

## Appendices to the Public Comments of Citizens for Voluntary Trade

Before: Judge Graham C. Mullen

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## Appendix A—Documents From Mountain Health Care's Website

Source: [http://](http://www.mountainhealthcare.com/pressrelease.htm)

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### *Mountain Health Care To Dissolve, Liquidate Assets*

Asheville, NC—(Friday, Dec. 13, 2002)—Mountain Health Care (MHC), the largest preferred provider health care network in Western North Carolina, confirmed today that it has consented to the decision by the U.S. Department of Justice (DOJ) to dissolve and liquidate its assets. The company hopes to sell its assets to a new buyer that will continue to provide physicians' services to the community, which includes 22 western North Carolina counties.

The government Friday filed what's known as a complaint and consent decree in U.S. District Court in Asheville, triggering a timetable for dissolution in April, 2003.

According to Todd Guthrie, M.D., chairman and president of the board of Mountain Health Care, the filing is a result of two years' review of documents and several health care organizations in the region as part of an examination of antitrust rules that effectively prohibit physicians from operating provider networks. To date, only Mountain Health Care is affected by this ruling.

MHC is privately held, with 401 physician stockholders, and that fact alone—not the admission of any unlawful conduct—is a substantial reason for the government-ordered closure. "We are but one of numerous physician-owned organizations operating under similar business models from across the nation who are facing the same situation," Guthrie said. "While we don't find solace in that fact, it is important to know that we apparently have not been singled out."

"We are terribly saddened and shocked by this news," he said. "Since 1994, Mountain Health Care has been a vibrant, pro-competitive force in our community, helping to protect the health of nearly 70,000 of our neighbors at reasonable and competitive prices. We obviously disagree with the DOJ decision."

Mountain Health Care has more than 1,800 providers including hospitals, ancillary services, laboratories and primary and specialty care providers.

Chief Executive Officer Ellen M. Wells, said that all stockholders, third party administrators and brokers and nearly 300 employers representing about 70,000 employees, have been notified of the government's decision. She said there are no benefits in challenging the decision.

"According to our attorneys, our only opinion was to go to trial against the DOJ, and we were advised that the cost of doing so far exceeded an amount we can afford," Wells said. "Simply put, we don't have the same resources as Microsoft, for example, which did take on the government in protracted legal proceedings. It would be ethically and morally wrong for us to pass costly legal expenses on to our customers and ultimately to patients," she said.

Wells emphasized that the consent decree filing is not evidence of any wrongdoing, rather an agreement to dissolve and sell its assets to another owner. "The reason is that Mountain HealthCare is a large, physician-owned network, and government antitrust guidelines are complex and permit physicians to own and operate networks only under very narrow circumstances. They don't treat physician-owned companies like they do others owned, for example, by insurance companies. We think this is wrong."

Wells also pointed out that the government's antitrust rules for networks are not simple. "The DOJ thought Mountain HealthCare network included too many physicians—which we though benefited consumers since it gives them more physicians from which to choose, as opposed to a smaller, more restrictive network."

With respect to sale of its assets, Guthrie said the board has already discussed such a sale with a number of potential buyers who are interested in doing business in the Asheville areas. "We hope to liquidate our assets to a buyer that will continue to provide physicians' and other providers services to our community. In the meantime, we will continue to respond to the needs of our constituency," Guthrie said.

Guthrie said the review process and identity of potential buyers is confidential. "Mountain HealthCare will maintain high-quality, proficient levels of professional service to its network and employers until the assets sale process is complete", Wells said.

### *Competition Needs To Grow Between Insurance Companies*

By M.D. Stephan Buie

Posted: Dec. 30, 2002 11:06 p.m. (Asheville Citizens Times)

The Citizen-Times reported on Dec. 14 that the U.S. Justice Department has ordered Mountain HealthCare to dissolve, based on accusations of price fixing. People interviewed in the article expressed the hope that dissolving Mountain HealthCare will lead to increased competition and lower health-care costs. What people outside health care do not understand is that for the last 10 years or more physician costs have been controlled by managed care companies and have risen at a rate lower than general inflation. The competition that is needed is among insurers, and dissolving Mountain HealthCare will decrease that competition rather than increase it.

Mountain HealthCare is an association of independent medical practices and was set up not to fix prices, but to compete with managed care organizations. It is not an insurance company, but provides a panel of physicians for insurance companies to

contract with. It was established with the advice of attorneys who are experts in federal antitrust law. It works through a blind messenger system, whereby MHC negotiates a rate for services with an employer and then sends those rates to each member practice. Each practice independently decides whether to accept the rate or to counter propose a different rate. All members have been informed that it is not legal to consult with other practices about their participation or their rates. Employers were free to negotiate with other managed care organizations. The physician members also are on panels of other managed care organizations. It is not clear to me how this is price fixing, but as the article indicates, MHC, unlike Microsoft, does not have the money to battle the Department of Justice.

The article about the Mountain HealthCare dissolution stated, "local businesses were socked with premium increases of 30 percent or more this year." Insurance rates are affected by physician costs, hospital costs, drug costs, and the administrative costs of the insurance companies, whose major executives have salaries in the millions of dollars. Managed care organizations were initially created to contain costs and to increase efficiencies in health care. They were successful in decreasing costs initially, and brought increases down to the rate of general inflation. After they cut the fat out of the provider systems, though, it is not clear that they have been as effective in trimming their own fat. Their methods of controlling costs have led to greater inefficiencies in medical practices, however, in terms of collecting for charges and excessive requirements for treatment plans. Managed care organizations have taken a hard line with payment to physicians, either decreasing payments or holding them steady during the last 10 years. The individual medical practice has no bargaining power with these large companies. It is their way or the highway. If you own a business, imagine running that business without a price increase for the last 10 years.

MHC gave local physicians an organization that provided employers what they need from a managed care organization but would be more responsive to the physicians. In fact, I have often been frustrated that MHC was not more responsive to the needs of the physicians. Their billing was often as confusing as the managed care organizations, but at least they answered the phones when we called.

More physicians are moving away from enrollment in managed care organizations and are demanding cash payment for services. Billing for our services has become extremely complex, time-consuming and costly. Each managed care organization may have several claim centers. If we send our claim to the wrong one, it is rejected without explanation. Their claim centers apparently have no cross-referencing so they can't tell us the correct center to send the claim to. The insurance staff in my office have become convinced that this confusion is intentional, as the harder it is to collect for services, the less the insurance companies have to pay. They do not want to make the system work because it is to their benefit for it not to work.