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

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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

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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

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[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]

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[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

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[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.

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[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

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[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

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[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]

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[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]

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[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.

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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

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[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

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[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]

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[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,

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[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

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[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

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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

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

Bureau of Competition

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Assistant Director

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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

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[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

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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.

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

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

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SB 256

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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
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APPROVED:

David R. Pender
Deputy Assistant Director
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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
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Juneau, Alaska 99801
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Interim
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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,