STATEMENT

OF

DONALD CRANE
CHIEF EXECUTIVE OFFICER

CALIFORNIA ASSOCIATION OF PHYSICIAN GROUPS

BEFORE THE

FEDERAL TRADE COMMISSION/DEPARTMENT OF JUSTICE

JOINT HEARINGS ON
HEALTH CARE AND COMPETITION LAW AND POLICY

MAY 7, 2003

INTRODUCTION

Thank you for the opportunity to give this statement on behalf of the California Association of Physician Groups ("CAPG"). My name is Donald Crane. I am the Chief Executive Officer of CAPG. CAPG represents 117 medical groups, independent practice associations and other organizations of physicians throughout the state of California. Approximately half of all practicing physicians in California are affiliated with members of CAPG. These physician provide medical care to approximately 11.5 million Californians.

Throughout the nation, but particularly in California, a profound and rapid change is taking place in the way in which health care is made available to consumers. During the 1990s, there was a proliferation of managed care arrangements, in which insurers contracted with physician joint ventures or physician groups to provide medical and other health care related services to consumers with per capita fees paid to the physician group. These arrangements led to substantial success at moderating the rate of inflation for health care costs and in encouraging physician groups to organize, both financially and clinically, to achieve greater efficiencies.

In recent years, the health care market has changed; consumers have expressed a desire for wider choices and less rigid controls in how they choose and access health care services. Employers and health care insurers have responded by offering consumers options that afford a wider array of choices and the economies of varying benefit structures that are affordable, all of which have led to a rapid migration to preferred provider organizations ("PPOs").

Recognizing the changing dynamics in the California health care market, physician groups are developing means by which their financial and clinical arrangements, built in response to the incentives of capitation, can transition to the more open PPO system, with its fee for service payment arrangements, and yet maintain and expand the kinds of financial, administrative and clinical integration that has yielded such substantial benefits for consumers in the managed care arrangements.

As physician groups struggle to accommodate to this evolving health care market, they are cognizant of their obligation to be in compliance with the nation's antitrust laws. Physician groups are mindful of the Department of Justice ("DoJ") and Federal Trade Commission ("FTC") Statements of Antitrust Enforcement Policy in Health Care ("Statement") and, in particular, Statement 8 of that Policy. The Policy and Statement 8 were issued in the 1990s when managed care capitated arrangements had gained significant acceptance.

CAPG submits this Statement to formally request that the DoJ and FTC reexamine the Statement to insure that applicable antitrust laws and their enforcement are not an impediment to physician groups as they develop new integration approaches in response to the evolving health care market.[1]

Section I of this Statement discusses the dynamic evolution of the health care market, nationally and in California, and includes data and other market information. In Section II, the paper explores those aspects of the Statement that impact physician groups. Section III examines the limitations the Statement places on physician groups in their efforts to develop procompetitive collaborations and the need to update Statement 8.[2]

Section I -- The Changing Health Care Market

The groundswell of medical group and independent practice association (IPA) development that this country witnessed in the 1990s occurred primarily in response to the expansion of HMOs and pre-paid (capitated) forms of reimbursement. Some of these physician organizations could not withstand the low reimbursement rates and high level of financial risk inherent with HMO capitated contracting in the late 1990s and have since ceased to exist. The physician organizations that are still in operation today, while they have weathered the economic pressures of managed health care, are now threatened with new challenges. The management systems, clinical programs and technological infrastructures in which they have invested in order to enhance operational efficiency and improve the quality and service of medical care delivery are increasingly focused on a shrinking patient population. This is due to the decreasing enrollment of HMOs and the rise of PPO and other fee-for-service-based health insurance structures.

Since the majority of physicians still practice in small medical groups (less than 8 physicians) which are incapable of making significant management, clinical and technology investments, IPAs have been the predominant mechanism through which physicians have gained access to contracts under which they provide care for HMO patients. However, since many IPAs currently find it difficult (or impossible) to meet the critical tests of financial or clinical integration for fee-for-service (PPO) contracts

[1] The Statement, itself, is a living document. Its introduction notes various changes issued in an effort to have antitrust law and its enforcement properly keep pace with market developments. Indeed, the Statement's Introduction concludes by noting: "The Agencies recognize the importance of antitrust guidance in evolving health care contexts. Consequently, the Agencies continue their commitment to issue additional guidance as warranted."

[2] As the DoJ and FTC have recognized, "a perception that the antitrust laws are skeptical about agreements among actual or potential competitors may deter the development of procompetitive collaborations." Antitrust Guidelines for Collaborations Among Competitors, issued by the Federal Trade Commission and the U.S. Department of Justice, April 2000, p.1.

contained in the Statements, they have been limited in their ability to facilitate agreement on financial or other contractual terms between physicians and payers. This ultimately could prove to be the final straw in the future of any rational organizational structure for the vast majority of physicians in California and other parts of this country. That is, without the ability to play a meaningful role vis-à-vis PPO plans, many IPAs may find it impossible to continue to support the infrastructure required to effectively coordinate and enhance the quality and efficiency of patient care. This ultimately will be costly to patients, employers, and even health insurers through the financial and clinical inefficiencies inherent in the current PPO system. Additionally, it is important to note that most hospital systems do not accept capitation or risk and that healthplans are moving away from risk products. The IPA is the only model left that is currently restricted to risk only. As the HMO product continues to decline, the risk increases to IPAs forcing further financial problems.

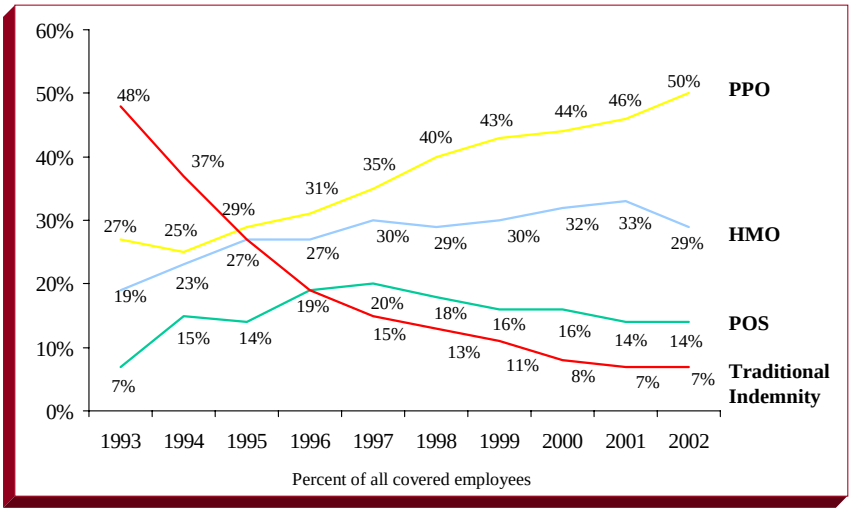
The Key Facts

Changing health plan enrollment -- from capitated to fee-for-service

Nationally, the health care market is changing rapidly (See, Figure 1, below.) Of particular interest is the rapid growth of PPO products.

❑

Figure 1
National Employee Enrollment (1993-2002)

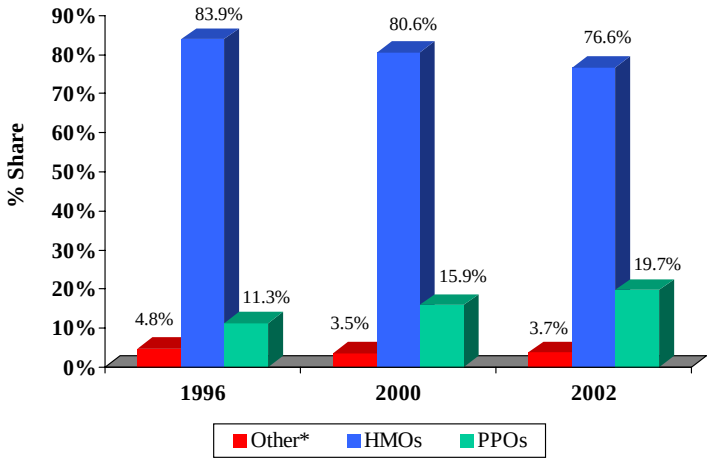


Source: Mercer Human Resource Consulting, 2002

Power97/CAPG/Charts.ppt

This trend is being seen in California in an even more pronounced fashion: As Figure 2, below, shows, the largest purchaser of health care in California, the California Public Employee Retirement System, has seen a rapid shift toward the PPO option.

Figure 2
Enrollment in CalPERS Health Plan Options, 1996-2000:
Active and Retiree Enrollment in Basic Plans



* Association Plans
Source: California Healthcare Foundation, 2002
Allen Baumgarten, California Managed Care Review, 2002

Power97/CAPG/Charts.ppt

In keeping with this shift in consumer choice, health plans across the nation, and especially in California, including some of the most significant HMO type plans (such as PacifiCare and Health Net), are shifting their business models. Some large insurers (e.g., United HealthCare) are exiting the HMO business in many markets.

The trend away from managed care and toward PPOs can be seen in the Medicare program. The Medicare+Choice (M+C) program, risk bearing structure, has experienced rapid decline in recent years. M+C HMO products have abandoned many previously served areas and have increased consumer costs while decreasing benefits in most other areas. Recently, the Centers for Medicare & Medicaid Services (CMS) has launched a demonstration project intended to promote the delivery of a PPO product through organized groups and IPAs. This reflects the recognition by the CMS of the value and efficiencies that can be delivered by IPAs within PPO product lines. Currently, Congress is debating substantial reforms to the Medicare program that would create a much greater role for PPOs in Medicare.

The Challenge for IPAs in Adjusting to a Changing Market

IPAs face the dilemma of needing to respond to the rapidly changing marketplace while maintaining and expanding their mechanisms for care coordination and quality assurance for a variety of fee-for-service health insurance products (i.e. PPOs and other models). Current guidelines as set forth in Statement 8 restrict their ability to effectively respond. They are constrained from pursuing PPO contracting models without first demonstrating full-scale clinical integration. Yet, they cannot rapidly put the infrastructure in place to achieve clinical integration without the additional income that PPO contracting would provide.

In a broader context, this is a societal dilemma. While the prospects for financially and clinically integrated physicians groups offer enormous consumer benefits, few, if any IPAs have achieved optimal integration. Many physician groups, such as California IPAs, have made very good progress toward optimal integration, given managed care's demands for greater efficiency. However, that progress has substantially slowed as health plans have aggressively underfunded medical groups and IPAs.

It is widely recognized that California's health care premiums are lower than elsewhere throughout the United States. One important study found that average family premiums were lower in California than in any other state.[3] Another study[4] found that HMO premiums are 13-14 percent lower in California than the rest of the U.S. Point of service plans ("POS") are also approximately 10 percent less costly in California. HMO and POS products are still the predominant, and in some cases sole sources of revenue for IPAs in California. Furthermore, they provide the foundation on which IPAs develop compensation structures for physicians in their network.

Even the CMS recognizes the higher costs of operation for small medical practices in California, as indicated by the geographic practice cost indices (GPCI) that are used to calculate Medicare fee-for-service reimbursement. Exhibit A provides the practice expense GPCI for all localities in California, all of which are significantly greater than 1 (1 being the national average). In fact, the California practice expense GPCI are higher than any other part of the country, other than New York City (Manhattan, Queens, and Long Island/New York suburbs GPCI for practice expense are 1.351, 1.228, and 1.251, respectively).

Given the depressed premiums in California, and the pressure from physicians to receive equitable reimbursement (in many cases currently below Medicare

---

[3] See, Aventis Pharmaceuticals Managed Care Digest Series/HMO PPO Digest 2002, (data source: SMG Marketing-Verispan LLC.)

[4] Kaiser/HRET California Employer Health Benefits Survey, Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2002.

reimbursement rates), IPAs' operating margins are generally extremely small, or negative. Most IPAs cannot improve margins simply by paying physicians less, since HMO payments to the IPAs are often already lower than what is adequate to cover operating expenses. The focus for many groups is on managing medical costs (utilization) which is also challenged by mandated benefits, new technology, and a public that desires unlimited choice and access to a wide range of medical services.

The financial status of risk-bearing provider organizations in California was dramatically illustrated in 2001, when they were required to report their financial status to the State of California's Department of Managed Health Care ("DMHC")[5]. The four fiscal indicators for risk-bearing provider organizations that were required included the following:

- Maintaining positive working capital
- Maintaining positive tangible net equity
- Payment of claims within state-mandated timeframes
- Using specific guidelines to calculate claims liability (incurred but not reported claims)

Only 44 percent of the state's risk bearing organizations met all four measures; 22 percent met only three indicators, and 33 percent met two or fewer.[6]

Those physician organizations and IPAs are functioning with thin operating margins. While many continue to invest in the necessary infrastructure to manage their operations, the capital available to make significant investments is extremely limited. Therefore, in order to take strides to develop the capabilities to allow clinical integration, most will require a period of at least two to three years to incrementally invest and develop these systems. This is occurring at the same time that HMO enrollment is declining in many markets, which increases the fixed cost burden for these organization, further limiting available capital.

Even the strongest IPAs must maintain sizable cash reserves in order to meet the regulatory and fiscal requirements of accepting capitation. Therefore available capital is further constrained due to the need to maintain these cash balances.

IPAs do recognize that they must create mechanisms to achieve greater clinical integration among their members in order to facilitate their ability to effectively

[5] This reporting requirement was discontinued in 2002 pursuant to a Superior Court ruling, so no updated publicly available information is available.

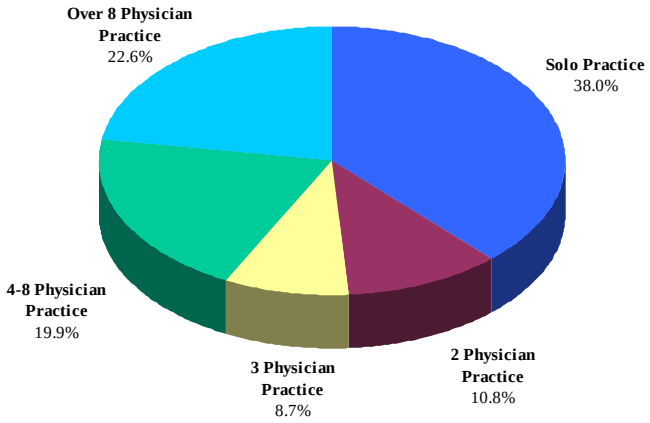
[6] www.hmohelp.ca.gov/press/news/caljournal/20020701 printed 6/3/2003, page 6.

respond to the marketplace -- which is moving increasingly to PPOs and other non-risk-structured health insurance products. Therefore, they are developing the information systems and technical capability to share clinical data. However, as noted previously, this will take time to fully implement.

The Essential Role of IPAs in the Evolving Health Care Market

CAPG believes that achieving the balance between cost containment, quality of care, and consumer choice in the evolving health care market will be impossible without the kind of care coordination IPAs are designed to achieve. The most recent data indicates that more than 75 percent of physicians practice in groups of eight or less (see Figure 3). Given the administrative and technical sophistication required to coordinate care for administrative and quality efficiency, it is highly unlikely that small, isolated groups of physicians could successfully meet that objective. IPAs that accept professional risk (capitation) have evolved from their experience in meeting the demands of a managed care oriented health care system to do just that. Small, independent physician practices are coordinated through the IPA with the objective of achieving optimal administrative and clinical efficiencies.

Figure 3
Distribution of Physicians by Size of Practice
1999
(Excluding Physicians in Institutional Settings)*



All Physicians in Noninstitutional Settings

* Percentages may not sum to 100 because of rounding.
Source: AMA, Physician Socioeconomic Statistics, 2000-2002 edition

Power97/CAPG/Charts.ppt

Antitrust policy in the new health care market should facilitate an orderly transition of market participants, not act as an impediment to the necessary transition. While antitrust policy must guard against anticompetitive behavior, the policy should also seek to permit health care delivery system evolution that achieves the appropriate balance of cost containment, quality of care and choice.

As the health care market transitions from an HMO-dominant model to one where PPOs and other, more open-choice models are emerging as significant entities, antitrust policy should seek to build upon and extend the successes achieved through reliance on IPAs for coordination of care and integration of administrative and clinical systems.

Simply put, if the success that IPAs have delivered to the HMO managed care system is to be repeated in a more open choice, PPO-oriented system, IPAs must be allowed to transition in an orderly fashion. IPAs and the physicians that participate in them bring processes, technologies, and orientation to the practice of medicine that cannot be found elsewhere. If IPAs are not permitted to transition to the new health care system in an orderly fashion, the benefits of those processes, technologies and orientation will be lost.

Section II -- Statement 8, Antitrust Policy as Applied to Physician Groups

Safety Zones

Statement 8 is specifically applicable to the issues at hand. It articulates current DoJ and FTC policy, an analytical framework and enforcement guidelines for "Physician Network Joint Ventures"; that is, "physician controlled ventures in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services." Such ventures include the kinds of arrangements employed by physician groups, IPAs and similar entities.

Statement 8 designates certain antitrust "safety zones" for physician groups. Arrangements which fall within these zones do not violate antitrust policies. These safety zones differ based on a group's exclusivity or non-exclusivity. In either case there must be sharing of substantial financial risk among the group's physicians to fall within the zone.

The issue of exclusivity turns on whether physicians in the group are exclusive to the group (that is, the physicians' services are available only to consumers whose coverage is provided by an insurer with whom the physicians' group contracts) or whether the

physicians are free to contract with other groups or directly with other insurers. Statement 8 notes that a group may be either exclusive or non-exclusive and still fall within the safety zone, depending on the percentage of physicians in the group relative to all physicians in the particular market. In either case, to fall within the safety zone, the physicians in the group must share substantial financial risk.

Statement 8 notes that substantial financial risk sharing is perhaps the best indicator of sufficient integration by group physicians to achieve significant operational and clinical efficiencies. The Statement sets out several examples of substantial risk sharing, including:

- Payment by an insurer to the group at a "capitated" rate;
- Various financial incentives used by the group to encourage physicians to achieve particular cost-containment goals.

Outside the Safety Zones

The changes occurring in the California health care market are requiring physician groups to consider new structures and fee arrangements which do not fall within the safety zones . Statement 8 notes that arrangements that do not fall within the safety zones "may have the potential to create significant efficiencies, and do not necessarily raise substantial antitrust concerns." Indeed, Statement 8 sets the goals of the DoJ and the FTC "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."

To that end, Statement 8 provides that for those arrangements which do not fall within a safety zone, the DoJ and FTC will not find a *per se* antitrust violation but will instead employ a rule of reason analysis "if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements by the network [group] physicians are reasonably necessary to realize those efficiencies."

Further, Statement 8 notes that even in the absence of substantial risk sharing, a group may have sufficient integration to demonstrate that it is likely to produce significant efficiencies. Evidence of such integration includes the implementation "of an active and ongoing program to evaluate and modify physician practice patterns and create a high degree of interdependence and cooperation among physicians to control costs and ensure quality." As the Statement indicates, programs of this sort might include health care services utilization monitoring and control for purposes of cost

containment and quality assurance, careful selection by the group of physicians who support efforts at cost efficiency and quality assurance , and significant investment of capital in necessary infrastructure and capability to realize the claimed efficiencies.

The rule of reason analysis takes four steps:

1) Define the relevant market.
2) Evaluate the competitive effects of the physician joint venture.
3) Evaluate the impact of procompetitive efficiencies.
4) Evaluation of collateral agreements.

Section III -- The Changing Health Care Market, Physician Groups and the Need to Update Statement 8

Physician Groups are working hard to evolve their business offerings, systems, administrative and financial structures and clinical integration strategies to compete in the rapidly emerging PPO oriented health care market. The goals of this effort are to give patients a new managed PPO product that they want and that policy makers think they need; a managed and efficient PPO product that delivers high quality at the lowest reasonable cost.

It is important to note that the new health care market and its tilt toward PPO and other more open, wider choice, non-capitated arrangements also is seeking to increase competition among providers based on quality competition. This can be seen in many ways. All of California's major insurers are implementing "pay for performance" financial incentives that can only be delivered through organized groups and IPAs. Providers of health care services that achieve particular measures of quality receive a payment above the standard payment. Many employers are demanding that providers collect and report quality performance data and are disclosing that data to consumers who will use that data to make performance based provider purchasing decisions.

These efforts to develop quality competition in the health care sector have been underway for a number of years, but are just now reaching the market. As health care quality becomes valued, it is flatly the case that the most efficient means of achieving and reporting on higher quality performance is through organized systems of care, such as IPAs. The "pay for performance" initiatives discussed above prove this.

In order to permit physician groups to evolve to meet the demands of the changing market, the DoJ and FTC should engage in a proactive, inclusive examination of the ways in which Statement 8 impedes this market evolution, the consequences of those impediments, and revisions and updates to Statement 8, including Example 2

(Physician Network Joint Venture involving risk sharing and non-risk sharing contracts), that would enable physician groups to give their patients an efficient managed PPO product that they want, and that policy makers think they need.

As part of this examination, the DoJ and FTC should consider appropriate revisions to the analytical framework of Statement 8 to reflect the Supreme Court's admonition in California Dental Association v. FTC, 526 U.S. 756 (1999) that the enforcement agencies should be careful not to condemn certain practices under a per se or "quick look" analysis in situations where they lack substantial experience with those practices. Consideration should also be given to providing more specific guidance on how quality of care enhancements will be taken into account in assessing the competitive consequences of physician joint ventures.[7] Finally, as discussed more fully hereafter, consideration should be given to the following issues:

- Greater recognition of the value of the spillover or "halo" effects which result from managed care oriented physician groups (IPAs) participation in PPOs.
- Recognition of the opportunities and challenges that exist in applying utilization and quality of care systems developed for HMOs to PPO products.
- Recognition of the complex issue of physician compensation methodologies, and the implications for network formation, consumer choice and the economic impact on consumers.
- Recognition of the interplay between issues of physician exclusivity and the ability to justify and implement investments in clinical integration strategies and programs..

From HMO to PPO: Capturing the "Halo" Effect

Under the incentives of managed care and capitated pre-paid fees, physician groups have developed and implemented processes and systems to manage utilization, assure and improve quality of care, provide preventive care, manage patients with chronic illnesses, examine the credentials of physicians, receive and act on consumer grievances, provide services to prevent illness and support wellness and a range of other activities that all observers agree bring financial and quality efficiencies to the health care market.

[7] Chairman Muris and Commissioner Leary have both recognized the importance of addressing quality issues in an antitrust analysis involving the delivery of health care services. See Timothy J. Muris, "Everything Old is New Again: Health Care and Competition in the 21st Century," prepared for 7th Annual Competition in Health Care Forum on November 7, 2002, pp. 18, 25-26, Thomas B. Leary, "The Antitrust Implications of 'Clinical Integration': An Analysis of the FTC Staff's Advisory Opinion to MedSouth," pp. 13-14.

While PPO fee-for-service arrangements do provide the opportunity for wider choice of providers, they sacrifice many of the most valuable financial and clinical benefits of prepaid managed care arrangements. Nevertheless, physicians who are oriented to providing integrated managed care services can and already do bring significant benefits to the delivery of care to PPO subscribers, including quality of care benefits which would likely not be available under an HMO arrangement.. It is widely recognized in California that physicians that see both HMO and PPO patients treat them the same. They do not differentiate. They adhere to HMO practices and protocols whey they treat their PPO patients. This is the essence of the halo effect and is a powerful efficiency that should be promoted.

The logical and most efficient way for physician groups to transition to the new requirements of the market is to build off the base of experience and systems infrastructure that they developed in response to HMO managed care.

Such a strategy would involve developing a network of physicians that could be offered to the PPOs from those physicians that have been part of the physician group's managed care/HMO network. Such a PPO group would already understand and comply with the group's integration strategies. Physician behavior and organizational efficiencies developed in the managed care offerings would spill over to the new physician group PPO product and provide the basis for further integration. This "halo" effect is specifically described in Example 2 of Statement 8 which recognizes the "significant efficiencies from the capitated arrangements that carry over to the fee-for-service business." However, Example 2 describes a limited set of facts and without more, Statement 8, including Example 2, fails to provide sufficient flexibility to enable physician groups to respond to changing market conditions by building on this "halo" effect to provide high quality, cost effective PPO services.

Statement 8, including Example 2, Must Be Updated to Enable Physicians Groups to Maximize the Value to Consumers of PPO fee-for-service Arrangements

As discussed above, many IPAs lack the financial resources to rapidly put in place the complete infrastructure and processes that would be required to achieve the full-scale clinical integration described in Statement 8. Nor do current reimbursement levels permit the use of withholds or similar financial incentives to encourage cost containment by physicians. Nevertheless, it is in the best interest of consumers to allow physician groups to respond to the evolving health care market. Although Example 2 recognizes the potential benefits which result from a managed care oriented physician group's participation in PPO contracting where there is neither full-scale clinical integration or substantial financial risk sharing, its view of this "halo" effect is much too restrictive.

Most IPAs in California do not use fee-for-service fee schedules as a mechanism for reimbursement for their HMO physician network. Primary care physicians are typically capitated (a fixed payment per member per month), as are many specialists. Therefore, in order to achieve the "same fee schedule" requirement as specified in Example 2, it would virtually require the dismantling of existing compensation structures that have been effective in aligning incentives and achieving financial integration for HMO contracts. It would not make any sense to maintain capitated arrangements for PPO contracts that are based on fee-for-service structures.

While it is true that PPO patients would receive the benefit of the efficiencies and care management approaches that many physicians have become accustomed to with HMO contracts, it is not practical to assume (as Example 2 appears to do) that the *same* procedures would automatically apply to all PPO patients. PPO patients are not required to remain within a given IPA network for all of their care. They may seek primary care from a provider in one IPA and specialty care from another. That is the freedom of choice individuals are seeking when they select a PPO option. Therefore, the IPA would not impose the same authorization requirements on PPO patients as is required of HMO patients. And so, it is impractical to assume that precisely the *same* "utilization management" mechanisms would be used on both PPO and HMO patients.

Example 2 also requires that the panel of providers is the same between the HMO and the PPO plans. It is conceivable that an IPA might want a broader network of physicians that are willing to participate in the PPO plans than those that might participate in HMOs, since patients are seeking more choice in a PPO than that which is typically available in an HMO. Or, alternatively, there may be some physicians that currently contract through the IPA for their HMO patients that do not wish to participate with the IPA for PPO contracts -- since they prefer to either pursue direct contracts with the PPO or obtain them through another organization.

Physician groups which have competed to the benefit of consumers under HMO plans can compete to the benefit of consumers in PPOs. Without organized physician group involvement in IPAs or similar networks, the benefits of the halo effect will be lost to consumers. The patterns of practice, team work, quality mechanisms, disease management and prevention programs cannot be successful outside organized systems of care.

For the good of their patients, physician groups must be permitted to evolve new products to compete in response to new market conditions. Given the different economic incentives of capitation and fee-for-service, physician groups will need to develop new medical management strategies and economic models that respond to

fee-for-service incentives, but maintain the benefits of financial and clinical integration. While many aspects of physician group managed care strategies will be readily transferrable to fee-for-service plans, others will require additional investments of time and capital. Physician groups are willing to make those investments, but must be permitted to respond to the market's preference for PPO market even while in the process of developing, acquiring and implementing new human and technology systems. Statement 8 and Example 2 impede their ability to do so.

An IPA, which has a meaningful plan to use the information technology , medical management systems, infrastructure and experience it has developed for HMOs, to transition to integrated structures for PPOs that will enhance the quality of care delivered and do so in a cost-effective manner, should be allowed to offer PPO products to payers and negotiate with them on a collective basis while it is implementing the plan. Such a plan might include, among other things, a specific timetable for full implementation and a reasonable allocation of projected revenues to be used for such integration. Consideration should be given to updating Statement 8 and Example 2 to permit such an approach.

Antitrust policy in PPO fee-for-service area appears to prefer that physicians enjoy non-exclusive arrangements with their physician group under which physicians are permitted to participate in more than one group or be allowed to directly contract with health insurers. So, in Example 2, the physicians participate in the IPA on a non-exclusive basis. The DoJ and FTC are urged to consider the implications of such a system. The ability of physician groups to manage their physicians, conduct oversight, assure accountability and employ peer review strategies to control utilization and optimize quality will be substantially eroded, if not lost all together. The benefits of practice management and information technology ("IT") systems will be substantially limited if physician groups face a risk that the investments required for training, IT installation, care management, etc. will be dissipated by physicians contracting outside the group. No business would make substantial investments in their workforce if the workforce were not totally dedicated to the business's objectives.

CONCLUSION

IPAs have the capability to make a positive impact on the cost and quality of health care delivered through fee-for-service models such as PPOs. Many have implemented the information technology, management systems, and infrastructure in a physician-directed model to best serve patients in HMO managed care plans. However, Statement 8 significantly impedes these physician organizations' ability to effectively transition to more clinically and financially integrated structures for PPOs. That is,

what comes first: clinical integration, or a business model that will pay for the required expanded infrastructure? Statement 8 in its current form makes it very difficult for IPAs to develop a sustainable business model to respond to the demands of the marketplace.

Exhibit A

Geographic Practice Cost Index
California

Region/Locality	Carrier ID	GPCI Practice Expense
Anaheim/Santa Ana	3114626	1.184
Los Angeles	3114618	1.139
Marin/Napa/Solano	3114003	1.248
Oakland/Berkeley	3114007	1.235
San Francisco	3114005	1.458
San Mateo	3114006	1.432
Santa Clara	3114009	1.38
Ventura	3114617	1.125
Rest of California (S)	3114699	1.034
Rest of California (N)	3114099	1.034

F:\EXCEL97\CAPG\[GPCI-Calif.xls]Sheet1

Source: Centers for Medicare and Medicaid Services website:
cms.hhs.gov/physicians/mpgsapp/display.asp (6/04/03)