February 26, 2002

The Honorable Chief Justice Ronald M. George
and Honorable Associate Justices
California Supreme Court
350 McAllister Street
San Francisco, CA 94102

Re: Letter Supporting California Medical Association's Petition for Review*:*
California Medical Association, Inc. v. Aetna et al., S103631
(Cal. Rule of Court 28(f).)

Dear Chief Justice George and the Honorable Associate Justices of the Court:

On behalf of the American Medical Association, I urge the Court to grant review in this case.

A. Amicus, The American Medical Association, Is Concerned That Managed Care Organizations In California Have Evaded The Knox-Keene Act, To The Economic Detriment of Physicians And the Endangerment of Patient Care.

The American Medical Association ("AMA") is the nation's largest professional organization of physicians. AMA's 275,000 members practice in all fields of medical specialization and in every state. Founded in 1847, the AMA is an Illinois not-for-profit organization.[1] The objects of the Association are to promote the science and art of medicine and

[1]The AMA submits this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies ("Litigation Center"). The Litigation Center, a coalition of the AMA and

the betterment of public health.

AMA and its membership are deeply concerned about the medical, legal and ethical issues raised by the development of managed care in this country. AMA is concerned that the Court of Appeal's opinion in this case – which implicitly condones predatory behavior by health care plans by refusing to recognize a remedy for it– will fundamentally damage the practice of medicine in our nation today. The Court of Appeal's opinion also reads this state's regulatory scheme, the Knox-Keene Health Care Service Plan Act of 1975, as if it is optional. It only applies, apparently, when the plans have decided not to opt out of it by delegation. This is inconsistent with the purpose and intent of Knox-Keene, and every other managed care regulatory scheme in the country. AMA urges this Court to grant review in this case.

B. This Court Should Grant Review To Consider The Important Issues Raised In This Case Regarding the Plans' Misuse of Their Monopsony Power.

In this case, CMA's allegations, which must be deemed true since this case comes up to this Court after a judgment entered upon the granting of a demurrer, include the following:

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50 state medical societies, was established to present the views of the medical profession to the courts.

·Physicians' access to the majority of insured patients in this state depends upon their participation in managed care plans offered by defendants."[2]

·In order to have access to patients, physicians must enter into Intermediary Physician Agreements or otherwise be accepted onto the plans' panels.[3]

However, the IPA agreements are financially unsound, and not made on an actuarially sound basis:[4]

· The plans know that the Intermediaries are financially unstable and unable to pay defendants.[5]

·In fact, the plans have caused the intermediaries' instability because they use their market power to dictate financial terms to the IPAs which do not cover the costs of medical care.[6]

As noted by the National Association of Managed Care Regulators and other authorities,

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[2]Slip. Op. p. 5.

[3]*Id.*

[4]*Id.*, p. 20, fn. 19.

[5]*Id.* at p. 20 & n. 5.

[6]*Id.*

the plans are delegating their own very large financial risks to groups of professionals who, while schooled in medicine, are generally neither experts in financial management nor able to access the large amounts of capital

necessary to fund what is essentially the management of a specialized insurance company.[7]

"[A]n inherent unfairness may exist between the MCO [the plans] and the network [medical groups] as players in this market."[8] The plans and the medical groups are in "unequal bargaining positions." The plans have become increasingly dominant in the health care insurance markets through consolidation and mergers in the industry.[9] They thus have the market power to

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[7]Overby & Hall, Insurance Regulation of Providers That Bear Risk (1996) 22 Am. J. L. & Med. 361, 365-367; National Association of Managed Care Regulators, "*Downstream Risk & Delegation"* (June 1, 2001) p. 17 also available at http://www.namcr.org in the "Resources" section (hereafter "NAMCR").

[8]*Id.*

[9]The consolidation of health insurance markets is exhaustively documented in Foreman et al., *Competition in Health Insurance: A Comprehensive Study of US Markets* (AMA 2001). For example, in 1990, there were 19 HMOs in California; by 1999 these 19 have consolidated so that there are now only 6 companies. (Managed Care Health Care Improvement Task Force (January 1998) "*Improved*

dictate terms.

On the other hand, "[t]he [medical group] network, an entity that is often run on a part-time basis by practitioners who are often untrained in matters of business, accepts, based on whatever data it has, what is offered. . . ." *Id.*

The plans, in other words, are able to dictate to physicians financial terms which are not actuarially sound due to their use of their monopsony power over the health care markets.

C. This Court Should Grant Review To Consider The Implications of the Plans' Predatory Use of Their Monopsony Power And The Resulting Effects on the Health Care System.

Managed Care in California," Interstudy Competitive Edge Survey, 2.2; California Association of Health Plans (May 1999) "*1999 Profile Annual Report*;" and Department of Corporations, May, 1999.

"Monopsony is defined as a market situation in which there is a single buyer or a group of buyers making joint decisions. Monopsony and monopsony power are the equivalent on the buying side of monopoly and monopoly power on the selling side."[10] While monopoly power is market power exerted by a seller of services, monopsony power is characterized by an ability to exploit those providing the service through the fees it pays them.

[10]Lipsey, Steiner & Purvis, *Economics* (7th ed. 1984) 976, cited in *United States v. Syufy Enterprises* (9th Cir. 1990) 903 F.2d 659, 663 n. 4.

It is a common error to suppose that because a monopsonist lowers the price of the goods it purchases, it does no harm to consumers.[11] As the United States Department of Justice has explained, however, when a health plan uses its market power to lower the cost of physician services to unreasonable levels, this assumption is incorrect.[12] The question in such a case is whether the plan, as the buyer of services, uses its monopsony power in a way which will adversely effect its "output" market, that is, whether, ultimately, the depressed prices caused by the monopsonist plans will have an adverse effect on consumers.[13] When prices paid to physicians are artificially decreased by plans using their monopsony power, physicians' ability or desire to remain in the health care market is adversely effected; it is therefore an illegal use of

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[11]Hovenkamp, Federal Antitrust Policy: The Law of Competition and Its Practice (2d Ed. West 1999) § 1.2b at p. 14.

[12]See Buyer Power Concerns and the Aetna-Prudential Merger, Address by Marius Schwartz, United States Department of Justice, Economic Director of Enforcement, Antitrust Division, Text of Speech Released November 30, 1999, §§ IIA & III.

[13]*Id.*

buying power.[14]

Stated another way, "monopsony is . . . just as inconsistent with consumer welfare as monopoly is.[15] "Indeed, one should *never* presume that the lower prices paid by a monopsonist are passed to consumers as lower resale prices."[16]

Here, for example, the monopsonist plans are using their market power as the purchasers of medical services to force a reduction – an unreasonably low price — for physicians' services. In the short term, the price of health insurance premiums for the consumer may or may not be effected. But for the same price, the consumer is not obtaining the same quality of service – a working relationship with a health care provider – that the consumer would otherwise be able to purchase in a market free of the monopsonist plans' predatory conduct. The plans retain as profits the money which would have been used to fund a financially viable, actuarially sound, health care delivery system.

D. This Court Should Grant Review Because CMA Has Stated Valid Causes of Action Against the Plans.

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[14]*Id.*

[15]Hovenkamp, *supra*, at p. 16.

[16]*Id.*

In their interpretation of the Knox-Keene Act, the plans and the Court of Appeal read the word "plan" in Health & Safety Code section 1371 and other sections of the Act as obligating the plans to pay health care costs only when the plans have not delegated their responsibilities to someone else. Under that interpretation, the Knox-Keene Act's requirements apply to plans – only when the plans decide they apply. This is an unprecedented reading of a regulatory enactment. If there is ambiguity in the Knox-Keene Act, however, it should be construed in favor of the intent of the Act to protect consumers, not in favor of the plans' wholesale avoidance of their obligations under the Act.[17]

Even assuming arguendo that Knox-Keene does not expressly prohibit the plans' use of their market powers in the way that CMA has alleged here, certainly, Knox-Keene does not expressly approve of that conduct. As in *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163, 189-190, the respondent plans here use their "government-protected position" and their "legally privileged status" to engage in predatory conduct in the health care markets. The plan's predatory conduct should therefore be actionable as "unfair" competition even if, assuming for the sake of argument, it is not expressly prohibited by the Knox-Keene Act.[18]

The Knox-Keene Act is strengthened, not impaired when courts construe it consistently

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[17]Code of Civil Procedure § 1859.

[18]*Cel-Tech, supra,* 20 Cal. 4th at p. 180; see also *All Care Nursing Service Inc. v. Bethesda Memorial Hospital, Inc.* (11th Cir. 1989) [whether hospital's and agencies' agreements for purchasing nursing services violated antitrust laws is a question of fact].

with its Legislative purpose: as an Act designed to protect consumers, not to immunize market players. There is thus no conflict between the Act and the theories of liability espoused by CMA in this case.[19] CMA should be allowed to present its case to a trier of fact.

E. This Court Should Grant Review Because The Court of Appeal's Opinion Jeopardizes The Quality of Health Care In California.

[19]See *Humana Inc. et al. v. Forsyth* (1999) 525 U.S. 299 [suit against health insurer for racketeering activities did not "impair" or supersede state law].

The Court of Appeal's opinion in this case jeopardizes the continued viability of health care delivery in California. "[T]he precarious state of the physician-group system is threatening the entire structure of managed care in California."[20] It is well known that "[m]ore than 100 medical groups have gone bankrupt over the last two years."[21] Additionally, according to state regulators, "[a]bout a quarter of the state's medical groups that take flat-per-patient-fee contracts from HMOs are in financial trouble. . . ."[22]

The human impact, the impact on patients, is profound. As Senator Jackie Speier recently noted, when a large medical group with 240,000 enrollees closed:

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[20]Bernstein, "*Ailing Doctor Groups In Critical Need of Remedy*," Los Angeles Times (Nov. 5, 2000) Business Part C, Page 1, Financial Desk.

[21]*See* "Smart Remarks: *Commentary on the Physician Solvency Issue in California*," text of Sen. Speier's remarks in October 2001 to the California Healthcare Foundation. For the full text see admin.chcf.org/documents/chcf/solvencySmartRemarks.pdf. This document can also be found by entering its title in www.google.com.

[22]Beeman, The Press Enterprise (August 31, 2001) Section A, p. A01.

> The human impact was reflected by the chilling statistic that 2,000 pap smears and 200 biopsies were left unread. . . .
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> A radiation oncologist reported that even though continuity of care is required by law for cancer therapy, a voicemail message was left by a plan telling her to stop treating patients since she belonged to a bankrupt IPA. Patients on Coumadin were told that they had to drive 30 miles to San Francisco for blood tests. Patients were being ripped away from their doctors after 10 to 15 years of care.[23]

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[23]Speier, *supra*.

Patients of a bankrupt medical group have found their patient files locked in a warehouse.[24] As Daniel Zingale, the director of the Department of Managed Health Care, has explained:

> "We've literally had situations where the parking lot of the medical group is filled with patients who came for appointments, and the door is locked, with a notice posted that the group is bankrupt. . . " [25]

As in all things, "[s]ick patients might have a tougher go of it." Surgeries might "suddenly need to wait" because the patient's relationship with his or her chosen surgeon has been severed.[26]

These problems affect many people. Millions of Californians are enrolled in health care service plans.[27] The closure of but two of the more than one hundred health plan intermediaries

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[24]Rosenblatt, Los Angeles Times, *Dollars & Sense: Patients Caught In Feuds* (November 12, 2001) Part S, Health, p. 1.

[25]Beeman, *supra*.

[26]Bernstein, Los Angeles Times, (September 12, 1999) Business; Part C; Page 1; Financial Desk.

[27]Health & Saf. Code, § 1342.1(a)(1) [Legislature's finding of fact].

involved in this problem in this State impacted more than one million patients.[28] This Court should grant review in this case to safeguard the quality of patient care in this state.

[28]Speier, *supra.*

F. This Court Should Grant Review Because This Case Involves Issues of National Significance Which Should Be Decided by This State's Highest Court.

This case, indeed, involves issues of national significance. Throughout the United States, "states are now beginning to realize that RBPGs [risk-bearing provider groups] pose a significant potential for financial insolvency that could leave subscribers without a source of medical care."[29]

For example, the Attorney General of the State of Texas just days ago filed a complaint against Pacificare of Texas after three of Pacificate's delegated networks filed for bankruptcy protection. The Texas AG sued on the ground that the plan had improperly delegated responsibilities to its physician networks.[30]

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[29]Overby & Hall, *supra*, 22 Am. J. L. & Med. at 362; Glabman, Managed Care (Dec. 2000) "*Downstream Without A Paddle;"* also available at www.managedcare.mag.com/archives [quoting senior policy analyst for the National Council for State Legislators: "It became painfully apparent only this year that something really had to be done."]

[30]BNA Health Care Daily Report (Feb. 12, 2002) *Texas AG Files Suit Against PacifiCare of Texas, Alleges Payment Delays, Other Deficiencies* [quoting

The National Association of Managed Care Regulators, which includes California regulators, issued its definitive position paper on "Downstream Risk & Delegation" in Managed Care in June of 2001.[31] The NAMCR clearly came out in favor of the position that HMOs cannot delegate ultimate responsibility for the

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the Texas Attorney General: "When doctors and hospitals don't get paid as they should – or when they should – and as a result terminate their relationship with a health plan, patients suffer the consequences. . .]"

[31]NAMCR, *supra.*

delivery of and payment for care, even if the plans try to do so by contract. As the NAMCR states:

> It is our opinion that the MCO, as the licensed entity, shall be ultimately responsible in all aspects regardless of how delivery of, and payment for care is subcontracted or shared or how many levels of subcontracting are involved.[32]

This is a problem of national importance. Among other states, Colorado, Connecticut, Kentucky, Maine, Maryland, Minnesota, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Texas, Virginia and Wisconsin have confronted or are confronting similar or identical problems due to the failure of intermediary organizations.[33]

Managed care has great promise in this country as a health care delivery system which could be economical and accessible to many patients. However, in order for managed care to function properly and efficiently, it must be held accountable to state regulatory requirements and to general principles of good faith and fair dealing. A grant of review in this case is thus also necessary to ensure the continued viability of the managed care system, which is a matter of statewide as well as national importance.

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[32]NAMCR, *supra*, at p. 44 (emphasis as shown).

[33]NAMCR, *supra*, pp. 31-40, Glabman, *supra*; American Medical News (Dec. 17, 2001) "*Don't Get Caught Unaware If Your IPA Fails,*" pp. 1-2.

G. Conclusion

Amicus AMA respectfully urges the Court to grant review in this case.

Dated: Respectfully submitted,

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