

Statement of Interest

The Voluntary Trade Council (VTC), acting under 16 C.F.R. § 2.34(c), files this public comment in response to the Commission's announcement of a proposed order in the above-captioned matter.

The VTC is a nonprofit research and education organization that develops practical solutions to the problems caused by violent state intervention in free markets. We focus on the harm caused to individuals and businesses by the enforcement of antitrust and other "competition" laws. Through publications, filings with government agencies, and the Internet, we apply the principles of free market economics and rational ethics to contemporary antitrust policies and cases.

The VTC has a longstanding interest in the Federal Trade Commission's formulation and enforcement of antitrust policy in the health care industry. The VTC and its officers have filed comments in approximately two dozen cases brought by the FTC against physician and hospital groups since 2001.

Introduction

Preferred Health Services, Inc., is a physician-hospital organization based in Seneca, South Carolina, that is composed of approximately 100 physicians and Oconee Memorial Hospital. According to the FTC, Preferred Health is the "contracting representative" for its physician members in negotiation with third-party payers including insurance companies and other managed care organizations.

The FTC's complaint has accused Preferred Health of employing "unfair methods of competition," in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by fixing prices and refusing "to deal with payors except on collectively agreed-upon terms." In other words, the FTC claims Preferred Health is an illegal cartel that has eliminated price competition among health care providers in the Seneca area with respect to third-party contracts.

Since 2001, when President Bush took office and appointed Timothy Muris FTC chairman (and his successor Deborah Platt Majoras), the Commission has brought 22 cases – including this one – encompassing more than 11,000 physicians and other health care providers for alleged Section 5 violations similar to those described above.¹ All but one of these cases has been settled without any form of a trial. The last case remains pending before the Commission on appeal from an administrative law judge.²

As in 20 of the previous 21 cases, Preferred Health has chosen to waive its right to due process rather than contest the FTC's accusations. The proposed order now before the Commission would bar Preferred Health from "entering into or facilitating any agreement between or among any health providers":

1. to negotiate with payors on any health care provider's behalf;
2. to deal, not deal, or threaten not to deal with payors;

¹ The Department of Justice, under the direction of President Bush's appointees, has brought one antitrust case against a physician group, a Sherman Act charge against the former Mountain Health Care, P.A., of Asheville, NC, which was composed of more than 1,200 physicians and other health care providers.

² *In the Matter of North Texas Specialty Physicians*, FTC Docket No. 9312.

3. on what terms to deal with any payor; or
4. not to deal individually with any payor, or to deal with any payor only through an arrangement involving the respondents.³

The proposed order further prohibits any “exchanges of information” among health care providers regarding third-party contract terms.

The proposed order claims to permit “joint negotiations” when certain conditions are met. For example, if physicians “share substantial financial risk” with the intent of controlling costs, they may be allowed to negotiate with payers as a group. In any case, however, Preferred Health is prohibited from negotiating with any payer on behalf of any Preferred Health member for a period of three years.

Comments

[I]n all we do to improve health care in America, we will make sure that health decisions are made by doctors and patients, not by bureaucrats in Washington, D.C.

- President George W. Bush

President Bush's words have long fallen on deaf ears at the Federal Trade Commission. Dating back to the presidency of Mr. Bush's father, the FTC has used the antitrust laws as a proverbial “weapon of mass destruction” against health care providers who challenge the network of state-sponsored cartels that form the managed care industry. The Commission has said that it is only protecting the right of consumers to receive the “benefits of competition” among health care providers. But the truth has been long understood, if not always stated publicly: Antitrust prosecution of physicians

³ Analysis of Agreement Containing Consent Order to Aid Public Comment, p. 2.

is a protectionist tactic designed to insulate managed care organizations from free market economic principles.

It must be understood from the outset that the Federal Trade Commission is not a free market agency. The Commission does not provide services for a fee the way a free market organization would. The FTC's revenue is acquired through force, primarily a tax on corporate mergers under the Hart-Scott-Rodino Act, and the remainder from general tax revenues or specific excises (such as the mandatory fees for the Do Not Call registry.) None of this revenue is contributed voluntarily to the FTC, as its providers may not withhold payment without surrendering fundamental economic and civil liberties.

With its stolen funds, the FTC proceeds to intervene in the operation of the market. *Intervention*, as economist Murray Rothbard eloquently defined the term, means “the intrusion of aggressive physical force into society; it means the substitution of coercion for voluntary actions.”⁴ Rothbard noted that it is government – the State – that performs most interventions, because it is “the only organization in society legally equipped to use violence.”

Many people, including perhaps FTC officials, would argue that it is unfair to call government intervention “violent,” as that term is more commonly applied to *direct physical* acts such as murder or assault. But violence is violence even when achieved by threats or mental coercion. Mario Puzo noted in his famous Mafia novel, *The Godfather*,

⁴ Murray N. Rothbard, *Man, Economy, and State with Power and Market*, p. 877 (Scholar's ed. 2004).

"[a] lawyer with a briefcase can steal more than a thousand men with guns." Cases such as the Commission's prosecution of Preferred Health prove Puzo's theory.

The proposed order against Preferred Health is an attempt to ratify the FTC's violent intervention in the contractual relationship between the physician group and various third-party payers in the Seneca region. The FTC justifies its violence on the grounds that Preferred Health is the actual aggressor, because it "coerced" payers into signing contracts without providing adequate competition among individual physicians.

Paragraph 26 of the FTC's complaint expressly refers to the "coercive tactics" of Preferred Health wherein the group used its "dominant market position in the Seneca area" to obtain price increases beyond what FTC claims the market would have otherwise yielded. Paragraph 25 offered one example of what these so-called "coercive tactics":

Cigna of South Carolina, Inc. ("Cigna"), is a payor doing business in the Seneca area. In early 2000, Preferred Health physician members who had direct contracts with Cigna terminated those contracts, and informed Cigna that Preferred Health would now jointly handle their contract negotiations. In late 2000, Preferred Health proposed its fee schedule to Cigna, which contained rates that were approximately 5% to 40% higher than the rates that Cigna had been paying under direct contracts with Preferred Health physician members. Confronted with Preferred Health's collective demands, and needing Preferred Health's physician members to assemble a marketable health plan in the Seneca area, Cigna, in March 2001, agreed to Preferred Health's price demands. Preferred Health did not notify physician members of the Cigna contract and fee schedule until after Cigna signed the contract.

A rational observer would describe what took place between Preferred Health and Cigna as a *negotiation*. The FTC contends that it was *coercion*, however, because Cigna was “forced” to meet Preferred Health’s demand for a price increase – a price increase it could only demand, the FTC says, because all of the member physicians joined together and negotiated as a block. Had the physicians negotiated individually, the FTC contends, Cigna would have been able to obtain a lower, “competitive” price.

Of course, there was nothing remotely coercive about Preferred Health’s actions negotiations with Cigna. Preferred Health did not – to use another reference to *The Godfather* – stick a gun to the head of Cigna’s negotiator and state that either his brains or his signature would be on a contract for a 40% increase. Cigna was free at all times to simply walk away from the table.

The FTC claims Preferred Health’s actions were still coercive because Cigna (and other payers) needed Preferred Health’s physicians to “assemble a marketable health plan in the Seneca area.” But a payer’s *needs* do not create a *right* to obtain physician services at any price the payer unilaterally dictates. Preferred Health’s members have every right to seek the best price that the market will bear for their services. They are not ethically – or *legally* – obligated to accept a payer’s offer. Free market principles apply irrespective of whether the physicians act individually or through a freely-chosen common agent.

The FTC ignores the fact that Preferred Health had no power to compel its members to act without their consent. In fact, unlike labor unions – which are exempt from the

antitrust laws – Preferred Health has no ability to force any physician to participate in joint contracting activity. A labor union, in contrast, is granted a state-sanctioned monopoly (another violent intervention in the market) that excludes non-union competitors and compels employers to collectively bargain. The contradiction is telling: The government deems forced unionization compatible with free markets while condemning voluntary association as “coercive” and illegal.

The FTC's position is further undermined by the fact that the alleged victims of Preferred Health's “coercion” are themselves state-sanctioned cartels: managed care organizations. Cigna, United Healthcare, and Carolina Care Plan represent thousands of individual consumer-patients. The Commission cannot credibly maintain that such cartels are pro-free market while simultaneously outlawing smaller groups of physicians. A free market requires reciprocity – one party cannot be afforded a right denied the other except by voluntary agreement. The Commission seeks to force Preferred Health's members to negotiate from a position of weakness against much larger payers.

Unequal bargaining power is only a symptom of the root problem, however. The managed care system itself demonstrates the government's repudiation of free market principles with respect to health care. Managed care creates a third-party intervention between physicians and patients that exist in virtually no other market. When a customer purchases food, for instance, she does not pay a premium to a third party who then dictates what food she can and cannot consume. Instead, she goes to the store and

buys the food. Health care largely operated the same way until the 1960s, when government intervention – in the form of Medicare and Medicaid – transferred the responsibility to pay for services from the consumer to a third-party entity.

Companies like Cigna and United are not free-market entities. They are byproducts of state intervention. When health care costs soared in the years following the creation of Medicare and Medicaid, Congress and the state legislatures repeatedly escalated their interventions in order to bring costs under control (indeed, cost containment is a stated motive of the FTC's prosecution of this case.) As physician Miguel Faria, Jr., explained, these interventions did not protect competition or free markets, but rather created the hybrid state-corporate known as managed care:

The concept of managed care was not the marvelous creation of laissez faire capitalism and Adam Smith's invisible hand of supply and demand, or a derivation of the ancient and beneficent precepts of Hippocrates, but an invention of politicians and academicians acting as central planners, working under the auspices of Republican President Richard Nixon and Democratic Senator Ted Kennedy in the early 1970s.

First, under President Nixon's policy of wage and price controls, the revised Health Manpower Act of 1971 essentially adopted HMOs as state policy and favored by tax policy. Further legislation, the HMO Act of 1973, mandated businesses with more than 25 employees to offer HMOs to their employees and provided for special government-backed grants and loans for federally qualified HMOs. Yet, despite all the favorable government legislation initiated then, this collectivist vision did not take hold until the 1990s.

Second, the McCarran Ferguson Law of 1946, a law that permits insurance companies to be the only industry given significant exemptions from antitrust laws (and therefore, of itself monopolistic), allows managed care/HMOs to set doctors' and hospital fees (including capitation), reimbursements, benefits, insurance premiums, etc. If two or more

physicians were alleged to have discussed fees, in any way, shape or form, the hand of the Federal Trade Commission (FTC) would fall heavily on them, as has happened with a group of obstetricians here in Georgia. Third, the ERISA laws (Employee Retirement Income Security Act) of 1974, which were set up to protect employee pension funds in employer-provided, self-insured plans, has until recently been used effectively by managed care and HMOs as a shield to protect themselves against medical liability lawsuits. In other words, in cases of medical malpractice, the HMOs are not liable; only the individual physicians involved are medically liable and accountable, so that when managed care bureaucrats deny the use of certain diagnostic procedures or therapeutic techniques for cost-containment (the hallmark of managed care), the plans and their administrators, are exempted from lawsuits of medical malpractice. The officials say they are not practicing medicine, only administering the fiduciary responsibility of their plans, and suggest physicians stand by the Hippocratic Oath. Yet, the fact is that the Oath has been trampled under the ethics of managed care with perverse incentives that reward doctors who are paid more to deliver less care to their patients.

And lastly, managed care and HMOs should not be considered free market medicine because, as a result of the discovery and deliberations of the landmark lawsuit, *AAPS v. Clinton* (1993), the public found that the managed care industry with representatives and/or employees from the largest insurance companies, as well as the Henry Kaiser Permanente and the Robert Wood Johnson Foundations, were working behind closed doors, alongside government employees in violation of the open-door requirements of the Federal Advisory Committee Act (FACA). This unholy cooperation of corporate entities and the government working in partnership setting public policy is referred to by the eminent Austrian economist, Ludwig von Mises, as corporatism, a form of socialism, which is perhaps more aptly named economic fascism, but certainly not free enterprise capitalism.⁵

The FTC's case against Preferred Health is based on the fallacy than additional intervention will somehow undo the damage caused by all of the previous interventions – none of which are the fault of Preferred Health. In every instance where the state's

5 Miguel A. Faria, Jr., M.D., *Managed Care – Corporate Socialized Medicine* <available online at <http://aapsonline.org/jpands/hacienda/article10.html>>.

intervention has failed to produce the desired outcome, the response of government officials has not been to look at their own shortcomings, but to cast aspersions on a non-government scapegoat. Here, Preferred Health's members are the scapegoats for a managed care system that has routinely failed its customers.

Nowhere in the complaint or other public case documents does the FTC discuss the market conditions for health care services in Seneca, South Carolina. There is no examination of why physicians sought the price increases they did. These price increases may have been necessary to guarantee the financial solvency of Preferred Health's members or otherwise prevent them from leaving the Seneca area for a more profitable geographic market. From the FTC's perspective, however, it is sufficient to cry "price fixing" and condemn Preferred Health *per se* without conducting any fact-based analysis of the marketplace.

The only economic factor that the FTC considered in this case was the impact of Preferred Health's joint contracting on the RBRVS, the formula used by the federal government to determine reimbursements to health care providers under Medicare and Medicaid. Paragraph 11 of the complaint notes that managed care payers use RBRVS as a benchmark for their own contract offers, for example offering reimbursements at "110% of 2003 RBRVS." The FTC views provider contract demands beyond a certain factor of RBRVS to be "anti-competitive," and thus illegal under the antitrust laws.

Once again, the FTC's actions contradict free market principles. RBRVS is not a valid benchmark for *market* prices, because RBRVS is itself a government price control

scheme. Although RBRVS claims to be based on “objective” economic analysis, it is still a centralized, arbitrary price system. As Dr. Faria noted, the original HMO Act that created managed care was adopted as part of the Nixon administration's “wage and price controls.”

RBRVS is based on a premise familiar to adherents of Marxism: the objective theory of value. This theory – also known as *labor theory of value* – holds that all goods and services exchange at the value of the labor required to produce them. Labor earns a subsistence wage for producing goods, and the purchaser of labor (the capitalist) makes his profit by adding the labor to raw materials.

RBRVS attempts to put labor theory of value into practice by driving prices down to the point where physicians may only earn a “subsistence wage.” The government refers to this as “cost containment,” but in fact cost has nothing to do with it. RBRVS sets a uniform reimbursement level for a particular service irrespective of the actual cost or quality. These are price controls designed to reduce government expenditures on Medicare, not a method of delivering physician services with a greater degree of economic efficiency.

Third-party payers express their contract offers in terms of RBRVS for the same reason the government does: to reduce expenditures on physician services. Third party payers generate profits by maximizing their collection of premiums from individual customers while minimizing the amount of health care actually provided. The system is designed to collectivize patient care by making it impossible to determine market

prices; RBRVS prices are based on the arbitrary, often random, drawing of relationships between various medical services. It is akin to determining the prices of food by relating the price of bananas to the price of peanut butter and then to the price of tomato soup.

The paradox, of course, is that it is government intervention through Medicare and Medicaid – and the subsequent creation of managed care organizations through subsidies – that caused the rapid increase in health care expenditures in the first place. With the government subsidizing some health care customers and third-party payers replacing direct market interaction for others, health care demand has consistently risen since the 1960s. Simultaneously, the government restricts the supply of health care services through mandatory licensing of providers and the regulation of insurance (dictating what services must be covered, prohibiting discrimination by insurers, etc.) These interventions have combined to wreck the free market price system, which depends on minimal (and preferably no) intervention and a *subjective* theory of value.

Dr. Jane Orient, executive director of the American Association of Physicians and Surgeons, explained in an article opposing the adoption of RBRVS that recognizing the subjective theory of value would truly restore economic decision-making power to health care consumers:

The objective theory of value considers only the producer and completely neglects the consumer. Nowhere does the calculation of “relative value” consider the most important factor: the benefit to the person who purchases the goods or services.

In contrast, the **subjective theory of economic value** proposes that the value of an object is not inherent in the thing itself, but exists in the mind of the person who values it.

As Bettina Bien Graves pointed out, this theory “represented a completely new, revolutionary approach to economics. For the first time, the individual actor himself became the unit with which economics was concerned. His actions, his responses . . . , were recognized as the key to explaining market phenomena”.

The ranking of values varies with each individual, depending on personal circumstances and expectations. A person may be willing to make great sacrifices to obtain certain services, but will purchase others only if they are very cheap. For example, to one person cancer chemotherapy or surgery may seem a burden so great that the expectation of benefit may not be worth the price (either in money or suffering). To another, a small chance of cure may be worth any amount of pain and all of his worldly possessions. No third person can make a determination of the value of the service, even though its cost to the persons providing it may be exactly the same in the two instances.

According to the subjective theory of value, costs are basically **opportunity costs** incurred by a decision-maker, i.e. the value of the other goods or services he is willing to forego in order to obtain the goods or services under consideration. Such must be borne exclusively by the person making the decision; they cannot be shifted to others. Nor can they be measured by others, since subjective mental experience cannot be directly observed. (However, the subjective value is reflected in the price that an individual is willing to pay.) Further, costs are dated at the moment of final decision or choice. A recalibration of the relative value scale every five years is far too slow to account for changes in the personal circumstances of the actors in any economic transaction.

The objective theory of value must be assumed by those who believe in central planning by omniscient planners. The subjective theory of value is espoused by those who believe in economic freedom, in the rights of individuals to engage in voluntary transactions that they perceive to be of mutual benefit.⁶ (Emphasis in original and citations omitted.)

⁶ Jane M. Orient, M.D., *The Resource-Based Relative Value Scale: A Threat to Private Medicine* <available at <http://aapsonline.org/brochures/rvs50.htm>>.

Dr. Orient said RBRVS effectively abolished the right of individual patients to contract with physicians and replaced it with a form of central planning where “[t]he patients’ values are completely excluded from the equations.”

Paragraph 27 of the FTC’s complaint said Preferred Health’s joint contracting was illegal, in part, because it was not “reasonably related to any efficiency-enhancing integration.” This assertion is a classic error arising from the objective theory of value. The Commission is substituting its own judgment for that of consumers (and producers) and deciding the type and level of integration that “reasonably” justifies a voluntary economic transaction. This is economic planning in its purest form, and it is not in any respect a legitimate effort to protect consumers or the free market.

Conclusion

The FTC’s proposed order undermines free market principles, violates the rights of Preferred Health and its members, and creates unjust protectionist barriers in favor of third-party payers in the Seneca, South Carolina, health care market. In addition, for the reasons explained in our *amicus curiae* brief to the FTC in the North Texas Specialty Physicians case (that we choose not to repeat here), the Commission lacks the constitutional authority to engage in economic planning under the pretext of antitrust enforcement. Accordingly, there are no grounds for the Commission to issue its proposed order against Preferred Health, and no need to make the prerequisite public interest determination.

Respectfully Submitted,

_____/s/_____
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