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Joint Negotiation by Health-Care Professionals: H.R. 1304, "Quality Health-Care Coalition Act of 2000"

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Summary

H.R. 1304, "Quality Health-Care Coalition Act of 1999," amended and passed by the House on June 30, 276-136, would enable health-care professionals to negotiate jointly with non-federally affiliated health plans concerning "the terms of any contract under which the professionals provide health care items or services for which benefits are provided under such plan" (except that discussions about requiring abortion coverage are exempt from the negotiation exemption), thus altering existing antitrust law so that joint negotiation by health-care entities that, but for their joint activity, would normally be competitors, would no longer be considered unlawful. A sense of Congress amendment states that medical decisions should be made by health care professionals and patients. This report will set out, briefly: the present antitrust law and some relevant exemptions from it; some pertinent parts of the "Statements of Antitrust Enforcement Policy in Health Care,"[1] and the major provisions of H.R. 1304. It will be updated to reflect changes in the legislative status of H.R. 1304.

The relevant provision of current antitrust law is section 1 of the Sherman Act (15 U.S.C. § 1), which prohibits contracts or conspiracies in restraint of trade. When joint activity concerns pricing or output decisions it is not only prohibited, but generally considered *per se* violative of the antitrust laws (*i.e.*, automatic – requiring no detailed analysis of the circumstances surrounding, and admitting of no justification for, the challenged activity).[2] Section 1 is the provision which normally would be applicable to

[1] Issued jointly by the Department of Justice and the Federal Trade Commission (FTC), August 28, 1996 (hereinafter, Health Care Guidelines, or Guidelines).

[2] Generally, only those restraints deemed *unreasonable* have been prohibited (Standard Oil Co. of New Jersey v. United States, 221 U.S. 1 (1911); Board of Trade of the City of Chicago v. United States, 246 U.S. 231, 238 (1918): "... the legality of an agreement cannot be determined by so simple a test as whether it restrains competition. Every agreement concerning trade, every (continued...)

joint activities – especially those pertaining to price/fees – of entities engaged in commerce. With the exception noted below at page 3, physicians are not exempt from the prohibitions of section 1 – whether they agree on fees among themselves or, as in the case under consideration in H.R. 1304, conclude an agreement in concerted negotiations with a buyer of group members' services ("health care professional" joint negotiation with a "health plan.").[3] Joint action deemed "noncommercial" is not generally considered violative of the antitrust laws;[4] the FTC, for example, has never prosecuted a case in which physicians have negotiated collectively with a health plan on an issue directly involving patient care.[5] Nevertheless, there is also some indication that only *noncommercial entities* which take concerted action to further some social welfare objective are completely protected, even when they are driven by objective(s) which may be highly partisan.[6]

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regulation of trade, restrains. ... The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition."). On the other hand, " ... there are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use [*i.e.,. per se* unreasonable]." Northern Pacific Railway Co. v. U.S., 356 U.S. 1, 4 (1958).

[3] *See e.g.*, Goldfarb v. Virginia State Bar, 421 U.S. 773, 787. Activity that would normally be considered *per se* unlawful if carried out jointly by individual competitors – if carried out by an entity that is sufficiently integrated to have formed a new entity with an identity apart from its individual components – is, however, generally considered to be that of a true "joint venture"; and is treated not as *per se* violative of the antitrust laws, but analyzed under the antitrust Rule of Reason, which balances the anticompetitive results of a transaction against any procompetitive effect that might be produced by the activity (see discussion *infra* re Physician Network Joint Ventures under the Health Care Guidelines).

[4] Klors, Inc. v. Broadway-Hale Stores, Inc. 359 U.S. 207, 213 n. 7(1959) (Sherman Act "is aimed primarily at combinations having commercial objectives ...."); *see also* State of Missouri v. NOW, 620 F.2d 1301 (8th Cir. 1980), *cert. denied*, 449 U.S. 842 (1980) (no relief to governments challenging NOW's convention boycott of states that had not ratified the Equal Rights Amendment); NOW v. Scheidler, 968 F.2d 612, 617-23 (7th Cir. 1992), *rev'd on other grounds*, 510 U.S. 249 (1994) (antitrust claim charging conspiracy by antiabortion group to shut down abortion clinics dismissed).

[5] Robert Pitofsky, Chairman of the FTC, testifying before the House Judiciary Committee at June 22, 1999 hearings on H.R. 1304. Presumably, Pitofsky was referring to physician negotiation *directly* about quality-of-care issues; the Agency *has*, however, prosecuted *indirect* joint action designed to achieve some likely permissible result (*see, e.g.*, note 6).

[6] In FTC v. Superior Court Trial Lawyers Ass'n., 493 U.S. 411 (1990), the FTC challenged a work-stoppage by court-appointed attorneys, allegedly instituted on behalf of the criminal defendants they served. Although the Court was sympathetic to the attorneys' arguments that the level of service to indigent defendants was significantly and adversely affected by the limited resources available to the attorneys; and that the concerted action to get increased compensation was but a means to secure higher quality service, it said: "[Although] ... the quality of representation may improve when rates are increased, ... that fact is [not] an acceptable justification for an otherwise unlawful restraint of trade. ... No matter how altruistic the motives of respondents ..., it is undisputed that their immediate objective was to increase the price that they would be paid for their services" 493 U.S. at 427. The arrangements made lawful in H.R. 1304 were justified as
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Antitrust immunity (exemption(s) from the operation of the antitrust laws) has specifically been provided in such areas as labor relations, certain insurance practices, and in instances in which private actors are "third-party beneficiaries" of the states' so-called "state action" immunity; a brief discussion of the first two areas follows.

Labor

The antitrust statutory exemption declares that the "labor of a human being is not a commodity or article of commerce" (15 U.S.C. § 17); it specifically authorizes the formation and existence of labor unions, and recognizes the "legitimate objects" of members' labor-related activities. Pursuant to labor law, *employees* (here, doctors who are employed by hospitals or health plans) are granted collective bargaining rights by the National Labor Relations Act;[7] and several sections of the Norris-Laguardia Act (29 U.S.C. §§ 101-115), which expressly permit parties to a "labor dispute" to act "singly or in concert" (29 U.S.C. § 104); or prohibit federal courts from issuing injunctions in a "labor dispute" on the ground that the participants are "engaged in an unlawful combination or conspiracy" (29 U.S.C. § 105). The judicially created labor-antitrust exemption, which holds that Congress' desire to foster collective bargaining is best furthered by permitting *employees* who wish to jointly negotiate the *terms of their employment* to do so without fear of violating the antitrust laws, requires the following: (1) the practice(s) being negotiated must inherently constitute a mandatory subject of collective bargaining (*i.e.*, be *bona fide* terms or conditions of employment); (2) the practice(s) being negotiated should be no more restrictive than is absolutely necessary to realize the goal(s) it (they) purport(s) to achieve; (3) the practice(s) must be embodied in a valid, genuinely negotiated collective bargaining agreement.[8]

Insurance (McCarran-Ferguson Act)[9]

15 U.S. § 1012(b) mandates not only that the "business of insurance" shall be regulated at the State level, but also that "No Act of Congress shall be construed to invalidate, impair, or supercede any law enacted by any State for the purpose of regulating the business of insurance ... unless such Act specifically relates to the business of insurance." Federal antitrust law does not specifically relate to the business of insurance,

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necessary to "enhance the quality of patient care" in the bill as introduced; the legislation continues to be titled, "Quality Health-Care Coalition Act."

[7] Specifically, 29 U.S.C. § 157.

[8] The recent decision of the House of Delegates of the American Medical Association (AMA) to form a collective bargaining unit would have little impact on the current debate concerning the right of physicians to bargain collectively, and would alter the current status of bargaining unit physician-employees only in that they would, when selecting a bargaining unit representative (as allowed by 29 U.S.C. § 157), be able to choose the AMA-sponsored union: "fewer than 20% (or 108,000) of physicians are in employed, nonsupervisory positions that would make them currently eligible to bargain collectively." 77 ANTITRUST & TRADE REGULATION 34 (July 8, 1999).

[9] 15 U.S.C. §§ 1011-1015; for a more thorough treatment of the background and history of McCarran-Ferguson, *see* Cohen, "The McCarran-Ferguson Act's Exemption of the Business of Insurance From Federal Antitrust Law," CRS Report 90-212, April 24, 1990.

and neither the term nor its scope were defined in McCarran-Ferguson; accordingly, some observers held/hold federal antitrust law inapplicable to any action undertaken by any member of the insurance industry, a position seemingly endorsed in the "Finding" in H.R. 1304, as introduced, that "[t]he McCarran-Ferguson Act has created an enhanced opportunity for market power of insurance companies in health care and has given such companies significant leverage over health care providers and patients" reflected that confusion. In fact, as was indicated in testimony at the June 1999 hearings, case law seems to indicate that the Act probably does not either permit or authorize insurance companies to merge or to otherwise acquire or maintain market power,[10] although the McCarran-Ferguson protection/immunity available to the "business of insurance" does permit *some* joint action by insurance companies (*e.g.*, the sharing of actuarial data) that might ultimately facilitate the acquisition of market power.

Health Care Guidelines[11]

"Physician Network Joint Ventures" (physician-controlled ventures in which the networks' physician participants collectively agree on prices or price-related terms and jointly market their services) are addressed in Guideline number 8, which notes that "[t]ypically, such networks [*e.g.*, IPAs or PPOs][12] contract with [health] plans to provide physician services to plan subscribers at predetermined prices, and the physician participants in the network agree to controls aimed at containing costs and assuring the appropriate and efficient provision of high quality physician services."[13] The "antitrust

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[10] In 1969, the Supreme Court decided that the "business of insurance" concerned the "insurance relationship." In Securities and Exchange Commission v. National Securities, Inc., the Court allowed the application of a state statute aimed at protecting the stockholders of insurance companies during a merger (393 U.S. 453, 460 (1969)). Ten years later, in Group Life & Health Insurance Co. v. Royal Drug Co., it pointedly noted that McCarran-Ferguson exempted "the 'business of insurance,' not the 'business of insurors'" (440 U.S. 205, 211 (1979)). Most recently, the Court relied on National Securities to allow policyholders to maintain a RICO (Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § § 1961-1865) action against insurance companies that allegedly gained discounts for hospital services but did not pass them on to insureds; it found that the action would not violate the proscriptions of McCarran-Ferguson: "... RICO advances the State's interest in combating insurance fraud, and does not frustrate any articulated Nevada policy [concerning insurance regulation] ...." (Humana Inc. v. Forsyth, 119 S.Ct. 710, 719 (1999)).

[11] HEALTH CARE GUIDELINES reprinted at 71 ANTITRUST & TRADE REGULATION REPORT Special Supplement (August 29, 1996). The Guidelines are described and summarized in *Update on Provider-sponsored Organization and the Antitrust Laws*, Appendix to the 1997 Annual Report to Congress prepared by the Physician Payment Review Commission.

[12] Individual practice associations; preferred provider organizations.

[13] 71 ATRR Special Supplement at S-15. The joint marketing of their services to health care plans by various kinds of physician joint network associations, and whether such action should be considered as insurance activity and licensed as such, is addressed in Hirshfeld, *Assuring The Solvency of Provider-Sponsored Organizations [PSOs]*, 15 HEALTH AFFAIRS 28 (Fall 1996); and, with respect to organizations which are Medicare providers, Polzer, *Medicare PSOs*, NATIONAL HEALTH POLICY FORUM Issue Brief No. 72.

safety zone" for physician joint networks allows participation in "exclusive" networks[14] by 20 percent or less of the physicians "in each physician specialty with active hospital staff privileges in the relevant geographic market,"[15] and 30 percent or less for *bona fide* "non-exclusive" networks, and requires that "participants in a physician network joint venture must share substantial financial risk in providing all the services that are jointly prices through the network."[16] The Guideline emphasizes, however, that "merely because a physician network joint venture does not come within a safety zone in no way indicates that it is unlawful under the antitrust laws."[17]

The FTC's recent complaint against Mesa County IPA[18] illustrates the circumstances that will generally result in antitrust enforcement action. Paragraph Six of the amended complaint states that the IPA "was formed ... to promote the collective economic interests of Mesa County physicians. ...[it] has acted to restrain competition by, among other things, facilitating, entering into, and implementing agreements among its members, express or implied, to fix price and other competitively significant terms of dealing with payers, or by collectively refusing to deal with payers. Paragraph Twelve charges that the "physician members of ... Mesa County IPA have not integrated their practices to create efficiencies sufficient to justify their acts and practices...." Part II of the consent order mandates that the IPA, "directly or indirectly, or through any corporate or other device, in connection with the provision of physician services in or affecting commerce, ... cease and desist from":

> A. Entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding to:
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> 1. *Negotiate on behalf of any participating physicians with any payer or provider*; .... (emphasis added)

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[14] Those in which physician participants may not generally practice individually, or affiliate with other networks or health plans, *i.e.,*. may not either continue their individual practices or affiliate with other networks or plans.

[15] *I.e.,* the geographic market in which the group operates and from which it can reasonably expect its patients to come.

[16] 71 ATRR Special Supplement at S-16. Risk sharing is used as an indicator of sufficient integration in the network to allow for treatment as a single entity (joint venture) rather than as a collection of competitors, and eligible for Rule of Reason versus *per se* antitrust analysis; acceptable risk-sharing arrangements may include capitation, fee withholds or other financial incentives (*e.g.*, performance "targets"), and payment agreements under which participants agree to payment as a predetermined percentage of a plan's premiums or revenue. "In accord with general antitrust principles, physician network joint ventures will be analyzed under the rule of reason, and will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies." *Id.* at S-17- S-18.

[17] *Id.* at S-15.

[18] In re Mesa County Physicians Independent Practice Association, Inc., Docket No. 9284, original complaint issued May 12, 1997; amended complaint and proposed consent order issued May 4, 1999, released May 20, 1999.

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

As noted above, *employees* may currently negotiate jointly with their employers pursuant to either the non-statutory "labor-antitrust" exemption or the authorization contained in various provisions of 29 U.S.C.; H.R. 1304 would extend that authorization to non-employee, independent physicians and other "health-care professionals."[19] It would create the legal fiction that, for purposes of joint negotiation with non-federally affiliated health plans,[20] they are "employees" "entitled to the same treatment under the antitrust laws" as are "bargaining units which are recognized under the National Labor Relations Act" (section 2(a)).

H.R. 1304 differs from the "bargaining unit" authorization in 29 U.S.C. § 157 in that it expressly does "not confer any right to participate in any collective cessation of service to patients"(section 2(c)(1)); the labor provision expressly allows "other concerted activities." Further, the bill does not, as does the nonstatutory labor-antitrust exemption, distinguish between mandatory and permissive subjects of bargaining. Any action taken "in good faith reliance" on the above authorization would not be subject to civil or criminal antitrust "sanctions," or to damages "beyond actual damages incurred" (section 2(b)).

The bill, which does not yet have any companion or similar legislation in the Senate, is as notable for what it does not contain as for the collective negotiation it sanctions. There is no limit on the subjects of that negotiation, so that fees could be negotiated even with health plans that realistically exercise only minimal market power (a proposed amendment would have denied the negotiation exemption to any discussion of fees); recently enacted, similar, but more limited, legislation in Texas,[21] on the other hand, is specifically limited to "physicians," and requires that before fees may be negotiated, the State Attorney General must find that a health plan enjoys "substantial market power." Nor is there any requirement that a negotiating unit either (1) be geographically or numerically circumscribed, or (2) not contain more than a single type of health care professional: multi-state, or multi-discipline, health care professional negotiating units consisting of *e.g.,* all of the physicians, RNs, LPNs, physical therapists, *etc.*,in any size delineated area, are theoretically possible).

The authority conferred by H.R. 1304 is limited to 3 years from the date of enactment, after which time the General Accounting Office is to study the bill's "impact," and make recommendations concerning its continuation (sections 2(d), 2(i)).

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[19] Defined broadly to include "an[y] 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 [not necessarily a degree or a license] that confers expertise in the provision of [those things]" (section 2(j)(3)) (Emphasis added).

[20] "Health plan" is defined as "a group health plan or a health insurance issuer that is offering health insurance coverage" (section 2(j)(2)(A)).

[21] Vernon's Annotated Texas Stats. Insurance Code Arts. 29.01- 29.14; the statute sunsets in September 2003 (Art. 29.14).