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Testimony of Michael P. Connair, M.D.
Vice President

Of the

Federation of Physicians and Dentists (FPD)

And of the

National Union of Hospital and Healthcare Employees (NUHHCE)

Affiliated with

American Federation of State, County and Municipal Employees (AFSCME)

Before the

U.S. House of Representatives Committee on the Judiciary

Subcommittee on Courts and Competition Policy

For the hearing on

Antitrust Laws and Their Effect on Health Care Providers, Insurers and Patients

December 1, 2010

American Federation of State, County and Municipal Employees, AFL-CIO
TEL (202) 429-1000 **FAX** (202) 429-1293 **TDD** (202) 659-0446 **WEB** www.afscme.org 1625 L Street, NW, Washington, DC 20036-5687

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Thank you Mr. Chairman and distinguished members of the Subcommittee for inviting me to testify today. I am Dr. Michael P. Connair, a solo practitioner of orthopedic surgery in Connecticut, past president of the Connecticut Orthopaedic Society, member of the Connecticut State Medical Society, the American Academy of Orthopaedic Surgeons, the American Medical Association, and the Vice President of the Federation of Physicians and Dentists and the National Union of Hospital and Healthcare Employees (NUHHCE) which are affiliated with the American Federation of State, County and Municipal Employees (AFSCME, AFL-CIO). I trained at Harvard Medical School and its affiliated hospitals and am now an Assistant Clinical Professor of Orthopaedics at Yale. My clinical practice includes caring for private patients insured by commercial and government insurers and taking care of the orthopedic needs of children served by the Spina Bifida Clinic at Yale New Haven Hospital.

My unpaid union role for 14 years has been to educate physicians about the lawful procedures necessary to obtain fairer contractual terms from commercial health insurers, consistent with the 1996 Department of Justice/Federal Trade Commission (DOJ/FTC) *Statements of Antitrust Enforcement Policy in Health Care*. These contracts between insurers and physicians, so-called provider agreements, regulate not only the reimbursement that physicians receive, but greatly affect the quality of medically necessary care that physicians are allowed to provide for patients. Physician members of three of the groups that I helped organize were subsequently sued by DOJ for alleged antitrust violations, despite Herculean efforts to follow the cumbersome third-party messenger model outlined by DOJ. (See Reference Notes 1, 2 and 3.) The physician members of these three groups had simply refused to be coerced into contractual arrangements that would have resulted in a 20% or more decrease in reimbursement. Many doctors were threatened by the insurers with contract termination for refusal to accept their unilateral demands.

I fully support and agree with the earlier testimony today of my orthopedic colleague Dr. Peter Mandell and want to make several additional points from the perspective of a labor union vice president who practices medicine. (Reference Note 4.)

Union members have a significant stake in health care, because unions represent the largest block of organized consumers in the nation. Unions also sponsor health plans through funds that are jointly-trusteed with management. And of course, many union members,

including myself, work in the health care industry and rely on help with employment contract negotiations.

Quality of care always has been a primary concern for the labor movement. Working families frequently give up wage increases in order to maintain their health care coverage. Unions bargain to ensure that coverage for working families will actually provide the care they need when they get sick. Too often, the quality of coverage does not meet this test because insurance companies, rather than physicians, inappropriately dictate the care a patient deserves and ultimately receives. If harm occurs to a patient because of an administrative decision by an employer-funded ERISA insurance plan, the insurer cannot be sued for damages caused by cutting corners to increase profits. Physicians are often powerless to insist upon the best care, yet can be held responsible if a bad outcome occurs.

The contractual relationship of individual physicians to a commercial health care insurer is similar to the weak position that unorganized service workers face against an employer that unilaterally provides unfair wages and poor working conditions in order to maximize profit. There is much more at stake in a one-sided physician-insurer "provider agreement" than physician finances. Health care quality and access are impacted by a bad provider agreement. Bad contracts give insurers the legal "right" to limit care and impose substandard care on workers and all consumers. As a practical matter, insurers possess monopsony power as the purchaser of physician services in virtually all U.S. markets and doctors have no choice but to participate in these contracts. Even if a physician could afford to drop out of these contracts, patients usually cannot afford to pay for physician services out-of-pocket. I have actually stayed in bad plans at the request of valued patients with whom I have an established relationship – as a powerless solo practitioner, what else can I do?

I outlined some of the most egregious contractual terms that adversely impact patient care in oral and written testimony to the full House Committee on the Judiciary in 1998 in support of the "Quality Health-Care Coalition Act of 1998" (H.R. 4277), legislation sponsored by former Rep. Tom Campbell and later also by Chairman Conyers. (Reference Note 5.) This legislation would have allowed physicians to collectively bargain all contractual terms with insurers including those provisions that affect the quality of patient care. These harmful contractual terms include:

- Contracts that discourage appropriate specialty care;
- Unreasonable administrative barriers to prompt and reasonable care;
- Forcible separation of patients from trusted physicians;
- Low paying contracts which result in high volume but lower quality care;
- Capitation schemes which pay physicians not to treat patients; and
- Contracts that can be unilaterally modified by the insurer without negotiation.

The ability of a physician to ask or demand a fair contract from an insurer has deteriorated further since the 1998 hearings on H.R. 4277. Since then, a lack of antitrust enforcement against insurers and more than 30 cases against physicians has made insurers downright arrogant in their treatment of physicians and patients. The DOJ/FTC antitrust enforcement pattern with respect to the physicians-insurer contracting process has had a chilling effect on physicians' willingness to resist substandard provider agreements either for their own

financial survival or to protect the quality of patient care and the access to care. David Balto, former Director for Policy and Evaluation in the FTC's Bureau of Competition, commented on the economic impact of the 31 such physician cases brought by the DOJ and FTC between 2000 and 2008. He said the "Bush Administration spent a disproportionate amount of resources on physicians – bringing 31 cases... These enforcement actions may have resulted in many enforcement actions without much benefit to consumers or impact in the market." (Reference Note 6.) But Mr. Balto was referring to pricing and did not consider the negative cumulative impact that repeated legal assaults on physicians have had on the availability of primary care physicians. The unprecedented use of antitrust enforcement has augmented insurer bargaining power and ability to intimidate physicians into accepting low fees or even ceasing to practice medicine. As monopolists, these same insurers suffer no loss of business for diminishing the availability or quality of important medical services.

Since 1997, the Federation of Physicians and Dentists, NUHHCE and AFSCME have worked extensively to level the playing field for physicians with respect to their employment relationship with insurers. Much of that effort has been devoted to defending doctors against antitrust allegations made by insurers; DOJ responds to insurance company complaints against physicians with costly subpoenas, depositions and consent decree negotiations. The legal costs for physicians to defend themselves against a DOJ or FTC investigation or prosecution are so punitive that physicians sign humiliating consent decrees simply to avoid a trial. During the DOJ antitrust case against the orthopedists of Delaware in 1998, the legal defense costs to deal with approximately 20 depositions and 80 subpoenas and the negotiation of a consent decree totaled $1.5 million, and that was without a trial!

The labor movement is also greatly concerned about skyrocketing costs aggravated by monopoly and oligopoly pricing of insurance products in many markets. Antitrust enforcement efforts with respect to insurance company mergers and acquisitions by federal and state agencies have been tepid at best. The recent DOJ litigation against Blue Cross of Michigan was newsworthy in part because such actions are infrequent. Consider my own State of Connecticut, where the number of health insurers has dwindled from eight to only three or four insurers depending on a patient's geographic location in the State. Most recently, UnitedHealthcare acquired HealthNet, but DOJ and the FTC did not review the merger – simply letting these enormous national insurers get bigger under the false premise that some economies of scale would funnel down to patients. Well, in Connecticut, with the extreme premium rate requests, we have not seen those economies of scale – although the insurer profit margins have increased.

Like many health care policy makers in Congress, the labor movement agrees that there is a pressing need to grow the ranks of primary care providers. But insurance company practices are inhibiting this growth by undervaluing the work of these doctors. By failing to adequately compensate primary care physicians, the industry is driving doctors into specialties that will provide an adequate return on the educational investment and time needed to become a doctor. Primary care physicians are often paid less for an office visit than a plumber or veterinarian. Dedication alone will not pay office overhead, malpractice insurance premiums and medical school debt.

Some primary care physicians, sick of fighting insurers, give up private practice and become hospital employees. This trend is not always in the best interest of patients whose health care needs do not always align with the hospital's financial needs. Employed physicians may not

be able to advocate as effectively for patients if care decisions might threaten job security. Allowing hospitals and health systems to get larger is not the answer either, as this could also lead to increased control by a few select entities large enough to dictate pricing and unfairly compete with independent physicians and privately owned ancillary facilities.

Health care benefits are part of a worker's overall compensation provided in lieu of additional wages. Unopposed monopoly/oligopoly pricing of insurance products robs workers and employers of value. When one-third of health care dollars are diverted away from patient care, workers are shortchanged. DOJ and the FTC have done little to control the consolidation of the insurance industry into fewer and larger insurers with increasing market influence.

For example, for many years in the Philadelphia, Pennsylvania metropolitan area, there have been only two insurers. Annual double digit premium increases are routine, in some cases as high as over 50%. As a result, low-income hospital workers covered by one multi-employer fund faced with such increases have agreed to forego negotiated wage increases in order to assist their employers in paying for increased premiums.

A false semblance of market stability results when physicians sign substandard contracts without a fight. The one-sided antitrust prosecutions and forced consent decrees, always against doctors and *never* against insurers, are often highly unfair, especially when the policing efforts of DOJ lack adequate oversight by the courts. Often the insurance company contractual demands that caused physicians to revolt in the first place are not set forth in the consent decree. Dr. Mandell, in his testimony today, refers to the onerous Idaho consent decree. A description of the insurance company activities precipitating the Delaware and Cincinnati cases are not included in those consent decrees.

Federal judges are mandated by the 2004 amendments to the Tunney Act to review antitrust consent decrees for fairness and impact on the public. This is not routinely done. In public remarks made on February 28, 2007, Jay L. Himes, then-Chief of the Antitrust Bureau in the Office of the New York Attorney General, stated that the Tunney Act was amended in 2004 to ensure that the courts "undertake meaningful and measured scrutiny of antitrust settlements to ensure they are truly in the public interest..." (Reference Note 7.) During debate on the 2004 amendments, then-Chairman F. James Sensenbrenner commented that the amendments were to ensure judicial review beyond the "mockery of justice" standard. In the Senate, Senator Mike DeWine stated that "mere rubber-stamping [of consent decrees] is not acceptable." But DOJ has not taken this view of federal court review of its consent decrees. After a consent decree was signed by the obstetricians of Cincinnati three years ago, there were several requests made of Judges Sandra S. Beckwith and Timothy S. Hogan to review the shotgun consent decree. In the Response to Public Comments by U.S. Attorney Gregory Lockhart concerning these requests, he stated that the Tunney Act (APPA) "does not permit the Court to review the efficacy or 'correctness' of the United States' enforcement policy or its determination to pursue – or not pursue – a particular claim in the first instance... the district court should not second-guess the prosecutorial decisions of the Antitrust Division..." He goes on to say that "the court is only authorized to review the decree itself." His statement contradicts the intent of the amended Tunney Act as noted by Senator DeWine and Chairman Sensenbrenner.

As a physician dedicated to providing the best care possible for my patients, and as a member of a labor union dedicated to the welfare of its members and all consumers, I am pleased

that the negative effect of antitrust enforcement policy on patient care is being examined by this Committee. A rebalancing of the contractual power between physicians and insurers needs to take place in order to guarantee patient access to quality medical care. ***Antitrust legislative reforms*** must include a reconsideration of the right of physicians to collectively negotiate with payers. ***Antitrust regulatory reforms*** must include an update of the *1996 Statements of Antitrust Enforcement Policy in Health Care* consistent with current market realities, and the collective negotiation rights necessary for physicians to develop and participate in quality initiatives such as Accountable Care Organizations. ***Antitrust enforcement reforms*** must start and end with an evenhanded application of the rules of competition by DOJ and the FTC consistent with the intent of the Sherman Act. That includes independent review of the last 35 consent decrees for fairness.

I want to thank Chairman Conyers, Chairman Johnson and members of the Subcommittee for holding this hearing. I am pleased to answer any questions you may have.

Reference Notes:

1. USA v. Federation of Physicians and Dentists, et. al. in Delaware (Case No. 98-475)
2. USA v. Federation of Physicians and Dentists, et. al. in Cincinnati (Case No. 1:05-cv-431)
3. USA and Idaho v. Idaho Orthopaedic Society, Idaho Sports Medicine Institute, Doerr, Hessing, Kloss, Lamey and Watkins (Case No. 10-268-S.EJL)
4. Peter J. Mandell, M.D. and AAOS, December 1, 2010, Statement on DOJ/FTC Enforcement of Antitrust Laws against Physicians to House Judiciary Subcommittee
5. Michael P. Connair, M.D. and AFSCME, July 29, 1998, House Judiciary Testimony in support of The Quality Health-Care Coalition Act of 1998
6. David Balto, "An Open Letter to the Next Federal Trade Commission Chairman," *GPC: The Online Magazine for Global Competition*, January 2009
7. Jay L. Himes, Chief, Antitrust Bureau, Office of the New York Attorney General, remarks to COMPTEL PLUS, Spring Convention and Expo, Las Vegas, NV, February 28, 2007.

CURRICULUM VITAE

MICHAEL P. CONNAIR, M.D., P.C.
12 VILLAGE STREET, SUITE 8
NORTH HAVEN, CT 06473
(203) 777-2044

EDUCATION:

HARVARD MEDICAL SCHOOL, Boston, MA
M.D. 1975

HOLY CROSS COLLEGE, Worchester, MA
B.A., Physics, 1971

LA SALLE ACADEMY, Providence, RI
Graduated 1967

MEDICAL TRAINING:

HARVARD GENERAL SURGICAL SERVICE, Boston, MA
Two years of General Surgical Residency-New England Deaconess Hospital, Boston City Hospital, Cambridge City Hospital, Mt. Auburn Hospital, V.A. Hospital, Faulkner Hospital.

1977 to 1980

HARVARD COMBINED ORTHOPEDIC SURGERY RESIDENCY, Boston, MA
Orthopedic Residency: Massachusetts General Hospital, Children's Hospital Medical Center, Peter Bent Brigham Hospital, Beth Israel Hospital, Robert Brigham Hospital, New England Baptist Hospital.
Six months as Registrar at Northwick Park Hospital, London, England.

8/80 to 4/81

CHILDRENS HOSPITAL MEDICAL CENTER, Boston, MA
Chief Residency and then Fellowship (under John Hall, M.D.)

PROFESSIONAL POSITIONS:

12/80 to 5/81

HARVARD UNIVERSITY HEALTH SERVICES, Cambridge, MA
Consulting Orthopedic Surgeon (with admitting and operating privileges at Brigham & Women's Hospital, Boston, MA).

6/81 to 5/83

NEW HAVEN ORTHOPEDIC GROUP, New Haven, CT
Orthopedic Surgeon, Group Practice

1983 to present

YALE NEW HAVEN SPINA BIFIDA PROGRAM, New Haven, CT
Spina Bifida Program-Clinic Attending and Orthopedic Consultant

1983 to present	**SOLO ORTHOPEDIC SURGERY PRACTICE**, North Haven, CT
1985 to 1998	**AREA COOPERATIVE EDUCATIONAL SYSTEM** (ACES: Greater New Haven school system for students with special needs), Orthopedic Consultant.
HOSPITAL AFFILIATIONS:	**YALE SCHOOL OF MEDICINE**, New Have, CT Status: Assistant Clinical Professor of Orthopaedics **YALE NEW HAVEN HOSPITAL**, New Haven, CT Status: Attending **HOSPITAL OF ST. RAPHAEL**, New Haven, CT Status: Attending **YALE AMBULATORY (TEMPLE) SURGICAL CENTER** (Outpatient Surgery Center), New Haven, CT
BOARD CERTIFICATION:	**AMERICAN BOARD OF ORTHOPEDIC SURGERY** Board Certified, 1987; Recertified, 1995 & 2006
STATE LICENSE:	Connecticut.
PROFESSIONAL SOCIETIES AND INTERESTS:	American Academy of Orthopedic Surgeons Board of Councillors (2007-Present) American Medical Association Connecticut State Medical Society (Board of Councillors). New Haven County Medical Association (Councillor) New Haven Medical Association New Haven Independent Physician's Association (Executive Board Member) Hospital of St. Raphael, IPA (Executive Board Member- 1990 to 1993) Yale New Haven Hospital, (PHO Contract Committee Member- 1996 to 2000)

PROFESSIONAL SOCIETIES AND INTERESTS (continued)

Connecticut Orthopedic Society (Executive Board Member-1994 to present; Vice-President 1996 to 1997; President 1997-1999)
Federation of Physicians and Dentists, (Coordinator and organizer for physician unionization 1995 to present; Vice President 1998 to present)
National Union of Hospital and Healthcare Employees, (AFSCME, AFL-CIO) (Vice President 2002-Present)

LECTURES TO MEDICAL SOCIETIES ON PHYSICIAN UNIONIZATION, PHYSICIAN EMPOWERMENT AND ANTITRUST ISSUES (including regional and national medical society meetings)

Western Orthopedic Association Annual Meeting (8/96)
Hartford Orthopedic Forum (6/97)
Ohio Orthopedic Society Annual Meeting (5/97)
Massachusettes Orthopedic Society (5/97)
Plastic Surgical Society of Connecticut (2/97)
New England Orthopedic Association Annual Meeting (6/97)
Mid-Central States Orthopedic Association Annual Meeting (6/97)
American Acamdemy of Orthopedic Foot Surgery Annual Meeting (7/97)
Urologist of Connecticut
Tennessee Orthopedic Association Annual Meeting (8/97)
Summer Institute of the American Academy of Orthopedic Surgeons (Course Lecturer, managed care 9/97)
New England Neurosurgical Society Annual Meeting (9/97)
American Academy or Orthopedic Surgeons Board of Councillors Bi-Annual meeting (10/97)
American Academy of Orthopedic Surgeons Health Policy Council (2/97)
New Haven Medical Association (11/97)
Maryland Orthopedic Association (12/97)
Staff of Hospital for Joint Diseases, New York (12/97)
Dowling Lectureship St. Francis Hospital, Hartford
Washington, D.C. Orthopedic Society (12/97)
Neurosurgical Society of the Virginias Annual Meeting (1/98)
Prince William County (Virginia) Medical Society (3/98)
American Association of Physicians of Indian Origin, Washington, D.C. (3/98)
American College of Surgeons, Long Island Chapter (4/98)
Mid-American Orthopedic Association Annual Meeting (4/98)

LECTURES:
(Continued)

American Academy of Ophthalmology Mid-Year Forum (4/98)
Arlington (Virginia) County Medical Association (4/98)
North Dakota Medical Association Annual Meeting (5/98)
Baltimore City Medical Society (5/98)
Prince George (Maryland) County Medical Association (5/98)
Connecticut State Medical Society Annual Meeting, Orthopedic Section (6/98)
New Hampshire State Medical Society Meeting (6/98)
Michigan Orthopedic Society Annual Meeting, Presidential Guest Lecturer (6/98)
Montgomery County (Pennsylvania) Medical Society (7/98)
Faculty and Staff of the Jefferson University Medical School (7/98)
American Association of Hip and Knee Surgeons Annual Meeting (11/04)
Idaho Orthopedic and Hand Society Annual Meeting (9/06)
Yale Orthopaedic Department Grand Rounds (3/07)
Lectures between 8/98 and present also include:
American Academy of Orthopedic Surgeon, Annual Meeting, Texas Orthopedic Association, Cardio Thoracic Surgeons of Connecticut, Utah Orthopedic Society, and others

ADDITIONAL SPEAKING ENGAGEMENTS:

Hospital staffs or general or specialty physician groups in Rhode Island, Massachusetts, New Hampshire, Connecticut, New York, New Jersey, Pennsylvania, Washington, D.C., Virginia Maryland, Delaware, California, Arizona, Florida, Illinois, Ohio, North Dakota, Michigan, Nevada, Texas and South Carolina

Oral and written testimony given to the U.S. House of Representatives Judiciary Committee concerning antitrust relief for physicians (7/98)
Written testimony and press conference presentation for Campbell/ Conyers Bill (6/99)
Oral and written testimony to CT State legislature Committees concerning antitrust relief for physicians.

UNIONIZATION EFFORTS:

Aided in organizing viable union chapters of the Federation of Physicians and Dentists in Rhode Island, Connecticut, Virginia, Maryland, Texas, Washington, D.C., Pennsylvania, Ohio, Illinois, Utah, Idaho, Florida, Arizona, Michigan, Delaware, Nevada to assist physicians in dealing with managed care insurance contracts on behalf of themselves and their patients.