DEPARTMENT OF JUSTICE

Statement by

JOEL I. KLEIN
Assistant Attorney General
Antitrust Division
U.S. Department of Justice

Before the
House Judiciary Committee
on
H.R. 1304, The Quality Health-Care Coalition Act Of 1999

Washington, D.C.
June 22, 1999

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 employed 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 non-mandatory 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 requiring 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.