COUNTERVAILING POWER PANEL
FTC/DOJ HEALTH CARE HEARINGS
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PREPARED REMARKS OF MARK TOBEY[1]

I am honored to have been invited to these important hearings.

INTRODUCTION

Whatever insights I may offer on the subject of countervailing power are based on my experience at the Texas Attorney General's Office implementing the State of Texas' physician joint negotiation statute. That statute, passed in 1999, was the first of its kind. It seeks to address a perceived imbalance of negotiating power between physicians and health benefit plans by allowing groups of competing physicians to band together upon approval by the attorney general in order to negotiate specified fee and non-fee-related issues with named health benefit plans. The statute reflects an attempt by the Texas legislature to confer state action antitrust immunity on the joint negotiation process.

In these prepared remarks I seek to describe the essential features of the Texas statute and to explain how the Texas Attorney General implemented the statute. Only one group has sought approval for joint negotiations under the statute. In August 2001, then-Attorney General John Cornyn authorized a group of eleven physicians from Henderson, Texas to negotiate jointly with Blue Cross and Blue Shield of Texas. Although Blue Cross declined to negotiate under the framework of the Texas statute with the Henderson group, our experience may be of interest to this panel. In that regard, I offer a couple of observations.

I. THE TEXAS STATUTE

A. PREAMBLE

In the preamble to the Texas statute, codified as Chapter 29 of the Texas Insurance Code, the legislature found that joint negotiations by physicians "will result in procompetitive effects in the absence of any express or implied threat of retaliatory joint action, such as a boycott or strike, by physicians."[2] While recognizing potential anticompetitive effects of joint negotiation of fee-related issues, the legislature "recognized that there are instances in which health plans dominate the market to such a degree that fair negotiations are unobtainable absent any joint action on behalf of physicians."[3]

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[1] Assistant Attorney General, Chief, Antitrust Section, Office of the Attorney General - State of Texas. The views and opinions expressed herein are my own and not necessarily those of the Texas Attorney General's Office. I gratefully acknowledge the contribution of my colleague, Kim Van Winkle, to every aspect of our implementation efforts.

[2] TEX. INS. CODE, § 29.01.

[3] *Id.*

B. SCOPE

The law allows physician joint negotiation regarding most types of commercial medical and surgical health insurance plans but excludes most governmental health benefit plans as well as supplemental single benefit and long term plans from its purview.[4] Managed care Medicaid programs and Texas' Children's Health Insurance Program are excluded from joint negotiation over fees.[5] The Texas statute applies only to physicians and podiatrists and not to other providers such as dentists.[6]

C. JOINT NEGOTIATION STANDARDS

Chapter 29 sets forth the criteria for approving joint negotiations, as well as the approval process and how such negotiations will be conducted. The attorney general may authorize joint negotiation of fee-related terms through an approved physician's representative only where the health benefit plan "has substantial market power and those [fee-related] terms and conditions have adversely affected or threaten to adversely affect the quality and availability of patient care."[7] The attorney general determines what constitutes substantial market power.[8] The statute further provides that the attorney general "shall approve" a request to enter into joint negotiations or a proposed contract if "the attorney general determines that the applicants have demonstrated that the likely benefits resulting from the joint negotiation or proposed contract outweigh the disadvantages attributable to a reduction in competition that may result. . ."[9]

With regard to specified non-fee-related issues, competing physicians in the same market may "meet and communicate for the purpose of jointly negotiating" those terms and conditions.[10] The criteria for approving non-fee-related negotiations are less rigorous than for fee-related negotiations. For non-fee-related negotiations, no substantial market power finding is required, and no determination need be made that the quality and availability of patient care is threatened. If the likely benefits outweigh the disadvantages from reduced competition, joint negotiations of non-fee-related terms are permitted.[11] Non-fee-related terms and conditions are defined to include clinical

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[4]TEX. INS. CODE, § 29.03.

[5]TEX. INS. CODE, § 29.06(c).

[6]TEX. INS. CODE, § 29.11.

[7]TEX. INS. CODE, § 29.06(a).

[8]*Id.*

[9]TEX. INS. CODE, § 29.09(b).

[10]TEX. INS. CODE, § 29.04.

[11]TEX. INS. CODE, § 29.09(b).

practice guidelines, payment procedures, referral procedures, "formulation and application of physician reimbursement methodology," quality assurance programs, and utilization review.[12] Fee-related terms and conditions include fees, discounts, capitation payment amounts and RBRVS conversion factors.[13]

The joint negotiation group is limited to no more than 10% of the physicians in a health benefit plan's defined geographic service area although the attorney general may vary that number up or down.[14] In performing its analysis, the statute directs the attorney general to "consider distribution by specialty and its effect on competition."[15]

D. JOINT NEGOTIATION PROCESS

Once the attorney general authorizes the joint negotiation, the joint negotiation group may communicate with each other,[16] and with the authorized physicians' representative[17] about the terms and conditions to be negotiated. The joint negotiation group may agree to be bound by the terms and conditions negotiated by the physicians' representative "at the option of each physician."[18] Chapter 29 preserves the ability of health benefit plans engaging in joint negotiations to contract individually on different terms and conditions with physicians in the group.[19] There is no requirement that health benefit plans participate in approved joint negotiations.

The Texas statute expressly prohibits action "to jointly coordinate any cessation, reduction or limitation of health care services",[20] and includes a provision requiring that the physicians' representative warn physicians of the potential for legal action when acting outside the authority of Chapter 29.[21] Chapter 29 also prohibits use of the joint negotiation process to address a requirement imposed by a health benefit plan that physicians or groups must participate in all of the products

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[12] TEX. INS. CODE, § 29.04.

[13] TEX. INS. CODE, § 29.05.

[14] TEX. INS. CODE, § 29.09(6).

[15] TEX. INS. CODE, § 29.09(b).

[16] TEX. INS. CODE, § 29.07(1).

[17] TEX. INS. CODE, § 29.07(2).

[18] TEX. INS. CODE, § 29.07(4).

[19] TEX. INS. CODE, § 29.07(5).

[20] TEX. INS. CODE, § 29.10.

[21] *Id.*

offered by the plan.[22] Another provision prohibits joint negotiations to restrict non-physician health care providers from participating in health benefit plans "based substantially on the fact that the health care provider is not a licensed physician . . ."[23]

In terms of approvals, the attorney general must approve or disapprove the physicians' representative, the details of proposed negotiations and any resulting contracts, based on a filing made through the physicians' representative. The filing must specify the identity of all participants, the proposed subject matter of the negotiation, a plan of operation to ensure compliance with Chapter 29, and a statement of the benefits of the proposed contract and its impact on the quality of patient care.[24]

The attorney general has 30 days to issue a written approval or disapproval of the initial filing and each proposed contract and is subject a petition for writ of mandamus if deadlines are not met.[25] If the attorney general disapproves, the attorney general must explain any deficiencies and how such deficiencies could be remedied.[26] Chapter 29 further provides: "An approval of the initial filing . . . shall be effective for all subsequent negotiations between the parties specified . . ."[27] However, after approval of the initial filing, the physicians' representative must inform the attorney general within 14 days if negotiations fail to commence or terminate.[28] If joint negotiations resume within 60 days of this notification, they may proceed under the terms of the previous filing.[29] The physicians' representative must present each resulting contract for approval subject to the same requirements.

Chapter 29 gives the attorney general rulemaking authority and the ability to set fees that cover the costs of administration of the statute.[30] It also authorizes and directs the state insurance

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[22]*Id.*

[23]*Id.*

[24]TEX. INS. CODE, § 29.08. The implementation rules adopted by the attorney general, discussed *infra*, specify in detail the information that must be provided in an application for joint negotiation.

[25]TEX. INS. CODE, § 29.09.

[26]TEX. INS. CODE, § 29.09(a).

[27]TEX. INS. CODE, § 29.09(c).

[28]TEX. INS. CODE, § 29.08(3).

[29]*Id.* The implementation rules adopted by the attorney general address the requirements for resuming negotiations more than 60 days later.

[30]TEX. INS. CODE, § 29.11.

department to collect certain enrollment information on an annual basis and to determine on an annual basis the impact of Chapter 29 joint negotiations on average physician fees in the state.[31]

II. THE TEXAS ADMINISTRATIVE RULES

Over the course of nearly nine months, the Texas Attorney General's Office sought input into the rules that govern administration of the Texas physician joint negotiation statute. Throughout the rulemaking process, our goals were to enable physicians to use the law efficiently and effectively while satisfying the requirements for state action immunity and fulfilling our statutory obligation on behalf of Texas consumers to manage and monitor the physicians' joint negotiations with health plans.[32]

A. SUBSTANTIAL MARKET POWER

In deciding what information was essential to collect from physicians, particularly as to substantial market power, we took as a model the monopsony competitive effects analysis that is embodied in the Revised Final Judgment resolving competitive issues arising out of Aetna's proposed acquisition of Prudential's health insurance business.[33] Pursuant to that consent judgment, Aetna agreed to divest certain health plan networks in Dallas and Houston. The basis for the divestitures was Aetna's market power as both a seller of health insurance services to employers and as a purchaser of medical services provided and sold by physicians.

Doctors that we interviewed in Dallas and Houston in the course of that investigation told credible stories that they would have no ability to discontinue participation with the combined Aetna/Prudential, despite having quit Aetna earlier over issues such as the handling of its formulary, its pre-certification procedures or its low reimbursement rates. They said they would have no viable alternative because of Aetna's size after its proposed acquisition of Prudential's HMO and network-based POS plans, and because of the percentage of their patients that were associated with the merging entities. Several practice groups told us that although they managed to rebuild their practices after the earlier loss of Aetna patients, they could not suffer the economic detriment if they were now forced to replace all of their Prudential patients, in part because obtaining new patients is a slow process and physicians' services cannot be stored. Instead, these doctors felt that post-merger they had no alternative except to sign Aetna contracts with the same terms and conditions they had previously rejected and accept whatever reimbursement rates they were offered.

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[31] TEX. INS. CODE, § 29.06(b)(1) and (2).

[32] The implementation rules can be found at 1 T.A.C. §§ 58.1-58.53, or on our internet site at www.oag.state.tx.us (Click on "Publications").

[33] *United States and State of Texas v. Aetna, Inc., et al.*, No. 3-99CV1398-H (N.D. Tex.) (Complaint filed June 21, 1999). The Complaint and Competitive Impact Statement discuss this issue, and are available at the website of the Antitrust Division of the Department of Justice: usdoj.gov/atr.

Rather than suffer the potentially insurmountable losses to their practices, these doctors indicated that they would do such things as eliminate Saturday clinics, use more non-physician personnel in patient encounters and spend less time with each patient. Survey data indicated that for significant numbers of Houston and Dallas physicians, the combined entity represented 20% or more of their patient loads. DOJ and the Texas Attorney General's Office concluded that the proposed acquisition would give Aetna the ability to depress physician reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in the quality of physician services.

Our decision to use the Aetna/Prudential merger review as a touchstone for analysis of proposed physician joint negotiations is further supported by the legislative history of the Texas statute. During a committee hearing, the house sponsor, Representative John Smithee, cited the pending Aetna/Prudential merger and its potential adverse effects on patient care in Dallas and Houston as justification for the bill.

Therefore, in our rules, we ask each member of the proposed joint negotiation group to provide confidential information about which payors constitute the lion's share of their respective books of business and what each payor reimburses for certain key procedure codes. The goal is to determine whether the health benefit plan with which negotiations are desired has the same kind of seller and buyer side power as was found potentially to affect quality or availability of care in the Aetna/Prudential matter.

B. OTHER ADMINISTRATIVE PROVISIONS

Our administrative rules owe a debt too large to enumerate to various federal antitrust guidelines and advisory opinions. For example, we wanted to minimize the risk that applicants could misuse information obtained through the joint negotiation process. Accordingly, the Texas rules draw upon the DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care in such matters as the collective provision of fee-related information (Statement 5) and the exchange of price and cost information (Statement 6). Among other things, we require that the physicians' representative carefully set forth the procedures for developing the fee information necessary to compile the initial application to the attorney general.[34] We counsel that a third party rather than one of the physicians in the joint negotiation group should serve as physicians' representative in an application to negotiate jointly over fees. Regarding pre-application discussions to determine interest in engaging in the Chapter 29 process, we counsel that such discussions should not move beyond an expression of general dissatisfaction and evaluations of whether the issues warrant the formation of a negotiation group.[35]

As to market definition we apply the concepts outlined in the horizontal merger guidelines. In order to perform the analysis we are prepared to seek information from knowledgeable third

[34] 1 T.A.C. § 58.11(e)(1).

[35] See the "Dear Physician" letter on our internet site at www.oag.state.tx.us (Click on "Publications").

parties outside of that submitted in the application by interviewing or issuing subpoenas to major employers, competing health benefit plans and the plan that is the subject of the joint negotiation.

III. ANALYSIS OF THE HENDERSON, TX PHYSICIAN APPLICATION

During the summer of 2001 the attorney general reviewed the first application for joint negotiation, from a group of eleven physicians in rural Henderson, Texas. The group consisted of physicians in solo and partnership practices, including three family practitioners, two obstetrician-gynecologists, an internist, a pediatrician, a general surgeon, an orthopedic surgeon, a podiatrist, and an ophthalmologist. All were members of the 28-member Rusk County Medical Alliance, a physician-hospital organization affiliated with Henderson Memorial Hospital. The group sought permission to jointly negotiate fee-related and non-fee-related terms and conditions in their PPO and POS contracts with Blue Cross and Blue Shield of Texas ("BCBSTX").

In conducting our review, we gathered and analyzed information from BCBSTX and other market participants such as employers, hospitals, competing health plans and PPO networks. Based on all of the evidence, we found that the statutory requirements for joint negotiation were satisfied and approved the application on August 30, 2001.

A. BARGAINING POWER OF JOINT NEGOTIATION GROUP

The size and composition of the joint negotiation group was well within statutory guidelines. Its members represented less than 1% of all the physicians in BCBSTX's Northeast Texas service area. Similarly, the joint negotiation group represented less than 10% of each physician specialty in the relevant geographic market for those services. Henderson is a small town in a rural area with large numbers of Medicare and Medicaid patients and a history of being under served by certain physician specialties. Henderson residents obtain both primary and specialty care in the nearby cities of Tyler and Longview as well as in Henderson. Accordingly, the relevant market for these physicians' services includes Rusk, Smith, and Gregg Counties. The primary care physicians (PCPs) in the joint negotiation group represented less than 1% of all PCPs in the three-county market, and the specialists in the joint negotiation group represented less than 10% of their respective specialties in the three-county market. Because there were adequate numbers of alternative physicians in each specialty available in this market for BCBSTX to contract with, and none of the physicians in the joint negotiation group were essential for the formation of a marketable network, we concluded that the joint negotiation group would not possess market power.

B. BARGAINING POWER OF BLUE CROSS BLUE SHIELD

We found that BCBSTX was the largest commercial health plan in the three-county area. It controlled a significant share of the privately-insured covered lives in this market and generally

across East Texas. Its next largest competitor was only about half its size. It appeared that BCBSTX was particularly dominant in the market for employers with 50 or fewer covered lives. The departures of two competitors that wrote this type of coverage in this market may have increased BCBSTX's dominance.

Moreover, BCBSTX was the largest private purchaser of physician services in this market; the physicians in the joint negotiation group derived a large share of their commercial revenues from BCBSTX. Even when payments from Medicare and Medicaid were included, BCBSTX accounted for a significant share of these physicians' revenues. The evidence indicates that these physicians are locked in to their contracts with BCBSTX; their practices could not absorb the loss of BCBSTX revenues, and the pool of non-BCBSTX patients with commercial insurance from which they could re-build their patient load is relatively small. Furthermore, BCBSTX contracted with physicians on a "take it or leave it" basis in this market, and had not revised its fee schedule for over five years. Based on the specific facts of this application, therefore, we found that BCBSTX had substantial market power vis-a-vis the physicians in the joint negotiation group.

C. EFFECTS ON QUALITY AND AVAILABILITY OF CARE

We also found that BCBSTX's dominant position and its terms and conditions for physician compensation threatened to adversely affect the quality and availability of patient care in the Henderson area. As mentioned previously, BCBSTX had not increased or otherwise adjusted its fee schedule in over five years. In general, its rates were lower than those paid by other commercial plans. Its rates for primary care codes were equivalent to Medicare's. While it was difficult to discern the specific impact of these rates on a particular physician's practice, there was evidence that these rates, combined with BCBSTX's large share of the market and ability to impose price cuts on locked-in physicians, threatened to adversely affect the quality and availability of patient care. Physicians who could not terminate their contracts with BCBSTX (or credibly threaten to do so) would likely be forced to cut their office staff, which can lead to an increase in mistakes and more administrative duties being placed on medical staff. Physicians could be forced to work longer hours, which would similarly have an adverse impact on quality, or adopt other cost-cutting measures that adversely impact the quality of care. BCBSTX's low rates also apparently had hampered efforts to recruit and maintain adequate numbers of physicians in Henderson, a rural market historically under served by various physician specialties. In some circumstances, quality of care could also suffer due to lack of local access to certain specialists.

D. BALANCING BENEFITS AGAINST DISADVANTAGES

The preceding findings and analysis informed our final determination that the likely benefits resulting from the proposed joint negotiations outweighed the disadvantages attributable to any reduction in competition that may have resulted. This was true with respect to both the fee and non-fee negotiations. The likely benefits of the proposed joint negotiations included alleviation of the threats to quality and availability of care discussed above, improvements in access to local physicians, continuity of care, and improved outcomes due to more prompt treatment. In addition,

we found that joint negotiations may lead to improvements in administrative procedures by addressing issues such as retrospective coverage denials, prompt payment issues, and misinformation given to patients about their benefits.

On the other side of the equation, we found the potential harm to competition was negligible. As discussed previously, the joint negotiation group represented only a small portion of the relevant three-county market for each physician specialty, so it would not wield undue leverage in negotiations with BCBSTX. Moreover, the group included only one physician (or partnership practice) in each type of specialty, so the formation of the group would not reduce existing competition among these specialists. The only combination of competitors was with respect to the PCPs in the group, and the reduction in competition among PCPs was insignificant because there are many other PCPs in the market with which BCBSTX could form a marketable provider panel. Accordingly, we found that the likely benefits of the joint negotiations described above outweigh the minimal reduction in competition that may have resulted.

E. TERMINATION OF JOINT NEGOTIATION AUTHORITY

BCBSTX refused to participate in the approved joint negotiations. Although BCBSTX engaged in messenger-model negotiations with the Henderson PHO during the pendency of the application, the physicians' representative informed us in December 2001 that BCBSTX had declined to enter into joint negotiations with the Henderson group. Therefore, on December 21, 2001, the Office of the Attorney General notified the physicians' representative that she was no longer authorized to initiate or engage in joint negotiations, and the physician members of the joint negotiation group were no longer authorized to share fee-related information with one another or to coordinate their responses to BCBSTX contract proposals.

IV. OBSERVATIONS

I offer the following general thoughts about joint negotiation statutes as a means for examining the effect of countervailing power on quality and availability of care:

- The Texas physician joint negotiation statute represents a good faith attempt to test the effect of countervailing power in a reasonably circumscribed setting, although the limited experience of Texas does not permit us to draw any conclusions.

- The characteristics of medical practice seem to make physicians susceptible to lock-in; anecdotal evidence seems to suggest it can occur.

- Despite the foregoing, solid economic evidence that patients will benefit from a broader application of countervailing power is missing.

- A requirement that health plans negotiate is impractical and not essential.

- State-action approach has inherent problems - the process is burdensome and immunity is uncertain.

- Antitrust may not be the best vehicle for addressing physician contracting problems.