Prepared Statement
of
Federal Trade Commission

Presented by

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Federal Trade Commission

Before The
Committee on The Judiciary
United States House of Representatives

Concerning H.r. 4277
the "Quality Health-care Coalition Act of 1998"

July 29, 1998

INTRODUCTION

Mr. Chairman and Members of the Committee, I am pleased to appear before you today to present the testimony of the Federal Trade Commission concerning H.R. 4277, which would create an exemption from the antitrust laws to enable health care professionals to negotiate collectively with health plans over fees and other terms of dealing. The Commission believes that the interests of consumers would be harmed by such an exemption. The immunity that would be granted by H.R. 4277 is unnecessary to protect legitimate collaboration among competing health care providers. It would immunize anticompetitive activities that could diminish the effective functioning of health care markets. This, in turn, could harm consumers and raise health care costs, and would likely encourage those in other industries to seek similar special interest exemptions.

We are aware that some health care providers, as well as others, have expressed concerns about the effects that certain managed care arrangements may have on the quality of

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Committee today would undermine efforts to address concerns about the current state of our health care system.

In this testimony, the Commission will first briefly discuss the role of antitrust law enforcement in the health care area, and then address the proposed legislation under consideration by the Committee. We understand that H.R. 4277 is intended to allow health care professionals to present a united front when negotiating with health plans over fees and other terms governing the plans' dealings with health care providers, and the Commission's testimony is based on its understanding of that intent.

I. THE ROLE OF ANTITRUST IN THE EVOLVING HEALTH CARE SYSTEM

A key focus of the Commission's efforts in the health care area has been to help assure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. The development of these new arrangements, which have helped substantially to slow the rate of increase in health care costs, depends on vigorous competition among market participants. To that end, the Commission, the Department of Justice, and state antitrust enforcers have challenged numerous practices that restrict competition among health care providers when those restraints have harmed consumers. These practices include price fixing, ethical restrictions on the dissemination of truthful information, restraints on physician participation in HMOs and other types of managed care organizations, and efforts by some health care providers to stifle cost-containment efforts.

In over 20 years of antitrust law enforcement in the health care area, the Federal Trade Commission has addressed numerous instances of collective activity by otherwise independent health care providers aimed at third-party payers whose policies or mere existence the providers found objectionable for one reason or another. A broad range of payers, including Blue Shield plans, health maintenance organizations (HMOs) and other managed care plans, dental insurers, and state Medicaid programs, at various times, have been the targets of such actions. Early cases involved instances of collective boycotts or similar activity by physicians and other health care providers to prevent HMOs from entering the market.[(1)] Subsequently, the vast majority of cases has involved collective action aimed solely or primarily at increasing (or preventing reductions in) payment levels to providers. This collective activity has involved joint agreement and/or collective negotiation on prices or reimbursement issues, often accompanied by actual or threatened coercive boycotts to pressure payers into accepting the terms demanded by the providers.[(2)]

Most of the Commission's past enforcement actions have been directed at health care providers' efforts to forestall the development of, or raise prices charged to, privately funded health plans. Yet for many citizens, private insurance is unavailable. Many states are currently developing forms of publicly-sponsored insurance to provide medical coverage for the otherwise uninsured. One of our most recent health care enforcement actions involved such a program.

The Commonwealth of Puerto Rico developed a program for providing health care coverage for the uninsured, known as the Reform, which currently covers about 30% of the population. In late 1996, the College of Physicians and Surgeons decided to take collective action in an attempt to raise their reimbursement level under the Reform, which would have raised the costs of health care to the citizens of Puerto Rico. The College ultimately called an eight-day strike, with physicians closing their offices and, in some cases, canceling elective surgery without notice. The potentially serious impact on patients of such anticompetitive behavior is obvious. The FTC and the Commonwealth of Puerto Rico jointly filed a complaint and obtained a consent agreement, under which the College and three large medical groups that contracted with the government paid $300,000 in restitution and agreed not to engage in future boycotts or unintegrated collective price fixing.[(3)]

We believe that sound antitrust enforcement in situations like the one in Puerto Rico has been a major factor in permitting the emergence of alternative health care arrangements that today vie for the patronage of consumers, private employers, and government purchasers. Although health care markets have changed dramatically over time, and continue to evolve, collective action by health care providers to block innovation and interfere with cost-conscious purchasing remains a significant threat to consumers. The prospect of effective antitrust enforcement therefore continues to be a crucial, positive influence on the marketplace which encourages better responses to consumer demands for high-quality and cost-effective health care.

While many of our cases have focused on health care providers' efforts to obstruct managed care plans, we wish to emphasize that the Commission does not favor any particular model of health care delivery -- whether it be fee-for-service, managed care, or some other type of arrangement. Our goal simply is to deter restraints that unduly limit the options available in the market or artificially raise prices, so that consumers will be free to choose the health care arrangements they prefer at competitive prices.

II. THE ANTITRUST EXEMPTION FOR HEALTH CARE PROFESSIONALS EMBODIED IN H.R. 4277 WOULD BE A RADICAL DEPARTURE FROM EXISTING LABOR LAW STANDARDS

As presently drafted, H.R. 4277 would create a broad antitrust exemption for price fixing and boycotts by physicians, dentists, and other health care professionals, by granting competing providers the same antitrust exemption that is accorded to employees who create legitimate labor organizations to negotiate with employers. The bill states that any group of health care professionals that negotiates with a "health insurance issuer," such as an HMO or commercial health insurer, is entitled to "the same treatment under the antitrust laws as that which is accorded to members of a bargaining unit recognized under the National Labor Relations Act." Workers in such bargaining units enjoy what is known as "the labor exemption" from the antitrust laws.[(4)] In essence, the labor exemption allows employees to unionize and use collective economic pressure against an employer to gain higher wages and more favorable working conditions. Thus, the bill would create a "collective bargaining" exemption to allow doctors and other health care professionals to

exert economic pressure on health plans to gain higher fees and other, more favorable, terms of dealing. As was noted earlier in this testimony, challenges to such collective action have been and continue to be a central focus of antitrust enforcement in the health care sector because of the harm such activity inflicts on consumers.

It is important to recognize that the labor exemption already operates in the health care sector under the same standards that apply in other industries -- that is, where there is a "labor dispute" involving a bona fide labor organization. Thus, physicians who are employees are *already* covered by the labor exemption under current law. The exemption, however, is limited to the employer-employee context. An antitrust defendant must demonstrate that the dispute at hand grew out of an employer-employee relationship -- *i.e.*, a "labor dispute" -- to successfully invoke the labor exemption.[(5)] But when independent business people combine to enhance their entrepreneurial interests, rather than to affect some employer-employee relationship, the labor exemption does not apply.[(6)]

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 an amendment to Section 2(3) to provide expressly 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) (emphasis supplied).

Some self-employed physicians have contended that they must contract with dominant purchasers, and that managed care health plans control their medical practices to such a degree that they are effectively "employees." To the extent that sufficient control in fact exists to create an employment relationship, no legislative exemp[illegible]

- The physicians themselves make the fundamental decisions that determine the profitability of their practices. For example, they decide whether to be sole practitioners or join a group practice, have virtually total control over their expenses (such as the cost of their offices, equipment, and staff), and can vary their incomes by choosing to work more hours.

- The physicians spend only a minority of their time and derive only a minority of their incomes from services provided to the HMO's members. They treat patients who are members of other HMOs, are covered by other types of private health insurance or the Medicare program, or who pay directly for physicians' services.

- Many of the restrictions and procedures imposed on the physicians by the HMO's contracts were mandated by state law, either directly or by virtue of state law requiring certification by an accrediting organization whose standards require the procedures in question. Under labor law principles, restrictions and procedures imposed by governmental regulation do not amount to control by an employer.

In sum, H.R. 4277 is designed to confer the labor exemption on those whose situations are vastly different from those eligible for the exemption under long-standing and well-established principles of labor law. Moreover, the bill makes no provision for bringing these providers within the regulatory scheme of the labor laws that applies to others entitled to the labor exemption. Instead, it would merely grant them a broad immunity to present a "united front" when negotiating price and other terms of dealing with health plans, without any efficiency benefits for consumers or any regulatory oversight to safeguard the public interest. The Commission believes that enacting a labor exemption for health care providers who are not employees is not justified, and would seriously harm competition and consumers. In addition, providing such an exception to a requirement that applies to all other professionals -- that they must be employees in order to qualify for the labor exemption -- is likely to encourage others who do not meet that standard to seek such special treatment. H.R. 4277, therefore, would be the first step on a slippery slope.

III. THE PROPOS34 Td [0 ae prpti3(qu)4(x)0(e)4Thew [(l)N prrR00(pt)-2(i)-2osd(d t)- tddit publiy

As some Members of this Committee may recall, in 1996 the Federal Trade Commission and the Department of Justice revised their health care guidelines to emphasize that

physicians and other health care professionals that could seriously harm consumers and undermine efforts to make available and promote high quality, cost-effective health care for consumers. For example, the bill would permit otherwise competing health care providers to jointly agree to raise their prices and increase their payments from insurers and other payers, at the expense of consumers. Like the physicians in the Puerto Rico case discussed above, they could "strike" by refusing to provide services to patients covered by payers who did not accede to their payment and other demands.

Third-party payers, attempting to respond to the demands of their customers to control costs, increasingly have sought to obtain lower fees from providers, and to develop ways to control what previously was the providers' virtually unrestricted ability to provide expensive health care services to patients, even when such services were unnecessary or inappropriate. Not surprisingly, at various times payers have faced concerted opposition to their cost-containment efforts from some health care providers, in an effort to thwart what the providers perceived as unwarranted intrusions into their professional practice autonomy.[(12)] Many of these instances involved assertions that the collective conduct was aimed, at least in part, at protecting consumers and assuring quality of care. For example, this was precisely the rationale used by the AMA to justify its ethical prohi tn (M)1(A(y)22(i6(a)6(l p)2(r)5

other terms for the market.[18]

CONCLUSION

The health care system is a complex and dynamic sector of our economy. New arrangements and approaches to delivering and paying for care are continually emerging in

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 order); *Montana Associated Physicians, Inc./Billings Physician Hospital Alliance, Inc.*, C-3704, 62 Fed. Reg. 11,201 (March 11, 1997) (consent order); *Physicians Group, Inc.*, 120 F.T.C. 567 (1995) (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); *Southbank IPA, Inc.*, 114 F.T.C. 783 (1991) (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, et al.*, 110 F.T.C. 175 (1988) (consent order); *Preferred Physicians, Inc.*, 110 F.T.C. 157 (1988) (consent order); *Michigan State Medical Society*, 101 F.T.C. 191 (1983); *Association of Independent Dentists*, 100 F.T.C. 518 (1982) (consent order).

3. *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. Oct. 2, 1997).

4. The labor exemption from the antitrust laws is derived from Sections 6 and 20 of the Clayton Act and Section 4 of the Norris-LaGuardia Act. The exemption has two branches: (1) the "statutory exemption," which is based on the express wording of the statutory provisions; and (2) the judicially created "nonstatutory exemption," which harmonizes the policies underlying the National Labor Relations Act of 1935 ("NLRA") with the antitrust laws.

5. *See, e.g., H.A. Artists & Assocs. v. Actors Equity Ass'n*, 451 U.S. 704, 717 n.20 (1981) ("a party seeking refuge in the statutory exemption must be a bona fide labor organization and not an independent contractor").

6. *Columbia River Packers Ass'n v. Hinton*, 315 U.S. 143 (1942). *Accord, Los Angeles Meat and Provision Drivers Union, Local 626 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).

7. Letter from Dorothy L. Moore-Duncan, Regional Director, Region Four, NLRB, to Robert F. O'Brien (January 8, 1998). The decision currently is on appeal to the full NLRB.

8. United States Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement*

Policy Statements: An Overview," 10 *The Chronicle* 2 (Fall 1996). *See, generally*, Hirshfeld, "Interpreting the 1996 Federal Antitrust Guidelines for Physician Network Joint Ventures," 6 *Ann. Health L.* 1 (1997); Miles, "Joint Venture Analysis and Provider-Controlled Health Care Networks," 66 *Antitrust L. J.* 127 (1997).

10. Section 4001 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, August 5, 1997.

11. *See, e.g.*,United States Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, issued August 28, 1996, *supra* n. 8, at Statement 4 ("Providers' Collective Provision of Non-Fee-