106TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
106–625

QUALITY HEALTH-CARE COALITION ACT OF 2000

MAY 18, 2000.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. HYDE, from the Committee on the Judiciary, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 1304]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 1304) to ensure and foster continued patient safety and quality of care by making the antitrust laws apply to negotiations between groups of health care 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, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

TABLE OF CONTENTS

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Quality Health-Care Coalition Act of 2000".

SEC. 2. APPLICATION OF THE ANTITRUST LAWS TO HEALTH CARE PROFESSIONALS NEGOTIATING WITH HEALTH PLANS.

(a) IN GENERAL.—Any health care professionals who are engaged in negotiations with a health plan regarding the terms of any contract under which the professionals provide health care items or services for which benefits are provided under such plan shall, in connection with such negotiations, be entitled to the same treatment under the antitrust laws as the treatment to which bargaining units which are recognized under the National Labor Relations Act are entitled in connection with such collective bargaining. Such a professional shall, only in connection with such negotiations, be treated as an employee engaged in concerted activities and shall not be regarded as having the status of an employer, independent contractor, managerial employee, or supervisor.

(b) PROTECTION FOR GOOD FAITH ACTIONS.—Actions taken in good faith reliance on subsection (a) shall not be the subject under the antitrust laws of criminal sanctions nor of any civil damages, fees, or penalties beyond actual damages incurred.

(c) LIMITATION.—

(1) NO NEW RIGHT FOR COLLECTIVE CESSATION OF SERVICE.—The exemption provided in subsection (a) shall not confer any new right to participate in any collective cessation of service to patients not already permitted by existing law.

(2) NO CHANGE IN NATIONAL LABOR RELATIONS ACT.— This section applies only to health care professionals excluded from the National Labor Relations Act. Nothing in this section shall be construed as changing or amending any provision of the National Labor Relations Act, or as affecting the status of any group of persons under that Act.

(d) 3-YEAR SUNSET.—The exemption provided in subsection (a) shall only apply to conduct occurring during the 3-year period beginning on the date of the enactment of this Act and shall continue to apply for 1 year after the end of such period to contracts entered into before the end of such period.

(e) LIMITATION ON EXEMPTION.—Nothing in this section shall exempt from the application of the antitrust laws any agreement or otherwise unlawful conspiracy that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care professional or group of health care professionals with respect to the performance of services that are within their scope of practice as defined or permitted by relevant law or regulation.

(f) NO EFFECT ON TITLE VI OF CIVIL RIGHTS ACT OF 1964.—Nothing in this section shall be construed to affect the application of title VI of the Civil Rights Act of 1964.

(g) NO APPLICATION TO FEDERAL PROGRAMS.—Nothing in this section shall apply to negotiations between health care professionals and health plans pertaining to benefits provided under any of the following:

(1) The medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) The medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) The SCHIP program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(4) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

(5) Chapter 17 of title 38, United States Code (relating to Veterans' medical care).

(6) Chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

(7) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(h) GENERAL ACCOUNTING OFFICE STUDY AND REPORT.—The Comptroller General of the United States shall conduct a study on the impact of enactment of this section during the 6-month period beginning with the third year of the 3-year period described in subsection (d). Not later than the end of such 6-month period the Comptroller General shall submit to Congress a report on such study and shall include in the report such recommendations on the extension of this section (and changes that should be made in making such extension) as the Comptroller General deems appropriate.

(i) DEFINITIONS.—For purposes of this section:

(1) ANTITRUST LAWS.—The term "antitrust laws"—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section 5 applies to unfair methods of competition, and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) HEALTH PLAN AND RELATED TERMS.—

(A) IN GENERAL.—The term "health plan" means a group health plan or a health insurance issuer that is offering health insurance coverage.

(B) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—The terms "health insurance coverage" and "health insurance issuer" have the meanings given such terms under paragraphs (1) and (2), respectively, of section 733(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)).

(C) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given that term in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)).

(3) HEALTH CARE PROFESSIONAL.—The term "health care professional" means an individual who provides health care items or services, treatment, assistance with activities of daily living, or medications to patients and who, to the extent required by State or Federal law, possesses specialized training that confers expertise in the provision of such items or services, treatment, assistance, or medications.

PURPOSE AND SUMMARY

H.R. 1304 would allow doctors and other health care providers an antitrust exemption for the limited purpose of bargaining collectively with health insurers and health maintenance organizations. The core provision of the bill provides that any group of health care professionals which is negotiating with a health plan shall, in connection with those negotiations, have the same antitrust exemption that labor unions have.

BACKGROUND AND NEED FOR THE LEGISLATION

In recent years, health insurers and health maintenance organizations ("HMOs") have increasingly asserted control over health care decisions that health care providers and patients once made. The insurers and HMOs contend that these kinds of controls are necessary to keep prices low and to keep health insurance coverage affordable. Providers contend that these kinds of controls invade the traditional provider-patient relationship and that they keep prices so low that doctors cannot practice economically. Providers further contend that in negotiating contracts that establish these controls the insurers have much greater bargaining power than do individual providers.

H.R. 1304 arises from this last point. Proponents argue that providers will be able to get a fair deal in these negotiations only if the law allows them to band together to negotiate with insurers and HMOs. They argue that providers cannot engage in these

kinds of joint negotiations without an antitrust exemption. They also believe that patients will be better served because the providers will use their greater bargaining power to seek contracts that allow the insurers less control over patient care.

Critics argue that the bill would harm consumers because it would allow providers to fix prices and engage in group boycotts thereby driving up the cost of insurance. To the extent that health insurance premiums do rise, critics argue that this would cause a corresponding drop in Federal tax revenue because of the deductibility of such premiums. The bill places no limits on the percentage of providers in a market that could band together. Thus, providers, particularly in smaller markets, could exercise high degrees of market power. They also contend that under current guidelines issued by the Federal Trade Commission and the Department of Justice, providers are free to band together in group practices and negotiate directly with employers if they do not like the deals they get with insurers. Ultimately, they argue that the bill would end the ability of competitive forces to control health care costs and to improve efficiency.

Because of the disagreement and uncertainty as to how the bill will work under actual market conditions, the committee adopted a 3-year sunset provision during its markup. This provision will allow a short experiment with the bill before any decision as to whether to continue it. During the third year, the General Accounting Office will conduct a study of how the bill has worked and recommend whether it should be extended.

HEARINGS

The full Judiciary Committee held 1 day of hearings on H.R. 1304 on June 22, 1999. The committee heard testimony from 13 witnesses. In the 105th Congress, the full committee held 1 day of hearings on similar legislation, H.R. 4277, on July 29, 1998. At that hearing, the committee heard testimony from six witnesses.

COMMITTEE CONSIDERATION

On March 30, 2000, the Full Committee met in open session and ordered favorably reported the bill H.R. 1304, as amended, by a vote of 26 to 2 with one member passing, a quorum being present.

Various amendments were considered as follows. On March 16, 2000, the committee began its consideration of H.R. 1304. Chairman Hyde offered an amendment that made four changes to the bill. The Hyde amendment: (1) struck the findings section; (2) added language clarifying the non-strike language in the bill; (3) added language clarifying that the bill applies only to providers who are excluded from the National Labor Relations Act and does not change or amend the NLRA; and (4) added a 3-year sunset and provided for a Federal Trade Commission study of how the bill is working during the first 6 months of the third-year of the 3-year period. The Hyde amendment passed by voice vote.

Mr. Conyers offered an amendment to strike the definitions of "Medicare+Choice organization," "Medicare+Choice plan," and "Medicaid managed care entity" from the bill and also delete these

terms from the definition of a "health plan." This first Conyers amendment passed by voice vote.

Mr. Nadler offered an amendment to provide that the antitrust exemption provided in the bill does not apply to any agreement that excludes or limits the performance of services by any other health care professional or group of health care professionals within their lawful scope of practice. During consideration of this first Nadler amendment, Mr. Watt asked for and received unanimous consent to add the language of the Watt-Waters amendment to the first Nadler amendment. The Watt-Waters amendment provided that nothing in the bill shall be construed to affect the application of Title VI of the Civil Rights Act. The first Nadler amendment, with the Watt-Waters amendment added, then passed by unanimous consent.

After consideration of the first Nadler amendment, with the Watt-Waters amendment added, the committee recessed with no amendment pending.

On March 30, 2000, the committee resumed its consideration of H.R. 1304. At that time, Mr. Nadler offered a second amendment in lieu of his first amendment. This second Nadler amendment was identical to the first, including the addition of the Watt-Waters amendment, except that it added the phrase "or otherwise unlawful conspiracy" after the word "agreement." By unanimous consent, the committee adopted the second Nadler amendment in lieu of the first Nadler amendment.

Mr. Pease offered an amendment that would have required health care providers seeking to use the exemption provided by the bill to get prior approval from the Federal Trade Commission orthe Department of Justice before beginning collective bargaining. Mr. Goodlatte offered a second degree amendment to the Pease amendment that would have required preapproval only for groups comprising 20% or more of the relevant market. The committee passed the Goodlatte second degree amendment by a rollcall vote of 17–13. Afterwards, Mr. Pease withdrew his underlying amendment. As a result, neither the Pease amendment nor the Goodlatte second degree amendment became part of the bill as ordered reported.

Mr. Conyers offered a second amendment that provided that nothing in the bill shall apply to negotiations between health care professionals and health plans pertaining to benefits under Federal health programs. The second Conyers amendment also changed the Hyde amendment so that the General Accounting Office would perform the study of the bill instead of the Federal Trade Commission. The second Conyers amendment was adopted by voice vote.

After consideration of the second Conyers amendment, the committee proceeded to vote on the motion to report favorably the bill, as amended, as described above.

VOTES OF THE COMMITTEE

The committee took two rollcall votes during its consideration of H.R. 1304.

1. Mr. Pease offered an amendment that would have required health care providers seeking to use the exemption provided by the bill to get prior approval from the Federal Trade Commission or

the Department of Justice before beginning collective bargaining. Mr. Goodlatte offered a second degree amendment to the Pease amendment that would have required preapproval only for groups comprising 20% or more of the relevant market. The committee passed the Goodlatte second degree amendment by a vote of 17–13. Afterwards, Mr. Pease withdrew his underlying amendment. As a result, neither the Pease amendment nor the Goodlatte second degree amendment became part of the bill as ordered reported. The vote on the Goodlatte second degree amendment was as follows:

ROLLCALL NO. 1

	Ayes	Nays	Present
Mr. Sensenbrenner	X		
Mr. McCollum	X		
Mr. Gekas	X		
Mr. Coble	X		
Mr. Smith (TX)	X		
Mr. Gallegly	X		
Mr. Canady	X		
Mr. Goodlatte	X		
Mr. Chabot			
Mr. Barr		X	
Mr. Jenkins	X		
Mr. Hutchinson	X		
Mr. Pease	X		
Mr. Cannon	X		
Mr. Rogan	X		
Mr. Graham		X	
Ms. Bono			
Mr. Bachus			
Mr. Scarborough			
Mr. Vitter	X		
Mr. Conyers		X	
Mr. Frank			
Mr. Berman		X	
Mr. Boucher	X		
Mr. Nadler		X	
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren			
Ms. Jackson Lee		X	
Ms. Waters		X	
Mr. Meehan		X	
Mr. Delahunt			
Mr. Wexler		X	
Mr. Rothman		X	
Ms. Baldwin		X	
Mr. Weiner		X	
Mr. Hyde, Chairman		X	
Total	17	13	

2. The committee voted to adopt the motion to report favorably the bill, H.R. 1304, as amended, by 26 to 2 with one member passing. The vote on the motion to report favorably the bill, H.R. 1304, as amended, was as follows:

ROLLCALL NO. 2

	Ayes	Nays	Present
Mr. Sensenbrenner		X	
Mr. McCollum	X		

ROLLCALL NO. 2—Continued

	Ayes	Nays	Present
Mr. Gekas		X	
Mr. Coble	X		
Mr. Smith (TX)	X		
Mr. Gallegly	X		
Mr. Canady	X		
Mr. Goodlatte	X		
Mr. Chabot			
Mr. Barr	X		
Mr. Jenkins	X		
Mr. Hutchinson	X		
Mr. Pease			
Mr. Cannon			
Mr. Rogan			
Mr. Graham	X		
Ms. Bono			
Mr. Bachus			
Mr. Scarborough	X		
Mr. Vitter	X		
Mr. Conyers	X		
Mr. Frank			
Mr. Berman			PASS
Mr. Boucher	X		
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren	X		
Ms. Jackson Lee	X		
Ms. Waters	X		
Mr. Meehan	X		
Mr. Delahunt			
Mr. Wexler	X		
Mr. Rothman	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Hyde, Chairman	X		
Total	26	2	1 PASS

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the committee reports that the findings and recommendations of the committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

COMMITTEE ON GOVERNMENT REFORM FINDINGS

No findings or recommendations of the Committee on Government Reform were received as referred to in clause 3(c)(4) of rule XIII of the Rules of the House of Representatives.

NEW BUDGET AUTHORITY AND TAX EXPENDITURES

The Congressional Budget Office cost estimate, which appears below, fulfills the requirements of clause 3(c)(2) of House Rule XIII.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the committee sets forth, with respect to the bill, H.R. 1304, the following estimates and comparisons prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act of 1974. The first estimate was prepared on the bill as introduced. The second estimate was prepared on the bill as reported. The committee has also included correspondence between Representative Campbell and the Congressional Budget Office relating to the estimates.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 15, 1999.

Hon. HENRY J. HYDE, *Chairman,*
Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1304, the Quality Health-Care Coalition Act.

If you wish further details on this estimate, we will be pleased to provide them. The principal CBO staff contact is James Baumgardner, who can be reached at 225–0810.

Sincerely,

DAN L. CRIPPEN, *Director.*

H.R. 1304—Quality Health-Care Coalition Act of 1999.

As introduced on March 25, 1999.

SUMMARY

H.R. 1304 would exempt health care professionals from antitrust laws when they negotiate with health plans over fees and other terms of any contract under which they provide health care items or services. Professionals who form coalitions for that purpose would receive the same treatment under antitrust laws that labor organizations receive for collective bargaining activities under the National Labor Relations Act. The Congressional Budget Office (CBO) concludes that under the bill some health professionals, including doctors, dentists, and pharmacists, would join together and negotiate for higher compensation and greater flexibility in the provision of care, thereby increasing private and public expenditures for health care.

The bill would affect both federal revenues and outlays. By increasing costs to private health plans, H.R. 1304 would result in higher private health insurance premiums. In the case of employer-sponsored health plans, higher premium contributions charged to employers would be passed on to employees in the form of lower cash wages and other fringe benefits. Reductions in those taxable forms of compensation would lead to lower federal and state tax revenues. 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.

H.R. 1304 would also raise the costs of several federal health programs. Direct spending for the Federal Employees Health Bene-

fits Program (FEHBP), Medicaid, and the State Children's Health Insurance Program (SCHIP) would grow by an estimated $165 million in 2001 and by $11.3 billion over the 2001–2010 period. Discretionary spending by federal agencies for the FEHBP would increase by another $0.5 billion over ten years. Other federal programs could also be affected, but CBO has not yet completed estimates of those effects.

The bill contains an intergovernmental mandate as defined by the Unfunded Mandates Reform Act (UMRA), but CBO estimates that it would impose no significant costs. Thus, its costs would not exceed the threshold established in that act ($55 million in 2000). However, state, local, and tribal governments would face higher expenses as purchasers of health care for their employees and as providers of health care under Medicaid, and they would realize lower income tax collections because taxable income would be lower. The bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 1304 is shown in Table 1. The bill would add to discretionary spending by all federal agencies for employee health benefits and would affect mandatory spending in budget function 550 (health). It would also reduce federal revenues.

BASIS OF ESTIMATE

Under the bill, some health professionals would join together to negotiate for higher compensation and greater flexibility in the provision of care. CBO assumes that it would take five years for the bill to have its full effect on the health care market. Once that effect was obtained, CBO estimates that H.R. 1304 would increase national expenditures on private health insurance by 2.6 percent in 2006 in the absence of any compensating changes on the part of health plans or other entities.

Allowing health care professionals to bargain collectively with health plans would result in higher health care expenditures for two reasons. First, the increased market power achieved by providers who could form and maintain effective coalitions would allow them to obtain higher fees from the health plans. Second, the greater flexibility that health professionals would obtain in the provision of care would lead to greater utilization of services.

Effect on Fees for Health Care

For the purposes of this estimate, health care professionals are separated into three categories: physicians, dentists and other health care professionals, and pharmacists. Based on projections of national health expenditures for 2000, private health insurance spending for physicians will equal an estimated $128 billion, spending for dentists and other health professionals will total $53 billion, and spending for prescription drugs and related items will be $59 billion.

TABLE 1. ESTIMATE OF THE BUDGETARY EFFECTS OF H.R. 1304, THE QUALITY HEALTH-CARE ACT

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
REVENUES											
On-Budget: Income and Medicare Payroll Taxes	0	-100	-260	-430	-620	-840	-950	-1,000	-1,060	-1,120	-1,190
Off-Budget: Social Security Payroll Taxes	0	-45	-110	-190	-280	-370	-420	-440	-470	-490	-520
Total	0	-145	-370	-620	-900	-1,210	-1,370	-1,440	-1,530	-1,610	-1,710
DIRECT SPENDING											
Federal Employee Health Benefits for Annuitants	0	5	10	20	25	35	40	40	45	50	50
Medicaid	0	150	330	550	805	1,110	1,220	1,340	1,475	1,620	1,780
SCHIP	0	10	20	40	60	75	75	80	85	90	100
Total	0	165	360	610	890	1,220	1,335	1,460	1,605	1,760	1,930
SPENDING SUBJECT TO APPROPRIATION ACTION											
Federal Employee Health Benefits for Active Workers	0	10	20	30	45	60	65	65	70	75	80
Indian Health Service	Not Yet Estimated										
Tricare (Department of Defense)	Not Yet Estimated										
Other Federal Health Programs	Not Yet Estimated										

NOTE: SCHIP = State Children's Health Insurance Program.

Physicians. The effect on health care costs of allowing physicians to form coalitions to bargain with health plans would depend on the gain obtained by each physician joining a coalition and the number of physicians who would join.

Based on studies of the effects of unionization on the compensation of employees, CBO estimates that, on average, doctors who join an effective coalition would secure an increase in fees averaging 15 percent. Only a fraction of all physicians would become members of such coalitions, however.

Currently 20 percent of physicians are nonsupervisory employees of a health organization and, therefore, are already eligible to form a union. (They would not be directly affected by the bill.) Of those approximately 100,000 physicians, about 40 percent are either members of unions or covered by a collective bargaining agreement. CBO expects that fraction to grow over the next several years.

Of the approximately 400,000 practicing physicians who would be newly eligible to form a coalition under the bill, CBO estimates that about one-third would join an effective coalition within five years. (In addition, some physicians who did not join an effective coalition would benefit from negotiated increases in fees.) Together with the growing fraction of employee-physicians who are expected to be union members, we estimate that under the bill almost 40 percent of physicians would be union or coalition members by 2006.

About 30 percent of all physicians would join effective coalitions because of the legislation. Assuming a 15 percent average increase in fees, total physician fees would rise by about 4.5 percent. Because physicians represent about one-third of insured national health expenditures, CBO estimates that the effect of newly eligible physicians joining those coalitions under H.R. 1304 would be to in-

crease total private health insurance expenditures by 1.6 percent in 2006.

Dentists and Other Health Professionals. Like physicians, dentists and other health professionals who join an effective coalition under the bill would obtain higher fees from health plans. CBO assumes that those health professionals would secure the same 15 percent average increase in fees if they were able to form effective coalitions. However, CBO expects that the fraction of dentists and other health professionals who would maintain an effective coalition would be lower than the proportion of participating physicians. Also, dentists and other health professionals account for a much smaller percentage of private health expenditures than do physicians. As a result, CBO estimates that higher fees for dentists and other health professionals would increase private health expenditures by about 0.3 percent in 2006.

Pharmacists. H.R. 1304 would also make pharmacists eligible to form a coalition to negotiate with health plans over the net margins received for filling prescriptions. CBO assumes that pharmacists who could maintain an effective coalition would have the same bargaining power as other health professionals. Thus, on average, they would be able to negotiate an average increase of 15 percent in their net margins. CBO expects that about one-third of pharmacists would join an effective coalition. CBO estimates that higher fees paid to pharmacists as a result of H.R. 1304 would increase private health insurance expenditures by 0.1 percent.

Effect on Health Care Utilization

Health care professionals who formed an effective coalition under the bill would also be likely to bargain with managed care plans for greater flexibility in the provision of care. Those plans control costs to a certain extent by regulating the quantity of services performed. Not all managed care plans limit the use of services to the same extent, however. Preferred provider organizations (PPOs), for example, control costs by negotiating discounts on the prices of services and exercise very little management over the use of services. Health maintenance organizations (HMOs), in contrast, often have tighter utilization controls.

Negotiations allowed under the bill would weaken the utilization management controls used by some plans. Fee-for-service plans and PPOs would not be directly affected because they have extremely limited utilization controls. Group- and staff-model HMOs would also be unlikely to be significantly affected because the physician groups that work in those types of HMOs have a long history of less costly practice styles, exemplified by lower rates of hospitalization. Also, physicians who are employees of HMOs can already unionize under current law so any behavior they might undertake to increase utilization would not be a direct result of H.R. 1304.

In contrast, other forms of HMOs and point-of-service plans tend to be staffed by independently practicing doctors who are less integrated into the organization. Those plans have brought about utilization savings through various forms of financial incentives and administrative requirements. Such control mechanisms could be partly dismantled as the result of collective negotiations by the physicians that staff such network plans. For those plans, utiliza-

tion management now yields about a 5 percent savings compared to indemnity insurance. CBO estimates that 50 percent of the utilization savings associated with coalition physicians who contract with those managed care plans would be lost as a result of the bill. This increase in utilization by coalition physicians would raise private health expenditures by 0.3 percent.

While CBO believes that professionals who form coalitions would gain the most flexibility under this bill, the utilization effect might not be limited to health professionals who are members of a coalition. If professionals in coalitions changed the way they practice medicine, that would affect conventions of medical practice more generally. That is, the changes in the way those professionals practice their trade could spill over to the rest of the physician population. The presence of this effect is based on evidence that physicians usually adhere to the norms of practice established by their peers. CBO expects that such changes in professional practice would only increase utilization by about one-fifth of the increase in utilization that would occur in managed care plans whose utilization controls would be weakened through negotiation. This spillover effect would raise private health expenditures covered by insurance by an additional 0.3 percent.

Effect on Federal Revenues and Direct Spending

H.R. 1304 would reduce federal revenues and increase direct spending (see Table 1). By increasing premiums for employer-sponsored health benefits, it would substitute nontaxable employer-paid premiums for taxable wages and would therefore decrease federal income and payroll tax revenues. CBO estimates that the bill would reduce federal tax revenues by $145 million in 2001 and by $10.9 billion over the 2001–2010 period. Social Security tax revenues, which are off-budget, account for about 30 percent of those totals.

The legislation would impose additional costs on several federal health programs because they would be subject to similar price and utilization pressures. CBO has completed preliminary estimates of the effects on the Federal Employees' Health Benefits Program, Medicaid, and the State Children's Health Insurance Program (SCHIP). CBO estimates the bill would not have a significant effect on spending by Medicare because Medicare's administered pricing systems insulate the program from pricing changes in the private sector. CBO expects the proposal would also increase spending by the Indian Health Service, Tricare, and other federal health programs, but has not completed estimates of those effects.

CBO estimates H.R. 1304 would increase direct spending by FEHBP (for annuitants), Medicaid, and SCHIP by $165 million in 2001 and by $11.3 billion over the 2001–2010 period. Assuming appropriation of the necessary amounts, CBO estimates the proposal would increase discretionary spending by federal agencies for the FEHBP for active workers by $10 million in 2001 and $0.5 billion over ten years. CBO has not completed estimates of the effect on discretionary spending for other federal health programs.

PAY-AS-YOU-GO CONSIDERATIONS

Because the bill would affect federal revenues and direct spending, pay-as-you-go procedures would apply. The direct spending and

revenue effects are shown in Table 1. For pay-as-you-go purposes, only the effects in the current year, the budget year, and the succeeding four years are counted.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 1304 contains an intergovernmental mandate as defined by UMRA, but CBO estimates it would not impose significant costs on state, local, or tribal governments. By exempting health care professionals from certain antitrust laws, the bill would preempt state laws that govern similar exemptions under current law, and therefore would be a mandate as defined by UMRA. However, because the bill would not require states to take action as regulators in order to comply with the new exemption, and in some cases might reduce oversight responsibilities, CBO estimates the mandate itself would impose no costs on state, local or tribal governments.

State, local, and tribal governments would experience an increase in premiums for health insurance for their employees and would also incur an increase in Medicaid costs. State expenditures for Medicaid and SCHIP would increase by $120 million in 2001 and by $2.3 billion over the 2001–2005 period. At present, CBO cannot estimate the likely increase in the cost of health insurance for employees of state, local, and tribal governments.

Most states that tax income use the federal adjusted gross income measure as the basis of their tax calculations. Consequently, substituting non-taxable income for taxable income for federal income tax purposes would have the effect of decreasing state income tax collections as well.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains no private-sector mandates as defined in UMRA.

ESTIMATE PREPARED BY:

Federal Cost Estimate: James Baumgardner, Karuna Patel, and Tom Bradley
Impact on State, Local, and Tribal Governments: Leo Lex
Impact on the Private Sector: James Baumgardner and Karuna Patel

ESTIMATE APPROVED BY:

Robert A. Sunshine
Assistant Director for Budget Analysis

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, March 16, 2000.

Hon. DAN L. CRIPPEN, *Director,*
U.S. Congress,
Congressional Budget Office, Washington, DC.

URGENT

DEAR DIRECTOR CRIPPEN: Thank you for the copy of your office's cost estimate for HR 1304, the Quantity Health-Care Coalition Act,

which I received last night. The bill is to be considered by the Judiciary Committee today.

I write to draw to your attention five points in that analysis on which I would appreciate your further thought. As this bill is about to be considered in the Judiciary Committee, and, hopefully, will be on the floor shortly thereafter, I respectfully request your immediate attention to the following major points.

(1) The analysis estimates an increase in fees paid to doctors. It assumes 100% of that increase in fees will be passed along to employers. However, the increase in fees that might occur would be presented to the HMO or the insurer in the first instance, not to the employer. Under normal economic assumptions of derived demand, unless demand for the insurance product is 100% inelastic, some of an increase in fees will be borne by the HMO in the form of lower profit to its shareholders. Your analysis appears to assume a 100% pass-along, however. May I respectfully ask, on what basis do you assume an elasticity of derived demand of zero for employee insurance services by employers?

(2) Your analysis assumes that: "higher premium contributions charged to employees would be passed on to employees in the form of lower cash wages and other fringe benefits." Once again, that assumes a zero elasticity, this time, the elasticity of demand for health insurance (as opposed to other forms of compensation) by employees. If, however, there is non-zero elasticity, we would expect some of the higher premium contributions to be absorbed by a change in the ratio of compensation elements, favoring cash over health insurance. That effect would actually INCREASE the portion of an employee's compensation package that is taxable.

May I respectfully ask, on what basis do you assume a zero elasticity of demand for employer-provided health insurance by employees?

(3) On the same point as number 2, you assume the employer passes along 100% of the higher HMO cost to the employee in the form of "lower cash wages and other fringe benefits." However, unless the employer's derived demand for labor has zero elasticity, one would expect a sharing of this increased cost, with the employer bearing part of them. The tax revenue result would result in lower profits for the employer, which would lower tax revenues, but this would offset the diminished revenue predicted by your study from lower wages for employees, and I do not know, a priori, which effect is greater.

May I respectfully ask, on what basis do you assume a zero elasticity of derived demand for labor?

(4) Your study predicts that doctors would receive higher fees and greater flexibility within HMO's, and from this your conclude that employers (including government employers) would have to pay more for HMO coverage of their employees. However, to the extent HMO's now become more attractive to doctors, there also ought to be an effect of a higher percentage of medical care being delivered through HMO's rather than under alternative systems (like fee-for-service, and PPO's). Since you assume that HMO's deliver medical care at lower cost than these alternative systems, you

ought to have estimated savings from the substitution effect, along with the higher cost from the price effect.

May I respectfully inquire on what basis you failed to include any effect from an expected increase in doctors choosing to be part of HMO's?

(5) You assume, as a result of HR 1304, doctors will on average receive higher fees. However, I do not see anywhere in your analysis where you consider the higher personal income tax derived from those higher fees. Nevertheless, you did include the effect of paying the higher fees on the revenue derived from employers and employees. Indeed, that is the principal basis for your conclusion of revenue loss to the federal treasury.

May I respectfully inquire why you did not include any estimate of higher income taxes derived from the higher fees to medical doctors that your analysis predicts?

Thank you for your consideration of the foregoing five points. Your response in the earliest possible time-frame would greatly assist in the fair consideration of this bill.

With best regards,

TOM CAMPBELL, *Member of Congress.*

cc. Hon. Henry Hyde
Hon. John Conyers

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 22, 2000.

Hon. TOM CAMPBELL,
House of Representatives, Washington, DC.

DEAR CONGRESSMAN: I am pleased to respond to your letter of March 16, 2000, requesting additional information on the Congressional Budget Office's estimate of the budgetary impact of H.R. 1304, the Quality Health-Care Coalition Act.

Your letter raises five points—the first four of which involve the extent to which increases in health insurance costs resulting from the bill would cause changes in taxable wages and salaries. CBO estimates that H.R. 1304 would increase private health insurance costs by 2.6 percent *before* accounting for the responses of health plans and others to the potentially higher prices.

As you point out, health plans, firms, and workers would have incentives to adjust in a number of ways to this increase in the price of insurance. Those adjustments would result in reductions in coverage by employers and employees, changes in the types of health plans that are purchased, and reductions in the extent of coverage through increased deductibles, higher copayments, or other changes in the scope or generosity of benefits. In the short run, plans and employers might also absorb some of the cost in the form of lower profits.

CBO assumes that such behavioral responses would offset 60 percent of the potential impact of the bill on workers' compensation other than health benefits. We estimate that the remaining 40 percent of the 2.6 percent potential increase, or about 1 percent of private health insurance costs, would be passed through to workers in the form of reduced compensation (other than health benefits). We

further adjust the estimate to account for some reductions in other fringe benefits.

To illustrate our calculation, consider the estimate for 2006, the first fiscal year in which CBO projects the full effects of the bill would be realized. In that year, tax-sheltered, employment-based health insurance premiums are forecast to be almost $445 billion. In order to arrive at our estimate of the federal revenue loss, CBO applies only 40 percent of the 2.6 percent estimated impact of the bill on private health insurance expenditures to the baseline amount of $445 billion. After a reduction to account for changes in other fringes, an average marginal tax rate is applied to give the estimated revenue loss of $1.37 billion. The estimate would have been over twice as large if we had not considered the behavioral changes in response to the increased costs.

Your fifth point addresses the larger issue of the shift of resources into the medical sector that would occur under the bill. While it is true that more resources would be spent on physicians' services, fewer dollars would be spent on goods and services outside of the health services sector. The resulting higher incomes and taxes in the medical sector would be offset by lower incomes and taxes elsewhere. National income, overall, would not be affected. The revenue loss captured in our estimate is due to another effect of the bill—the shift in workers' compensation from wages and salaries, which are taxable, to employer-provided health benefits, which are not taxed.

I hope this information is helpful to you. If we can be of further assistance, please let us know. The CBO staff contact on this subject is Tom Bradley, who can be reached at 226–9010.

Sincerely,

DAN L. CRIPPEN, *Director.*

cc: Honorable Henry J. Hyde
Chairman
Committee on the Judiciary

Honorable John Conyers, Jr.
Ranking Democratic Member

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, April 16, 2000.

Hon. DAN L. CRIPPEN, *Director,*
U.S. Congress,
Congressional Budget Office, Washington, DC.

DEAR DIRECTOR CRIPPEN: Thank you for your letter of March 22, in response to my letter of March 16, regarding HR 1304. I had the benefit of speaking with your associate, Mr. Bradley, following receipt of your letter; and I base this request on facts that I learned in that conversation. I attach copies of all previous correspondence for your convenience.

I raised five points in my letter of March 16. Your reply of March 22 responded to four of those five. I understand your reply to my point number 5 and concede that you are correct. Thank you for clarifying that for me. My point number 4 received no reply, and I will turn to that shortly. As to points 1–3, I have a simple request for clarification.

Point A. The health care impact on ultimate consumers is 1% not 2.6%. My points 1–3 were that any increase in reimbursements to health care professionals would not show up 100% as increases in health care costs to consumers, because some of the increased cost will be absorbed by employers (point 1), some will be absorbed by HMO's (point 2); and some will be absorbed by employees choosing less health care in their package of compensation (point 3).

Your original March 15 letter to Chairman Hyde made no mention of these possible effects. Your response of March 22, claims that you took all of these into account: "CBO assumes such behavioral responses would offset 60 percent of the potential impact of the bill on workers' compensation other than health benefits." However, your letter of March 15, nowhere mentions this 60% offset. When I spoke with Mr. Bradley, he said to me "it probably was an oversight to have omitted the 60%" from the March 15 letter. I now understand, of course, what you meant, but by showing the apparent inconsistency, I hope to elicit from you a clarifying statement.

Here is how the two letters appear inconsistent: 1) March 15, page 2: "CBO estimates that HR 1304 would increase national expenditures on private health insurance by 2.6 percent in 2006 in the absence of any compensating changes on the part of health plans or other entities"; and 2) March 22, page 1: "CBO estimates that HR 1304 would increase private health insurance costs by 2.6 percent before accounting for the responses of health plans and others to the potentially higher prices. * * * CBO assumes that such behavioral responses would offset 60 percent of the potential impact of the bill on workers' compensation other than health benefits. We estimate that the remaining 40 percent of the 2.6 percent potential increase, or about 1 percent of private health insurance costs, would be passed through to workers in the form of reduced compensation (other than health benefits.)" [emphasis in original] The problem is that, since your March 15 letter said 2.6%, and never mentioned the 1% number, and because the March 15 letter never spelled out what the "compensating changes on the part of health plans or other entities" were, some are inaccurately citing your March 15 letter for the proposition that HR 1304 will increase health care costs to individuals by 2.6%.

May I please ask for you to write a letter to me, with a copy to all shown as cc's on this letter, that your calculations actually reflect a 1%, not a 2.6%, increase in health care costs to the ultimate consumers? As you might sympathize—debate on the floor is often truncated, and I fear that the 2.6% number will be bandied about, when the correct number is 1%.

Point B. Where did the 60%–40% come from? Secondly, now that I know you applied an assumption of only a 40% pass through to ultimate consumers, and I'm glad you did—I need to know where you obtained that estimate? Neither letter cites any study whatsoever that the combined elasticity effects to which I referred would have a 40% pass-through effect. When I queried Mr. Bradley on this, he responded that he was using a "rule of thumb." Please check with him, that's exactly what he said, as I'm sure he'll tell you. I asked him if he had any studies to rely on, and he said no, just the "rule of thumb." At the least, readers of your March 15 and March 22 letters should know that your numbers embed a rather major assumption for which no scholarly or research work is cited.

Believe me, I'm glad you used some "rule of thumb" rather than assuming a 100% pass-through, as I had originally thought, based on your March 15 letter. But how can any fair critic assess this estimated pass-through, when there is no authority cited for it except a "rule of thumb"?

Point C. The effect of change in behavior by medical professionals. Lastly, I recur to point 4 of my letter of March 16. There, I raised a point very different from the elasticity question discussed above. I said that, since HR 1304 would make HMO's more attractive to medical professionals, we could expect more of them joining HMO's. Since HMO's deliver health care at lower cost, on average, than fee-for-service or PPO's (an assumption that underlies all your estimates), there should be some cost saving from more doctors entering HMO's, even as I grant a higher cost per HMO. As you can see, this is not a question of "pass through." It is an entirely different factor. And it was not included in your analysis.

I was very disappointed in Mr. Bradley's answer on this. He said, that this, too, was included in the "rule of thumb." I really must protest. I can understand using a "rule of thumb" for estimating elasticities; but to say that that included consideration of this substitution effect as well strains my credibility. Rather, what seems to me, is that you simply did not consider this factor. That's ok, if you can consider it now. But to say, it too, was under the 60%–40% rubric, without any citation for how much of the estimated 60% offset was due to this effect, and how much to the elasticity effect, is unacceptable to me. This was made all the more so because I had concluded the discussion of the "rule of thumb" with Mr. Bradley before turning to this effect, he had said the "rule of thumb" was a pass-through estimate, he had made no mention of it also including the substitution effect, but when I pointed out your March 22 letter had simply not responded to point 4 of my March 16 letter, Mr. Bradley swept this quite different point up into the same "rule of thumb." If your "rule of thumb" included this substitution effect, to what degree? Can you kindly tell me how the 60% offset was calculated—how much for elasticity between medical professional and HMO, how much for elasticity between HMO and employer, how much for elasticity between employer and employee, and how much for the substitution effect as more doctors agreed to enter HMO's?

Point D. Amendments in Committee to exclude all federal programs. Lastly, you are in receipt of a request, I believe, from Chairman Hyde to update your March 15 letter to reflect the fact that a Conyers Amendment was accepted in mark-up, following the date of your March 15 letter, to exclude all federal health programs from this bill. Turning to page 3 of your March 15 letter, Table 1, I observe several lines under the categories of "Direct Spending" and "Spending Subject to Appropriation Action" that should be adjusted because of this amendment. Can you kindly let me know when you have done so?

Director Crippen, despite my disappointment on Point C above, I do want you to know that I appreciate your sincere efforts to respond to my points, and Mr. Bradley's patience in dealing with me on the telephone. Our interests are exactly the same—to provide the most accurate estimates possible of the fiscal effects of this leg-

islation; and I fully recognize the difficulty of your work and the professionalism with which you and your staff execute it.

Kind regards,

TOM CAMPBELL, *Member of Congress.*

cc: Speaker Hastert
Chairman Henry Hyde
Chairman Goodling
Chairman Bliley
Chairman Kasich
Chairman Dreier
Chairman Thomas
Ranking Member Conyers
Congressman Goss
Members of the House Judiciary Committee
Parliamentarian Charles Johnson
Mr. Tom Bradley, CBO

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 17, 2000.

Hon. HENRY J. HYDE, *Chairman,*
Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1304, the Quality Health-Care Coalition Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact for federal costs and intergovernmental mandates is James Baumgardner, who can be reached at 225–0810.

Sincerely,

DAN L. CRIPPEN, *Director.*

Enclosure

cc: Honorable John Conyers Jr.
Ranking Democratic Member
Honorable Tom Campbell

H.R. 1304—Quality Health-Care Coalition Act of 2000.

As ordered reported by the House Committee on the Judiciary on March 30, 2000

SUMMARY

H.R. 1304 would exempt health care professionals from antitrust laws when they negotiate with health plans over fees and other terms of any contract under which they provide health care items or services. Professionals who form coalitions for that purpose would receive the same treatment under antitrust laws that labor organizations receive for collective bargaining activities under the National Labor Relations Act. This antitrust exemption would apply only to negotiations occurring within three years following enactment. The Congressional Budget Office (CBO) concludes that under the bill some health professionals, including doctors, dentists, and pharmacists, would join together and negotiate for higher

compensation and greater flexibility in the provision of care, thereby increasing private and public expenditures for health care.

The bill would affect both federal revenues and outlays. By increasing costs to private health plans, H.R. 1304 would result in higher private health insurance premiums. In the case of employer-sponsored health plans, higher premium contributions charged to employers would be passed on to employees in the form of lower cash wages and other fringe benefits. Reductions in those taxable forms of compensation would lead to lower federal and state tax revenues. CBO estimates that federal tax revenues would fall by $145 million in 2001 and by $3.6 billion over the 2001–2010 period if H.R. 1304 were enacted.

H.R. 1304 would also raise the costs of several federal health programs. Direct spending for the Federal Employees Health Benefits Program (FEHBP), Medicaid, and the State Children's Health Insurance Program (SCHIP) would grow by an estimated $128 million in 2001 and by $2.5 billion over the 2001–2010 period. Discretionary spending by federal agencies for the FEHBP, the Tricare program of the Department of Defense, and the Indian Health Service would increase by about $150 million over ten years.

H.R. 1304 contains an intergovernmental mandate as defined by the Unfunded Mandates Reform Act (UMRA), but CBO estimates that it would impose no costs on state, local, or tribal governments. Thus, the costs of the mandate would not exceed the threshold established in that act ($55 million in 2000, adjusted annually for inflation). However, state, local, and tribal governments would face higher expenses as purchasers of health care for their employees and as providers of health care under Medicaid. In addition, they would realize lower income tax collections as a result of lower levels of taxable income. The bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 1304 is shown in Table 1. The bill would add to discretionary spending by all federal agencies for employee health benefits and would affect mandatory spending in budget function 550 (health). It would also reduce federal revenues.

BASIS OF ESTIMATE

Under the bill, some health professionals would join together to negotiate for higher compensation and greater flexibility in the provision of care. Allowing health care professionals to bargain collectively with health plans would result in higher health care expenditures for two reasons. First, the increased market power achieved by providers who could form and maintain effective coalitions would allow them to obtain higher fees from the health plans. Second, the greater flexibility that health professionals would obtain in the provision of care would lead to greater utilization of services.

Because the bill contains a sunset provision, the full effects that the antitrust exemption could have on the health insurance market are likely not to be realized. CBO assumes that it would take five years for such legislation to have its full effect of increasing annual national expenditures on private health insurance by almost 2.6 percent in the absence of any compensating changes on the part of

health plans or other entities. Although the full effects would not be realized prior to sunset (three years following enactment), the effects of the legislation would likely persist beyond the third year for several reasons: contracts negotiated during the first three years might extend beyond that period; health plans might go through an adjustment period while re-establishing utilization controls in the post-sunset period; and, since fee levels for health professionals would have been established at higher levels than would occur under current law, the market would take some time to readjust once the original antitrust treatment was restored. Because of the sunset provision, CBO estimates that the increase in private health insurance premiums, before compensating changes on the part of health plans and other entities, would rise to 1.5 percent in 2003 and 2004 and then gradually shrink, reaching 0.1 percent in 2010.

TABLE 1. ESTIMATE OF THE BUDGETARY EFFECTS OF H.R. 1304, THE QUALITY HEALTH-CARE ACT

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
REVENUES											
Income and Medicare Payroll Taxes (On-Budget)	0	-100	-255	-430	-505	-410	-290	-205	-145	-100	-70
Social Security Payroll Taxes (Off-Budget)	0	-45	-115	-190	-225	-180	-125	-90	-65	-45	-30
Total	0	-145	-370	-620	-730	-590	-415	-295	-210	-145	-100
DIRECT SPENDING											
FEHBP for Annuitants	0	4	9	15	16	9	5	2	1	1	*
Medicaid	0	115	250	410	455	335	245	180	130	95	70
SCHIP	0	5	12	20	23	16	10	7	5	4	3
Total, On-Budget	0	124	271	445	494	360	260	189	136	100	73
FEHBP for Postal Workers and Annuitants (Off-Budget)	0	3	7	0	0	0	0	0	0	0	0
Total, Direct Spending	0	128	278	445	494	360	260	189	136	100	73
SPENDING SUBJECT TO APPROPRIATION ACTION											
FEHBP for Active Workers	0	5	11	17	18	10	5	3	1	1	*
Indian Health Service	0	1	2	3	3	2	2	1	1	*	*
Tricare (Department of Defense)	0	5	9	14	14	9	6	4	3	2	1
Total	0	11	22	34	35	21	13	8	5	3	1

NOTES: FEHBP = Federal Employee Health Benefits. SCHIP = State Children's Health Insurance Program. * = less than $500,000.

Health plans, firms, and workers would have incentives to adjust in a number of ways to the increase in the price of insurance that would occur under the bill. Those adjustments would result in reductions in coverage by employers and employees, changes in the types of health plans that are purchased, and reductions in the extent of coverage through increased deductibles, higher copayments, or other changes in the scope or generosity of benefits. In the short

run, plans and employers might also absorb some of the cost in the form of lower profits.

CBO assumes that such behavioral responses would offset 60 percent of the potential impact of the bill on workers' compensation other than health benefits. We estimate that the remaining 40 percent of the 2.6 percent potential increase, or about 1 percent of private health insurance costs, would be passed through to workers in the form of reduced compensation (other than health benefits). We further adjust the estimate to account for some reductions in other fringe benefits. With the sunset provision, CBO estimates that an increase of 0.6 percent in private health insurance costs would be reflected in reduced compensation.

Effect on Fees for Health Care

For the purposes of this estimate, health care professionals are separated into three categories: physicians, dentists and other health care professionals, and pharmacists. Based on projections of national health expenditures for 2000, private health insurance spending for physicians will total an estimated $128 billion, spending for dentists and other health professionals will amount to $53 billion, and spending for prescription drugs and related items will be $59 billion. The following discussion of the basis of CBO's estimate pertains to the effects that would occur if the antitrust exemption were to attain its full effects. Because of the sunset provision included in the bill, however, those potential effects would not be fully realized.

Physicians. The effect on health care costs of allowing physicians to form coalitions to bargain with health plans would depend on the gain obtained by each physician joining a coalition and the number of physicians who would join.

Based on studies of the effects of unionization on the compensation of employees, CBO estimates that, on average, doctors who join an effective coalition would secure an increase in fees averaging 15 percent. Only a fraction of all physicians would become members of such coalitions, however.

Currently 20 percent of physicians are nonsupervisory employees of a health organization and, therefore, are already eligible to form a union. (They would not be directly affected by the bill.) Of those approximately 100,000 physicians, about 40 percent are either members of unions or covered by a collective bargaining agreement. CBO expects that fraction to grow over the next several years.

Of the approximately 400,000 practicing physicians who would be newly eligible to form a coalition under the bill, CBO estimates that about one-third would join an effective coalition within five years if there were no sunset provisions included in the bill. (In addition, some physicians who did not join an effective coalition would benefit from negotiated increases in fees.) Together with the growing fraction of employee-physicians who are expected to be union members, we estimate that almost 40 percent of physicians would be union or coalition members by 2006 if there were a permanent antitrust exemption. If there were no sunset provisions in the bill, about 30 percent of all physicians would eventually join effective coalitions because of the legislation. Assuming a 15 percent average increase in fees, total physician fees would rise by about 4.5 percent. Because physicians represent about one-third of in-

sured national health expenditures, CBO estimates that the effect of newly eligible physicians joining those coalitions under H.R. 1304 would be to increase total private health insurance expenditures by 1.6 percent in 2006 if the exemption were permanent. Because the bill includes a sunset provision, those full effects on costs would not be attained.

Dentists and Other Health Professionals. Like physicians, dentists and other health professionals who join an effective coalition under the bill would obtain higher fees from health plans. CBO assumes that those health professionals would secure the same 15 percent average increase in fees if they were able to form effective coalitions. However, CBO expects that the fraction of dentists and other health professionals who would maintain an effective coalition would be lower than the proportion of participating physicians. Also, dentists and other health professionals account for a much smaller percentage of private health expenditures than do physicians. As a result, CBO estimates that higher fees for dentists and other health professionals would increase private health expenditures by about 0.3 percent in 2006 in the absence of the sunset rules.

Pharmacists. H.R. 1304 would also make pharmacists eligible to form a coalition to negotiate with health plans over the net margins received for filling prescriptions. CBO assumes that pharmacists who could maintain an effective coalition would have the same bargaining power as other health professionals. Thus, on average, they would be able to negotiate an average increase of 15 percent in their net margins. CBO expects that about one-third of pharmacists would join an effective coalition. CBO estimates that higher fees paid to pharmacists as a result of H.R. 1304 would potentially increase private health insurance expenditures by 0.1 percent.

Effect on Health Care Utilization

Health care professionals who formed an effective coalition under the bill would also be likely to bargain with managed care plans for greater flexibility in the provision of care. Those plans control costs to a certain extent by regulating the quantity of services performed. Not all managed care plans limit the use of services to the same extent, however. Preferred provider organizations (PPOs), for example, control costs by negotiating discounts on the prices of services and exercise very little management over the use of services. Health maintenance organizations (HMOs), in contrast, often have tighter utilization controls.

Negotiations allowed under the bill would weaken the utilization management controls used by some plans. Fee-for-service plans and PPOs would not be directly affected because they have extremely limited utilization controls. Group- and staff-model HMOs would also be unlikely to be significantly affected because the physician groups that work in those types of HMOs have a long history of less costly practice styles, exemplified by lower rates of hospitalization. Also, physicians who are employees of HMOs can already unionize under current law so any behavior they might undertake to increase utilization would not be a direct result of H.R. 1304.

In contrast, other forms of HMOs and point-of-service plans tend to be staffed by independently practicing doctors who are less integrated into the organization. Those plans have brought about utilization savings through various forms of financial incentives and administrative requirements. Such control mechanisms could be partly dismantled as the result of collective negotiations by the physicians that staff such network plans. For those plans, utilization management now yields about a 5 percent savings compared to indemnity insurance. CBO estimates that 50 percent of the utilization savings associated with coalition physicians who contract with those managed care plans would be lost as a result of the bill. This increase in utilization by coalition physicians would raise private health expenditures by 0.3 percent if the antitrust exemption were permanent.

While CBO believes that professionals who form coalitions would gain the most flexibility under this bill, the utilization effect might not be limited to health professionals who are members of a coalition. If professionals in coalitions changed the way they practice medicine, that would affect conventions of medical practice more generally. That is, the changes in the way those professionals practice their trade could spill over to the rest of the physician population. The presence of this effect is based on evidence that physicians usually adhere to the norms of practice established by their peers. CBO expects that such changes in professional practice would only increase utilization by about one-fifth of the increase in utilization that would occur in managed care plans whose utilization controls would be weakened through negotiation. This spillover effect would potentially raise private health expenditures covered by insurance by an additional 0.3 percent.

Effect on Federal Revenues and Direct Spending

H.R. 1304 would reduce federal revenues and increase direct spending (see Table 1). By increasing premiums for employer-sponsored health benefits, it would substitute nontaxable employer-paid premiums for taxable wages and would therefore decrease federal income and payroll tax revenues. CBO estimates that the bill would reduce federal tax revenues by $145 million in 2001 and by $3.6 billion over the 2001–2010 period. Social Security tax revenues, which are off-budget, account for about 30 percent of those totals.

The bill contains a provision maintaining antitrust liability for coalitions of health professionals in negotiations involving services furnished to beneficiaries of certain federal health benefit programs, including Medicare, Medicaid, the State Children's Health Insurance Programs, the Department of Defense's program to insure private health care delivered to members of the uniformed services and their dependents (Tricare), veterans' health services, the Federal Employees Health Benefits Program, and the Indian Health Service. The provision aims to insulate federal programs from any increased costs resulting from health professional collective bargaining, but CBO believes that the provision would be only partly successful.

Negotiations between health professionals and health plans that would be sanctioned by the bill would likely lead to increased compensation for services and a relaxation of some of managed care's

controls over the use of those services. Health plans contracting to provide services to federal programs would not be able to separate these effects for federal beneficiaries completely. Higher compensation rates would increase the market price for professional services, and plans serving federal programs might have to increase their payment for services to assure an adequate supply to federal enrollees. Reducing managed care plans' controls over services would raise community standards for how intensively certain services are used, and plans serving a federally-sponsored population would likely need to provide comparable treatment.

The degree to which plans currently distinguish between federal and nonfederal enrollment groups would also affect the degree to which the bill's language aimed at excluding federal programs would limit federal costs. Industry practice generally distinguishes Medicare and Medicaid enrollees, but other federal groups, such as FEHBP and Tricare, may be grouped under the same contract that covers services provided to employees of private firms. It is likely that the clause aimed at excluding federal programs would ultimately be subject to litigation, because plans and providers negotiating a contract that covers services provided to employees of private firms would seek to include or exclude federal enrollment in the covered population, depending on which they feel is to their advantage. Thus, how that clause would ultimately be interpreted or applied is very uncertain.

CBO expects that, because managed care penetration in federal health programs is lower than in the private sector, the bill would have a commensurately lower effect on the costs of federal programs than on costs to the private sector. The provision to retain the antitrust sanctions for collective bargaining over services to federal beneficiaries would further reduce, but not eliminate, the effect of the bill on spending for federal health programs. On the other hand, behavioral responses for federal programs would not offset as much of the potential impact of the bill as they would in the private sector.

CBO estimates that H.R. 1304 would not have a significant effect on spending by Medicare because Medicare's administered pricing systems insulate the program from pricing changes in the private sector. However, the bill would increase direct spending by FEHBP (for annuitants), Medicaid, and SCHIP by an estimated $124 million in 2001 and by $2.5 billion over the 2001–2010 period. In the years of the projected maximum impact (2003 and 2004), the bill would increase spending by FEHBP, Medicaid, and SCHIP by 0.3 percent. In addition, CBO estimates that spending by the Postal Service for FEHBP coverage of postal workers and annuitants would increase by $3 million in 2001 and $7 million in 2002. By 2003, however, CBO anticipates that the service would increase postal rates and offset those costs. Costs to the Postal Service are classified as off-budget and would not be subject to pay-as-you-go procedures.

Assuming appropriation of the necessary amounts, CBO estimates the legislation would increase discretionary spending by federal agencies for the FEHBP for active workers by $5 million in 2001 and $71 million over 10 years.

CBO expects the proposal would also increase spending by the Indian Health Service and Tricare by about $80 million over ten

years. The effect on spending by other federal health programs would be negligible.

PAY-AS-YOU-GO CONSIDERATIONS

Because the bill would affect federal revenues and direct spending, pay-as-you-go procedures would apply. The direct spending and revenue effects are shown in Table 2. For pay-as-you-go purposes, only the effects in the current year, the budget year, and the succeeding four years are counted.

TABLE 2. ESTIMATED PAY-AS-YOU GO EFFECTS OF H.R. 1304

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in receipts	0	-100	-255	-430	-505	-410	-290	-205	-145	-100	-70
Changes in outlays	0	124	271	445	494	360	260	189	136	100	73

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 1304 contains an intergovernmental mandate as defined by UMRA, but CBO estimates that the mandate would impose no costs on state, local, or tribal governments. By exempting health care professionals from state, as well as federal, antitrust laws, the bill would preempt state law, and therefore would be a mandate as defined by UMRA. However, the bill would not require states to take action as regulators in order to comply with the new exemption and in some cases might reduce their oversight responsibilities.

With certain health care professionals exempted from antitrust laws, state, local, and tribal governments would experience an increase in premiums for health insurance for their employees and would also see an increase in Medicaid and SCHIP costs. Those governments, like private entities, could take a number of actions to adjust to the increased premiums for their employees: reduce or change coverage options, require higher copayments, or increase deductibles. Over time, any remaining increase in costs would be passed through to workers in the form of reduced compensation (other than health benefits).

The bill would maintain antitrust liability for health professionals who provide services for federal health benefit programs, including Medicaid and SCHIP. However, those programs would not be completely shielded from the market changes precipitated by the bill. Consequently, CBO estimates that state expenditures for Medicaid and SCHIP would increase by about $90 million in 2001 and by about $1.2 billion over the 2001–2005 period.

Most states that tax income use the federal measure of adjusted gross income as the basis of their tax calculations. Consequently, the effect of substituting non-taxable income for taxable income for federal income tax purposes would have the effect of decreasing state income tax collections as well.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains no private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATE

On March 15, 2000, CBO provided an estimate of H.R. 1304, as introduced. The estimated costs of the reported bill are lower because they reflect two modifications in the bill. The first modification limits the antitrust exemption to a period of three years. The second excludes federal programs from the antitrust exemption.

This estimate also includes spending subject to appropriation for Tricare and the Indian Health Service. (CBO had not completed those analyses for the estimate of the introduced version of the bill.) Finally, this estimate displays separately the off-budget component of the change in FEHBP spending (for the Postal Service).

ESTIMATE PREPARED BY:

Federal Cost Estimate: James Baumgardner (225–0810), Karuna Patel (225–2598), Tom Bradley (226–9010), Charles Betley (226–9010), Eric Rollins (226–9010), and Sam Papenfuss (226–2840)

Impact on State, Local, and Tribal Governments: Leo Lex (225–3220)

Impact on the Private Sector: James Baumgardner (225–0810) and Karuna Patel (225–2598)

ESTIMATE APPROVED BY:

Robert A. Sunshine
Assistant Director for Budget Analysis

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the committee finds the authority for this legislation in Article I, section 8 of the Constitution.

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

H.R. 1304, as introduced, consists of three sections.

Section 1. Section 1 provides that H.R. 1304 may be cited as the "Quality Health-Care Coalition Act of 1999."

Section 2. Section 2 sets forth congressional findings relating to the bill.

Section 3. Subsection 3(a) provides that any group of health care professionals which is negotiating with a health plan shall, in connection with those negotiations, have the same antitrust exemption that labor unions have. The term "health care professional" is defined in subsection 3(d) to include nurse-practitioners and pharmacists within the exemption.

Subsection 3(b) provides antitrust immunity for actions taken in good faith reliance on the exemption provided by subsection 3(a).

Subsection 3(c) provides that the exemption provided in subsection 3(a) shall not confer any right to participate in a collective cessation of services not otherwise permitted by law.

Subsection 3(d) provides definitions of the terms "antitrust laws," "health plan," "health insurance coverage," "health insurance issuer," "group health plan," "Medicare+Choice organization," "Medicare+Choice plan," "Medicaid managed care entity," and "health care professional" as those terms are used in the bill. The

term "health care professional" is broadly defined so that it includes nurse-practitioners and pharmacists within the antitrust exemption provided for in the bill.

H.R. 1304, as reported by the committee, consists of two sections.

Section 1. Section 1 provides that H.R. 1304 may be cited as the "Quality Health-Care Coalition Act of 2000." The change from 1999 to 2000 was made as a technical correction.

Section 2. Section 2 of the bill as reported now contains the operative provisions of the bill. Section 2 of the bill as introduced contained congressional findings relating to the bill. At the markup, the findings were deleted and what had been § 3 became § 2.

Subsection 2(a) provides that any group of health care professionals which is negotiating with a health plan shall, in connection with those negotiations, have the same antitrust exemption that labor unions have. The term "health care professional" is defined in § 2(h)(3) to include nurse-practitioners and pharmacists within the exemption.

Subsection 2(b) provides antitrust immunity for actions taken in good faith reliance on the exemption provided by § 2(a).

Subsection 2(c)(1) provides that the exemption provided in § 2(a) shall not confer any new right to participate in a collective cessation of services not already permitted by existing law. The original language read: "The exemption provided in subsection (a) shall not confer any right to participate in any collective cessation of service to patients not otherwise permitted by law." Because unions are otherwise permitted by law to strike and because this exemption gives health care professionals the same antitrust exemption that unions have for collective bargaining purposes, some argued that this language might be circular. The Hyde amendment rewrote this language to read: "The exemption provided in subsection (a) shall not confer any new right to participate in any collective cessation of service to patients not already permitted by existing law." This amendment was intended to eliminate the circularity problem and more accurately state the intent of the provision.

Subsection 2(c)(2) provides that bill applies only to health care professionals excluded from the National Labor Relations Act and that it shall not be construed as changing or amending the NLRA or affecting the status of any group under the NLRA. This amendment clarifies that the committee intends H.R. 1304 to exempt self-employed healthcare professionals from antitrust laws and not to place them under the jurisdiction of the National Labor Relations Act or the National Labor Relations Board. This clarifying language was added by the Hyde amendment.

Subsection 2(d) provides that the exemption provided in § 2(a) shall only apply during the 3-year period beginning on the date of enactment, but that it shall continue to apply to contracts negotiated under the exemption for one additional year after the end of the 3-year period. In other words, contracts may be negotiated during the 3-year period. During the fourth year, no new contracts may be negotiated, but contracts negotiated during the 3-year period may continue to be carried out during the additional year. The Hyde amendment added this language.

Subsection 2(e) provides that the exemption provided in § 2(a) does not apply to any agreement or otherwise unlawful conspiracy that excludes or limits the performance of services by any other

health care professional or group of health care professionals within their lawful scope of practice. This language was added by the Nadler amendment.

Subsection 2(f) provides that nothing in this section shall be construed to affect the application of Title VI of the Civil Rights Act. This language was originally offered by Mr. Watt and Ms. Waters. At Mr. Watt's request, the committee incorporated this language into the Nadler amendment by unanimous consent.

Subsection 2(g) provides that nothing in the bill shall apply to negotiations between health care professionals and health plans pertaining to benefits under certain enumerated Federal health programs: Medicare, Medicaid, SCHIP, medical care for the uniformed services, veterans' medical care, FEBHP, and the Indian Health Care Improvement Act. This language was added by the second Conyers amendment.

Subsection 2(h) provides for the General Accounting Office to conduct a study of how the bill has worked during the first 6 months of the third year of the 3-year sunset period. The GAO will make recommendations to Congress as to whether the exemption should be extended. The Hyde amendment added this language but provided for the study to be done by the Federal Trade Commission. The second Conyers amendment amended the Hyde amendment to have the study done by the GAO.

Subsection 3(d) provides definitions of the terms "antitrust laws," "health plan," "health insurance coverage," "health insurance issuer," "group health plan," and "health care professional" as those terms are used in the bill. The term "health care professional" is broadly defined so that it includes nurse-practitioners and pharmacists within the antitrust exemption provided for in the bill. The bill as introduced included definitions of "Medicare+Choice organization," "Medicare+Choice plan," "Medicaid managed care entity," but the first Conyers amendment deleted these definitions from the bill and also deleted these terms from the definition of a health plan.

AGENCY VIEWS

Statement of Robert Pitofsky,[1] chairman, Federal Trade Commission

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

[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.

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

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

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.

I. 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]

---

[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.

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-

---

[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).

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

---

[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.

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

---

[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).

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 anesthesiol-

ogists 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

---

[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*).

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

---

[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).

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

---

[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*).

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

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 pref-

[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).

erences. 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.[35] 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.

---

[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. *Quality First: Better Health Care For All Americans* 3–4 (1998). Much work already is being done to develop and improve methods for measuring and communicating information about health plans' performance and the quality of services they provide.

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

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.

Statement of Joel Klein, Assistant Attorney General, Antitrust Division, Department of Justice

INTRODUCTION

Chairman Hyde, Ranking Member Conyers and members of the Committee, I am pleased to be invited here to present the views of the Antitrust Division on H.R. 1304, the Quality Health-Care Coalition Act of 1999. I would like to start by briefly summarizing the importance of competition to the economy. Then I will turn to the specifics of the bill. In brief, the Division strongly opposes H.R. 1304. We believe it takes the wrong approach to problems raised by managed care, an approach that will harm consumers of health care in the future.

For over a century, the United States has committed itself to protecting competition in the vast majority of markets in the economy. Free-market competition is the engine that has made the American economy the envy of the world. The Sherman Act, passed in 1890, has been called the Magna Carta of free enterprise. In general, the United States operates a free-market economy that allows free and unfettered competition, subject to the antitrust laws. Time and again, relying on free-market competition has allowed consumers numerous benefits, including more innovation, more choice and lower prices than that of economies where free competition has been limited.

In particular, our nation's economic vitality depends upon the competitive structure of the health care industry. In 1997, the latest year for which data are available, annual revenues of health care professionals covered by the Sherman Act ranged between $300–400 billion, about 4–5% of the GDP.

H.R. 1304 would change, for the health-care industry, the competitive system applicable to the rest of the American economy. It would uniquely authorize health care professionals who are not em-

ployed by health insurance plans, and thus not exempt from antitrust scrutiny under existing law, to negotiate collectively with any health plan over fees and collectively to refuse to deal with any plan that did not accede to their demands. Current law already provides an exemption from the antitrust laws for doctors and other health care professionals in an employee-employer context. Like other employees, employed doctors and other health care professional employees may collectively bargain with their employer without antitrust scrutiny. But, like all who are not employees, independent-contractor doctors and other health care professionals in private practice must satisfy the antitrust laws when negotiating with those that purchase their services.

This bill would allow non-employee, health care professionals collectively to raise their fees to health insurers without fear of antitrust liability and without regard to competitive market forces fostered by the antitrust laws. This increased cost ultimately will be borne by consumers. There is no justification to accord special status to health care professionals under the antitrust laws, differentiating them from other professionals and independent contractors such as architects, engineers, or lawyers. It would be both unwise and harmful to consumers to grant them a special exemption.

We want to be clear, however, that we have and will continue to enforce the antitrust laws in this area, and will rigorously pursue evidence of collusion regardless of whether providers or insurers are involved.

COMPETITION IN HEALTH CARE: BOTH HEALTH INSURANCE AND PROVIDER MARKETS NEED TO FUNCTION COMPETITIVELY

As in other markets, the goal for health care markets should be to ensure that consumers benefit from a competitive marketplace where neither the buyers nor sellers unlawfully exercise market power. Policy should focus on ensuring that there is a competitive marketplace where neither health insurance plans nor health care professionals are able to obtain or exercise market power to distort the competitive outcome. Any other result inevitably will lead to governmental regulation of the health care market—an outcome that is not likely to produce desirable results for consumers. We have learned this lesson over time from other industries and we should be sure we continue to apply it to health care markets as well. The injection of competition into health care markets over the past decade has helped hold down increases in health care costs.

The preference for market competition over regulation, of course, is dependent on the assurance that the enforcement of the antitrust laws will prevent all participants in a market from obtaining or exercising market power through anticompetitive means. Thus, federal antitrust enforcement must ensure that neither health insurance plans nor health care professionals utilize anticompetitive means to distort the competitive outcome in the health care industry. The Antitrust Division has been active in pursuing that important role.

To keep health insurance markets competitive, the Division carefully scrutinizes mergers and other activities among health insurance plans that may harm consumers by raising prices or limiting the scope or quality of care. For example, last year the Division investigated the proposed acquisition of Humana by United Health

Care. The parties abandoned the transaction during the course of the review. This week the Division concluded that Aetna's proposed acquisition of Prudential's health care business would violate the antitrust laws unless Aetna undertook substantial divestitures in Dallas and Houston to eliminate the market power it otherwise would have gained from the merger.

The Aetna case is an extremely important precedent in this regard. The Division, after a thorough investigation, determined that the merger of these health plans was anticompetitive in two separate ways. First, we believed the merger would lead to market power in the sale by Aetna of health maintenance organization services in certain markets. The combined market share which would have resulted from the merger in Houston and Dallas were over 63 percent and 42 percent, respectively. We believed this would give Aetna the ability in those markets to increase its price or lower its quality of service for its HMO customers. Second, we believed that the merger would lead to market power in the purchase of doctors' services by Aetna. The divestiture which we accepted addressed both of these concerns. This was the first merger case in which the Division was faced with a concern that a combination of health plans would give the resulting plan market power in the purchase of doctors' services. It clearly establishes the precedent that unacceptable aggregations of market power by health plans will not be allowed to the detriment of consumers and health care professionals.

At the same time, we also have pursued anticompetitive actions by health care professionals, who have sought to use market power to demand anticompetitive concessions from health plans. In both our *Federation of Physicians and Dentists* and our *Federation of Certified Surgeons and Specialists* cases (discussed below), we established that competing doctors took joint action contrary to the antitrust laws to increase their reimbursement rates at the expense of consumers' pocketbooks.

Our ultimate goal is the preservation of competition at all levels of the health care industry. It has become clear over the years that consumer welfare and patient choice are best preserved by relying on antitrust principles to assure the proper operation of health care markets just as they are in other markets. Permitting providers to form bargaining groups in response to perceived bargaining leverage by insurers will not decrease the cost of health care or increase the quality of patient care.

THE RATIONALES FOR THE BILL SUPPORT NEITHER THE NEED NOR THE DESIRABILITY OF AN ANTITRUST EXEMPTION

There are various arguments that supporters of bills like this one have used to argue their case. On closer inspection, those arguments often are not aligned with the competitive realities of the marketplace and do not support the adoption of an antitrust exemption. Supporters often argue that the McCarran-Ferguson antitrust exemption lets insurers collude, so doctors should be allowed to collude as well; that health plans have all the bargaining power and tremendous market share; that doctors will only use their power to increase the quality of care; and that the bill will protect doctors and not increase costs to consumers, just affect the health plans' profits. Let me address each of these briefly.

The McCarran-Ferguson Act Does Not Give Insurers Leverage

The bill's "Findings" assert that increasing concentration among health care plans, enhanced by the McCarran-Ferguson Act, gives insurance companies significant leverage over health care providers and patients and, therefore, warrants permitting health care professionals to negotiate collectively with health plans to create more equal negotiating power, which will promote competition and enhance the quality of patient care. The claim that the McCarran-Ferguson Act ("McCarran"), 15 U.S.C. §§ 1011–1015, has given insurers significant market leverage over health care providers and patients appears to reflect a widely held misperception.

McCarran provides insurers with a limited exemption from the antitrust laws, but twenty years ago the Supreme Court in *Group Life and Health Co.* v. *Royal Drug*, 440 U.S. 205 (l979), clearly held that McCarran does not exempt insurers' dealings with health care providers from antitrust scrutiny. To the extent insurers' dealings with health care professionals are in violation of the antitrust laws, McCarran provides no obstacle to prosecution of such claims either by the affected providers or by state or federal enforcement agencies. When the Division learns about exclusionary or collusive activities among health plans, it carefully reviews them, and if necessary, takes appropriate action. In the past few years alone, the Division aggressively challenged contractual provisions imposed by payers on Rhode Island dentists, *U.S.* v. *Delta Dental of Rhode Island*, and Cleveland area hospitals, *U.S.* v. *Medical Mutual of Ohio, Inc.*, when it determined that those provisions were resulting in higher costs and diminished choices for health care consumers.

Thus, the claim that McCarran gives insurers leverage in their dealings with health care providers is illusory and should not support passage of this bill or increasing the bargaining leverage of health care providers.

Health Plan Bargaining Power

The relative bargaining power of plans and providers varies tremendously among markets. Although there have been several mergers of health plans over the last few years, in our view there still exists a significant number of competing health insurance plans, none of which dominates, and there has been new entry into various local markets. Between 1994 and 1997 over 150 new HMOs were licensed across the country. Moreover, over the last decade, as enrollment in managed care plans has grown, the market shares of many once-dominant Blue Cross and Blue Shield plans has eroded, resulting in decreasing, rather than increasing, concentration among health insurers in certain markets.

To the extent that there is a concern that mergers will increase the bargaining power of health insurance plans, our enforcement in the Aetna case should convincingly establish that antitrust enforcers will not allow anticompetitive mergers that will produce market power by health insurance plans in the market for purchasing provider services.

Quality Concerns Do Not Justify The Antitrust Exemption

The proposed bill makes no attempt to distinguish between joint negotiations by health care professionals that are designed to enhance efficiency, reduce costs and improve quality of care and those

designed simply to increase the providers' income. The American Medical Association, in its written testimony submitted to this committee last year in support of the predecessor to H.R. 1304, acknowledged that "[m]ost studies comparing the quality of care in managed care plans and traditional indemnity plans have found the quality of care to be comparable." This is not to say that there may not be problems concerning the quality or scope of services under managed care that require correction; just that problems of poor-quality care are not endemic to managed care.

The concern relevant to this bill, however, is whether doctors will use the power granted them by an antitrust exemption to increase the quality of patient care. Our history of investigations, including our recent cases against two federations of competing doctors involving group boycotts and price-fixing conspiracies, leads us to have concerns because the proposed bill provides no assurance that health care professionals would direct their collective negotiating efforts to improving quality of care, rather than their own financial circumstances.

In our *Federation of Certified Surgeons and Specialists* case, twenty-nine otherwise competing surgeons who made up the vast majority of general and vascular surgeons with operating privileges at five hospitals in Tampa formed a corporation solely for the purpose of negotiating jointly with managed care plans to obtain higher fees. Their strategy was a success. Each of the twenty-nine surgeons gained, on average, over $14,000 in annual revenues in just the few months of joint negotiations before they learned that the Division was investigating the conduct. The participants in that scheme did not take any collective action that improved quality of care.

In the *Federation of Physicians and Dentists* case, we allege that most of the orthopedic surgeons in Delaware agreed among themselves to boycott Blue Cross Blue Shield of Delaware after Blue Cross announced it was going to reduce fees paid to orthopedic surgeons and other physicians. Blue Cross is one of four major private insurance plans operating in Delaware, and a number of smaller plans operate there also. Blue Cross's proposed fees, however, were still higher than those paid to orthopedic surgeons in Philadelphia, a nearby major medical center recognized for quality care, and in line with fees paid to other types of specialists in Delaware. Although the defendant organization claimed quality-of-care concerns in directing its member surgeons' collective opposition to Blue Cross's proposed fee reductions, the surgeons themselves conceded that they provide the same high quality of care to their patients regardless of the payment level. Indeed, there is no evidence that any of the orthopedic surgeons participating in the alleged conspiracy even sought to evaluate the impact that Blue Cross' proposed fee reduction would have on their cost structure or on their ability to provide quality care.

Both of these cases, as well as many other cases brought by both the Division and FTC, illustrate the serious harm to consumers that would result from passage of the proposed bill, with very limited, if any, concomitant improvement in quality of patient care.

The Bill is Likely to Raise Costs Substantially to Consumers and Taxpayers

The bill's potential adverse economic impact on consumers is large. Our investigations reveal that when health care professionals jointly negotiate with health insurers, without regard to antitrust laws, they typically seek to significantly increase their fees, sometimes by as much as 20–40%. For example, in our recent Tampa case discussed above, the otherwise competing surgeons, through joint negotiations with health plans, had succeeded in raising their fees 20–30% prior to learning of our investigation. Exempting such joint activity through enactment of H.R. 1304 would permit health care professionals to negotiate and effectuate such increases in countless markets throughout the country. In view of the size of expenditures for health care services and the large number of patients receiving care, the potential anticompetitive costs that would be borne by consumers are large.

There appears to be no dispute that the bill will result in health plans paying higher fees to health care professionals. At a hearing of this Committee last year on a precursor bill, Representative Campbell acknowledged that the bill would enable health care professionals to obtain higher fees from health care insurers but maintained that such cost increases would be absorbed by managed care plans, rather than passed on to consumers. *See* Transcript of the July 29, 1998 Hearing before the U.S. House of Representatives Committee on the Judiciary on H.R. 4277 at 12, 27, 38–40. Conventional economic theory and business realities lead, however, to the opposite conclusion. Health insurers will pass on to consumers most, if not all, cost increases that they would incur in collective negotiations under H.R. 1304.

Economic theory predicts that an increase in the cost of an input in nearly every instance translates into a higher output price. Only in those rare cases where a different input can be used as a perfect substitute will an increase in the cost of an input not give rise to a price increase to the consumer. But, because of both licensing requirements and the nature of services provided, there are no good substitutes for physicians, pharmacists, therapists, dentists, or other health professionals. Consequently, health insurers are virtually certain over time to pass through to consumers and taxpayers most, if not all, of the increase in costs for any covered services provided by health care professionals. *See, e.g.*, Wholey, Feldman, and Christianson, "The Effect of Market Structure on HMO Premiums," 14 *J. Health Economics* 81, 89, l00 (l995) (finding that increases in provider costs increase health plan premiums); M. Pauly, "Managed Care, Market Power, and Monopsony," 33:5 *Health Services Research* 1439, 1450 (Dec. 1998, Part II) ("In virtually any model of profit-seeking firms, an increase in marginal cost of an input translates into a higher equilibrium output price.").

The realities of the health insurance business also contribute to our conclusion that health insurers will pass on most of any cost increases for professional services resulting from H.R. 1304, services that ordinarily constitute about 40–50 percent of a health plan's total costs. For the last few years, premiums closely reflected insurers' costs, and a leading health care policy "think-tank" predicts that "over the longer term, the underlying cost of health care remains the dominant influence on the direction of premium

trends." *See* Center for Health System Change, "Despite Fears, Costs Rise Modestly in l998," Data Bulletin No. 13 (Fall l998) at 2.

Increases in the cost of services provided by health care professionals resulting from enactment of H.R. 1304 will undoubtedly have a direct and predictable effect on consumers and taxpayers, resulting in the transfer of funds to providers and making health care insurance coverage increasingly unaffordable for many. Medicare and Medicaid programs, for example, will incur substantial additional costs to meet increased premiums from managed care plans. Alternatively, managed care plans will cease serving Medicare and Medicaid beneficiaries in high-cost areas or reduce nonmandatory benefits.

Employers and employees in the private sector also will be confronted with increased costs of health insurance as a result of this bill. The inevitable increase in premiums would lead to more consumers either losing or foregoing their health care coverage and likely would increase the ranks of our nation's uninsured. Faced with substantial increases in premiums, more employers may stop offering their employees health insurance or will decrease benefits, and more workers who are eligible for employer-sponsored insurance may nevertheless reject coverage as their shared costs increase. Such trends also will translate into additional Medicare and Medicaid costs.

There Is a Better Approach to Deal with Problems Raised by Managed Care

The stated objective of the proposed bill is to "enhance the quality of patient care" and implicitly to resolve some of the problems attributed to managed care. One of the ways is to pass a Patients' Bill of Rights that provides critical patient protections, such as guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; access to a fair, unbiased and timely internal and independent external appeals process to address health plan grievances; and an enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions. The Administration continues to urge the Congress to pass a strong, enforceable Patients' Bill of Rights in this legislative session. Some of these quality of care issues and other problems frequently associated with managed care, however, may be resolved without any legislation since there are already legitimate ways for physicians and other health care professionals jointly to influence or make recommendations on quality of care issues. *See, e.g.*, United States Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, issued August 28, l996, 4 Trade Reg. Rep. (CCH) ¶13,153, at Statement 4 ("Providers' Collective Provision of Non-Fee-Related Information to Purchasers of Health Care Services") and Statement 5 ("Providers' Collective Provision of Fee-Related Information to Purchasers of Health Care Services").

For example, the American College of Physicians-American Society of Internal Medicine and 21 other physician groups recently wrote letters to national managed care organizations urging them not to adopt mandatory hospitalist programs, that is, programs re-

quiring primary-care physicians to turn over care of their patients to hospital-based physicians when a patient needs hospital care. In response, the health plans clarified that their hospitalist programs were voluntary.

Legislation should not, as would H.R. 1304, injure the public by eliminating competition in health care provider markets in the hope that it will indirectly solve the problems of managed care facing consumers. Providers have their own self interests, and our enforcement actions and other experience suggest that their actions may not be congruent with the interests of consumers.

CONCLUSION

We oppose this legislation which would immunize independent-contractor doctors and other health care professionals in private practice from antitrust prohibitions. This bill is the wrong way to deal with problems identified with managed care and will harm consumers of health care in the future. The bill would hurt consumers and taxpayers by raising the costs of both private health insurance and governmental programs with no assurance that quality of care would be improved. The better approach is to empower consumers by encouraging price competition, opening the flow of accurate, meaningful information to consumers, and ensuring effective antitrust enforcement both with regard to buyers (health insurance plans) and sellers (health care professionals) of provider services. Competitive issues are best dealt with in a manner which promotes competition, not retards competition, as this bill would do if enacted.

ADDITIONAL VIEWS

We have concerns regarding the possible effect of H.R. 1304, the "Quality Health Care Coalition Act of 1999." This legislation gives to health professionals in their negotiations with health plans similar treatment under the antitrust laws that is given to employees in bargaining units that are recognized under the National Labor Relations Act. Under the current provisions of the bill, we are concerned that health care professionals could engage in price fixing that otherwise would be per se illegal under Federal and State antitrust laws.

The special exemption created by this legislation would apply indiscriminately throughout the country, allowing bargaining units to form that could include up to 100% of the providers in a geographic area. They could negotiate with health plans of all sizes, including plans that have very small market shares or that have recently entered an area. They would be allowed to negotiate with respect to all types of issues, including financial terms such as prices and reimbursement levels.

As the Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") who oppose the bill have testified, H.R. 1304 could result in higher health care costs for consumers, employers, and Government health care programs.[1] One study conducted by Charles River Associates estimated that the cost of H.R. 1304 would range from $35 billion—$80 billion annually.

More recently, the Congressional Budget Office (CBO) analyzed the effect of this legislation on public and private health insurance programs. CBO found that the bill would increase direct Federal spending and reduce Federal revenues by substantial amounts. Federal spending on Medicaid, State Child Health Insurance Program (SCHIP) and the Federal Employees Health Benefits Program (FEHBP) would increase by $11.3 billion over 10 years if H.R. 1304 were enacted, according to CBO. Federal revenues would decline by an estimated $10.9 billion over the same period, largely due to the fact that health insurance premiums would rise by an estimated 2.6 percent, according to the CBO analysis.

The results of higher premiums are only too familiar—an increase in the number of Americans who lack health insurance. These effects will be felt especially by the children of the working poor. Under the SCHIP program, the Federal Government provides a fixed sum of money to States, which provide health insurance coverage to children in low-income families. By increasing the costs

[1] See Statement of Joel I. Klein, Assistant Attorney General, Antitrust Division, presented on June 22, 1999; Statement of Robert Pitofsky, Chairman, Federal Trade Commission, presented on June 22, 1999. In addition to the FTC and DOJ, H.R. 1304 is also opposed by the Consumer Federation of America, the Antitrust Section of the American Bar Association, and numerous groups representing employers, health plans and non-physician providers.

of insuring children, H.R. 1304 could decrease the number of children who obtain insurance under the program.

The committee's decision to adopt a "sunset" provision will, of course, force CBO to assume that doctors will not be able to form these associations after 3 years and, therefore, reduce CBO's estimate of the costs. While this will appear to mitigate the worst effects of this bill, it will not eliminate those effects. Indeed, a sunset may serve to encourage health care providers to form associations more quickly than they otherwise would (in order to beat the deadline) and to make greater demands with respect to their fees and other contractual provisions. Additionally, it is indeed rare for Congress not to extend programs beyond the date of their "sunset."

Despite the evident adverse effects of this bill on health care consumers, some have argued that the bill is necessary in order to allow physicians to negotiate collectively in order to improve the quality of patient care. In fact, the exemption that the bill grants is not needed to permit physicians and other health care professionals to raise legitimate quality of care issues or to organize in ways that will benefit consumers. In guidelines issued in 1996, the DOJ and FTC explained that under existing antitrust laws, providers can discuss collectively with health plans issues involving legitimate quality of care concerns, as long as they do not engage in boycotts or other joint activity that could limit the choices available to consumers. The guidelines also explain how providers can organize networks and joint ventures that enable them, under existing antitrust laws, to negotiate collectively with health plans.

This legislation has been opposed by many non-physician provider groups that are concerned that it will remove the protection that they currently have under the antitrust laws against attempts by physicians to limit their role in the health care delivery system. While the committee voted to adopt an amendment offered by Mr. Nadler that was aimed at addressing these concerns, the American Nurses Association, the American Academy of Nurse Practitioners and the American College of Nurse Midwives believe that the amendment will be ineffective and they continue to strongly oppose the bill.

Unlike bargaining units under the National Labor Relations Act, or negotiating agents under State laws that grant a State action exemption for joint physician collective negotiations (such as in Texas under Texas S.B. 1468), H.R. 1304 provides for no oversight of the negotiation process by any Federal or State agency. During the Judiciary Committee's consideration of H.R. 1304, Mr. Pease offered an amendment that would have given to the FTC and DOJ some degree of oversight responsibility over these collective negotiations. Under the amendment, health care professionals that wished to gain the exemption under H.R. 1304 would first have to obtain prior approval from the FTC or DOJ based on their determination that the exemption would promote competition and enhance the quality of patient care. Failure of the FTC or the DOJ to act within 180 days would result in the application being deemed approved. It is only reasonable to require those seeking special and unprecedented treatment under the antitrust laws to undergo some review to ensure that their arrangements will benefit consumers. However, as an indication of our continuing good

faith efforts to find an appropriate balance between competing legitimate concerns, the amendment was withdrawn, and further discussions on the matter will continue.

The American public is best served by a health care system that relies on competition to spur innovation, reduce costs, and improve quality. H.R. 1304 takes a step backward by giving to one component of the health care system—doctors and other health care professionals—the right to form bargaining units with the market power to obtain whatever they might demand. The result could be much higher health care costs for everyone, and reduced access to health care by those who can least afford it. We believe H.R. 1304 should include provisions allowing Government oversight authority in the bill's final version.

EDWARD A. PEASE.
GEORGE W. GEKAS.

FURTHER ADDITIONAL VIEWS

H.R. 1304, which is sponsored by Congressman Tom Campbell and myself, gives health care professionals immunity from antitrust laws when they negotiate as a group with health maintenance organizations ("HMOs") and other large health plans. This legislation responds to the unlevel playing field facing independent physicians engaged in negotiations with health insurers and other third party payers. H.R. 1304 enjoys bipartisan support and is strongly supported by a wide array of health care professional and trade organizations, including the National Medical Association, the American Medical Association, the American Federation of State, County and Municipal Employees, the National Community Pharmacists Association and the AFL–CIO Health Fields Division, among others.

The health provider market is heavily concentrated among health insurance companies, preferred provider organizations, HMOs and other third party payers, such as Blue Cross Blue Shield.[1] A recent study of market concentration by the Robert Wood Johnson Foundation found that "both the group and individual [health insurance] markets are heavily dominated by relatively few large insurers."[2] At the same time, many doctors have opted to work directly for these insurance companies, rather than compete with them directly, with 56% of physicians currently treated as employees.[3] The remaining doctors operate independently, but many have entered into contractual relationships with third party payers whereby they agree to work under specified fees, terms, and conditions in exchange for being placed on preferred physician lists. These physicians are often subject to one-sided "take it or leave it" contracts with insurers which not only offer inadequate fees, but severely limit their ability to service their patients.[4] Since the case law has generally provided that medical professionals are not entitled to any benefit under the statutory labor exemption,[5] H.R. 1304

---

[1] See Milt Freudenheim, *Concern Rising About Mergers In Health Plans*, N.Y. Times, January 13, 1999, at A1.

[2] See Deborah J. Chollet *et al., Mapping Health Insurance Markets: The Group and Individual Health Insurance Markets in 26 States* (October 1997). The report noted that in North Dakota, Blue Cross Blue Shield controlled 93% of the market in 1995 and that in Illinois the largest insurers held 60% of the individual market in 1995. *Id.* at ii, 13, 21.

[3] *AMA Socioeconomic Monitoring Survey: Physician Marketplace Statistics* (1997).

[4] See Steven Greenhouse, *Angered by H.M.O.'s Treatment, More Doctors Are Joining Unions*, N.Y. Times, January 13, 1999, at A1.

[5] *H.A. Artists & Associates, Inc.* v. *Actors' Equity Association*, 451 U.S. 704, 717 (1981) (where union members customarily secure employment through negotiating agents whose fees are calculated as a percentage of union members' wages, agents not considered independent contractors, but a genuine labor group exempt from antitrust violations); *Columbia River Packers Association* v. *Hinton*, 315 U.S. 143 (1942) (arrangement by which fisherman's union acted as a bargaining agent for selling fish to packers and canners found not to be exempt because the fishermen were independent businessmen and the dispute involved the sale of fish rather than wages, hours, or other conditions of employment). However, the exemption will apply in cases where the individuals are truly comparable with and competing with other groups of employees. See e.g., *American Federation of Musicians* v. *Carroll*, 391 U.S. 99 (1968) (independent contractor

Continued

responds by giving them the same statutory antitrust exemption that ordinary employees receive when they collectively bargain.[6] I support this legislation for several reasons which I outline below.

I. AN UNLEVEL PLAYING FIELD EXISTS.

First, an unlevel playing field exists between large insurance companies and independent health care providers. It is unrealistic to expect a local doctor to have anywhere near the financial capacity or legal wherewithal to negotiate fair or reasonable contract terms with a multibillion dollar health insurer. Because of current antitrust interpretations, physicians cannot even communicate with each other to discuss the one-sided contract terms which are being proposed to them. The result is that physicians often have little choice but to accept one-sided, non-negotiable service agreements. Along these lines, I would note that independent health care providers, although technically "independent contractors" are not in a significantly different position from ordinary "employees" negotiating with large employers in other industries because HMOs and other managed care companies exert an enormous amount of control over their practice of medicine.

A corollary problem is that these one-sided agreements are slanted in a manner which works to the disadvantage of patients. Such contracts include clauses which, among other things: (1) limit a doctor's ability to discuss medical issues and options with their patients (known as "gag clauses"); (2) discourage appropriate specialist referrals; (3) set forth unreasonable administrative barriers to appropriate tests and prompt and reasonable care; and (4) provide financial incentives which reward physicians for not treating patients.[7] I agree with Representative Campbell who has stated that if they are given greater negotiating power, "first on the list of contractual terms that health-care professionals will demand is a greater right to prescribe and care for patients as they see fit."

II. H.R. 1304 ALSO BENEFITS NON-PHYSICIAN PROVIDERS.

In addition to protecting physicians, the legislation will also apply to protect other health care professionals who face unfair ne-

---

band leaders treated as labor group because where there was job or wage competition or some other economic inter-relationship affecting legitimate union interests between the union members and the independent contractors).

With regard to the health care field, see e.g., *Michigan State Medical Society*, 101 F.T.C. 191 (1983) (FTC found that Michigan State Medical Society in encouraging its members to withdraw from Blue Cross and Blue Shield of Michigan as a method of pressuring Blue Cross during negotiations over its reimbursement policies violated antitrust; La Association Medical, 60 Fed. Reg. 35, 907 (FTC July 12, 1995) (resolving claims that a medical association, its psychiatry section, and individual physicians conspired to organize a concerted boycott by psychiatrists of a government insurance program in an attempt to obtain higher reimbursement rates and adoption of exclusive referral rules).

[6] Because Congress was concerned with using capital in an anticompetitive manner, rather than labor, it has enacted a statutory exemption to the antitrust laws with respect to labor activities. In 1914, Congress enacted section 6 of the Clayton Act providing that "labor . . . organizations, or the members thereof, shall not be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws." In 1932, Congress further strengthened the exemption through the Norris-Laguardia Act which clarified the Clayton Act's prohibition against the issuance of injunctive relief in labor disputes and specified that activities such as creating unions, nonviolent picketing, and strikes do not violate the law.

[7] See generally, *The Quality Health Care Coalition Act of 1999: Hearing on H.R. 1304 Before the House Comm. on the Judiciary*, 106th Cong. (1999) (statement of Ratcliffe Anderson, Jr., M.D., Executive Vice President and Chief Executive Officer, American Medical Association) [hereinafter *Quality Health Care Coalition Act Hearing*].

gotiating positions vis-a-vis the health insurance industry. For instance, community pharmacists have complained that they are not permitted to mutually discuss or respond to insurance company demands because they are independent, but that chain stores, representing thousands of outlets, can agree or disagree together when a third-party payer presents a contract to them.[8]

Additional non-physician providers, such as nurse practitioners, nurse anesthetists, nurse midwives, physical therapists, optometrists, osteopaths, psychotherapists, and chiropractors, that practice independently, may encounter difficulties very similar to those encountered by independent physician providers when negotiating contract terms with health insurers. Thus, these providers may also benefit from this legislation. There were, however, concerns raised by these groups that H.R. 1304 could permit groups of physicians to negotiate unfair agreements with health plans that could put non-physician providers at a competitive disadvantage.[9]

To address this issue, Representatives Nadler, Frank, and Jackson Lee offered an amendment at the Full Committee markup which stated that "nothing in this section shall exempt from the application of the antitrust laws any agreement or otherwise unlawful conspiracy that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care professional or group of health care professionals with respect to the performance of services that are within their scope of practice as defined or permitted by relevant law or regulation."[10] The amendment clarifies an important point in connection with the legislation to which it is attached: that H.R. 1304 does not exempt from the antitrust laws negotiations which lead to agreements or conspiracies to exclude or limit the role of competitive health care providers in managed care and insurance arrangements. More specifically, it does not, in the name of "collective bargaining" or otherwise, enable some classes of health care professionals to attempt to exclude others from access to health care markets, or to deprive consumers of the choice of and access to the wide range of high quality and cost-effective health care professionals. This should address the concerns raised by non-physician health care providers.

Over the years, the antitrust laws have, in fact, been enforced in various cases to prohibit specific anti-competitive actions of physicians or other health care professionals. I regard it as essential that the antitrust laws remain effective to maximize consumer choice among all segments of the health care provider community, and this will clearly be the case under H.R. 1304.

---

[8] See generally, *Quality Health Care Coalition Act Hearing* (statement of John Rector, Vice President, National Community Pharmacists Association).

[9] The particular concern alleged was regarding contract terms: (1) that require a physician to be present for certain procedures, even though non-physician providers can furnish the procedures independently under State and Federal law; (2) that impose "quality" standards that forbid or discourage referrals to non-physician providers; (3) that mandate certain educational or experience requirements that typically can be met by most physicians, but by only few or no non-physician providers; or (4) that establish reimbursement rates that are so low for non-physician providers that it is not viable for any of them to participate with health plans as independent providers. This kind of anti-competitive behavior may threaten to raise prices of health care services and to restrict consumer choice of those services.

[10] Sec. 2(e).

III. CURRENT LAW FAVORS INSURANCE COMPANIES.

Finally, I support H.R. 1304 because current law unfairly favors insurance companies. Not only can insurance companies require health care professionals to sign unfair contracts, but they also benefit from the 1945 McCarran-Ferguson Act, which partially exempts the insurance industry from the Federal antitrust laws.[11] This law, which this committee had voted to scale back under Chairman Brooks,[12] means that huge insurance companies may be permitted to conspire together to limit health care competition, but that the independent physicians cannot develop any sort of coordinated response.

CONCLUSION

As Dr. Fitzhugh Mullan wrote in an issue of *The Washington Post*, "No one is in a better position than medical professionals to point out where the system is being stretched thin, where health plans are stinting on patient care or where people lack care altogether. . . . . Physicians are ideally placed to serve as monitors and watchdogs of the commercial forces that determine so many clinical decisions these days."[13] Under H.R. 1304, health professionals will have the right to collectively bargain with health care service plans and the ability to reach more equitable and fair agreements with HMOs for the purpose of achieving improved health care for the American consumer. For the reasons discussed above, I strongly support this legislation.

JOHN CONYERS, JR.

○

[11] In reaction to *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944), holding that the insurance industry was a business in interstate commerce subject to the Sherman Act, Congress enacted the McCarran-Ferguson Act, which created a statutory antitrust exemption for insurance companies. In order to qualify under the McCarran exemption from Federal antitrust liability, the insurance company must be able to prove that the challenged activity is a part of "the business of insurance," the activity is regulated by State law, and the activity does not constitute an agreement or act to boycott, coerce, or intimidate. Although many thought the exemption was intended to be temporary, it has continued unabated for more than 50 years.

Health insurers also benefit from an exemption from liability suits for their failure to provide care because of ERISA law as well. Courts have consistently held that ERISA preempts State law medical malpractice claims against entities involved in the administration or delivery of health care benefits under an ERISA plan. Thus, while an injured person typically sues an HMO in State court, arguing that it is an ordinary malpractice case, the HMO typically removes the case to Federal court, arguing that it is governed by the Federal law on employee benefits. The HMO contends that it makes "benefit decisions" (rather than medical decisions) in the course of managing employee benefit plans and that it, therefore, should not be held responsible for any negligence by a physician.

[12] See H.R. 9, approved by the committee in 1994 and 1992. Neither bill was taken to the House floor.

[13] Fitzhugh Mullan, *A Look at . . . Unionizing Doctors; I Joined Once. Now I'm Not So Sure*, The Washington Post, July 18, 1999, at B3.