Competing in the marketplace:

How physicians can improve quality and increase their value in the health care market through medical practice integration

Second edition with new preface and appendixes

AMA
AMERICAN MEDICAL ASSOCIATION

Acknowledgments

This document was developed by the American Medical Association Private Sector Advocacy Unit.
The Private Sector Advocacy Unit wishes to express its appreciation to the following individuals for their assistance.

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Table of contents

Preface

Produced by the American Medical Association (AMA), "Competing in the marketplace" provides a practical and pragmatic overview of the integration options—ranging from mergers to a wide variety of other contractual arrangements—that are available to physicians. While recognizing that many of its members either already are or want to practice independently or within a small practice group, the AMA also recognizes that many changes in the marketplace have placed severe financial strains on physicians that can only be addressed by some form of integration by physicians.

"Competing in the marketplace" provides a range of integration options that address the desire of many physicians to retain some level of autonomy while at the same time acknowledging the realities of today's marketplace. To help physicians choose for themselves a level of integration that makes sense given their specific goals, the AMA identifies many of the benefits and drawbacks of several integration arrangements in this resource.

The AMA also recognizes that physician integration efforts sometimes raise antitrust issues. For example, antitrust issues arise when physicians seek to jointly negotiate fee arrangements with health insurers. This resource identifies the relevant antitrust concerns that may be of concern when physicians seek to jointly negotiate fees and describes the current state of the law on the subject. This resource is not, however, designed to provide an antitrust opinion on any specific physician network or specific physician joint venture. Instead, it is designed to point out possible antitrust pitfalls and describe generally the types of arrangements that are acceptable under the antitrust laws, as those laws are currently interpreted.

Originally published in March 2008, this second edition contains three additional appendixes to reflect marketplace updates and relevant AMA efforts that have occurred in recent months.

AMA advocacy efforts to promote fair managed care contracting

Increasing the ability of physicians to negotiate jointly

Some degree of uncertainty exists with respect to the application of the antitrust laws to physician joint ventures and other integration efforts. Ironically, a significant source of this uncertainty arises from antitrust guidelines that the federal antitrust enforcement agencies created to clarify the application of the antitrust laws to physician joint ventures. The problem is that these guidelines were created more than a decade ago and were based on a market environment that was very different from the one physicians face today. For example, the guidelines do not recognize the substantial market power created by the consolidation of health insurance markets and do not account for the deleterious effects of this consolidation.

Appendix A and AMA efforts to revise FTC guidelines

Given the major changes that have taken place in the market since the antitrust guidelines were drafted, the AMA is actively working to have the guidelines revised. Appendix A, "Physician networks and antitrust: A call for a more flexible enforcement policy," is the AMA's submission to the Federal Trade Commission (FTC) requesting revision of the guidelines. In its submission, the AMA has shown that the economic models that underlie the guidelines no longer have any relevance. For example, when the guidelines were originally issued, payers did not have the amount of economic power that they currently possess. Also, physicians and health insurers were experimenting with capitation arrangements and risk pools that necessitated physician sharing of substantial financial risk favored by the guidelines. Both of these economic models have since been largely rejected by consumers and, for the most part, have failed as business arrangements. Patients are demanding more creative options, but the longstanding guidelines are making it difficult for physicians to jointly develop such options.

Finally, technologies have emerged that have given physicians many more highly efficient integration options that did not exist ten years ago. For example, health information technology (HIT) systems have made it possible for physicians to form networks that can significantly increase the level of care physicians provide to their patients. However, such HIT systems are very expensive and require a high degree of training and cooperation to make them properly function. For the large majority of physicians, such systems are not practical without some level of integration with other physicians. The AMA has pointed out to the FTC that its current enforcement policy, as disclosed in the guidelines, is actually hindering the development of HIT systems.

Redressing the increasing consolidation of the health insurance market

While antitrust enforcement has been both vigorous and misguided with respect to physician networks, it has been virtually absent in health insurance markets. In the past 12 years, there have been more than 400 mergers between health insurers, and only three have been challenged by the federal antitrust enforcement agencies. While large health insurers have posted very healthy profits since 2000, premiums for consumers have increased without a corresponding increase in benefits. In fact, during the same time period, consumers have faced increased deductibles, copayments and coinsurance. This situation has effectively reduced the scope of patients' health benefits coverage.

The power health insurers have garnered through rapid, large-scale consolidation has been exercised to the detriment of consumers and physicians. Patient premiums have soared in this increasingly consolidated market, and physician reimbursement has decreased. As premiums have risen, many employers have stopped providing coverage, substantially limited or reduced the scope of benefits provided, and/or asked employees to pay a significantly higher share of the overall premium, thus effectively shrinking the scope of coverage. As of 2006, premiums for employer-based health insurance rose more than twice as fast as overall inflation and wages for the seventh straight year. Since 2000, the amount that workers pay toward family health care coverage has skyrocketed 84 percent, and 5 million fewer workers were receiving job-based coverage in 2006 than six years earlier. During the same period, average wages increased only 20 percent.[1] These soaring costs have directly contributed to an increase in the number of uninsured Americans—in fact, research shows that a one percent increase in premiums results in a net increase of 164,000 individuals in the uninsured population.[2]

Despite premium increases, powerful health insurers have depressed physician revenues.[3] The median real income of all U.S. physicians remained flat during the 1990s and has since decreased.[4] The average net income for primary care physicians, after adjusting for inflation, declined 10 percent from 1995 to 2005, and the net income for medical specialists declined two percent. Health insurer executives and shareholders, on the other hand, have reaped enormous monopoly profits.[5] The major national firms experienced double-digit growth in their profit margins between 2001 and 2008.[5]

The consolidation of health insurers has also created an extreme imbalance in health insurer-physician contracting that threatens all aspects of patient care. Health insurers are able to dictate important aspects of patient care and include terms in their contracts with physicians that intrude into medical care decisions.[6] Physicians have little to no ability to influence health insurer contracts that touch on virtually every aspect of the patient-physician relationship. This means that physicians must agree to contracts that often include provisions that make it difficult—if not impossible—for them to promote what they deem to be the optimal care for their patients. For example, many contracts define "medically necessary care" in a manner that allows the health insurer to overrule the physician's medical judgment and require care at the lowest cost, even though that lower cost care might not be the optimal care for the patient. Other health insurer contracts require compliance with undefined "utilization management" or "quality assurance" programs that often are nothing more than thinly disguised cost-cutting programs that penalize physicians for providing care they deem necessary. Some health insurers' contracts have gone so far as to require the physician to suffer a significant financial penalty if the physician fails to use a designated setting for services, even when the use of that setting would jeopardize the patient's health or impose a significant hardship.

It is clear that neither physicians nor their patients—the ultimate consumers of health care—are benefiting financially from health insurer consolidation. While physicians have a legal and ethical duty to their patients, publicly-traded health insurers are primarily obligated to their shareholders. It is the AMA's opinion that

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[1] The Kaiser Family Foundation and Health Research Educational Trust. *Employer Health Benefits 2006 Annual Survey*. *www.kff.org/insurance/7527/upload/7527.pdf*. Accessed December 10, 2008.

[2] Chernew M, Cutler D, Keenan P. Increasing health insurance costs and the decline in insurance coverage. *Health Serv Res*. 2005;40(4):1021–1039. doi: 10.1111/j.1475-6773.2005.00409.x.

[3] Hammer PJ, Sage WM. Monopsony as an Agency and Regulatory Problem in Health Care. 71 Antitrust L.J. 949 (2004).

[4] Tu HT, Ginsburg PB. Losing Ground: Physician Income, 1995–2005. Tracking Report No. 15. Washington, DC: Center for Studying Health Systems Change; June 2006.

[5] Robinson JC. Consolidation and the transformation of competition in health insurance. *Health Aff*. 2004;23(6):11–24. doi: 10.1377/hlthaff.23.6.11.

[6] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2007 Update*. Chicago, IL: American Medical Association; 2007.

dominant health insurers should not be allowed to impose take-it-or-leave-it contracts that undermine the provision of quality patient care and the physician-patient relationship. In fact, physicians remain the least consolidated component in the health care industry—most are in practices with four or fewer physicians and simply have no negotiating power with health insurance behemoths.

The AMA is concerned that the United States is heading toward a health care system dominated by a few publicly traded companies that operate in the interest of shareholders and not primarily in the interest of patients. It is time for lawmakers and regulators to take a serious look at the long-term negative impact of consolidated health insurance markets on the nation's health care system. Toward that end, the AMA has taken a lead role in voicing this problem to legislators, regulators and other policy makers and in seeking redress.

Appendix B and "Competition in health insurance" resource

The AMA has recently completed the seventh edition of "Competition in health insurance: A comprehensive study of U.S. markets"—a report tracking the consolidation of the health insurance industry. Selections from the introduction to this publication can be found in Appendix B. (Visit the AMA Web site for a complete copy of this resource.) In this most recent study, the AMA applied standards used by the federal antitrust enforcement agencies and found that 94 percent of the metropolitan statistical areas (MSA) it examined are highly concentrated. Further, in 89 percent of those MSAs, a single health insurer holds at least 30 percent of the market for commercial health insurance.

The AMA has also been actively opposing proposed health insurer mergers. In 2008 the AMA opposed two high profile mergers: those of UnitedHealthcare (UHC) and Sierra Health Services in Nevada, and of Highmark and Independence Blue Cross (IBC) in Pennsylvania.

In the Nevada case, the AMA, the Nevada State Medical Society, the Clark County Medical Society and coalition partners helped persuade the Nevada Attorney General to impose significant restrictions. Those restrictions include, among other things, an agreement that UHC will not: (1) enter into or enforce certain "all products" clauses, (2) enter into "most favored nations" clauses or exclusive contracts, (3) use the Ingenix database to determine out-of-network reimbursement rates for a period of two years, or (4) acquire FISERV Nevada, the dominant third-party administrator in that state. The Department of Justice also required divestiture of UHC's Medicare Advantage business.

Appendix C and AMA efforts at the congressional level

More recently, the merger of Highmark and IBC in Pennsylvania has focused attention at both the federal and state level on the ever-rising levels of consolidation in health insurance markets. The AMA and Pennsylvania Medical Society are urging the Pennsylvania Department of Insurance to block the merger. The AMA has also testified before the U.S. Senate. The AMA's written statement—"Consolidation in the Pennsylvania health insurance industry: The right prescription?"—that was presented to the U.S. Senate Judiciary Committee's subcommittee on antitrust appears in Appendix C. The AMA's submission to the U.S. Senate specifically addresses the pending merger in Pennsylvania, which is indicative of the consolidation taking place in many payer markets. As explained in the AMA's submission, this merger, if allowed, will have deleterious effects on both patients and physicians.

Conclusion

The AMA believes it is time to re-examine the legal landscape that has deprived physicians of fair opportunities to collaborate while, at the same time, allowing nearly unfettered consolidation of health insurance markets. If not corrected, the imbalances in the marketplace will have serious negative long-term consequences for health care delivery. The AMA hopes the information and guidance provided in this resource will help recalibrate the system.

Competing in the Marketplace:

How physicians can improve quality and increase their value in the health care market through medical practice integration

American Medical Association
March 2008

Introduction

The American Medical Association (AMA) has developed this guidance (Guidance) to apprise its members of the lawful ways in which they may integrate with other independent, and sometimes competing, physician practices in order to respond proactively to the changing practice environment and bargain collectively with health insurers and other third-party payers. This Guidance covers options approved by the federal agencies that enforce the antitrust laws: (1) mergers of previously separate physician practices and (2) financial and clinical collaborative arrangements. This Guidance does not address options involving non-physicians, e.g., physician hospital organizations. The AMA will address physician/non-physician integration in a separate guidance. This separate guidance will discuss how physicians may integrate with non-physicians without forfeiting the practice autonomy that is essential to quality medical care and professional satisfaction. Although this Guidance confines its focus to physician integration and how, in some cases, that integration may legally and appropriately necessitate joint negotiation of fees, the AMA continues to strenuously advocate through all legally appropriate channels to effect changes in both the antitrust laws and antitrust enforcement policy as a means of empowering physicians in their relationships with dominant health insurers[1]. For further information regarding this Guidance, please contact Wes Cleveland or Henry Allen, American Medical Association, at (312) 464-5000 or via email at *wes.cleveland@ama-assn.org* or *henry.allen@ama-assn.org*.

The purpose of this Guidance

The market and regulatory environment within which physicians practice is undergoing rapid and dramatic change. This change is motivating many physicians to explore the potential benefits of practice integration. Perhaps the strongest motivations driving physicians towards greater integration and mutual interdependence are the growing expectation for physicians to adopt expensive automated medical record and pharmacy order entry systems and the emergence of pay-for-performance bonus systems by governmental agencies and health insurance companies. Electronic record systems and pay-for-performance initiatives require sophisticated care delivery and data reporting systems.

Physicians in solo or small group practice may find it prohibitively expensive and time consuming to participate in and take advantage of these market and reimbursement changes. Physicians may be compelled to explore ways to integrate their activities with their colleagues to acquire or develop these tools in an interdependent fashion without violating legal and regulatory requirements.

Physicians may be unaware of the flexibility permitted by the numerous lawful collaboration options available to them. In many cases, physicians will be able to: (1) remain in their local practice settings, (2) oversee many day-to-day practice operations, and (3) be rewarded based on individual productivity while still achieving the level of integration necessary both to amass the capital required for health information technology (HIT) and other technological investments and to bargain collectively with health insurers and other third-party payers for the payment required to support a state-of-the-art medical practice. Physicians will also likely be able to continue to work with primary care physicians (PCPs) and the medical specialists with whom they have established professional relationships—indeed, most successful physician practice integrations involve

[1]AMA Policy H-380.987, which was reaffirmed in June 2006, states: "Our AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association." The AMA continually seeks to make the reform expressed in H-380.987 a reality. In 2007 the AMA undertook a number of high-profile and proactive efforts to achieve antitrust reform and expects to do the same in 2008.

increased collaboration among physicians who already have cooperative call, consultation and referral relationships.

The AMA has developed this Guidance describing medical practice integration options as one means of helping physicians successfully adapt to a changing practice environment.

New reasons driving physician practice integration

Recent groundbreaking changes in health care policy and reimbursement methodologies are providing new, and often compelling, reasons for physicians to work in much closer collaboration than in the past. In his 2004 State of the Union Address, President George W. Bush announced a federal policy to ensure that most Americans have an electronic health record by 2014. The potential benefits of widespread HIT implementation are enormous—a 90 percent adoption of HIT in inpatient and outpatient settings is projected to result in average annual savings of $77 billion.[2] In a December 2007 report, the Commonwealth Fund indicated that accelerated provider adoption of HIT could result in net health system savings reaching $88 billion over the next ten years[3]. Accordingly, several major federal agencies significantly altered their enforcement policies to facilitate physician adoption of HIT. However, for physicians to acquire, implement, and maintain an HIT system, they need extensive financial resources that in turn may require that they form a fully merged firm or integrated joint venture.

Another significant recent development motivating physicians to integrate their practices is the implementation of quality-based reimbursement mechanisms by health insurers, state and federal governments, and other payers. The following are a few examples of these types of quality-based reimbursement programs.

- A Physician Quality Reporting Initiative (PQRI) has been established within Medicare by the Tax Relief and Health Care Act of 2006. Congress has funded this program with $1.35 billion. The program increases by 1.5 percent payments to physicians and Medicare Part B practitioners who report information related to specific quality measures[4]. Similarly, the Medicare Payment Advisory Commission has continuously recommended to Congress the incorporation of quality incentives into Medicare's payment systems for physicians and health care providers.[5]

- Basing physician reimbursement on performance measures is gaining popularity among commercial health insurers. A recent publication issued by the Minnesota Medical Association in November 2007 entitled "A Review of Pay for Performance in Minnesota" (Minnesota P4P Review) illustrates this phenomenon. The Minnesota P4P Review shows how health insurers are utilizing specific practice measures to evaluate physician performance and structure reimbursement. The Minnesota P4P Review describes specific measures employed by each health insurer utilizing a pay-for-performance program.[6]

- The reimbursement transformation described in the Minnesota P4P Review is indicative of a national phenomenon. For example, on August 27, 2007, the Leapfrog Group and Med-Vantage published the results of a survey of 75 purchasers, government agencies, and health insurers. The results show that pay-for-performance programs had grown dramatically from 39 in 2003 to 148 in 2007.[7] According to the survey, since 2004 the top reason for implementing pay-for-performance programs remains improving clinical outcomes. The report also indicated that over 70 percent of all pay-for-performance programs are working to expand the scope or number of performance measures utilized and that "Advanced P4P programs are now developing tools to measure improvements in outcomes and eligibility for rewards directly from medical charts."

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[2]R. Hillestad, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R Taylor, Can Electronic Medical Records Systems Transform Health Care? Potential Health Benefits, Savings, and Costs, *Health Affairs* 24, No. 5 (2005): 1103-1117.

[3]Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending, The Commonwealth Commission on a High Performance Health System, December 2007, located at *http://www.commonwealthfund.org/usr_doc/Schoen_bendingthecurve_1080.pdf?section=4039*.

[4]A resource entitled "2008 Physician Quality Reporting Initiative Specifications Document" provides detailed descriptions of the 2008 quality measures and how to effect associated reporting. This resource is located at *http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIMeasureSpecs.pdf*. Further information concerning the 2008 PQRI program is located at the following address on the CMS Web site: *http://www.cms.hhs.gov/PQRI/35_2008PQRIInformation.asp#TopOfPage*.

[5]See e.g., K. Milgate and S. Cheng, Pay-For-Performance: The MedPAC Perspective, *Health Affairs* 25, No. 2 (2006): 413-419.

[6]The Minnesota P4P Review is available at *http://www.mmaonline.net/Portals/mma/Publications/Reports/P4P%20Report.pdf*. The Minnesota P4P Review describes the Minnesota Medical Association's policies regarding pay-for-performance programs. The AMA also has adopted Principles and Guidelines for the formation and implementation of pay-for-performance programs, as well as an extensive white paper entitled "Physician Pay for Performance (PFP) Initiatives." Both AMA documents can be viewed at *http://www.ama-assn.org/ama/pub/category/18016.html*.

[7]See *http://www.leapfroggroup.org/media/file/MV-Leapfrog_P4P_Press_Release.pdf*.

Closer integration enables many physicians to finance, develop, implement, and maintain the infrastructure necessary to collect, track and report the types of quality information that these performance-based reimbursement programs presuppose. Closer integration may also be essential to create the collaborative environment needed to make real quality improvement. Without collaborative implementation of practice standards and the infrastructure needed to support and monitor the effect of that collaboration, physicians may be disadvantaged in demonstrating quality outcomes and may ultimately be unable to compete in the changing health care market.

Finally, health insurers, employers and consumers are demanding data on physician performance upon which to base informed health care purchases. This information can be based on a number of factors, including: adherence to quality outcome and process measures; patient satisfaction survey results; and, increasingly, assessments of the cost of care. Health insurers are now ranking physicians based on quality and cost-related metrics and disseminating that ranking information to the pubic as an aid to physician selection. Insurers are also using these ranking systems to score or "tier" physicians, with higher scoring physicians receiving superior reimbursement or patient "steerage."[8] Many physicians view integration as a means of developing the infrastructure that can capture their own performance data—data that is essential to correct any inaccuracies in designations imposed on them by third-parties.

Tools already exist that can greatly facilitate medical practice and the integration process

Many physicians are already achieving remarkable success with affordable HIT systems. Physicians are improving practice efficiency and productivity by utilizing relatively simple HIT tools in their offices. For example, patient registries[9] are enabling practices to evaluate and track the care of one patient, as well as populations of patients, by using nationally recognized evidenced-based clinical performance measures[10] aligned with benchmarks. In this way, registries can highlight actionable items—when a patient's care does not meet population-based goals, for example, or when an assessment is overdue. This type of comparative analysis can greatly facilitate a practice's ability to take advantage of pay-for-performance reimbursement mechanisms. HIT can also incorporate non-physician staff into a practice's clinical workflow. This incorporation has allowed one network to provide each physician an additional 3.5 hours of revenue per month.[11] HIT programs can also facilitate patient compliance by providing patients with post-visit print-outs that show the patient's trends over time and goals for the next visit. The Docsite Web site is one of a number of Web sites that describes some of the HIT practice tools that physicians are currently utilizing.[12]

Additional reasons to integrate

Aside from these recent policy and reimbursement integration drivers, among the more significant motivations that may help to explain the trend toward greater integration among physicians is the desire to aggregate capital for the significant information and technology investments that are involved in health care delivery. Individuals and entities seek to share the risks they must bear, especially when capitated payments are involved. For instance, creating a larger group practice may provide a way for physicians to pool the financial risks associated with treating unusually costly patients. Integration may also be driven by economies in monitoring and evaluation. Larger groups may be able to use costly management information systems to evaluate performance and promote themselves to third-party payers. Finally, integration may yield negotiating efficiencies vis-à-vis large third-party payers. For example, a solo physician is likely to have less skill than a professional manager retained by an integrated group in negotiating and analyzing managed care contracts. Moreover, larger integrated groups may be favored by

[8]The AMA's Private Sector Advocacy unit has developed a number of advocacy resources to help physicians understand and, if necessary, challenge health insurer quality rankings. See *http://www.ama-assn.org/ama/pub/category/18016.html*.

[9]A patient registry is an electronic or manual system that compiles and manages information on a practice's chronically ill population. By using a patient registry, the physician can monitor the incidence and course of chronic diseases and observe the condition of patients before and after medical interventions. While simple manual patient registries function primarily as storehouses for information, electronic patient registries use practice-management software to perform multiple tasks. For further information regarding patient registries, see the document entitled "Patient registries: Outcomes and pay-for-performance: Can patient registries help?" This document has been developed by the AMA's Private Sector Advocacy unit and is available to AMA members at *http://www.ama-assn.org/ama/pub/category/14416.html*.

[10]The National Quality Measures Clearinghouse defines "clinical performance measure" as "A subtype of quality measure that is a mechanism for assessing the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient in the optimal time period." The National Quality Measures Clearinghouse is sponsored by the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, and provides a glossary of clarifying definitions and examples of terms used to describe common properties of health care quality measures. This glossary can be viewed at *http://www.qualitymeasures.ahrq.gov/resources/glossary.aspx*.

[11]See *http://www.docsite.com/solutions/population_management/*.

[12]See generally *www.docsite.com/*. The AMA does not endorse any HIT vendor.

managed care organizations because they offer payers the mix or geographic scope of services that patients want or the payers need to offer. (See Exhibit A for a more detailed description of reasons supporting integration).

The necessity of strategic and business planning

The decision as to whether and how to integrate should be based on an assessment of the relevant market, the capabilities and compatibility of the participants, and the business prospects of the combined entity.

An obvious integration goal is to enable the physician practice either to be the highest quality/best-value producer or to have a significant economic stake in an entity having those same attributes. Factors that will enhance a physician's ability to succeed are:

- Collaboration with an integrated network of primary care physicians, specialists, and appropriate allied health personnel;
- Ability to access, coordinate, or develop data that demonstrate competitive costs and outcomes;
- Retention of organizational flexibility to modify incentives and to respond to regulatory, technical and practice pattern changes; and
- Commitment to motivating and supporting the best clinical practices.

Physician groups will also need strong management that can negotiate and analyze managed care contracts. Physician group management should be able to access and develop the kinds of information systems that are required to assume capitated risk or to demonstrate the effectiveness in a fee-for-service system.

The complexity and interdependence of integrated arrangements are likely to result in governance changes. For example, some integrated entities may delegate decision-making responsibilities to professional management—a significant culture change from the typical shareholder governance of most physician groups. The effective allocation and coordination of administrative and clinical decision-making responsibilities will be a major challenge for any integrated organization.

Exhibit A describes some factors that may be considered as part of a strategic planning process. Exhibit B illustrates elements that may serve as part of a business planning process.

The structure of this Guidance

This Guidance is composed of three parts. Part I discusses physician practice mergers (Merger Model). Part II examines financial and clinical collaborative models (collaborative models) through which physicians may integrate their separate practices. Part III contains an analysis of the antitrust issues implicated when physicians utilize a joint venture or competitor collaboration to negotiate fee-related terms with health insurers and other purchasers of physician services.

Those interested in exploring antitrust issues prior to examining the specifics of the merger or collaborative models may wish to proceed immediately to Part III. Physicians should keep in mind, however, that their primary motivation for integrating should be to bring to market a valuable and competitive product that they could not otherwise produce acting independently. Physicians should develop their models and only then determine whether their proposal needs some tweaking or modifications because of the antitrust laws. Physicians should not view the antitrust laws as a bar that prohibits them from creating innovative health care products that enhance quality and lower cost.

Although in some cases this Guidance provides legal information, this Guidance does not provide legal advice. Physicians thinking about embarking on a practice merger or a financial or clinical integration project are strongly encouraged to obtain the advice of private legal counsel experienced in antitrust law and physician-specific legal and reimbursement issues before proceeding.

I. The Merger Model

A. Introduction

The Merger Model is not a new concept. By "merger" this Guidance means the consolidation of separate physician practices into one surviving medical group in which participating physicians have a complete unity of interest. The merged firm controls all of the resources of the combined practices such that none of the participating physicians compete with one another. Physicians have been merging into such firms for many years. For example, the Marshfield Clinic, the Mayo Clinic, the Cleveland Clinic and the Palo Alto Medical Foundation are all examples of

long-standing, successful, fully-merged medical practices.[13] For many physicians, practicing in that environment is ideal, as the continuing growth of such practices through medical group practice hiring and merging attests.[14] Many physicians remain reluctant, however, to consider a practice merger for fear of having to forfeit all of their autonomy and reward for individual productivity.

At the same time, many physicians are realizing that the Merger Model may be a more flexible practice model than they had appreciated. The Merger Model in many cases allows participating physicians to: (1) remain in their local practice settings, (2) oversee many day-to-day practice operations, and (3) be rewarded based on individual productivity. Much of this flexibility is due to new technology that has permitted a level of integration that, in the past, could only be achieved by setting up shop in a single location. Developments in telecommunications, Internet access and functionality, and practice management software now permit firms to function in an integrated manner, even if their physical offices are located all around the country.

B. General requirements for fully integrated physician practice mergers

1. Creating a single legal entity

Typically, under the Merger Model, the merged independent physician practices create a single legal entity. Any number of legal forms may be used, e.g., a professional corporation, professional association, limited liability corporation or a partnership, although individual state laws may circumscribe legal structure.

For the remainder of this Guidance, the single legal entity is designated the "merged medical practice" (MMP). The physician practices that are merged into the MMP are referred to as "practice divisions" (PDs) in the sense that although the merging physicians will no longer be practicing medicine through their separate pre-merger practices, one can for organizational or conceptual purposes consider them as divisions (or perhaps subsidiaries) of the MMP. It may be possible, for example, for the pre-merger practices to retain a sense of post-merger identity by functioning as PD/profit centers within the MMP. In some circumstances, PDs may also continue to function as holding companies which lease certain PD assets to the MMP. (See I.B.5 below).

2. Each physician practice will generally have to make a capital investment in the single legal entity.

Practices wanting to merge into the MMP must be prepared to make a capital investment in the MMP, e.g., by directly contributing funds or through the assistance of an authorized lender. While it is true that a larger medical group might have sufficient capital and be in the market to purchase assets of smaller practices and employ the formerly independent physicians, this is not the typical scenario. More commonly, small and solo practice physicians come together to create new, larger medical practices. The particular type of investment may again depend on state law. For example, if the MMP is a professional corporation, the PDs would have to purchase MMP shares. The capital investment here may be significant because it must fund all of the following: corporate restructuring; consolidation; the purchase of any necessary operational infrastructure, such as a practice management system; and, depending on projected market demand, the development of ancillary services.

While the capital investment may be substantial, technological advancements may make the integration of practice management systems less expensive than in the past. In many cases, merging practices may be able to integrate their business and information systems using existing hardware, e.g., workstations and servers. Additionally, there are a number of companies that can provide turnkey information services that can include virtually all business systems, e.g., scheduling and practice management software, as well as central business office functions.

3. All PDs must be integrated into, and be subject to, the MMP's governance.

The PDs will transfer all governing authority to the MMP. The MMP will have ultimate governing authority over all of the following: practice assets; liabilities; budgets; compensation; salaries; revenue and cost distribution; the operation of all PD business systems, e.g., billing, collection, accounting, and financial reporting systems; managed care contracting; and general administrative processes and information systems. The MMP will also have ultimate authority over the distribution of PD income and expenses, and

[13]See *www.marshfieldclinic.org/patients/default.aspx* (Marshfield Clinic Web site); *www.mayoclinic.com/* (Mayo Clinic Web site); *www.clevelandclinic.org/* (Cleveland Clinic Web site); and *http://www.pamf.org/* (Palo Alto Medical Foundation Web site).

[14]See e.g., L.P. Casalino, The Growth of Single-Specialty Medical Groups, *Health Affairs* 23, No. 2 (2004): 82-90.

the MMP's tax identification number and provider numbers must replace those of the PDs.

4. The MMP should hold itself out to the public as a single medical practice.

Once the MMP is formed and operational, all PDs will likely promote a new practice name but may link their prior practice affiliation with the group in order to transfer their goodwill to the combined entity and assure patients of equivalent or improved quality. Each individual PD site should be re-designated as an MMP site, under the MMP's new name subject to transitional use of any valuable prior trade name.

5. Leasing arrangements

Each PD may need to reassign any office space and other leases to the MMP. In cases in which a prior physician practice owns medical equipment, furniture or other similar assets, the PD may in some circumstances be able to choose between (1) transferring ownership of those assets to the MMP or (2) functioning as a holding company for those assets and leasing them to the MMP. In some cases, the MMP may want to consider establishing a separate legal entity that holds all practice equipment and other tangible assets that are then leased by the MMP.

6. Consolidation of PD employee benefit plans/ employee transfer

Subject to employee leasing arrangements for certain regions, it may make the most economic sense to consolidate PD employee benefit plans into a single MMP plan. The MMP should employ all PD physicians. Although the MMP can employ all non-medical personnel as well as PD physicians, in some cases the MMP may wish to establish a separate legal entity to employ all non-physicians. In states having strong corporate practice of medicine prohibitions, a separate entity may allow easier buy-in to and buy-out from the MMP for new physicians and may permit ownership by nonphysicians.

7. MMP-controlled billing and collections operations

Before the MMP commences operations, all merging practices must transfer the ultimate authority over their billing and collections operations to the MMP. All PD billings and collections must be performed under the MMP's federal income tax identification number and/or provider numbers. All professional and any ancillary revenue generated by PD physicians or clinical staff will be collected by agents of the MMP, deposited in MMP controlled accounts and owned by the MMP.

Transferring ultimate control and responsibility for PD billing and collections operations does not mean, however, that all billing staff need to be located in the central MMP office. In many cases, efficient and accurate billing and collection activities require a close cooperation and consultation between practicing physicians, health care professionals and billing staff that can only be achieved when those physicians, professionals and staff work side-by-side at the same location. PD practices should expect, however, that they will be required to provide regular billing and collection data to the MMP to ensure adherence to MMP-wide billing and collection policies and compliance with regulatory requirements.

8. Quality-of-care-related functions

Because the development of a cost control and quality improvement infrastructure are essential not only in creating and enhancing efficiencies but also to respond competitively to emerging market demands and public and private value-based reimbursement methodologies, the MMP may need to develop formal group-wide quality improvement programs that mandate PD physician participation. These programs could encompass peer review, utilization review, quality assurance, and the adoption of clinical performance measures and associated benchmarks. Because some MMPs may be comprised of specialty-specific PDs, the development of these quality-of-care-related protocols will probably require significant input and ongoing implementation by relevant PD physicians.

9. The MMP will perform all risk-based and fee-for-service contracting.

The PDs will transfer all authority to negotiate, execute, retain and manage all payer, e.g., health insurer, contracts to the MMP. Each PD should terminate its existing payer agreements, which the MMP will then renegotiate. For fee-for-service contracts, the MMP should develop a single fee schedule. The MMP will negotiate all payer contracts *exclusively*, which means that payers will only be able to contract with the PDs through the MMP.

10. Physicians may continue to practice in their offices.

Under the Merger Model, physicians are able to remain in, and practice at, their own offices. While merger requires the central governance of all practice business functions and operations, it does not require relocation of physician practices to centralized facilities. Although state licensure issues complicate the consolidation of practices located in different states, these practices too may consider using the Merger Model to create a fully-integrated practice.

11. Physicians may retain a significant degree of autonomy over local practice operations.

Although the MMP has overarching, group-wide governing authority, the MMP may delegate significant authority to a PD managing physician, physician group and/or office manager to enable them to oversee the day-to-day clinical and administrative operations of each satellite office. For example, each PD can have its own medical director and/or quality assurance committee to which the MMP may delegate responsibility for oversight of the PD's delivery of medical services. This delegation recognizes that local control of these operations may be preferable to management from a centralized source that may not be familiar with the particular PD's practice environment. It also recognizes that specialty and/or sub-specialty PDs may be in a much better position to monitor and control the quality of specialized medical services than a centralized body of physicians lacking the PD physicians' expertise. The MMP could also delegate day-to-day PD operations, such as patient scheduling, call scheduling and the ordering of practice supplies.

12. The Merger Model allows physicians to be rewarded for individual productivity.

Central to the success of any fully-integrated medical group is finding a compensation model that rewards individual productivity and at the same time promotes overall group performance. Unless the compensation model can achieve a balance between these two goals, it is unlikely that a fully-integrated practice organized under the Merger Model will enjoy the physician practice satisfaction enabling the longevity or stability necessary to deliver projected efficiencies and bring a beneficial consumer product to market. The following describes just a few ways in which compensation can be structured in the Merger Model.

(a) Allocating income and practice expenses

Some physicians may not be aware that there are numerous ways under the Merger Model that the MMP may reward physicians for their individual productivity and many different ways to allocate practice expenses. Although some medical groups may compensate their physicians based on a straight salary or on an equal share of the medical group's net income, these arrangements are not always necessary or appropriate. The following are just a few compensation models that can be used to reward productivity and allocate expenses under the Merger Model:

(i) Paying individual physicians a salary plus a performance bonus;[15]

(ii) Paying the individual physician his or her collections less a pro rata share of collection expenses as a percentage of his/her collections to the group's total collections,[16] less an equal share of fixed overhead costs;

(iii) Paying the individual physician his or her collections less an equal share of fixed overhead expenses less a pro rata share of collection expenses as allocated per (ii) above, less certain expenses that can be directly attributed to the physician.[17]

(iv) The Merger Model also allows the Board of the MMP to delegate control of PD physician revenue, expenses and compensation to the PD. PD physicians will still need to share responsibility for expenses incurred on the corporate level by the MMP.[18] After this

[15]There are many ways to structure this bonus. The bonus could, for example, be based on relative value units or patient encounters.

[16]For example, if, in a three-physician medical group, Physician A earned 50% of the entire practice collections and the other two physicians (Physicians B and C) accounted each for 25%, Physician A would also be allocated 50% of the group's collection expenses, with Physicians B and C each being allocated 25% of the group's collection expenses.

[17]For example, in footnote 19, the physicians would share equally all fixed overhead expenses, e.g., utility bills; Physician A would be allocated 50% of the group's collection expenses, and Physicians A, B, and C would be allocated expenses directly attributable to them, e.g., cell phone usage.

[18]These expenses will include the MMP's start-up costs and expenses incurred on a regular basis, e.g., central administrative costs, billing and collections operations, payment of medical liability insurance, accounting, legal, and other consulting and professional fees.

expense sharing, the MMP may be able allocate and distribute to each PD the remaining expenses and revenue that are directly attributable to the PD's operations.[19] Each PD may then allocate expenses and distribute income to its physicians according to a formula determined by the PD that reflects each individual PD's productivity and efficiency.

There are many other ways in which the Merger Model may structure physician compensation. The main point of highlighting the different compensation methodologies described in (i) through (iv) above is to remove any physician misperception that, by utilizing the Merger Model, physicians cannot be rewarded for their initiative or entrepreneurial spirit.

II. Collaborative integration models

A merger is not for everyone. Some physicians do not want to lose the degree of autonomy required by a merger. Other physicians do not want to contribute all of the financial and human capital needed to make a merger work. Still others may not want the level of risk created whenever a group of individual physicians combine to make a group practice. For these physicians, there is a wide range of collaborative arrangements available. Indeed, the type of collaborative arrangement a group of physicians can adopt is really a function of their creativity and understanding of what patients, employers, health insurers and other payers want.

Some physicians may develop a "joint venture" or a collaboration of actual or potential physician competitors (a "competitor collaboration") offering the advantages of substantial clinical integration and risk sharing to health insurers. Other physicians may simply want to sign a contract with a firm that acts as a messenger communicating offers to health insurers and providing some basic information services. Which of these arrangements makes sense for any individual physician depends on that physician's personal preferences and practice goals. The less integration between otherwise competing physicians, the less they can do collectively in the marketplace under the antitrust laws.

Physicians can choose from an almost infinite range of integration options. From a business perspective, the level of integration a group of physicians should adopt depends on their business goals and the types of services demanded by patients and payers. Whenever actual or potential physician competitors want to collectively negotiate fees with health insurers, they must integrate to a significant degree in order to avoid the prohibition against price-fixing contained in the antitrust laws. Put differently, if physicians do not consider it essential to collectively negotiate their fees, the level of integration they select is a business decision as to the most effective way of structuring their joint venture. However, if physicians want to collectively negotiate and set their fees, they must establish a level of integration that will take their collective action beyond the scope of the rule against price-fixing. The following section will generally describe the integration options that various physician groups have used in the past but without analyzing their antitrust ramifications. The antitrust limitations and concerns are discussed in Part III.

A. Financial integration

1. Introduction

"Financial integration" as used in this paper refers to the collective negotiation of risk-based contracts with health insurers. Typically under these arrangements, individual physicians will enter into a contract with a firm that will collectively negotiate risk-based contracts on behalf of its member physicians. Physicians may create and own the entity negotiating the risk-based contracts, join as members to a preexisting entity or simply sign participating agreements.

Under this type of arrangement, physicians are not integrating their practices as they would in a merger. Instead, physicians are authorizing a separate entity to negotiate risk-based contracts on their behalf. The risk sharing aspect of these agreements is invariably connected to a program of utilization review, practice protocols and quality benchmarks. These utilization review programs, protocols and benchmarks are created because they are essential for making risk-based contracting profitable for the entity negotiating the contracts and the participating physicians. Physicians, therefore, have a strong financial incentive to comply with the established cost and quality control measures. A well-known organizational structure through which physicians have successfully integrated financially is the independent practice association (IPA).

[19]Examples of directly attributable expenses include expenses associated with clinical and administrative support staff located at each PD practice site, the costs of the PD's supplies and PD overhead.

2. What sharing financial risk means

There is no single definition for financial risk sharing. Instead, a wide range of risk sharing methodologies is available to physicians:[20]

(a) Capitation arrangements;

(b) Percentage of premium or revenue compensation arrangements;

(c) The creation of significant financial incentives for participating physicians as a group to achieve specified cost containment goals, such as:

Withholding from all participating physicians a substantial amount of the compensation due them with distribution of that amount to the physician participants only if cost containment goals are met; or

Subjecting participating physicians to substantial financial rewards or penalties based on group performance in meeting overall cost or utilization targets for the network as a whole; and

(d) Global fee or all-inclusive case rate arrangements.

This is not an exhaustive list of risk-sharing arrangements. The Federal Trade Commission and the Department of Justice have recognized, for example, that "new types of risk-sharing arrangements may develop" and that the examples of substantial financial risk sharing previously provided do not "foreclose consideration of other arrangements through which the participants in a physician network joint venture may share substantial financial risk...."[21] Accordingly, physicians can explore new methods of sharing substantial financial risk in order to "ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition."[22] There are virtually unlimited opportunities for structuring creative risk-sharing arrangements that capitalize on physician expertise and commitment, as evidenced by the wide variety of gain-sharing arrangements in which physician groups successfully reduce hospitalization, worker absenteeism or emergency department use.

3. Benefits and drawbacks of financial risk sharing

Financial risk sharing arrangements have various benefits. First, they are well-recognized and understood by employers and health insurers. Accordingly, they are potentially easier to market than more novel methods of integration. Second, physicians sometimes have considerable discretion concerning the extent to which they enter into risk contracts. For example, although a physician may be contracted with a health maintenance organization (HMO) to receive capitated payments, the HMO contract may represent only a small portion of the physician's payer mix, which otherwise could consist primarily of fee-for-service contracts that lack any risk-sharing elements. Physicians may, therefore, be able to control to some extent the level of risk they assume and the impact risk contracting will have on their practice. Third, risk-sharing physician contracts contain terminology that is by now familiar to many physicians.

Financial risk sharing, however, has some drawbacks. First, a physician will have to keep track of the patients that are covered by the risk-sharing arrangement and have the capability of applying the cost-saving measures and utilization controls to those patients. Second, if many of the physicians involved in the risk-sharing arrangement do not follow the cost-saving measures and utilization protocols, a real risk exists that the negotiating entity will fail, and the participating physicians will lose money on the arrangement. This is a risk that even the physicians that fully comply with the cost-saving measures and utilization protocols would face.

B. Clinical integration

1. Introduction: Overview of clinical integration

In a nutshell, clinical integration arises when a group of physicians puts in place a series of procedures that modify the manner in which they provide health care services to patients and communicate with one

[20]These examples are taken from Statements of Antitrust Enforcement Policy in Health Care ("Health Care Guidelines") that were jointly issued by the Department of Justice and the Federal Trade Commission in 1996. The Statements can be viewed at *www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf*.

[21]Id. at 86-87.

[22]Id. at 88.

another. Clinical integration arrangements may offer the most efficiency in multi-specialty settings in which primary care physicians coordinate patient care with specialists and the various specialists coordinate care among themselves, and in single specialty settings in which, through closer collaboration, the group is able to provide care more efficiently. As stated by the FTC, a clinically integrated physician network creates "a degree of interaction and interdependence among the physician participants in their provision of medical services, in order to achieve jointly cost efficiencies and quality improvements in providing those services, both individually and as a group."[23]

Physicians can combine clinical integration with financial risk sharing, but this is not always necessary or appropriate. As with financial risk sharing, physicians are free to choose any level of clinical integration if they do not collectively negotiate fee-for-service contracts. If physicians want to collectively negotiate fee-for-service contracts, they will have to create a network with a significant level of clinical integration. The antitrust analysis for clinical integration models is contained in Part III below.

2. Basic elements of a clinically integrated network

There is not much written concerning pure clinical integration models. This should not be a significant impediment to creating a clinical integration template because the basic elements of a clinical integration arrangement are commonly known in the market. Further, at least three FTC advisory letters have set forth the details of some clinically integrated networks. (This paper will subsequently refer to these opinions and correspondence as "Agency guidance").[24] In 2007 alone, the FTC issued a favorable advisory opinion to the Greater Rochester Independent Practice Association (GRIPA) concerning its proposed clinical integration program and favorable follow-up correspondence to MedSouth regarding its program.[25] The importance of this Agency guidance from an antitrust perspective is addressed in Part III below. The following description of the elements of a clinically integrated network is derived primarily from Agency guidance. This Agency guidance describes steps actually taken by some physicians to clinically integrate their practices.

Overall, clinical integration involves "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[26] Some of the basic elements include: (1) mechanisms that control utilization and establish quality benchmarks; (2) practice protocols that are designed to improve care; (3) information databases and sharing treatment information in order to streamline care and lower costs; (4) selectively choosing physicians that will actively participate in the operation of the clinically integrated network, follow the practice protocols and work towards achieving the quality benchmarks; and (5) investment of the financial capital needed to create necessary infrastructure.

(a) Electronic health records and HIT generally

An effective clinical integration program will almost certainly have an integrated HIT system, which may include, but is not limited to, e-prescribing and electronic health records. A robust HIT system allows physicians to share clinical information concerning their common patients and enables physicians to collaborate in and coordinate patient care by providing immediate access to clinical and outpatient data.[27] Consequently, an integrated HIT system

[23]Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition, Federal Trade Commission, to John J. Miles, (MedSouth, Inc.) (June 18, 2007) (MedSouth II) at 2, located at *www.ftc.gov/bc/adops/070618medsouth.pdf*.

[24]Letter from Jeffrey W. Brennan, Assistant Director, Health Care Services & Products Division, Bureau of Competition, Federal Trade Commission, to John J. Miles, (MedSouth, Inc.) (February 19, 2002) (MedSouth Advisory Opinion) at *www.ftc.gov/opa/2002/02/medsouth.shtm*; Letter from David R. Pender, Acting Assistant Director, Health Care Services & Products Division, Bureau of Competition, Federal Trade Commission, to Richard A. Feinstein, (California Pacific Medical Group, Inc.) (April 5, 2005) (Brown and Toland correspondence) at *http://www.brownandtoland.com/publish/en/about/news_room/-ftc_information.-Par-0005-DownloadFile.tmp/4.5.05FTCNotice.pdf*; Letter from David R. Pender, Acting Assistant Director, Health Care Services & Products Division, Bureau of Competition, Federal Trade Commission, to Clifton E. Johnson and William H. Thompson, (Suburban Health Organization) (March 28, 2006) (SHO Advisory Opinion) at *www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaff-AdvisoryOpinion03282006.pdf*; Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition, Federal Trade Commission, to John J. Miles, (MedSouth, Inc.) (June 18, 2007) (MedSouth II) at *www.ftc.gov/bc/adops/070618medsouth.pdf*; Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition, Federal Trade Commission, to Christi J. Braun and John J. Miles, (Greater Rochester Independent Practice Association Inc.) (September 17, 2007) page 5, note 14 (GRIPA Advisory Opinion) located at *www.ftc.gov/os/closings/staff/070921finalgripamcd.pdf*.

[25]GRIPA Advisory Opinion; MedSouth II.

[26]Health Care Guidelines at 91.

[27]See e.g., MedSouth Advisory Opinion at 4; GRIPA Advisory Opinion at 5; Brown & Toland Medical Group's Second Follow-Up PPO Submission at 1 located at *www.ftc.gov/os/adjpro/d9306/index.shtm*.

is typically essential for creating a high degree of interdependence and cooperation between physicians in the network. The network should endeavor to capture as much information as practicable concerning the care provided to network patients.

Physicians may also achieve remarkable results using patient registry systems. A patient registry can generate significant practice efficiencies and therefore lower costs and improve care. Accordingly, physicians may want to use a patient registry as an initial step toward a complete transition to an integrated HIT system. The initial use of a patient registry may be particularly attractive to physicians who have not obtained sufficient capital to fund HIT implementation or who want to adopt a wait-and-see attitude concerning the success of the network.

(i) Acquiring and implementing HIT systems: financial and human capital

Acquiring and implementing an HIT system can entail a significant financial investment. One study examining the electronic health record (EHR) acquisition costs of solo and small group practices concluded, "Initial EHR costs were approximately $44,000 per FTE provider per year, and ongoing costs were about $8,500 per FTE provider per year."[28] These costs may be prohibitive for many solo and small group practices acting individually. Nevertheless, solo and small group practices may, by combining to form a clinical integrated network, create economies of scale sufficient to purchase an effective HIT system. For example, GRIPA estimated its costs to implement a Web-based clinical information management system at $7,000 per physician and estimated hardware costs at $6,000-$7,000 per physician office.[29] Although another large IPA, Brown & Toland, estimated that implementing and managing an electronic Internet-based medical records system would cost $12 million over a ten-year period, this cost was presumably allocated over the 700 physicians that would be utilizing the system.[30] Additionally, recent regulatory guidance issued by the Office of the Inspector General of the U.S. Department of Health and Human Services, the Center for Medicare and Medicaid Services, and the Internal Revenue Service now enables some third parties greater flexibility to subsidize physicians' purchase of HIT.[31]

Implementing an HIT system may also necessitate a significant contribution of human capital. Physicians and their office staff will be required to devote time to training on clinical integration program requirements and on the HIT system. GRIPA estimated that the dollar value of lost patient revenue due to time spent on such training was $3,200 per physician.[32]

(ii) Utilization of the HIT system

Based on Agency guidance, it may be useful for the network to require all participating physicians to utilize the HIT system. More specifically, the network could mandate, as a condition of initial and continuing participation, that all network physicians undergo training on HIT system use and appropriately utilize the system on an ongoing basis. To ensure required utilization, the network may want to have a mechanism in place to: (1) monitor individual physician HIT use; and (2) generate regular performance reports based in part on whether or not the physician appropriately utilized the HIT system as instructed.[33]

(b) Development of clinical performance measures and associated benchmarks

(i) The development of clinical quality and efficiency measures/reporting

[28]R.H. Miller et al., "The Value of Electronic Health Records in Solo or Small Group Practices," *Health Affairs* 24, No. 5 (2005): 1127-1137, at 1130.

[29]GRIPA Advisory Opinion at 14-15.

[30]Brown & Toland Medical Group's PPO Submission at 1, located at *www.ftc.gov/os/adjpro/d9306/-index.shtm*.

[31]See *http://oig.hhs.gov/authorities/docs/06/OIG%20E-Prescribing%20Final%20Rule%20080806.pdf* (describing new safe harbors to the federal antikickback statute for e-prescribing and electronic health records); *http://frwebgate3.access.gpo.gov/cgibin/waisgate.cgi?WAISdocID=64425227342+0+0+0&-WAISaction=retrieve* (establishing new exceptions from the Stark statute for e-prescribing and electronic health records); *http://www.irs.gov/pub/irs-tege/ehrdirective.pdf*; *http://www.irs.gov/pub/irs-tege/ehr_qa_062007.pdf* (allowing nonprofit hospitals to donate electronic health records systems without violating otherwise applicable federal tax law requirements and IRS regulations).

[32]GRIPA Advisory Opinion at 15.

[33]GRIPA Advisory Opinion at 7.

The collaborative development and implementation of evidence-based clinical performance measures and associated benchmarks is a standard element in a clinically integrated network.[34] The FTC, for example, has acknowledged that "[w]ide-spread attention has been given to the prospect that greater adherence to practice guidelines based on solid evidence can improve the quality, and in many cases reduce the cost, of medical care."[35] Performance measures and benchmarks are probably essential because the network will need to use them to evaluate whether physicians, both individually and in the aggregate, are achieving the network's quality and utilization goals. These measures can focus on processes and outcomes measures.[36] Based on Agency guidance, a network may want its measures to cover the majority of the participating physicians' patients and most of the diagnoses and conditions that are prevalent in the participating physicians' practices.[37] Participating physicians could be required to report data to the network concerning measure compliance, e.g., why in specific cases a physician determined that it was not medically appropriate to follow a performance measure.[38]

The AMA and the Physician Consortium for Performance Improvement

Physicians interested in developing a clinically integrated network may obtain evidence-based clinical performance measures on a wide range of diseases and conditions from a number of sources. One excellent source is the AMA-convened Physician Consortium for Performance Improvement® (PCPI). The PCPI is comprised of over 100 national medical specialty and state medical societies, the Council of Medical Specialty Societies, American Board of Medical Specialties and its member-boards, experts in methodology and data collection, the Agency for Healthcare Research and Quality, and the CMS. The PCPI has already developed 213 performance measures concerning 31 clinical topics that are now available for implementation.[39] A network may in some circumstances be able to supplement nationally-recognized performance measures with measures based on the unique experience of its physicians.[40]

Upfront commitment to measure compliance and implementation

Agency guidance indicates that a network may want to require, as a condition of network participation, that each physician agree to be subject to performance evaluations based on compliance with applicable clinical performance measures.[41] Upfront agreement may be crucial because measure compliance may constrain some physicians' practice patterns and ultimately lead to disciplinary action or even network expulsion for chronic noncompliance. In addition to clinical performance measures, some clinically integrated programs utilize case and disease management programs to improve the care of, and reduce expense concerning, the treatment of chronic diseases.[42]

To maximize collaboration as well as compliance, it is generally prudent for a network to involve as many network physicians as practicable in the process of implementing clinical performance measures and establishing appropriate benchmarks. Measure/benchmark collaboration can be an excellent means of fostering the interdependence and coordinated care between network physicians that is imperative for substantive, effective clinical

[34]See e.g., MedSouth Advisory Opinion at 3; MedSouth II at 3-4; Brown & Toland Medical Group's PPO Submission at 5-7 located at *www.ftc.gov/os/adjpro/d9306/-index.shtm*; GRIPA Advisory Opinion at 6-8. See also Statement 8's example of a clinically integrated network. Statement 8 at 107.

[35]MedSouth Advisory Opinion at 4.

[36]See e.g., GRIPA Advisory Opinion at 8, which provides an example of a process measure (percentage of diabetic patients receiving an eye exam") and an outcome measure ("measuring percentage of diabetic patients achieving hemoglobin A1c measures of less than seven percent").

[37]MedSouth estimated that its measures would cover 80-90% of the diagnoses that were "prevalent in its physicians' practice." MedSouth Advisory Opinion at 3.

[38]See generally GRIPA Advisory Opinion at 7; MedSouth Advisory Opinion at 3.

[39]See the PCPI's Web site at *http://www.physicianconsortium.org*.

[40]See e.g., Brown & Toland Medical Group's Follow-Up PPO Submission at 8-9 located at *www.ftc.gov/os/adjpro/d9306/-index.shtm*.

[41]See e.g., MedSouth Advisory Opinion at 3; Brown & Toland Medical Group's Follow-Up PPO Submission at 8; GRIPA Advisory Opinion at 7.

[42]See e.g., GRIPA Advisory Opinion at 6.

integration.[43] One way that the network can maximize collaboration is to establish a committee (or committees) that fairly represents network physicians to oversee all aspects of the measure implementation and benchmark development process. The network may also want to ensure that specialists or subspecialists who will be affected by a measure participate in the measure's implementation and in the development of the measure's associated benchmarks.[44] One way to ensure this specialty input is through the creation of specialty advisory committees.[45]

Upfront commitment to participation in monitoring and enforcement processes

As a condition of inclusion in the network, the network might also require its physicians to agree to contribute to oversight and operations functions on an ongoing basis. These ongoing commitments can include: reporting data to the network, collaborating with other participating physicians in providing patient care, and serving on the network's committees, including peer review, quality assurance or other committees charged with monitoring and, if necessary, enforcing compliance with clinical performance measures and other network requirements.

(ii) Tying quality and utilization benchmarks to clinical performance measures

Based on Agency guidance, a network may wish to tie its evidence-based performance measures to pre-established quality and, where appropriate, utilization benchmarks applicable to both individual physicians and to the network as a whole. For example, for each measure, the network may wish to establish a target percentage of compliance for all physicians (individually and then in the aggregate) who have patients to whom the measure applies. For example, in MedSouth, the network set an aggregate compliance rate goal of 79 percent with respect to a colon cancer screening measure (and actually achieved an 88 percent compliance rate).[46] Once the network obtains reliable information concerning the achievement of its goals, the network could make that information available to consumers and other health care service purchasers. Release of information regarding positive achievements may increase the network's stature and reputation in the market and could help make physicians individually and collectively accountable for their performance.[47]

There are a number of organizations that may provide useful benchmarks.[48] For example, MedSouth attempts to use the Healthcare Effectiveness Data and Information Set (HEDIS) goals for its benchmarks, when applicable. In cases in which no national benchmark is available, it may also be appropriate for the network to set benchmarks based on the experience of network physicians[49] or on the community performance goal set by a payer.[50] The Integrated Health Association (IHA) is an excellent source for benchmark information.[51] The FTC's follow-up correspondence to MedSouth concerning MedSouth's clinical integration program contains an informative description of how a clinically integrated network can establish and then achieve performance measure benchmarks.[52]

(iii) Publication, education, review, and modification of clinical performance measures and ongoing commitments

Once network physicians have collaboratively implemented clinical performance measures

[43]GRIPA Advisory Opinion at 6-7.

[44]See e.g., MedSouth Advisory Opinion at 3; Brown & Toland Medical Group's PPO Submission at 5; MedSouth II at 6; GRIPA Advisory Opinion at 6-9.

[45]See e.g., GRIPA Advisory Opinion at 6.

[46]MedSouth II at 5.

[47]MedSouth Advisory Opinion at 4.

[48]The GRIPA Advisory Opinion at 15-16 lists a number of governmental and private nonprofit organizations which have developed benchmarks.

[49]In the GRIPA Advisory Opinion, if no national, regional, or local benchmarks were available, then GRIPA would set its initial benchmark at the 80th percentile of current network performance. GRIPA Advisory Opinion at 8.

[50]MedSouth II at 4.

[51]See the IHA Web site located at *www.IHA.org*.

[52]MedSouth II at 5.

and their associated benchmarks, the network could publish the measures to the entire network and educate physicians whose practices will be affected by each measure. It may be prudent for a network committee to review the measures periodically to ensure that measures incorporate recent research and technological advancements. Measure review might take into account other relevant factors, e.g., whether the measure effectively modified physician behavior, whether it helped the network reach its performance goals and whether the network should modify the measure.[53] A formal process could also regularly solicit feedback from physicians to determine whether the network should revise specific measures. To solidify physician commitment to measure compliance, the network may require each physician to review and sign off on any applicable measure at its introduction and whenever the measure is subsequently modified.[54]

(iv) Monitoring individual physician and aggregate network performance

Agency guidance indicates that a network seeking to clinically integrate may want to develop a formal process or establish a committee, e.g., the Clinical Integration Committee (CIC) that: (1) monitors and evaluates individual physician compliance with the network's measures and benchmarks, (2) works with individual physicians to improve their performance, and (3) compares its physicians' aggregate performance with the measures and benchmarks to determine whether or not aggregate utilization and quality benchmarks are being achieved as expected.[55] To achieve (1) through (3), network systems may ultimately need to be able to collect accurate information concerning network physicians' practice and referral patterns. It may also be desirable for network systems to capture reasons why a physician or patient may not be following a particular measure, e.g., when not following the measure might be appropriate given unique patient characteristics, such as the possibility of an allergic reaction, lack of insurance coverage or religious considerations.

To support the ongoing monitoring process, it may be useful for the network's information systems to be able to generate regular reports concerning individual and aggregate physician measure compliance rates. These reports could be made available to the CIC or other committee that is performing the network's monitoring function, as well as to individual physicians.[56] These reports may enable physicians to monitor their own compliance as well as their peers' compliance via the monitoring committee. These reports can include the following types of information: (1) the physician's compliance rate under each applicable measure, (2) a comparison of the physician compliance rate with the rate of the prior evaluation period, (3) a cumulative compliance rate for each measure that is applicable to the individual physician, (4) the average compliance rate for all physicians to whom each measure applies, and (5) a network-wide performance report.[57]

Obviously, the monitoring and evaluation process must be fair. Ensuring the accuracy of practice information that the monitoring and evaluation processes receive is essential because the network will use that information to determine measure effectiveness and whether modification is appropriate.[58] Accuracy is also essential because the information will be used to evaluate all physicians' performance, and the receipt of financial rewards or network discipline may hinge on the results of that evaluation. The monitoring and evaluation process should also include a mechanism through which affected physicians may provide feedback concerning evaluative reports and enable reports to be corrected, if necessary, based on that feedback.

If in the course of the monitoring/evaluation process, the network is not achieving some of its benchmarks, then the CIC or other responsible

[53]See MedSouth Advisory Opinion at 3.

[54]See e.g., MedSouth II at 4.

[55]See e.g., the Agencies' example of a successful clinically integrated network in the Health Care Guidelines at 107.

[56]In GRIPA there reports were provided on a quarterly basis. GRIPA Advisory Opinion at page 9.

[57]See GRIPA Advisory Opinion at 9.

[58]MedSouth II at 3.

committee may want to investigate the root cause of the deficiency and develop a documented rectification strategy, which may include: (1) general network education, (2) convening with affected specialties to determine whether physician practice patterns need to be changed or whether patient education or intervention is necessary, (3) revising the measures, (4) reevaluating benchmarks, (5) creating medical-management programs to work with physicians and their patients, (6) developing corrective action plans for physicians who are not following measures as appropriate, or (7) working with payers to identify other ways to improve network performance.[59]

(v) Monitoring patient compliance with physician recommendations and care plans

Patients who do not follow physicians' recommendations can significantly hinder the network's ability to achieve its benchmarks and negatively reflect on physician measure compliance. A network may want to monitor reports in order to be able to differentiate between appropriate and inappropriate reasons that physicians or patients may not have followed applicable measures so that physicians are not penalized unnecessarily. If inappropriate patient deviation from measures is an issue, patient education may be desirable.[60]

(c) Compliance enforcement and rewards

Agency guidance indicates that the network may want to have a standing committee and formal process in place that will educate, counsel, more closely monitor, or impose corrective action or behavior modification on noncompliant physicians. If necessary, the network must be prepared to expel chronically noncompliant physicians.

An inability to consistently enforce the clinical integration program's requirements will ultimately compromise the network's ability to generate expected quality improvements and efficiencies, resulting in the program's failure. Yet some network physicians may find the prospect of imposing discipline unpleasant. Imposing discipline for noncompliance may be the most significant obstacle to creating and maintaining a clinically integrated network. Participating physicians must, therefore, be prepared to play an active role in enforcing network requirements. Accordingly, the network may wish to require each physician to agree, as a condition of participation, to be subject to the network's educational and disciplinary processes and to participate in the peer review and enforcement processes at the network's request.[61] For example, in GRIPA all participating physicians were required, if selected by lot, to participate on the network's Quality Assurance Council, which was responsible for reviewing measure compliance and for implementing decisions regarding physician discipline and sanctions.[62] Depending on the circumstances, networks may also consider the use of external decision makers for significant disciplinary matters to eliminate claims of improper bias.

A network's ability to financially reward participating physicians may be essential for the network's long term success. Networks can reward physicians individually and/or in the aggregate through a wide array of options, e.g., based on individual or aggregate physician compliance with clinical performance measures or on the aggregate achievement of particular quality or utilization benchmarks. Reward mechanisms may also be utilized within the context of payer quality-incentive reimbursement programs, e.g., pay-for-performance mechanisms. For example, in MedSouth, performing physicians were able to realize fee increases over the last three years in conjunction with pay-for-performance programs.[63] GRIPA also plans to pursue pay-for-performance and gain-sharing arrangements with payers that could result in further financial rewards.[64] GRIPA also represented to the FTC that, through its clinical integration program, it would be seeking and expecting to receive higher physician reimbursement rates from payers.[65]

[59]See GRIPA Advisory Opinion at 9.

[60]Id.

[61]GRIPA Advisory Opinion at 7; see also MedSouth Advisory Opinion at 3.

[62]GRIPA Advisory Opinion at 15.

[63]MedSouth II at 4.

[64]GRIPA Advisory Opinion at 9.

[65]GRIPA Advisory Opinion at 26.

(d) Selectively choosing network physicians who are likely to further the network's efficiency objectives

One indication of an effective clinical integration program is the network's selectively choosing, both initially and on an ongoing basis, network physicians who are likely to further the network's efficiency objectives.[66] Selectivity evidences the commitment to the network's quality and utilization goals that is essential if the clinically integrated program is to achieve significant efficiencies.[67]

Selectivity means that the network ultimately only includes those physicians who are committed to the clinical integration program's goals *and* who agree to be subject to the network's requirements. One suggested way of implementing and documenting selectivity is to require as a condition of network membership that a participating physician sign a written agreement wherein the physician acknowledges that the physician: (1) has received information concerning the network's requirements; (2) will be subject to the network's data collection, monitoring, referral, practice modification and disciplinary requirements; and (3) will participate in the network's peer review and enforcement committees and processes when asked.[68]

Selectivity may also be an ongoing, not just an initial, aspect of an effective clinically integrated network. As the network implements its requirements, physicians who initially sought network membership may decide that they do not want to be subject to the network's participation obligations. MedSouth appears to have experienced this ongoing selectivity. After noting that since 2002 MedSouth's clinical integration program had witnessed a reduction of PCP and specialist participation, the FTC stated "The reduced number of physicians participating in the program since MedSouth's inception may well be indicative that a program of clinical integration requires a very serious commitment and effort by physicians…as well as the physicians' weighing of the economic costs and benefits of participating in such a program."[69]

(e) Network size and scope

Physicians interested in forming a clinically integrated network may want to consider structuring the network around primary care physicians and the medical specialists with whom they have established professional relationships. For example, MedSouth's clinical integration program included specialists to whom MedSouth's PCPs most frequently referred. MedSouth estimated that its member specialists accounted for 90 percent to 95 percent of the PCPs' specialty referrals, although the specialists also received large numbers of referrals from sources outside of MedSouth's clinical integration program. GRIPA appears to have followed a similar approach; it estimated that 93 percent of referrals occurred within the clinically integrated network.[70] In GRIPA the network physicians also agreed to refer patients to other GRIPA network physicians, "except in unusual circumstances."[71] The FTC has indicated that an in-network referral requirement is likely to foster efficiencies because it: (1) helps assure that the network's patients will receive care under the oversight of the network's performance measures and other quality improvement mechanisms and (2) facilitates the network's ability to capture more information regarding patient care and network physician performance.[72]

(f) A market must exist for the clinically integrated network's services.

Physicians should engage in careful business planning when thinking about whether or not to create or participate in a clinically integrated physician network. One key component of the planning

[66]Health Care Guidelines at 91; MedSouth II at 3.

[67]GRIPA Advisory Opinion at 13-14.

[68]See e.g., MedSouth Advisory Opinion at 3.

[69]MedSouth II at 8.

[70]MedSouth Advisory Opinion at 2; GRIPA Advisory Opinion at 5 note 13.

[71]GRIPA Advisory Opinion at 5, 13. The AMA has policy concerning out-of-network referrals. For example, H-285.914 Patient Access to Specialty Care in Managed Care Systems states in part "Our AMA: (1) will take all appropriate action to require all health plans or sponsors of such plans that restrict a patient's choice of physicians, hospitals, or surgical pathology and cytopathology services, to offer, at the time of enrollment and at least for a continuous one-month period annually thereafter, an optional and affordable 'point-of-service-type' feature so that patients who choose such plans may elect to self-refer to physicians, hospitals, or surgical pathology and cytopathology services outside of the plan at additional cost to themselves."

[72]Id.

process is determining whether a market for the potential network's services exists. Otherwise, physicians may spend significant human and financial capital on a product in a market lacking the level of demand necessary for long term success.

Consequently, physicians thinking about developing a clinically integrated network must do so within the context of ongoing and transparent discussions with employers and other purchasers of health care services, including health insurers and other payers. These discussions will be crucial for success—not only will they help determine whether a market for a clinically integrated product exists; the discussions will also ensure that any clinically integrated product can be structured to match the unique needs of the local health care market. These unique needs may include quality and physician performance initiatives of interest to employers and health insurers, e.g., pay-for-performance programs.

Because a clinically integrated network must be developed within the context of discussions with health care purchasers, clinical integration should not be conceived as a means primarily of collectively negotiating price-related terms with health insurers. Rather, physicians should regard clinical integration as a means by which they may proactively position themselves to improve patient care and anticipate changes in public and commercial reimbursement mechanisms, as well as strengthening their economic position, reputation and value in the market.

III. Antitrust issues

A. The Sherman and Clayton Acts: A general overview

The antitrust laws are built upon a number of federal laws that prohibit a wide range of anticompetitive conduct. While these laws are expressed in very general terms, they are supplemented by a significant body of case law and by actions taken by the federal agencies responsible for the public enforcement of the antitrust laws. In the case of physician mergers and integration efforts, the primary antitrust laws that physicians must consider are Section 1 of the Sherman Act and Section 7 of the Clayton Act.[73]

1. Section 7 of the Clayton Act

Section 7 of the Clayton Act ("Section 7") prohibits mergers that may substantially lessen competition. An analysis under Section 7 asks whether a merger will result in such a concentration of economic power in the hands of the merged entity that the new entity could exert market power. "Market power" is commonly understood to mean the ability by a firm to raise price above the competitive level or to reduce output below the competitive level.

Case law and the federal antitrust enforcement agencies recognize that it is difficult, if not impossible, in most situations to directly measure market power. Given this practical difficulty, market power is typically evaluated indirectly. This indirect evaluation requires identification of the markets in which the merged entity operates. Then, the merged entity's share of those markets is calculated. With respect to physician practices, market share is commonly calculated by comparing the number of physicians in any given specialty working for the merged entity with the total number of physicians in those specialties who are located in the relevant geographic market. The market share of the merged entity is used as a proxy for market power. How high a market share is needed to create a presumption of market power is a complex issue that depends on many different factors. The issue of market power and its relation to market share is addressed below in Section B(4).

2. Section 1 of the Sherman Act

Section 1 prohibits concerted conduct between individual competitors that unreasonably restrains trade. The first and most basic question in any Section 1 analysis is whether the conduct is concerted (i.e., contracts, combinations or conspiracies) or unilateral. Without this distinction, Section 1 would conceivably outlaw every corporation, partnership and independent firm that assembles employees that could have competed against one another. The fact that every individual firm must set its own prices does not turn these firms into price-fixing conspiracies.[74] Instead, the antitrust laws recognize that the marshalling of economic resources and actors is oftentimes essential to the efficient provision of goods and services. For

[73]There are other antitrust laws that may have relevance to the creation and subsequent operation of a merged entity and integrated physician network. This Guidance is not intended to provide a comprehensive analysis of all of the antitrust laws or all of the antitrust ramifications that are raised by the creation and operation of a merged entity or integrated physician network.

[74]*Texaco Inc. v. Dagher*, 547 U.S. 1, 8 (2006).

example, Boeing Corporation hires engineers who could theoretically compete against one another and against Boeing Corporation, and to that extent Boeing is a combination of numerous competitors. It is absurd to think, however, that Boeing Corporation violates Section 1 of the Sherman Act when it sets its own prices and decides how much to produce.

The antitrust laws do not have special rules for physicians. Physicians can lawfully create firms by merging their practices. *If physicians properly merge their practices, they will not violate Section 1 when this new merged firm sets prices on behalf of the firm's physicians.*

If individual physicians engage in any collaborative activity short of a full merger to sell their services or to pursue other objectives, then the antitrust inquiry becomes whether this concerted conduct unreasonably restrains trade. The word "unreasonable" is critical because the courts recognized shortly after the enactment of the Sherman Act that some level of cooperation between competitors is oftentimes essential to consumer welfare. Generally speaking, the antitrust laws only condemn those restraints that injure consumers.[75] The Supreme Court has explained that the proper focus of antitrust inquiry is "whether the effect . . . of the practice is to threaten the proper operation of our predominantly free market economy—that is, whether the practice facially appears to be one that would . . . tend to restrict competition and decrease output, and in what portion of the market, or instead one designed to 'increase economic efficiency and render markets more rather than less competitive.'"[76]

Arrangements between competitors can enhance efficiency and benefit consumers. The struggle with respect to the enforcement of the antitrust laws is distinguishing concerted conduct that benefits consumers by creating efficiencies and is procompetitive from concerted conduct that harms consumer welfare and is therefore anticompetitive.

The per se test

As the antitrust laws evolved, the courts created two basic tests for distinguishing procompetitive from anticompetitive conduct. One test is the application of the so-called per se prohibitions. The *per se* prohibitions are based on the belief that certain types of behavior are so blatantly anticompetitive that any consideration into their possible procompetitive effects is unnecessary. Accordingly, an arrangement falling under a *per se* prohibition is condemned as "unreasonable" without conducting any analysis into whether the concerted conduct actually has any effect (positive or negative) on competition or consumers. The traditional *per se* offences include price-fixing, market allocation agreements, customer allocation agreements, certain group boycotts and some tying arrangements. With respect to *per se* unlawful price-fixing, for example, the only issue is whether a price-fixing agreement exists. Whether the price-fixing arrangement can benefit consumers or creates efficiencies is not a question a court or an enforcement agency will consider. Relatedly, a court will not determine if the price-fixing agreement actually harmed consumers.

A benefit provided by the use of *per se* prohibitions is that the *per se* prohibitions define with a high degree of clarity the types of concerted conduct in which competitors cannot engage. This clarity, however, comes with some costs. For example, *per se* prohibitions may outlaw arrangements that are procompetitive and will benefit consumers.

The rule of reason test

The second test is the so-called rule of reason. Under the traditional rule of reason test, a court was required to determine whether the restraint was, on balance, anticompetitive. Thus, a court needed to determine whether the concerted conduct was anticompetitive and then determine whether procompetitive benefits also existed. Many types of concerted activity were lawful under the rule of reason because a threshold showing for any liability was the existence of market power. This reflects the recognition by the courts that firms or individuals engaged in concerted conduct could not harm competition if they lacked market power. Put differently, without market power the concerted conduct could not harm consumers by harming competition.

This traditional dichotomy between the *per se* rule and rule of reason underwent considerable modification over the last 20 years. Driving this change was the

[75]See e.g., *Reiter v. Sonotone Corp.*, 442 U.S. 330 (1979).

[76]Broadcast Music Inc. v. Columbia Broadcasting Systems, Inc. (ASCAP), 441 U.S. 1, 19-20 (1979).

recognition that a broad interpretation of the *per se* prohibitions would prevent the development of many collaborative undertakings that could create significant benefits for consumers and actually make markets more competitive. This did not mean, for example, that blatant or "naked" price-fixing arrangements were thought to have procompetitive possibilities. What was recognized is that an otherwise lawful joint venture or collaborative undertaking may need a price-fixing component in order to operate efficiently. Condemning the price-fixing component without giving any thought to the efficiencies the venture or collaboration could create would prevent the realization of those efficiencies and stands the antitrust laws on their head. This concern has resulted in the steady erosion of the *per se* prohibitions and their limitation to the most blatant types of anticompetitive conduct. The result is that concerted conduct that was once considered *per se* unlawful is now analyzed under the rule of reason.

These changes, however, have also changed the rule of reason. Today, the first question under the rule of reason is whether the arrangement raises obvious antitrust concerns or has a component that raises an obvious antitrust concern. A good rule of thumb is that a form of concerted conduct similar to an arrangement that traditionally fell under a *per se* prohibition will raise antitrust concerns. For example, a joint venture between a group of physicians that, among many other things, negotiates prices with payers for its members will raise an antitrust issue. The joint negotiation of fees embedded in the arrangement is a form of price-fixing. If the arrangement does raise a price-fixing concern, the issue becomes whether the participants can show that the venture has real and substantial procompetitive benefits. They must also show that the price-fixing component is "reasonably related" to the procompetitive benefits and "reasonably necessary" to the realization of these procompetitive benefits. Suspect arrangements that are not tied in this manner to a procompetitive efficiency are considered unlawful. When this connection does exist, the analysis will look to whether the arrangement gives the participants in the collaborative activity market power. A collaborative endeavor that gives its participants the ability to exert market power will raise serious antitrust risks. Without market power, however, it is unlikely that the arrangement could harm competition or consumers, and is therefore unlikely to raise antitrust problems.

3. The enforcement of the antitrust laws

The single largest source of antitrust enforcement comes from the private sector. The antitrust laws authorize the commencement of private lawsuits for antitrust violations by those persons or entities injured by the unlawful conduct. To give added incentives for private antitrust lawsuits, a successful antitrust plaintiff is entitled to treble damages and the payment of its attorneys' fees by the defendant[s]. Private parties also are oftentimes responsible for reporting possible antitrust violations to the federal enforcement agencies.

The Federal Trade Commission (FTC) and the United States Department of Justice, Antitrust Division (Antitrust Division) (collectively referred to as the "Agencies"), also play a significant role in the enforcement of the antitrust laws. The Agencies have the ability to investigate possible antitrust violations and commence enforcement proceedings. The Department of Justice can also criminally prosecute blatant *per se* violations of Section 1 of the Sherman Act. The FTC and Antitrust Division, however, do much more than investigate antitrust violations and commence lawsuits. These Agencies provide advisory letters to firms concerned about the possible antitrust ramifications of a proposed collaborative arrangement. These advisory letters are published and provide insight into how the Agencies will evaluate various arrangements. These advisory letters, however, are not binding on a court and therefore have limited value when defending a civil lawsuit. The FTC and Antitrust Division have also issued various guidelines explaining how they will apply the antitrust laws in various settings. The most important guidelines for physicians are the Health Care Guidelines and the Antitrust Guidelines for Collaborations Among Competitors (1999) ("Collaboration Guidelines"). Finally, the FTC and Antitrust Division publish speeches given by their top personnel that provide some additional guidance as to how certain arrangements are viewed.

B. Physician collaborative arrangements

When independent physicians pool resources in order to engage in a common endeavor and the physicians are actual or potential competitors, they are engaged in what may be characterized as a "competitor collaboration" or "joint venture." Such joint ventures may involve the formation of a new legal entity or simply be a contractual arrangement for pooling resources, sharing risks and/or clinically integrating their professional activities. Such

collaborative arrangements are subject to review under Section 1 of the Sherman Act, as well as Section 7 of the Clayton Act (under certain circumstances). If these collaborating physicians want to collectively negotiate fees with payers through the venture, a significant antitrust issue is raised.

In order to avoid liability under Section 1 of the Sherman Act for price fixing, the threshold issue is whether the physician competitors have sufficiently integrated their economic resources and whether the price-fixing component to their venture is "reasonably related" and "reasonably necessary" to the creation of the efficiencies promised by the venture.

Simply characterizing a new legal entity comprised of potential or actual physician competitors as a joint venture will not save it from condemnation, if it does not provide the appropriate efficiencies. A good example can be found in the FTC enforcement action of *In the Matter of Surgical Specialists of Yakima,* P.L.L.C. (SSY).[77] In this action, competing physician practices created a legally separate and distinct limited liability corporation. The FTC alleged that while SSY was characterized as an *integrated* single entity, the physician practices members of SSY: (1) were separate and independent from SSY in all material respects, (2) were not subject to the control of SSY, (3) did not unify their economic interests and incentives through SSY, and (4) were not significantly integrated (either clinically or financially). The FTC accused SSY of fixing prices for its members by jointly negotiating non-risk contracts, because SSY's negotiating fees on behalf of its members constituted the combined action of those members and not unilateral action by SSY.

Many physician joint ventures, e.g., IPAs, do much more than simply negotiate contracts for their physicians. They may engage in significant risk sharing or create clinical programs designed to improve the level of care they provide. Such efforts vary considerably, and the relevant antitrust question is whether these integration efforts make the joint negotiation of fees reasonable under Section 1 of the Sherman Act. As discussed below and consistent with the antitrust laws being a "consumer welfare prescription," the antitrust inquiry must determine whether these efforts are likely to achieve significant efficiencies.

1. The Messenger Model

Physicians are interested in negotiating favorable pricing terms with health insurers or other payers. However, when competing physicians (or their firms) try to collectively negotiate price, they confront the rule against price-fixing. Two traditional ways for physician groups to overcome the rule against price-fixing have been to employ a pure "messenger model" or to financially integrate.

The messenger model is described in the Health Care Guidelines.[78] The messenger model allows independent physicians to jointly market themselves as a network. In contrast to a joint negotiation, the messenger model is a process whereby physicians use a common messenger to convey information on fees and fee-related terms that an individual physician is willing to accept. This is done by having a messenger manage a process whereby each of the physicians in the network arrive at individual agreements with the payer. It is not a process for joint negotiations of fees.

In the "messenger model" process, each physician (or physician group) independently communicates to the messenger the fee range the physician is willing to accept. The messenger then aggregates the information obtained from each physician. The messenger generally develops a schedule that shows the percentage of physicians would accept offers at various fee levels. However, the messenger may not share this information with any of the physicians.

After aggregating the data, the messenger presents the schedule to payers. Any payer may then make an offer to the physicians in the network. The messenger may accept the offer on behalf of any physician who has given the messenger authority to accept offers within the fee range specified by the physician. The messenger must forward any offer that is not within the fee range authorized by a physician to that physician for acceptance or rejection. After establishing whether a physician will accept the offer, the messenger then communicates the physician's decision to the payer.

The messenger may not engage in any negotiations with the payer on behalf of physicians involved in the messenger model process. The messenger may not advise physicians concerning whether to accept

[77]See *http://www.ftc.gov/os/caselist/0210242.shtm*.

[78]See Health Care Guidelines at pages 125-127.

the offer or not. Independent physicians utilizing the messenger model process may not communicate with each other about whether to accept a given offer or not. The messenger may also not, directly or indirectly, lead or facilitate a boycott of a payer that is designed to influence the terms of the payer's offer. In short, the messenger model process does not allow self-employed physicians the ability to collectively negotiate fees with health plans or otherwise agree on what fee schedule they collectively will accept. (The messenger may, however, provide objective information to physicians in the network about a contract offer made by a payer, such as the meaning of terms and how the offer compares to offers made by other payers).

Physicians utilizing the messenger model process should ensure that the process comports with the requirements specified in the Health Care Guidelines and other sources of Agency guidance concerning the messenger model process. The Agencies consistently assert allegations of price fixing and other antitrust violations against alleged misuse of the messenger model process.[79]

In some circumstances, the messenger model may be a very useful tool for physicians. An excellent example is Bay Area Preferred Physicians (BAPP), an organization that, as a result of sophisticated computer programs, has functioned as a very efficient "messenger."[80] BAPP is sponsored by eight California county medical associations, and its governing board of directors is comprised of two physicians from each of those associations. BAPP reviews, analyzes and executes PPO agreements on behalf of physician members. Prior to operating, BAPP sought an advisory opinion from the FTC concerning its proposed messenger model. As proposed, a non-physician employee of BAPP would act as a messenger to convey payer offers to participating physician members and to communicate to payers which BAPP physician members would accept the payer's offer. BAPP would execute and administer a contract if 50 percent or more of its physicians were willing to accept a particular payer's offer. Alternatively, a payer whose offer was not accepted by 50 percent of the physicians could elect to approach physicians directly to negotiate individual contracts. In that case, BAPP would provide the payer with the names of the physicians who were willing to accept the contract offer. In response, the FTC issued a favorable advisory opinion stating that "In the context of BAPP's entire proposed operation as you described it to us and as we analyze it above, it appears unlikely that the [50 percent] rule's implementation would reveal information that could be used strategically for anticompetitive purposes."[81]

2. Financial integration

When otherwise competing physicians financially integrate, there are associated efficiencies that can benefit consumers. Recognizing this consumer benefit, the antitrust laws allow physicians engaging in a proper level of financial integration to jointly negotiate fees without violating the rule against price fixing. The Health Care Guidelines emphasize that the common feature underlying financial integration is the sharing of substantial financial risk. It is believed that this risk sharing provides strong incentives for physicians to practice efficiently by cooperating in the controlling of costs and in improving quality.[82] The sharing of financial risk also makes it necessary for the physicians sharing the risks to jointly negotiate the fees they received under the risk-based contracts. It is critical, however, that physicians recognize that their sharing risks with respect to risk-based contracts will not justify the joint negotiation of other non-risk contracts.

There are many ways in which physician practices can financially integrate that will place the joint negotiation of fees into the rule of reason and then allow them to demonstrate that the joint negotiation of fees is reasonable. The Health Care Guidelines provide a nonexclusive list of the assorted arrangements that constitute "risk sharing." These arrangements include: (1) capitated rate arrangements in the health insurer or other payer pays the network a fixed "predetermined payment per covered life . . . in exchange for the joint venture's (not merely an individual physician's) providing and guaranteeing provision of a defined set of covered services . . . ," and (2) risk pools, which are described as the "withholding from all physician participants in the

[79]*See e.g., In the Matter of Health Care Alliance of Laredo, L.C.* (where a Texas IPA entered into a consent agreement with the FTC pursuant to FTC allegations that the IPA improperly used a messenger model to negotiate physician contracts). The consent decree can be accessed at *http://www.ftc.gov/opa/2006/02/laredo.shtm*.

[80]The BAPP website is located at *http://www.bapp.bz/*.

[81]The FTC advisory opinion can be viewed at *http://www.ftc.gov/bc/adops/bapp030923.shtm*.

[82]Health Care Guidelines at 72.

network a substantial amount of the compensation due to them, with distribution of the amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole . . . ."[83]

A capitated payment arrangement creates risk for the network and its physicians because the network must provide the covered services for a fixed rate. If the network does not institute utilization controls and treatment protocols designed to keep costs down, the network and the participating physicians will lose money. This provides strong incentives for the network to institute and for the physicians to follow such controls and protocols. This will have the potential of lowering prices and make the network more competitive.

Risk pools are another common method used by physician networks to create financial risks and rewards that have the benefit of increasing efficiency. If the physician network withholds a significant portion of the funds received under fee-for-service arrangements and pays its participating physicians a discounted fee, the potential distribution of withheld funds creates an incentive to follow efficiency protocols created by the network. No magic number exists for the size of the risk pool. FTC advisory letters suggest that a 15 percent withhold may not be sufficient[84] to justify the joint negotiation of contracts, while a pool within a 15 to 20 percent range might be sufficient.[85] The size of the necessary withhold depends on the nature of the venture and its importance to the participating physicians. For example, the size of the necessary withhold can depend on the number of patients the participating physicians expect to receive under the contract subject to the risk pool.

3. Clinical integration

The FTC has more recently recognized that the consumer welfare enhancing integration that necessitates joint negotiations with payers need not be limited to financial integration. Instead, clinical integration may suffice. This type of integration, like the internal arrangements of any firm, should improve organization and coordination of work and obtain the benefits of division of labor. The FTC requires integration that contains an "active and ongoing program to evaluate and modify practice patterns by the group's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[86] The Health Care Guidelines suggest that among the ways a network can satisfy the clinical integration standard is by establishing utilization control mechanisms, selectively choosing group physicians, and investing significant capital both monetary and human to realize efficiencies.[87] Moreover, the network will have to demonstrate that the "prices to be charged for the integrated provision of services are reasonably necessary to the venture's achievement of efficiencies…."[88]

In the absence of financial incentives that will encourage the achievement of efficiencies, the FTC demands a level of clinical integration that compels the participating physicians to act in an interdependent manner. The FTC has strongly stated in advisory letters that a clinical integration program must have some teeth. Specifically, the program must have the ability and the will to adopt and implement clinical performance measures and measurable performance goals that the physician firm enforces by disciplining or terminating physicians who do not adhere to its standards.[89] These integration steps must create a level of interdependence between the participating physicians that makes the joint negotiation of fees "reasonably necessary" to the proper functioning of the venture.

The FTC in advisory letters has described the sort of clinical integration that enables a physician network to negotiate fees without the negotiation violating the rule against price-fixing. For example, in its review of MedSouth, a multispecialty physician practice association in Denver, Colorado, the FTC concluded that MedSouth produced through its

[83]Id at 68-69.

[84]Letter from FTC to Paul W. McVay, President, ACMG, Inc. (July 5, 1994), available at *www.ftc.gov/bc/adops/007.shtm*.

[85]Letter from FTC to David v. Meany, Esq., on behalf of Yellowstone Physicians, L.L.C. (May 14, 1997), available at *www.ftc.gov/bc/adops/yelltone.shtm*.

[86]Health Care Guidelines at 90-91.

[87]Id. at 91.

[88]Id.

[89]Compare the MedSouth Advisory Opinion with the SHO Advisory Opinion.

clinical integration program sufficient interdependence between its physicians to justify the joint negotiation of fees. MedSouth's extensive clinical program included a Web-based electronic clinical data record system that allowed its physicians to access and share medical information, including transcribed patient records, office visit notes, lab reports and similar clinical information. Also important was MedSouth's plan to adopt and implement clinical performance measures and performance goals and to monitor and enforce physician compliance with those goals and measures.[90]

There is no modern case law that addresses the analysis of clinical integration under the antitrust laws. At the moment, the primary source of guidance comes from FTC advisory letters, speeches by FTC commissioners and the Health Care Guidelines. Whether the currently existing advisory letters represent a floor concerning the level of integration necessary for joint negotiations remains to be seen. Nevertheless, Agency guidance provides some positive precedent that physicians can look to in determining whether embarking on a clinically integrated collaborative project makes sense for them in their local health care market.

4. Market power and ancillary restraints

As explained above, the prohibition against price-fixing raises a structural issue for physicians that they can overcome with proper financial risk sharing or clinical integration. Once the structural issue is resolved, the next issue under the rule of reason is whether the venture will have market power.

The market power inquiry directly addresses the question whether the physician venture actually has the ability to injure competition and consumers by, for example, forcing fee increases upon payers or preventing the formation of rival physician networks. A venture's ability to increase the fees received by its physicians should be based on its providing an overall better product that consumers want and are willing to purchase at a higher price.

A critical step in any market power analysis is calculating the venture's market shares in the relevant markets for antitrust purposes. The first step in calculating a venture's market share[s] involves identifying the markets in which that venture operates. These markets, however, may not be the same types of markets that are commonly referred to in business planning. A relevant market for antitrust purposes is based on a specialized analysis developed to meet the purposes and goals established by the antitrust laws. Accordingly, it is important that physicians contact antitrust counsel concerning this issue and not rely exclusively on the markets identified in their business plans.

Under the antitrust laws, a "market" consists of what are called the relevant product market and the relevant geographic market. A relevant product market is defined by identifying the products or services provided by the venture and then identifying the reasonable substitutes for those products and services. With respect to physicians, relevant product markets are typically based on specialty or type of practice. For example, patients cannot substitute cardiac services if they have a problem with their eyes. Accordingly, ophthalmic services and cardiac services will typically represent separate product markets. The relevant product market[s] in any given situation will depend on the unique facts and structure of the physician network. Most physician ventures will involve many different relevant product markets.

After the relevant product markets are identified, the next step is identifying the relevant geographic market for those products or services. A relevant geographic market is the area in which consumers can reasonably obtain the relevant products or services. For example, if a physician venture operates in county A, the relevant geographic market will include county A. The issue then becomes whether consumers in county A can reasonably obtain competing services outside county A. Defining a relevant geographic market is a fact intensive process that will turn on many different factors. For example, geographic markets can vary in size based on the product or service at issue. The size and shape of a geographic market is also influenced by geography.

Once the product and geographic markets are established, market shares are calculated. With respect to physician ventures, market shares are typically based on the number of physicians that provide the relevant services in the geographic market. For example, if a venture has 10 urologists, and there are 50 urologists practicing in the geographic market, the venture will have a 20 percent market share in urology services.

[90]Other examples are the GRIPA Advisory Opinion and the Brown and Toland correspondence. The FTC approval of the GRIPA network was based on the following clinical integration features: (1) systems and programs to improve quality and efficiency, (2) selective participation of network physicians in the proposed program, (3) physician investment of monetary and human capital in the proposed program, and (4) measurement and evaluation of performance results.

While a high market share does not necessarily mean that a physician venture has market power, a low market share will prevent a finding of market power.

Related to the issue of market power is the nature of the relationship between the venture and the participating physicians. Some ventures will not act as the exclusive negotiating agent for the participating physicians. Under this type of arrangement, the physicians are free to enter into contracts with payers through other ventures or individually. Market share figures will oftentimes provide a poor estimation of market power when a venture is a non-exclusive negotiating agent for the participating physicians.

Some physicians may determine that the economic structure of their venture requires exclusivity with respect to the negotiation of provider contracts with payers. An exclusive bargaining arrangement between the venture and its participating physicians is not *per se* unlawful. Exclusive arrangements are common throughout the economy and typically create efficiencies. For this reason, exclusive dealing arrangements are evaluated under the rule of reason, and an antitrust plaintiff or a government agency must show that the exclusive arrangement forecloses a significant share of the market from other competitors or consumers. Such a demonstration requires proof that the entity involved in the exclusive arrangement has market power.

Market shares become much more significant when a physician venture is the exclusive negotiating agent for its participating physicians. Under the Health Care Guidelines, an exclusive venture with more than a 20 percent market share will fall outside the so-called antitrust safety zone.[91] It is important to understand, however, the limited nature of the "safety zone." A venture's having a market share above the safety zone does not mean that the venture has market power. The safety zones express the FTC and Antitrust Division's judgment that a venture with a market share falling within the safety zone cannot have market power. Ventures having market shares above the safety zone will not necessarily raise antitrust problems. Some courts, for example, have stated that market shares up to 30 percent cannot, as a matter of law, support a finding of market power.[92] Whether a market share raises a market power issue is an issue a physician venture should discuss with antitrust counsel.

Moreover, even if the exclusive network were found to possess some degree of market power, an antitrust tribunal may nevertheless conclude that, on balance, the exclusive arrangement did not unreasonably restrain trade. For example, without exclusivity, physicians might not invest in a joint venture by coordinating their work, purchase expensive technologies, pool knowledge by educating each other on best practices, or engage in forms of practice supervision to advance patient care. Concerns about "free-riding" and externalities may make it impossible for the venture to have even initial success. For example, when individual members can exploit the superior skills they acquire inside the joint venture by entering into their own deals with payers at prices lower than the joint venture's prices, a free rider problem arises. This "free rider" problem can create incentives for other physicians in the network to "do the same thing" before they are left with nothing. This race to the bottom can doom even the most promising venture. The free rider problem is well-recognized in economics, by the FTC and the courts. It is also well-recognized that exclusive dealing arrangements are a common method of preventing free riding.

Conclusion

This Guidance describes some integration methodologies that physician practices may consider if they are seeking new ways of creating a more efficient and value-added means of delivering health care. Depending on local circumstances, these models may be available to solo and small group practices. These models may be of interest to independent practice associations that are considering ways to increase their efficiencies by further integration. These models may also be open to larger group practices. Although particular antitrust analyses will vary depending on the facts and circumstances of particular practice environments, the experience of existing physician practices, guidance from the Agencies and legal authority indicate that the integrative models described in this Guidance may in some circumstances enable physicians to: (1) jointly negotiate lawfully fee-for-service contracts with third-party payers and (2) foster the development of efficiencies that will be highly valued in the rapidly evolving health care delivery market.

[91]Health Care Guidelines at 80.

[92]See Id. at 79-87.

Exhibit A
Evaluating affiliation options

Assessing the other entity

Compatibility

1. Shared interests and goals
2. Compatible culture, management philosophy, mission and ethical directives or standards
3. Ability to manage change
4. Articulation of a coordinated strategic plan providing mutual advantage
5. Degree of current interdependence
6. Shared clinical expertise and priorities

Financial strength

1. Capital to fund growth, facility expansion and information systems
2. Financial stability (debt/equity ratio)
3. Access to capital
4. Market share/service and geographic coverage/ potential for growth
5. Profit margins/fixed expense levels/efficiency of service
6. Capacity to assume risk

Management strength

1. Expertise in marketing, office operations, billing and collections
2. Procurement advantage
3. Expertise on information systems
4. Managed care contracting/capitation contract expertise
5. Access to managed care payers
6. Expertise in site selection and outpatient service development
7. Expanded referral base
8. Ability to recruit and retain primary care physicians and need specialists
9. Clinical reputation and expertise
10. Ability to satisfy regulatory, licensing and reimbursement criteria
11. Expertise in other ancillary services (e.g., behavioral health, outpatient services)
12. Demonstrated ability to package and price comprehensive benefit package, including outpatient services

Assessing the combined entity

Perceived synergies

1. Potential expense savings for lower unit costs, more efficient utilization and economies of scale
2. Revenue enhancement
3. Market share expansion
4. New products/services
5. Greater utilization of existing facility
6. Avoidance of learning curve expense
7. Greater ability to assume risk and provide a broad array of service

Other considerations

1. Other up-front benefits (e.g., access to new software, purchasing efficiencies and reimbursement expertise)
2. Access to better liability insurance coverage and reinsurance
3. Effect on current referral sources/access to practice sites
4. Licensing, certificate of need and other regulatory issues
5. Antitrust, Medicare, fraud and abuse, private inurement and corporate practice of medicine restrictions
6. Ability to retain/necessity to fire key employees
7. Effect on existing contracts
8. Costs of integration (consultant fees, lease buy-out, severance, etc.)

Assessing the deal terms

Financial issues

1. Valuation of practice assets and intangibles, including effect of not-for-profit as opposed to for-profit status of other entity
2. Percentage participation in profits from professional fees
3. Participation in total enterprise profits and/or cost savings
4. Allocation of managed care contract revenues
5. Upside and downside risk allocation (e.g., salary guarantees, bonus formulas, etc.)
6. Effect of legal restrictions on physician ownership and referral

Governance issues

1. Allocation of clinical/administrative decisions (e.g., selection of hospital, admission and length-of-stay decisions; participation in central appointment scheduling; etc.)
2. Management strength
3. Degree of physician input/control over profitability and compensation (e.g., setting office visit fees, etc.)
4. Retained autonomy by physicians and/or other institutions relative to other business decisions
5. Control over contracting, purchasing, technical personnel, scope of service and other affiliations
6. Control over managed care contracting, selection, pricing and other terms (including provider eligibility, selection and utilization criteria)
7. Limits on and rights to participate in other affiliations

Other terms

1. Physician control over practice efficiencies
2. Historic relationship
3. Willingness to assume risk
4. Noncompete covenants and dissolution terms
5. Tax and retirement considerations

Exhibit B
Community physician organization: Business plan outline

I. Executive summary

a. Brief description of objectives and business opportunity
b. Company capability/services description
c. Quantification of financial requirements, sources and uses of proceeds
d. Description of organizational and management structure
e. Summary of market competition
f. Identification of earnings, projections and potential return

II. Business objectives and opportunity

a. To develop a physician-controlled organization capable of assuming capitated risk and demonstrating quality outcomes to employers, insurers and other payers
b. To create efficiencies in health care delivery through limiting participation to quality providers whose participation would be attractive to plan beneficiaries
c. To assure a continuum of quality care over hospital, outpatient, physician office and home health settings
d. To identify appropriate interventions for high-risk patients at early stages through improved preventive, diagnostic, treatment and rehabilitation services
e. To rely upon and utilize the professional judgment of physicians to serve the health needs of the individual patient and through education, peer review and other techniques to assure quality and cost-effective care

III. Description/capabilities/services

a. Network description
- Listing of physician providers via selection criteria, geographic coverage, specialties and hospital affiliations
- Identification of hospital and other facilities contracting with the physician organizations
- Identification of management information systems and other methods of addressing effectiveness, patient access and claims management
- Description of unique attributes to success

b. Service description
- Managed care products
- Claims administration
- Utilization and peer review
- Identification of services provided through subcontracts and affiliations with other health providers
- Availability of reinsurance

c. Operations description
- Explanation of physician organization's mechanism for administering managed care contracts
- Procedures by which physician organization educates, motivates and manages the physicians, including the establishment of protocols
- Management incentives for use of treatment protocols and for cost effective and quality of care
- Use of gatekeepers, inpatient specialists and other treatment protocols for the management of patient care
- Identification of areas in which physician autonomy produces savings and clinically appropriate care

d. Revenue sources

- Practice revenues
- Key managed care contracts/key employer contracts
- Facility revenues
- Employer programs
- Management service organization and other service income

IV. Quantification of financial needs

a. The organization requires capital to integrate information systems and to build and create a provider network capable of meeting the above objectives
b. As set forth in the projections, the organization needs to develop an administrative infra-structure capable of implementing quality assurance and peer review functions
c. The organization needs capital to purchase an existing managed care entity with whom a substantial number of its physicians are within the provider network
d. The sources and uses of funds

V. Management and organizational structure

a. Form of entity
b. Equity ownership and governance structure
c. Identification of board members and qualifications
d. Resumes and backgrounds of administrators

VI. Market analysis

a. Identification of existing HMO, PPO and other health networks in the market place and a summary of their products
b. A description of the trends relative to managed care products
c. Identification of Medicare/Medicaid managed care initiatives
d. Identification of target market
e. Listing of competing providers
f. Assessment of physician organization's position in the market of terms of market share, quality, geographic coverage, and other indicators of sustainability and long term viability

VII. Marketing strategy

a. Strategy which permits physician organization to be price competitive, to differentiate itself and otherwise have a sustainable market share
b. Identification of provider relations and methods for preserving same
c. Listing of specific pricing policies of practice (i.e., discount or premium pricing based upon market strategy)
d. Covered lives
e. Marketing method (preexisting contracts, perspective contracts, other programs)

VIII. Financial

a. History of the entity or predecessor entity
b. Financial projection for three to five years (first year by month and second year by quarters and later years annually)
c. Identification of key assumptions and explanations of projections
d. Listing of key business ratios (debt to equity, cash flow and income to senior debt interest and to senior debt service, net worth, current assets to current liabilities ratio, return on invested asset, return on equity, etc.)
e. Description of sources and uses of funds
f. Illustrative example of return to investors, including description of exit strategies (such as recapitalization, sale of enterprise, eliminated paydown of debt from cash flow or other)

Appendix A

Physician networks and antitrust: A call for a more flexible enforcement policy

The American Medical Association with Sidley Austin LLP

June 2008

I. Introduction

Over the last thirty years, antitrust enforcement in health care has been a major priority of federal antitrust authorities. Both antitrust Agencies—the Federal Trade Commission (FTC) and the Department of Justice (DOJ)—have devoted considerable resources to actions involving health care services. Within health care, no group has received greater attention from the Agencies than physicians.

We believe that changes in health care markets warrant a shift in focus. When the Agencies charted their current course, payers did relatively little to manage the cost or volume of services provided. Today the landscape is far different. Governmental and private payers take a much more active role in regulating the price and volume of physician services. Further, consolidation among private payers has resulted in more powerful health insurers and a substantial reduction in physician autonomy. These forces reduce both the practical and the economic risks of joint activity among physicians.

Equally important, professional, market and regulatory developments are encouraging physicians to collaborate in new ways. In particular, the federal government is encouraging physicians and other providers to invest in health information technology ("HIT") to facilitate the collection and sharing of clinical data. HIT "has the potential to significantly increase the efficiency of the health sector" and to "improve the quality of care." [1]

However, the adoption of HIT requires a level of physician investment and network integration that pose significant barriers to implementation. At the same time, the emergence of new reimbursement mechanisms such as "pay for performance"— i.e., paying physicians in part based on their ability to meet or exceed quality or other performance benchmarks—place a premium on physicians' ability to collect and utilize HIT. For physicians, who still practice predominantly in small groups, network arrangements provide one way of achieving the economies of scale necessary to participate in these initiatives.

Despite these developments, enforcement policy—embodied today in the *Statements of Enforcement Policy in Health Care* developed jointly by the FTC and the DOJ during the 1990s—still casts a suspicious eye on physician collaboration through network arrangements. The AMA submits that the *Statements of Enforcement Policy* go too far in deterring the formation and operation of legitimate physician networks. Joint contracting arrangements that are ancillary to the implementation of HIT or to the participation in innovative payment arrangements among other physician collaborations on quality improvement, ordinarily create plausible efficiencies and should not face summary condemnation. Accordingly, the AMA proposes a modification of the existing standards to reflect changes in the health care market and to provide greater flexibility for physicians to engage in procompetitive joint arrangements.

This paper begins by describing changes in the health care market since the Agencies adopted their current enforcement policy relating to physician networks. It then describes the *Statements* and considers whether antitrust law leaves room for a change in policy. Finally, the paper describes a more flexible approach based on the rule of reason.

II. Changes in the health care marketplace

Since the *Statements of Enforcement Policy* were last revised in 1996, health care market conditions have changed in significant ways. The principal changes include (a) increasing health insurer consolidation and market power; (b) a retreat from financial risk-sharing between health insurers and physicians; and (c) the emergence of HIT and new payment methodologies.

A. Health insurer monopsony power

The Agencies adopted the *Statements of Enforcement Policy* shortly before a tidal wave of mergers swept through the health insurance industry. In the last decade, dozens of major health insurer mergers have resulted in an increasingly consolidated payer market. Premiums have steadily increased, even as patient co-pays and deductibles have expanded, effectively shrinking the scope of coverage. As a result of these mergers, health insurance markets throughout the country are at levels of concentration associated with monopsony power.

The AMA's most recent study of the health insurance industry shows that 96% (or 299 of 313) of the metropolitan statistical areas ('"MSAs") analyzed by the AMA, are controlled by a single insurer with a combined HMO/PPO market share of 30% or more.[2] The report further shows that 64% (or 200 of 313) of the MSAs were controlled by a single insurer with a combined HMO/PPO market share of 50% or greater.[3] In addition, 96% of the MSAs studied by the AMA are considered highly concentrated (with a Herfindahl-Hirschman Index above 1,800) under the Agencies' Horizontal Merger Guidelines.[4] The AMA's "study shows unequivocally that physicians across the country have virtually no bargaining power with dominant health insurers and that those health insurers are in a position to exert monopsony power."[5] Put another way, if physicians were to refuse the terms of the dominant health insurer, they would likely suffer an irrecoverable loss of revenue. Consequently, physicians can be forced to accept inadequate reimbursement rates likely to lead to a reduction in the supply of physician services—despite the demand for such services by patients. Indeed, recent projections by the Health Resources and Services Administration suggest a looming shortage of physicians in the United States.[6]

It is a mistake to assume that, when insurers push down the cost of physician services, their interests are perfectly aligned with those of consumers.[7] Health insurers who exercise monopsony power by driving physician fees below the competitive level may cause patients to receive an inadequate level of service and quality.[8] Also, because health insurer monopsonists typically are also monopolists, lower input prices (for physician services) do not lead to lower consumer output prices (for health care premiums).[9] Indeed, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers.[10] Although compensation to physicians has been reduced, health insurance premiums have continued to increase rapidly.

In this environment, one of the key concerns historically animating antitrust enforcement policy in health care—preventing physicians' collective resistance to the entry of managed care—has only marginal relevance. Between the statutorily-fixed prices of Medicare and Medicaid in the governmental sector, and the negotiating leverage of private health plans that dominate commercial markets, there is only a narrow slice of the market left that is even theoretically vulnerable to a physician-orchestrated conspiracy.

B. Retreat from risk-sharing

In 1996, when the *Statements of Antitrust Enforcement Policy* were adopted, managed care was in its ascendancy. Many in health care expected to see continued growth in HMOs and other forms of risk sharing. Today, by contrast, employers and other purchasers of health care coverage have largely rejected payer-provider risk-sharing arrangements.[11] Many IPAs that previously attempted to share financial risk experienced significant financial losses and ceased offering the model.[12] Consumers also resisted arrangements that placed physicians at financial risk. Contrary to early predictions, in most areas of the country physician capitation proved to be an unpopular and highly controversial payment methodology. Employers wanted broad networks that allowed patients a significant choice among physicians, but without any perceived incentives to ration care.

C. The emergence of HIT and new payment methodologies

One of the more significant and promising developments in the health care market since the promulgation of the *Statements* in the mid-90s is the emergence of HIT. HIT has the potential, if adopted widely and used effectively, to save the health care sector about $80 billion annually (in 2005 dollars).[13] At the same time, by making it possible for physicians to collect and analyze vast numbers of patient encounters, HIT promises to drive advancements in medical science and clinical practice.

Notwithstanding the tremendous promise of HIT, its adoption has lagged.[14] To date, only 14% of physicians have minimally functional EMR systems.[15] Solo or single partner practices, accounting for about half of all doctors, had the lowest level of comprehensive EMR use—7.1% of solo practitioners, 9.7% of those with a partner.[16] The Congressional Budget Office (CBO) attributes this disappointing response to challenges in implementing HIT systems and to physician inability to achieve

financial returns from HIT sufficient to offset its daunting implementation costs.[17] Most of the benefits of HIT—such as less duplication of diagnostic tests or increased availability of patient data—accrue to health insurance companies or patients rather than to the physicians who incur the costs of implementation. This lack of symmetry leads the CBO to conclude that "[h]ow well HIT lives up to its potential depends in part on how effectively financial incentives can be realigned to encourage the optimal use of the technology's capabilities."[18] Network arrangements provide one way for physicians in small practices both to spread the costs of HIT implementation and to internalize the potential gains from enhanced efficiency.

Closely linked to the adoption of HIT is the emergence of a new payment methodology known as "pay for performance" ("P4P"). The core purpose of P4P is to provide financial incentives for physicians to meet pre-established performance benchmarks. While P4P is in its infancy and has raised a host of methodological concerns – including errors in data used, over-reliance on cost measures, and lack of transparency and physician input in performance metrics – it is "now routinely used by both private and public payers in the U.S. health care system."[19] A majority of commercial HMOs use P4P, and the Center for Medicare and Medicaid Services has been directed by Congress to adopt value-based purchasing.[20] P4P depends upon accurate and medically appropriate performance measurement, which in turn depends upon HIT. If the adoption of P4P spreads and its use expands, physicians in small practices will face yet another force driving them into "integrated care networks that [will] allow the physicians to more seamlessly coordinate care."[21]

III. Current enforcement policy

A. The statements of enforcement policy in health care

The initial version of the Statements was released in September, 1993. Issued in response to calls from the American Medical Association, the American Hospital Association, and other leading health care organizations, the Statements reflected a significant effort to provide heightened clarity to medical professionals and companies. The Statements articulated in a clear, accessible format policies that had emerged previously only in advisory letters, speeches, and consent decrees.

1. Financial integration

As originally issued, the Statements contained eight separate policy statements. Statement 8, entitled "Physician Network Joint Ventures," identified two features of particular importance to the antitrust analysis of physician networks: (1) the size of the network, in terms of participating physicians, as a measure of potential market power; and (2) whether the physicians had integrated their practices by sharing "substantial financial risk." The AMA's focus is on the latter requirement.

As set forth in the initial version of the Statements, physicians in a contracting network could share "substantial financial risk" in either of two ways: (1) by accepting "capitated" or "per-member per-month" payments; or (2) by incentivizing physicians to contain costs through the use of a substantial withhold from payments. With capitation or substantial withholds in place, the network would be deemed to have sufficient financial incentive to enhance efficiencies. Otherwise, without such financial integration, a physician network that engaged in joint price negotiations with health insurers would be summarily condemned as a *per se* illegal price-fixing agreement.

The concept of integration as an antitrust guidepost did not originate in the Statements. Rather, antitrust law has long sought to distinguish between mere cartels and legitimate joint ventures. "Integration" is used as shorthand to describe attributes that make a joint arrangement sufficiently likely to generate efficiency that application of the rule of reason is appropriate. What was distinctive in the Agencies' approach was the suggestion that, in the specific context of physician contracting networks, only the sharing of "substantial financial risk" would suffice to allow the network to escape application of the *per se* rule. Other forms of integration—structural, functional, or transactional—would not carry the day.

With the rapid decline of risk sharing arrangements since the Statements' inception, the requirement of financial risk-sharing as the defining feature of a legitimate physician network proved unduly restrictive.

2. Clinical integration

In the 1996 version of the Statements, the Agencies recognized a second type of integration that could qualify a physician network for rule of reason treatment. "Clinical integration," as defined in the Statements, is

evidenced "by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and to create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[22] Clinical integration as so defined represented a sort of "as if" standard: A physician network that acted "as if" its members shared financial risk—by instituting the types of cost containment techniques that would necessarily be in place for a capitated group – might qualify for rule of reason treatment despite the absence of "substantial financial risk."

For several years following the publication of the 1996 Statements, the Agencies gave no further guidance on the meaning of clinical integration. In 2002, however, the Commission issued a staff advisory letter to MedSouth, Inc., an IPA based in Denver, Colorado with over 400 physicians.[23] And in 2007, the Commission issued a staff advisory letter to the Greater Rochester Independent Practice Association, Inc. (GRIPA), a network based in Rochester, New York with over 600 physician members.[24] The MedSouth and GRIPA letters demonstrate how high the bar has been set for physician networks seeking to qualify for rule of reason treatment through clinical integration.

While the MedSouth and GRIPA arrangements are not identical, they bear significant similarities. Notably, both networks were originally built for capitation, but needed to be re-tooled in the face of market resistance. Thus, both MedSouth and GRIPA were constructed "as if" the physicians would be sharing substantial financial risk. Only when risk contracting proved to be commercially infeasible did the networks seek Commission approval for their programs of clinical integration.

In addition, both MedSouth and GRIPA made significant investments in capital and resources, using a cadre of consultants and technology experts to assist in the effort. Both networks invested in electronic medical records and tracking technology to share information on their patients and to monitor data relating to utilization and medical outcomes. And both networks developed clinical practice guidelines and procedures for monitoring compliance with them. In both instances, the Commission advisory letters noted no apparent anticompetitive motivation for the physicians' efforts.

Despite these features, neither MedSouth nor GRIPA achieved agency approval easily or without significant caveats. Both letters reflected intensive Commission investigation of the networks' histories, purposes, contracting mechanisms, disciplinary methods for non-compliant physicians, and strategies for producing efficiencies. Each involved a searching examination of the so-called "ancillarity" of the networks' pricing mechanisms to their efficiency-enhancing potential. Each left the Commission plenty of room to bring a later enforcement action if the networks' operations could not later be shown to produce significant efficiencies.

Interestingly, however, both MedSouth and GRIPA included a structural feature which might have persuaded the Commission to forego such probing examination. Both networks were "non-exclusive" in the sense that members were permitted to, and did, participate in other contracting networks. The Statements make clear that whether a network is judged to be "non-exclusive" depends on the "physician participants' activities, and not simply by the terms of the contractual relationship."[25] In both MedSouth and GRIPA, the Commission was persuaded that the network was designed to be truly non-exclusive. In practical terms, this meant that any payer that did not wish to support the physicians' experiment in clinical integration could simply walk away, without losing access to any desirable physicians who belonged to the network.

Without the ability to force any payer to accept its terms, it is difficult to see how either network could have an anticompetitive effect—even if it were not particularly adept at generating efficiency. Indeed, the Commission appeared to recognize as much when it stated in *GRIPA*:

> [I]t appears that, if GRIPA in fact operates as it has proposed, Rochester-area payers unwilling for whatever reason to negotiate and contract jointly with physicians through GRIPA nevertheless should be able to deal individually or through other networks in order to obtain the services of GRIPA's member physicians. Under these conditions, it appears unlikely that GRIPA's program would permit it or its physician members to exercise market power or have anticompetitive effects in the market for physician services in the Rochester area.[26]

If a non-exclusive network has no discernible mechanism by which to restrain trade, why require it to adopt all the bells and whistles of clinical integration in order to escape summary condemnation? Why not let it sink or swim in the market? One answer may be that the law simply does not leave room for such ventures. The AMA addresses that issue below.

B. Does antitrust law leave room for greater flexibility in the concept of integration?

As their name attests, the Statements of Antitrust Enforcement Policy in Health Care represent enforcement policy rather than law. As such, the Statements do not necessarily stand at the outer boundaries of what antitrust law permits. Indeed, the AMA submits that the Statements impose restrictions tighter than required by either the law itself or by sound enforcement policy in the current market environment.

Outside the health care context, courts and the Agencies themselves apply a more flexible analysis than is found in the *Statements*. For example, in the Agencies' guidelines on competitor collaboration, the Agencies make no mention of financial or clinical integration. Instead, the *Competitor Collaboration Guidelines* ask more generally whether a joint venture involves "an efficiency-enhancing integration of economic activity" and whether any restraints are "reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits."[27] The Supreme Court, too, in its joint venture cases has eschewed any fixed formulation of what may constitute integration sufficient to warrant rule of reason treatment.

The Agencies' approach to integration has its origins in the Supreme Court's decision in *Arizona v. Maricopa County Medical Society*.[28] *Maricopa* involved physician foundations in Phoenix and Tucson, Arizona. Both foundations included a large number of the physicians in the community; the Maricopa County foundation included over 70% of the county's physicians. And both foundations established maximum fee schedules that were voted on and approved by their memberships. In a 4-3 decision, the Supreme Court held that these maximum fee schedules represented *per se* unlawful price-fixing agreements.

In so holding, the Court distinguished the foundations from "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit."[29] The physicians in the foundations did not put up capital; they did not accept capitation, but instead billed on a fee-for-service basis. Nor did the Court observe any other indicia of integration among the physician practices that comprised the foundations. By contrast, Justice Powell and the two justices who joined his dissent reasoned that the foundations were comparable to the joint licensing arrangements held subject to the rule of reason rather than the *per se* rule in *Broadcast Music Inc. v. CBS*.[30]

Since *Maricopa* was decided, the Agencies have struggled to determine its proper scope. Read for all its worth, *Maricopa* might be said to prohibit any fee-for-service contracting by a physician-sponsored network. But the Agencies have not read the decision this broadly, and for good reasons. *Maricopa* was decided by a closely divided Court and is in significant tension with other Supreme Court cases holding joint arrangements to be subject to the rule of reason.[31] Indeed, the strictest reading of *Maricopa* might prohibit even the robust programs of clinical integration considered in *MedSouth* and *GRIPA*.

Further, the principal issue before the Court in *Maricopa* was whether maximum price-fixing should be treated differently under Section 1 of the Sherman Act from minimum price-fixing. In upholding the application of the *per se* rule to both forms, the Court had no need to—and did not—consider the potential efficiencies of joint contracting. Nor did the Court consider whether the foundations' fee schedules had any actual harmful effect on competition.

In addition, *Maricopa* was decided in 1982, at the dawn of health care antitrust enforcement—only a few years after the Supreme Court held in *Goldfarb v. Virginia State Bar* that professions were subject to the antitrust laws.[32] Nothing in the decision suggests that it was intended to provide the final word on whether and under what conditions physician networks might qualify for rule of reason treatment. If anything, the decision can be criticized as a rush to judgment on a relatively new business form with which the judiciary lacked the experience usually considered necessary before a practice is deemed *per se* unlawful.[33]

Finally, the Supreme Court has long recognized that "the boundaries of the doctrine of *per se* illegality should not be immovable."[34] This principle applies to the antitrust Agencies as well as courts. Indeed, it is the Agencies that have often led the way toward judicial abrogation of *per se* rules when "the economic realities underlying earlier decisions have changed."[35] For all these reasons, *Maricopa* should not be viewed as posing an obstacle to a more accommodating enforcement policy for physician networks.[36]

IV. A reconsideration of existing policy

This section describes a more flexible approach to analyzing the activities of physician networks engaged in joint contracting. It begins by describing the potential efficiencies of joint contracting by a physician network. It then considers whether joint pricing is "reasonably necessary" to the attainment of these efficiencies. Finally, it applies the rule of reason to the network's activities.

A. Efficiencies in physician network contracting

The Agencies have long been skeptical of the potential for efficiencies in joint contracting by a physician network. In *GRIPA,* the Commission compared the transactional efficiencies of network contracting to those offered by a mere cartel.[37] The AMA believes the Agencies have been too dismissive. While the efficiencies offered by joint contracting in a physician network may not always be sufficient to warrant a favorable outcome under the rule of reason, these efficiencies should almost invariably be enough to avoid application of the *per se* rule. In the current environment, this is particularly true of networks formed to facilitate joint investment in and use of HIT.

Joint contracting by physicians in a network can result in significant cost savings both for payers and for physicians. On the payer side, joint contracting can make it possible for a payer to obtain ready access to a panel of physicians offering broad geographic and specialty coverage.[38] Because physicians still practice predominantly in solo practice or in small groups, creating a physician panel can be a very time-consuming and expensive task for a payer seeking to enter or expand its place in a market. In its complaint in *United States v. Aetna*, the Justice Department noted that "effective new entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years and costs approximately $50,000,000."[39] When the initial task of network formation is undertaken by the physicians themselves, the costs of entry and expansion for payers may be substantially reduced. Joint contracting thus has the potential both to reduce costs for payers and to increase competition in payer markets. These are cognizable efficiencies, with real potential to lower premiums and expand coverage for purchasers. Any doubt concerning the intrinsic efficiency of physician networks is eliminated by the thriving rental network business that has emerged to service the needs of self-insured employers and even national insurers with inadequate directly contracted networks.

Joint contracting can also make physician contracting more efficient and lead to better informed contract decisions. Most physician practices are simply too small to afford to hire businesspersons and lawyers to review their contracts with payers. Such practices do not have the resources to analyze complex contracts. Whereas payers have sophisticated actuarial and financial resources that enable them to structure and evaluate complex contract proposals, physicians are often in the dark when they consider a contract. By pooling their resources, physicians can spread the costs associated with the analysis of payer contracts, and develop appropriate counter-offers that can benefit physicians, payers, and patients. The effect is to enhance the efficiency of the physicians' practices and make them more responsive to the demands of competition.

Likewise, joint contracting makes it much more practical for physicians to create a network that will facilitate collaboration on information technology, data collection, and other programs designed to monitor patient care and improve quality. Indeed, joint contracting is essential for those physicians in small or solo practices who wish to participate in performance-based payment initiatives. P4P initiatives are often specifically targeted at medical groups or networks rather than small practices. As a Commonwealth Fund study on P4P recently noted:

> Smaller groups generally have few incentives for care coordination, as they usually do not receive payment beyond the evaluation and management fees they are able to bill for acute visits. However, by banding together under the umbrella of organizations, and becoming eligible for performance payments through [the Medicare P4P Demonstration Project] or similar incentive programs, they have more motivation and support for care coordination.[40]

Under existing enforcement policy, however, physicians in small practices must either lose out on such programs or take the risk that their venture will fall short of the Agencies' notions of clinical or financial integration.

B. Is joint contracting "reasonably necessary" to the attainment of efficiencies?

For a joint venture to qualify for rule of reason treatment under the antitrust laws, it is not enough that the venture generate efficiencies. In addition, to the extent that the venture involves agreements on price, such agreements must be "reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits."[41] This requirement that price restraints be

"ancillary" to the procompetitive features of a joint venture is well established in the *Statements* and in case law.[42] We think that, in the context of a physician network engaged in the acquisition and deployment of HIT, this requirement is readily met.

The Commission gave the issue of so-called "ancillarity" extensive consideration in its advisory letters to *MedSouth* and *GRIPA*. In the end, the Commission found that joint negotiation of network contracts was ancillary to the networks' procompetitive purposes. For example, in *GRIPA*, the network asserted that it could establish an effective program of care coordination among its members only if all physicians were contractually bound at the same time. Achieving this goal required that the physicians be represented jointly rather than individually in contract negotiations with payers. As the Commission stated:

> Identifying up front a set network of physicians, all of whom will participate in all aspects of the program of integration regarding all patients covered under all GRIPA contracts, on its face appears calculated to assure that those efforts will have maximum application and efficacy. And this can only be achieved if GRIPA jointly negotiates the contracts with payers on behalf of all of its physician members.[43]

In reaching this conclusion, the Commission considered the proposition that, because some programs promoting clinical coordination and quality improvement are initiated and administered by payers, a physician-sponsored program cannot "ever be 'reasonably necessary' to achieving the efficiencies of clinically integrated programs."[44] The Commission properly rejected this conclusion. The standard for "ancillarity," after all, is one of *reasonable* necessity, not absolute necessity. It does not mandate a "one-size-fits-all" solution. As the Commission recognized, "[d]ifferent types of programs may have different strengths and weaknesses, and the market should determine which programs are most desirable." Moreover, "the competitive restraints that may accompany integrated physician-initiated network programs must be evaluated for their reasonable necessity in the context in which they occur."[45]

The same reasoning should apply generally to physician networks that acquire and use HIT to collect medical data regarding the physicians' collective performance and use it to enhance quality. Joint contracting is reasonably necessary to the efficiencies created by an HIT-driven network for several reasons. First, as in *GRIPA*, the network may need an up-front commitment from its physicians to participate in all contracts negotiated by the network in order to ensure the integrity of the network's program of data collection and analysis. Without such a commitment, the network cannot know in advance how many physicians will participate, and therefore cannot effectively determine the degree to which the efficiencies of its quality improvement program will be realized.

Second, joint contracting makes it much more practical for physicians to make investments in HIT to monitor patient care and improve quality. HIT systems require considerable investments in time and money. As noted in a recent Congressional Budget Office report, acquiring an office-based HIT system costs between $25,000 and $45,000 per physician, with an additional recurring cost of 12 to 20 percent of that amount in annual operating and maintenance expenses.[46] In addition to these out-of-pocket costs, physicians must also "devote considerable time to training, to personalizing the system, and to adapting their work processes to achieve the maximum benefits."[47]

Physicians cannot be expected to bear such costs without a reasonable prospect of making a return on investment.[48] Yet, as the CBO report notes, from the perspective of a small physician practice, most of the benefits of HIT accrue to payers and other third parties. For example, information technology systems may reduce the frequency of primary and specialty physicians ordering the same test. Although physicians are committed to increasing the quality of care and reducing unnecessary care, neither primary care physicians nor specialists reap an economic advantage by eliminating this duplication. Network formation provides a method for physicians to deal with this "externality"—i.e., to internalize the gains of HIT while spreading its costs, which in turn makes it more likely that physicians will invest in HIT. If in this process the network were to charge higher unit prices than individual members, there remains the potential for overall savings to consumers. As the Commission recognized in GRIPA:

> Higher unit prices may be of little concern to a customer if they occur within integrated programs that result in lower total costs (e.g., through elimination of unnecessary and inappropriate utilization of services) and higher quality (e.g., better medical outcomes).

GRIPA, at 27.

Third, joint contracting addresses a potential "hold out" problem faced by networks that develop HIT. As

documented in the CBO report, HIT is characterized by network effects: Some of its benefits increase in value as more providers purchase and use interoperable systems. Accordingly, physicians may wish to postpone the commitment decision until more of their colleagues have purchased systems, allowing them to benefit from others' experience. More importantly, many physicians may decide it is better to wait and see if the organization succeeds than to join it up front. To solve this hold out problem, the HIT network needs the up-front commitment of its physicians to participate in network contracts. This commitment makes it more likely that the HIT network will achieve the necessary critical mass to achieve efficiencies. Potential hold outs who are not willing to make that commitment risk exclusion from the network's contracts.

Because network joint contracting is reasonably necessary to achieving the efficiencies associated with the adoption and implementation of HIT, networks involved in the use of HIT should generally be accorded rule of reason treatment. The required nexus between joint pricing and the potential for efficiency is even more evident when the adoption of HIT is linked to alternative payment mechanisms. For example, in the context of P4P initiatives, most solo or small physician practices lack the scale to participate. By teaming up with other practices in a network, small practices may gain the scale necessary both for care coordination and for the aggregation of data necessary to implementation of performance-based incentives. Accordingly, negotiation by a network of performance-based incentives tied to the achievement of specified quality goals by the network's members should be treated as "ancillary" to the network's procompetitive purposes.

3. Application of the rule of reason

Once the efficiencies of joint contracting are recognized both as non-trivial and as "ancillary" to a network's procompetitive purposes, the rule of reason provides the appropriate analytical approach for balancing those efficiencies against the potential for harm to competition. In the case of a non-exclusive network—one that does not prohibit its members, in law or in fact, from contracting with payers apart from the network—the potential harm to competition is minimal. As explained above, without the ability to force a payer to do business with the network, the physicians have no mechanism for forcing up fees.[49] Non-exclusive networks therefore should generally be found lawful under the rule of reason, without the need for extensive analysis.

Exclusive physician networks may require a more searching examination under the rule of reason. A critical consideration at the outset is the percentage of physicians in the geographic market who participate in the venture. If a large percentage of the available physicians participate in an exclusive network, the network may have the potential to exercise market power.[50] In that event, it then becomes appropriate to look at the competitive effects. Among the potential procompetitive effects, exclusivity may reflect the physicians' enhanced commitment to working together in the network to achieve efficiencies. Without exclusivity, physicians might not invest in a joint venture by coordinating their work, purchase expensive technologies like HIT, pool knowledge by educating each other on best practices, or engage in forms of practice supervision to advance patient care. Concerns about externalities—that are acute in the context of HIT—may make it impossible for the network to have initial success. In addition, exclusivity may help address physician concerns that some members will "free ride" on the network's efforts by using the jointly-developed HIT to strike their own separate deals with payers. It is well-recognized that exclusive dealing arrangements are a common method of preventing free riding.[51]

In the analysis of an exclusive physician network possessing high market shares and engaged in the acquisition and use of HIT, additional considerations under the rule of reason may include:

- How much capital and time have the physicians invested in the acquisition, operation, and maintenance of HIT?
- How effectively is the network using HIT to collect and analyze medical data?
- To what extent is the network able to document cost savings and improvements in quality resulting from the use of HIT?
- To what extent has the use of HIT enabled the network to participate in performance-based payment or other alternative forms of reimbursement?

As is always the case under the rule of reason, these considerations should be carefully examined to determine whether the network's procompetitive benefits outweigh its anticompetitive effects. The fundamental point, however, is that competitive harm should not merely be presumed, but should be determined based upon a full consideration of the record.

V. Conclusion

Price-fixing is, and of course should continue to be, treated as the most serious form of antitrust offense. However, the Statements overestimate the anticompetitive potential that networks lacking market power have on the ability to restrain trade. Arrangements that create plausible efficiencies while posing little risk of anticompetitive injury should not face summary condemnation.

Also, antitrust enforcement policy must adjust to market developments. Presently, however, the Statements impede the ability of physician networks to achieve plausible efficiencies through joint contracting on a basis that would allow for the implementation of HIT and the participation in P4P and other quality initiatives.

Accordingly, the AMA proposes the following modifications of the existing Statements to reflect changes in the health care market and antitrust law and to provide greater flexibility for physicians to engage in procompetitive joint arrangements.

1. Physician networks supported by plausible efficiencies should not face summary condemnation under the *per se* rule or the "inherently suspect" standard. The Agencies should explicitly recognize that joint contracting is ordinarily reasonably necessary to the attainment of the plausible efficiencies associated with implementing HIT or participating in P4P, among other physician collaborations on quality improvement.

2. Non-exclusive physician networks—those in which the physicians are genuinely available to contract with payers separately from the network—should almost always be found lawful under the rule of reason.

3. Exclusive physician networks should be evaluated under the rule of reason. Absent proof of market power or actual anticompetitive effects, such networks should be found lawful. If an exclusive network is shown to have market power or to result in anticompetitive effects, the network should be viewed under a full rule of reason analysis that balances the anticompetitive effects against efficiencies created by the exclusive network. Among the expected benefits of exclusivity that the Agencies should explicitly recognize are the elimination of free riding and the removal of obstacles to the acquisition and implementation of HIT.

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[1] Congressional Budget Office, "Evidence on the Costs and Benefits of Health Information Technology," (May 2008) (hereinafter "*CBO Report*"), at 1.

[2] American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2007) at 5, available at http:www.ama-assn.org/ama/pub/category/9573.html.

[3] *Id.*

[4] *Id.*

[5] *Id.* at 2.

[6] *See* Health Resources and Services Administration, *Physician Supply and Demand: Projections to 2020* (Oct 2006) (projecting a shortfall of approximately 55,000 physicians in 2020); *see also* Merritt, Hawkins, et al., *Will the Last Physician in America Please Turn Off The Lights? A Look at America's Looming Doctor Shortage* (2004) (predicting a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically beyond the current range of two to five week).

[7] Affidavit of Professor David Dranove at 6-7 (May 13, 2008) submitted in United States v. UnitedHealth Group Inc. and Sierra Health Service Civil No1:08-CV-00322.

[8] Mark V. Pauly, "Competition in Health Insurance Markets," 51 Law & Contemp. Probs. 237 (1998).

[9] Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004).

[10] See Testimony from "Examining Competition in Group Health Care," Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and "Health Insurer Consolidation – The Impact on Small Business," Hearing before the House Small Business Committee, 110th Cong. (Oct. 25, 2007).

[11] *In the Matter of North Texas Specialty Physicians*, FTC Docket No. 9312, slip op. at 46.

[12] *See* FTC Staff Advisory Opinion to MedSouth, Inc. (Feb. 19, 2002), at http://www.ftc.gov/bc/adops/medsouth.htm [hereinafter "MedSouth"] (acknowledging that many financially integrated IPAs have "experience significant financial difficulties under [capitated] contracts, and a number of the organizations [have] declared bankruptcy. In the wake of this experience, payers and most physician groups,…terminated their capitated contracts").

[13] *CBO Report*, at 18.

[14] *Id.* at 19.

[15] Office of National Coordinator for Health Informational Technology (July 2007).

[16] *Id.*

[17] *CBO Report*, at 19-20.

[18] *Id.* at 7.

[19] M. Rosenthal, B. Landon, et al., "Climbing Up the Pay-For-Performance Learning Curve: Where Are the Early Adopters Now?," 26 Health Aff. 1674 (2007).

[20] M. Rosenthal, R. Dudley, "Pay-for-Performance: Will the Latest Payment Trend Improve Care?," 297 J.A.M.A. 740 (2007).

[21] Pham & Ginsburg, *supra*, at 1596; see *id.* at 1590 ("One obstacle to performance measurement and incentive programs' have an impact remains the fragmented nature of U.S. care delivery systems.").

[22] U.S. Department of Justice & Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (Aug. 1996) (hereinafter "*Health Care Statements*" or "*Statements*"), at 72-73.

[23] Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to John J. Miles (Feb. 19, 2002) ("*MedSouth*"). When the FTC took a second look at MedSouth five years later, the network had decreased in size to 280 physicians. See Letter from Markus H. Meier to John J. Miles (June 18, 2007).

[24] Letter from Markus H. Meier to Christi J. Braun & John J. Miles (Sept. 17, 2007) ("*GRIPA*").

[25] *Health Care Statements*, at 66.

[26] *GRIPA*, at 26.

[27] *Antitrust Guidelines for Collaborations Among Competitors* (April 2000) ("*Competitor Collaboration Guidelines*") at § 3.2.

[28] *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

[29] *Id.* at 356.

[30] *Broadcast Music, Inc. v. Columbia Broadcasting System*, 441 U.S. 1 (1979) ("*BMI*").

[31] *See*, e.g., *BMI*, 441 U.S. 1; *National Collegiate Athletic Association v. Board of Regents*, 468 U.S. 85 (1984) ("*NCAA*").

[32] 421 U.S. 773 (1975).

[33] *See* 457 U.S. at 367 (Powell, J., dissenting).

[34] *Leegin Creative Leather Prods., Inc. v. PSKS, Inc.*, 127 S. Ct. 2705, 2721 (2007) (overruling *per se* rule against vertical price restraints).

[35] *State Oil v. Khan*, 522 U.S. 3, 21 (1997) (overruling *per se* rule against maximum vertical price-fixing).

[36] The Fifth Circuit's recent decision in *North Texas Specialty Physicians* is not to the contrary. ___ F.3d ___ (5th Cir. 2008). Indeed, rather than finding a *per se* violation by the physician network in that case, the court viewed the network's activities under the rule of reason.

[37] *GRIPA*, at 23 ("Any joint marketing arrangement, and indeed any cartel, provides transaction costs efficiencies when compared to engaging in individual sales transactions in markets with numerous participants.")

[38] *See* F. Easterbrook, "Maximum Price Fixing," 48 U. Chi. L. Rev. 886, 898-99 (1981) (noting transactional efficiencies of joint contracting by physician network).

[39] *United States v. Aetna*, No. 3-99CV1398-H (N.D. Tex.) (complaint filed June 21, 1999).

[40] M. Trisolini, G. Pope, et al., "Medicare Physician Group Practices: Innovations in Quality and Efficiency," The Commonwealth Fund (2006), available at www.commonwealthfund.org/usr_doc/971_Trisolini_Medicare_physician_group_practices_i.pdf.

[41] *Competitor Collaboration Guidelines* at § 3.2.

[42] *See*, e.g., *NCAA v. Board of Regents of the Univ. of Oklahoma*, 468 U.S. 85 (1984).

[43] *GRIPA*, at 19.

[44] *Id.* at 17.

[45] *Id.*

[46] *CBO Report*, at 17 (and studies cited therein).

[47] *Id.* at 19.

[48] *Id.* (noting that "many providers cannot generate the additional income necessary to justify the significant investment in time and money that the adoption of such a system would require").

[49] *See* H. Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* § 5.6 (1994) (a non-exclusive physician network is "absolutely inconsistent with the economics of cartelization: no cartel could restrict its output and raise price if it permitted its members freely to come and go, or to make unlimited 'non-cartel' sales.").

[50] The effect of high physician market shares on consumer welfare depends on the pre-existing concentration of health plan purchasing power. See Roger Blair & Jill Herndon, *Physician Cooperative Bargaining Ventures: An Economic Analysis*, 71 Antitrust L.J. 989 (2004); Tom Campbell, *Bilateral Monopoly in Mergers*, 74 Antitrust L.J. 521 (2007).

[51] *See e.g., Continental T.V. , Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977).

Appendix B

Selections from the introduction to "Competition in health insurance: A comprehensive overview"

A. Overview

This book, the seventh edition of the American Medical Association's "Competition in health insurance: A comprehensive study of U.S. markets," presents new data on the degree of competition in different regions of the country. It is intended to help researchers, policymakers, and federal and state regulators identify areas of the country where consolidation among health insurers may have harmful impacts on consumers, providers of care and the economy.

Are health insurance markets competitive, or do health insurers possess and exercise market power? Are proposed mergers between insurers likely to maintain, create or enhance such power? These are important questions of public policy because market power is harmful to society when it hampers competition. When an insurer exercises market power in its output market, premiums faced by purchasers of coverage are higher than in a competitive market. When an insurer exercises market power in its input market, payments to providers are below competitive levels. And in both instances, the quantity of coverage sold falls below the output level that would be observed in a competitive market. In short, when market power is exercised by health insurers, it adversely affects consumers' health insurance coverage and health care.

This study finds that the vast majority of health insurance markets across the United States are highly concentrated and are dominated by one or two health insurers. Such high concentration is an important issue of public policy because it facilitates the use of market power, which may have anti-competitive effects.

A first step in assessing the existence of market power (or potential market power) is to examine market concentration, as concentration facilitates market power. Market concentration is an integral component of antitrust analysis. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) consider post-merger market concentration in their evaluation of proposed horizontal mergers between firms.[1] It is critical to have information on the degree of concentration readily available. In this study, we present information on market concentration in the health insurance industry. Using the most comprehensive source of data to date on health maintenance organization (HMO) and preferred provider organization (PPO) enrollment, we report commercial market shares and Herfindahl-Hirschman Indices (HHIs) in 42 states and 314 smaller geographic areas across the United States.[2]

Applying the DOJ/FTC merger guideline standards, we find that 94 percent of the metropolitan statistical areas (MSAs) we examined are highly concentrated (HHI>1,800), and in 89 percent of MSAs, a single health insurer holds at least a 30 percent share of the commercial market.

Our finding that health insurance markets are highly concentrated, coupled with higher insurance premiums, higher profits, lower scope of benefits and high barriers to entry, leads us to conclude that insurers are exercising market power in many parts of the country.

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[1] U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines, April 8, 1997.

[2] The smaller geographic areas include metropolitan statistical areas and metropolitan divisions as defined by the U.S. Office of Management and Budget. The vast majority of these areas are metropolitan statistical areas, while a few of them are metropolitan divisions, which are subcomponents of very large metropolitan statistical areas (e.g., New York, Chicago). For convenience, both of these smaller areas will be referred to as MSAs throughout the report.

Appendix C

Statement of the American Medical Association to the Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights, United States Senate

RE: Consolidation in the Pennsylvania health insurance industry: The right prescription?

Presented by Henry S. Allen Jr., Esq.

July 31, 2008

I. Opening statement

The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on the Judiciary on consolidation in the Pennsylvania health insurance industry. We commend Chairman Kohl, Ranking Member Hatch, Senator Specter and the other members of the Subcommittee on Antitrust, Competition Policy, and Consumer Rights for your leadership in recognizing the threats that health insurer consolidations pose to the delivery of health care in Pennsylvania and across the country.

The AMA believes that competition, not consolidation, is the right prescription for health insurer markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

In Pennsylvania where health insurer entry from outside the state has been difficult and little incumbent competition exists, the potential competition that Highmark poses to Independence Blue Cross ("IBC" or "Independence") is the only market mechanism that protects patients from higher premiums. This potential competition also offers the prospect that physicians practicing in IBC's territories will have somewhere else (i.e., Highmark) to sell their services.[1] A merger would foreclose this alternative and provide the merged firm with the sort of monopsony power[2] that is depriving physicians of the ability to negotiate competitive health insurer contract terms in markets around the country. Accordingly, the AMA opposes the proposed merger of Highmark and IBC.

II. Merger to monopoly

The market shares of Highmark and IBC are more than sufficient for the merger to be found presumptively illegal under both Section 7 of the Clayton Act (15 USC § 18) (Section 7) and the Pennsylvania Insurance Holding Companies Act("PAIHCA"). Monica Noether, PhD, a former Deputy Assistant Director of the Federal Trade Commission Bureau of Economics[3], has concluded that the merger would combine a Highmark market share of 42 percent with that of IBC's share of 30 percent, and would result in a combined entity with more than 70 percent of the fully and self-insured commercial health insurance market in the Commonwealth.[4] The resulting post-merger level of market concentration, and the increase in that market concentration caused by the merger, triggers the presumption that the merger may substantially lessen competition or tend to create a monopoly under both Section 7 and the PAIHCA.[5] Moreover, under federal antitrust law, the resulting entity's possession of a 70 percent market share also establishes a prima facie case of monopoly power, a conclusion buttressed by the substantial barriers to market entry (also documented in Dr. Noether's report).[6] In short, this proposed merger is so anticompetitive that it amounts to a merger to a monopoly.

Highmark/IBC's statement addressing the PAIHCA's competitive standard omits any discussion of entry into the market—a factor, that under the Act, may

be considered in determining whether a merger has anticompetitive effect.[7] The reason for this omission is obvious. In Pennsylvania health insurance markets there has been very little in the way of new entry.[8] Health insurers that have successfully competed in other parts of the nation including Aetna, United HealthCare, and Cigna, have barely any presence in Pennsylvania. This is consistent with the federal antitrust enforcement agencies' observation that national plans have been unsuccessful entering some of the Blue Cross dominant markets in recent years.[9]

Entry is difficult.[10] As the Federal Trade Commission has reported, there are significant barriers to entry in health insurance markets. These barriers include the problems of: (i) developing a health care provider network; (ii) developing sufficient business to permit the spreading of risk; and (iii) contending with established insurance companies that have built long term relationships with employers and other consumers. Because there has been little to no entry in either of Highmark's orIBC's dominant market areas, this merger would permanently eliminate their biggest potential rival.[11]

III. Highmark and IBC are best characterized as "competitors"

In a failed effort to avoid a prima facie violation, Highmark/IBC assert in their "Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d)" that they do not compete in the same market that they operate in different regional markets.[12] Consequently, their economist Barry Harris, PhD claims, "[t]he consolidation does not result in any anticompetitive effects."[13] The insurance market in Pennsylvania, however, *is* regional, and thus, the merger will substantially reduce competition. IBC and Highmark are dominant in each of the alleged regionalized markets. In the absence of a merger, Highmark's entry as a competitor would result in a substantial deconcentration of IBC's regionalized market.[14]

Highmark has the means other than through merger to enter IBC's regional territory. As an established Blues insurer in Pennsylvania, Highmark does not face the barriers to entry confronted by other insurers. In the past, Highmark would have marketed its Blue Shield plan in IBC's territory of southeastern Pennsylvania, but for Highmark's 1996 purchase agreement with IBC. Pursuant to that agreement, Highmark exited southeastern Pennsylvania by selling interests in two plans to IBC and promising not to re-enter IBC's territories under the Blue Shield service mark for ten years.[15] That market division agreement expired around the time this consolidation was proposed. Presently, in the absence of this agreed-upon territorial restraint, Highmark is free, capable, and desirous of offering its services in the southeastern Pennsylvania territory where IBC presently sells. In fact, Highmark has previously successfully marketed its products in southeastern Pennsylvania.[16] It could easily offer products there again, using the network of physicians it already has under contract in that region. Highmark only needs to add a relatively small number of hospitals to that network. Expanding state-wide is also made easier by the presence of companies that rent networks in Pennsylvania.[17] With the strong appeal of the Blue Shield Trademark, Highmark could accomplish its CEO's stated goal of gaining state-wide presence[18] — a goal that is consistent with serving employers whose employees reside state-wide.[19]

Highmark's and IBC's ability to compete with each other is not altered by the status of the parties as Blue Cross/Blue Shield licensees. The Blue Cross and Blue Shield Association (BCBSA) explained in its correspondence to acting Insurance Commissioner Ario that, "Nothing in the license agreements prevents a licensee of the Blue Cross brand from using that brand to compete against a licensee of the Blue Shield brand, and visa versa within its license service area … [M]oreover, BCBSA licensed companies may compete anywhere with nonBlue branded business, and many do."[20] Accordingly, Highmark as a Blue Shield licensee can compete in IBC's territories notwithstanding IBC's status as a Blue Cross licensee. In addition, IBC would be free to compete against Highmark in western Pennsylvania using, for example, "Amerihealth HMO" as its product.

Although Highmark and IBC have engaged in an agreement to divide the market, there are reasons of principle and policy for characterizing their proposed merger as one that lessens competition or tends to create a monopoly. First, there is no meaningful difference between actual and potential competition.[21] As Areeda & Hovenkamp observe in the leading treatise on antitrust law, once a firm like Highmark is recognized as a factor "in future predictions about the market, that firm must be counted as a competitor even though that firm has not yet won its first bid or indeed has not made any bid at all."[22] Thus, the foreclosure of this future market role serves "to lessen competition." Second, a restrictive reading understates the competitive significance of mergers that, like here, occur in highly concentrated non-competitive markets.[23] Indeed, where the merger results

in a market share of monopoly proportions, the merger should constitute a Section 2 offense of monopolization because it eliminates either actual or potential competition.[24]

In sum, Highmark and IBC cannot escape the anticompetitive implications of their combined market share by arguing that they are not rivals in each other's markets. IBC and Highmark are actual competitors, as best evidenced by their agreement not to compete, which was required to control the natural rivalry between them.

IV. Anticompetitive effects of merger in the insurance market where physicians sell their services

The merger would result in a dominant health insurance company with monopsony power in insurance markets where physicians sell their services. Consequently, physicians could be forced to accept inadequate reimbursement, which would likely to lead to a reduction in the supply of physician services in spite of the demand for such services by patients. This is particularly significant given that recent projections by the U. S. Health Resources and Services Administration already suggest an impending shortage of physicians.[25]

It is a mistake to assume that when insurers push down the cost of physician services, insurers' interests are perfectly aligned with those of consumers.[26] Because health insurer monopsonists typically are also monopolists in the output market for healthcare insurance, lower input prices (for physician services) do not lead to lower consumer output prices (for health care insurance premiums).[27] Indeed, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers. Although compensation to physicians has been reduced, health insurance premiums have continued to increase rapidly.[28]

Clearance of this merger by the U.S. Department of Justice (DOJ) greatly concerns the AMA.[29] The Department of Justice has challenged only three of more than 400 mergers involving health insurers and managed care organizations over the past 12 years.[30] As a result, markets for third-party payors, especially commercial insurance plans, have grown increasingly concentrated. In almost every state, one of three major insurance firms is the market leader. In most of these states, Blue Cross and Blue Shield is the dominant firm. For example, in 2002, Blue Cross and Blue Shield controlled 39 percent of the Maine market; by 2006, this had grown to 63 percent.[31] The Government Accountability Office (GAO) estimates that the largest insurer in each state of the United States typically has a 43 percent share of the market for small group coverage, a 10 percent increase in less than five years.[32] Other studies indicate that in 16 states, one insurer controls over half of the market.[33] This consolidation has developed mostly through mergers and acquisitions. Studies have shown unequivocally that in this market environment, physicians across the country have virtually no bargaining power with dominant health insurers that are monopsonists.[34]

V. Why competition is good

Competition is essential to the health of the free market. Competition among insurers forces them to hold the line on premiums. With average premiums exceeding $12,000 for a family plan, even a few percentage points would make a significant difference for the typical family.

Examples of the benefits of competition among Blues plans can be found in the ongoing rivalry between Highmark and Capital BlueCross.[35] Some of the benefits have been documented in the testimony of Anita Smith, President and Chief Executive Officer of Capital BlueCross. She emphasizes that the competition between Capital BlueCross and Highmark has improved efficiency, innovation, quality, and price. Such benefits have also been discussed in the press. For example, *The Philadelphia Inquirer* carried an article on June 9, 2008, entitled "What can happen if Blues Compete; In a Swath of Pa., Capital and Highmark both offer health insurance."[36] The article contrasts the marketplace for insurance in southeast Pennsylvania, where IBC has no Blue rival, with the central area of the state, where Capital and Highmark are rivals. In central Pennsylvania, the article concludes, competition for the contract prevails, thus benefiting patients and providers. Patients and physicians should also reap the benefits of Highmark's and IBC's future competition. The firms should not be allowed to merge into a monopoly.

VI. Conclusion

The proposed merger will have anticompetitive effects in patient and physician service markets. IBC and Highmark have maintained dominant market positions for decades. There has been little to no entry by competitors into

the territories they dominate. In essence, this merger represents a contractual extension of their explicit agreement not to compete. By clearing this proposed merger, the Department of Justice has demonstrated its lack of federal antitrust enforcement in health insurance markets. Accordingly, the AMA respectfully requests that this Committee urge the federal antitrust enforcement agencies to more rigorously enforce the antitrust laws with respect to future health insurer consolidations.

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[1] See Lawrence A. Sullivan & Warren S. Grimes, The Law of Antitrust: An Integrated Handbook §11.3b-.3b1 (2000) (for a discussion of the consumer welfare benefits of potential competition).

[2] Text from: "Agenda for Joint FTC / DOJ Hearings on Health Care and Competition Law and Policy" (Washington D.C., Thursday, April 24, 2003) Available from: http://www.ftc.gov/ogc/healthcarehearings/030405hcagenda.shtm; Accessed 07/30/2008. This source defines monopsony as a "substantial market power being exercised by buyers over sellers. In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services).

[3] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report).

[4] *Id*. at 7.

[5] The PAIHCA at 40 P.S. § 991.1403(d)(2)(i) provides that a highly concentrated market is one in which the share of the four largest insurers is 75 percent or more of the market. In a concentrated market when an insurer with a 4 percent market share acquires one with a 4 percent share, that would constitute a prima facie violation of the act's competitive standards. *Id*. The Noether Report at Exhibit 2 documents that in a statewide Pennsylvania market, the four largest insurers possess a total market share of 86 percent. Moreover, the shares of merging firms dramatically surpasses the 4 percent. *See also* Horizontal Merger Guidelines, US Department of Justice and Federal Trade Commission at *http://www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html*. In *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963), the U.S. Supreme Court announced a rule of presumptive illegality in the context of heavily concentrated markets. In that case, the acquiring firm held a 30 percent market share, while the acquired firm's market share was only 3 percent.

[6] *See e.g. United States v. Grinnell Corp*, 384 US 563, 571 (1966) (The existence of monopoly power may be inferred from a predominant share of the market).

[7] *See* 40 P.S. § 991.1403(d)(2)(iv).

[8] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report, 8-11).

[9] "Improving Health Care. A Dose of Competition, Federal Trade Commission and Department of Justice" (July 2004) at 8-11.

[10] *Id*.

[11] *See* Affidavit of Professor Dranove, Exhibit 1.

[12] "Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d)", at 1-2.

[13] Comments by Barry C. Harris, PhD, in the Pennsylvania Insurance Department Public Informational Hearings July, 2008.

[14] For a discussion of these factors in a merger context, *see United States v. Marine Bancorporation, Inc*., 418 U.S. 602 (1974).

[15] December 6, 1996 Purchase Agreement between IBC and Pennsylvania Blue Shield, Section 7.2, at 10.

[16] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report, 12)

[17] For a list of these companies see Noether Report at 7.

[18] "Talking with Ken Milani," Harrisburg, Patriot News, July 22, 2007.

[19] Dranove Affidavit, Exhibit 1.

[20] Dec. 21, 2007 correspondence from Roger G. Wilson, Senior Vice President and General Council, Blue Cross Blue Shield Association to Joel Ario, Acting Insurance Commissioner.

[21] IV Areeda & Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and their Application* ¶907 (2007) (Exhibit 2) (which explains that there are good reasons for not reading the Clayton Act requirements narrowly).

[22] *Id*.

[23] *Id*.

[24] *Id*. at ¶912(Exhibit 3).

[25] *See* Health Resources and Services Administration, *Physician Supply and Demand: Projections to 2020* (Oct 2006) (which projecting a shortfall of approximately 55,000 physicians in 2020); *see also* Merritt, Hawkins, et al., *Will the Last Physician in America Please Turn Off The Lights? A Look at America's Looming Doctor Shortage* (2004). (which predicts a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically beyond the current range of two to five weeks).

[26] Mark V. Pauly, "Competition in Health Insurance Markets," 51 Law & Contemp. Probs. 237 (1998).

[27] Peter J. Hammer and William Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004). *See also Dranove Affidavit*, Exhibit I.

[28] *See* Testimony from "Examining Competition in Group Health Care," Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and "Health Insurer Consolidation – The Impact on Small Business," Hearing before the House Small Business Committee, 100th Cong. (Oct. 25, 2007).

[29] See Highmarks Press Release of July 17, 2008.

[30] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets* / 2007 Update, 1

[31] Robert Pear, "*Loss of Competition Is Seen in Health Insurance Industry*", New York Times, Apr. 30, 2006, at Section 1, 131.

[32] *Id.* at Section 1, 21.

[33] James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, 23 Health Affairs 11, 13-14 (2004).

[34] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets* / 2007 Update, 2.

[35] Anita Smith. "Testimony before the Commonwealth of Pennsylvania Senate Banking and Insurance Committee Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (January 30, 2008). Available from: https://www.capbluecross.com/PressRoom/NewsReleases/testimony.htm; Accessed 07/29/2008.

[36] Exhibit 4.

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