STATEMENT OF

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on behalf of the

ANTITRUST COALITION FOR CONSUMER CHOICE IN HEALTH CARE

FTC/DOJ JOINT HEARINGS ON
HEALTH CARE AND COMPETITION LAW AND POLICY

Session on

HEALTH INSURANCE/PROVIDERS: COUNTERVAILING MARKET POWER

May 7, 2003

I very much appreciate the opportunity to participate in today's hearing on "countervailing market power" on behalf of the Antitrust Coalition for Consumer Choice in Health Care ("ACCC-HC"). ACCC-HC is a diverse group of employers, health plans, hospitals, providers, and others involved in the purchase, management, and delivery of health care services. ACCC-HC members are dedicated to the preservation and promotion of competition in health care markets through strong antitrust enforcement.

Over the past few years, ACCC-HC has actively opposed various proposals to amend the federal antitrust laws to provide an exemption to health care providers that would allow them to negotiate collectively with health plans.[1] State legislatures have also considered, and in a few cases adopted, similar proposals.[2] All of these initiatives are premised on the assumption that an exemption would be beneficial since it would allow providers to exercise countervailing market power to balance what are assumed to be dominant health plans.

As I will describe below, such an exemption would mark a radical departure from existing antitrust principles. Providing a "pass" to cartels so they can exercise countervailing power is unnecessary. Such a proposal would be

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1 *See e.g.* H.R. 1120, 108th Cong., 1st Sess., "Health Care Antitrust Improvements Act of 2003; H.R. 1304, 106th Cong., 1st Sess., "Quality Health Care Coalition Act of 1999."

2 *See e.g* Tx. Ins. Art. 29.01 *et seq* N.J.S.A. § 52:17B-196 *et seq*.

virtually impossible to implement. And, most importantly, it would have the end result of reducing innovation, driving up health care costs, and harming consumers.

A. A "Countervailing Market Power" Exemption Would Be a Radical Departure from Longstanding Antitrust Principles

At the outset, it is important to recognize the radical nature of the proposition we are discussing here today. Allowing an unintegrated group of providers to collectively negotiate with health plans in order for them to exercise countervailing market power would immunize what has long been viewed as the most hard core of antitrust violations – naked price-fixing – which typically is subject to criminal prosecution. Moreover, the courts have repeatedly considered, and rejected, the argument that the need to acquire "countervailing market power" justifies what would otherwise be an illegal arrangement.[3]

Perhaps the most relevant judicial discussion of the countervailing market power issue is in the somewhat aptly named *Kartell* [4] case. *Kartell* involved a challenge by several Massachusetts physicians to the practice by the local Blue Shield plan of prohibiting participating physicians from balance billing – that is, enforcing the requirement that such physicians accept Blue Shield's reimbursement as payment in full. The physicians argued, among other things, that Blue Shield had substantial market power, and that its balance billing ban had the result of

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[3] *See* R. Pitofsky, *Thoughts on "Leveling the Playing Field" in Health Care Markets,* Remarks before the National Health Lawyers Association Twentieth Annual Program on Antitrust in the Health Care Field, February 13, 1997, and cases cited therein, available at <http:www.ftc.gov/speeches/pitofsky/nhla.htm>.

reducing quality, discouraging the entry of new doctors, and discouraging doctors from introducing new highly desirable medical techniques.

Judge Breyer declined to address the issue of whether or not Blue Shield had market power – he assumed for the sake of argument that it did, and that it used that power to obtain "lower than competitive prices."[5] But he flatly rejected all the physicians' assertions that this alleged market power justified special rules governing how Blue Shield must contract with participating physicians. Judge Breyer began by noting that the antitrust laws do not prohibit monopoly pricing, absent evidence that the prices are predatory, nor do they contemplate that courts should attempt the almost impossible task of determining what might be a "competitive" or "reasonable" price. Moreover, Judge Breyer noted that in this case, what the physicians were complaining about were prices that they deemed to be *too low*. Observing that the Sherman Act had been enacted in order to protect consumers against prices that were *too high*, Judge Breyer declared:

> "[T]he relevant economic considerations may be very different when low prices, rather than high prices are at issue. These facts suggest that courts at least should be cautious—reluctant to condemn too speedily—an arrangement that, on its face, appears to bring low price benefits to the consumer.[6]

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[4] *Kartell v. Blue Shield of* Massachusetts, 749 F. 2d 922 (1st Cir. 1984), *cert denied* 471 U.S. 1029 (1985).

[5] The court expressed an unwillingness to evaluate the record on market power that the district court had described as "two competing mountains of mostly meaningless papers." *Id.* at 927.

[6] *Id.* at 931.

Judge Breyer also noted that judicial hesitancy was warranted where the subject matter – medical costs -- was an area of great complexity, and also one in which the price system was supervised by state regulators. In conclusion, he noted that all these factors counseled against "departing from present law or extending it to authorize increased judicial supervision of the buyer/seller bargain," and that there was "no need to blaze new trails" in this area.

As I will describe below, just as there was no need to "blaze new trails" to condemn Blue Shield's balance billing ban, neither should new rules be adopted to allow cartels to negotiate with health plans with impunity.

B. Physicians Do Not Need Special Treatment to Bargain Effectively with Health Plans

Before addressing the practicalities and policy considerations of granting a "countervailing market power" exemption, we first should ask whether such special treatment is really needed to enable physicians to bargain effectively with health plans. The answer, for a number of reasons, is "no."

First, given the large number of competing health plans and the importance of government payers such as Medicare and Medicaid, it is doubtful that there are *any* markets in which a single private health plan has monopsony power. These hearings already have devoted considerable attention to this issue, and it is not the focus of discussion here today. But certainly the evidence is clear that in all markets providers are paid from a number of sources, and in even the most highly

concentrated health plan markets, the largest health plan accounts for only a minority of revenues to providers.[7]

Second, in many markets, it is evident that it is the physicians who have substantial market power. For example, in rural or semi-rural areas, only a few physicians can constitute a majority, or in some cases, 100%, of the physicians in a given specialty, and there are essentially no substitutes to whom health plans can turn for physician contracts. And in urban areas, single specialty group practices – some of which can include twenty, thirty or more physicians -- clearly can be "must have" providers without which a health plan cannot effectively compete. Moreover, the recent trend in which consumers have been expressing strong preferences for broad provider networks has significantly limited the ability of health plans to market networks that do not include a very wide selection of providers.

Third, the FTC and DOJ *Statements of Antitrust Enforcement Policy in Health Care*[8] make it clear that physicians can collaborate under existing antitrust laws in many ways that will enable them to contract more effectively with health plans:

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[7] *See* S.Kanwit, *The Myth of Health Plan Monopsony Power,* Statement before the FTC and DOJ Joint Hearings on Health Care Competition Law and Policy, April 25, 2003, available at <http://www.ftc.gov/ogc/healthcarehearings/docs/030425kanwittestimony.pdf>;
M. Noether, *Competition in Health Insurance and Physician Markets: A review of "Competition in Health Insurance: A comprehensive Study of U.S. Markets" by the American Medical Association* (2002), available at < http://www.ftc.gov/os/comments/healthcarecomments/accchcattach2.pdf>.

- **The antitrust laws allow providers to express their concerns about patient and quality of care issues**. Section 4 of the *Health Care Antitrust Guidelines* specifically addresses joint action by health care providers to furnish information to health plans about non-fee issues. Physicians need not fear an antitrust challenge based on communications or discussions they may have — with each other, with health plans, or with the public — concerning quality of care, patient care, or other non-fee issues. And, indeed, the agencies have never brought an enforcement action involving such conduct.

- **The antitrust laws allow providers to communicate with each other, and to health plans, about health plan contract terms and fee-related issues.** In a separate section of the *Health Care Antitrust Guidelines*, the federal antitrust agencies have established a "safety zone" for the collective provision of fee-related information, such as historical fees or other aspects of reimbursement. This safety zone applies so long as the data is submitted to a neutral third party, and is disseminated in aggregate (anonymous) form that does not reflect pricing or related information that is less than three months old.[9]/ Thus, for example, providers seeking higher reimbursement rates may jointly furnish health plans information about their historic costs, charges, or reimbursement amounts. In addition, the agencies note that the collective provision of information or views concerning prospective fee-related matters also will not raise antitrust concerns, as long as providers make independent decisions concerning their participation with health plans.[10]

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[8] Department of Justice & Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (1996), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,153 ("*Health Care Antitrust Guidelines*"), available at <www.ftc.gov/reports/hlth3s.htm>.

[9] *Id.* at 43.

[10] Both the DOJ and the FTC have recently issued favorable business review and advisory opinions in response to requests by physician organizations regarding plans to survey physicians and publish information concerning the average reimbursement rates offered by health plans in which they participate. Letter from Charles A. James, Ass't Attorney General, to Jerry B. Edmonds, Williams, Kastner & Gibbs, PLLC, dated September 23, 2002, re Washington State Medical Association, available at < http://www.usdoj.gov/atr/public/busreview/200260.htm>; Letter from Jeffrey W. Brennan, Assistant Director, Health Care Services & Products, Federal Trade Commission to

- **The antitrust laws also allow providers to share information with each other so they can better understand the terms and conditions of health care contracts and make more well-informed decisions concerning which contracts they wish to sign.** Thus, for example, providers can employ an agent who gives them objective information comparing the reimbursement rates and other terms offered by health plans in their community. Providers also can share information that will help them interpret health plan contracts. Many medical societies, including the American Medical Association, furnish their members with detailed information on reviewing health care contracts.[11] They also provide assistance to their members in interpreting and advocating for changes in contract provisions. For example, the AMA's Division of Physician and Patient Advocacy has staff that is "available to consult with and assist state and county societies in representing individual physicians and groups before health plans."[12]

- **Physicians also can join together in partially-integrated joint ventures that allow them to remain in independent practice, yet still negotiate collectively.** The most common form of these ventures is the independent practice association" or "IPA" which can take on substantial financial risk and jointly negotiate on behalf of its members. Some IPAs have grown extremely large, with more than 1000 members. The federal agencies also have recognized that such networks do not need to take on financial risk, but can receive rule of reason treatment under the antitrust laws and jointly negotiate even if they are only "clinically integrated."[13] .

Gregory G. Binford, Benesch Friedlander Coplan & Aronoff LLP, dated February 6, 2003 re PriMed Physicians, available at < http://www.ftc.gov/bc/adops/030206dayton.htm>.

[11] For example, the American Medical Association has posted on its Web site (at <www.ama-assn.org/physlegl/legal/doc4.htm>, a comprehensive annotated model managed care contract that explains in great detail the types of provisions found in most managed care contracts and suggests language that would be most favorable to physicians.

[12] American Medical Ass'n, *Legal Issues for Physicians* <www.ama-assn.org/physlegl/legal/doc5.htm>.

[13] *See e.g.* Letter from Jeffrey W. Brennan, Assistant Director, Health Care Services & Products, Federal Trade Commission to John J. Miles, Ober, Kaler, Grimes & Shriver (February 19, 2002) re

Finally, it should be noted that health insurers operate in a highly regulated environment. While some of these regulations are aimed primarily at the interface between health plans and their customers, others directly regulate provider contracts or the formation of provider networks. Such regulations ensure that health plans – no matter what their size or market power – will have their contracts and network formation activities closely scrutinized.

C. Implementing a Countervailing Market Power Exemption Would Raise Insurmountable Practical Problems

Assume, notwithstanding the above discussion, that there are situations in which a health plan does have market power, and one wishes to establish some form of special treatment that would allow unintegrated groups of physicians to deal collectively with this dominant health plan. Putting aside whether or not this would be good policy – an issue I will deal with below – any such effort would undoubtedly run into insurmountable practical problems.

At the outset, since the entire premise for allowing physicians to collectively negotiate is to the enable them to "level the playing field" with a dominant health plan, there must be a way to identify when a health plan has achieved the kind of dominance for which countervailing market power is an appropriate remedy, and also to identify who should be the beneficiaries of such collective action. But as the debates in these hearings already have demonstrated, there is serious disagreement over what market conditions, if any, would warrant a

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MedSouth, Inc. (approving physician group that would be clinically, but not financially integrated, and which would include over 400 physicians in the south Denver area), *available at* <http://www.ftc.gov/bc/adops/medsouth.htm>.

countervailing market power defense. Moreover, even if a consensus could be reached on this question, the gathering and analysis of data to determine whether those conditions are present would be a daunting task and, as is the case in many market power assessments, the data would be subject to conflicting interpretations. The result would be tremendous uncertainty as to whether the conditions that warrant a countervailing market power exemption should apply. This would make antitrust counseling extremely difficult, particularly because a "wrong" decision could expose the physician group to prosecution for a *per se* offense. While conceivably the exemption might be granted only in situations in which the government has first made a market power assessment, few enforcement agencies have the expertise and resources to make such determinations on an advisory basis.[14]

Next, it would be necessary to determine who should be the beneficiary of the countervailing market power exemption. Allowing all physicians in a particular market to band together would tip the balance far too heavily to one side.[15] But which physicians should be in, and which ones out? Establishing some limit on the market share of those who are in would raise the same kind of difficult market

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[14] Thus, for example, the FTC and DOJ in issuing advisory opinions or business review letters typically do not perform market assessments, but rather simply accept as given the description of the market as presented by the requester, with the opinion or review expressly limited to the extent to which the request accurately describes market conditions.

[15] Thus, for example, one proponent of granting a limited countervailing market power exemption has suggested that a safe harbor be granted only for small players with a collective market share of 20 percent or less in any relevant market. Grimes, *The Sherman Act's Unintended Bias Against Lilliputians: Small Players' Collective Action as a Counter to Relational Market Power,* 69 Antitrust L. J. 195, 234 (2001).

definition and analysis questions discussed above, but in this case would need to be applied to each of a multitude of individual physician specialties.

And even if it were possible to determine when a countervailing market power exemption should be granted, and who should be the beneficiary, some form of regulation over the resulting negotiations would be needed to ensure that they do not stray into inappropriate territory – and this would be a virtually impossible task. For example, the group that is allowed to collectively negotiate should not be permitted to use their market power to disadvantage competitors – such as non-physician providers. Nor should they be allowed to exercise their market power against health plans that are not deemed to be dominant. But it is difficult to imagine how one could guard against such "spillover" effects. After having negotiated collectively with the "dominant" plan, presumably raising their rates for that plan, it is highly unlikely that the same physicians would offer lower rates to any other health plans in the market. Thus, the net result would be higher prices for all health plans – whether they are large or small.

D. A Countervailing Market Power Exemption Would Not Benefit Consumers

Finally, a countervailing market power exemption is simply bad public policy. It would result in higher prices for consumers for two reasons. First, physicians would undoubtedly be successful in raising their negotiated fees. For the most part, such fees would not reflect increased output or quality, but simply a transfer of wealth from consumers to doctors. Second, a countervailing market power exemption would dull the incentives that existing antitrust policy gives

physicians to form joint ventures that have the potential to produce substantial efficiencies. Today, physicians know that if they wish to negotiate collectively, they must economically integrate through merger or some form of clinical or financial integration. While such endeavors may result in varying degrees of efficiencies, they at least have the *potential* to reduce costs and improve quality, and thereby ultimately benefit consumers. A countervailing market power exemption promises no such potential benefits.

E. Conclusion

Our health care system is increasingly relying on a competitive marketplace to reduce health care costs and improve quality. Towards this end, our focus should be on more vigorous antitrust enforcement – not less. A countervailing market power exemption would be a giant step in the wrong direction. It is not necessary, impractical and would ultimately be harmful to consumers.