprofit Managed Care Firms

Plan	*Members*
Kaiser	8.2
Harvard	1.2
GroupHealth	0.9
Tufts	0.7
Providence	1.0
Sloans Lake	1.5
Medica	0.8
Total	14.3

Members in millions. Source: Plans' Internet Web pages and InterStudy (1999a)

The issue of HMO and insurer power is relatively widespread. According to InterStudy data, in 1998 more than three-fourths of the Metropolitan Statistical Areas in the U.S. (82%) had at least one "dominant" HMO (a dominant HMO has a market share

greater than 33%) (InterStudy, 1999). Forty MSA markets have two dominant HMOs, automatically giving them Hirschman-Herfindah Index (HHI) levels in excess of 2000.[12] Almost half of the MSAs have an HMO with a market share of 50% or more. These MSAs have an HHI of at least 2500 and are extremely concentrated. Here the dominant HMO most certainly has power to fix premiums and provider prices. It is extremely doubtful whether provider negotiating units would prevail when dealing with these payers.

Nor is it required for HMOs to operate at this level in order to achieve economies of scale. Studies indicate that HMO economies of scale are exhausted at levels less than 100,000 members (Given, 1996; Wholey, 1996). At least 166 HMOs in the U.S. operate with more members than this (InterStudy, 1999), suggesting the presence of substantial diseconomies of scale in their operations. The sole purpose for growing HMO size would, therefore, appear to be perfection of market power. To conclude, as does the Charles River Study, that provider negotiating units would be able to out-negotiate large HMOs to compel these firms to give-back most or all managed care savings is, simply put, erroneous.[13]

Finally, the assumption that health professional negotiating units will out-negotiate HMOs assumes that large national negotiating units will form with little cost and with ease. The same assumptions were made during the late 1980s and early 1990s regarding IPAs. The difficult and troubling history of IPAs negates this assumption. Unable to control use, many IPAs suffered from high medical loss ratios.[14] Between 1988 and 1994 a number of them exited the market. Formation, operation and control of IPAs tended to be difficult and costly. Many physicians viewed them with skepticism and refused to join. Of those who joined, many lost their investment. Those groups that formed to negotiate with large health plans found such negotiations to be protracted, costly and not particularly profitable.

f. Conclusions regarding Charles River Study cost estimates

The Charles River Study estimate of the cost of provider negotiation unit legislation (the Campbell Bill) is replete with unwarranted assumptions and questionable methodology. The Charles River estimates of $17.2 to $27.4 billion in annual price effect savings from managed care and $14.8 to $32.1 billion in annual utilization effect savings are based on uncritical application of prior studies that themselves contain numerous problems and improbable assumptions. In particular, the Charles River Study assumes that the level of savings will be the same for all providers: hospitals, physicians, dentists and other health care professionals. This assumption is clearly without basis.

The independent calculation of price and utilization effects in the Charles River Study may well double-count managed care savings. Indeed, footnote 11 to the Charles River Study states (based on a Mercer/ Foster Higgins national survey) that the ratio of

---

[12] This level of competition would be classified by the U.S. Justice Department as highly concentrated for purposes of evaluating the impact of a potential merger on competition (U.S. Department of Justice, 1992).

[13] Indeed, a countervailing power response to monopoly would appear to be welfare-improving (Scherer, 1990).

[14] The high medical loss ratios of IPAs also negates the cost savings findings of Lewin-VHI, Barents and Charles River.

managed care costs to traditional indemnity costs is 0.939. This suggests that managed care savings are approximately six percent. If, as suggested by the Charles River Study, managed care cost savings ranges from 21% to 47%, the cost difference between managed care and indemnity coverage would be in this range.

In addition, the Charles River Study assumes that all health care professionals will join negotiating units if the Campbell bill were enacted and that these units will compel large managed care firms to give-back half to all of managed care cost savings. Neither assumption is warranted. Many health care professionals are employees and are already able to join unions. Union participation rates for private businesses are less than ten percent. Even in the most unionized sector of the economy, government workers, participation rates are only 40%. Negotiating units under the Campbell bill will be required to bargain with large national and local managed care firms. These firms have millions of members and sufficient assets to conduct protracted and costly negotiations. Their incentive to avoid giving back cost savings will be substantial.

In short, it is highly unlikely that the cost increases the Charles River Study estimates will actually be observed following passage of the Campbell bill.

2. A more reasoned approach to estimating the cost of the Campbell bill.

Given the problems evident in the Charles River Study, what cost estimation technique will provide better answers? What is the projected cost of the physician negotiating unit legislation contained in the Campbell bill? A reasonable approach is to follow the reasoning of the Charles River Study, albeit with more appropriate assumptions regarding managed care savings, physician participation in negotiation units and the level of "give-backs" of managed care savings. Under this approach the projected cost of the Campbell bill is $71 to $814 million.

a. A refined estimate of managed care savings "give-backs"

As discussed above, the Charles River Study employs distorted and inflated estimates of managed care cost savings, assumes that all health care professionals will join negotiating units and concludes that most of the managed care cost savings will be given back as a result of negotiations between professionals and managed care plans. Use of more appropriate assumptions produces a substantial change in cost projections.

(1) Managed care savings

In order to provide a more appropriate estimate of managed care cost savings we conducted a time series analysis of costs for physician services, dental services and other professionals' services. The data for the study were taken from public information sources. Cost data were taken from the Health Care Financing Administration's report of national health expenditures for 1960 to 1997 (Health Care Financing Administration, 1999). In order to assess the impact of managed care on all expenditures for each category, public and private, we included in the analysis all expenditures for physician services, dental services and other professional care.

We used enrollment data for HMOs and PPOs as provided by the American Association of Health Plans (American Association of Health Plans, 1998). Data were available through 1996. We projected enrollment for 1997 using a simple linear growth rate. For periods earlier than 1976 we assumed that HMO enrollment was stable at the 1976 figure of six million members. Since PPOs only came into being in the early 1980s, we assumed there was essentially no PPO enrollment prior to 1984.

There has been substantial inflation in medical care costs over the past thirty years. This inflation has differed from inflation rates attributable to producers and consumers generally. The Department of Labor computes and publishes a "Consumer Price Index of Medical Care Commodities" (Bureau of Labor Statistics, 1999). We used this index to deflate expenditures for physician, dental and other professional services.

The empirical method used to assess managed care cost savings attributable to managed care was ARIMA time series analysis. ARIMA models "filter" or control for three types of trends: step processes where beginning values at a particular time are taken from ending values of the preceding time period (the "I" in ARIMA), moving average processes that show the effect of changes that die out over a shorter time (the MA in ARIMA) and autoregressive processes that reflect permanent changes to a dynamic system (the AR in ARIMA).

The first step in developing an ARIMA model is to estimate the underlying dynamic processes of the variable of interest. In this case the variables of interest were

total (deflated) national expenditures for physician services, for dental services and for other professional care. We estimated ARIMA models for each of these variables. The results for physician expenditures are contained in Exhibit 2. The first part of Exhibit 2 shows the deflated trend in physician expenditures for 1960 to 1976. The second part shows the basic Box Jenkins model for physician expenditures. The model is differenced and employs an AR(1) process. Physician expenditures are a "step process." After differencing (to control for prior years' levels of expenditures for physician services), the AR(1) component of the model indicates that systematic impacts on physician expenditures are "permanent" at a one period lag. The basic Box Jenkins model is a good one. It has an R^2 of 0.99[15], a statistically significant and stable coefficient for the AR(1) process (between -1 and +1) and an autocorrelation Q statistic at lag 24 (here, 9.7) that indicates that the model residuals are "white noise" (Q<32).

To evaluate the impact of managed care[16] we combined HMO and PPO membership to create a new value called managed care membership (MC).[17] ARIMA models assess impact by incorporating a "transfer function." In our study we used managed care membership as a transfer function to assess the impact of managed care on physician expenditures. As shown in the third part of Exhibit 2, the resulting differenced AR(1) model with a five period lag for managed care membership, MC(5), meets the conditions for a good ARIMA model. The model's R^2 is high, the AR coefficient is stable and statistically significant, the coefficient for managed care is statistically significant and the autocorrelation function Q statistic at lag 24 (10.2) indicates that the residuals are white noise. Managed care showed the most significant and substantial impact at a five period lag.

Applying the results of this model to projections of deflated physician expenditures in 2000, managed care would be expected to produce a savings of 5.9% in projected physician expenditures. This estimate is consistent with the low end of the range of savings estimates used in the Charles River Study (six percent) and is close to the low end of The Lewin Group's estimate of managed care cost savings (7.5%). Reversing the medical price deflator produces estimates of total physician expenditures for 2000 of $240 billion.[18] Projected 2000 managed care savings attributable to physician expenditures would, therefore, be $14.2 billion.

We also performed a time series analysis of deflated expenditures for dental services and the services of other professionals. The coefficients for managed care in these models were small and not statistically significant. From this, we cannot conclude that managed care had any significant impact on expenditures for dental services or for

---

[15] High R^2 values are expected for ARIMA models.

[16] There are causality issues related to any economic model. By virtue of their lag structures, ARIMA models have fewer causality issues than other econometric methods. However, the relationship between managed care and physician expenditures is merely a statistical association and may not be causal in nature.

[17] The impact of managed care is not a dichotomous concept. Managed care has grown over time - it was not present one year and absent the next. The best indicator of the role of managed care is the number of covered lives enrolled in managed care plans - or the proportion of total expenditures that are attributable to managed care plans. Because we were able to locate data on the former measure of managed care penetration, we used it for this study.

[18] HCFA estimates put 2000 physician expenditures at $258 billion (Health Care Financing Administration, 2000).

other professional care. This is consistent with the observation that managed care does not substantially impact the markets for dental care and for other professional services.[19]

In short, we estimate that the 2000 physician expenditure savings related to managed care is 5.9%. Because we modeled the impact of managed care on total physician expenditures our projection includes the full range of managed care's impact including price effects and utilization effects (reduced amounts paid for total physician care), public and private expenditures and amounts paid under fee for service as well as managed care plans. It is this level of savings that we use to consider the potential impact of the Campbell bill.

(2) Physician participation in negotiating units

As discussed above, the Charles River Study assumed that all patient care physicians would join negotiating units. This assumption ignores the fact a great number of physicians would not join negotiating groups under the Campbell bill. As shown in Table 4, there are a substantial number of physicians engaged in patient care (47.6%) who are employed physicians (Emmons & Kletke, 1999). These physicians are currently eligible to negotiate with their employers in collective bargaining units under the labor exception to the antitrust laws contained in the National Labor Relations Act (NLRA). Accordingly, we estimate that 52.4% of physicians who are engaged in patient care are candidates to join physician negotiating units under the Campbell bill (we define them as "eligible").

Among the physicians who are candidates to join, what is likely to be their actual participation rate? The Charles River Study assumed that all physicians would participate, ignoring negotiating unit participation rates in all other sectors of the economy. As described above, in 1998 only 9.5% of private industry workers, 33.8% of federal government workers, 27.8% of state government workers and 43.8% of local government workers who were candidates to join negotiating units elected to do so (Bureau of Labor Statistics, 1999). Using the endpoints of this range, 5.0% (52.4% * 9.5*) to 22.9% (52.4% * 43.8%) of physicians engaged in patient care are likely to join physician negotiating units under the Campbell bill.

[19] Substantial amounts of care for these services are paid out of pocket. To the extent that managed care is involved in dental care, it often operates as a payment mechanism rather than as a cost control or discount device.

Table 4
Patient Care Physicians Likely to Join Negotiating Units

Types of physicians	Number	Percent
All patient care physicians	620,631	100.0%
Employed physicians		
Medical practices	47,731	
Graduate medical education	95,808	
Medical school faculty	36,797	
Hospitals	32,720	
Federal government	16,947	
HMOs	9,925	
Ambulatory care	6,500	
Other employers	35,588	
State & local government	13,614	
Total employed	295,630	47.6%
Negotiation unit eligible	325,001	52.4%

Source: Emmons & Kletke (1999)

Physicians are engaged in a private enterprise. Moreover, most self-employed physicians are, by their makeup, "independent" in their business and medical practice orientation. By virtue of this we would expect negotiation unit participation to be at or below the low end (private industry) of the range, rather than at the level of government workers' negotiating unit participation. In addition, physicians who practice in areas with less managed care market power and higher fee structures are also unlikely to participate in negotiating units. Again, we would expect negotiating unit participation to tend toward the lower rather than the higher end of the projected participation range. Finally, physicians who are patient care oriented or service oriented as opposed to business oriented may be less likely to join negotiating units. Once again, we would expect negotiation unit participation rates to be at or lower than 5.0%. To conclude, as does the Charles River Study, that physician negotiating unit participation will include 100% of physicians engaged in patient care simply ignores the reality of physician practice, the number of employed physicians and the general disinclination of Americans workers to join negotiating units.

(3) Managed care firms and insurers' willingness to "give-back" savings

The Charles River Study assumed that half to all of managed care savings would be "given back" when professional negotiating units bargain with managed care firms and health care insurers. This level of give-backs is most unlikely to occur. As discussed in part one above, more than 108 million Americans are members of (or insured by) "large" national and regional managed care firms and health insurers. These firms continue to

enjoy substantial growth.[21] Since many managed care markets are now mature, this growth is often at the expense of other smaller HMOs. These large firms can be expected to use substantial resources to avoid give-backs of managed care savings. The incentives that they have to hold the line on health care costs, both in terms of shareholder profit and the need to maintain premium levels charged to employers, suggests that the Charles River give-back range is exaggerated.

Further, InterStudy data show that there is a "dominant" managed care firm in 81% of the MSA markets in the U.S. (InterStudy, 1999). InterStudy defines a dominant HMO as one with a market share in excess of 33%. Physician negotiation units are unlikely to have much of an advantage, if any, in their negotiations with dominant managed care firms. In half of the MSA markets a managed care firm holds at least a 50% market share. Negotiations with such firms will be even more difficult.

Accordingly, for the purposes of this study we assume that savings give-backs, if any, will range from 10% to 25% of managed care savings. Because managed care firms and insurers are so large, have substantial amounts of knowledge regarding provider practice patterns and have strong financial incentives to avoid give-backs, negotiating unit legislation will probably produce give-backs substantially below this range. We have used a generous range for give-backs to strengthen the credibility of the study.

(4) Calculation of costs using more appropriate assumptions

Having developed a more-reasoned set of assumptions regarding managed care cost savings attributable to total national expenditures for physician services, portions of patient care physicians who are eligible for and likely to join negotiation units and a more considered give-back range, calculation of increased costs attributable to the negotiating unit legislation is relatively straightforward. As shown in Table 5, given total annual managed care savings attributable to payment for physician services of $14.2 billion, negotiation unit physician participation of 5.0% to 22.9% of all patient care physicians (9.5% to 43.8% of eligible physicians) and a give-back rate of 10% to 25%, the projected cost of the Campbell bill is $71 to $814 million.

Table 5
Cost of Negotiation Unit Legislation

Savings[1]	Likely to join %[2]	Give-back (GBR)	Cost[1,3]
14.2	5.0%	10%	0.0706
14.2	22.9%	25%	0.8142

[1]Billions
[2]Eligible * Likely to join
[3]Savings*Member%*GBR

HCFA projects total payment for physician services in 2000 to be $258.7 billion (Health Care Financing Administration, 2000). If physician negotiation unit legislation raises costs by $0.07 to $0.8 billion, it will increase projected physician expenditures by

[21] See, for example, the discussion of Blue Cross plans' growth at the Blue Cross and Blue Shield Association web site (Blue Cross and Blue Shield Association, 2000). See also, web sites for California Blue Shield (Blue Shield of California, 2000) and Independence Blue Cross (Independence Blue Cross, 2000).

0.03% to 0.3%. This study projects 2000 physician expenditures at $240 billion. Increased costs of $0.07 to $0.8 billion will increase projected expenditures by 0.03% to 0.34%. HCFA projects total national health expenditures of $1316 billion for 2000. The projected cost increases attributable to the Campbell bill are 0.005% to 0.06% of national health expenditures.

(5) Comparison of Charles River Study with Foreman Study

There is a substantial difference between the Charles River Study projections of the cost of the Campbell bill and the projections contained in this study. Charles River projects added costs of $30 to $85 billion. We project costs of $0.7 to $0.8 billion. What are the reasons for the difference?

As shown in Table 6, our study evaluates the impact of the Campbell bill on physician expenditures because our models for the impact of managed care on expenditures for dental services and other professionals' services found no significant effect. The Charles River Study assumed that the managed care savings rate it took from the hospital and physician literature applied to dentists and other professionals as well. This difference makes projected costs in the Charles River Study 1.5 times higher .

Table 6
Comparison of Charles River Study and Foreman Study of Campbell Bill Costs

Type	Foreman		ChasRiver			Multiple
	%	amount	%		amount	
Managed Care Savings	physicians only		all professionals			1.5
Price effect			6-25% of 80%	4.8%-20%	16.6-25.6	
Spillover-price			7-10% of 20%	1%-2%	1.2-1.8	
Utilization effect			8-22% of 80%	6.4-17.6%	14.8-32.1	
Utilization spillover			11% of 80%	8.80%	20.5	
Total MC Savings	5.90%	14.2		21%-48.4%	35-80	3 to 8
Physician Eligibility	52.4%		100%			20
Physicians joining	9.5%-43.8%		100%			2 to 10
Give-back rate	10-25%		50-100%			2 to 10
Total		0.07-0.8			35-80	200-1000

Collectively, the Charles River Study assumes managed care cost savings rates of 21% to 48.4%. See Table 6. This is substantially higher than the 5.9% managed care savings rate generated by the ARIMA models used in this study. The Charles River figures are based on the highest available savings estimates and ignore lower savings

estimates published in a number of other studies. Moreover, the four categories of savings estimated by Charles River provide for substantial double counting. Some savings estimates are unsupported by any empirical evidence. To use these figures Charles River ignored a Lewin report that found managed care reduced premiums for private insurance by 7.5% to 11%.

Also as shown in Table 6, the Charles River Study assumes that provider negotiating units will compel half to all of managed care savings to be "given back." This assumes that all provider negotiating units will break even or totally prevail in their negotiations with large national and regional managed care firms that hold substantial market power and have strong financial incentives to resist the negotiating pressures of the negotiating units. The Charles River give-back assumptions inflate cost findings by two to ten times those generated in our study.

Collectively, the cost findings of the Charles River Study that the Campbell bill will raise year 2000 physician expenditures by $35 to $80 billion are approximately 58 times greater than the $71 to $814 million in costs estimated by our study. The break downs in Table 6 show how this difference is generated. By and large the difference is attributable to a series of assumptions by Charles River that overestimate the impact of managed care and provider expenditures and overestimate physicians' probable response to the proposed legislation. The impact of the failure of these assumptions is joint, not several and generates a substantial overestimation of the impact of the Campbell bill.

---

[22] Given HMO growth from 1997 to 1998, some of the new members were not members for all of 1998.

3. Current antitrust law does not permit effective physician negotiating units.

The Charles River Study claims that current antitrust law permits formation and operation of effective provider negotiating units. The main basis for this contention is the 1996 Federal Trade Commission and Department of Justice *Statements of Antitrust Enforcement Policy in Health Care* (Federal Trade Commission and U.S. Department of Justice, 1996). These Statements permit physicians to negotiate collectively if they form a network and substantially integrate their practices and/or share substantial financial risk. These networks are limited to 20% of the physicians in a market if they are exclusive and 30% if they are non-exclusive. There are significant barriers to forming networks. Formation of networks capable of assuming substantial financial risk and integrating multiple independent practices are major undertakings that require significant expertise and financial capital not readily available to many independent practitioners.

The Charles River Study also argues that Justice and the FTC rarely prosecute physician network joint ventures, that it is easy to obtain advisory opinions regarding joint ventures, (citing no data or studies at all) that competition among health plans is intense and that in most markets concentration is low, that formation of cartels by managed care plans would be unsuccessful, that antitrust laws are applied to health plans, that physicians are continuing to join larger groups and that bilateral monopoly would lead to better outcomes. None of these arguments is based on facts or on published studies. Most of it is merely the unsupported opinion of the Study's author.

First, the contention that competition among health plans is intense and that in most markets concentration is low simply ignores the facts underlying the current managed care environment. Leading health economists are concerned about growing concentration in managed care markets (Gaynor, 1999; Haas-Wilson, 1998; Pauly, 1998). InterStudy data show that growing concentration in managed care markets is clearly a problem. 280 of the 316 MSA markets in the U.S. are *highly concentrated* using the InterStudy analogue of the HHI, the InterStudy Index of Competition (InterStudy, 1999). 259 of 316 MSAs have at least one dominant HMO (one with a market share greater than 33%) (InterStudy, 1999). 151 of the 316 MSAs have an HMO with at least a 50% market share. These MSAs have an HHI of at least 2500 and an Index of Competition at 0.75 or lower, making them highly concentrated as well. 40 markets have two dominant HMOs (InterStudy, 1999) automatically giving them HHI levels in excess of 2000, making them *highly* concentrated without reference to any other activity. Not only are these markets concentrated, concentration has been growing over time. There is evidence of exit from concentrated markets. Competition among health plans is not, as a general rule, intense and it has waned. Moreover, the safe-harbor provisions of the FTC and DOJ Statements are insufficient to deal with the current level of managed care firm concentration. Non-exclusive physician negotiating unit joint ventures that could form to balance the market power of dominant HMOs (a 33% market share) in 259 of the 316 MSAs would be outside of the safe harbor provisions in the Statements. Physician negotiating units that form at a level to deal with the firms that hold 50% of the market (as is the case in 151 of 316 MSAs) would be so far outside the safe harbor provisions that they would most likely be prosecuted by the FTC and the DOJ and would be subject to private antitrust

suits. In short, current antitrust safe harbor provisions do *not* give physicians enough latitude to deal with the managed care market concentration problem.

Second, the position that any level of collective physician action is appropriate since the FTC and DOJ rarely prosecute physician joint ventures also fails the reality test. Collective physician negotiating activity absent substantial integration or sharing of substantial financial risk clearly violates the Sherman Act barring contracts, combinations and conspiracies in restraint of trade. (15 U.S.C. section 1). The FTC and DOJ do in fact investigate and prosecute physician joint ventures. In 1998 the formation of physician unions in Delaware and the Philadelphia areas became the subject of a well-publicized DOJ investigation. The mere fact of an investigation can be chilling to physicians. The time, expense and notoriety involved in a prosecution can be a substantial detriment to the formation of physician negotiating units. The mere threat of prosecution can be a substantial impediment. Moreover, the Statements only apply to FTC and DOJ enforcement policy. Private parties (managed care firms) can successfully bring a civil antitrust action (including a claim for treble damages) if physicians attempt to negotiate collectively. In short, to suggest that providers (as the Charles River Study would urge) should rely upon prosecutorial discretion to avoid responsibility for violating the antitrust law rather than amending the law itself, is an inappropriate basis to formulate public policy.

Third, the statement that the problem of managed care firm concentration will go away because many physicians are joining large groups anyway ignores current reality and fails to consider the economic effect of this trend. Even the largest of physician groups does not have nearly the size, the resources or the market share to successfully negotiate with large national and regional managed care firms with millions of members and billions of dollars in income and assets. Were such groups to form through acquisitions and mergers, the consolidations would be subject to the antitrust laws. Moreover, this position fails to address the question of whether the provision of medical care through large physician groups is economically efficient. This question has not been studied in detail. Were we to encourage the formation of massive physician practices merely to negotiate with massive managed care firms, an unintended consequence of such a public policy might be a substantial diminution in medical practice efficiency.

Fourth, the Charles River contention that antitrust enforcement regarding managed care firms is vigorous and that managed care cartels will not work is inaccurate. Antitrust enforcement at the federal level has been anything but vigorous. Although it has been presented with a substantial number of Hart Scott Rodino reviews of managed care firm mergers and acquisitions, the Department of Justice has elected to challenge only one merger. The problem that Campbell attempts to address is the growing market power of existing firms and its misuse. To date, neither the FTC nor the DOJ has brought an action to challenge misuse of any managed care firm's market power. Moreover, to claim that cartels will not work is a non sequitor. The problem lies not with collective action by managed care firms, but with the size and power of a number of existing managed care firms that are having an adverse impact on providers, on employers and on the public.

The Charles River Study's position, that there is no need for changes in the antitrust law to deal with growing concentration in managed care markets, ignores facts

regarding concentration and mistakes the current state and application of the antitrust laws.

4. Campbell bill benefits

The Charles River Study contains a discussion of the costs of the Campbell bill, with no recognition of any potential benefits. The failure to consider any benefit from the legislation is yet another indication of bias in that study. The main point of the legislation is that there is a need to "level the playing field," to remedy the situation where much smaller professional groups are required to negotiate with large managed care organizations and providers.

Indeed, many if not most of the dominant managed care plans unilaterally dictate physician contracts terms so that one might be hard-pressed to conclude that managed care firms negotiate at all (Freudenheim, 1998). For example, many of the contracts between managed care firms and physicians give the managed care firm the power to fix a fee schedule and to change it at any time (Independence Blue Cross, 1999). Given the growing market power of managed care firms, some health economists question whether this growing concentration is healthy (Gaynor & Haas-Wilson, 1999; Pauly, 1998). If large managed care firms have market power, legislation that permits a countervailing power response by allowing physicians to negotiate with such firms as a group, could have a welfare-improving effect (Scherer & Ross, 1990).

An unbiased evaluation of the impact of the Campbell bill would consider the benefits of the bill as well as its costs. Some of these benefits are not quantifiable. For example, if physician contracts were improved, more physicians might be willing to join managed care provider networks. The quality of the networks might increase. With a wider range of choice, fewer patients might go "out of network," reducing out of pocket costs to consumers. Physicians could negotiate for improvements in a range of ancillary services. For example, if physicians were able to successfully negotiate for improved drug formularies or better physician choice in drug prescribing, patient care could improve and, once again, consumers' out of pocket expenditures (related to consumer payment for non formulary drugs) might decrease. Physicians could negotiate for improved laboratory services. Again, quality could increase and out of pocket expenditures might be less. While these benefits might be hard to quantify, there are other benefits related to pricing for physician services that can be evaluated.

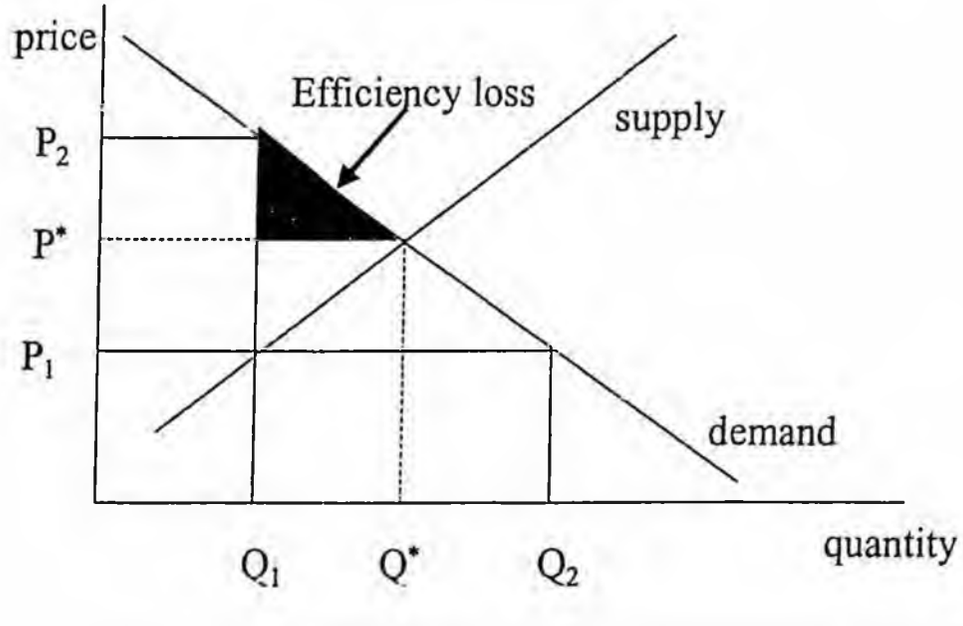
In this part of the study, we evaluate the beneficial impact of the Campbell bill strictly in terms of the negotiation of fees. Since large managed care firms and health insurers have market power over input price (medical care provider services) they can dictate fees for physician services below competitive (optimal) levels (the physicians' marginal cost of providing service including the opportunity cost of their own time). If managed care firms and health insurers fix fees below physicians' marginal cost there will be inefficiency losses often called welfare losses or deadweight loss. In this part of the study we simulate the level of welfare loss that may be attributable to managed care firm market power and consider the potential welfare gain that might be produced by the Campbell bill.

Graphically, as shown in Figure 1, there is in theory an optimal price (P^*) where marginal revenue equals marginal cost, supply and demand equate and markets clear. There is no surplus or dearth of provider services. If the managed care firm forces

physician price below P^* quantity (or quality) of services provided will drop, and there will be surplus demand (the difference between Q_2 and Q_1). Actual price (P_1) will be less than the price should be at this level of service (P_2). The efficiency loss or lost consumer surplus is represented by the shaded triangle.

Unfortunately, figures for physician practice costs and prices (by payer) are not available. As was the case in parts one and two above, in order to estimate the potential welfare loss from managed care firm pricing strategies we perform a simple simulation. Again we use InterStudy data for physician payment per member per month by HMOs in regional (MSA) markets (InterStudy, 1999). We assume that physicians in the bottom quartile receive payment below their marginal cost of providing service and that the marginal cost of providing physician services is equal to the lowest payment per member per month of the physicians in the third quartile, $39. See Exhibit 2. The average fourth quartile physician receives $31.81 per member per month, $7.19 or 18.4% below marginal cost.

Figure 1
Below Market Pricing Welfare Loss



Using estimates of welfare loss from transportation industry studies (Gomez-Ibanez, 1999) and applying them in the context of buyer market power, one measure of welfare loss is:

$$\Delta W = 0.5 * \Delta P * \Delta Q$$

where W is a welfare measure, ΔP is the difference between actual price and marginal cost price and ΔQ is the difference between. In our simulation, ΔP is $7.19 per member per month or $86.28 per member per year. If half of the number of uninsured Americans is an approximation for ΔQ on the assumption that half of the uninsured level is due to insurance premiums and half is attributable to health care insurer pricing policies, ΔQ would be 22.1 million (U.S. Department of Commerce, 1999). ΔW or the total inefficiency loss would be $1.9 billion. If the Campbell bill permitted fourth quartile physicians to eliminate below-market pricing, welfare could be improved by as much as $1.9 billion. If half of fourth quartile physicians participated in negotiation units and successfully negotiated away the below market pricing differential, nearly $1.0 billion in inefficiency losses would be eliminated.

Thus, if the Campbell bill cost is $71 to $814 million as shown above for the first estimation technique, the simulated benefits of the Campbell bill that would be produced by eliminating market distortions would balance or outweigh its costs. Moreover, the true harm addressed by the Campbell bill is not the current level of provider payments, but the imbalance that could be generated by a continuation of the current trend toward greater concentration in health care financing services markets. If current trends were to continue to the extent that ΔP and ΔQ increased, the inefficiency losses would magnify.[23] If, for example, ΔP were to double from the level included in the simulation and ΔQ increased by half, inefficiency losses would increase to $6 billion. If the Campbell bill permitted physicians to negotiate more effectively with managed care firms and health care insurers to the extent that any portion of such a loss could be avoided its benefits would far outweigh its costs.

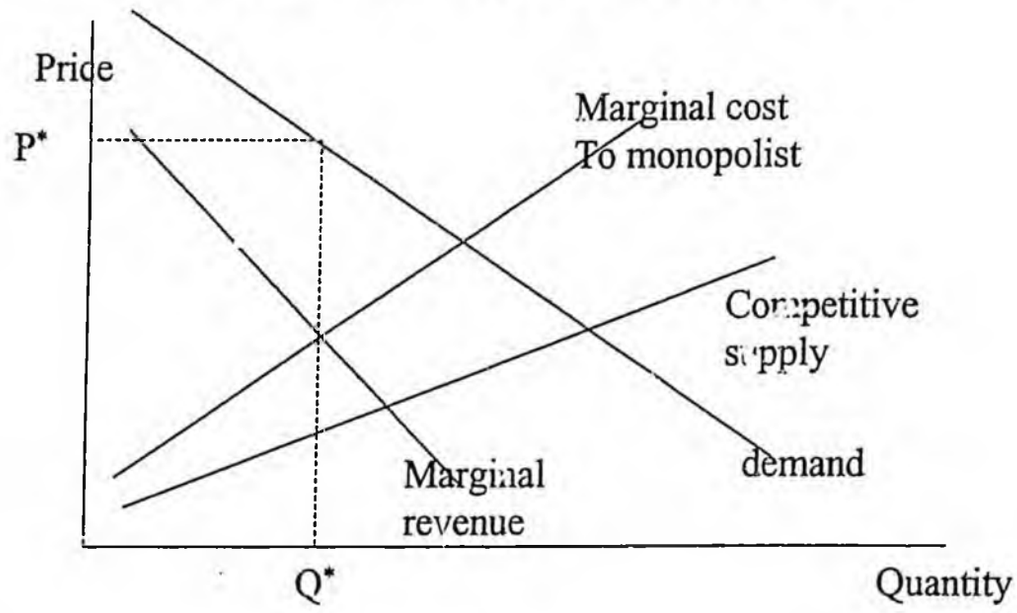
In addition, where a monopsonist buyer also holds monopoly power in output markets (dominant managed care firms with regard to HMO, POS and PPO products may have market power), there is a second distortion. As shown in Figure 2, the monopolist will fix marginal cost equal to marginal revenue. Because the monopolist faces a downward sloping demand curve the resulting equilibrium occurs at a higher price and at a lower output quantity than would be the case in a competitive setting (the firm fixes price where supply equals demand). Thus, both the input (factor) market and the output market operate with price and quantity distortions (Layard and Walters 1979).[24] If large managed care firms hold and exercise monopoly and monopsony power, the potential benefit from enactment of the Campbell bill could be substantially greater than the input factor deadweight loss estimated above.

---

[23] This is not an unreasonable concern. For example, in the summer of 1998 Independence Blue Cross announced unilateral reductions of physician fee payment schedules - to 80% of amounts paid by Medicare. These payment levels may have been 20% to 30% below market. Given IBC's input price advantage, in order to compete other providers would have to follow suit. In this sense bad can be said to drive out good.

[24] If demand also relates to quality, quality demanded by the monopsonist and supplied by the monopolist will also be lower than in a competitive equilibrium.

Figure 2
The Monopolist in the Output Market



5. Conclusion.

The Campbell bill has been introduced to deal with concerns about the growing market power of large managed care firms and health insurers. The bill's proponents are attempting to permit physicians and other health care professionals to use countervailing power to negotiate better contracts with managed care payers. Many of these entities are so large that they dictate contract terms. The bill would help to prevent inefficient pricing by managed care payers who can now unilaterally fix provider fees. Using inflated cost projections provided by a Charles River Study, opponents of the legislation argue that the bill will cost too much, in the range of $35 to $80 billion. However, these estimates assume that price discounts and utilization reductions for all health care professionals are the same, use inordinately high estimates for managed care cost savings, assume that all providers will join negotiating units, and that such units will compel large regional and national managed care firms to give-back all of the savings that they have obtained over time. The Charles River Study ignores any benefit whatsoever that may be produced by the legislation.

A more considered estimate of the cost of the Campbell bill is $71 to $814 million. Moreover, a simulation of benefits of the Campbell bill produces current benefits of $1.0 to $1.9 billion by eliminating distortions related to under market pricing. Therefore, the legislation has the potential to produce greater future benefits than its costs if the trend toward consolidation of managed care firms and unilateral reductions in physician fees continues unabated. If leveling the playing field is a genuine policy concern, the benefits of the Campbell bill may well outweigh its costs.

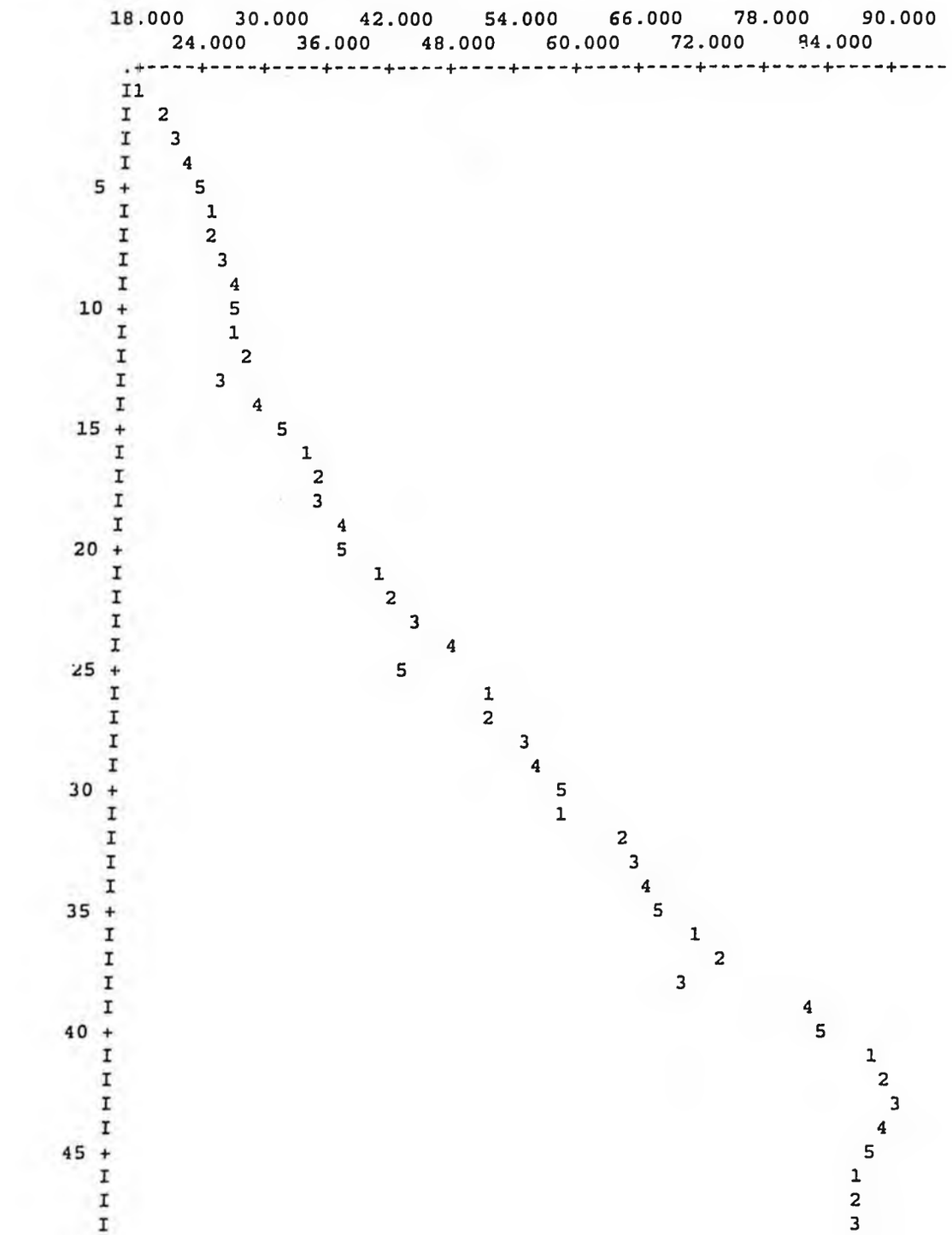
Exhibit 1
Study Data

Year	Physician Expends	Deflated Physician	Dental Expends	Other Prof Expends	HMO Members	PPO Members	MC Members	Mprice Index
1960	5283	28.16	1963	604	6.0	0.0	6.0	22.3
1961	5517	28.96	2079	632	6.0	0.0	6.0	22.9
1962	5909	26.72	2198	666	6.0	0.0	6.0	23.5
1963	6658	29.47	2344	705	6.0	0.0	6.0	24.1
1964	7706	32.09	2589	769	6.0	0.0	6.0	24.7
1965	8191	34.72	2793	865	6.0	0.0	6.0	25.2
1966	8807	35.70	2961	955	6.0	0.0	6.0	26.3
1967	9867	36.03	3409	1060	6.0	0.0	6.0	28.2
1968	10754	38.66	3664	1140	6.0	0.0	6.0	29.9
1969	12059	38.81	4174	1252	6.0	0.0	6.0	31.9
1970	13579	42.06	4669	1406	6.0	0.0	6.0	34.0
1971	15033	43.77	5181	1601	6.0	0.0	6.0	36.1
1972	16656	45.84	5516	1847	6.0	0.0	6.0	37.3
1973	18417	48.97	6323	2103	6.0	0.0	6.0	38.8
1974	20974	44.81	7076	2380	6.0	0.0	6.0	42.4
1975	23909	52.42	7956	2730	6.0	0.0	6.0	47.5
1976	27101	53.08	8972	3216	6.0	0.0	6.0	52.0
1977	31387	55.96	10055	3793	6.3	0.0	6.3	57.0
1978	33810	57.93	10957	4518	7.5	0.0	7.5	61.8
1979	38814	60.15	11893	5464	8.2	0.0	8.2	67.5
1980	45232	60.35	13323	6352	9.1	0.0	9.1	74.9
1981	52164	66.10	15698	8180	10.2	0.0	10.2	82.9
1982	57692	66.81	16953	9423	10.8	0.0	10.8	92.5
1983	64626	67.99	18271	10709	12.5	4.8	17.3	100.6
1984	72586	69.66	19833	13623	15.1	9.6	24.7	106.8
1985	83618	73.66	21650	16639	18.9	14.3	33.2	113.5
1986	93068	75.08	23108	19285	25.7	19.1	44.8	122.0
1987	104138	71.48	25343	22606	29.3	23.9	53.2	130.1
1988	118692	84.34	27460	26787	32.7	28.7	61.4	138.6
1989	131301	85.26	29496	29785	34.7	33.4	68.1	149.3
1990	146346	89.86	31566	34675	36.5	38.2	74.7	162.8
1991	162167	91.64	33348	38267	38.6	43.8	82.4	177.0
1992	175912	92.53	37013	42089	41.4	50.5	91.9	190.1
1993	185929	91.01	39526	46145	45.2	60.6	105.8	201.4
1994	192998	90.24	42394	49612	51.1	72.5	133.6	211.0
1995	201863	89.07	45000	53627	59.1	91.8	150.9	220.5
1996	208509	88.56	47541	57472	67.5	97.8	165.3	228.2
1997	217628	88.58	50648	61916	75.9	103.8	179.7	234.6

Expenditures in millions

Exhibit 2
ARIMA Analysis of Managed Care Cost Savings

1. Time series plot for deflated physician expenditures (1960-97)



2. Basic Box Jenkins Model. Differenced - AR(1)

PARAMETER LABEL	VARIABLE NAME	NUM./ DENOM.	FACTOR	ORDER	CONS-TRAINT	VALUE	STD ERROR	T VALUE
1 C		CNST	1	0	NONE	646.8229	413.8828	1.56
2	PHYS	AR	1	1	NONE	.9291	.0560	16.59

TOTAL SUM OF SQUARES	.181837E+12
TOTAL NUMBER OF OBSERVATIONS	38
RESIDUAL SUM OF SQUARES.	.923980E+08
R-SQUARE	.999
EFFECTIVE NUMBER OF OBSERVATIONS . .	36
RESIDUAL VARIANCE ESTIMATE	.256661E+07
RESIDUAL STANDARD ERROR.	.160206E+04

TIME PERIOD ANALYZED	3 TO 38
NAME OF THE SERIES	MOD1R
EFFECTIVE NUMBER OF OBSERVATIONS . . .	36
STANDARD DEVIATION OF THE SERIES . . .	1602.0650
MEAN OF THE (DIFFERENCED) SERIES . . .	-.0001
STANDARD DEVIATION OF THE MEAN	267.0108
T-VALUE OF MEAN (AGAINST ZERO)	.0000

AUTOCORRELATIONS

1- 12	-.09	.08	.06	-.02	-.02	-.17	.13	-.09	-.13	.03	.06	.00
ST.E.	.17	.17	.17	.17	.17	.17	.17	.18	.18	.18	.18	.18
Q	.3	.5	.7	.7	.7	2.0	2.9	3.2	4.1	4.1	4.3	4.3
13- 24	-.13	-.03	-.08	.05	-.13	.09	-.14	-.04	.03	-.04	-.02	.01
ST.E.	.18	.18	.18	.19	.19	.19	.19	.19	.19	.19	.19	.19
Q	5.3	5.3	5.8	6.0	7.2	7.8	9.3	9.4	9.5	9.7	9.7	9.7
25- 35	-.02	-.01	.02	.06	.02	.01	.04	-.01	-.01	.00	-.01	
ST.E.	.19	.19	.19	.19	.19	.19	.19	.19	.19	.19	.19	
Q	9.8	9.8	9.9	10.4	10.5	10.5	10.9	10.9	11.0	11.0	11.2	

3. Managed care Box Taio transfer function model. Differenced AR(1). Managed care impact at lag five.

PARAMETER LABEL		VARIABLE NAME	NUM./ DENOM.	FACTOR	ORDER	CONS-TRAINT	VALUE	STD ERROR	T VALUE
1	C		CNST	1	0	NONE	2.6410	.5492	4.81
2		MC	NUM.	1	5	NONE	-.0329	.0165	-1.99
3		PHYS	AR	1	1	NONE	-.3583	.1415	-2.53

TOTAL SUM OF SQUARES	.285387E+05
TOTAL NUMBER OF OBSERVATIONS	48
RESIDUAL SUM OF SQUARES.	.269971E+03
R-SQUARE	.989
EFFECTIVE NUMBER OF OBSERVATIONS . .	43
RESIDUAL VARIANCE ESTIMATE	.627840E+01
RESIDUAL STANDARD ERROR.	.250567E+01

TIME PERIOD ANALYZED	6 TO 48
NAME OF THE SERIES	MOD1R
EFFECTIVE NUMBER OF OBSERVATIONS . . .	43
STANDARD DEVIATION OF THE SERIES . . .	2.5057
MEAN OF THE (DIFFERENCED) SERIES . . .	.0000
STANDARD DEVIATION OF THE MEAN	.3821
T-VALUE OF MEAN (AGAINST ZERO)	.0000

AUTOCORRELATIONS

1- 12	.01	.09	.11	.01	-.07	-.03	.12	-.04	.03	.03	.00	.02
ST.E.	.15	.15	.15	.16	.16	.16	.16	.16	.16	.16	.16	.16
Q	.0	.4	1.0	1.0	1.2	1.2	2.0	2.1	2.1	2.2	2.2	2.2
13- 24	.23	-.19	-.01	-.04	-.03	.02	-.10	.01	-.04	-.08	-.08	.02
ST.E.	.16	.17	.17	.17	.17	.17	.17	.17	.17	.17	.17	.17
Q	5.6	7.9	7.9	8.0	8.1	8.1	8.9	8.9	9.1	9.6	10.2	10.2
25- 36	.07	-.12	-.06	-.11	-.12	-.11	-.06	-.04	-.04	-.00	.01	.02
ST.E.	.17	.18	.18	.18	.18	.18	.18	.18	.18	.18	.18	.18
Q	10.7	12.3	12.8	14.5	16.6	18.5	19.1	19.4	19.7	19.7	19.7	19.8

References

American Association of Health Plans, *Managed Care Facts*, Washington, DC: AAHP, January, 1998, 2.

American Association of Health Plans, "Number of People Enrolled in HMOs, 1976 - 96 (Millions)," http://www.aahp.org, 2000, 30/01/00.

Anderson, E. Ratcliffe, Jr., "Statement of the American Medical Association to the Committee on the Judiciary," Washington, DC, 22/06, 1999.

Barents Group, LLC, *Impacts of Four Legislative Provisions on Health Care Consumers: 1999-2003*, 22/04, 1998.

Blue Cross and Blue Shield Association, "Quick Facts About the Blue Cross and Blue Shield Family," http://www.bluecares.com/, 2000, 30/01/00.

Blue Shield of California, "1998 Annual Report," http://www.blueshieldca.com/, 2000, 30/01/00.

Bureau of Labor Statistics, U.S. Government Printing Office, 1999, Consumer Price Index of Medical Care Commodities.

Bureau of Labor Statistics, *Union Members in 1998*, USDL 99-21, Washington, DC: U.S. Government Printing Office, 1999.

Emmons, David W., *The Impact of Managed Care on National Health Spending: A Critical Review of the Literature*, American Medical Association, June, 1995.

Emmons, David W., and Philip R. Kletke, *The Practice Arrangements of Patient Care Physicians, 1998*, American Medical Association, 1999, 8 pgs.

Federal Trade Commission and U.S. Department of Justice, *Statements of Antitrust Enforcement Policy in Health Care*, U.S. Government Printing Office, 1996.

Fong, Tony, "Health Plan Returns Power to the Doctors; UnitedHealth Will Trim Costs by Cutting Reviews," *The San Diego Union-Tribune*, 1999, 1, San Diego, CA.

Freudenheim, M., "Insurers Tighten Rules and Reduce Fees for Doctors," *The New York Times*, 28 June 1998, 1.

Gaynor, M., and Deborah Haas-Wilson, "Change, Colsolidation and Competition in Health Care Markets," *Journal of Economic Perspectives*, *13*(1), 1999, 141-64.

Given, Ruth. S., "Economies of Scale and Scope as an Explanation of Merger and Output Diversification Activities in the HMO Industry," *Journal of Health Economics*, *15*, 1996, 685-713.

Gomez-Ibanez, Jose A., "Pricing," in Jose A. Gomez-Ibanez, William B. Tye and Clifford Winston, ed., *Essays in Transportation Economics and Policy*, Washington, DC: The Brookings Institution, 1999, 99-136.

Haas-Wilson, Deborah, and Martin Gaynor, "Increasing Consolidation in Healthcare Markets: What Are the Antittrust Policy Implications?" *HSR: Health Services Research*, *33*(5), 1998, 1403-19.

Health Care Financing Administration, "National Health Expenditure Amounts, and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years 1970-2008," http://www.hcfa.gov/stats/, 2000, 30/01/00.

Health Care Financing Administration, *National Health Expenditures Aggregate Amounts and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years 1960-97*, 1999.

Hospital and Health System Association of Pennsylvania, *Profiles in Managed Care*, 5th Edition, July, 1999.

House of Representatives, *Quality Health-Care Coalition Act of 1999*, in *Quality Health-Care Coalition Act of 1999*, 106th, 1st, 1999.

Independence Blue Cross, "1998 Annual Report," http://www.ibx.com/, 2000, 30/01/00.

Independence Blue Cross, *Provider Contracts*, 1999, PA Department of Insurance.

InterStudy, *Deluxe MSA Profile*, Excelsior, MN: InterStudy Publications, 1999.

InterStudy, *The InterStudy Competitive Edge, Biannual Report of the Managed Care Industry*, Excelsior, MN: InterStudy, Inc., 1999.

Layard, P.R.G., and A.A. Walters, *Microeconomic Theory*, New York, NY: McGraw-Hill Book Co., 1979.

Luft, Harold S., *Health Maintenance Organizations: Dimensions of Performance*, John Wiley & Sons, 1981.

Noether, Monica G., *Antitrust Waivers for Physicians: Costs and Consequences*, Charles River Associates, June, 1999.

Pauly, Mark V., "Managed Care, Market Power and Monopsony," *HSR: Health Services Research*, *33*(5), 1998, 1439-60.

Phelps, Charles E., *Health Economics*, 2d Edition., Reading, MA: Addison-Wesley, 1997.

Reinhardt, Uwe W., "Should Physicians Unionize? No, Patients Would Pay the Price," *The Wall Street Journal*, 1999, 1, New York, NY.

Scherer, F.M. and Davis Ross, *Industrial Market Structure and Economic Performance*, Boston, MA: Houghton Mifflin Co., 1990.

Shiels, John F., and Randall A. Haught, *Managed Care Savings for Employers and Households: 1990 Through 2000.*, Washington, DC, 1997.

U.S. Department of Commerce, *Statistical Abstract of the U.S.*, Washington, DC: U.S. Government Printing Office, 1999.

U.S. Department of Justice, *Trade Reg Rep.*, *4*(13,104), 1992, 41552*Horizontal Merger Guidelines*, vol. 4 of *Federal Register*.

Wholey, Douglas, Roger Feldman, "Scale and Scope Economies Among Health Maintenance Organizations," *Journal of Health Economics*, *15*, 1996, 657-84.

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-5903
PHONE: (907)269-5100
FAX: (907)276-3697

March 31, 2000

Senator John Torgerson
Co-chair Senate Finance Committee
State Capitol Building
Juneau, Alaska 99801-1182

Re: Senate Bill 256

Dear Senator Torgerson:

Pursuant to your request, the State of Alaska, Department of Law submits the following written comments regarding Senate Bill 256, "An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health benefit plan that has substantial market power." These comments assume that proposed amendments number 1 through 4, offered by the bill's sponsor, Senator Kelly, on March 27, 2000, will be incorporated into a committee substitute, as you had requested. In general, the department has serious legal and policy concerns regarding the collective bargaining aspects of this bill. We believe that the bill if passed in its present form may result in substantial harm to consumers in the form of increased health care costs and reduced health care options. Further, the level of state involvement provided in the legislation may not be sufficient "active state supervision" under the state action doctrine to immunize physicians from federal anti-trust enforcement. While the majority of our comments in this letter relate to Section 3 of the bill, we also ac concerns related to Section 2 of the bill in the final numbered paragraph of this letter.

I. Purpose of Senate Bill 256, Section 3.

Under current law, collective negotiations of price and price related terms by physicians is considered "per se" illegal price fixing in violation of state and federal antitrust laws. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). Section 3 of SB 256, displaces free market competition and state antitrust laws and allows competing physicians to collectively negotiate with health plans on non-price and price terms of a contract under certain circumstances. Section 3 also attempts to provide the physicians immunity from prosecution under federal antitrust laws, through the state action doctrine, by establishing a review process of the negotiations and contracts through the Office of the Attorney General.

II. Issues relating to SB 256, Section 3.

A. Harm to Consumers.

The Department of Law agrees with the concerns relating to collective negotiations by physicians raised by Federal Trade Commission (FTC) representative, Richard Feinstein, in the oral testimony given before the Finance Committee on February 25, 2000, and in the letters submitted to the Committee dated May 13, 1999, and October 29, 1999, relating to collective negotiation legislation in Texas and Washington, D.C. Specifically, according to the FTC, allowing physicians to collectively negotiate on price terms will not ensure better care for patients, and may result in substantial harm to consumers. For instance, likely increased rates negotiated by physicians under negotiated contracts threatens to raise health care costs for individuals, employers, and state and federal governments, and may reduce access to care and increase the number of uninsured. The FTC's conclusions are based on prior investigations and enforcement actions where similar results occurred when physicians collectively negotiated price terms. *See* October 29, 1999 letter from FTC to Robert R. Rigsby, Office of Corporate Counsel, Washington, D.C., pg. 2.

Further, as discussed by Robert Lohr, Director, Division of Insurance, in his March 30, 2000, letter submitted to the Senate Finance Committee, a recent study conducted by Charles Rivers Associates, Inc., estimates that private health insurance premiums would rise by approximately 5 to 13 percent under the pending federal legislation (H.R. 1304) permitting health care professionals to negotiate collectively with health care plans. Based on this study, and Mr. Lohr's discussions, it can be assumed that Alaska will experience similar increased health care costs as a result of collective negotiations by physicians, absent adequate limits on the collective bargaining.

B. Limits on collective bargaining are not sufficient to protect consumers from substantial harm.

1. Market share limits.

SB 256 provides that health plans must have substantial market power, defined as 15% of the market share, in order to allow price negotiations by physicians. Further, where a health plan has less than 5% market share, the physician group may not exceed 30% of the market in the physician's geographic service area.

Although the bill appears to make the concept of market power an important limitation on physician's ability to collectively negotiate price terms, these provisions are not based on accepted concepts of market power in a legal or economic sense. See FTC letter dated October 29, 1999. Specifically, a 15% market share is not ordinarily presumed to constitute market power. Therefore, although a health plan may meet the presumption of market power under the bill, it may not in fact have the market power which gives them the ability to reduce prices below competitive levels, justifying collective negotiations by physicians.

Further, the bill's limits on physician group size do not reflect the potential market power (ability to raise prices) of physician groups. SB 256 lacks a cap on the market share of a physician group when negotiating with a health plan with greater than 5% market share. This may result in a disproportionately large physician group (up to 100% of the market share in a geographic market) negotiating with a small health plan (small as 5% market share), resulting in substantial market power by the physicians. Further, the limit on the market share of physicians groups (30 %) negotiating with small (less than 5%) health plans does not necessarily reflect market power, and may underestimate the economic clout of a physician group which is dealing with the small health plan.

2. Prohibition on boycotts/concerted action.

Another limitation in SB 256 relates to the prohibitions on boycotts and concerted action by physicians. Two sections in the bill dealing with these provisions raise significant questions of interpretation and may not offer adequate protections to consumers.

Section 23.50.020 (a) of the bill prohibits competing physicians from engaging in boycotts relating to the non-price terms and conditions listed in that subsection. However, a similar prohibition is absent from the price and price related terms and conditions listed in subsection (c). It is not clear whether this omission was purposeful, or a drafting error. The effect is significant, however, in that the prohibition on boycotts is absent for price and price related terms.

Subsection (h) of the bill, relating to concerted action by physicians, does not fully correct the problem. Subsection (h) provides that new section 23.50.020 does not authorize competing physicians to act in concert in response to a report issued by an authorized third party related to the third party's discussions or negotiations with a health benefit plan. First, this section does not clearly prohibit concerted action, such as boycotts. It only states that it is not authorized by the section. Subsection (h) needs to be amended to provided that concerted action is clearly prohibited, as it is in subsection (a). Second, the only conduct that is affected under subsection (h) is concerted action in response to third party discussions/negotiations with health plans. Concerted conduct by physicians prior to, or during negotiations, is not affected by this section. Therefore, for instance, a boycott or strike by physicians in response to a health plan's refusal to collectively negotiate with a physician group on price terms would not be prohibited by this subsection.

Another issue, which must be clarified, relates to the definition of boycott. As the FTC points out in its letter to the Washington D.C. Corporate Counsel, dated October 29, 1999, it is unclear whether the boycott prohibition is intended to bar agreements not to deal with health plans except on collectively-determined terms, or whether it would only prohibit agreements to withhold services from third parties, in order to pressure health plans to accede to the contract terms demanded by the physician group. *Id* at pg. 4. The bill needs to be clarified to indicate which type of boycott is prohibited by this section, the former being the much more coercive type of boycott which should not be allowed.

Even if the bill was amended, as suggested above, so that it was clear that all types of boycotts and concerted action are prohibited by physicians, SB 256's authorization of collective bargaining would still present a serious risk of anticompetitive harm. The FTC has previously observed that collective negotiations by nature convey an implied threat that if the health plan does not agree to the terms the physician group is bargaining for the plan will be unable to obtain agreements with individual group members. *Id.* By immunizing agreements among physicians on the prices and other terms they will accept from a health plan, SB 256 facilitates coordinated conduct among physicians, such as collusive refusals to deal that, even though not authorized by the bill, would be difficult to detect and prosecute. Because the purpose of the bill is to allow physicians to exert leverage over health plans in order to get more favorable terms, prohibiting concerted action by physicians would likely not eliminate the coercive force of collective bargaining, or obviate concerns that the bill would increase the likelihood of concerted refusals to contract with health plans. *Id.*

C. Immunity Issues – State Action Doctrine

Under the "state action" doctrine, states may override the national policy favoring competition and provide that aspects of their economies will be governed by regulation rather than market forces. A state may not confer antitrust immunity on private parties by fiat, however, it may "displace competition with active state supervision if the displacement is both intended by the State and implemented in its specific detail. Actual state involvement, not deference to private price fixing arrangements under the general auspices of state law, is the precondition for immunity from federal law." FTC v. Ticor Title Insurance Co., 504 U.S. 621, 112 S. Ct. 2169, 2176 – 77 (1992).

Active supervision, for the purpose of obtaining immunity under federal antitrust law means that the regulatory agency must "have and exercise ultimate control over the challenged conduct." Patrick v. Burget, 486 U.S. 94, 100 (1988). In this context the issue is whether "the state has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among the parties." FTC v. Ticor, 112 S. Ct. at 2177. The Court has held that a state did not actively supervise price arrangements when it did not establish the prices, review the reasonableness of the prices, monitor market conditions, or engage in any pointed reexamination of the program. California Retail Liquor Dealers Assoc. v. Midcal Aluminum, Inc., 445 U.S. 92, 105-106 (1980).

Several aspects of the provisions of SB 256 raise questions as to the adequacy of state supervision authorized by the bill, thereby reducing the likelihood that the legislation meets the requirements of the state action doctrine immunizing physicians from prosecution under federal antitrust laws. First, the limited nature of information that a third party representative must provide to the Attorney General to obtain approval to negotiate raises the question as to the extent the Attorney General can exercise sufficient independent judgment and control to make the determinations required under the bill. For example, the Attorney General must determine whether the third party has complied with the physician market share limits under the bill in order to decide whether the proposed negotiations exceed the authority granted under the

chapter. However, the third party is not required to provide any information necessary to make such a determination, such as information relating the physicians they represent, their specialty areas, market shares, etc.

Second, the bill imposes substantial responsibilities on the Attorney General to approve or not approve a proposed negotiated contract, utilizing specific criteria, but provides only a very short time frame (30 days) within which to make that fact intensive determination, and does not require that the parties provide any information to the Attorney General to make such a determination. Moreover, the regulatory scheme established by the bill contains no mechanism for members of the public, or others affected by the decision, to offer evidence and argument relating to the costs or benefits of the proposed contracts. All of these factors suggest that no substantive review is contemplated by the legislation, nor would the Attorney General be in a position to exercise independent judgment and control in determining the reasonableness of negotiated terms of the contract.

Finally, rather than putting the burden on the proponents of a contract to demonstrate that the proposed contract complies with the articulated standards, SB 256 puts the burden on the Attorney General to make that determination without any information to assist in the review. This is contrary to established legal principals that the party requesting a change from the status quo has the burden of proving that the requested action is justified. The proponents of a negotiated contract are the entities with the information and knowledge necessary to establish that the criteria have been met. SB 256's failure to ' ' the burden on the proponents of the contract to demonstrate that the standards for approva. ave been met is further indicia that a substantive review of the contract terms is not contemplated by the legislation.

For these reasons, it may be found that the level of state involvement provided in SB 256 may not be sufficient "active state supervision" under the state action doctrine to immunize physicians from federal antitrust enforcement.

D. Issues relating to proposed amendments 3 and 4.

1. Proposed Amendment # 3 inserts the word "geographic" before the term service area throughout section 3 of the bill and defines the term "geographic service area" to mean the "geographic area of the physicians seeking to jointly negotiate." Several issues arise with this new amendment which need to be addressed. First, it is unclear what standards are to be used to determine the geographic area of a physician under the new definition. This will need to be clarified before an accurate and consistent market share analysis can be performed under the bill. Second, insertion of the word "geographic" on pg. 7, line 3, does not make sense within the context of subsection (c), and should be removed or the subsection reworded to accomplish the intended purpose of the subsection. Third, under the new amendments a health plan's market share is calculated based on the physician group's geographic service area. It will need to be confirmed that information can, in fact, be obtained about a health plans market share within a particular physician group's geographic service area. If it cannot, then the market share analysis contemplated in the bill will not be able to be performed. Fourth, it is unclear what the purpose or meaning is for the second half of subsection (1) on pg. 7, line18, as amended. This provides

an alternative means of measuring the market share of a health plan, but it is unclear what is meant by the language or how it is different from the first half of the sentence.

2. Proposed Amendment # 4 inserts standards for approval by the Attorney General of a collective negotiation. Several issues arise under this new amendment which need to be addressed. First, although it is implied that the standards are applicable to the approval of a negotiated contract, the amendment actually states that they are for approval of a "collective negotiation". It needs to be clarified what the standards are applicable to. Second, a number of the standards are vague, making it impossible to determine what factors are contemplated under the standard and whether the factors are appropriate for the Attorney General's consideration. For instance, it is not clear what sort of factors or terms would fail under the category "promotion of health care infrastructure and medical advancement" found in subsection (i)(3). Third, to provide a balanced consideration of factors, the standards should be amended under subsection (j) to allow the Attorney General to consider whether the proposed contract terms impose impediments or decrease access to quality patient care, when weighing the anticompetitive effects of the contract terms.

III. ERISA Preemption Issues

Under the HES committee substitute, Section 3 of the bill was amended to apply to "health benefit plans" instead of "health care insurers." We understand that this change was made to include self funded health plans within the scope of Section 3 in addition to fully insured plans. This change, however, raises a federal preemption issue under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA preempts all state laws that relate to an employee benefit plan, which by definition includes a "health benefit plan." ERISA regulates the administration of employee health care benefits as well as the structure of the plans. While there is case law that may seem to narrow the breadth of the broad ERISA preemption, this bill is still a high risk of preemption to the extent that the bill will affects the benefits and administration of a health benefit plan. This risk can be avoided by restricting the application of Section 3 to entities traditionally regulated under Alaska's insurance laws, which was the approach used by Texas in similar legislation passed in 1999.

IV. Miscellaneous Issues – Section 3

Written testimony submitted to the committee and proposed AS 23.50.020(f)(2) indicate that negotiation with an authorized third party is not mandatory for health benefit plans. However, the language in proposed AS 23.50.020(c)(2) (page 7 in the bill) implies that all health benefit plans are required to negotiate with an authorized third party unless it can prove that it does not have substantial market power. The bill needs to clarify whether such negotiations are voluntary or not.

By using the term "health benefit plan" in Section 3 of the bill, insurance companies will not be subject to the requirements under that section, as may have been intended. Also, the contracts entered into under Section 3 will not be subject to the requirements in Section 2, because Section 2 applies to contracts between providers and managed care entities like

insurance companies, not health benefit plans. If this is not the legislature's intent, then the bill should be amended to clarify that contracts entered into under Section 3 are also subject to the requirements of Section 2.

V. Miscellaneous Issues - Section 2

The "managed care" definition in Section 2 implies that Alaska law permits an arrangement in which an insured is required to use only certain providers. But current Alaska statute, AS 21.51.120, AS 21.54.020(a), and AS 21.87.120 – 21.87.130, does not allow such an arrangement outside of an HMO. Accordingly, the definition should be amended to avoid any confusion over what is allowed under current law. Current law does allow, however, financial incentives to use certain providers.

The "managed care entity" definition includes a reference to "employer or employee health care organization." It is not clear what is meant by this reference, since the term is not defined under the bill. To improve clarity, the bill should be amended to define this term.

If you have any questions regarding these written comments, you can reach both of us at 907-269-5100.

Very truly yours,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: Julia Coster
Assistant Attorney General

Signe Andersen
Assistant Attorney General

JC:jem

cc: Senator Pete Kelly
Pat Pourchot, Governor's Legislative Director
Deborah Behr, Department of Law
Chrystal Smith, Department of Law
Bob Lohr, Division of Insurance
Sally Saddler, Department of Community and Economic Development

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 3, 2000

SUBJECT: Managed care and physician collective negotiation - (CSSB 256(HES))

TO: Senator Pete Kelly
Attn: Lorna

FROM: Michael F. Ford
Legislative Counsel

You have asked for our comments on the Department of Law's review of CSSB 256(HES). Given the time constraints, our comments limited to areas we disagree or feel require explanation and are listed as described in the letter of the Department of Law dated March 31, 2000:

I. Purpose of Section 3 - We agree with this comment.

II. Issue relating to Section 3 -

A. Harm to consumers - We believe that these comments raise serious issues that should be considered by the legislature in considering enactment of SB 256. However, we cannot agree with the Department of Law that it can be assumed that Alaska will have increased health care costs if physicians are allowed to collective negotiate. But this question should, again, be carefully considered by the legislature;

B. Insufficient limits on collective bargaining - The Department of Law criticizes the bill for not using accepted legal or economic concepts of market power. Specifically, the memo points out that 15 percent of the market may not constitute substantial market share. It is certainly within the power of the legislature to establish a legal point beyond which a health benefit plan is presumed to have a substantial market share. This is what SB 256 does. Therefore it is incorrect to say that SB 256 does not impose market limitations in a legal sense. The memo is correct however, in that the market limits imposed under SB 256 may not reflect economic realities. The further comments of the memo on market power by physician groups (Sec. 23.50.020(e)(6)) may also be correct. Again, this is a matter that should be considered in the committee process. Regarding the memo's comments on boycotts or concerted action, the structure of the bill is taken from the existing Texas law. We agree that the questions raised by the memo regarding the extent of the prohibition against boycotts contained in Sec. 23.50.020(a) and whether to define the term "boycott" should be considered by the committee.

C. Immunity issues - state action doctrine - The memo raises questions regarding whether the bill constitutes "active state supervision" sufficient to avoid federal antitrust problems. Our only comment on this issue is that if necessary, the state could adopt regulations to strengthen or modify the supervision provisions of SB 256. The problems raised in the memo seem to be of the kind that could be resolved in this manner;

D. Issues relating to amendments 3 and 4 - We agree that "geographic" should not be inserted in front of "service" on page 7, line 3.

III. ERISA preemption issues - We agree that a federal preemption issue is raised by sec. 3 of SB 256. However, we believe that while preemption is possible, this language is necessary in order to allow the bill to have the broadest application possible.

IV. Miscellaneous issues - Sec. 3. - Regarding the use of the terms "managed care entity" as in sec. 2 and "health benefit plan" as in sec. 3, we agree that insurers are not covered in sec. 3 and the provisions of sec. 2 will not apply to contracts described under sec. 3. However, this appears to be the intent of those sections.

V. Miscellaneous issues - Sec. 2 - We agree that the definition of "managed care" should be amended on page 4, line 29, to delete "that requires the member to use, or". This change would avoid the implication that (except in the case of an H.M.O.) the insured can be required to use only certain health care providers.

Please contact me if you have further questions.

MFF:glc
00-156.glc

SB 256

Tony Knowles, Governor

Alaska Department of Community and Economic Development

Division of Insurance
3601 C Street, Suite 1324, Anchorage, AK 99503-5948
Telephone: (907) 269-7900 • Fax: (907) 269-7910 • Text Telephone: (907) 465-5437
Email: Insurance@dced.state.ak.us • Website: www.dced.state.ak.us/insurance/

March 31, 2000

The Honorable John Torgerson, Co-Chair
Senate Finance Committee
Alaska State Senate
Room 516 Capitol Building
Juneau, Alaska

Dear Senator Torgerson:

You have requested the written comments of the Division of Insurance on SB 256, "An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health care insurer that has substantial market power." The Division opposes this legislation because we believe it would harm Alaskans by significantly increasing health care costs.

Alaskans already face high and steeply rising health care costs. During the past three years, based on the experience of a major health insurer, private health insurance rates have risen 61.8%.

Year	% Increase
1999	11.9%
1998	25.6%
1997	15.1%

The most credible study on the cost impacts of legislation like this has been prepared by Charles River Associates (a respected antitrust economics consulting firm) for the Health Insurance Association of America and updated this month. It is entitled "The National Costs of Physician Antitrust Waivers" (copy attached). It analyzed the cost impact of a similar national bill, H.R. 1304, that would grant doctors 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. The study concluded that a $29 to $95 billion increase in health insurance premiums, or a 5 to 13 percent hike in private health insurance premiums, would result.

The U.S. Congressional Budget Office estimated the cost of H.R. 1304 and on March 15, 2000 concluded:

> By increasing the cost to private health plans, higher premium contributions charged to employers would result in higher insurance premiums... CBO estimates that federal tax revenues would fall by $145 million in 2001 and by $10.9 billion over the 2001-2010 period if H.R. 1304 were enacted.

During the same ten-year period federal spending on the State Children's Health Insurance Program would increase by $11.3 billion because of this bill. Other federal spending impacts have not yet been analyzed.

Proponents of SB 256 argue that this is a patient rights issue. It is not a patient's right to pay more for the same service so that health care providers may charge more for their services. Alaskans cannot afford to pay 5 to 13 percent more for health care as a direct result of this bill.

Thank you for the opportunity to comment.

Sincerely,

Robert A. Lohr
Director

SB 256

The National Costs of Physician Antitrust Waivers

Introduction

The Quality Health-Care Coalition Act of 1999 (H.R. 1304), introduced by Representative Thomas Campbell on March 25, 1999, would cause "the antitrust laws [to] apply to negotiations between groups of healthcare 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." This legislation would grant physicians and other healthcare 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 utilization review or management protocols.

The legislation is based on the premise that "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." Advocates of collective bargaining for health care providers argue that, as a result of numerous consolidations, health plans have gained significant market power in recent years. This market power, it is alleged, has allowed them to negotiate provider payment rates that are so low that providers can no longer deliver the high quality health care services demanded by patients. The proposed legislation is therefore required, it is alleged, to "level the playing field."

This justification for the proposed antitrust immunity legislation ignores three important factors, all of which argue against its merits:

- The legislation will raise health care costs, financed by both the public and private sectors, considerably;
- Legitimate mechanisms exist already in the application of the antitrust laws by which health care providers can collaborate to negotiate with health plans when it is pro-competitive for them to do so; and
- Consolidation among health plans has been subject to substantial antitrust scrutiny of its own, both at the federal and state levels. The health insurance industry remains very competitive, making it improbable, if not impossible, for it to exert significant market power in its negotiations with health care providers.

We discuss each of these arguments below.

Costs of Collective Bargaining Legislation

Legislation that immunizes physicians and other health care providers from antitrust scrutiny

opens the door for anticompetitive activities that could raise health care costs by reducing providers' incentives to offer competitive prices and to comply with the cost-effective utilization controls that have enabled managed care organizations to reduce the rate of health care cost inflation substantially. While private health insurance premiums increased by 10.9 percent between 1991 and 1992, by 1996, the annualized rate of increase was only one half of one percent.[1] As managed care plans have enrolled an increasing proportion of private and publicly insured individuals, their effect on overall health care cost trends has become stronger. Legislation that grants market power to an important sector of the health care industry is likely to undermine many of the competitive benefits of managed care, which historically have been passed on to employers and consumers.

Managed care has achieved savings on physician and other professional provider fees for at least two reasons. First, managed care companies have been able to reduce the prices they pay for each provider service by encouraging vigorous competition among providers. In their efforts to attract enrollees, competing managed care plans have passed these savings on to employers and employees. Second, by "managing" the services that are covered, managed care companies have been able to minimize the excessive utilization of medical services that had characterized the industry. Such overuse is common when the amount consumers of a good pay is not directly related to the quantity that they consume. for example, when enrollees pay a fixed health insurance premium regardless of the number and complexity of health services they use. This divergence between the consumer and the payor creates an externality or 'moral hazard' characterized by the enrollee who faces lower costs than the value of the services consumed, and, therefore, purchases too much health care. In addition, prior to managed care's introduction of capitation or other forms of risk sharing, the physician also had financial and defensive incentives to encourage the use of too much care. By requiring both subscribers, through copays, and physicians, through risk sharing, to bear some of the costs of a claim, managed care insurance policies have reduced total costs. The introduction of managed care is the private market's partially successful attempt to align physician and consumer incentives to induce cost-effective utilization, thereby reducing costs and improving consumer welfare.

One would expect that if health providers were allowed to bargain collectively, they would attempt to regain some of their lost earnings by negotiating a return to the old rules. Such a return would decrease consumer welfare. Moreover, unions or other physician groups also support the types of provisions that are encompassed by various recent forms of "Patients' Bill of Rights" or "Medical Necessity" legislation, such as "any willing provider" (AWP) and/or "freedom of choice" (FOC) requirements. Such requirements would further reduce managed care companies' ability to contain costs by reducing their ability to "manage" utilization and to negotiate fee discounts. For example, to date, managed care companies have been able to negotiate lower prices with providers in exchange for higher volumes, but if every physician can become part of the network (as is the case of AWP requirements), higher volumes cannot be

---

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

assured to member physicians. The effect would be to make the health plan a common carrier and to increase costs.[2]

In the cost model below, we estimate a range of likely dollar impacts for each of four related effects, two price effects and two utilization effects. Each estimate within the range reflects a particular scenario; scenarios vary according to the assumptions made about the parameters that define the model, as outlined below.

We predict the annual total dollar impact of the proposed legislation to range from approximately $29 billion up to about $95 billion in increased expenditures for personal health care services (financed by both the public and private sectors).[3] These figures represent from about 2 ½ percent to 8 percent of total personal health care expenditures[4] predicted for the year 2000 in the National Health Expenditures Projections published by the Health Care Financing Administration (HCFA).[5] The percentage impact on annual private health insurance premiums can be expected to be greater since most private insurance is now some form of managed care: premiums are anticipated to rise by approximately 5 to 13 percent. It is reasonable to anticipate that the short-run impact of the antitrust exemption legislation will result in costs toward the lower end of the range, about 2.5 to 4 percent of personal health care expenditures or 5 to 7 percent of private health insurance premiums. In the longer run, larger impacts can be expected as health care providers increasingly gain the upper hand in negotiations with public and private payors, from 6 to over 8 percent of personal health care expenditures and 10 to 13 percent of private health insurance premiums. These effects will persist; the levels of annual health care costs and private insurance premiums will remain higher than they would have been in the absence of the legislation.[6]

---

[2] W. Duncan Reekie, "Competition in Health Care: Is it Working?" *International Journal of the Economics of Business*, 4 November 1997, pp. 323-334.

[3] Alternative scenarios of the model produce projected impacts ranging from $22 billion to $130 billion, however the two most extreme scenarios are probably less likely than the more intermediate values. In all cases, the text focuses on the range of estimates implied by scenarios 2 through 5. The tables indicate the more extreme values.

[4] HCFA reports health care expenditures by both sources and uses of funds. Personal health care expenditures is a broad category of uses which excludes research, administrative costs, and public health activities. Private health insurance is one of the categories of sources of expenditures.

[5] All of the projections described in this report are derived from year 2000 predictions of health expenditures. While the true dollar projections for later years are likely to be higher because of higher anticipated spending in the absence of the legislation, the percentage impact should remain constant.

[6] This projected increase in the level of expenses is additional to already projected inflationary increases in premiums.

Price Effects

The two price effects focus on the increase in physician and other health care provider fees that is likely to occur when providers no longer face the competitive incentive to discount their prices. The first effect measures the costs associated with the anticipated increase in provider payments required of public and private managed care plans[7] when provider discounts are reduced. The second, related, effect is a spillover onto the payment rates faced by non-managed (indemnity) insurance arrangements.

Managed care has been credited with achieving provider discounts ranging from 5 to 6 percent with some loosely managed plans to 20 or 25 percent with more tightly managed plans. A review by the Barents Group of studies performed by CBO, Lewin-VHI, and itself found discounts ranging from 6 to 15 percent relative to fee-for-service plans, from which it calculated an "all HMO" average discount of 13 percent.[8] Our estimates of the price effect on managed care include assumptions that the discounts enjoyed by managed care plans range from 6 to 25 percent. We estimate scenarios that reflect six different assumptions about the average level of discounting achieved by managed care: 6 percent, 10 percent, 13 percent, 15 percent, 20 percent, and 25 percent.[9] We assume that from one half to all of these discounts would disappear if providers were allowed to negotiate collectively, and estimate scenarios that reflect 50, 60, 75, 85 and 100 percent losses of existing discounts by public and private managed care plans. The combined effect of these two assumptions is that provider fees paid by managed care plans would rise somewhere between 3 percent (.5 x 6) and 25 percent (1 x 25). These percentage increases are applied to the provider fees paid by public and private managed care plans.

We base our projected dollar increases in health provider fees on data from the National Health Expenditure Projections, 1999 (based on the National Health Accounts) for the year 2000, published by the Health Care Financing Administration. The National Health Expenditure Projections distinguish among a variety of expenditure categories. For estimating the possible effect of the antitrust exemption on health provider fees paid by managed care organizations, we

---

[7] H.R. 1304 defines a "health plan" as 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." Section 3d2(A).

[8] Barents Group L.L.C., Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003. Report prepared for The American Association of Health Plans, April 22, 1998.

[9] In fact, much of the economic literature on the effects of collective bargaining or unions suggests wage effects that are 20-30 percent. See, for example, N. Rose, "Labor Rent Sharing and Regulation: Evidence from the Trucking Industry." *Journal of Political Economy* 95, 1987; C. Robinson, "The Joint Determination of Union Status and Union Wage Effects: Some Tests of Alternative Models." *Journal of Political Economy* 97 (1989); R. Edwards and P. Swaim, "Union-Nonunion Earnings Differentials and the Decline of Private-Sector Unionism." *American Economic Review* 76 (May 1986).

rely on projections of expenditures on Physician Services, Dental Services, and Other Professional Services as the legislation focuses on all health providers. [10]

We consider fee increases affecting managed care plans covering privately insured as well as publicly insured individuals. We estimate the proportion of private expenditures for physicians attributable to managed care plans as approximately 85 percent.[11] To be conservative, we assume that only half of this percentage (42.5 versus 85) of out-of-pocket expenditures are associated with managed care enrollees. We calculate the proportion of Medicare and Medicaid based on data available from HCFA on the proportion of each program's expenditures attributable to their risk plan enrollees.[12] We assume that the same percentage of public expenditures (other than Medicare or Medicaid) is managed as for private insurance expenditures, since these expenditures are primarily worker's compensation and military programs, both of which are commonly covered by private managed care.

---

[10] Estimates of the fees paid by managed care plans are a composite of data from several sources. We base the estimate of the effect on private spending on HCFA's projected 2000 spending for physician, dentist, and other health professional services by private insurance. A portion of out-of-pocket expenditures are grouped with private managed care payments.

[11] We assume, based on a variety of studies, that 85 percent of physician payments are through managed care plans. In a study prepared for AAHP, Barents Group assumes a 70 percent penetration rate but argues that 85 percent is a more current estimate. Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans, 1998 reports a rate of 87 percent. Health Affairs, January/February 1998 reports a rate of 81 percent. KPMG Peat Markwick's Health Benefits in 1998 reports that 86 percent of employees are in managed care plans. Most recently, the Kaiser Family Foundation/Hospital Research and Educational Trust ("KKF/HRET") Employer Health Benefits 1999 Annual Survey estimated that 91% of all covered workers are enrolled in some type of managed care plan. The 85 percent figure that we use is derived as the proportion of privately employed individuals enrolled in managed care adjusted for the differential between average per capita premiums for managed and indemnity enrollees. The KKF/HRET report provides the data necessary to estimate this adjustment. It identifies the annual cost per employee for a traditional indemnity plan, PPO, POS, and HMO. The survey also reports the percentage of employees enrolled in each type of plan. This information is used to estimate the average per-employee cost of a managed care plan (a weighted average of the costs of PPO, POS, and HMO plans). The ratio of managed care costs to traditional indemnity costs is .932. The portion of expenditures attributable to managed care is adjusted down using this ratio based on the assumption that managed care plans achieve some cost savings. It is worth noting that the implied estimate of a 7 percent savings attributable to managed care is lower than many others cited in this report. The Mercer study is based on a limited set of employers and does not account for any systematic differences in health status between managed and indemnity enrollees.

[12] We use HCFA figures on total Medicare and Medicaid expenditures as well as the proportions that cover enrollees in risk-based programs. The Profile of Medicare Chartbook reports that 13 percent of Medicare expenditures were for managed care in 1996. A more recent figure cited in the *Wall Street Journal* (2/21/99) suggests that 15 percent of Medicare beneficiaries in 1998 were enrolled in risk programs. The 1998 HCFA 64 reports Medicaid expenditures attributable to managed care as 10.4 percent if the total. In the case of Medicaid managed care expenditures, the proportion (10.4 percent) reflects estimates collected from the states. This figure may be somewhat conservative, since approximately 40 percent of all Medicaid enrollees belong to managed care plans.

We follow an analogous methodology for estimating the proportion of dentist and other health provider fees attributable to managed care. To be conservative, we assume that half of the percentage of physician expenditures in each category that is attributable to managed health care is appropriate for dentists and other health providers. That is, we define approximately 45 percent of expenditures on dentists and other health professionals as managed.[13]

Our estimates of the annual costs of antitrust immunity in terms of higher health care provider fees charged to managed care plans range from $10.8 to $30.7 billion. These figures imply that total expenditures on health provider services will increase by 2.7 to 7.7 percent of total expenditures on health professionals and by .9 to 2.7 percent of total personal health care expenditures.

We assume that the vast majority of the effect of an antitrust exemption on fees negotiated with providers will impact managed care plans and, as a result, employers and their employees. A spillover effect, however, will also occur if increases in managed care fees occasion a rise in the price paid by private indemnity plans or public fee-for-service programs. In the case of fees, we assume the spillover is small, ranging from zero to 10 percent of the price increase absorbed by managed care.[14] We also assume that public fee-for-service payors, which generally pay based on established fee schedules will not face a fee increase. This assumption may also be conservative, particularly since we use current Medicare and Medicaid risk plan penetration rates, even though the managed segment of these programs is growing rapidly. The spillover effect ranges from $.4 to $2.1 billion.

Combining the measured effects of fee increases both on managed care expenditures directly and as a spillover to indemnity payments results in an estimated annual increase in expenditures for health care providers of $11.2 to $32.8 billion.

Utilization Effect

The very title, "Quality Health-Care Coalition Act of 1999," implies that the legislation is intended to permit collective negotiations not only on the basis of price, but also on the types of services that managed care organizations will be required to cover. Therefore, it is reasonable to expect that the legislation would permit physicians and other health care providers to demand that managed care organizations cover the same types of services outlined in many of the related pieces of legislation currently under debate that are labeled "Patients' Bill of Rights" acts.

While the fee impact of an antitrust exemption for physicians and other health providers is likely limited to the services that they provide directly, the legislation's impact on service utilization

---

[13] We do not have data that address directly the percentage of dental and other professional fees that are covered by managed care.

[14] For example a 5 percent spillover implies that for a 10 percent increase in the fees paid by managed care plans, indemnity prices would increase by ½of 1 percent.

has much broader implications. Health providers such as physicians or other professionals are responsible for ordering the vast majority of services consumed by patients. To the extent that the legislation reduces managed care plans' ability to maintain policies that providers do not support, its impact on utilization of all managed health care services could be substantial. Moreover, to the extent, as suggested by several studies, that there are substantial "spillover" effects from managed care to fee-for-service settings in utilization patterns, any change in the ability of managed care plans to "manage" care will affect the entire health care sector (including traditional programs).

Several estimates exist of the costs associated with various patient protection and bill of rights proposals. These other pieces of legislation generally focus on particular services, such as emergency room care or specialty services. Therefore, the cost increases that they postulate are attributable to the legislation's anticipated effect on utilization are likely to be smaller than those that could occur, if, in the long run, managed care plans lose all control over utilization because of the proposed antitrust exemption. In that case, it is possible that all the savings attributable to managed care would disappear, not only for managed care plans but also for all payors and their enrollees. While this prediction may seem extreme, it is a useful scenario to consider.

The Barents Report, cited earlier, reviews various estimates of the utilization savings attributable to various forms of managed care relative to traditional fee-for-service indemnity coverage. It finds savings ranging from 4 to 18 percent from utilization management activities, depending on the type of plan. Based on relative enrollments, the weighted average of these effects is 6.8 percent. Barents also attributes an additional 4 percent savings to utilization review, regardless of the nature of the managed care arrangement. The technical expert panel that it convened agreed that somewhere between 60 to 90 percent of these savings could be lost if legislation making such activities less permissible were enacted. Based on these findings, we posit a range of costs resulting from increases in utilization attributable to the antitrust exemption ranging from 3 to 9.7 percent.[15] This increase in utilization is expected to apply to both private and publicly funded managed care plans. It is expected to occur across all services to some extent, although the impact may be anticipated to be most substantial on the services provided directly by the professional providers for whom the legislation is designed.[16]

We estimate the potential dollar increase in expenditures resulting from reduced ability to perform utilization review and management activities from the National Health Expenditures

---

[15] Applying Barents Group's analysis to the issue at hand results in an estimated cost increase due to increased utilization of health care services of between 6.5 percent and 9.7 percent. However, to the extent that health providers do not reclaim complete control of medical decisions from managed care companies and/or that their control does not affect utilization of all health care services, the increase in costs will be smaller. Therefore, we posit that the cost increase that would result from increased utilization falls within the range of 3 percent to 9.7 percent.

[16] The more modest estimates of increased utilization account for a smaller impact on the cost of increased utilization of other health care services than on those provided by health professionals.

Projections for the year 2000 for all personal health expenditures. The dollar estimate ranges from $16.2 to $43.1 billion annually, or 1.4 to 3.7 percent of total personal health expenditures.

Various studies suggest that the utilization review and management activities practiced by managed care have had spillover effects onto the practice of medicine that is still reimbursed on a fee-for-service basis.[17] That is, health care providers tend not to have multiple practice styles that depend on the source of payment, but rather practice reasonably uniformly. Therefore, to the extent that utilization increases in the managed care sector, at least some increase in utilization in the non-managed sector should be anticipated as well. We estimate that the spillover utilization increase ranges from zero (no spillover) to half of the utilization cost increase that would be experienced by managed care. This results in up to an additional $19.6 billion, or 1.7 percent of total personal health care expenditures.

Summary of Cost Increases

Table 1 presents the dollar cost increase estimates from each of the four components under six different combinations of assumptions (each of which is labeled a "scenario"). For each scenario, the cost effects are provided for private insurance, all private and public expenditures, and for private and public combined.[18] The results do not account for such "second order" effects as the tax consequences that depend on who bears the private sector cost increase.[19] Nor do they account for the interaction between price and utilization effects,[20] or the effect of higher health care premiums on the number of uninsured.[21]

---

[17] See, for example, L. Baker, "The effect of HMOs on Fee-for-Service Health Care Expenditures: Evidence from Medicare." *Journal of Health Economics*, 1997; DJ Gasket and J. Haley, "The Impact of HMO Penetration on the Rate of Hospital Cost Inflation, 1985-1993." *Inquiry* 34, Fall 1997; T. M. Wickziger and P.J. Feldstein, "The Impact of HMO Competition on Private Health Insurance Premiums, 1985-1992." *Inquiry* 32, Fall 1995.

[18] There is nothing "magic" about the six scenarios chosen; rather, they reflect combinations of parameters that seem to be potentially reasonable alternative scenarios. Other combinations are also possible but produce similar estimates of impact as the ones presented.

[19] Private health plans will presumably pass on the cost increases in the form of higher premiums to employers. Whether employers bear the additional burden or pass it on to employees in the form of lower wages will affect total tax collections. Most researchers assume that most of the cost increases will be passed on.

[20] That is, higher health provider fees will be applied to a larger number (higher utilization) of provider services, compounding the aggregate effect on cost.

[21] As prices increase, consumers (employers and individuals) may reduce their purchases of health care. Some consumers may discontinue their health care coverage. While our estimates do not reflect this effect, to the extent it occurs, the newly uninsured will likely respond in one of two ways: join public assistance programs and/or seek high cost health care services through the emergency room. In either case, a larger portion of the cost burden will fall on the public sector. Therefore, the magnitude of aggregate spending subject to the effects of collective bargaining legislation may not change significantly. Moreover, these individuals will receive health care coverage that they find less preferable to the coverage they would otherwise have received.

Table 2 presents the same results as a percentage of private and public health expenditures, as well as on private health insurance premiums. In each case, percentages are taken of the expenditures in question, for example, the percentage impact on private insurance expenditures is calculated from a base of all private health insurance expenditures. It should be noted that the approximately $17 billion in expenditures by the FEHBP program are included in private health insurance rather than public expenditures.

The total predicted annual impact ranges from about $29.2 billion (when provider fees increase by 6 percent, utilization increases by 3 percent, and there is a 5 percent spillover effect on price and a 10 percent spillover effect on utilization) to $95.4 billion (when prices increase by about 17 percent, utilization rises by 8 percent, there is a 10 percent price spillover, and a 40 percent utilization spillover).

Both tables distinguish between the legislation's likely impact on private and public spending based on the sources of funds reported in the National Health Expenditure Projections. Between approximately 70 and 80 percent, depending on the particular scenario, of the expected incidence will fall on the private sector. We also distinguish between direct and spillover effects, with the latter accounting for about 8 to 23 percent of the total predicted increase in costs.

As a basis of comparison with other studies, Table 2 also presents the impact on private health insurance premiums. This impact ranges from 4.7 percent to 13.2 percent of predicted year 2000 premiums. Given the competitive nature of the health insurance industry, it is anticipated that this impact would be passed on in the form of higher premiums to employers. Higher premiums would, in turn, likely be at least partially passed on to employees.

In the short run, the more conservative scenarios are likely more appropriate predictions of the likely effects of the antitrust immunity legislation. As new patterns of negotiations between providers and plans become more established, the larger predictions may be increasingly likely.

Current Antitrust Enforcement of Provider Networks

The analytical framework used by the antitrust agencies to evaluate collective negotiation by physicians over price and price-related terms is primarily set forth in Statements 8 and 9 of the Federal Trade Commission and Department of Justice Statements of Antitrust Enforcement Policy in Health Care, most recently updated in 1996 (Statements).[22] As FTC chairman Robert Pitofsky noted last year, the statements "have been widely cited for reducing uncertainty and

[22] While health care is the only industry in which the antitrust agencies have issued industry-specific Statements, the agencies emphasize that these Statements are meant only to clarify the application of standard antitrust principles to the health care area and are not meant to indicate there is more lenient or more strict application of the antitrust laws in such markets.

recognizing that wide range of joint activities by health care providers potentially can be pro-competitive and benefit customers."[23]

Below, we discuss the analytical principles set out in these Statements as well their practical application to current antitrust policy enforcement. Overall, many types of physician networks are regarded as lawful by the agencies, provided these organizations also create value for their customers and do not pose a substantial threat to competition.

The Health Care Statements

The Statements first describe those types of physician networks in which collective fee negotiation will not be challenged by the agencies absent extraordinary circumstances. The Statements strongly emphasize that these safety zones are not meant to establish ceilings on the types of physician activities that are considered lawful, but rather establish floors below which collective negotiation by physicians will not be challenged.

Two criteria must be met in order for physician network joint ventures to qualify for these so-called "safety zones." The first is that all physician-owned organizations that wish to engage in collective fee negotiation must "share substantial financial risk." The sharing of financial risk is primarily manifested in the way in which the network, or each individual physician within the network, is compensated. The key element is that compensation must somehow be tied to the performance of the entire group.[24] Financial risk sharing is not an end in itself. Rather, what is important is that such financial risk sharing is likely to affect physician incentives in a way that will encourage them to engage in a broad range of efficiency generating activities relating to clinical, as well as business, operations. Further, since they are at risk for the performance of the group as a whole, collective control over the financial terms at which the group sells it services can be justified as well.

The second criterion that must be satisfied in order for collective negotiation by physicians to qualify for safety zone treatment concerns the market share of the venture. Thus, when a network is exclusive, and meets the financial risk-sharing criterion discussed above, the network must encompass no more than 20 percent of the providers in the relevant market(s) to qualify for safety zone treatment. On the other hand, if the financial risk-sharing criterion is met, and the network is non-exclusive, a 30 percent threshold applies.[25]

---

[23] Robert Pitofsky, Prepared Statement of Federal Trade Commission Concerning H.R. 4277, The Quality Health-Care Coalition Act of 1998. July 29, 1998.

[24] The Statements also emphasize that the examples of financial risk sharing enumerated therein are not meant to be an exhaustive list and that it is not the agencies' intention to drive the form or structure of physician networks. Indeed, in 1996 the Statements were revised to list several forms of financial risk sharing not included in the previous versions.

[25] Because physician networks may represent themselves as non-exclusive while behaving in an exclusive manner, the agencies lay out several criteria that must be met beyond a simple declaration of non-exclusivity. However,

The Statements also make it clear that physician networks that do not qualify for "safety zone" treatment are often also lawful. Thus, the Statements indicate that physician joint ventures that share substantial financial risk, but fall outside the market share thresholds, even significantly so, may be procompetitive depending on a number of factors, such as the number of physicians in an area, the circumstances surrounding the formation of the venture (e.g., whether the venture formed at the initiative of payors rather than providers), the degree of exclusivity, steps taken to prevent anticompetitive spillovers, and the number of competitors to the proposed venture.

Similarly, the Statements emphasize that ventures that do not share financial risk may also be lawful, if the venture creates significant efficiencies. This can be true even when its membership exceeds the market share thresholds. Indeed, the revised versions of the Health Care Statements issued in 1996 have significantly expanded the discussion regarding the types of arrangements that establish such efficiency potential.

The Statements also describe how physician organizations that do not wish to share substantial financial risk or otherwise integrate can still lawfully offer their services to employers and third-party payors using one of several types of "messenger models." The key ingredient underlying these messenger models is that the messenger must not negotiate on the providers' behalf nor should it in any way facilitate an agreement among competitors on prices or price-related terms.

Antitrust Policy in Practice

The actual application of antitrust policy to the health care area is manifested in various consent agreements negotiated by the agencies with physician organizations and through the agencies' Business Review and Advisory Opinion processes. It would appear that enforcement actions have only been brought against organizations whose structure and conduct indicated they posed a substantial threat to competition without any significant offsetting efficiency potential. Nevertheless, as evidenced by the agencies' Business Review and Advisory Opinion processes, it would appear that a number of types of physician network arrangements are lawful.

Consent Decrees

The agencies have prosecuted only a handful of physician network joint ventures through the years. These entities involved physician groups holding extremely high market shares that were involved in arrangements that indicated they were cartel devices aimed solely or primarily at increasing prices and that held out very little prospect of efficiency benefit and engaged in conduct.

---

it may be difficult to establish the fact of non-exclusivity when managed care has not yet penetrated an area. The Statements recognize this dilemma and lay out several scenarios where a physician network can establish the fact of non-exclusivity even in situations where such a network constitutes the first managed care entrant to an area. For example, example 6 regarding physician network joint ventures discusses an IPA with more than 30 percent of the physicians in a rural area where managed care has not yet entered that appears, nonetheless, to be non-exclusive.

For example, in 1996 the FTC took action against Montana Associated Physicians Inc. (MAPI). According to the FTC's complaint, there were approximately 115 physician-shareholders in MAPI who comprised approximately 43 percent of all physicians in Billings, Montana and over 80 percent of all "independent" Billings physicians (those who were not part of a large multispecialty physician practice known as the Billings Clinic or employed by a hospital). The physicians agreed to settle charges that MAPI acted as a group to delay the entry of managed care into Billings and to raise the prices its members would accept from insurers. Among the actions cited in the complaint was that when a PPO sought to collect fee information from MAPI members in order to devise a proposed fee schedule, MAPI urged its members to submit prices higher than they currently were charging in order to inflate said fee schedule.

Another recent example involves the North Lake Tahoe Medical Group, Inc. The physician membership of this organization comprised at least 78 percent of the physicians in a market designated as the North Lake Tahoe area of California and at least 70 percent of the physicians in a market designated as the South Lake Tahoe area of California. Among the actions cited in the complaint was that the organization encouraged its members to departicipate from a Blue Shield PPO and threatened area employers that few of its members would continue to participate with Blue Shield, and that these employers should contract with payors that had agreed to contract with the IPA.

As exemplified in the preceding examples, there are clearly cases where physician networks have been little more than cartel devices and continued antitrust enforcement in this area appears warranted.

Advisory Opinions and Business Review Letters

In order to reduce the inevitable uncertainty associated with antitrust enforcement, the agencies have indicated that persons seeking guidance regarding the legality of their conduct can take advantage of the Department of Justice's "Business Review Letter" procedure or the Federal Trade Commission's "Advisory Opinion" procedure. These processes do not appear particularly burdensome[26] and generally provide quick turnaround.

Since the 1996 version of the Statements was issued, the agencies have issued 10 opinions involving horizontal agreements among physicians; they approved all of these[27]. These business

[26] For a list of the materials required see Judith Moreland, "Overview of the Advisory Opinion Process at the Federal Trade Commission." Speech presented at the National Health Lawyers Association, Antitrust in the Healthcare Field, Washington, DC, February 13-14, 1997.

[27] The following opinions specifically involving horizontal networks involving physicians (as opposed to horizontal agreements among providers in general) were issued during this time period: Sierra CommCare, Inc. (8/15/96); Cincinnati Regional Orthopedic and Sports Medicine Association (10/4/96); Santa Fe Managed Care Organization ("SFMC") (2/12/97); Southwest Orthopedic Specialists (6/10/97); Vermont Physicians Clinic (7/30/97); First Priority Health System ("FPHS") (11/3/97); Heritage Alliance/Lackawanna Physicians' Organization (9/15/98); Yellowstone Physicians LLC (5/14/97); Phoenix Medical Network, Inc. (5/19/98); and, Associates in Neurology, Inc. (8/13/98).

letters and advisory opinions attest to the numerous types of lawful physician organizations that appear to be forming in the marketplace, including multi-specialty and single specialty networks; networks of various sizes (ranging from 11 physicians to over 250), and networks in rural as well as all sizes of urban areas. Almost all of the networks addressed in these opinions were non-exclusive in nature and almost all involved financial risk sharing of some type.[28] Many of the review letters described numerous other ways they would seek to control costs and generate value for their customers.

Also of interest is that most of the organizations approved by the agencies exceeded the market share thresholds established in the safety zones, often by a substantial amount. For example, in its May 14, 1997, advisory opinion for Yellowstone Physicians L.L.C., the FTC approved a venture that proposed to contract with 39 percent of the active physicians in the Billings, Montana area and considerably higher percentages in some specialties. Indeed, in the area of general surgery, Yellowstone proposed to have 64 percent of the general surgeons as participants, though those surgeons practiced in three different practice groups.

Current antitrust policy appears to offer physicians significant scope to form organizations that can engage in collective negotiation provided those organizations do not pose a substantial threat to competition and provide value for their customers. Indeed, as seen in the agencies' business letters and advisory opinions, such organizations can be viewed as lawful even when they exceed the market thresholds laid out in the Statements, even by a significant amount. Nevertheless, as evidenced by the agencies' enforcement actions, physician-controlled networks can well be cartel devices whose sole purpose is to increase prices or forestall the entry of managed care. Thus, continued vigilance still appears warranted to ensure that innovative cost and quality assurance efforts in the physician services area will continue.

Competition among Health Plans

Competition remains intense among health plans. In most markets, the concentration of health plans is low. No single managed care company is in a position unilaterally to increase the price of health care coverage above the competitive rate. Any attempt by a single plan to increase prices above the competitive level would be offset by its competitors (HMO, POS, and PPO, and traditional health insurers) taking the opportunity to grow their businesses at the expense of the plan attempting to raise its rates. Similarly, any attempt by a single plan to decrease the rates it pays providers below the competitive level would be offset by its competitors taking the opportunity to grow their businesses at the expense of the plan attempting to reduce its fees paid to providers.

Health plan markets are not highly concentrated. In virtually every market, there are numerous players, all providing services that cover a continuum of options. Plans vary in specifics, such as copays, formularies, deductibles, etc. Still, despite the lack of homogeneity of the products

---

[28] Two exceptions were Sierra CommCare, Inc. and Santa Fe Managed Care Organization, which indicated that for contracts not involving risk, the messenger model would be utilized.

offered, plans compete with one another for enrollment. Any measure of concentration must both identify all firms providing health care coverage and quantify the number of enrollees in each firm. In reality, it is nearly impossible to obtain this information. For example, although it is possible to obtain detailed information on commercial HMO/POS enrollment data from InterStudy[29] and Medicare and Medicaid HMO enrollment data from HCFA, there is no reliable private or public source of information concerning PPO or self-funded HMO enrollment.[30] Yet, even using incomplete data limited to HMOs that are available, it is evident that the industry is not concentrated in most areas. For example, of the 316 Metropolitan Statistical Areas (MSAs) for which InterStudy provides HMO enrollment data, 184 have at least five HMOs competing with one another. Over 100 MSAs have eight or more HMOs competing. Many MSAs have in excess of ten HMOs competing with one another.[31] Most of the MSAs with few plans have low HMO penetration and/or small populations.

Not only are there many companies already in the business of selling health care products in nearly every MSA, entry is relatively easy. Despite physicians' allegations to the contrary, both industry analysts and academics recognize this fact. For example, Geoffrey E. Harris, managing director for Salomon Smith Barney, noted recently that the number of HMOs competing in local markets grew from 550 in 1993 to 800 by the end of 1998.[32] Professors Deborah Haas-Wilson and Martin Gaynor also found that, "potential entrants into the market for insurance do not appear to be scarce."[33] Growth has been very rapid during profitable periods. Any current absence of growth should be attributed to a lack of profits at this time, not to barriers to entry.

Competition leads both to low prices for consumers and to efficient production. With no monopoly profits to be earned, companies can only stay in business if they minimize the costs of production. Society benefits from competition because resources are allocated to where they are most valuable. Consider, for example, Ocean State Physicians Health Plan's successful entry into Rhode Island. Ocean State, like many other managed care plans, was able to erode the incumbent's (in this case, Blue Cross Blue Shield's (BCBS)) near-monopoly market share by introducing a plan with lower reimbursement rates to physicians. The strategy was extremely

---

[29] Interstudy Publications, MSA Profile Database version 8.2, January 1, 1998.

[30] Although InterStudy does collect PPO data, the company recognizes that its PPO enrollment data are incomplete.

[31] In this business, each health plan must be viewed as a competitive threat. Unlike firms that produce widgets, health plans are typically not capacity constrained. For example, if a particular health plan were to win a large contract, it could readily increase the size of its physician panel and/or rent a physician network. Expansion can be accomplished rapidly. As a result, using current shares to measure concentration overstates the likely market power that a large plan would have.

[32] "Wall Street Comes to Washington: Analysts' Perspectives on Health System Change." Issue Brief, Center for Studying Health System Change, No. 17, December 1998.

[33] Deborah Haas-Wilson and Martin Gaynor, "Increasing Consolidation in Healthcare Markets: What Are the Antitrust Policy Implications?" *Health Services Research* 33, December 1998, Part II.

profitable and forced BCBS to renegotiate lower physician fees. Consumers directly benefited because prices for health care coverage declined.[34]

Similarly, competition prevents any health plan from being able to earn excess profits by reducing fees to physicians below competitive rates. If a health plan attempted to pay less than the competitive wage to its providers, both existing firms and entrants would use this as an opportunity to increase their market shares. Since very few physicians sell their services exclusively to a single managed care plan, physicians would readily encourage their patients to switch their coverage to a plan where the physician earned higher fees. Patients are far more loyal to their doctors than to their managed care plans. The fact that competition prevents health plans either from earning excess profits to the detriment of either consumers or health care providers is an example of what Adam Smith termed the "invisible hand" at work.

The Formation of a Cartel Would Be Unsuccessful

There is also no evidence that managed care plans have colluded in the past, or would be able to collude in the foreseeable future. Economic theory suggests that as the number of firms increases, the likelihood of successful collusion declines, because the more members in a cartel, the more difficult it is to agree on what price to charge and/or who may sell the restricted quantity of the product. Enforcement is also more difficult as the number of members grows. Moreover, as the number of purchasers (in this case, employers and individuals) increases, the likelihood of successful collusion declines. With many buyers making independent purchase decisions, it is difficult to determine whether increased sales by a particular firm (plan) occurred randomly or if those sales should be viewed as evidence of that firm's (plan) "cheating" on its fellow cartel members by offering lower prices (or higher quality) than that agreed upon by the cartel. Managed care is characterized by both many sellers and many buyers. Over the past several years, the identity of who offers health care plans has changed as firms have entered and exited. On the buyer side, many employers switch the plan or plans they offer to their employees relatively often. Any attempt to collude in this market would be extremely difficult.

Moreover, the low profit margins experienced by many managed care organizations in recent years hardly suggest cooperation, either explicit or implicit. According to InterStudy, in 1998, in over two thirds of the MSAs, HMOs, as a group, were unprofitable. That is, in 213 MSAs, the HMOs, as a group, had negative operating margins.[35] In that same year, Business Insurance reported that stock prices of the health maintenance organizations it tracked declined 1.82 percent. By March of this year, the group's stock price had declined another 5.45 percent.[36]

---

[34] Lawrence G. Goldberg and Warren Greenberg, "The Response of the Dominant Firm to Competition: The Ocean State Case." *Health Care Management Review* 20, Winter 1995.

[35] Operating margins equal premium revenues minus medical and administrative expenses.

[36] "Analysts Predict Improved HMO Stock Performance," *Business Insurance*, March 22, 1999.

Antitrust Laws Are Applied to Health Plans

Both federal and state antitrust laws are applied vigorously to health plans. Given the importance of this industry to consumers, each proposed acquisition receives careful scrutiny, with both private and public parties given ample opportunity to raise any concerns they might have. Although some mergers have been completed virtually unchallenged, this does not imply that they were not reviewed by the antitrust agencies, but rather that no competitive issues were identified. Others have gone forward only after federal and/o. state agencies have been assured that the proposed merger would have no anticompetitive consequences.

In at least one instance, this has meant that the companies were required to divest certain plans. In June 1995, United HealthCare announced its intention to acquire MetraHealth. While the main effect of the merger was to provide United with a presence in additional markets, in St. Louis, the merger would have resulted in the post-merger company having what state authorities worried was too large a share of managed care enrollment. As a result, the Missouri Department of Insurance ordered United HealthCare to divest its MetraHealth subsidiary in the St. Louis area. To avoid litigation that might have postponed or jeopardized the merger, United agreed.

In 1998 United HealthCare and Humana entered into merger negotiations. Both the DOJ and several states expressed an interest in better understanding whether the merger might reduce competition. The investigation was cut short by the two companies' decision not to proceed with the merger.

Later in 1998, Aetna US Healthcare announced it intended to acquire Prudential's health care division. The proposed acquisition of Prudential by Aetna has received careful scrutiny, both by the federal and state regulators. In response to the initial Hart-Scott-Rodino filing submitted by the merging parties, the DOJ issued an extensive second request requiring Aetna, alone, to provide to the DOJ more than 300 boxes of materials and more than one million pieces of paper for the government's review.[37] After nearly seven months, the Department of Justice and Texas Attorney General required divestitures in Dallas and Houston prior to approving the transaction. The merger was not completed until all regulators were sufficiently comfortable that it would not be problematic for consumers.

Physicians Are Increasingly Joining Large Groups

In recent years, physicians are increasingly joining large groups. Factors encouraging consolidation include reduction in transactions costs in negotiating contracts with managed care companies, risk sharing, and the need to purchase expensive equipment. Approximately 60 percent of physicians belong to groups with three or more physicians; these figures are expected

[37] "Aetna Chief Frustrated by Long Review of Planned Acquisition of PruCare Unit," *Wall Street Journal*, May 7, 1999.

increase dramatically in the next few years.[38] Many practice groups have several hundred physicians.

Large groups are especially effective when bargaining with managed care companies. In many geographic areas, it is nearly impossible to offer a plan that does not include one or more particular physician groups. This fact enhances the bargaining power of these (and other) large physician groups, counterbalancing any power that a health plan might attempt to exert over doctors. It is in physicians' interests to sign contracts with every managed care company willing to pay competitive fees. In this way they can offer their existing and prospective patients the maximum flexibility possible.

Consider, for example, the dispute between Aetna and the Genesis Group in Dallas, a dispute that arose, in part, from Aetna's "all product" policy. In protest to the requirement that every doctor who contracted with Aetna to participate in any Aetna physician panel must participate in all Aetna physician panels, Genesis Group, and its 748 doctors, terminated its contract with Aetna.[39] Thus, despite Aetna's size, the Company learned it was far from the "only game in town." Indeed, the Genesis Group had contracts with over 80 other managed care companies.[40] This abundance of contracts permitted Genesis to encourage its doctors' patients to switch health plans so that they would not have to switch physicians.[41] The press documented the group's success, for example, noting that one human resources director acknowledged that, rather than wait for employee complaints, she added another plan that included the Genesis Group. The papers also reported that Dr. Shouse, vice chairwoman of the Genesis Physicians Practice Association, noted that a physician could expect to drop Aetna with little or no change in cash flow.[42] In contrast, Aetna lost enrollment and revenues from the Genesis departure.

Health plans understand the importance of large physician groups. According to Tony Van Roekel, president and general manager of CIGNA Texas and Louisiana, "We put a big emphasis on the importance of a win-win relationship with the physicians as individuals and as members of larger groups. When physician groups terminate particular plans because of disputes or other reasons, the loss is very significant to the patients the plan serves."[43] Similarly, Pat Feyen,

---

[38] "Wall Street Comes to Washington: Analysts' Perspectives on Health System Change," Issue Brief, Center for Studying Health System Change, No. 17, December 1998.

[39] Aetna was able to get some Genesis doctors to sign individual Aetna contracts.

[40] Joanne Wojick, "400 Dallas Doctors Walk Out on Aetna," *Business Insurance*, October 26, 1998.

[41] In 1995, 62 percent of insured workers were offered two or more health plans (up from 52 percent in 1993), and 84 percent of insured employees at firms with greater than 200 workers had choice of health plans. Gail Jensen et al., "The New Dominance of Managed Care: Insurance Trends in the 1990s," *Health Affairs* 16, January/February 1997, pp. 125-136.

[42] Lisa Tanner, "Physicians Playing 'Power Game' with Health Insurers," *Dallas Business Journal* 21, No. 49, p. 8.

[43] The Gale Group, "Genesis Doctors Challenge Aetna Direct Contract Numbers, Offer Suggestions for Patients Affected by Physician/HMO Dispute," PR Newswire, September 3, 1998.

president of PacifiCare Texas noted, "With the size of physician organizations, the potential loss of one large group is a significant issue for any health plan product. It really puts the impetus on full disclosure, good working relationships and setting expectations between the physician group and the health plan up front."[44]

Finally, the presence of large physician groups as well as loosely structured IPAs facilitates an entrant's ability to establish a provider network because there are fewer entities with which a plan must contract and resulting reduced transaction costs. For example, by negotiating with only three Houston physician groups, Baylor, MD Anderson, and the University of Texas, an entrant could build a provider network with approximately 1,500 physicians.[45]

Bilateral Market Power

Physicians argue that they must be permitted to form unions in order to negotiate on a more equal footing with health plans. Even assuming that it were true that a health plan had monopsony power over physicians, permitting physicians to form a union to bargain with that health plan (e.g., to countervail the monopsony power by permitting the physicians to become a monopoly) will not necessarily lead to a better outcome, either financially or clinically, for patients. Whether society as a whole would benefit or be worse off depends on the responses of all the players (plans, employers, providers, and patients) in that particular market. A priori, it is impossible to know whether this "second best" solution would lead to an improvement or a deterioration in the allocation of resources.

It is even more difficult to predict the effect on society's welfare that the formation of a physician union would have if physicians do not sell their services to a single health plan but instead sell to a few health plans in a given market. Since there is no general theory regarding the welfare effects of oligopoly, it is not possible to draw any conclusion about when encouraging the existence of countervailing power is likely to help or harm society.[46]

Conclusion

Managed care has played a substantial role in the reduction in the rate of health care spending growth that has occurred over the last decade. It has accomplished this reduction through a combination of negotiated discounts with providers and controls on service utilization. The Quality Health-Care Coalition Act of 1999, and similar legislation that would permit collective

---

[44] Charles Ornstein, "Aetna Has Little Luck Re-signing Doctors." *Dallas Morning News*, September 1, 1998.

[45] Harris County Medical Society. "Impact of Aetna Merger on Houston Physicians, A Report by HCMS." http://www.hcms.org/aetna/mainpage.htm. March 31, 1999.

[46] Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets." Working Paper 7112, National Bureau of Economic Research. May 1999.

bargaining by health care providers considered in several states,[47] threatens to undermine managed care's ability to maintain health care cost increases at modest levels.

We estimate that if this, or similar, legislation were enacted, total annual personal health care spending would rise between 2.5 and 8.3 percent, or by $29.2 to $95.4 billion dollars annually. Approximately seventy to eighty percent of this increase would be borne by the private sector (including the effect on private insurance, federal employees' health benefit programs and out-of-pocket expenditures). A larger impact on public spending could be expected in the future if the current trend of increasing managed care penetration in Medicare and Medicaid continues. Private health insurance premiums would increase annually by 4.7 to 13.2 percent ($18.0 to $51.1 billion). Annual impacts toward the lower end of the range can be anticipated to result fairly quickly, while the longer-term impact could fall toward the upper end of the range.

These results are fairly consistent with other analyses of "patients rights legislation" that predict somewhat smaller impacts for narrower pieces of legislation that would result in lesser reductions in managed care's ability to "manage." For example, a study by the CBO of the revised, more narrowly focused Patients' Bill of Rights Act of 1999 (S. 6)[48] estimates that its long-run impact on private health insurance premiums would equal 4.8 percent. The Barents Group study, cited earlier, focuses on specific pieces of legislation. For example, it estimates that medical necessity legislation, would result in a 4.1 to 6.1 percent increase in health plan costs, before consideration of any spillover effects.

Proponents of the collective bargaining legislation argue that it is necessary to protect patients from restrictions on medical practice that lead to poor quality care. These proponents allege that consolidation among health plans has provided them with market power sufficient to reduce provider payments below competitive levels and to place restrictions on utilization that result in insufficient care being delivered. Such arguments, however, ignore the fact that the antitrust agencies have been active in providing alternative mechanisms for physicians and other providers legitimately to negotiate collectively when such activities enhance consumer welfare. Moreover, competition among health plans has been aggressive in recent years, as evidenced by their poor profits in recent years. Such competition does not suggest the exercise of market power by plans. Finally, recent consolidations among health plans have received careful scrutiny by the antitrust agencies to ensure that competition is maintained.

[47] The Texas legislature passed similar legislation in May 1999, which was signed by the governor.

[48] Congressional Budget Office, Cost Estimate: S. 6, Patients' Bill of Rights Act of 1999, June 16, 1999.

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%

	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 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%

	Costs as Percentage of Expenditure*			
Source of Cost	**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.

SB256

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

Bureau of Competition
William J. Baer, Director
Direct Dial
(202) 326-2932

May 13, 1999

The Honorable Rene O. Oliveira
Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Representative Oliveira:

The Bureau of Competition of the Federal Trade Commission is pleased to respond to your request, dated May 5, 1999, for comment on Senate Bill 1468, "An Act Relating to the Regulation of Physician Joint Negotiation" (SB 1468), which currently is being considered by the Texas legislature.(1) The bill would permit competing physicians to jointly negotiate contractual terms with health plans under certain circumstances. Our understanding is that SB 1468 has been adopted by the Texas Senate, and that a vote on a similar measure is expected in the House of Representatives in the very near future. Given the limited time available, we highlight three concerns about the bill, but are not able to provide a complete analysis of all the issues that the bill raises.

The Commission has previously expressed serious concerns about the impact on consumer welfare of a federal proposal to enact an antitrust exemption intended to authorize collective negotiation between health service practitioners and health plans. In testimony before the Committee on the Judiciary of the United States House of Representatives in July 1998, the Commission opposed enactment of H.R. 4277, the "Quality Health-Care Coalition Act of 1998." The Commission stated that the exemption would immunize "a broad range of anticompetitive joint conduct by physicians and other health care professionals that could seriously harm consumers and undermine efforts to promote high-quality, cost-effective health care for consumers." Furthermore, the Commission pointed out, the exemption would impair innovation in health care financing and delivery, and reduce choices among alternative health plans. Finally, the Commission noted that an antitrust exemption is not needed in order to allow physicians collectively to express their concerns about patient care and quality of care issues that may arise from their participation in managed care plans, or to permit them to enter into joint ventures that can offer better alternatives to patients or to health plans. A copy of the Commission's testimony is enclosed for your information.

The bill being considered by the Texas legislature differs from H.R. 4277 in various respects. In contrast to the federal proposal, which would simply provide an antitrust exemption for collective negotiations, SB 1468 requires some oversight of the negotiating process by the Texas Attorney General. In addition, SB 1468 would limit to 10% the proportion of physicians in a geographic area who could negotiate collectively, unless the Attorney General approved inclusion of a larger number in the group. The bill allows collective negotiation of certain types of fee-related issues only where the Attorney General determines that the health plan has substantial market power.

It is not clear, however, to what extent these differences would reduce the potential for anticompetitive effects otherwise likely to arise from the authorization of collective bargaining among competing physicians. For example, the provision in Section 29.09(b) that no joint negotiation shall represent more than 10% of the licensed physicians in a defined

geographic area provides no significant limitation on the aggregation of bargaining power by many types of physician groups. For many medical specialities, a group including *all* the physicians in a particular speciality or subspeciality would constitute less than 10% of all licensed physicians, and their combination in a single bargaining group could give them significant market power over health plans.[2] Although the bill permits the Attorney General to raise or lower the percentage in particular cases, it does not provide any standards to guide the Attorney General's decision. It is unclear, for example, whether the bill's intent is that the Attorney General limit bargaining groups to 10% of a properly defined antitrust market. Without such a limitation, the 10% cap on the size of physician bargaining groups does not protect against the risk of substantial consumer harm.

Second, it is not clear to what extent the bill's use of a health plan market power screen for some types of collective bargaining would limit potential consumer harm. The bill prohibits collective negotiation on certain specified fee-related issues, unless the Attorney General determines that a health plan with which physicians are negotiating possesses "substantial market power." However, the bill provides no standard for determining when substantial market power will be deemed to exist. We are uncertain whether the intent is to have the Attorney General apply established antitrust principles of market power analysis, or whether the reference in the bill's preamble to "imbalances" in bargaining power suggests some other approach that would compare the bargaining power of a plan to that of an individual physician. In addition, the scope of arrangements to which the market power screen applies is limited. For example, negotiating over formulation and application of physician reimbursement methodology is not subject to the requirement that the health plan have substantial market power, though such matters plainly can have a direct and substantial effect on fee levels. Collective negotiation about other "non-price" issues also can have a substantial effect on the cost of services that the plan covers, as well as limiting the options available to plans to meet consumer demand for high-quality and affordable health insurance.

Third, the bill imposes substantial responsibilities on the Attorney General that could be difficult to carry out given the time frames provided in the bill and the fact-intensive nature of the issues. Moreover, we note that the regulatory scheme established by the bill contains no mechanism for members of the public, or others who stand to be affected by the Attorney General's decision, to offer evidence and views pertaining to the costs and benefits of the proposal or any of the underlying issues. In addition, the bill provides little guidance as to how the discretion granted to the Attorney General is to be exercised. For example, section 29.09(b) of the bill directs the Attorney General to approve a request to enter into joint negotiation or a proposed contract if the applicants demonstrate that "the likely benefits resulting from the joint negotiation or proposed contact outweigh the disadvantages attributable to a reduction in competition" that may result, but it provides no criteria to guide the Attorney General in evaluating benefits or disadvantages, or in weighing one against the other.[3]

We hope you find these comments helpful. Should you have any additional questions concerning this issue, please contact Richard Feinstein at 202-326 3688.

Sincerely yours,

William J. Baer

Enclosure

---

1. This letter represents the views of the staff of the Bureau of Competition of the Federal Trade Commission and does not necessarily represent the views of the Commission or any individual Commissioner.

2. Physicians differ as to specialities and these individual specialties may constitute different product markets.

Moreover, relevant geographic markets may differ as to specialty.

3. The nature of the oversight actually exercised by the Attorney General is important to the question whether private parties acting pursuant to the statute would be exempt from the federal antitrust laws by virtue of the "state action doctrine." The "state action doctrine" allows a state to override the national policy favoring competition where the state legislature clearly articulates a policy to displace competition with regulation, and state officials actively supervise private anticompetitive conduct. *See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). The active supervision requirement "is designed to ensure that the state action doctrine will shelter only the particular anticompetitive acts of private parties that in the judgment of the State, actually further state regulatory policies." *Patrick v. Burget*, 486 U.S. 94, 100 (1988). The question to be addressed in any individual case, therefore, is "whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S.621, 634-35 (1992). We note in particular that Section 29.09(c) of the bill provides that an approval of the initial filing for authorization to bargain collectively covers all subsequent negotiations between the parties, apparently without regard to whether circumstances have changed such that the subsequent bargaining might no longer qualify for approval.

SB256

Elizabeth Helder
Phone: 202-326-2545
FAX: 202-326-3384
Bureau of Competition
Federal Trade Commission
Washington, D.C. 20580

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20589

Bureau of Competition

Richard A. Feinstein
Assistant Director

Direct Dial
(202) 326-3688

October 29, 1999

Robert R. Rigsby
Interim Corporation Counsel
Office of the Corporation Counsel
Government of the District of Columbia
441 Fourth Street, N.W., Tenth Floor North
Washington, D.C. 20001

Re: Physicians Negotiation Act of 1999

Dear Mr. Rigsby:

This letter is a response to your request for comment by Federal Trade Commission staff on the "Physicians Negotiation Act of 1999," Bill No. 13-333 in the District of Columbia Council. This bill is intended to permit competing physicians to engage in collective bargaining with health plans. As is discussed below, the Commission has opposed enactment of a bill currently before Congress, H.R. 1304, that would create an antitrust exemption for collective negotiations between health care providers and health plans. Such an exemption, the Commission stated, will not ensure better care for patients, and threatens to raise health care costs and reduce access to care. In my view, the District of Columbia proposal raises similar concerns.

In addition, it is doubtful that the D.C. bill in its current form would immunize physicians from liability for conduct that violates the federal antitrust laws. State economic regulation can immunize private parties from federal antitrust liability, but only where it satisfies the requirements of the "state action" doctrine. It is unclear whether enactments of the District of Columbia Council would be treated as equivalent to statutes of a state legislature for purposes of the state action doctrine. Moreover, even assuming the Council has the ability to confer state action immunity, the level of governmental involvement called for in the bill falls far short of the "active state supervision" that the Supreme Court has required to displace federal antitrust law.

Background

Antitrust law already allows doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The Federal Trade Commission and the Department of Justice have issued health care policy statements that emphasize physicians' ability under the antitrust laws to organize networks and other joint arrangements to deal collectively with health plans and other purchasers.[1] In addition, health care professionals can, through their professional societies and other groups, jointly

provide information and express opinions to health plans.[2] Legislative proposals to permit collective bargaining by health care professionals, however, such as the one pending in the District of Columbia, seek to authorize conduct that would otherwise constitute unlawful price fixing or other serious antitrust violations.

The Commission's June 1999 testimony on H.R. 1304 before the House Judiciary Committee explains its opposition to creating an antitrust exemption to allow otherwise unlawful collective bargaining by competing health care providers. The Commission's belief that such an exemption could cause serious harm -- to consumers, employers who provide health care coverage for employees, and to federal, state, and local governments -- is based on its experience investigating the effects of numerous instances of collective bargaining by competing health care providers. For example, the Commission, after a joint investigation with the Commonwealth of Virginia, issued a consent order settling charges that a group of physicians in Danville, Virginia, agreed on reimbursement rates and other terms of dealing with health plans, and agreed not to deal with plans that did not meet those terms.[3] The Commonwealth of Virginia collected $170,000 in damages and penalties for the increased costs the state was forced to bear in providing health care benefits to its employees as a result of the physician group's conduct.[4] Likewise, the Commission took enforcement action against collective fee demands by pharmacists in the State of New York that cost the state an estimated $7 million in increased health benefits costs for state employees.[5]

Without antitrust enforcement to block such price fixing, the Commission stated, "we can expect prices for health care services to rise substantially." Raising health care costs and making health insurance less affordable, the testimony observed, threatens to increase the already substantial uninsured population, and thereby reduce access to health care services. In addition, the Commission noted that the exemption could also allow physicians to collectively demand terms from health plans that would make it difficult for consumers to choose to obtain services from allied health care providers, such as nurse-midwives.

The Commission emphasized that immunizing collective bargaining would impose costs without any guarantee that patients' interests in quality care would be served:

> 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.[6]

The Commission's testimony also pointed out that other approaches to improve quality and protect consumers have been proposed that would not sacrifice the benefits of competition by granting collective bargaining rights to health care professionals, and briefly described some of those proposals. A copy of the testimony (Attachment A) is enclosed for your information.

I am also enclosing a copy of a letter from FTC staff discussing a collective bargaining bill in Texas (Attachment B). The letter notes that the Texas bill, while different in certain respects from the federal proposal, still carries substantial potential for consumer harm.

The District of Columbia Bill

The District of Columbia bill closely follows model state legislation on physician collective negotiations developed by the American Medical Association. In fact, the bill appears to adopt all of the provisions of the AMA model except Section 1, which is a declaration of legislative purpose. I will first discuss a few issues regarding the scope of conduct the bill seeks to authorize, and then analyze the question whether the bill would be effective in creating immunity from federal antitrust law for private parties acting pursuant to its provisions.

The Scope of Permitted Conduct

The collective bargaining permitted by the bill is subject to certain limitations not present in the federal proposal, but these limitations are ambiguous in some important respects. As a result, it is difficult to ascertain the precise scope of conduct that the bill would seek to authorize. In any event, however, the two primary ways that the bill limits collective bargaining -- the market share limitations and the ban on boycotts -- appear to leave consumers at risk of substantial harm.

First, the bill's reach depends in part on market shares of health plans and, to a lesser extent, physician groups. It authorizes collective negotiation with health plans, but negotiation over certain price-related terms is limited to situations in which the health plan has "substantial market power," which, under the bill's terms, exists when a health plan's market share exceeds 15%. In addition, under section 5(f), where a health plan has less than a 5% market share, the physician group may not exceed 30% of physicians (or of a particular physician type or specialty) in the health plan service area.

Although the bill appears to make the concept of market power an important limitation on some forms of collective bargaining, it is unclear how market shares are to be delineated or applied. According to the bill, substantial market power exists if the health plan has a 15% share of any of the following: (1) the number of covered lives as reported by the insurance commissioner; (2) the actual number of consumers of prepaid comprehensive health services; or (3) a particular "market segment," to wit: "Medicare, Medicaid, or commercial, managed care and health maintenance organization." Although category (1) appears straightforward, it is unclear to us what is intended by the other two categories. Moreover, it is not clear what geographic area would be used to calculate market shares, at least with respect to categories (2) and (3), or which payers are to be included in the market share calculations.

Aside from the ambiguity, however, the bill's provisions are not based on accepted concepts of market power in a legal or economic sense. Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only if based upon a properly defined market. Even if the bill's categories correctly identified relevant markets, a 15% market share (let alone a share above 5%) is not a level ordinarily presumed to constitute market power.[7] In addition, the bill does not take into account ease of entry in assessing market power, as antitrust analysis ordinarily would.

The limitation on the "market share" of physician groups negotiating with small health plans (which sets a higher threshold for physician market power than for health plan market power) also does not reflect market power, and may understate the economic clout of a physician group. The 30% share limitation is based on the portion of physicians "in

the health plan service area or proposed service area." There is no reason, however, to expect that a health plan service area would necessarily represent an appropriate geographic market for the physician services in question. Indeed, geographic markets for physician services may vary by specialty. A health plan service area could well be broader that the geographic market for physician services, with the result that the 30% cap would not prevent aggregation of physicians with substantial market power within the service area negotiating with very small health plans.

The other major limitation in the bill, section 2(b), which provides that "Nothing herein shall be construed to allow a boycott," also raises significant questions of interpretation and may not offer significant protection to consumers. First, its wording and placement could be read to suggest that the limitation applies only to the conduct authorized in Section 2, rather than the entire bill. If that were the case, other sections of the bill could permit physicians to engage in boycotts. Second, the term "boycott" has been subject to varying interpretations, in some cases being understood as collective refusals to deal to force a party to accept terms, and in others limited to refusals to deal with third parties to pressure another party with whom the group has a dispute.[8] It is unclear whether the bill is intended to bar agreements not to deal with health plans except on collectively-determined terms, or whether it would only prohibit agreements to withhold services from third parties (patients or others), in order to pressure health plans to accede to the contract terms demanded by the physician group.

The federal collective bargaining bill excludes from its authorization "collective cessation of services to patients" (*i.e.*, boycotts in the narrow sense), and the Commission in its testimony (p.8) observed that "this limitation takes virtually nothing away from the coercive power the bill grants to providers." Furthermore, as the testimony explains, a collective refusal to contract, if it did not force the health plan to capitulate to physician demands for fee increases, could result in patients' having to pay medical bills out of their own pockets, and thus would impose formidable obstacles to patients seeking care.

Even if it were clear that the D.C. bill would not protect physicians' concerted refusals to deal with health plans, however, its authorization of collective bargaining would still present a serious risk of anticompetitive harm. As the Commission has previously observed, collective negotiations by their very nature can convey an implicit threat that if the health plan does not agree to terms acceptable to the physician group, the plan will be unable to obtain agreements with group members.[9] By immunizing, and thereby encouraging, agreements among physicians on the prices and other terms they will accept from health plans, the bill would facilitate coordinated conduct among physicians, such as collusive refusals to deal that, even though not immune, would be difficult to detect and prosecute. I would also note that the analysis that accompanies the AMA model legislation makes it clear that the bill's purpose is to allow physicians to exert "leverage" over payers in order to obtain more favorable terms. Thus, excluding concerted refusals to contract from the bill's protections would not appear to eliminate the coercive force of collective bargaining, or obviate concerns that the bill would increase the likelihood of concerted refusals to contract.

I would also note that the analysis in the AMA model states that Section 2 allows physicians to discuss managed care contract terms "free from the antitrust risk that normally accompanies such collaborative activity." You may wish to advise Council members that the antitrust laws do not prohibit the mere discussion of issues such as those enumerated in Section 2 unaccompanied by agreements on the terms on which the

physicians will deal.

Immunity Issues

Under the judicially-created "state action" doctrine, states may override the national policy favoring competition and provide that aspects of their economies will be governed by state regulation rather than market forces. States, however, may not simply authorize private parties to violate the antitrust laws.[10] Instead, a state must substitute its own control for that of the market. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct. *See California Retail Liquor Dealers Assen v. Midcal Aluminum, Inc.*, 445 U.S. 92 (1980).

A threshold issue is whether the District of Columbia is equivalent to a state for purposes of the state action doctrine, or otherwise has the ability under federal law to create antitrust immunity for private parties. I am not aware of any controlling authority on the question, and I am not in a position to offer an opinion.[11] It is, of course, a key question to be resolved, because if the Council lacks authority to create antitrust immunity through adoption of a regulatory scheme, physicians acting in reliance on the bill would be exposed to significant risk of antitrust liability.

Assuming, however, that the Council has the authority to create state action immunity, the critical question is whether the bill establishes a scheme with sufficiently active state supervision of private conduct to satisfy the second prong of the state action test. The bill's authorization of collective bargaining appears to satisfy the requirement of a state policy to supplant competition. But in order for state supervision to be adequate for state action purposes, state officials must "have and exercise ultimate control over the challenged anticompetitive conduct." *Patrick v. Burget*, 486 U.S. 94, 100 (1988). On this second requirement for immunity, the bill falls far short.

Section 6 of the bill provides that the representative who will negotiate on behalf of physicians must obtain approval from the Mayor to undertake negotiations. The Mayor is to withhold approval if "the proposed negotiations would exceed the authority granted under this act." Section 6(b). The Mayor is to make this determination within 30 days based on information identifying the representative, its plans and procedures, and "a brief report" identifying the proposed subject matter of the negotiations and the expected benefits to be achieved. In addition, the representative must furnish for the Mayor's approval, prior to dissemination, a copy of "all communications to be made to physicians related to negotiations, discussions, and health plan offers." The bill does not grant the Mayor the power to review and disapprove contract terms or other matters on the ground that they are unreasonable, unjust, or otherwise contrary to the interests of consumers.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own." *Patrick* at 106. It is not met where the reviewing state official does not evaluate the substantive merits of the private action. *Id.* at 102-105. Thus, the Court has held that a state did not actively supervise price arrangements when it did not establish the prices, review the reasonableness of prices, monitor market conditions, or engage in any "pointed reexamination" of the program. *Midcal*, 445 U.S. at 105-106. Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of

the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S.621, 634-35 (1992).

The apparently limited nature of the Mayor's authority to review and approve the authorized private conduct alone makes the bill on its face inadequate to establish active supervision. Other aspects of the bill also raise questions as to the adequacy of supervision. For example, the limited nature of information that a physician representative must provide to obtain approval would raise questions as to the extent to which government officials have exercised "sufficient independent judgment and control." Indeed, it is unclear that the Mayor would even have sufficient information to determine whether the group's negotiations complied with the market share limitations of the bill. In addition, the bill's failure to specify a standard against which the Mayor would evaluate proposed collective bargaining activities further suggests that no substantive review is contemplated.

Parties claiming immunity under the state action doctrine bear the burden of establishing that they are entitled to such immunity. Thus, should the Council desire to go forward with a collective bargaining bill, it will be important to ensure that the bill establishes a regulatory scheme that meets the rigorous requirements that the Supreme Court has established. Otherwise, physicians relying on the bill's provisions to provide antitrust immunity would risk exposure to potentially significant financial liability for their actions.

* * *

I hope you find these comments helpful. The views expressed in this letter, of course, do not necessarily represent the views of the Commission or any individual Commissioner. Should you have any additional questions, feel free to contact me at 202-326-3688.

Sincerely,

Richard A. Feinstein
Assistant Director

Attachments

Endnotes

1. *See* Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (August 1996) (available at www.ftc.gov/reports/hlth3s.htm).

2. *See, e.g., Schachar v. American Academy of Ophthalmology*, 870 F.2d 397 (7th Cir. 1989); Statements 4 & 5 of Statements of Antitrust Enforcement Policy in Health Care, *supra* note 1.

3. Physicians Group, Inc., 120 F.T.C. 567 (1995) (consent order).

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

5. *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).

6. Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 21, 1999) at 10.

7. *See, e.g.*, Statement 8 of Statements of Antitrust Enforcement Policy in Health Care, *supra* note 1 (establishing antitrust "safety zone" for physician network joint ventures that constitute 20 percent or less of the physicians in each physician specialty in the relevant geographic market)

8. See *Hartford Fire Insurance Co. v. California*, 509 U.S. 764 (1993). In *Hartford*, which construed the meaning of the term "boycott" for purposes of the McCarran-Ferguson Act, Justice Scalia, writing for the majority, distinguished between boycotts and "concerted agreements to seek particular terms in particular transactions," which he termed "cartelization." *Id.* at 801-802. A boycott, Justice Scalia wrote, is limited to a refusal to deal with a party in order to obtain an objective collateral to the boycotters' relationship with that party. *Id.* at 801. He also pointed to a distinction in labor law between a strike, *i.e.*, a collective refusal to deal with an employer to obtain better contract terms from that employer, and a boycott, involving a work stoppage designed to put pressure on some other employer.

9. *See* Michigan State Medical Society, 101 F.T.C. 191, 296 n.32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); *see also* Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations)..

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

11. In *American Telephone & Telegraph Co. v. Eastern Pay Phones*, Inc.., 767 F. Supp. 1335 (E.D. Va. 1991), the court ruled that a regulatory scheme of the District of Columbia did not provide state action immunity, without discussing whether the District stands on the same footing as states with respect to the state action doctrine. An earlier case (arising prior to Congress' grant to the District of home rule powers) involving the District of Columbia Armory Board, a governmental entity, evaluated antitrust immunity claims with reference the Board's federal enabling legislation. *See Hecht v. Pro-Football, Inc.*, 444 F.2d 931 (D.C. Cir 1971).

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

Bureau of Competition

Richard A. Feinstein
Assistant Director

Direct Dial
(202) 326-3688

February 23, 2000

Representative John W. Turner
Minority Spokesman
House Judiciary Committee, Civil Law
Illinois House of Representatives
2139-O Stratton Building
Springfield, Illinois 62706

Re: Illinois House Bill 4478

Dear Mr. Turner:

This letter responds to your request for comment on HB 4478, a bill to authorize competing health care providers to engage in collective bargaining with health plans over fees and other terms. Given your desire to receive our response before a hearing on the bill scheduled for February 24th, my comments necessarily will be brief.

At the federal level, the Commission has opposed enactment of an antitrust exemption for collective bargaining between health care providers and health plans, concluding that such an exemption would not ensure better care for patients, and would threaten to increase health care costs and reduce access to care. FTC staff comments analyzing physician collective bargaining bills introduced in Texas and the District of Columbia (bills similar in a number respects to HR 4478) noted those bills raise concerns of consumer harm similar to those expressed by the Commission regarding the federal proposal. I have enclosed for your information the Commission's June 1999 testimony on the federal bill, H.R. 1304, and the FTC staff letters on the Texas and D.C. bills.

The Commission's testimony in opposition to the federal collective bargaining bill makes three fundamental points that may be of interest in your consideration of HB 4478:

- Discussions between health care professionals and health plans are not illegal under current antitrust law. Health care professionals can, through their professional societies and other groups, jointly provide information and express opinions to health plans. An exemption for collective bargaining by health care professionals, however, would allow conduct that would otherwise constitute unlawful price fixing or other serious antitrust

violations.

- The Commission's experience investigating numerous cases of collective bargaining by competing health care providers has shown that an antitrust exemption for such joint negotiations would harm consumers, employers, and federal, state, and local governments. For example, collective fee demands by pharmacists in the State of New York cost the state an estimated $7 million in increased health benefits costs for state employees.[1]

- An antitrust exemption for collective bargaining is not the way to improve health care quality. Immunizing collective bargaining imposes costs without any guarantee that patients' interests in quality care would be served. As the Commission's testimony states:

> 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.[2]

In addition, the letters on the Texas and D.C. bills may be of particular interest to you because of similarities between HB 4478 and those bills. For example, each of those bills limits collective bargaining over fees to instances in which the health plan has "substantial market power," which both HB 4478 and the D.C. bill define as a market share in excess of 15 percent. As the letter on the D.C. bill (at p. 4) notes, however, there are significant problems with equating a health plan's market share above15 percent with "substantial market power":

> Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only if based upon a properly defined market. Even if the bill's categories correctly identified relevant markets, a 15% market share . . . is not a level ordinarily presumed to constitute market power.

Likewise, the letters on the Texas and D.C. bills note that a limitation on the size of physician bargaining groups (also contained in HB 4478) would not be meaningful if it (a) does not bar the

---

[1] *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).

[2] Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 21, 1999) at 10.

aggregation of a large portion of physicians in a given *specialty*, as opposed to all physicians; and (b) assesses market share in a geographic area that bears no necessary relation to a true antitrust geographic market for the physician services in question. Thus, the letters conclude, the caps on the size of the bargaining group would not prevent consumer harm. Finally, the letter on the D.C. bill explains (at p. 4-5) that a provision expressly excluding boycotts from the bill's protections (similar to Section 25(e) of HB 4478) still leaves consumers exposed to substantial risk of injury from anticompetitive behavior by bargaining groups.

I hope you find these brief comments helpful. The views expressed in this letter, of course, do not necessarily represent the views of the Commission or any individual Commissioner. Should you have any additional questions, feel free to contact me at 202-326-3688.

Sincerely,

Richard A. Feinstein

Richard A. Feinstein
Assistant Director

Enclosures

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

Bureau of Competition
William J. Baer, Director
Direct Dial
(202) 326-2932

May 13, 1999

The Honorable Rene O. Oliveira
Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Representative Oliveira:

The Bureau of Competition of the Federal Trade Commission is pleased to respond to your request, dated May 5, 1999, for comment on Senate Bill 1468, "An Act Relating to the Regulation of Physician Joint Negotiation" (SB 1468), which currently is being considered by the Texas legislature.(1) The bill would permit competing physicians to jointly negotiate contractual terms with health plans under certain circumstances. Our understanding is that SB 1468 has been adopted by the Texas Senate, and that a vote on a similar measure is expected in the House of Representatives in the very near future. Given the limited time available, we highlight three concerns about the bill, but are not able to provide a complete analysis of all the issues that the bill raises.

The Commission has previously expressed serious concerns about the impact on consumer welfare of a federal proposal to enact an antitrust exemption intended to authorize collective negotiation between health service practitioners and health plans. In testimony before the Committee on the Judiciary of the United States House of Representatives in July 1998, the Commission opposed enactment of H.R. 4277, the "Quality Health-Care Coalition Act of 1998." The Commission stated that the exemption would immunize "a broad range of anticompetitive joint conduct by physicians and other health care professionals that could seriously harm consumers and undermine efforts to promote high-quality, cost-effective health care for consumers." Furthermore, the Commission pointed out, the exemption would impair innovation in health care financing and delivery, and reduce choices among alternative health plans. Finally, the Commission noted that an antitrust exemption is not needed in order to allow physicians collectively to express their concerns about patient care and quality of care issues that may arise from their participation in managed care plans, or to permit them to enter into joint ventures that can offer better alternatives to patients or to health plans. A copy of the Commission's testimony is enclosed for your information.

The bill being considered by the Texas legislature differs from H.R. 4277 in various respects. In contrast to the federal proposal, which would simply provide an antitrust exemption for collective negotiations, SB 1468 requires some oversight of the negotiating process by the Texas Attorney General. In addition, SB 1468 would limit to 10% the proportion of physicians in a geographic area who could negotiate collectively, unless the Attorney General approved inclusion of a larger number in the group. The bill allows collective negotiation of certain types of fee-related issues only where the Attorney General determines that the health plan has substantial market power.

It is not clear, however, to what extent these differences would reduce the potential for anticompetitive effects otherwise likely to arise from the authorization of collective bargaining among competing physicians. For example, the provision in Section 29.09(b) that no joint negotiation shall represent more than 10% of the licensed physicians in a defined geographic area provides no significant limitation on the aggregation of bargaining power by many types of physician groups. For many medical specialities, a group including *all* the physicians in a particular speciality or subspeciality would constitute less than 10% of all licensed physicians, and their combination in a single bargaining group could give them significant market power over health plans.[2] Although the bill permits the Attorney General to raise or lower the percentage in particular cases, it does not provide any standards to guide the Attorney General's decision. It is unclear, for example, whether the bill's intent is that the Attorney General limit bargaining groups to 10% of a properly defined antitrust market. Without such a limitation, the 10% cap on the size of physician bargaining groups does not protect against the risk of substantial consumer harm.

Second, it is not clear to what extent the bill's use of a health plan market power screen for some types of collective bargaining would limit potential consumer harm. The bill prohibits collective negotiation on certain specified fee-related issues, unless the Attorney General determines that a health plan with which physicians are negotiating possesses "substantial market power." However, the bill provides no standard for determining when substantial market power will be deemed to exist. We are uncertain whether the intent is to have the Attorney General apply established antitrust principles of market power analysis, or whether the reference in the bill's preamble to "imbalances" in bargaining power suggests some other approach that would compare the bargaining power of a plan to that of an individual physician. In addition, the scope of arrangements to which the market power screen applies is limited. For example, negotiating over formulation and application of physician reimbursement methodology is not subject to the requirement that the health plan have substantial market power, though such matters plainly can have a direct and substantial effect on fee levels. Collective negotiation about other "non-price" issues also can have a substantial effect on the cost of services that the plan covers, as well as limiting the options available to plans to meet consumer demand for high-quality and affordable health insurance.

Third, the bill imposes substantial responsibilities on the Attorney General that could be difficult to carry out given the time frames provided in the bill and the fact-intensive nature of the issues. Moreover, we note that the regulatory scheme established by the bill contains no mechanism for members of the public, or others who stand to be affected by the Attorney General's decision, to offer evidence and views pertaining to the costs and benefits of the proposal or any of the underlying issues. In addition, the bill provides little guidance as to how the discretion granted to the Attorney General is to be exercised. For example, section 29.09(h) of the bill directs the Attorney General to approve a request to enter into joint negotiation or a proposed contract if the applicants demonstrate that "the likely benefits resulting from the joint negotiation or proposed contact outweigh the disadvantages attributable to a reduction in competition" that may result, but it provides no criteria to guide the Attorney General in evaluating benefits or disadvantages, or in weighing one against the other.[3]

We hope you find these comments helpful. Should you have any additional questions concerning this issue, please contact Richard Feinstein at 202-326 3688.

Sincerely yours,

William J. Baer

Enclosure

---

1. This letter represents the views of the staff of the Bureau of Competition of the Federal Trade Commission and does not necessarily represent the views of the Commission or any individual Commissioner.

2. Physicians differ as to specialities and these individual specialties may constitute different product markets. Moreover, relevant geographic markets may differ as to specialty.

3. The nature of the oversight actually exercised by the Attorney General is important to the question whether private parties acting pursuant to the statute would be exempt from the federal antitrust laws by virtue of the "state action doctrine." The "state action doctrine" allows a state to override the national policy favoring competition where the state legislature clearly articulates a policy to displace competition with regulation, and state officials actively supervise private anticompetitive conduct. *See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). The active supervision requirement "is designed to ensure that the state action doctrine will shelter only the particular anticompetitive acts of private parties that in the judgment of the State, actually further state regulatory policies." *Patrick v. Burget*, 486 U.S. 94, 100 (1988). The question to be addressed in any individual case, therefore, is "whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S.621, 634-35 (1992). We note in particular that Section 29.09(c) of the bill prov s that an approval of the initial filing for authorization to bargain collectively covers all subsequent negotiati between the parties, apparently without regard to whether circumstances have changed such that the s ent bargaining might no longer qualify for approval.

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

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:

- 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 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.

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 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 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 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 "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 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.

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 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 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 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 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 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.

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.

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.[36] 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 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.

---

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.

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

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).

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

5. *Id.* at 234-35.

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 (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).

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.

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.

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).

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 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*).

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.

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).

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/reports/hlth3v.htm).

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

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).

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).

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.[35]

35. Report at 3-4.

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

Federal Trade Commission
IPA Investigation

Analysis

by

Integrated Medical Practices, LLP

Gary B. Schwartz, MPH
and
Angel L. Fields
PRACTICE CONSULTANTS
Established in 2000
(907) 452-3772

January 1, 2000

SB 256

Post-it® Fax Note 7671	Date 3/2
To (S) FINANCE	From FBKS UA
Co./Dept	Co
Phone #	Phone #
Fax # 465-4779	Fax #

FEDERAL TRADE COMMISSION INVESTIGATION OF THE ALASKA HEALTHCARE NETWORK, INC. "WITHOUT MERIT"

The Alaska Healthcare Network, Inc. ("AHN") should be shielded from the Federal Trade Commission ("FTC") challenges of unlawful competitive practices since the physician network: 1) is a "non-exclusive" entity whose members contract individually with health plans and who may affiliate with other networks, 2) has never negotiated prices for the provision of health and medical care services with third party insurance carriers, 3) has not collectively refused to deal with third party carriers, 4) has never disclosed the fees of competing medical practices to one another, and 5) has met or exceeded antitrust safety zones or safe harbor provisions that would not be contested under the antitrust laws. Physician service integration through AHN has resulted in improved quality care, access to multi-specialty medical disciplines, and significant efficiencies that should be analyzed under the rule of reason.

The FTC should encourage AHN's efforts with third party insurance carriers who do not have adequate resources to individually contract with physicians and have limited market penetration in the Fairbanks region. AHN performance of delegated administrative services at no cost to the carriers and the provision of RBRVS median fee information to the carriers has been useful and appreciated. According to FTC enforcement policies "a network that uses an outside agent to collect and analyze fee data from physicians for use in developing the network's fee schedule, and avoids the sharing of such sensitive information among the network's physician participants, may reduce concerns that the information could be used by the network's physician participants to set prices for services they provide outside the network". The AHN median fees provided by an administrative agent of the network were considered by the insurance carriers in preparing their fee offers which were subsequently "messaged" by the non-physician administrator to the individual AHN medical practices.

Since AHN is not currently involved in financial risk (no health benefit plan offers risk contracting in Fairbanks), it is incumbent upon the Network to integrate economically and clinically to create significant efficiencies and never to discuss physician fees or health plan fee offers among the AHN physician participants.

According to FTC antitrust guidelines "physician network joint ventures that do not involve the sharing of substantial financial risk may be lawful if the physicians' integration through the joint venture creates significant efficiencies and the venture, on balance, is not anti-competitive". Examples of possible cost savings methodologies available to physician networks include "improved cost controls, case management and quality assurance, economies of scale, and reduced administrative or transaction costs".

AHN creates efficiencies through its group purchasing programs for medical liability coverage, clinic equipment and supplies, and clinic waste disposal. This economic integration results in substantive cost savings due to economies of scale and reduction of

transaction costs. Further cost savings are available to the AHN affiliated medical practices if they elect to purchase the Medic computer system recommended by AHN.

AHN is clinically integrating with its affiliated medical practices by implementing quality care programs and reviewing appropriate service utilization by AHN physicians. AHN will evaluate individual physician participants' and the network's aggregate performance consistent with clinical guidelines adopted by the network (quality goals and outcomes). These clinical guidelines impact the treatment and utilization of services, and will be used as benchmarks in evaluating individual practitioners and network aggregate performance. In time, physician practice patterns may be modified based on the evaluation of AHN's medical director and the Utilization Management and Quality Improvement Committee.

In cooperation with Aetna US Healthcare, AHN and its participating medical practices are currently involved in physician credentialing, case management, pre-authorization of some medical and institutional services, and retrospective service review. AHN has developed a formulary which is cost effective, efficacious, and reflects prescribing patterns by the physicians in Fairbanks.

There are barriers to fully integrating clinical services among the AHN affiliated medical practices. Differing opinions among physician members regarding the functionality of a case management information system and more importantly the amount of capital ($350,000 plus) to purchase an information system necessary to collect and analyze physician and institutional data on the quality, cost, quantity, and services provided or referred by AHN physicians; to perform claims processing and adjudication; to monitor performance of the AHN affiliated medical practices and individual physicians against quality and cost benchmarks; and evaluate patient satisfaction. AHN will provide payers with detailed reports on the cost and quantity of services provided, and on the network's success in meeting quality, cost effectiveness, and access goals.

AHN has an agreement with a part time medical director (independent contractor) to perform quality care and service utilization activities. The AHN medical director's responsibilities (see attached position description) was made available to the FTC and fully discussed with FTC attorneys by AHN's Executive Director.

This position paper represents the views of Gary B. Schwartz, MPH who served as Executive Director of the Alaska Healthcare Network since its establishment in 1996 until 2000.

ALASKA HEALTHCARE NETWORK, INC.

Position: Medical Director

Qualifications: The Medical Director shall be a physician member of Alaska Healthcare Network, Inc. (AHN) with general knowledge in all fields of medicine and appropriate managerial skills to make decisions on joint practice matters effecting the quality and delivery of medical services.

Authority: The Medical Director, at the discretion of the AHN Board of Directors, is granted ultimate authority over the development and implementation of measures which assure the provision of high quality, cost effective medical services by the AHN participating physicians. The Medical Director will report to the Board of Directors.

Responsibilities:

1. Develop and provide medical supervision and direction over quality assurance programs, case management, and utilization review activities undertaken by the AHN Board of Directors and the Quality Improvement Committee.

2. Provide education to AHN member physicians regarding the efficient utilization of health care resources and implementation of health care guidelines.

3. Provide medical expertise and, if necessary, intervention in resolving difficult or questionable practices with respect to primary care delivery and/or specialty referral services.

4. Determine the appropriateness of specialty referral, addressing medical necessity, scope of services, and procedures to be provided within and external to the network.

5. Provide medical authorization (approval or denial) of specialty referral and claims payment external to the network.

6. Determine financial liability for unauthorized referrals or care provided beyond the scope of AHN responsibility.

7. Serve as medical liaison and arbitrator in respect to all AHN third party contracts where quality and delivery of medical services is concerned.

8. Attend and participate in all meetings of the AHN Members, Board of Directors, and the Utilization Management and Quality Improvement Committee as practical and appropriate.

9. Develop physician membership criteria for acceptance in AHN and oversee the development and implementation of the credentialing program.

Adopted by the AHN
Board of Directors

SB 256

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of

NORTH LAKE TAHOE MEDICAL GROUP, INC., a corporation.

File No. 981-0261

AGREEMENT CONTAINING CONSENT ORDER TO CEASE AND DESIST

The Federal Trade Commission ("Commission") having initiated an investigation of certain acts and practices of North Lake Tahoe Medical Group, Inc. ("Tahoe IPA"), hereinafter sometimes referred to as "proposed respondent," and it now appearing that proposed respondent is willing to enter into an agreement containing an order to cease and desist from those acts and practices, and providing for other relief,

IT IS HEREBY AGREED by and between Tahoe IPA, by its duly authorized officer and its attorney, and counsel for the Commission that:

1. Proposed respondent North Lake Tahoe Medical Group, Inc. is a corporation organized, existing, and doing business under and by virtue of the laws of the State of California, with its office and principal place of business located at P.O. Box 2466, Truckee, California 96160. North Lake Tahoe Medical Group, Inc., also has traded and done business as North Lake Tahoe IPA, North Lake IPA, and Tahoe IPA.

2. Proposed respondent admits all the jurisdictional facts set forth in the draft of complaint here attached.

3. Proposed respondent waives:

(a) Any further procedural steps;

(b) The requirement that the Commission's decision contain a statement of findings of fact and conclusions of law;

(c) All rights to seek judicial review or otherwise to challenge or contest the validity of the order entered pursuant to this agreement; and

(d) Any claim under the Equal Access to Justice Act.

4. This agreement shall not become part of the public record of the proceeding unless and until it is accepted by the Commission. If this agreement is accepted by the Commission it, together with the draft of complaint contemplated thereby, will be placed on the public record for a period of sixty (60) days and information in respect thereto publicly released. The Commission thereafter may either withdraw its acceptance of this agreement and so notify the proposed respondent, in which event it will take such action as it may consider appropriate, or issue and serve its complaint (in such form as the circumstances may require) and decision, in disposition of the proceeding.

5. Proposed respondent shall submit within thirty (30) days of the date that proposed respondent signs this agreement, and every thirty (30) days thereafter until the order becomes final, a report, pursuant to § 2.33 of the Commission's Rules, signed by the proposed respondent setting forth in detail the manner in which the proposed respondent is complying and will comply with the order when and if entered. Such reports will not become part of the public record unless and until the accompanying agreement and order are accepted by the Commission for public comment.

6. This agreement is for settlement purposes only and does not constitute an admission by proposed respondent that the law has been violated as alleged in the draft of complaint here attached, or that the facts as alleged in the draft complaint, other than jurisdictional facts, are true.

7. This agreement contemplates that, if it is accepted by the Commission, and if such acceptance is not subsequently withdrawn by the Commission pursuant to the provisions of § 2.34 of the Commission's Rules, the Commission may, without further notice to proposed respondent, (1) issue its complaint corresponding in form and substance with the draft of complaint here attached and its decision containing the following order to cease and desist in disposition of the proceeding and (2) make information public in respect thereto. When so entered, the order shall have the same force and effect and may be altered, modified, or set aside in the same manner and within the same time provided by statute for other orders. The order shall become final upon service. Delivery by the U.S. Postal Service of the complaint and decision containing the agreed-to order to proposed respondent's address as stated in this agreement shall constitute service. Proposed respondent waives any right it may have to any other manner of service. The complaint may be used in construing the terms of the order, and no agreement, understanding, representation, or interpretation not contained in the order or the agreement may be used to vary or contradict the terms of the order.

8. By signing this agreement containing consent order, proposed respondent represents that the full relief contemplated by this agreement can be accomplished. Proposed respondent has read the proposed complaint and order contemplated hereby. Proposed respondent understands that once the order has been issued, it will be required to file one or more compliance reports showing that it has fully complied with the order. Proposed respondent agrees to comply with the terms of the proposed order from the date it signs this agreement. Proposed respondent further understands that it may be liable for civil penalties in the amount provided by law for each violation of the order after the order becomes final.

ORDER

I.

IT IS ORDERED that, for the purposes of this order, the following definitions shall apply:

A. "Tahoe IPA" means North Lake Tahoe Medical Group, Inc., its directors, officers, employees, agents, representatives, predecessors, successors, and assigns; and its subsidiaries, divisions, groups, affiliates controlled by Tahoe IPA, and the

respective directors, officers, employees, agents, representatives, successors, and assigns of each.

B. "Payer" means any person that purchases, reimburses for, or otherwise pays for all or part of any health care services for itself or for any other person. Payer includes, but is not limited to, any health insurance company; preferred provider organization; prepaid hospital, medical, or other health service plan; health maintenance organization; government health benefits program; employer or other person providing or administering self-insured health benefits programs; and patients who purchase health care for themselves.

C. "Person" means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.

D. "Physician" means a doctor of allopathic medicine ("M.D.") or a doctor of osteopathic medicine ("D.O.").

E. "Participating physician" means any physician: (1) who is a stockholder, owner, or member of Tahoe IPA; (2) who has agreed to provide services through Tahoe IPA; or (3) whose services have been offered to any payer through Tahoe IPA.

F. "Provider" means any person that supplies health care services to any other person, including, but not limited to, physicians, hospitals, and clinics.

G. "Qualified risk-sharing joint arrangement" means an arrangement to provide physician services in which: (1) all physicians participating in the arrangement share substantial financial risk from their participation in the arrangement through: (a) the provision of physician services to payers at a capitated rate, (b) the provision of physician services for a predetermined percentage of premium or revenue from payers, (c) the use of significant financial incentives (e.g., substantial withholds) for its participating physicians, as a group, to achieve specified cost-containment goals, or (d) the provision of a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors; (2) any agreement on prices or terms of reimbursement entered into by the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement; and (3) the arrangement does not restrict the ability, or facilitate the refusal, of physicians participating in the arrangement to deal with payers individually or through any other arrangement.

H. "Qualified clinically integrated joint arrangement" means an arrangement to provide physician services in which: (1) all physicians participating in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, the physicians participating in the arrangement, in order to control costs and ensure quality of the services provided through the arrangement; (2) any agreement on prices or terms of reimbursement entered into by the arrangement is reasonably necessary to obtain significant

efficiencies through the joint arrangement; and (3) the arrangement does not restrict the ability, or facilitate the refusal, of physicians participating in the arrangement to deal with payers individually or through any other arrangement.

I. "Reimbursement" means any payment, whether cash or non-cash, or other benefit received for the provision of physician services.

II.

IT IS FURTHER ORDERED that Tahoe IPA, directly or indirectly, or through any corporate or other device, in connection with the provision of physician services in or affecting commerce, as "commerce" is defined in Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44, cease and desist from:

A Entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding to:

1. Negotiate on behalf of any physicians with any payor or provider for physician services;

2. Deal, or refuse to deal, with any payer or provider;

3. Determine or influence any terms, conditions, or requirements upon which any physician deals, or is willing to deal, with any payer or provider, including, but not limited to, terms of reimbursement; or

4. Restrict the ability of any physician to deal with any payer or provider individually or through any arrangement outside Tahoe IPA.

B. Exchanging, or facilitating the exchange of, information among physicians concerning the terms or conditions, including reimbursement, on which any physician is willing to deal with payers.

C. Encouraging, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited if the person were subject to this order.

PROVIDED that nothing in this order shall be construed to prohibit any agreement or conduct by Tahoe IPA that is reasonably necessary to form, facilitate, manage, operate, or participate in:

a. A qualified risk-sharing joint arrangement; or

b. A qualified clinically integrated joint arrangement, if Tahoe IPA has provided the prior notification(s) as required by this paragraph (b). Such prior notification must be filed with the Secretary of the Commission at least thirty (30) days prior to forming,

facilitating, managing, operating, participating in, or taking any action, other than planning, in furtherance of any joint arrangement requiring such notice ("first waiting period"), and shall include for such arrangement the identity of each participant; the location or area of operation; a copy of the agreement and any supporting organizational documents; a description of its purpose or function; a description of the nature and extent of the integration expected to be achieved, and the anticipated resulting efficiencies; an explanation of the relationship of any agreement on prices, or terms of reimbursement, to furthering the integration and achieving the expected efficiencies; and a description of any procedures proposed to be implemented to limit possible anticompetitive effects resulting from such agreement(s). If, within the first waiting period, a representative of the Commission makes a written request for additional information, Tahoe IPA shall not form, facilitate, manage, operate, participate in, or take any action, other than planning, in furtherance of such joint arrangement until thirty (30) days after substantially complying with such request for additional information ("second waiting period") or such shorter waiting period as may be granted by letter from the Bureau of Competition.

PROVIDED FURTHER, that nothing in this order shall prevent the Tahoe IPA from refusing to transmit any information to less than all of its participating physicians. Notwithstanding this proviso, the IPA shall not require, as a condition of transmitting information to participating physicians or for any other reason, that any offer by a payer or provider be made to all participating physicians or to any particular physician.

III.

IT IS FURTHER ORDERED that Tahoe IPA shall:

A. Within five (5) days after the date this agreement is signed by Tahoe IPA, provide to Blue Shield of California the names and addresses of all participating physicians, and request from Blue Shield of California the names of all participating physicians who either have terminated participation, or have given notice of intent to terminate future participation, in any Blue Shield of California health plan at any time between January 1, 1998, and the date this agreement is signed by Tahoe IPA.

B. Within ten (10) days after Tahoe IPA has received from Blue Shield of California the names and addresses requested in accordance with Paragraph III.A. of this agreement, give notice of the requirements of Paragraph III.C. of this agreement to any participating physician who either has terminated participation, or has given notice of future intent to terminate participation, in any Blue Shield of California health plan at any time between January 1, 1998, and the date this agreement is signed by Tahoe IPA.

C. Within twenty (20) days after Tahoe IPA has received from Blue Shield of California the names and addresses requested in accordance with Paragraph III.A. of this agreement, terminate the participation in Tahoe IPA of any physician who either has terminated participation, or has given notice of intent to terminate future participation, in any Blue Shield of California health plan at any time between January 1, 1998, and the date this agreement is signed by Tahoe IPA, unless any such physician:

1. who has terminated participation in any Blue Shield of California health plan, attempts in good faith to reestablish such participation for a period of at least six (6) months thereafter, or

2. who has given notice of intent to terminate future participation in any Blue Shield of California health plan, rescinds in writing such notice and continues such participation for a period of at least six (6) months thereafter.

IV.

IT IS FURTHER ORDERED that Tahoe IPA shall:

A. Within thirty (30) days after the date on which this order becomes final:

1. Distribute by first-class mail a copy of this order and the complaint to each participating physician, officer, director, manager, and employee, and to each payer enumerated in Attachment A to this order; and

2. Revise the Provider Services Agreement so that it is in conformance with the provisions of this order.

B. Terminate any agreement or contract with any payer for the provision of physician services that does not comply with Paragraph II. of this order at the earlier of: (1) the termination or renewal date (including any automatic renewal date) of such agreement or contract; or (2) receipt of a written request from a payer to terminate such agreement or contract.

C. For a period of five (5) years after the date this order becomes final:

1. Distribute by first-class mail a copy of this order and the complaint to each new participating physician, officer, director, manager, and employee within thirty (30) days of his or her admission, election, appointment, or employment; and

2. Annually publish in an official annual report or newsletter sent to all participating physicians, a copy of this order and the complaint with such prominence as is given to regularly featured articles.

V.

IT IS FURTHER ORDERED that Tahoe IPA shall file verified written reports within sixty (60) days after the date this order becomes final, annually thereafter for five (5) years on the anniversary of the date this order becomes final, and at such other times as the Commission may by written notice require, setting forth in detail the manner and form in which it has complied and is complying with the order. In addition to any other information

that may be necessary to demonstrate compliance, Tahoe IPA shall include in such reports: (1) information identifying each payer that has contacted Tahoe IPA for the purpose of contracting for physician services, the terms of any contract the payer was seeking with Tahoe IPA, and Tahoe IPA's response to the payer; (2) information sufficient to describe the manner in which participating physicians share financial risk in each qualified non-exclusive risk-sharing arrangement in which they participate; and (3) copies of the minutes of Tahoe IPA's annual meetings.

VI.

IT IS FURTHER ORDERED that Tahoe IPA shall notify the Commission at least thirty (30) days prior to any proposed change in Tahoe IPA, such as dissolution, assignment, sale resulting in the emergence of a successor corporation, the creation or dissolution of subsidiaries, or any other change in Tahoe IPA that may affect compliance obligations arising out of this order.

VII.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this order, Tahoe IPA shall permit any duly authorized representative of the Commission:

A. Access, during office hours and in the presence of counsel, to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and other records and documents in the possession or under the control of Tahoe IPA relating to any matter contained in this order; and

B. Upon five (5) days' notice to Tahoe IPA, and without restraint or interference from it, to interview officers, directors, or employees of Tahoe IPA.

VIII.

IT IS FURTHER ORDERED that this order shall terminate twenty (20) years from the date this order becomes final.

Signed this _____ day of ___ _____, 1998.

NORTH LAKE TAHOE MEDICAL GROUP, INC.
J. Christden Richards, M.D.
President

COUNSEL FOR NORTH LAKE TAHOE MEDICAL GROUP, INC.
Joel Goldman

COUNSEL FOR FEDERAL TRADE COMMISSION
Paul J. Nolan
Matthew D. Gold
Kerry O'Brien
Daniel Kotchen

APPROVED:

David R. Pender
Deputy Assistant Director
Bureau of Competition

Jeffrey Klurfeld
Director
San Francisco Regional Office

Richard Feinstein
Assistant Director
Bureau of Competition

Willard K. Tom
Deputy Director
Bureau of Competition

William J. Baer
Director
Bureau of Competition

Attachment A

Admar Corporation

Barton Memorial Hospital

Blue Shield of California

Blue Cross of California

CCN

First Health (Affordable Healthcare)

Health Net

Hometown Health Plan

Interplan Corporation

Multiplan

MMC/Cigna

Mutual of Omaha

PacifiCare

School Insurance Group

St. Mary's Health Network

Tahoe Forest Hospital

USA MCO

SB 256

Response to comments by
Gordon Evans
HIAA
2/22/00

Evans: *"Quality is not the driving force behind the physician collective bargaining movement -- it's economics.*

Fact: If this bill were only about financial concerns, a doctor's contract with a health benefit plan would be about half a page long. Certainly, financial concerns are a part of any contract. However, this involves the overall care of patients. This is about giving physicians some leverage to prevent the intrusion of a giant third party into the sacred physician/patient relationship.

Evans: *"Legitimate mechanisms already exist within the boundaries of current antitrust law under which health care providers can and so collaborate and negotiate with health plans, patients, and others on clinical or quality of care issues or other concerns they may have regarding the impact of managed care on the quality of care."*

Fact: Currently, physician organization is expensive, complex, and often not logistically possible.

Organization makes the physician sacrifice his professional independence and deprives patients of choice of delivery setting.

If physicians organize there is no legitimate means to determine if the group is organized in a manner which meets FTC requirements for negotiation. Moreover, the costs of obtaining a legal opinion that can't provide any guarantees can easily run into six figures even before the group is functional.

Even if the group does meet FTC standards it doesn't prevent the plan from threatening the group with an antitrust action, resulting in six figure legal fees and the achievement of the plan's ultimate goal -- ceasing physician negotiations.

Evans: *"Consolidation among health plans has been and continues to be subject to rigorous antitrust scrutiny, at both state and federal levels."*

Fact: Under this legislation physicians would yet be subject to FTC scrutiny as well as scrutiny by the Commissioner of Labor and Work force Development and Alaska's Attorney General.

Evans: *"Antitrust waiver legislation is anti-competitive and would raise costs for health care programs..."*

Fact: In talking to several third party payers who want to do business in the State of Alaska, they talk about the efficiencies of utilizing the services of an authorized third party to help them build a network. Therefore providing an antitrust exemption to allow authorized third parties to help health benefit plans enter the market would offer consumers more choices and be pro competitive.

As an example of how uncompetitive the current oligopsonic medical health care market is when it comes to individual physician contracts, many insurance contracts offer a "take it or leave it" approach. Contracts are non-negotiable.

When physician networks do fully integrate and evolve into an entity that can wield some power in the market, the health plan refuses to negotiate with the network and begins to break it apart into individual physicians who can again be bullied into accepting one-sided contracts. A recent memo from Aetna U.S. Healthcare in California contained the following language: **"In order to participate directly in All Aetna U.S. Healthcare products you will need to withdraw your affiliation with any/all Aetna U.S. Healthcare contracted IPAs and Medicaid Groups."**

Evans: *"Legislation at either the state or federal levels will be costly. ...health care premiums in the private sector would increase by 6 to 11 percent"*

Fact: The study in which Evans based his projected increase on was done by Charles River Associates in June of 1999 (see attached study). If one reads the study carefully, particularly the first several pages, it is evident that the conclusions are based on numerous assumptions which cannot be supported by any firm data because that data does not exist.

However, for the sake of argument, if we took 8% as a mid point, that would mean that physicians component of total health care expenditures would need to increase by 50% (physicians charges currently represent approximately 16% of total health care expenditures). It is doubted that

this hypothetical 50% increase in physician charges would pass muster with the State Attorney General and Commissioner of Labor.

Page 9, paragraph two of the study, attributes most of the projected increased health care expenditures to an increase in utilization. This presumably assumes that physicians would be successful in negotiating away any utilization review. This argument is flawed by simply looking at United Health Care's scrapping of their internal utilization review procedure regarding their review of medical treatment decisions made by the physicians providing the care (see attached news article). United Health Care was spending upwards of $100 million/year on the review process. Such a review process still has merit but it must be targeted to only those situations that warrant appropriate internal utilization review.

Negotiations allowed for in this bill are voluntary. The health plan doesn't even have to come to the table. The negotiations are non-binding. Either party can stop at any time without penalty, and the health plan remains free to contract with or offer different terms and conditions to individual physicians.

Remember, the Attorney General must ensure that there is adequate competition remaining in the marketplace. So any group of physicians asking permission to negotiate with a plan cannot be so large or contain such a large component of a particular specialty so as to eliminate competition in the market.

Evans: *"The Texas legislation allowed physicians to strike or boycott."*

Fact: Article 29.10 of the Texas law states: ***"Nothing contained in this chapter shall be construed to enable physicians to jointly coordinate any cessation, reduction, or limitation of health care services."***

Evans: "Physician collective bargaining legislation is opposed by the chairman of the Federal Trade Commission, Robert Pitofsky, who says that conferring a labor exemption on physicians would merely grant them 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."

Fact: The FTC Chairman Pitofsky (appointed by President Clinton) has traditionally opposed permitting independently practicing physicians to collectively negotiate under the National Labor Relations Act. However, this issue is irrelevant to this legislation because it does not permit or require mandatory collective bargaining under the NLRB; nor does it and does not permit physicians to organize as a union or any other labor

organization under the NLRA. Instead, this legislation allows physicians to jointly negotiate with health plans under limited circumstances - a process that is voluntary and non-binding.

Alaska State Legislature
Senator Pete Kelly

Session
Capitol Building, Room 510
Juneau, Alaska 99801
Phone: (907) 465-2327
Fax: (907) 465-5241

Interim
119 N. Cushman St. Suite 201
Fairbanks, AK 99701
Phone: (907) 456-8161
Fax: (907) 451-9293

Senate Bill 256

An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health care insurer that has substantial market power

Senate Bill 256 attempts to level the playing field for Alaska's patients and the physicians who care for them.

In a perfect world, equal bargaining power would exist between the medical care providers and the health insurers. Big hospitals have more equal bargaining power with the health insurers than the typical Alaskan physician in a solo or small group practice. Obviously, a gross inequity in bargaining power exists and there is no conceivable way any health insurer will bargain with an individual doctor regarding individual contract provisions other than on a take it or leave it basis. The resultant effect is physician service contracts heavily weighted in favor of the insurance company. The bottom line is that, in many respects, this adversely affects the care that patients receive. For example, requiring a physician to use a lower cost treatment when a higher cost treatment may be medically necessary or preventing a physician from discussing alternative treatments.

Independent, competing physicians are prevented from any collective action by the federal anti-trust laws to which, ironically, the insurers are not subject. This fact plus the market concentration of health insurers causes the imbalance in bargaining power. With insurers having such a high degree of leverage, a balance of interest no longer exists in the market for health care delivery and finance.

Senate Bill 256 can permit independent, competing physicians to collectively negotiate with health insurers in regard to the provisions of physician services contracts to provide quality health care to Alaskans. When the provisions set forth in SB 256 are met, behavior that would otherwise violate the anti-trust laws will be exempt from antitrust scrutiny. The test for qualifying exemption varies depending on the identity of the party performing the action in question. But SB 256 will still prohibit a group of independent competing physicians from striking or otherwise engaging in activities that would result in a boycott.

"STATE ACTION DOCTRINE"

WHAT IS IT?

- The most important concept for Alaska's doctors going into the next millennium.
- It allows independent, competing physicians to jointly negotiate terms of physicians services agreements with the insurance companies without violating federal anti-trust laws.
- It can only be created by an Act of the State Legislature that:
  1.) Clearly establishes a state policy;
  2.) Clearly describes the situation(s) in which it may occur (e.g., dominance in the marketplace by an insurer);
  3.) Clearly establishes active state oversight of the process; and
  4.) Clearly defines the process and who needs to represent the doctors in such negotiations.
- It creates a more fair and equitable negotiating process between doctors and the large and powerful insurance companies.
- It gives doctors the ability to protect their patients.
- TEXAS passed a STATE ACTION DOCTRINE bill, which was signed into law by Governor George W. Bush this past June.
- There are numerous other states considering similar legislation.

WHAT IT IS NOT!

- IT IS NOT a union creating device.
- IT IS NOT Collective Bargaining. (Only employed physicians and residents can collectively bargain with their employer.)
- IT IS NOT MANDATORY for either a doctor or for an insurance company.
- IT IS NOT A MECHANISM THAT WOULD ALLOW A DOCTOR OR DOCTORS TO STRIKE OR ENGAGE IN A BOYCOTT.

What Can Alaska's Doctors Do at this time in regards to joint negotiation with Insurance Companies

- NOTHING without being in violation of federal anti-trust laws.
- NOTHING means that you may not discuss the terms of an insurance company physician services contract with any colleague with whom you are in competition. (The Federal Government has defined your competition as any doctor within a certain geographic area, which in some circumstances could be the entire state.)
- NOTHING certainly means that you can not discuss your fees with any colleague. (However, insurance companies do this legally on a regular basis.)
- NOTHING means you can not discuss nor recommend signing or not signing any insurance company physician services contract with any colleague with whom you are in competition.

WHAT CAN BE DONE TO LEVEL THE PLAYING FIELD?

- Change federal anti-trust law—HR 1304 is such an attempt but is likely to languish for 3 or 4 years before Congress takes action.
- Pass a Law in Alaska creating a "State Action Doctrine".

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 18, 2000

Honorable Mike Miller
State of Alaska
Senate
State Capital, Room 119
Juneau, Alaska 99801-1182

RE: SB 256–"Fairness in Health Care Contracting"

Dear Senator Miller:

The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them. Thank you for this opportunity to testify on SB 256. It was ASMA, among other organizations, that represent physicians that sought the introduction of this bill.

Attached you will find a copy of a sectional analysis of SB 256. In this analysis you will see that ASMA strongly supports the enactment of this measure. However, several amendments are suggested. The major amendment would be to have this act apply to all types of health plans and not just those insured by health care insurers in Alaska. This suggestion would mean that physicians would also be allowed to jointly negotiate with large self-insured plans as well. (ASMA has already had discussion about this matter with Senator Kelly's staff prior to the introduction of SB 256).

SB 256 would create a more fair and equitable negotiating process between doctors and the large and powerful insurance companies. <u>This is not a measure that would allow doctors to strike or engage in any boycott of services</u>.

ASMA urges you to support SB 256 with the amendments suggested.

Sincerely,

Peter Lawrason

BY: Peter Lawrason, MD, President

FOR: Alaska State Medical Association

cc: Sen. Pete Kelly

JJJ/kms

Senate Bill 256
"Fairness in Health Care Contracting"
Sectional Analysis

Section 1

This section adds those provisions of any physician services contract that are either required or currently prohibited. The purpose, theoretically, for this section is to provide consistency with the provisions of HB 211 (Regulation of Managed Care) pertaining to physician services agreements. By including this section, the same requirements are in place for physician services contracts arrived at through joint negotiations.

AS21.42.175 is not stated correctly in that it would require the disclosure in each contract all of the rates of compensation for all providers with whom the health care insurer contracts. The intent is to have the contract clearly state the rate of compensation for the physician who is the party to that contract only. It should read as follows:

> "(4) clearly states the rate and method of compensation for each group managed care health plan for which the health care provider is to provide health care services for the covered persons;"

It is expected and desired to have SB 256 amended so that it covers negotiations with self-insured groups as well. When this happens, it is suggested that Section 1 not be in the form it currently is in. Those provisions in Section 1 should be included in a section under AS23.50. Perhaps, they could be included in AS23.50.025 a new section titled "Contract Provisions". The change in this "lead in" language could be changed to reflect the all inclusiveness (insured and self-insured plans) desired by using the term "health benefit plan" instead of the term "managed care entity". The term "health benefit plan" is defined in AS21.54.500 (15) and appears to include both insured and self-insured plans. (Other editorial changes would need to be made to reflect this change as well.)

Section 2

AS23.50.010

AS23.50.010 articulates the reasons for the Legislature to set policy to allow joint negations between a group of competing physicians and a health insurance company.

AS23.50.020

AS23.50.020 (a) enumerates those items which may be the subject of joint negotiations. Those items include clinical practice guidelines and coverage criteria; respective liability of physicians and health care insurers; administrative procedures that include methods and timing of payments to physicians; resolution despute procedures; patient referral procedures; application of the reimbursement methodologies to be used; quality assurance programs; utilization review procedures; and criteria for the selection and termination of participating physicians. Note that this subsection does not allow for negotiation of fees or payments. AS21.050.020 (b) prohibits joint negotiation for those fee or payment related items unless the conditions of AS21.050.020 (c) are met.

AS21.050.020 (b) prohibits joint negotiations involving fees or prices for services; the conversion factor in a RBRVS type payment methodology; amounts of discount on the physician's services; and dollar amounts for a "capitation" basis of payment. However, it still allows physicians to jointly and collectively petitions the government for a change in law that provides for payment to doctors under a governmental program (e.g., Medicaid).

The exception is made to allow for joint negotiation for those fee items listed in AS21.050.020 (b) when a health insurer has "substantial market power". AS21.050.020 (c) defines substantial market power when an insurer has more than 15% of the market place as measured by the number of people covered. Included in the numbers of people covered are those covered under Medicare and Medicaid if an insurer provides any claim payment services for the government for those programs. The concept is based in that all "bodies" covered and threats of not contracting with a certain physician are based on the deleterious effect on a physician's practice by removing those patents from his/her practice. Enumerating the persons covered may be difficult for the Division of Insurance. In fact, it is impossible for the Division of Insurance to compel self-insureds to provide it with those data. In one state currently addressing the State Action Doctrine exception issue (California), it is being considered to just require all health plans to negotiate with physicians without having to prove the "substantial market power" percentage. (Obviously this would allow physicians to still jointly negotiate and under active state oversight). The reason for this is that it is clear in California that less than 10 health plans dominate its market place. It is perceived that less than 6 health plans dominate Alaska's marketplace. One suggestion would be to make the negotiations a requirement but with a "rebuttable presumption" that a particular health insurer could make that it does not have "substantial market power" as defined as a market share that exceeds 15%.

AS21.050 (d) sets out the criteria for how those collective rights are to be carried out by the physicians jointly negotiating. The core provision is that negotiations are to be conducted through an "authorized third party" who will negotiate on behalf of the physicians who have joined together for that purpose. Conceivably,

that person acting as the authorized third party representative could be an IPA, a lawyer, a physician, a specialty medical society, a local medical association, a state medical association, etc. It is presumed a contractual relationship will exist between the represented physicians and the authorized third party that memorializes the obligations and requirements of the parties. This subsection states that the physicians who have joined for the purpose of negotiation may communicate with their authorized third party about terms and conditions, which are to be negotiated. The authorized third party is the sole person who is to negotiate on behalf of the doctors. Subsection (5) of this section may provide some confusion in that it would appear to defeat the purpose of the joint negotiations. The intent of subsection (5) is to provide, for example, for different rates of reimbursement to be included for different specialties. (For example, anesthesiologists are typically reimbursed in a different manner than a surgeon and both may be in the same group of physicians engaged in joint negotiations.) Generally, an authorized third party may not represent more than 30% of the physicians in a particular geographic area. However, if an insurer or health plan has 5% or more market penetration in a geographic area, then an authorized third party may represent more than 30% of the physicians. Obviously, the concern would be that physicians represented in great numbers would dictate the terms of a contract to an insurer or health plan. By the same token, for example, it would be unfair for a specialist, who is the only one in a particular area, not be able to join with other physicians to jointly negotiate. This is an area that active state oversight would be necessary so that a fair result for the general public would be the outcome.

AS21.050.020 (e) sets out what a person desiring to act as an authorized third party needs to do in order to act in that capacity. In short, the authorized third party needs to register with the Commissioner of Labor and Workforce Development. That registration requires an identification of the authorized third party and how that person intends to operate. It is presumed that this would include a detailed plan of operation along with the contract that it has entered into with the group of physicians to be represented. This must be done for each physician service contract that the authorized third party wishes to jointly negotiate on behalf of the physicians represented. The efficiencies or benefits that are expected to be achieved must be identified. The authorized third party is required to report to the Commissioner of Labor if a health care insurer or health plan declines to negotiate or terminates a negotiation within 14 days of receiving that decision. Also, if an insurer or health plan fails to respond within 14 days of a request for negotiation, that fast also needs to be reported to the Commissioner.

AS21.050.020 (f) requires the Commissioner, with the advice of the Attorney General, to either approve or disapprove a negotiated contract within 30 days of when it is presented. If it is disapproved, the Commissioner must give a written explanation of the deficiencies and how they could be corrected.

AS21.050.020 (g) prohibits the physicians represented from acting together in response to a report from their authorized third party regarding its discussion or negotiation with a health care insurer or health plan. The authorized third party has a duty to warn the physicians represented of the potential of legal action under state and federal anti-trust laws for exceeding the authority granted by this measure.

AS21.050.020 (h) limits the terms of any contract negotiated to 5 years. It is expected that terms of actual contracts will be for less than 5 years.

AS21.050.020 (i) keeps all documents relating to joint negotiations, that would come from both the physicians and insurers or health plans, confidential and not subject to public inspection.

AS23.50.030

AS23.50.030 creates a fee mechanism to cover the State's cost of providing its active oversight of the joint negotiation authorized by this bill. The fee is to be reflective of the actual costs that the State incurs. The Commissioner sets the fees by regulation and must report on the fees each year to the Office of Management and Budget. At least one other state in dealing with a "State Action Doctrine" exception (California) charges the regulatory costs to the health care insurers and health plans on a pro-rata share based on their market share. Theoretically, the cost should be the same without regard to who pays it. If the physicians pay it via their authorized third party, then they will negotiate sufficient payment levels to cover that cost. Conversely, if the insurers and health plans pay it, then they will negotiate a sufficiently lower payment level to cover that cost. The issue is what is the most efficient and fair method to cover the cost. Obviously, the physician community will not be supportive of a fee mechanism that requires a payment upfront only to have an insurer decline to negotiate and not receive any refund.

AS23.50.040

AS23.50.040 allows the Commissioner of Labor and Workforce Development to adopt regulations to implement this law.

AS23.50.099

AS23.50.099 is the definition section and contains the definition of the terms "authorized third party", "commissioner", and "health care insurer". These definitions are straightforward and unambiguous. This section will be expanded if the SB 256 is amended to also include self-insured health plans. For example, the term "health benefit plan" would need to be defined as it is in AS 21.54.500 (15).

Section 3

This section is needed to provide for joint negotiation by physicians under the "State Action Doctrine" exemption under Alaska's laws pertaining to competitive practices and regulation of competition.

JJJ/kms

Antitrust Relief

Egregious Contract Clauses

The Campbell bill would allow physicians to jointly negotiate against such clauses

The "Cheapest" Care

This clause allows the plan to restrict care to the cheapest treatments, not the best or most appropriate for the patient.

> "*Medical necessity* means the SHORTEST, LEAST EXPENSIVE, OR LEAST INTENSE LEVEL of treatment, care or service rendered, or supply provided, as determined by us [health plan], to the extent required to diagnose or treat an injury or sickness. [Emphasis added] (American Medical Security, Inc., plan supervisor and administrator for self-funded employee benefit plan)

The "Fall Guy"

Health plans shift liability to physicians for patient harm caused by the plan's own actions. Taken together these three clauses effectively require physicians to comply with the plan's decisions and policies - that directly affect the quality of patient care - while the plan avoids legal liability for them.

> "Provider agrees to participate in, cooperate with and comply with all decisions rendered in connection with [health plan's] Utilization Management Program..."
>
> "Provider agrees to render Covered Services to Beneficiaries...in accordance with... the clinical quality of care and performance standards that are professionally recognized andor accepted by [health plan]." - not necessarily the physician
>
> "PROVIDER SHALL BE SOLELY RESPONSIBLE for the quality of Covered Services rendered to beneficiaries." [Emphasis added]
>
> (Independence Blue Cross p. 2, Clause 1.13, p.4, Clause 2.2(a), and p.5, Clause 2.7 and 2.10)

Pass The Buck

Health plans shift responsibility to physicians for their own breaches of confidentiality.

> "Provider agrees to defend, hold harmless and indemnify Company and its officers, shareholders, employees, agents and subagents from any and all claims, causes of action, lawsuits, liabilities, damages and expenses ...arising from or relating to any release or disclosure MADE BY COMPANY..." [emphasis added] (Wellmark Blue Cross/Blue Shield of Iowa p. 10, clause 10.4)

The Great "Unknown"

Physicians are forced to agree to terms without knowing what they will be. In this example, the health plan would force a physician to participate in a plan without knowing the type of plan, the rules and procedures, the number of patients, the payment, etc.

> "Company reserves the right to introduce new Plans during the course of this agreement. Provider agrees that Provider will provide covered services to Members of such Plans under applicable compensation arrangements determined by company." (Aetna Specialist Physician Agreement, clause 8.2)

Our Way or the Highway!
Health Plans can unilaterally change the contract terms at any time without physician consent:

> "BLUE CROSS has established a Utilization Review (UR) program which shall seek to assure that Hospital Services or Medical Services provided to Members are Medically Necessary. The Utilization Review shall follow the procedures described on Exhibit C, attached to and made part of this Agreement. BLUE CROSS may change UR procedures by delivering amendments to, or a replacement for, Exhibit C at least thirty (30) days prior to implementation." (Blue Cross of California Prudent Buyer Plan, clause 7.1)

Surprise!
Changes can be made at any time *without notice:*

> "Provider agrees: a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (AS MODIFIED FROM TIME TO TIME) and decisions with respect to all members." (Aetna Specialist Physician Agreement, clause 4.2)

No competition
Health Plans prevent physicians from accepting any new patients from competing health plans.

> "To prevent discrimination against Company or its members, for such time as provider declines to accept new members as patients, provider shall not accept as patients additional members from any other health maintenance organization." (Aetna proposed Primary Care Physician Agreement, paragraph 1.2)

"Lemon Laws"
Health Plans insist upon contracts that do not disclose essential terms- one way is to refuse to disclose reimbursement rates and better yet, retain the right to change them at any time:

> "Company shall ... pay Provider for [services] rendered to Members in accordance with: (a) the THEN-CURRENT Company Reasonable, Equitable Fee Schedule (REF); or (b) the compensation arrangement THEN iN EFFECT as applicable to such Member's Plans; either of which may be modified from time to time by company." [Emphasis added] (Aetna Specialist Physician Agreement, clause 3.1)

Patients - Don't Bother Asking!
Gag practices prevent physicians from discussing treatment options with their patients if there is a chance that the health plan won't pay:

> "Provider shall not provide or threaten to provide inferior care or imply to members that their care or access to care will be inferior due to the source of payment." (Aetna Specialist Physician Agreement p. 2, clause 1.2)

Return to regular version

Published Feb 3 2000

American Medical Association

Physicians dedicated to the health of America

Memo to: Executive Directors
State Government Affairs Contacts
State Medical Societies
National Medical Specialty Societies

From: Ross N. Rubin, Vice President
Legislative Affairs

Rebecca A. Cerny, Director
Division of State Legislation

Date: February 17, 1999

Subject: AMA Model State Legislation on State Action Doctrine

As you know, one of the main focuses of the Association has been to identify strategies to help physicians achieve greater bargaining leverage against health plans. This is particularly important in the current health care market, where health plans have amassed enough market leverage to virtually dictate the terms of the contracts they offer physicians. To many physicians, the "strength in numbers" derived from coming together to negotiate fees and other contractual terms is the most obvious way to achieve favorable contracts with health plans. The antitrust laws, however, present a major roadblock to physicians, in that they prohibit physicians from coming together to bargain collectively with health plans and other payers.

At the June 1998 meeting, the House of Delegates adopted Resolution 258. Resolution 258 called upon the Association to develop a negotiating unit, within organized medicine and with no affiliation with national trade unions, free of antitrust constraints for all of its members in order to help level the playing field with health care payors. At the December, 1998 meeting, the House adopted Board of Trustees Report 14, which in part calls upon the Association continue to identify ways in which collaboration by physicians can benefit the public and to inform antitrust enforcement agencies of these findings. In addition, Board of Trustees Report 14 asked the Association to examine the feasibility of drafting model state legislation and, if appropriate, draft such legislation for dissemination. *The AMA Council on Legislation considered and approved model state legislation on the state action doctrine at its January 1999 meeting. The AMA Board of Trustees adopted the model state legislation during its February 1999 meeting.*

Enclosed you will find 1) a summary of the state action doctrine as it pertains to collective negotiation among physicians, including a discussion of the Washington state law on this issue, and 2) model state legislation relating to state action doctrine recently approved by the AMA's Board of Trustees. Please feel free to contact Ross Rubin at (312) 464 – 4040 or Rebecca Cerny at (312) 464 – 4503 with any questions you may have.

STATE ACTION DOCTRINE

The American Medical Association has been working to develop a collective bargaining unit, recognized under the National Labor Relations Act (NLRA), to provide a professionally grounded entity for physicians eligible to organize under that Act. The Association is also continuing to support federal legislation to amend the antitrust laws to allow physicians not eligible under the NLRA. It is expected that Representative Campbell will reintroduce his bill soon.

There is, however, an interim step that in some cases can permit independent physicians to negotiate with plans. This step is based on a line of cases that creates a "state-action doctrine" under the antitrust laws. (Parker v. Brown).

Summary of the State Action Doctrine

The state action doctrine was first set forth in a 1943 Supreme Court decision in *Parker v. Brown*. In general, it states that the **antitrust laws do not apply to action by a state operating in its sovereign capacity, or to private conduct compelled or approved by the state. In other words, where the requirements of the state action doctrine are met, behavior that would otherwise violate the antitrust laws will be exempt from antitrust scrutiny.**

The test for qualifying for the exemption varies, depending on the identity of the party performing the action in question:

1. Where the party is a state legislature or a state court, the exemption is complete, and no further inquiry is required;

2. Where the party is a state agency or local government official, further inquiry is required with respect to whether the action in question followed "clearly articulated and affirmatively expressed state policy;" and

3. Where the party is a private party, the test for qualifying for the state action exemption is the strictest. In addition to having to comport with the "clearly articulated and affirmatively expressed state policy" spelled out above; the action must be subject to "active state supervision." In other words, the state must, *in practice*, exercise some degree of independent judgment or control over the activity. Passive or theoretical power of a state to review private action will be insufficient to meet this standard.

Collective Negotiation Among Physicians Under the State Action Doctrine

Independent physicians fall into the category of private party. Therefore, actions taken by physicians that would ordinarily be illegal under the antitrust laws – in this instance, collective negotiation with health plans – will be exempt from antitrust scrutiny ***only to the***

extent that the activity comports with the requirements laid out above in item 3. Specifically, the antitrust laws will not prohibit independent physicians in a particular state from negotiating collectively with health plans where:

- **The relevant state has a "clearly articulated and affirmatively expressed state policy" that permits independent physicians to negotiate collectively with health plans.**

  The most obvious way for a state to lay out this policy is through legislation. If a state has on its books legislation specifically stating that physicians may negotiate collectively with health plans, then the first requirement for the state action exemption will be satisfied. *[It should be noted that the introduction of a bill that permits independent physicians to negotiate collectively with health plans is bound to generate a certain degree of controversy. This is because such legislation will be perceived as opening the door to activity that will have anti-competitive effects that will ultimately harm the consumer. For example, critics of such legislation might argue that allowing independent physicians to negotiate collectively with health plans will benefit physicians by helping them to keep their fees up, but will harm consumers in that higher fees will translate into higher premiums. Critics might also point to the risk of physicians engaging in boycott activity, where the health plans do not respond favorably to the terms and conditions the physicians demand in the course of the collective negotiations. This, too, could have a negative impact on consumers, who might not be able to secure medical services when needed. Consequently, to increase its chance of passage, such legislation must be carefully drafted, pointing out the possible pro-competitive reasons for allowing physicians to negotiate collectively with health plans. It should also contain provisions that provide reassurance to legislators that boycott activity, or other activity that causes direct harm to the consumer, will not qualify for antitrust exemption."*

- **The collective negotiations between physicians and health plans must be subject to "active" state supervision.**

  Although legislation should include a provision that gives a state body the authority to oversee physicians' collective negotiation activity, the mere inclusion of such language in a state statute will not be enough to constitute "active" state supervision. The state body must, in practice, review the negotiations, which might include following certain procedures that give the state body input into the negotiations themselves. A sound way to ensure that a state body has active oversight over the negotiations is to incorporate within the legislation certain duties of the state body in the course of physician negotiations. This way, negotiations can not go forward and be in compliance with the law unless the state body performs certain functions and, hence, is actively involved.

The Washington Example

Before moving directly into possible model legislation, it is helpful first to look at legislation that was passed in Washington state in 1995. This legislation was designed to provide independent physicians with increased negotiating power with health plans. The legislation serves as a good starting point with respect to drafting language that, when implemented, yields a paradigm in which physicians can collectively negotiate with health plans on certain issues without being subject to the antitrust laws. **However, the Washington law has one major shortcoming for our purposes, and that is that it specifically excludes collective negotiation over fees from state action exemption.** Consequently, while model legislation will borrow many of the provisions of the Washington statute, it will reach further to encompass collective negotiations over fees in identified circumstances.

In summary, the provisions of the statute are organized to address the following issues, in order:

1. The policy reasons for permitting collective negotiations in certain circumstances, and for disallowing collective negotiations in others.

2. The terms and conditions over which physicians may collectively negotiate with health plans

3. The terms and conditions over which physicians may not collectively negotiate with health plans

The first three provisions of the statute set forth Washington's "clearly articulated and affirmatively expressed state policy" in favor of collective negotiations between physicians and health plans on specified issues. Therefore, where physicians engage in the practices enumerated by the statutory provisions, they will be exempted from antitrust prosecution, provided the state actively supervises these activities. The remaining statutory provisions institute a formal process involving the state, thereby ensuring that the state is, in practice, actively involved in reviewing collective negotiations conducted by physicians. The provisions address the following issues:

1. The process competing physicians must follow when negotiating with health plans (e.g., physicians must negotiate through a third party they so authorize);

2. The information third parties must supply to the state prior to engaging in collective negotiations on behalf of physicians;

3. The requirement of state approval of the proposed activity as described within the information supplied by the third part representative; and

4. Loss of antitrust exemption as a result of physicians' acting outside of the parameters laid out by the statutory provisions.

Provided Washington physicians act in accordance with the statutory provisions, they will avoid scrutiny under the antitrust laws. However, the statute is actually quite limited with respect to what it allows physicians to do. Most notably, it forbids collective negotiations over fees or price information, and even backs up this prohibition with a policy statement that points to the anti-competitive effects of such practices.

WSMA's Negotiation Service

Following the passage of legislation allowing independent physicians to negotiate collectively with health plans, the Washington State Medical Association (WSMA) developed a negotiation service to assist Washington physicians in conducting such negotiations. The service was set up so that WSMA staff, in conjunction with outside legal counsel, would actually conduct the physicians' negotiations with health plans.

According to John Arveson at WSMA, thus far, the negotiation service has not been used to conduct any negotiations with health plans. When WSMA first announced the availability of the service to Washington physicians, the response was fairly good, with approximately 2400 physicians signing up. However, in light of increasing consolidation among health plans in Washington, the number of physicians signing up to take part in the service did not amount to a critical mass, for the purposes of "making a difference" against area health plans. By way of example, last summer, when one of Washington's largest HMOs offered a contract containing egregious terms and the negotiation service requested to negotiate with the HMO, the HMO declined to negotiate with the physicians.

The events that transpired following the HMO's refusal to negotiate with the physicians suggest that there might be increased demand for the negotiation service in the future. Considering the HMO's contract to be sufficiently egregious, the WSMA presented the contract to the state's insurance commissioner and put together a media campaign against the HMO's contractual practices. The insurance commissioner, who has a reputation for being very pro-consumer, found the contract to be in need of modification. As a result, the HMO is now in negotiations with the insurance commissioner over the terms of the contract. Because the commissioner is "not known to be particularly friendly" to insurance companies, Arveson notes that the next time the HMO is approached by the physicians to negotiate, it will be more open to private negotiations with physicians. Moreover, the media campaign has generated increased physician interest in participating in the negotiation service. Since this summer, WSMA has received an additional 200 to 300 physician applications.

When asked what impact allowing physicians to negotiate on fee-related issues in certain circumstances would likely have on interest in the negotiation service, Arveson said many more physicians would be interested. Therefore, the possibility of including a provision within proposed legislation that permits collective negotiation over fee-related issues in limited circumstances should not be overlooked.

Conclusion

While not a complete solution for independent physicians not eligible to negotiate under the NLRA, pursuit of state legislation to authorize negotiations provides an approach that can be utilized. Such a strategy is not without risk. By operating under the state action doctrine, a certain amount of autonomy will be lost, in that the state will now be involved in the negotiating process. State medical societies will have to weigh the benefits of the antitrust exemption under the state action doctrine against the risks of active state involvement.

MYTHS ABOUT PHYSICIAN NEGOTIATION
(SB1468/HB3039)

MYTH: *Doctors can form groups to negotiate now.*

FACTS:

1) Currently, physician organization is expensive, complex, and often not logistically possible.
2) Organization makes the physician sacrifice his professional option and **deprives patients of choice** of delivery setting.
3) If physicians organize there is no legitimate means to determine if the group is organized in a manner which meets FTC requirements for negotiation. Moreover, the costs of obtaining a legal opinion that can't provide any guarantees can easily run into six figures even before the group is functional.
4) Even if the group does meet FTC standards it doesn't prevent the plan from threatening the group with an antitrust action, resulting in six figure legal fees and the achievement of the plan's ultimate goal—ceasing physician negotiations.

MYTH: *The Federal Trade Commission and the Department of Justice are "easing up" on enforcement and investigation of physician networking and other initiatives.*

FACT:

At their recent joint report to the American Health Lawyers Association, the FTC and DOJ made it clear that physician mergers and other activities continue to be high on their enforcement agenda this year. For example, to show how nearly impossible it is to understand and/or comply with the law, their staff noted that if a physician merger includes the best physicians in the community (the "must haves"), it might be anti-competitive for this fact alone, even if physician organization doesn't have what the enforcement agencies traditionally consider "market power."

MYTH: *This is the first step in a plan by the AMA to unionize physicians.*

FACTS:

1) The AMA has plans to represent those physicians who are eligible to unionize today without the passage of SB 1468 under the National Labor Relations Act (NLRA). These physicians must be employed physicians, and the negotiations must be with their employer. **Texas has a prohibition of the corporate practice of medicine.** Therefore, Texas would not serve as a model for the AMA's ability to represent physicians in NLRA recognized negotiations with employers.
2) This has to do with the ability of physicians to engage in meaningful contract negotiations with very powerful, monopsonistic forces. This is about **a balance of power in the marketplace** and has nothing to do with unionizing.
3) This bill amends the insurance code and deals only with negotiations between physicians and managed care plans. Furthermore, the bill **specifically prohibits strikes and boycotts or any other tactic that would result in denial of patient care.** The AMA and TMA both believe that it is unethical to strike or otherwise use patients as a bargaining chip.

MYTH: *This bill is anti-competitive and such negotiations should be left to the two equally matched, sophisticated parties.*

FACTS:

1) These plans offer a "take it or leave it" approach. **Contracts are non-negotiable.** Furthermore, some plans control as much as 60% of the market. With this kind of market power, physicians have no ability to negotiate.

2) When physician networks do fully integrate and evolve into an entity that can wield some power in the market, the health plan refuses to negotiate with the network and begins to break it apart into individual physicians who can again be bullied into accepting one-sided contracts. A recent memo from Aetna U.S. Healthcare in California contained the following language: ***"In order to participate directly in All Aetna U.S. Healthcare products you will need to withdraw your affiliation with any/all Aetna U.S. Healthcare contracted IPAs and Medicaid Groups."***

MYTH: *These matters should be left to the "free market."*

FACT:
Sure, managed care companies say "free market" when they virtually own the market and have vast anti-trust protections which no other industry enjoys.

MYTH: *This bill will allow physicians to "price fix" and will increase health care costs.*

FACT:
This bill **does not allow physicians to discuss fees unless given specific permission by the Attorney General** to do so. In order for fees to be part of negotiations, the plan must have substantial market power. The AG must also consider the number of physicians involved in fee negotiations relative to the total number of physicians available in the geographic area. **There is no evidence that this bill will increase costs.** The thrust of this bill – and its clear language – is obviously directed to non-fee related, patient care issues.

MYTH: *This bill will increase the number of uninsured at a time when Texas has the dubious distinction of having the largest percentage of uninsured in the country.*

FACTS:

1) Health plans have used this argument over and over again to try to defeat every significant reform measure at the state and federal level. This is transparently self-serving and especially ironic because as managed care has grown, so has the number of uninsured.

2) Once again, the argument is smokescreen. As noted, the issue is irrelevant because any discussion on fees is limited to circumstances where the plan has substantial market power (as determined by the state).

3) Health plans have never been able to demonstrate cost increases specifically related to any managed care reforms.

4) In addition, health plans have not been able to substantiate their claims that small increases in cost result in loss of insurance coverage.

Managed Care Freedom of Choice Act
HB 3039/SB 1468

Question: Why should the Legislature pass this bill?
Answer: Managed care plans are merging at an alarming rate. These mergers are creating huge, powerful health plans that refuse to negotiate with physicians regarding onerous contract provisions. These "take it or leave it" contracts have requirements that can have direct impact on patient care. When physicians attempt to form networks that are large enough to oppose unreasonable contract provisions, the health plans threaten them with bringing an antitrust action. This is becoming a common ploy, not only in Texas, but in other states as well. This bill will give physicians limited protection from such threats when they attempt to negotiate for the removal of contract provisions that can interfere with patients' access to care.

Question: How can a state bill offer any protection from federal anti-trust laws?
Answer: Under a 1943 Supreme Court ruling, *Parker v. Brown*, states can supercede federal antitrust law if there is "a clearly articulated state policy," and "active state supervision." In general, the ruling states that the antitrust laws do not apply to action by the state operating in its sovereign capacity, or to private conduct compelled or approved by the state. In other words, where the requirements of the state action doctrine are met, behavior that would otherwise violate the antitrust laws will be exempt from antirust scrutiny.

Question: Will this bill allow physicians to strike or boycott?
Answer: No! In fact, such activities are specifically prohibited.

Question: Will the passage of this bill drive up health care costs by giving physicians the ability to set fees and other reimbursement rates?
Answer: No! This bill does not allow physicians to "price fix." Physicians may meet and discuss contract provisions only in most situations. These provisions include items like referral requirements, drugs to be included in formularies, access to certain kinds of specialty care for the plan's enrollees, utilization review criteria, etc. Fees can be discussed only in situations where the health plan has substantial market power in a specified geographic area. Substantial market power will be determined by the Attorney General.

Question: Will the physicians be able to act together and agree to accept or reject a health plans offer?
Answer: Yes. However, the plan is free to make offers to physicians individually as well. Physicians may not act in concert with the intent to fix prices, boycott, or otherwise have an unfair advantage over the health plan. Such actions would not be protected from antitrust actions.

Question: If physicians can't negotiate price in most cases, what advantage does this bill give them over what they are currently able to do?
Answer: In today's market, physicians are not allowed to even meet and discuss contracts without threat of an anti-trust action. This means that multi-billion dollar corporations with full time legal staffs present 80 page contracts to solo and small group practitioners. These doctors must retain legal advice just to understand what is included in the contracts. This advice often does not include the impact on patient care that some provisions can have. The doctors have no idea what should be eliminated or amended, and even if they did, the health plan will not make changes at the request of one or two physicians. When a health plan controls 30% or more of a market, it doesn't have to deal with individual doctors. This bill will allow physicians to join together to be represented by a knowledgeable individual who can facilitate discussions about the impact of various contract provisions. It will allow doctors to talk to one another, to educate one another, and to express concerns to the health plan as a group. When acting in accordance with the provisions of this act, the physicians cannot be threatened with an antitrust action.

Question: How does the state "supervise" these activities in order to meet the requirements under *Parker v. Brown*?
Answer: The physicians' representative will file a plan of operation with the Attorney General. The plan will include information on the representative, the physicians to be represented, the health plan with which negotiations will occur and the items for discussion. When the plan makes an offer to the physicians' representative, it will be filed with the Attorney General. The offer must be approved by the Attorney General before it is presented to the physicians.

Question: How will this bill improve patient care?
Answer: Contract provisions that impede the ability of physicians to advocate for their patients must be challenged. Unless there is a balance of power between huge, powerful managed care plans and physicians who care for patients, abusive managed care organizations will continue to place profits above patients. Physicians who refuse to cooperate will be driven from the market and patients will lose access to physicians. Diminished access delays care and decreases choice for every patient.

Testimony of James J. Jordan
Executive Director, Alaska State Medical Association
March 2, 2000
Senate Finance Committee
CS SB 256

Thank you for this opportunity to testify on SB 256. Today I'm going to keep my comments extremely brief.

SB 256, simply put, would let a group of independent, competing physicians jointly negotiate with a health benefit plan. It would allow joint negotiations on both non-fee related items as well as fee related items. However, for fee related items, the health benefit plan must have more than 15% of the market share in a certain geographic area before joint negotiations could be authorized by the Commissioner of Labor and Workforce Development. It is important to note that this is voluntary on all parties behalf and is also not "binding". You have been provided with a single page that diagrams how SB 256 would operate. Please note all the "decision points" at which either the Commissioner can exercise oversight and at which the health benefit plan can elect not to participate.

It is also important that SB 256 does not allow any strike or boycott by any group of physicians.

You will, no doubt, receive testimony that this bill will increase the cost of health care. First, no data currently exists to indicate what cost impacts may come about following the enactment of such a measure. Therefore, any cost estimates must be based on assumptions made. For example, HIAA has indicated that a possible cost impact will be in a range of a 6% to 11% increase in the private sector health care premiums. This estimate is based on the assumption that physicians will... "increasingly gain the upper hand in negotiations...". A significant portion of this increase is attributed by the HIAA to an assumed reduced ability to perform utilization review and management activities due to the assumed physicians' upper hand. It would seem that such an assumption may not be appropriate when you look at what Minneapolis based United Health Group has recently done. I have a copy for you of an American Medical News article of 12/6/99 that details United's decision. But, in short, United scrapped its utilization review of doctors' decisions because it was agreeing with 99% of those decisions. United was spending $100 million a year on this process nationwide. You might wish to consider a "sunset provision" for this bill so that a meaningful discussion can take place based on actual experience and data developed in Alaska as well as elsewhere around the country.

You will also, no doubt, receive testimony that would indicate that this bill is not necessary as physicians can currently form groups that can then negotiate with health benefit plans. This is an option that, in all practicality, is not available to Alaska's physician's. First, this option at best would only be available to physicians practicing in the largest urban areas of Alaska. Generally, such groups must fully clinically and financially integrate all physicians' practices into one. Such integration brings about

many and varied problems associated with reduced physician autonomy, integration of separate staff, developing a new group "culture", finding compatible partners, and defining who the leaders will be. Additionally, a Case Study Analysis of Physician Practice Mergers sponsored by the American Medical Association, American Academy of Dermatology, American Academy of Pediatrics, American College of Radiology, American Society of Plastic and Reconstructive Surgeons, Michigan Medical Society, and South Carolina Medical Association indicated that practice mergers typically increase rather than decrease physician overhead. This was attributed to merged practices incurring significant organizational expenses (consultant, attorney, and accountants), more extensive administration infrastruction, upgraded information systems, and did not produce significant economies in buying of supplies, insurance, equipment, etc. to offset other cost increases associated with the merger of practices. So, ironically, such organizations portrayed to be available seem to bring with them increased costs and less competition.

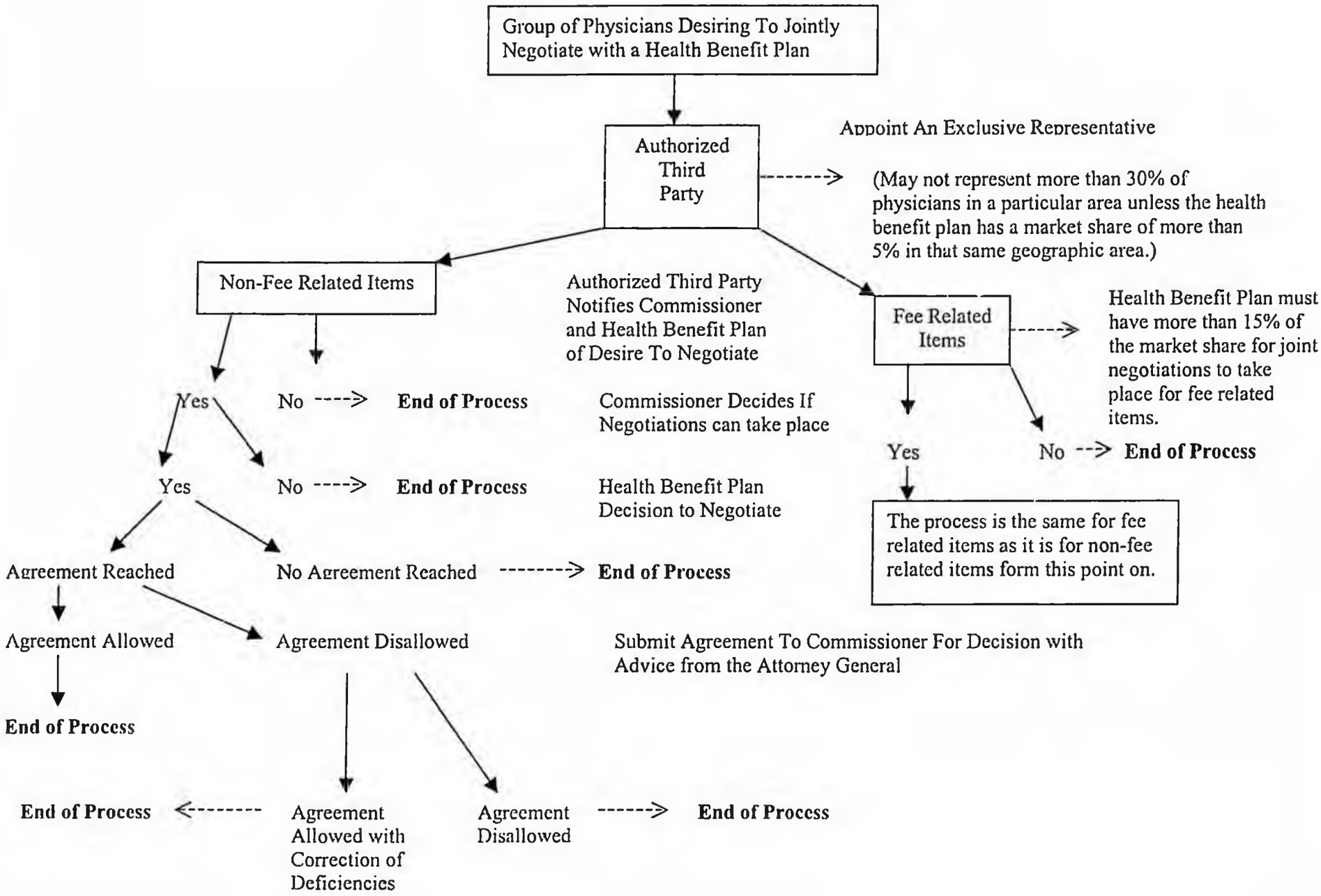
Finally, you may wonder why this bill should be passed when it is purely voluntary. First, this measure may provide a mechanism for new health benefit plans to enter Alaska on a more cost effective basis. For example, a new health insurer desiring to build a network of physicians may find it more cost effective to negotiate with groups of physicians rather than by one doctor at a time. Also, depending on who does or does not utilize this process and the experience of going through the process may suggest other approaches that would work better for Alaska's patients. Currently, the option of joint negotiation is not available and SB 256 would provide that option.

The Alaska State Medical Association urges your support of SB 256.

Thank-you and I'd be happy to answer any questions that you might have.

/kms

CS SB 256—"Fairness in Health Care Contracting"
Diagram of its Operation



American Medical NEWS

MEDICAL MARKETS

Authorization notice greeted with wary hope

Doctors welcome the news that they don't have to call United for approval anymore but add that their managed care hassles aren't over yet.

By Julie A. Jacob, *AMNews* staff. Dec. 6, 1999.

Beneath the flurry of enthusiastic media attention over UnitedHealth Group's decision to let doctors order medical tests or procedures without prior authorization, doctors are reacting with cautious optimism.

They say they welcome the return of medical decision-making into their hands. But they add that they are waiting to see the details of United's new policy and still are frustrated by things like authorization policies for prescription drugs.

United, which has been testing the no-authorization policy in selected cities since last year, announced Nov. 9 that it was dropping the requirement nationwide. The company decided to scrap authorization because the company was spending $100 million a year to review doctors' decisions and approving 99% of procedures anyway, said United's chief medical officer, Archelle Georgiou, MD. Most procedures that were denied were noncovered benefits such as cosmetic surgery, she added.

"We will assume the physicians have made the right clinical decision," Dr. Georgiou said.

But doctors still will be asked to notify United for hospital admissions, home health care and orders for some medical equipment, Dr. Georgiou said, so the insurer can coordinate the patient's care.

For example, instead of grilling a doctor about whether it is necessary for a patient to undergo a hysterectomy, she said, United will focus on making sure that the patient has a ride home from the hospital and understands postsurgical care.

The company also will beef up its use of physician profiling to give doctors feedback on how their practice patterns compare with their peers, she said.

Results from a pilot program in Tennessee, started last year, were promising, Dr. Georgiou said. After phasing out authorization requirements and introducing care coordination, medical costs dropped about 8% and utilization did not significantly increase, she said.

Minneapolis-based United has 14.5 million enrollees in 35 markets across the country. It has contracts with about 340,000 physicians, about 90% of whom are paid by fee-for-service reimbursement and 10% by capitation.

Paradigm shift or PR?

Reaction from physicians runs the spectrum from enthusiasm to skepticism.

A cardiologist in Austin, Texas, where United introduced the policy earlier this fall, called United's decision "a paradigm shift" in the way that managed care companies work with physicians.

"Instead of managed care organizations creating barriers that get in the way of the patient-physician relationship," said George Rodgers, MD, "they are now using resources to help coordinate and facilitate care. I think it is a great idea."

Dr. Rodgers added that he enjoys not having to call for approval before ordering a procedure.

Said Edward Homan, MD, an orthopedic surgeon in Tampa, Fla. "It's a win-win situation." But he added that he was "amazed that it has taken insurers so long to figure it out."

Added Michael Wasylik, MD, also an orthopedic surgeon in Tampa, "it's a major change for managed care ... but saying doctors can make decisions and take care of patients is a no-brainer."

But other doctors said they are skeptical that United really will stand behind its promise of paying for procedures that are not authorized in advance.

"I will continue to check everything, because insurance companies are pretty irresponsible in paying their bills, and patients don't know what their coverage is," said Ron Stark, MD, a hand surgeon in Milwaukee. "This thing is a big show. It is a public relations thing."

Carl Zimmerman, MD, an ob-gyn in Nashville, is taking a wait-and-see attitude. "It's too soon to tell and to assess what their motives will be," he said, adding that he wonders if United wants to protect itself from liability lawsuits, which claim the company is responsible for medical decisions.

Clay Newsome, MD, also an ob-gyn in Nashville, said he thought that United was sending physicians mixed signals.

At the same time that United has dropped authorization requirements, Dr. Newsome said, he's noticed that the insurer has tightened authorization procedures for prescription drugs and is bundling formerly separate procedures under one code. In addition, United notified doctors in Tennessee last summer that the insurer would fine doctors if customer service staff or patients complained that they were rude, Dr. Newsome said.

Doctors also noted that practitioners still would have to receive approval from United for mental health services. They said they also wanted to know more about how United intended to use its physician profiling data – whether it will be used just to help doctors improve their practices or if it will be used to drop doctors from the panel if they order too many procedures.

Dr. Georgiou responded that the company was planning to phase out authorization for mental health services within 18 months. It is also reviewing its pharmacy benefits policies, she said.

As for physician profiling, she said it was intended to help physicians improve their performance for things such as ordering beta-blockers for heart attack patients and ACE inhibitors for patients with congestive heart failure.

"We can't transition the whole company in a day," Dr. Georgiou said. "[Care coordination] is philosophy, and philosophies have to be consistent companywide."

Managed care evolution

But although doctors have mixed reactions to United's announcement, response from consumer advocates, organizations and analysts has been overwhelmingly positive.

"It's a step in the right direction," said Judy Waxman, director of government affairs for the consumers group Families USA. But she cautioned that "it is not the answer to every problem. ... There will still be pressure on doctors to carefully screen the kind of treatments that they recommend."

AMA President Thomas Reardon, MD, said United's action "is historic and represents a long-overdue victory for America's patients." He urged other insurers to follow United's example.

Analysts noted that it may be United following other insurers' example. United's move is part of a trend that has been quietly going on in managed care for several years to move away from procedure-by-procedure scrutiny and toward analysis of overall care patterns.

Authorization has "run its course," said Karen Miller, a partner with the Pace Group. Insurers are now turning their focus to long-term cost analysis, she said.

Insurers, meanwhile, scrambled to publicize that they also have been scaling back on authorization or have similar policies in place, at least for some of their plans. A spokeswoman for Humana said the company requires authorization for only a limited list of procedures, such as hysterectomies and spinal surgeries.

Kaiser Foundation Health Plans, which contract exclusively with Permanente Medical Groups, give the medical groups a set amount of money, which the medical groups then spend as they see fit for patient care, said a Kaiser spokeswoman.

Anthem's local plans set policies for procedure authorization, said an Anthem spokeswoman. But she noted that the general trend in Anthem plans has been toward reduced authorization requirements.

Mercer Inc. analyst John Ryan predicted that the industry would be watching closely to see if any of the other big players -- especially Aetna U.S. Healthcare -- discontinued authorization requirements completely for doctors in their HMO and point-of-service plans.

"Other insurers are being cagey -- Aetna particularly," Ryan said. "Aetna is the big one. Everyone wants to see what [it] will do."

Aetna is moving toward more of an emphasis on retrospective review of physicians' performance, but it has no plans to drop authorization requirements, spokeswoman Joyce Oberdorf said. It may be up to Aetna's purchasers to decide if they want those requirements dropped.

In an article that appeared in the Nov. 22 *Wall Street Journal*, Aetna chairman Richard Huber said that if employers wanted health plans with no authorization requirements, Aetna would offer them "in a heartbeat."

Ryan added that even though insurers appear to be pulling back from procedure authorization, they are not tossing cost controls out the window by any means. "I am sure they will continue to do review on the back end. They all have software to look for instances of unbundling and upcoding," Ryan said. "United will also look closely at utilization volumes and patterns and will devote more resources to physician profiling."

Back to top.

TESTIMONY ON SENATE BILL 256
ALASKA SENATE HESS COMMITTEE

February 21, 2000

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a trade association of the nation's leading commercial health insurance companies which provide health insurance for approximately 55 million Americans.

Thank you, Mr. Chairman, for providing an opportunity to present HIAA's position on Senate Bill 256. HIAA opposes SB 256 for two simple reasons -- first, giving physicians an antitrust waiver would deny consumers choice, quality, and affordability; and second, health care costs would increase significantly for both the public and private sectors.

In the past year, there has been significant debate at both the federal and state level about physician collective bargaining or physician antitrust waivers. Despite differences among the various proposals, there are four incontrovertible facts:

* Quality is not the driving force behind the physician collective bargaining movement -- it's economics. Legitimate mechanisms already exist within the boundaries of current antitrust law under which health care providers can and do collaborate and negotiate with health plans, patients, and others on clinical or quality of care issues or other concerns they may have regarding the impact of managed care on the quality of care.

* Second -- Consolidation among health plans has been and continues to be subject to rigorous antitrust scrutiny, at both the state and federal levels.

* Third -- Antitrust waiver legislation is anti-competitive and would raise costs for health care programs financed by both the public and private sectors -- through Medicare, Medicaid, and other government programs, as well as employer- and union-sponsored plans.

* Fourth -- Legislation at either the state or federal levels will be costly. For example, if legislation such as that proposed at the federal level (H.R. 1304 by Congressman Campbell) were to become law, health care premiums in the private sector would increase by 6 to 11 percent. Total annual personal health care spending would rise up to $80 billion annually. These added costs would be paid for by consumers, employers, and taxpayers, without any improvement in the quality of patient care. Or, at least 1.2 to 2.4 million more Americans would be uninsured.

Physicians, who are already among the nation's highest paid professionals, are among the least likely Americans to need the benefits of unionization. Over the last decade, as managed care has grown, physician incomes have increased more than 77 percent, with a median net income in 1997 of $199,600. Antitrust waivers or some other form of the special treatment that they are seeking through Senate Bill 256, would effectively allow physicians to further increase their salaries.

Moreover, the reality is that physicians are not seeking to form real unions. Rather, they seek to form unrestricted collective bargaining units without the regulatory oversight that all unions are subject to.

Physicians are asking state and federal governments for unique legal rights to engage in conduct that would otherwise be *per se* illegal under the antitrust laws. Granting physicians, whether as physician employees or as independent contractors, special waivers to collectively bargain and set prices, without regulatory oversight fundamental to the very concept of unionization, is unwarranted, not to mention detrimental to consumers.

Physician collective bargaining legislation is opposed by the chairman of the Federal Trade Commission, Robert Pitofsky, who says that conferring a labor exemption on physicians "would merely grant them 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."

Much has been made of the growth and consolidation of managed care organizations. In fact, physicians cite this as one of the reasons why they need antitrust waivers. Under current law, consolidation among health plans and insurers is subject to rigorous antitrust scrutiny at both the state and federal levels.

The health insurance industry continues to remain very competitive, making it improbable -- if not impossible -- for any one plan to be able to exercise significant market power in its negotiations with health care providers.

In conclusion, Mr. Chairman, collective bargaining for physicians truly would serve to benefit the few at the expense of consumers and taxpayers. It would level a devastating blow to the health care system and the success that market competition has achieved in limiting health-care inflation.

##

SENATE FINANCE COMMITTEE

S I G N - I N

SB 256-PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

NAME: Jim JORDAN Subject/Bill No: SB 256

Co./Dept./Title: Exec Director AK-MA Phone: 562-0304 X

Address: Anchorage Zip: _____

Do you wish to testify? X Yes ___ No X Respond To Questions

NAME: MIKE HANSEN Subject/Bill No: SB256

Co./Dept./Title: Exec Director Physician & Surgeons Phone: 561-7705 X

Address: Anchorage Zip: _____

Do you wish to testify? X Yes ___ No X Respond To Questions

NAME: Dr. George Rhyneer Subject/Bill No: SB256

Co./Dept./Title: _____ Phone: 561-7705 X

Address: Anchorage Zip: _____

Do you wish to testify? X Yes ___ No X Respond To Questions

NAME: Jeff Davis Subject/Bill No: _____

Co./Dept./Title: Exec Director, BC BSA Phone: 279-2404 X

Address: Anchorage Zip: _____

Do you wish to testify? X Yes ___ No X Respond To Questions

SENATE FINANCE COMMITTEE

S I G N - I N

SB 256-PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

NAME: Jack McRae / Ken Sorrin Subject/Bill No: SB256

Co./Dept./Title: Blue Cross Phone:

Address: Zip:

Do you wish to testify? X Yes ___ No X Respond To Questions

NAME: Guy Bell Subject/Bill No: SB 256

Co./Dept./Title: Retirement + Benefits Phone: 465-2292

Address: Zip:

Do you wish to testify? X Yes ___ No X Respond To Questions

NAME: Jim Jordan Subject/Bill No: SB 256

Co./Dept./Title: Exec Dir Phone: 562-0304

Address: AK St Medical Assn Zip:

Do you wish to testify? ___ Yes ___ No ___ Respond To Questions

NAME: Mike Hawsen Subject/Bill No: SB 256

Co./Dept./Title: Exec Dir Phone: 561-7705

Address: ~~AMA~~ AK Physicians & Surgeons Zip:

Do you wish to testify? ___ Yes ___ No X Respond To Questions

NAME: DR. Jerome List Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: Anchor Agl _____ Zip: _____

Do you wish to testify? ___Yes ___No X Respond To Questions

NAME: John Cyr Subject/Bill No: 256

Co./Dept./Title: NEA-AK Phone: 586-3096

Address: Juneau Zip: _____

Do you wish to testify? X Yes ___No ___Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? ___Yes ___No ___Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? ___Yes ___No ___Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? ___Yes ___No ___Respond To Questions

NAME: Lon Sorrin Subject/Bill No: SB 256

Co./Dept./Title: Asst. General Counsel BCBSA Phone: (425) 670-5786

Address: Mountlake Terrace WA Zip: 98043 X

Do you wish to testify? X Yes ___ No X Respond To Questions

NAME: Mike Ford Subject/Bill No: SB256

Co./Dept./Title: Leg. Legal Phone: X66657 X

Address: ___ Zip: ___

Do you wish to testify? ___ Yes ___ No X Respond To Questions

NAME: DWIGHT PERKINS Subject/Bill No: SB256

Co./Dept./Title: Dep. Comm. Dept of Labor Phone: 465-2700 X

Address: ___ Zip: ___

Do you wish to testify? X Yes ___ No ___ Respond To Questions

NAME: Nancy Weller Subject/Bill No: SB 256 X

Co./Dept./Title: DHSS - Div. Medical Assistance Phone: 465-5825

Address: PO Box 110640 Zip: ___

Do you wish to testify? ✓ Yes ___ No ___ Respond To Questions

NAME: GORDON EVANS Subject/Bill No: SB 252 X

Co./Dept./Title: HIAA Phone: 586-3210

Address: 211 4th St Suite 305, JUNEAU Zip: 99801

Do you wish to testify? X Yes ___ No ___ Respond To Questions

Teleconference Participants

TCN: 10647

Participant Lists

View List for

ANC | Testifiers | Go >>> | Close Window

Participants

Unidentified Testifiers: 0 Unidentified Observers: 0

ANCHORAGE (ANC)

1 Name:Bob Lohr Phone:
Address: Affiliation: Div Insura
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

---

2 Name:Julia Coster Ans ?s Phone:
Address: Affiliation: Dept Law
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

Teleconference Participants

TCN: 10470

Participant Lists

View List for ANC | Testifiers | Go >>> | Close Window

Participants

Unidentified Testifiers: 0 Unidentified Observers: 0

new list for

ANCHORAGE (ANC)

1 Name:Mr. Bob Lohr Phone:
Address: Affiliation: Div Insur
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

2 Name:Mr. Gary Ward Ans ?s Phone:
Address: Affiliation: DSS
City /St /Zip: Type: Testifier
Bill: SB 73: ASSISTED LIVING FACILITIES

3 Name:Mr. Jerome Selby Ans ?s Phone:
Address: Affiliation: Prov HS
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

4 Name:Mr. Dwight Becker Phone:
Address: Affiliation: DSS
City /St /Zip: Type: Testifier
Bill: SB 73: ASSISTED LIVING FACILITIES

5 Name:Ms. Kay Burrows Ans ?s Phone:
Address: Affiliation:
City /St /Zip: Type: Testifier
Bill: SB 73: ASSISTED LIVING FACILITIES

6 Name:Ms. Julia Coster Ans ?s Phone:
Address: Affiliation: A.G. offic
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

7 Name:Ms. Signe Andersen Ans ?s Phone:
Address: Affiliation:
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

also: UAF dropped offline
Helen Jamison, AMA, Chicago, is online for SB256

Teleconference Participants

TCN: 10470

Participant Lists

View List for

FBX | Testifiers | Go >>> | Close Window

Participants

Unidentified Testifiers: 0 Unidentified Observers: 0

FAIRBANKS (FBX)

1 Name:Ms. Monta Faye Lane Phone:
Address: AK CAREGIVERS ASSN Affiliation:
City /St /Zip: Type: Testifier
Bill: SB 73: ASSISTED LIVING FACILITIES

---

2 Name:Mr. Gary Schwartz Phone:
Address: Affiliation:
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

---

also: Ann Ringstad - UAF
R. Feinstein - Washington DC - SB256

Teleconference Participants

TCN: 10470

Participant Lists

View List for

FBX ▼ Testifiers ▼ Go >>> Close Window

Participants

Unidentified Testifiers: 0 Unidentified Observers: 0

[redacted] (FBX)

1 Name:Ms. Monta Faye Lane Phone:
Address: AK CAREGIVERS ASSN Affiliation:
City /St /Zip: Type: Testifier
Bill: SB 73: ASSISTED LIVING FACILITIES

2 Name:Mr. Gary Schwartz Phone:
Address: Affiliation:
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

3 Name:Mr. Michael Carroll Phone:
Address: Affiliation:
City /St /Zip: Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

also: Paul Smith from AK Health Care is online

Teleconference Participants

TCN: 10470

Participant Lists

View List for

ANC | Testifiers | Go >>> | Close Window

Participants

Unidentified Testifiers: 0 Unidentified Observers: 0

ANCHORAGE (ANC)

1
Name:Mr. Bob Lohr
Address:
City /St /Zip:
Phone:
Affiliation: Div Insur
Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

2
Name:Mr. Gary Ward Ans ?s
Address:
City /St /Zip:
Phone:
Affiliation: DSS
Type: Testifier
Bill: SB 73: ASSISTED LIVING FACILITIES

3
Name:Mr. Jerome Selby Ans ?s
Address:
City /St /Zip:
Phone:
Affiliation: Prov HS
Type: Testifier
Bill: SB 256: PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

4
Name:Mr. Dwight Becker
Address:
City /St /Zip:
Phone:
Affiliation: DSS
Type: Testifier
Bill: SB 73: ASSISTED LIVING FACILITIES