

**THE  
NEW ENGLAND  
COUNCIL**

**A PUBLIC HEALTH INSURANCE OPTION**

September 2009

Dear Member of Congress:

As you continue to consider healthcare reform legislation and all of its implications, I wanted to share with you the attached memorandum discussing the public health insurance option and several related issues that some of our members have raised. Our member companies, from financial services and insurance companies to academic and healthcare institutions, both large and small, make up a fair representation of the various stakeholder industries and groups participating in the healthcare reform debate.

The most contentious issue concerning healthcare reform continues to be the creation of a congressionally formed and federally controlled public health insurance option, or plan, to serve as the health insurer for those who are unable to obtain it through the employer based or individual market. Its supporters argue that through its government leverage or purchasing power, nation-wide availability, and lower operating costs, it will introduce greater competition into a health insurance market currently dominated by a few large insurers providing little choice to consumers. Its opponents believe that because of its publicly provided start-up funding, exemption from a multitude of federal and state operating restrictions, and the full faith and credit of the United States government behind it, a public plan will enjoy significant and, in their view, unfair competitive advantages over private insurers. They also believe that it places the government in the conflicting position of both competing with and regulating private insurers.

There are a number of fundamental and unresolved issues concerning a public plan's operation. These include the provider reimbursement rate under the public plan, and whether the public plan should have reserve funds; whether the collected plan premiums, co-pays and/or deductibles will adequately cover costs; what, if any, federal revenue might be required or is available to cover any public plan deficits, and its overall cost.

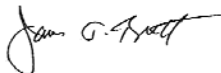
There are also questions concerning the wisdom of creating another public plan, given the financial condition of Medicare and its projected effect on deficit spending, outstanding public debt and our future national economy. And, as with the Massachusetts experience to date, whether some type of public/private plan could be a workable compromise.

Finally, the stated goal of increasing competition within the health insurance markets by creating a public plan to compete with private insurers on a level playing should be evaluated carefully if the legislation would also give the public plan license to engage in conduct that would expose the private insurers to the sanctions of federal antitrust law should they attempt to engage in that very conduct.

Given Congress' historical bent in favor of the free market, it should carefully consider whether the public plan proposal is one of those rare instances in which the societal benefits from dispensing with the normal competitive process exceeds the costs.

Please contact me if you have any questions.

Very truly yours,



James T. Brett  
President & CEO

**A PUBLIC HEALTH INSURANCE OPTION**

Many people believe that every American should have access to affordable medical care and treatment. Some go so far as to declare it a “right,” whether constitutionally provided or otherwise.<sup>1</sup> They think that accessing health care services should not resemble the typical retail transaction involving the purchase of consumer goods or services.<sup>2</sup> But it is now common for academics, policy-makers, activists and advocates, and members of the media alike to refer to the “healthcare industry” with its various “providers”, “payors”, and purchasers.”<sup>3</sup> Moreover, attempts to control health care spending through price control, treatment regulations and other measures have resulted in increasingly market-based decisions among physicians and hospitals, including those classified as non-profits or public charities.

There is little doubt that making affordable medical care available to all Americans would prove itself a great boon to society. A healthier workforce, for instance, would benefit the business community through increased production and decreased employee absence. The fundamental question, though, is how to pay for such coverage and who will pay for it. Providing treatment is enormously expensive, with current nationwide spending exceeding \$2.2 trillion, more than 16 percent of our gross domestic product. The level and quality of care and treatment are also concerns, with the United States behind much of the industrial world on quality of care indicators. And more than 45 million people, one-seventh of our population, remained uninsured in 2007. But coverage is not the same as access, and it is possible to have one without the other. Having coverage does not guarantee that one can easily find a doctor, for instance, as both Medicare and Medicaid participants report with increasing frequency.<sup>4</sup>

There is general agreement among healthcare policy experts that making or adopting certain system-wide changes, including but not limited to payment reform, quality of care measures, comparative effectiveness research, evidence-based medicine, and health information technology will result in marked improvements to both healthcare delivery and cost. While many of those concepts appear straightforward in theory, they have proven themselves extraordinarily difficult to draft legislatively, or achieve consensus on passage.

**I. Healthcare Reform Legislation**

The five Congressional committees with jurisdiction over health reform (the Senate Committees on Finance and on Health, Education, Labor and Pensions, and the House Committees on Ways and Means, on Energy and Commerce, and on Education and Labor) appear to favor an individual mandate, coupled with tax subsidies for low-income individuals and families. There seems to be consensus on the need for a health insurance “connector” or exchange to assist consumers with plan enrollment, set standards and distribute risk among insurers. There is recognition that the healthcare delivery system needs to be reformed to focus on paying for quality rather than quantity. The employer system would remain in place, although there remains debate within the Sen-

ate Finance Committee over whether some form of an employer mandate or “pay or play” system should be adopted. New investments will likely be made in prevention and wellness and in the health care workforce.

Both chambers now have, between them, three healthcare reform bills under serious consideration -- one in the House and two in the Senate. The three House committees referenced above have worked on various parts of their chamber's bill, H.R. 3200, with each committee reporting their amended version to House Rules where it will be crafted into a new draft to be debated by the full House.

The Senate Committee on Health, Education, Labor and Pensions (HELP) legislation received a favorable committee vote in mid-July. Within the Senate Finance Committee, a bipartisan group of six senators has conducted, and continues to conduct exhaustive negotiating sessions in an attempt to agree on the outline of a bill. Most recently, Senate Finance Chairman Max Baucus proposed legislation, in framework or outline form, that would establish consumer-owned insurance cooperatives instead of a public plan. Similar to the other measures, this proposal would bar insurers from denying insurance coverage to individuals because of pre-existing medical conditions, along with providing affordability tax credits to help low and middle-income families purchase private insurance coverage.

Each of the healthcare reform draft measures currently moving through Congress appear to feature several components based on the Massachusetts healthcare reform statute, including health insurance exchanges or gateways, income-based insurance premium subsidies, minimum policy coverage requirements, an individual mandate, with hardship-based exemptions and financial penalties for non-compliance, and, to varying degrees, an employer “fair share,” or “pay-to-play,” requirement. They also include attempts to implement numerous system-wide changes<sup>5</sup>

## II. The “Public Plan”

The most contentious issue continues to be the creation of a Congressionally formed and federally controlled public health insurance option, or plan, to serve as the health insurer for those who are unable to obtain it through the employer-based or individual market. Its supporters argue that through its government leverage or purchasing power, nation-wide availability, and lower operating costs, it will introduce greater competition into a health insurance market currently dominated by a few large insurers providing little choice to consumers. Proponents contend that lower provider reimbursement rates and lower administrative costs will result in lower premiums for consumers and force private insurers to become less autocratic in coverage determinations if they wish to compete for business. Suggestions include creating a public plan that would be administered by the Department of Health and Human Services (HHS) as a Medicare-like entity, or allowing each individual state to determine how best to administer one or several differing public plans, or establishing some type of regional or state based third-party administrator.<sup>6</sup> Supporters stress that healthcare expenditures would ultimately be lessened because of the administrative savings generated by a government-run plan, the lower provider payment rates used by the plan,

and from the application of payment innovations and system reforms to a greater share of the insured population.<sup>7</sup>

Those who oppose the “public plan” believe that because of its publicly provided start up funding, exemption from a multitude of federal and state statutory and regulatory operating requirements, and the full faith and credit of the United States government backing it up, a public plan will enjoy significant and, in their view, unfair competitive advantages over private insurers (e.g. federal and state antitrust laws applying to private insurers require a competitive marketplace barring agreements on price by private insurers, but a taxpayer financed public plan would enjoy an unfair competitive advantage by being able to artificially lower its prices).<sup>8</sup> Many insurance providers insist that such a plan will result, depending on each company’s book of business, in some insurers pulling their health insurance lines while others might be forced to go out of business altogether. They also believe that it places the government in the conflicting position of both competing with and regulating private insurers.<sup>9</sup>

There are a number of fundamental and unresolved issues concerning the rules and regulations that would apply to a public plan’s operation. The method for determining the provider reimbursement rate under the public plan would need to be set forth, along with whether the public plan would be required to establish provider networks on a voluntary basis or would be authorized by law to compel provider participation. Other drafting and policy issues requiring resolution include whether the public plan should have reserve funds to offset incurred but unreported claims, and if the collected plan premiums, co-pays and/or deductibles will adequately cover costs and what, if any, federal revenue might be required to cover public plan deficits. If federal revenue will be used for this purpose along with enrollee premiums, a funding source must be identified. There is also the question of how the public plan will be administered - whether the public plan would allow sufficient flexibility in terms of the types, prices, and number of health insurance policies available to the public.<sup>10</sup>

### III. Healthcare Reform in Massachusetts

The Congressional efforts to provide universal coverage have drawn, to a great extent, on the provisions of Massachusetts’ recent healthcare law, enacted in 2006 “to Promote Access to Affordable, Quality, Accountable Health Care.” Since implementation of the Massachusetts law, at least 406,000 previously uninsured people have enrolled in private or subsidized health insurance plans. The state recently estimated that more than 97 percent of residents in Massachusetts now have insurance coverage.<sup>11</sup>

The Massachusetts law requires employers with 11 or more workers to offer health insurance to their workers and contribute at least one-third of the cost of coverage, or pay an annual “fair share” contribution of \$295 per employee. It also contains an “individual mandate,” requiring all adults above certain income limits to have health insurance or pay a financial penalty, creates income-based health insurance subsidies, establishes a new public entity, the Commonwealth Health Insurance Connector Authority (known as the Connector) - a purchasing pool for individuals

and small groups, and provides standards for “minimum creditable coverage” requiring insurance coverage for a broad range of medical benefits.

The legislation has also created two new insurance programs - Commonwealth Care and Commonwealth Choice - to be overseen by the Connector. Commonwealth Choice is a non-subsidized insurance program for individuals and small employers. Commonwealth Care, a state-subsidized insurance program, serves individuals who meet certain income eligibility requirements. The Connector was established to “connect” eligible individuals, small employers, and health plans.

The Connector manages both the Commonwealth Care and Commonwealth Choice programs and determines the level of minimum creditable coverage necessary to meet the state’s individual mandate. Minimum creditable coverage (MCC) applies to all insurance products in Massachusetts, and although health plans may still impose reasonable exclusions and limitations, they must cover core services, including physician services, inpatient care, day surgery and diagnostic procedures, along with a broad range of medical benefits including preventive and primary care, emergency services, hospitalization, prescription coverage and mental health and substance abuse services. Beginning in 2010, creditable coverage must also provide x-rays, maternity and newborn care, radiation therapy and chemotherapy.

Any individual who does not qualify for an exemption from coverage but still fails to obtain insurance is subject to a penalty of up to 50% of the monthly premium for coverage that person should have had for each month that they are without it, an amount that could reach \$1,068 a year.<sup>12</sup> Employers who fail to make a “fair and reasonable” premium contribution to the health insurance of their employees are required to pay up to \$295 per year per employee, with the proceeds used to provide health coverage for the uninsured.<sup>13</sup>

Commonwealth Choice is a health insurance program administered through the Connector. The program offers unsubsidized coverage from private insurance carriers to individuals and families and to small businesses. Commonwealth Choice plans are available through the Connector, from brokers, and directly from participating insurance carriers. Individuals can choose from four levels of coverage offered by several carriers. Small employers will have the option of making these plans available to their employees or allowing them to purchase one of the plans directly from the Connector, using pre-tax dollars through a Section 125 plan. Individuals are eligible for Commonwealth Choice if they reside in Massachusetts, are 19 or older, and are ineligible for Commonwealth Care based on their income. Commonwealth Choice is targeted towards young adults, small employers, and employers not currently offering a Section 125 plan.

#### **A. Massachusetts’ Public/Private Plan**

Commonwealth Care is a managed care plan with five different coverage plans dependant on income. Plan Type I is for those earning 100 percent of the Federal Poverty Limit (FPL) or less, Plan Type II for those earning 100.1 percent of the FPL to 200 percent of the FPL, Plan Type III for those

earning 200.1 percent of the FPL to 300 percent of the FPL with either 1) a low premium option or alternatively 2) a low co-pay option.

Commonwealth Care is only available to uninsured individuals who earn less than 300 percent of the FPL and are ineligible for the state's Medicaid program, MassHealth. Individuals are considered uninsured if they are currently insured under COBRA, pay the full premium in the non-group market, or are in a waiting period prior to becoming eligible for an employer-provided plan. Conversely, individuals are considered insured if their (including a family member's) current employer offered them health insurance coverage within the last six months that covered at least 20 percent of the annual premium costs for a family and 33 percent of the annual premium costs for an individual.

Government-funded subsidies are provided to low-income individuals to assist with the purchase of health insurance. Commonwealth Care provides sliding-scale subsidies to individuals with incomes up to 300 percent of the FPL for the purchase of health insurance. The Connector set the subsidy schedule to make health insurance affordable for individuals, while also leaving the employer-based private system of health care financing intact. Individuals with incomes less than 150 percent of the FPL are not required to pay any premiums. The Connector reviews the insurance offered by private insurance companies and approves plans that meet service and cost standards and provides assistance to individuals and employers with their purchase of insurance coverage.

All Commonwealth Care members are enrolled in private insurance managed care organizations (MCOs). The State makes monthly payments, basically the equivalent of employers paying premiums, to the MCOs on behalf of each enrolled member. As discussed, Commonwealth Care members above a certain income level contribute a portion of the payment. It is specifically designed to provide coverage to those persons who cannot afford private plan premiums because of their income level. But Commonwealth Care does not consist of policies offered by the government itself. Instead, five private insurance carriers offer Commonwealth Care plans, and the Connector helps to administer these plans. Thus, it consists of publicly funded contracts with private health insurers.

#### **IV. Existing Federal Public Plans**

It seems to be self-evident that operating a public plan will involve complex and highly technical issues that require predictable and adequate level of resources, something that is at significant risk for Medicare and Medicaid, our most prominent existing public health insurance plans. The long-term risk posed by the increase in spending on our "entitlement programs" is widely recognized, with rising health care costs from Medicare and Medicaid generating the greatest concern among government policy analysts.<sup>14</sup>

The federal government currently funds and controls the operation of a number of public health insurance plans. Several of these, such as the Medicare program, are exclusively federally funded. Others, most notably Medicaid and the Children's Health Insurance Programs (CHIP), are jointly

funded by the federal government and the states. Private insurance entities participate in both state and federal plans as Medicare "fiscal intermediaries" and "carriers", for example.<sup>15</sup>

In 2007 Medicare and Medicaid, the two the two main sources of public financing for healthcare, accounted for close to 20% of the federal budget and more than 27% of total national healthcare expenditures.<sup>16</sup> By 2010, the Congressional Budget Office projects that close to 100 million people will be covered by Medicare and Medicaid.<sup>17</sup> Annual expenditures for Medicare are expected to rise to \$887 billion by 2018.<sup>18</sup>

Medicare itself is one of the largest reimbursers, or payors, in the United States healthcare system. The Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare, is by far the largest component of the Department of Health and Human Services (HHS), which itself is among the largest departments in the government with over 300 agencies, divisions, and programs, a budget exceeding \$500 billion and over 65,000 employees. Aside from Medicare and Medicaid, HHS oversees the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Public Health Service, the Centers for Disease Control and Prevention (CDC), the Administration for Children and Families, the Indian Health Service, etc. HHS is also the largest grant-making organization in the United States.<sup>19</sup>

The financial assets of the Hospital Insurance Trust Fund that pays for Part A of Medicare are projected to be exhausted by 2019. In early 2009, the Centers for Medicare and Medicaid Services reported that the economic crisis could cause the fund to be depleted earlier, by 2016. At that point, trust fund income would cover only 78 percent of scheduled benefits, falling to about 30 percent in 2082.<sup>20</sup> To finance Part A's expected needs through 2083, the Medicare payroll tax would need to be increased immediately by 122 %, program outlays would need to be reduced by 51 % immediately, or some combination of the two, according to the program's trustees. As with Social Security, eligibility for Medicare does not depend on income. Also, as with Social Security, much of Medicare is funded on a "pay-as-you-go basis," which means it depends primarily on today's working population to fund the expenses of today's beneficiaries.<sup>21</sup>

A number of factors have contributed to the rapid increase in Medicare spending. These include increases in overall medical costs, advances in health care delivery and medical technology, increases in the percentage of the population over 65, and longer life spans. By 2010, the Congressional Budget Office projects that close to 100 million people will be covered by Medicare and Medicaid, the two main sources of public financing for health care.<sup>22</sup> If significant reforms are not undertaken, benefits under entitlement programs will exceed government income by more than \$40 trillion over the next 75 years. According to the Government Accountability Office (GAO), this will cause debt ratios relative to GDP to double by 2040 and double again by 2060, reaching 600 percent by 2080.<sup>23</sup>

The Administration submitted a proposed budget that projects the federal deficit to reach about \$1.8 trillion this fiscal year. The Congressional Budget Office (CBO) released its preliminary analysis of the Senate Committee on Health, Education, Labor, and Pensions Affordable Health Choices

Act, indicating that its enactment (Title I) would result in a net increase in federal budget deficits of \$597 billion over the 2010-2019 period. The funding necessary to balance the budget will most likely be borrowed.<sup>24</sup> Lastly, government expenditures are projected to exceed total assumed revenue over the next 75 years, with the fiscal imbalance – between spending and revenue – growing larger each year into the future.<sup>25</sup>

#### V. The Public Plan and Administrative Savings

Supporters have cited Medicare's low administrative costs as an example of how a public plan will cost less and operate more efficiently than private insurers. But according to one former Medicare official lower costs do not necessarily mean efficient, or even adequate, performance:

On the operational side, there is not enough money to be able to even pay the bills in a reasonable way. The agency feels very vulnerable, in many ways, especially on the fraud issue, because the agency wishes it could do more, but the resources aren't there. And in many ways, right now CMS behaves like a resource starved agency, which it is. The staff feels a sense of fatalism when they begin complicated tasks that carry out the law. The sense develops because while the agency will do its best, we don't have enough resources to do all of these tasks well...<sup>26</sup>

Medicare's size, complexity, governance structure and statutory mandates appear to make it very difficult to manage. Despite its large program budget, Medicare has relatively limited administrative resources, making it hard to focus on more than one or two initiatives at a time. Systemic barriers have historically prevented CMS from acting on hundreds of ideas that have been advanced to reduce expenditures. Among CMS' administrative failures has been its inability to successfully adopt reforms, with numerous missed chances to contain costs and/or implement quality improvement over the last two decades, including multiple instances of identifying overpriced services but demonstrating an inability to stop this practice. Where there was some initial success with reform measures, the results were either limited or faded with time.<sup>27</sup>

Government health insurance plans, predominantly Medicare and Medicaid, currently account for 54 percent of all hospital revenues. By 2025, as increasing numbers of Americans become Medicare-eligible, the amount of taxpayer-funded hospital revenue is projected to rise to 66 percent, while the proportion of revenue from privately insured patients will continue to decline. Medicare reimburses only two-thirds of the costs for the services it covers and provides minimal long-term care coverage.<sup>28</sup> Since Medicare payments have historically been below hospitals' average costs, hospitals have been required to make up the difference by increasing the charges for providing care to privately insured patients. As the proportion of Medicare and Medicaid patients increases, privately insured patients will continue to be charged higher rates in order for many hospitals to remain open.<sup>29</sup>

This payment differential results in a cost shift from Medicare and Medicaid to private insurers. Overall, it represents 15 percent of the current amount spent by insurers on hospitals and physi-

cians. In other words, private insurers and their insureds are subsidizing the cost of Medicare by paying the amounts that the public plans should pay but do not. Thus, if Medicare and Medicaid paid market rates, the logic goes, hospitals could end the practice of shifting costs onto privately insured patients, allowing private insurers to reduce their payments to the medical providers but with healthcare providers still achieving the same overall reimbursement. Stated differently, if there were no cost shift, hospital and physician costs for privately insured patients would be 15 % lower.<sup>30</sup>

According to one Congressional Budget Office analysis, the public plan would pay healthcare providers at rates “comparable to privately negotiated rates,” resulting in premiums that are similar to private insurer premiums. Under this assumption, such “cost shifting” and “crowding out” of insurers as described above would not occur.<sup>31</sup> But this seemingly contradicts a committee summary describing the public plan’s anticipated effects whereby lower premiums are expected over time, in comparison to private insurers:

“[t]he negotiation for payment rates gives the Secretary the ability to quickly and aggressively promote payment policies that promote quality and best practices ... the public option would not need to raise premiums to support shareholder profits, extensive marketing, and extra risk reserves required to protect enrollees from plan insolvency or mismanagement of funds.”<sup>32</sup>

In addition, public plan supporters maintain that the plan would have sufficient market power to force providers to accept payment rates far below what private insurers pay, asserting that “it is important to recognize that the cost-containment potential of a public plan rests fully in its ability to leverage the power of the federal government as health care purchaser to encourage provider participation and reduce prevailing payment rates. Without taking advantage of that strength, the cost containment potential of the public plan option or an alternative would be tremendously weakened.”<sup>33</sup>

The Urban Institute Health Policy Center predicts that “47 million would enroll in coverage through the public plan,” close to 15 percent of the country’s population.<sup>34</sup> With this market impact, it seems likely that creating another publicly funded healthcare insurance plan will result in greater cost shift to the detriment of those with private coverage.<sup>35</sup>

Measured by past and present performance, those challenging a public plan managed by the government assert that such a plan would not necessarily be effective at controlling our overall healthcare costs. They contend that such a public plan would not necessarily provide high quality care - low-value care appears to be as pervasive in the single payer Medicare system, for instance, as it is elsewhere.<sup>36</sup> They also point out that public systems are also slow to innovate, i.e. as suggested by the fact that it took Medicare 40 years to add a prescription drug benefit, long after most private insurers had done so.<sup>37</sup>

## VI. The Public Plan and Potential Market Distortion

Nevertheless, public plan supporters continue to assert that its establishment will foster greater competition within the health insurance industry - competition that will help to prevent any one insurer from gaining excessive market power in its region – to the ultimate benefit of the consumer.<sup>38</sup> Private insurers would be forced to negotiate lower provider reimbursement rates and reduce coverage premiums in order to compete with the public plan. They assert that the outcome will be an effective cost containment mechanism that will amount to significant savings for the public and federal government.

Yet private insurers respond that by implementing these cost containment mechanisms the public plan would not “play by the same rules” as private insurers - those insurers are significantly restricted by government regulation from engaging in the practices that appear to be the intended method of operation for the plan. Allowing the plan to basically fix costs and underpay providers amounts to de facto government price control on the health insurance industry. Private insurers are prohibited by federal (and most states’) antitrust laws and insurance regulations from using their combined negotiating power to reimburse providers at less than current levels. And they point out that this is exactly how the public plan is expected to generate its greatest cost savings.

As drafted in H.R. 3200, the public plan would reimburse providers at Medicare rates plus 5 percent, administered rather than negotiated rates, while providing the Secretary of HHS with the discretion on how to determine those rates after several years. As amended by the Energy and Commerce Committee, the plan is required to negotiate reimbursement rates with providers that are no higher than the average of private plan rates or lower than Medicare rates.<sup>39</sup>

Viewed through antitrust policy lenses, an argument for these cost containment mechanisms comes perilously close to restating the position; long since rejected by the courts, that fixing prices by market participants is reasonable if the resulting prices are lower than free competition would yield. Such methods suggest a policy that works to displace, not encourage, the competitive model.<sup>40</sup>

Anticompetitive conduct is behavior by private businesses that tends to impair the opportunities of rivals and either does not further competition on the merits or does so in an unnecessarily restrictive way.<sup>41</sup> Congress has enacted legislation that prohibits the exercise of and attempt to exercise monopoly power by private competitors, and also unreasonable restraints of trade.<sup>42</sup> The intent to exercise monopoly power can be inferred from the exclusionary conduct of a company with monopoly power.<sup>43</sup> Attempted monopolization consists of a company engaging in predatory or anticompetitive conduct with a specific intent to monopolize, i.e. attempts to gain monopoly power by driving rivals from the market, which has a dangerous probability of achieving monopoly power.<sup>44</sup>

Congress has also prohibited price discrimination “where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to

injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination . . .<sup>45</sup> And Congress acted to ban mergers and consolidations, joint ventures or other acquisitions of assets by private companies if they "tend substantially to lessen competition or to tend to create a monopoly."<sup>46</sup>

An agreement between private competitors, and even non-competitors, to fix prices is illegal under antitrust law. In fact, agreements relating in any way to price, if only indirectly, amount to violations. For example, "price fixing" has been deemed to include concerted action among competitors that establishes minimum or maximum prices; establishes prices, such as the use of relative-value scales in determining charges for professional services; or establishes uniform contract terms, if this affects price.<sup>47</sup> Price fixing issues can arise in arrangements among Health Maintenance Organizations, independent practice associations and physician-hospital organizations. Other activities that may be considered restraints of trade include certain tying arrangements, where there is coercive use of market power to inhibit competition.<sup>48</sup>

In the case of *Arizona v. Maricopa County Medical Soc.*,<sup>49</sup> for example, medical care foundations designed by members of several local medical societies were setting maximum fee limits that physicians agreed to accept in full for services rendered to patients enrolled in health plans approved by the foundations. Additionally, the foundations conducted peer review and financial work for the insurance plans. The state Attorney General filed suit, maintaining that the medical societies, their member physicians and the foundations were basically fixing prices in violation of federal antitrust law. The defendants argued that their fee limit agreements did not constitute price fixing and that, given the cost savings realized by consumers because of the maximum fee limits, such agreements should be viewed as reasonable. The United States Supreme Court held that those arrangements were the kind of concerted restraint on competition illegal "per se" under the antitrust laws, and the price fixing agreement among these market competitors was struck down without any further economic analysis of its actual impact.

The Court concluded that the antitrust statutes did not give courts the discretion to consider whether the anti-competitive activity at issue was good public policy. The only substantive issue, unless the activity is exempted from antitrust enforcement on some other basis, is whether the arrangement has such a negative impact on competition that it constitutes an unreasonable restraint on trade. And where the act or practice is one of several practices traditionally regarded as illegal "per se" in other markets, that analysis is abbreviated and the negative impact on competition is assumed. Once the Court determined that the agreement constituted price fixing, it stated that if even if the effect of the price fixing involved in the case had indeed been to lower prices for the benefit of consumers, the cost of eliminating competition would nevertheless be presumed to outweigh any advantages of those lower prices.<sup>50</sup>

In other words, under antitrust law and the underlying policy, the reasonableness of a restraint on trade is judged entirely by its impact on competition. Only pro-competitive justifications for restraints on trade are allowed. Other social objectives of anti-competitive behavior, e.g., lowering

of prices for the services rendered, are generally considered to be irrelevant for purposes of anti-trust analysis.<sup>51</sup>

Viewed from the perspective of antitrust policy, those opposing the public plan assert that the ability of the plan to manipulate provider reimbursement on such a large scale involves the power to control the market and to set otherwise arbitrary and unreasonable prices – actions they could not undertake legally as private competitors. They contend that by substituting the judgment of one party, in this case the federal government, for the forces of the competitive health insurance market, this proposal to intentionally manipulate reimbursement interferes with the ability of hospitals, physicians and other healthcare providers to compete and survive in that market. They fear that reimbursement may be set too low through the public plan for the provider to deliver certain healthcare services to the public. They worry that this action may have the unintended consequence of discouraging providers from certain forms of practice, or prospective practitioners from entering the field.

They stress that price fixing within the private sector is prohibited because a successful price-fixing agreement essentially eliminates competition. Even when it is used for the consumer's benefit, the reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow. And once the price is established, it can remain unchanged based on the lack of competition. In fact, the agreement itself that creates such potential power may be determined to constitute an unreasonable or unlawful restraint of trade without further inquiry by the court. Against this background, they view it as unfair for the public plan to exercise such power, even if such power may be constitutionally permitted under the Commerce Clause, or constitute a permitted exercise of sovereign power under the 'state action' exception of the Parker Immunity doctrine.<sup>52</sup>

Other antitrust policies are implicated by the public plan. There are three major participants in the market for healthcare insurance: healthcare providers, insurers, and patients (and their employers). Healthcare providers, usually hospitals and physicians, provide services to patients and sell services to insurers. Insurers, mainly commercial health insurance companies, seek to buy medical services from healthcare providers on the best terms possible. The insurers in turn sell insurance services to individual patients and employers. Patients buy health insurance from insurers, usually through their employers, and sometimes buy services from healthcare providers. In the contract between a healthcare provider that sells medical services and an insurer that buys medical services, the agreed upon price is generally referred to as a reimbursement rate. Consequently, in a hospital-insurer contract, for example, the agreed-upon price may be a 90% reimbursement rate. A 90% reimbursement rate means that when the insurer must purchase services from the hospital the insurer gets a 10% discount off the hospital's regular price, also called the charge master or list price. It makes sense that healthcare providers prefer high reimbursement rates and insurers prefer low reimbursement rates, as each group pursues its own economic interest.<sup>53</sup>

Many providers are concerned that the public plan will force them to accept unreasonably low rates and unattractive contract terms. When an insurer increases the number of a physician's pa-

tients covered by one of its insurance plans, the cost to the physician of withdrawing from that plan in response to a lowering of rates increases. This is commonly referred to as “monopsony” - it is substantial market power being exercised by buyers over sellers, or the flip side of monopoly.<sup>54</sup>

The nature of the health care industry increases the possibility of a dominant health insurer exercising monopsony power over providers within a geographic region. Medical services cannot be stored or exported, so healthcare professionals are limited in “selling” these services to insurers and their customers within that region. If a group of physicians, for example, were to refuse the terms of the dominant health insurer within that region, they would likely suffer an irrevocable loss of revenue. Moreover, they could not take concerted action by agreement lest they violate antitrust law. Accordingly, their ability to so refuse those insurer’s terms depends on their ability to make up the lost business by coming to terms with an alternative health insurer. If that alternative is lacking, those physicians may be forced to reduce their level of service in response to a decrease in compensation. These physicians cannot readily contract with another insurer that has a substantially smaller marketshare because that insurer may not insure enough patients for the physicians to remain solvent, resulting in reduced services, greater waiting times, unacceptably short hospital stays, postponed or unperformed medical treatments, suboptimal alternative medical treatments, laboratory tests not performed, and other output restrictions on health services. It is for those reasons essential for medical providers to have access to competitive alternatives among health insurers.<sup>55</sup>

Some may argue that the principles governing competition should not be applied to healthcare, or that the delivery of healthcare services occurs through systems and not markets. But our courts have consistently ruled that there is nothing inherent in the makeup of healthcare services, or the way in which they are provided or financed, that changes the mandate established by Congress through antitrust legislation – an economic policy favoring competition even when complicated services such as healthcare are involved.<sup>56</sup> Accordingly, agreements between providers and health plans or providers and health insurers, including those that limit provider reimbursement or that are widely used throughout the insurance industry have been and will continue to be subject to antitrust scrutiny. For example, the Federal Trade Commission has prevented anticompetitive agreements among health care providers to fix the prices they charge to a health insurance plan, conduct likely to raise prices without improving care.<sup>57</sup>

The preceding discussion of antitrust law and its application to the healthcare industry is meant to demonstrate the perceived inequity of requiring private medical providers and health insurers, subject to all of the rules and regulations governing conduct on the free market, to compete with a public plan that will be exempted from these rules and regulations by its enabling legislation and the authority granted to Congress under the Commerce Clause.<sup>58</sup>

## VII. Conclusion

On these points, two years ago the Antitrust Modernization Commission (AMC) – an entity created by Congress to evaluate the application of our antitrust laws – dealt with the subject of antitrust exemptions by urging Congress to exercise caution, pointing out that antitrust exemptions usually “create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality, and reduced innovation.” Accordingly, the AMC recommended that such statutory exemptions should be granted “rarely” and only where proponents have made a “clear case” that exempting otherwise unlawful conduct is “necessary to satisfy a specific societal goal that trumps the benefit of a free market to consumers and the U.S. economy in general.”<sup>59</sup>

Since the public expects Congress to resolve the problems in our healthcare system, including high costs, uneven quality, and a growing number of the uninsured, the debate surrounding the public plan should be framed in those very terms. In attempting to remedy these problems in the context of antitrust policy and precedent, Congress should properly consider whether the public plan proposal is “one of those rare instances in which the societal benefits from dispensing with antitrust rules and the normal competitive process exceeds the costs.”<sup>60</sup> The stated goal of creating a public plan to compete with private insurers on a level playing field for the purpose of increasing competition within the health insurance market should be evaluated carefully with provisions that would also give the public plan license to engage in conduct that would expose the private insurers to the sanctions of federal antitrust law should they attempt to engage in that very conduct.<sup>61</sup>

Furthermore, a level playing field would require the public plan to comply with state and federal contract and tort laws, financial solvency rules, certain industry-mandated accounting rules determining current and future liabilities, state and federal tax obligations or community benefit provisions, certain state and local licensing requirements, etc.<sup>62</sup>

The Commonwealth Care program in Massachusetts provides an example of a public/private health insurance plan. If Congress ultimately chooses to include a public plan option within its reform legislation, it should look closely at the Massachusetts program, given the level of success demonstrated by private insurers in providing coverage to the previously uninsured under Massachusetts’ law.<sup>63</sup> Each state could be allowed to establish its own version of a public plan and choose whether to administer this plan directly or to do so through a MCO or other private administrator. Subsidies could be limited to those below a certain income level and eligibility limited to those low-income persons without health insurance, but preventing eligibility for those who refuse otherwise affordable coverage or voluntarily drop existing employer provided coverage is imperative. By erecting these “firewalls” the Massachusetts legislature prevented the crowding out, or large scale migration from private or employer sponsored health insurance to Commonwealth Care. Including sufficient barriers to preclude crowding out will avert much of the public versus private plan controversy. Since private insurers actually carry the risk and administer the insurance provided through the Connector, antitrust, reserve fund and capitalization requirements, and

other anticompetitive public versus private plan issues have not occurred, and are unlikely to do so.

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<sup>1</sup> Others, however, caution that "[f]or society as a whole, nothing comes as a 'right' to which we are 'entitled'. Even bare subsistence has to be produced.... The only way anyone can have a right to something that has to be produced is to force someone else to produce it... The more things are provided as rights, the less the recipients have to work and the more the providers have to carry the load." Thomas Sowell, Rose and Milton Friedman Senior Fellow, the Hoover Institution at Stanford University.

<sup>2</sup> Medical services differ from the typical service or commercial product purchased by consumers. The services of physicians, rendered on a patient-by-patient basis, rarely can be compared by the recipient. A person requiring medical service or advice has no ready way of comparing physicians or of "shopping" for quality medical service at a lesser price.

<sup>3</sup> Including The New England Council in this document.

<sup>4</sup> CRS Report R40517, "Health Care Reform: An Introduction," by Bob Lyke.

<sup>5</sup> This summary of the Senate HELP Committee "Affordable Health Choices Act" and the House Tri-Committee "America's Affordable Health Choices Act of 2009" (H.R. 3200) describes the key components of the legislation. The House Tri-Committee summary incorporates the major amendments to the legislation adopted by the three committees with jurisdiction during their mark-ups of the bill - identified using an abbreviation for the House panel that approved it - "E&C" for the Committee on Energy and Commerce; "E&L" for the Committee on Education and Labor; and "W&M" for the Committee on Ways and Means.

#### Senate HELP Committee Legislation, the "Affordable Health Choices Act," Health Insurance Coverage Provisions

*Individual Requirements* - the Senate HELP Committee legislation, establishes an individual mandate requiring all legal residents to obtain health insurance coverage. Individuals with income below 150 percent of the federal poverty level (FPL) would be exempt from this requirement and the penalty would be waived in certain other cases, e.g. purchasing coverage creates an exceptional financial hardship. Individuals not exempt from the coverage requirement would pay an annual financial penalty of 50 percent of the unsubsidized premium of a qualifying health plan that provided the lowest level of coverage through the applicable Gateway.

*Employer Requirements* - correspondingly, employers with more than 25 employees would be subject to a "play-or-pay" requirement. If such an employer did not offer qualified health insurance and contribute at least 60 percent toward the premium, it would be liable for an annual penalty (labeled an "equity assessment") that is initially equal to \$750 for each uninsured full-time employee and \$375 for similarly uninsured part time employees.

*Premium Subsidies to Individuals* - The subsidies available through the Gateways would be tied to the average of the three lowest premium bids submitted by insurers in each area of the country for each tier of coverage, called the "reference premium." For people with income between 150 percent and 200 percent of the Federal Poverty Level (FPL), the subsidies would apply to that average bid for the highest-tier plans; for people with income between 200 percent and 300 percent of the FPL, the subsidies would apply to that average bid for the middle-tier plans; and for people

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with income between 300 percent and 400 percent of the FPL, the subsidies would apply to that average bid for the lowest-tier plans. The subsidies would cap premiums as a share of income on a sliding scale beginning at 1 percent for those with income equal to 150 percent of the FPL, rising to 12.5 percent for those with income at 400 percent of the FPL. Those income caps would be indexed to medical price inflation. Individuals and families with income below 150 percent of the FPL would not be eligible for those subsidies. Generally, individuals with an offer of employer-sponsored insurance would not be eligible for Gateway subsidies under the proposal, but employees with an offer from an employer that was deemed unaffordable remain eligible. Individuals with an offer of employer-sponsored insurance would not be eligible for exchange subsidies under the proposal unless the offer from the employer was deemed unaffordable. An employer's offer of coverage is unaffordable if the portion of worker paid premiums exceeded 12.5 percent of the worker's adjusted gross income in 2013.

*Premium Subsidies to Employers* - the legislation would offer subsidies to small employers whose employees have low average wages and who offer health benefits to those employees. The amount of the subsidy would vary with the size of the employer (up to a limit of 50 workers), and employers that contribute larger amounts toward their workers' health insurance would receive larger subsidies.

*Insurance Exchange/Gateway* - authorizes the creation of an insurance exchange, the Affordable Health Benefit Gateway, in each state allowing qualified individuals and qualified employer groups to purchase affordable health insurance and related insurance products. If states establish Gateways by 2012 their residents will qualify for premium credits, but if a state fails to establish a Gateway by 2014, HHS will establish and operate that state's Gateway. The Gateways will establish procedures to qualify health plans, establish open enrollment periods, and assist consumers in the purchase of long term services and supports. A new Medical Advisory Council will make recommendations to the Secretary of HHS on the essential health care benefits that will qualify for income-related premium credits, affordability standards, and minimum coverage standards. Insurance policies that are sold through the Gateways would have actuarial values chosen by HHS from specified ranges within three tiers. The chosen actuarial values would equal 93 percent for the highest tier, 84 percent for the middle tier, and 76 percent for the lowest tier. Plans would be allowed to offer added coverage or benefits for an extra premium. The legislation includes a "public plan" that would be offered through Gateways. The plan would be established nationwide by the Secretary via contracts with local entities (which could include non-profit insurers) to administer the plan; payment rates would be negotiated by HHS. The public plan would offer the same tiers of benefits as other plans operating in the exchange, and its premium would vary from area to area to reflect the local costs of providing those benefits.

*Benefit Design* - new health insurance policies sold in the individual and group insurance markets would be subject to several requirements regarding their and pricing. Health status underwriting and the imposition of any preexisting condition exclusion would be prohibited in all individual and group employer markets. Rates within a geographic region could only vary by family composition, the value of the benefits package, and age by a factor of not more than two to one. Insurers operating in the individual and group health insurance markets would be required to issue coverage to all applicants, and could not limit coverage for preexisting medical conditions. Additionally, premiums for a given plan could not vary because of enrollees' health and could vary by their age to only a limited degree under a system known as adjusted community rating.

*Private Health Insurance* - all health insurance policies are required to incorporate incentives for high quality and preventive health care services. Dependents will be permitted to stay on their parents' policies through age 26. Lifetime and annual benefit limits will be prohibited in all individual and group policies with the provisions of existing policies that are maintained continuously grandfathered, or exempt, from this requirement. Authority is delegated to the Medical Advisory Council to establish minimum requirements for covered health benefits and to determine the level of coverage that individuals would need to obtain in order to qualify as having insurance. Insurers are required to maintain a minimum level of medical claims paid relative to premium revenues otherwise known as a "medical loss ratio", or to repay certain amounts to policyholders with the authority to set the minimum medical loss ration delegated to HHS.

*Cost* - The Congressional Budget Office estimates this proposal will cost \$615 billion over 10 years. Because the Senate HELP Committee does not have jurisdiction over the Medicare and Medicaid programs nor revenue raising authority, mechanisms for financing the proposal will be developed in conjunction with the Senate Finance Committee.

The House Tri-Committee Legislation – “America’s Affordable Health Choices Act of 2009” (H.R. 3200) Health Insurance Coverage Provisions

*Individual Requirements* - all legal residents would be required to enroll in a health insurance plan meeting certain minimum standards or face a tax penalty. Individuals not required to file a tax return would be exempt from the penalty; exemptions for hardship and other reasons would be determined by a new and independent federal agency overseeing the health insurance exchanges. The penalty assessed on people who would be subject to the mandate but did not obtain insurance would equal 2.5 percent of the difference between their adjusted gross income (modified to include tax-exempt interest and certain other sources of income) and the tax filing threshold. The amount of the penalty could not exceed the national average premium for plans offered in the exchanges.

*Employer Requirements* - employers with an annual employee payroll above \$250,000 would be subject to a “play-or-pay” requirement. Employers could “play” by offering coverage that meets the minimum benefit standards and making a minimum contribution toward the premiums (72.5 percent for individual premiums and 65 percent for family premiums). An E&L Committee amendment provides hardship exemptions for employers that would be negatively affected by job losses as a result of requirement. Employers that do not meet those requirements would be subject to a payroll tax, with the rate depending on their annual payroll, as follows: 2 percent, for firms with a payroll between \$250,000 and \$300,000; 4 percent, for firms with a payroll between \$300,000 and \$350,000; 6 percent, for firms with a payroll between \$350,000 and \$400,000; and 8 percent, for firms with a payroll above \$400,000. Employers could choose to “play” for full-time employees and “pay” for part-time employees and could also make separate elections for separate lines of business. Employers offering coverage would also be required to automatically enroll workers in single coverage.

An E&C Committee amendment extend the reduction in the pay-or-play requirement for small employers with annual payroll of less than \$750,000 and replaced the existing schedule as originally drafted with the following: Employers with an annual payroll of less than \$500,000 are exempt from the requirement. Employers with an annual payroll of between \$500,000 and \$585,000 failing to provide insurance as described would be responsible for paying an amount equal to 2% of their payroll. Employers with an annual payroll of between \$585,000 and \$670,000 failing to provide insurance as described would be responsible for paying an amount equal to 4% of their payroll. Employers with an annual payroll of between \$670,000 and \$750,000 failing to provide insurance as described would be responsible for paying an amount equal to 6% of their payroll.

*Public HealthCare Program Expansion* - eligibility for the Medicaid program would be expanded to all nonelderly individuals and families with income at or below 133 percent of the FPL. The federal government would pay 100 percent of the costs of newly eligible enrollees. States would be required to maintain their current eligibility levels for existing groups indefinitely. The federal government would fully subsidize the cost for some parents and childless adults who are currently covered by Medicaid under existing waivers that expand coverage. People eligible for Medicaid could not receive subsidies via an exchange. Newborns who would otherwise be uninsured would be automatically enrolled in Medicaid for 60 days (with the federal government paying 100 percent of their costs during that period), at which point there would be a determination of their eligibility for Medicaid or for subsidies provided through an exchange. Medicaid payment rates for primary care services would be increased to 80 percent of Medicare rates in 2010, 90 percent in 2011, and 100 percent beginning in 2012. The federal government would pay 100 percent of the cost of those increases. There would be a maintenance-of-effort requirement for the Children’s Health Insurance Program through 2013, at which point the program would be terminated. An E&C Committee amendment would require states to submit a state plan amendment specifying the payment rates to be paid under the state’s Medicaid program. And,

while the bill as drafted calls for the coverage expansions and the enhanced provider payments to be fully financed with federal funds, another E&C Committee amendment replaced full federal financing for Medicaid coverage expansions with 100% federal financing through 2014 and 90% federal financing beginning in year 2015.

*Premium Subsidies to Individuals* – individuals and families who enroll in exchange plans and have income between 133 percent and 400 percent of the federal poverty level (FPL) would be eligible for premium subsidies and cost-sharing subsidies. Federal premium subsidies in a given area would be tied to the average premium of the three lowest-cost plans providing basic coverage in the exchange in that area. The subsidies would limit an enrollee's contribution to a percentage of income ranging from 1.5 percent to 11.0 percent (see table); those caps would not be indexed over time. The federal government would fully fund cost-sharing subsidies, which would increase the actuarial value of enrollees' coverage to specified tiers based on income:

133-150% FPL: 1.5 - 3% of income  
150-200% FPL: 3 - 5% of income  
200-250% FPL: 5 - 7% of income  
250-300% FPL: 7 - 9% of income  
300-350% FPL: 9 - 10% of income  
350-400% FPL: 10 - 11% of income

However, an E&C Committee amendment replaced the above subsidy schedule with the following:

133-150% FPL: 1.5 - 3% of income  
150-200% FPL: 3 - 5.5% of income  
200-250% FPL: 5.5 - 8% of income  
250-300% FPL: 8 - 10% of income  
300-350% FPL: 10 - 11% of income  
350-400% FPL: 11 - 12% of income

Eligibility for subsidies would be determined on the basis of adjusted gross income (modified to include tax-exempt interest and certain other types of income). An E&C Committee amendment increases the affordability credits annually by the estimated savings achieved through adopting a formulary in the public health insurance option, pharmacy benefit manager transparency requirements, developing accountable care organization pilot programs in Medicaid, and administrative simplification. Another E&C Committee amendment increases the affordability credits annually by the estimated savings achieved through limiting increases in premiums for plans in the Exchange to no more than 150% of the annual increase in medical inflation and by requiring the Secretary to negotiate directly with prescription drug manufacturers to lower the prices for Medicare Part D plans. And yet another E&C Committee amendment limited eligibility for the premium and cost-sharing credits to employees whose employee premiums exceed 12% of individuals' income.

*Premium Subsidies to Employers* – the legislation creates a non-refundable tax credit for smaller employers. Based on an employers' size and average wages, the credit amount would gradually decrease as those two elements increase - the credit for employers with not more than 10 employees with annual average wages below \$20,000 equals 50 percent of the employer's premium share. Credit eligibility limited to those employers with not more than 25 employees with average annual wages of \$40,000.

*Insurance Exchange/Gateway* – the language establishes a federal Health Insurance Exchange (Exchange) as a marketplace for individuals and small employers to purchase coverage from private or public insurers. It sets and enforces insurance reforms and consumer protections, facilitates enrollment, and administers affordability credits. States may opt to operate their own Exchange in place of the national exchange as long as federal requirements are met. Full-time employees with an offer of employer-sponsored insurance would not be permitted to receive premium subsidies

through an exchange. Thereafter, those employees could receive the subsidies only if their contribution for that coverage was deemed unaffordable—which would be defined as exceeding 11 percent of their income. Part-time employees could receive the subsidies with no restrictions. Beginning in 2014, employers offering coverage would be required to pay the exchange a percentage of their average payroll per worker for each employee obtaining coverage with the exchange. The percentage would equal the percentage paid if that employer was subject to the play-or-pay penalty. The public health plan offered through the exchange (but run by HHS) would be required to meet the same benefit requirements and comply with the same insurance market reforms as private plans. Individuals with affordability credits could choose among the private carriers and the public option. The public plan must be self funded and not reliant on government revenue, and would be required to promote primary care, encourage coordinated care and shared accountability, and improve quality. The plan would pay Medicare rates for physicians and other practitioners - with a 5 percent bonus for providers that participate in Medicare and the public plan, Medicare rates for hospitals and other services and supplies, and negotiated rates for drugs and other items and services that are not on a fee schedule, for the first three years. HHS is authorized to establish a rate setting process after that. Provider participation in the public plan would be voluntary, but those who currently participate in Medicare are automatically considered to be participating in that plan unless they affirmatively “opt out.” E&C Committee amendments require the plan to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities, ensure that the plan is subject to guarantee issue and renewability, insurance rating rules, network adequacy, and transparency of information requirements like exchange offered private plans, and requires the plan to adopt a prescription drug formulary. An exchange would offer four different benefit categories of plans: a basic plan that includes an essential benefits package and covers 70% of the benefit costs; an enhanced plan that includes an essential benefits package, with reduced cost sharing compared to the basic plan, that covers 85% of the benefit costs; a premium plan that includes an essential benefits package, with reduced cost sharing compared to the enhanced plan, that covers 95% of the benefit costs, and a premium plus plan – a premium plan that provides additional benefits. Plans offered through an exchange must guarantee issue and renewability, allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment, and limit the medical loss ratio to a specified percentage. These plans must be state licensed, implement affordability credits, meet network adequacy standards, provide culturally and linguistically appropriate services, contract with essential community providers, and participate in risk pooling. Participating plans must offer one basic plan for each service area and may also offer additional plans. Lastly, the exchange requires risk adjustment for all participating plans. An E&C Committee amendment would require plans to provide information related to end-of-life planning to individuals and provide the option to establish advance directives and physician’s order for life sustaining treatment.

*Benefit Design* - policies would have to cover a broadly specified minimum benefit package (which was assumed to have the same scope of benefits as seen in a typical employer-sponsored plan) and would have to have a minimum actuarial value of 70 percent and a limit on out-of-pocket costs no greater than \$5,000 for individual coverage and \$10,000 for family coverage. (A health insurance plan’s actuarial value reflects the share of costs for covered services paid by the plan.) After 2013, the maximum levels of those out-of-pocket caps would be indexed to general inflation.

*Private Insurance* - the proposal prohibits insurers from refusing to sell or renew policies because of an individual’s health status, or “medical underwriting.” Insurers are also prohibited from excluding coverage of treatments for pre-existing health conditions, and the legislation prohibits lifetime and annual limits on benefits. The proposal also limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors. Premiums can vary based only on age, geography and family size. A new independent Advisory Committee consisting of practicing providers and other health care experts, chaired by the Surgeon General, will recommend a benefit package based on standards set in the legislation. This new essential benefit package will serve as the basic benefit package for coverage in the exchange and, over time, will become the minimum quality standard for employer plans. The basic package will include preventive services with no cost sharing, mental health services, dental and vision for children, and caps the amount of money a person or family spends on covered services in a year.

*Cost* - The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be \$1.042 trillion over ten years. Approximately half of the cost of the plan is financed through savings from Medicare and Medicaid, including incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing drug rebate provisions, reducing potentially preventable hospital readmissions, and cutting Medicaid DSH payments. The remaining costs are financed through a surcharge imposed on families with incomes above \$350,000 and individuals with incomes above \$280,000. The surcharge is equal to 1% for families with modified adjusted gross income between \$350,000 and \$500,000; 1.5% for families with modified adjusted gross income between \$500,000 and \$1,000,000; and 5.4% for families with modified adjusted gross income greater than \$1,000,000. These surcharge percentages may be adjusted if federal health reform achieves greater than expected savings.

Additional language in both proposals focuses on reforming the healthcare delivery system by revising payment methodologies and purchasing strategies to improve treatment outcome and reward quality instead of quantity; improve communication among providers to provide patient care through expanded health information technology; and increasing research on best practices and the comparative effectiveness of various treatments and tools that support evidenced based care.

<sup>6</sup> See the Senate Finance Committee's "Description of Policy Options," pp. 13-14, (May 14, 2009). The following options for a public health insurance plan were among those described by the Finance Committee:

"This proposal would establish a "Medicare-like" public health insurance option to be offered through the Exchange. The public option would be administered by a new agency within the Department of Health and Human Services (HHS). Eligibility rules, markets, and income related tax credits for the public option would mirror those for all other plans offered through the Exchange. Medicare providers would be required to participate in the public option, and would be paid Medicare rates plus 0-10 percent. Rating rules would apply to the public option in the same way that they apply to plans offered through the Exchange in the non-group and small group markets ... [r]isk adjustment would apply to the public option in the same way that it applies to plans offered through the Exchange in the non-group and small group markets ... [t]he public option would incorporate any medical delivery system reforms adopted from the overall reform effort. The public option would not have solvency requirements. The public option would start and accept enrollees on the same date that the Exchange begins ...

Proposal 2 would be similar to Proposal 1 with the following differences. First, instead of being operated by HHS, the public option would be administered through multiple regional third-party administrators (TPAs) who would be required to report to the Secretary. This governance structure will be separate from the agency overseeing competition among other private plan options. Second, the TPAs would be required to establish networks of participating medical providers. Payments for participating providers would be negotiated by the TPAs. Lastly, the public health insurance option would be required to have reserve funds ...

Proposal 3 envisions a State-run public option. This option could either be mandatory or optional for States but the details of its administration will be left to the States. One possible option for the States might be to allow individuals to purchase coverage through the State employee plans." *Id.*

The Senate Health, Education, Labor and Pensions Committee and the House Committees on Ways and Means, on Energy and Commerce, and on Education and Labor have also provided detailed policy discussion on the public plan option.

<sup>7</sup> Cathy Schoen, M.S., Karen Davis, Ph.D., Stuart Guterman, and Kristof Stremikis, M.P.P., "Fork in the Road: Alternative Paths to a High Performance U.S. Health System," *Washington Health Policy: The Week in Review*, (June 24, 2009).

<sup>8</sup> See *Infra*.

<sup>9</sup> For example, setting subsidies for individual premiums requires a balance between the need to make coverage affordable with the desire to minimize the potential for disruption in the current group insurance market. Also, in order to create an insurance plan under which providers would agree to be reimbursed, someone must investigate the providers to determine what levels of reimbursement would be high enough to attract sufficient numbers of providers to sign up but low enough to make the insurance plan competitive.

<sup>10</sup> The extent that a public option would constrain choices regarding coverage levels can be measured, to an extent, by the actuarial values assigned to the available plans. The actuarial value is the percentage of expected claims for covered services that an insurance plan will pay. Employer based plans usually have actuarial values between 80 and 95 percent. The actuarial value projected for Medicare benefits offered to a nonelderly population is roughly 75 percent. See "The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System: A series of issue summaries from the Congressional Budget Office," (May 27, 2009).

<sup>11</sup> Massachusetts Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," (August 2009). See also Massachusetts Division of Health Care Finance and Policy, "Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey," (December 2008).

<sup>12</sup> The purpose of the individual mandate is to strengthen the functioning of health insurance risk pools by making sure they include young and healthy people, who are more likely to go without insurance if it is not offered (and paid for) by their employer. Owens, Antoniya, "Who are the Uninsured and Why are They Uninsured?" New England Public Policy Center, Federal Reserve Bank of Boston, Policy Brief No. 07-3. (March 2007).

<sup>13</sup> This includes all employees at Massachusetts locations, whether or not they are Massachusetts residents. Employers are subject to the Fair Share Contribution if:

1. The employer has 11 or more full-time equivalent employees who are employed at Massachusetts locations, and
2. The employer does not make a "fair and reasonable" premium contribution towards health insurance for its employees.

The "fair and reasonable" contribution tests for employers are:

"Percentage of Full-Time Employees Enrolled": At least 25% of the full-time employees are enrolled in the employer's health insurance plan, and the employer is making a financial contribution to that plan, and

"Premium Contribution Standard": The employer provides at least 33% of the premium cost of the individual health insurance plan offered to its full-time employees.

Employers of 50 or fewer FTEs only need to meet one of these tests to avoid the Fair Share Contribution. Employers of 50 or more FTEs must meet both tests. A full-time employee is defined as someone who works 35 hours or more per week at a Massachusetts location, or works the number of hours required weekly to be eligible for an employer's full-timer employee health benefits. See Commonwealth Health Insurance Connector Authority, "Employer Handbook," Available at [www.mass.gov/connector](http://www.mass.gov/connector).

<sup>14</sup> "The federal budget is on an unsustainable path, primarily because of rapidly rising spending on health care. Federal outlays for Medicare and Medicaid have increased from 1 percent of gross domestic product (GDP) in 1970 to more than 5 percent in 2009; and the Congressional Budget Office (CBO) projects that under current policy, they will exceed 6 percent of GDP in 2019 and about 8 percent in 2029." Congressional Budget Office, "Health Care Reform and the Federal Budget," (June 16, 2009) as attached to letter to Senator Kent Conrad.

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<sup>15</sup> Congress founded the Medicare program, "Health Insurance for the Aged and Incapacitated Patient," as Title XVIII of the Social Security Act in 1965, Medicare is a major payor of healthcare coverage for patients over the age of sixty-five, the population that is usually thought of when discussing whom Medicare covers. Medicare also provides coverage for patients who are under sixty-five but who have a qualifying disability and persons with end-stage renal disease (ESRD). Medicare is divided into several parts: "Part A," "Part B," and Medicare+Choice (M+C) ("Part C"). In 2003, the Administration and Congress negotiated the terms of a new Medicare benefit, "Medicare Advantage" and "Part D," to provide coverage for outpatient take-home prescription drugs. See CRS Report RL 33712, "Medicare: A Primer," By Jennifer O'Sullivan.

Medicaid was enacted in 1965 in the same legislation that created the Medicare program. Medicaid is a jointly funded federal-state program that provides health insurance coverage for low-income families and children, people with disabilities, and some elderly. It is the nation's largest health insurance program, providing coverage for more than 61 million people at an annual cost of more than \$300 billion. Administration of Medicaid programs is left to the states, subject to federal guidelines. For example, each state establishes specific eligibility rules under Medicaid, but must also meet mandatory minimum federal requirements. See CRS Report RL33202, "Medicaid: A Primer," by Elicia J. Herz.

Moreover, it is often difficult to distinguish between public and private health insurance plans. Both Medicare and Medicaid have private plan options – Medicare Advantage Plans and commercial managed care plans, respectively – containing choices that are typically found in private coverage while both are publicly funded. Correspondingly, private health insurance is subject to much greater governmental oversight than other consumer products, with special regulations concerning benefits, marketing and pricing, and taxation. Differences generally include financing (tax revenue for public plans – premiums for private plans), eligibility (use of underwriting in private plans) and flexibility, with private health insurer plans able to adapt and innovate more quickly than public plans.

<sup>16</sup> Testimony of Peter R. Orszag before the Committee on Budget, United States Senate, January 13, 2009. <http://budget.senate.gov/democratic/testimony/2009/OrszagFINAL011309.pdf>.

<sup>17</sup> Congressional Budget Office, "The Long-Term Budget Outlook," (June 2009).

<sup>18</sup> Congressional Budget Office, "CBO's March 2008 Baseline: Medicare," (2008). ([www.cbo.gov/budget/factsheets/2008b/medicare.pdf](http://www.cbo.gov/budget/factsheets/2008b/medicare.pdf)).

<sup>19</sup> See the HHS Web site at <http://www.hhs.gov>.

<sup>20</sup> Social Security Administration (2008), "Status of the Social Security and Medicare Programs: A Summary of the 2008 Annual Reports," (March 2009) . ([www.ssa.gov/OACT/TRSUM/index.html](http://www.ssa.gov/OACT/TRSUM/index.html)); Centers for Medicare and Medicaid Services, "CMS Outlines Foundation to Improving Health Care" news release, (January 16, 2009). ([www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)); "A Citizen's Guide to the 2008 Financial Report of the United States Government," (2008).

Trust fund interest earnings and assets provide enough resources to pay full benefit payments until 2019 with general revenues used to finance interest and loan repayments to make up the difference between cash income and expenditures during that period. Pressures on the federal budget will thus emerge well before 2019. Present tax rates would be sufficient to pay 79 percent of scheduled benefits after trust fund exhaustion in 2019 and 29 percent of scheduled benefits in 2081. From the Government Accountability Office's (GAO) Audit Report on the United States Government's 2008 Consolidated Financial Statements.

Financial or fiscal condition not only considers the Government's current and past performance, but also its capacity to meet future demands and responsibilities. For example, the growing responsibilities associated with future social insurance benefits (e.g., Social Security, Medicare and Medicaid ) is a well-documented issue that impacts everyone, largely because of the aging of the 'baby boom' generation and rising health care costs. One must compare the resources that the Government expects to receive for these programs from dedicated sources (e.g., earmarked taxes, premiums) to what it expects to have to pay out in benefits over the next 75 years in current dollar terms - the actuarial present value of the Government's anticipated future benefits expenditures compared to its expected collections (e.g., taxes and premiums) for Social Security, Medicare and Medicaid over a 75-year period, *Id.*

Actuarial funding determines the annual cost to fund a program's cost of benefits that accrue during the current year, as well as the costs associated with any past service liability. One of the main principles of actuarial funding is that the cost of benefits for a current employee should be paid during the years of service of that employee. Under the pay-as-you-go method currently in effect, program expenditures are limited to paying benefits as they are claimed by beneficiaries. There are no provisions for advance funding for benefits to be paid in the future. Under a "funding schedule," a series of payments is established to pay the annual cost as well as amortize the unfunded accrued liability (actuarial liability less plan assets) over a period of years. See section 22C of Massachusetts General Laws Chapter 32 for an example of language creating a pension fund funding schedule.

<sup>21</sup> Social Security Administration (2008). "Status of the Social Security and Medicare Programs: A Summary of the 2008 Annual Reports," March. ([www.ssa.gov/OACT/TRSUM/index.html](http://www.ssa.gov/OACT/TRSUM/index.html)); The projected growth in entitlement spending under current law – chiefly for Social Security, Medicare, and Medicaid – will ultimately affect every citizen in the nation. Continued growth in health care costs is expected to cause government spending for its major health programs to grow faster than both the economy and Federal revenues over the next 75 years. Population aging will also cause the Government's Social Security and health program costs and expenditures to increase as a share of GDP over that period. Consequently, total Government expenditures are projected to exceed total assumed revenue throughout the projection period, with the fiscal imbalance – between spending and revenue – growing larger each year into the future; A Citizen's Guide to the 2008 Financial Report of the United States Government, 2008. See also Congressional Budget Office, "The Long-Term Budget Outlook: Federal Debt Held by the Public," (June 2009).

<sup>22</sup> Congressional Budget Office, "The Long-Term Budget Outlook," (June 2009). See also the 2001 and 2005 "Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds," Cited in Neuman, Tricia (2005). Kaiser Family Foundation (2005). "Medicare: The Basic." PowerPoint presentation at Alliance for Health Reform - Kaiser Family Foundation briefing, Exhibit 14, May 16. ([www.allhealth.org/BriefingMaterials/Neuman-210.pdf](http://www.allhealth.org/BriefingMaterials/Neuman-210.pdf)).

<sup>23</sup> "A Citizen's Guide to the 2008 Financial Report of the United States Government," (2008). See also Congressional Budget Office, The Long-Term Budget Outlook, (June 2009). The Government Accountability Office projects that payouts for Medicare, Medicaid, and Social Security will significantly exceed tax revenues over the next 75 years. The Medicare Part A (hospital insurance) payouts already exceed program tax revenues and Social Security payroll taxes fully cover payouts only until 2017. These deficits require funding from other tax sources or borrowing. The present value of these deficits, or unfunded obligations, is an estimated \$41 trillion. This is the amount that would have to be set aside during 2009 such that the principal and interest would pay for the unfunded commitments through 2082. Approximately \$7 trillion relates to Social Security, while \$34 trillion relates to Medicare and Medicaid. "A Citizen's Guide to the 2008 Financial Report of the United States Government," 2008.

<sup>24</sup> Congressional Budget Office, "A Preliminary Analysis of the HELP Committee's Health Insurance Coverage Provisions," (July 2, 2009).

<sup>25</sup> See note 24, *supra*.

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<sup>26</sup> See “Doing More With Less: A Conversation With Kerry Weems,” John K. Iglehar, Health Affairs (June 2009). Presumably, the public plan would have an administrative structure similar to the traditional Medicare program.

<sup>27</sup> See summary of comments by Thomas Ault and Bruce Vladeck from The Health Industry Forum, “A Call to Action: The Urgent Need for Federal Policies to Accelerate Delivery System Reform,” Conference Report pp. 3-13, (November 24, 2008).

A National Association of Social Insurance conducted in 2000 found that CMS faces “a pervasive and persistent shortage of resources” and that congressional micro-management of its administration remains large. Both the Medicare and Medicaid reimbursement systems involve thousands of moving parts that are connected. Tinkering with any component of either reimbursement scheme can ultimately result in the law of unintended consequences. *Id.*

<sup>28</sup> See Urban Institute Health Policy Center – Is the Public Plan Option a Necessary Part of Health Reform?”, John Holahan and Linda J. Blumberg August, 2009, “[p]rivate payment rates by commercial insurers are about 30 percent above those rates paid by Medicare”; Davis, Karen; Moon, Marilyn; Cooper, Barbara; Schoen, Cathy, “Medicare Extra: A Comprehensive Benefit Option For Medicare Beneficiaries,” Health Affairs Web Exclusive, (October 4, 2005) ([www.healthaffairs.org](http://www.healthaffairs.org)).

<sup>29</sup> See The Health Industry Forum, “A Call to Action: The Urgent Need for Federal Policies to Accelerate Delivery System Reform”, Conference Report (November 24, 2008).

Since providers must charge private payers more to make up the difference, these lower Medicare reimbursements result in significantly higher health insurance costs for consumers and employers. Further reducing Medicare payments, to the same payment-to-cost ratio that existed in the early 1990s, for example, would force private payers to pay some 60% above costs to compensate providers for government underpayment. Most hospitals, for their part, suggest that they could not continue in business if they had to accept Medicare rates from all comers even if there were no uncompensated care and if Medicaid rates were increased to the Medicare level. Thus, the failure to increase rates to offset these underpayments would most likely result in substantial reductions in quality and access.

<sup>30</sup> Milliman, Inc., an independent consulting firm retained by several hospital and insurer associations, developed an estimate of this cost shift based on fiscal year 2006 survey data from 4,927 short-term, community hospitals throughout the United States. The Milliman study measured the disparities among current payment rates between Medicare and Medicaid and private payers to both hospitals and physicians and found that annual health care spending for an average family of four is \$1,788 higher than it would be if Medicare and Medicaid paid hospitals and physicians private payor rates. Millman, Inc., “Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,” (December, 2008) at: <http://www.ahip.org/content/default.aspx?docid=25216>

Furthermore, the discrepancy in payment rate appears to be growing larger over time. In 1999, hospitals measured an 11.3 percent gap and a 16.0 percent gap in operating margin, respectively, between Medicare and Medicaid and private insurers. By 2006 this gap had grown to 32.5 and 37.8 percent.

<sup>31</sup> Congressional Budget Office, “A Preliminary Analysis of the HELP Committee’s Health Insurance Coverage Provisions,” (July 2, 2009). “The new draft also includes provisions regarding a “public plan,” but those provisions did not have a substantial effect on the cost or enrollment projections, largely because the public plan would pay providers of health care at rates comparable to privately negotiated rates - and thus was not projected to have premiums lower than those charged by private insurance plans in the exchanges,” *Id.*

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Crowding out of private health insurance occurs when enrollees who would have retained their private health coverage in the absence of a new program (such as a subsidized form of coverage), drop it in order to enroll in the new program.

<sup>32</sup> Senate Committee on Health, Education, Labor, and Pensions Summary, "A Strong Public Option: The Community Health Insurance Option," (July 2, 2009). The "Affordable Health Choices Act" creates an insurance exchange for each state, the "Affordable Health Benefit Gateway" (Gateway), to allow qualified individuals and qualified employer groups to purchase affordable health insurance. These Gateways will qualify health plans, establish open enrollment periods, and assist consumers in purchasing coverage. The public plan, called the Community Health Insurance Option, would be offered by the Gateway through contracts with local entities, including non-profit insurers, to administer the plan. Payment rates would be negotiated by the HHS Secretary. The public plan would offer the same tiers of benefits as other plans operating in the Gateway, and its premiums would vary from area to area to reflect the local costs of providing those benefits. A new Medical Advisory Council will make recommendations to the HHS Secretary concerning income-related premium credits, the affordability standards, and the minimum coverage standards for the public plan and other insurance offered through the Gateway.

<sup>33</sup> Urban Institute Health Policy Center – "Is the Public Plan Option a Necessary Part of Health Reform?", John Holahan and Linda J. Blumberg August, 2009; See also Cathy Schoen, M.S., Karen Davis, Ph.D., Stuart Guterman, and Kristof Stremikis, M.P.P., "Fork in the Road: Alternative Paths to a High Performance U.S. Health System," Washington Health Policy: The Week in Review, (June 24, 2009).

<sup>34</sup> Urban Institute Health Policy Center – "Is the Public Plan Option a Necessary Part of Health Reform?" John Holahan and Linda J. Blumberg August, 2009 at p.8.

<sup>35</sup> Some estimates indicate that when public insurance expands, between 17 percent to 50 percent of individuals who enroll already have access to job based insurance as well, suggesting that a public plan's cost-effectiveness as a tool to increase coverage for those without access is somewhat constrained. see L. Shore-Sheppard, T.C. Buchmueller, and G.A. Jensen. "Medicaid and Crowding Out of Private Insurance: A Re-Examination Using Firm Level Data," Journal of Health Economics, 19:61-91, (2000); D.M. Cutler and J. Gruber. "Does Public Insurance Crowd Out Private Insurance?" Quarterly Journal of Economics, 111(2):391-430, (1996); A.T. Lo Sasso and T.C. Buchmueller. "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," Journal of Health Economics, 23:1059-82, (2004).

<sup>36</sup> Gawande, Atul, "Annals of Medicine: The Cost Conundrum: What a Texas Town can Teach Us about Health Care," The New Yorker (June 1, 2009).

<sup>37</sup> "The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System: A series of issue summaries from the Congressional Budget Office," (May 27, 2009).

<sup>38</sup> According to analysts at The Urban Institute, neither the health insurance nor the provider markets meet the conditions for competitive markets. Consolidation has resulted in fewer insurers and providers in many markets. Also, the products sold within these markets are complicated and difficult to evaluate. It is a challenge for consumers to compare prices of either insurance products or services provided by hospitals and other health providers. Additionally, the barriers to entry in both markets are great. Insurer consolidation has led to greater profits, and while much of the hospital sector is not-for-profit, a lack of competition has meant investing the increased revenue in expensive technologies and developing new procedures. Urban Institute Health Policy Center – "Is the Public Plan Option a Necessary Part of Health Reform?" John Holahan and Linda J. Blumberg August, 2009 at p.3.

<sup>39</sup> As amended, the language resembles a contractual agreement between a supplier and a customer that requires the supplier to sell to the customer on pricing terms at least as favorable as the pricing terms on which that supplier

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sells to other customers – often referred to as a "most favored nation" ("MFN") clause. These clauses are often found in contracts between health insurers and hospitals or physicians, guaranteeing the insurer that the reimbursement rates it pays providers are no greater than those that its competitors have negotiated. But this language raises competitive concerns - it would seemingly discourage providers from lowering the reimbursement rates they negotiate with other private insurers to prevent them from having to reduce the rate negotiated with the public plan.

<sup>40</sup> *Arizona v. Maricopa County Medical Soc.*, 457 U.S. 332 (1982).

<sup>41</sup> *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 n.32 (1985).

<sup>42</sup> Section 1 of the Sherman Act prohibits concerted (i.e., two or more competitors) activities in restraint of trade:

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or within foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony ...

Section 2 of the Sherman Act prohibits monopolization and attempts or conspiracies to monopolize, and applies to attempts to gain monopoly power by driving rivals from the market:

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony . . .

15 U.S.C. ss. 1 & 2.

<sup>43</sup> *United States v. Aluminum Co. of Am.*, 148 F.2d 416, 432 (2d Cir. 1945) (Hand, J.) (in a monopolization case, "no intent is relevant except that which is relevant to any liability, criminal or civil: i.e. an intent to bring about the forbidden act"); *United States v. United Shoe Mach. Corp.*, 110 F. Supp. 295, 346 (D. Mass. 1953) ("Defendant intended to engage in the leasing practices and pricing policies which maintained its market power. That is all the intent the law requires when both the complaint rests on a charge of 'monopolizing', not merely 'attempting to monopolize'. Defendant having willed the means, has willed the end."), *aff'd*, 347 U.S. 521 (1954).

<sup>44</sup> *Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447, 456 (1993); *Amarel v. Connell*, 102 F.3d 1494, 1521 (9th Cir. 1996). In attempted monopolization cases, though, the defendant firm "has not yet achieved a position of power in the market but is trying to build up such a position. Being without power to exploit or exclude, such a firm must be shown to have a specific intent to achieve these results." A.D. Neale & D.G. Goyder, "The Antitrust Laws of the United States of America" 93 (3d ed. 1980).

<sup>45</sup> The Robinson-Patman Act provides:

It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality ... and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them . . . .

15 U.S.C. s. 13(a).

<sup>46</sup>Section 7 of the Clayton Act prohibits mergers, joint ventures, consolidations, or acquisitions of assets where the effect may be to substantially lessen competition or tend to create a monopoly. 15 U.S.C. s. 2, 15 U.S.C. s. 18, respectively.

<sup>47</sup> *Arizona v. Maricopa County Medica. Soc., Id.*

<sup>48</sup> 15 U.S.C. s. 1. A violation of Section 1 of the Sherman Act requires proof of the following three elements: a contract, combination or conspiracy; a restraint of trade; and an effect on interstate commerce.

<sup>49</sup> 457 U.S. at 332.

<sup>50</sup> Since this decision, the courts and the federal antitrust enforcement authorities, namely the Department of Justice and the Federal Trade Commission have created guidelines that , in certain circumstances, permit providers to join together for the purpose of negotiating and setting fees to be paid by large payor organizations. *See, e.g., Hassan v. Independent Practice Assn.*, 698 F.Supp. 679, 688-90 (E.D. Mich 1988).

<sup>51</sup> Thus, in an antitrust analysis involving the identification of unreasonable restraints on trade or competition, a court must examine the type of markets involved, i.e. who is selling what to whom, and the acts or practices involved to determine whether competition is unreasonably affected. The antitrust laws are intended to protect against harm to the competitive process, not merely harm to competitors. The law directs itself not against conduct which is competitive, even severely so, but against conduct which unfairly tends to destroy competition itself. *See, e.g., Brooke Group*, 509 U.S. at 224 (“It is axiomatic that the antitrust laws were passed for ‘the protection of competition not competitors’”), quoting *Brown Shoe Co. v. United States*, 370 U.S. 294, 320 (1962); *Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447, 458 (1993) (citations omitted); *Cargill v. Monfort of Colo., Inc.*, 479 U.S. 104, 122 (1986); *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977).

<sup>52</sup> *See United States v. Trenton Potteries Co.*, 273 U.S. 392, 397-398; *Albrecht v. Herald Co.*, 390 U.S. 145 (1968).

<sup>53</sup> *See Cascade Health Solutions v. Peacehealth*, 479 F3d 726 (9th Cir 2007).

<sup>54</sup> Antitrust laws, and the enforcement agencies, recognize the risks of undue power on the part of buyers. Excessive buying power, known as monopsony, enables buyers to depress prices below competitive levels. In response, sellers may reduce sales or stop selling altogether, ultimately leading to higher consumer prices, lower quality, or substitution of less efficient alternative products. *See* Antitrust Modernization Commission, Report and Recommendations (April 2007) at 335, available at [http://www.amc.gov/report\\_recommendation/toc.htm](http://www.amc.gov/report_recommendation/toc.htm).

<sup>55</sup> “Comments of the American Medical Association , Nevada State Medical Association and the Clark County Medical Society on the Proposed Consent Order,” *See United States v. United Health Group, Inc and Sierra Health Services, Inc.*, Civil No. 1:08CV00322 (D.D.C. May 15, 2008).

<sup>56</sup> *See* the Prepared Testimony of the Federal Trade Commission Before the Sub Committee on Consumer Protection, Product Safety and Insurance of the Senate Committee on Commerce, Science & Transportation, “The Importance of Competition and Antitrust Enforcement to Lower-Cost, Higher-Quality Health Care” July 16, 2009

<sup>57</sup> *See* Federal Trade Commission, FTC Antitrust Actions in Health Care Services and Products, available at <http://www.ftc.gov/bc/hcupdate031024.pdf>.

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<sup>58</sup> The Court has also held that those activities specifically required by a federal law or necessary to carry out the objectives of federal legislation, are exempt from antitrust liability through the "implied immunity" doctrine. *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City and Blue Cross Assoc.*, 452 U.S. 378 (1981); See also *Hospital Building Co. v. Trustees of Rex Hospital*, 691 F.2d 678 (6th Cir. 1982).

It is often difficult to reconcile the pro-competitive directive of the federal antitrust laws with the requirements of different federal regulatory schemes that promote or require non-competitive behavior among institutions otherwise subject to the antitrust laws. Where the courts are unable to separately reconcile antitrust and other congressional mandates, the courts treat any regulatory or other scheme enacted subsequent to the antitrust laws as effectively repealing the application of the antitrust laws to the extent necessary to carry out the new legislation. See "The Emerging Relevance of Antitrust Laws to the Delivery of Health Care," *Am J Public Health*; 75:407-411, (1985).

Such appears to be the case with this healthcare legislation.

<sup>59</sup> Antitrust Modernization Commission, Report and Recommendations (April 2007) at 335, available at [http://www.amc.gov/report\\_recommendation/toc.htm](http://www.amc.gov/report_recommendation/toc.htm).

<sup>60</sup> *Id.*

<sup>61</sup> Some think the goal is to stifle, not increase, competition:

"Do you really believe that private insurance could survive a "public option"? Or is this really a cover for the ideal of single-payer medical care? How could a private insurance company survive a "public option" given that private companies have to show a profit and government agencies do not have to - and given that a private enterprise must raise its own money to be solvent and a government option has access to others' money -- i.e., taxes?"

Dennis Prager, "10 Questions for Supporters of 'ObamaCare' ", *Jewish World Review* July 28, 2009.

<sup>62</sup> For example, health/life insurance companies in most states are subject to certain Risk-Based Capital (RBC) requirements specified by the National Association of Insurance Commissioners. An example of such reserve or solvency requirements for Health Maintenance Organizations (HMOs) in Massachusetts is set forth below. Along with solvency, minimum net worth and deposit obligations, the Massachusetts legislature established additional financial stability requirements as well.

See Sections 34 through 46 and Section 83 of St. 2003, c. 141 (Chapter 141). Each HMO must maintain a deposit with a trustee to be used exclusively to protect the interests of policyholders, enrolled members, and the general public that at all times must be valued at not less than \$1,000,000. Each HMO is required to maintain a minimum adjusted net worth. Chapter 141 provides for a statutory filing date of March 1 every year for an HMO in Massachusetts to file its annual financial statement. The annual statement must be maintained and prepared in accordance with statutory accounting practices and procedures now, rather than the formerly required generally accepted accounting practice. The annual statement also must be maintained and prepared in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners (NAIC). Each HMO that is part of a holding company system must file a detailed registration statement with the Division of Insurance. These registration requirements are comparable to the registration statement filing provisions applicable to insurers under to M.G.L. c. 175, s. 206C and 211 CMR 7.11, including a requirement that a domestic HMO notify the commissioner of any intent to pay an extraordinary dividend or extraordinary distribution that is subject to Division approval. Additionally, each HMO is required to notify the Division annually of any material change in the documents that the HMO has submitted in its license application. As such, each annual renewal application must also

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include a notice of any material changes. Similarly, mergers, acquisitions, and inter- and intra- company transactions that involve an HMO organization are required to comply with corporate transaction provisions. The Division must review and approve proposed corporate transactions that involve HMO organizational structures. Chapter 141 also added provisions for administrative supervision, rehabilitation and liquidation proceedings, as well as provisions for license revocation or suspension in the event that any HMO becomes financially distressed.

Once the insurance commissioner determines that the insurer is financially troubled, the commissioner is required to take steps to protect policyholders and claimants. The commissioner can order the insurer to take corrective steps and to suspend business. The commissioner can petition a state court either for an order of rehabilitation, if it is determined that the insurer's problems can be corrected, or for an order of liquidation, if it is not. The court's order of liquidation appoints the commissioner as liquidator, and the commissioner appoints a receiver. The receiver takes possession of the insurer's offices, records, and assets. Assuming the records are adequate, the receiver advises policyholders and claimants of the insurer's liquidation and of the process for filing a claim against the insurer's estate. All states had enacted life and health insurance guaranty fund laws by late 1992. See National Association of Insurance Commissioners, "Life and Health Insurance Guaranty Association Model Act," Model Laws, Regulations and Guidelines (Kansas City, MO: National Association of Insurance Commissioners, July 2003), pp. 520-1 through 520-51, for the text of the life and health guaranty fund model and citations to similar state laws.

<sup>63</sup> Of course, the Massachusetts health care reform plan, expected to cost \$1.2 billion over three years, has exceeded this cost for several reasons, including greater participation in the Commonwealth Care program than was first projected. The overall financial position improved somewhat in October 2008 when federal officials approved Massachusetts's application for a Medicaid waiver and committed to reimburse the State an estimated \$10.6 billion over the next three years, but this is not a long-term funding source.