PHYSICIAN PRODUCT AND GEOGRAPHIC MARKET DEFINITION

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California Medical Association

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Good morning. My name is Astrid Meghrigian and I am an attorney for the California Medical Association ("CMA"). I am here to offer the perspective of the California Medical Association and its member physicians on some of the questions presented.

CMA applauds the goals of the antitrust laws which are so important to ensure that markets operate competitively so as to maximize consumer welfare. However, we do not believe these goals can ever be met if a rigid antitrust approach is directed toward physicians in today's environment. With the managed care industry's severe underfunding of health care in California,[1] many physicians can no longer afford to provide the quality and level of care that is optimal with the inadequate reimbursement rates they currently receive. Many of these physicians have either gone bankrupt, closed their doors entirely, left the state, or restricted their practices. From the perspective of consumer welfare, it has been disastrous for everyone. Physician/patient relationships are needlessly destroyed, physician talent is sorrowfully wasted, and patient care is jeopardized through reduced access and longer waiting times.

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[1] See discussion below.

Physicians in California pose no anti-competitive threat. In fact, they cannot negotiate at all as a practical matter given the aggressive pricing schemes engineered by the few dominant players left in the managed care industry. Under these circumstances, we urge that physician conduct be viewed in the context of the anti-competitive environment created by many managed care organizations. The use of overly narrow definitions of products and geographic markets and mechanical and statistical approaches make little sense in today's marketplace for physician services.

PHYSICIAN PRODUCT MARKET

Under the rules of reason analysis, assessing the "market power" of a practice on competition requires defining the relevant market, which includes both product and geographic markets.[2] The courts and the 1986 agency "Statements Of Antitrust Enforcement Policy In Health Care" (hereinafter "Statements") have properly recognized that in defining the relevant product market, practical substitutes which are reasonably available to consumers for the services in questions should be identified. Put another way, "The classic test for defining the outer boundaries of a specific product market is to identify a set of goods or services that are reasonably interchangeable by consumers for the same purpose or use." (*HTI Health Services, Inc. v. Quorum Health Group, Inc.,* 960 F.Supp. 1104 (S.D.Miss. 1997).)

This is basically an objective test which requires an analysis of (1) what services are at issue, and (2) what type of health care providers can perform them. As the agencies in their "Statements" stated:

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[2] See *Copperweld Corp. v. Independent Tube Corp.* (1984) 467 U.S. 752, 768.

> Although all services provided by each physician specialty might be a separate relevant service market, there may be instances in which significant overlap of services provided by different physician specialties, and some circumstances, certain non-physician health care providers, justifies including services from more than one physician specialty or category of providers in the same market.

Thus, for example, in 1995, in FTC Staff Advisory Opinion regarding the establishment of an otolaryngology network took a broad view of the market for otolaryngology services in light of the wide mix of services provided by the specialists and the fact that those services were similarly provided by others within the profession.[3] Accepting the position of the otolaryngologists that family practice physicians and internists, allergists and immunologists, plastic surgeons and dermatologists all compete for the same type of services, the FTC properly concluded that all of the foregoing were covered in the relevant market. See also Letter from Ann K. Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice, to James M. Parker (October 31, 1994) (accepting representations that pulmonologists and other specialists, including family practitioners, were in competition with each other). The courts are in accord with this approach. See, for example, *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic* 65 F.3d 1406 (7th Cir. 1995) (submarkets of specific, narrowly defined medical procedures called diagnostic related groups could not be used to show monopoly power of physician clinic in the relevant market where, although physicians employed or under contract to clinic provided most of those procedures, other physicians were capable of performing those procedures were part of the market even if not presently active in it).

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[3] See letter from Mark J. Horoshak, Assistant Director of the FTC, to Thomas Rhodes, dated August 15, 1995.

These opinions properly take a practical and objective view of the situation by recognizing that physicians in different specialties may compete for various types of services, thus decreasing the apparent market power of a given group. While neither the agencies nor the courts have been willing to suggest that there is complete substitution across all specialties within medicine, "substitutability" is a matter of whether there are others who can do the job, not how well they do it.

CMA vehemently objects to the use of vague "quality" and "reputational" factors as effecting product market definition. First, federal antitrust analysis does not permit this type of subjective inquiry. Further, an evaluation of reputational and quality factors contradicts the core recognition of Section 6 of the Clayton Act that:

> . . . the labor of a human being is not a commodity or article of commerce.

When the labor involved is that of physicians practicing medicine, the Clayton Act itself recognizes that their services should not be treated as any other "article of commerce." The courts fully recognize this concept. For example, in *Jones v. Fakehany* (1968) 261 Cal.App.2d 298, the court recognized the distinction between the medical profession and general commerce, stating:

> The medical profession, like the legal profession, 'stands in a peculiar relation to the public and the relationship existing between the members of the profession and those who seek its services cannot be likened to the relationship of a merchant to his customer. [Citation]' [Citation omitted.] The practice of medicine should not be commercialized nor treated as a commodity in trade. (Opinions and Reports of the Judicial Council of the American Medical Association, 1966 Ed., p. 25.) Since the practice of medicine is a

> profession and not a business, the practices adopted by businesses are not necessarily suitable.

(*Id*. at p. 45.)

The *Fakehany* court went on to note the most important of the distinguishing features between the practice of medicine and other commercial enterprises—the "extremely dependent and trusting role assumed by the patient" and the patient's faith and confidence in the physician. Given the nature of these personal and sensitive relationships, case law appropriately distinguishes the practice of medicine from a service business.

Courts faced with antitrust challenges understand the personal and subjective nature of the practice of medicine and thus have rejected a qualitative analysis when defining an appropriate product market. Thus, for example, in *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, supra,* the HMO argued that a clinic possessed monopoly power because "the clinic's reputation is so superb that no one will sign up with an HMO or preferred-provider plan that does not have the clinic on its roster." The court explicitly refused to allow the clinic's reputation to be considered as part of its market share and hence penalize it for being the best, stating:

> The suggestion that the price of being "best" is to be brought under the regulatory aegis of antitrust law and stripped of your power to decide whom to do business with does not identify an interest that the antitrust laws protect. 'The successful competitor, having been urged to compete, must not be turned upon when he wins.'

(*Id.* at 1412.)

"Reputation" is simply not a matter that can be bought and sold. Thus, it is important to distinguish the concept of "good will" from "reputation."

Good will is an asset. It can be bought and sold separately from the people who created that good will. Good will in both the commercial and medical context, is tradable because of consumer ignorance, i.e., consumers will tend to go to a business where people did good work in the past, even though those people are no longer there at that business.

Professional and personal reputations are entirely different things. Reputation is the function of the individual whose reputation it is, and presumably rises and falls on a real time basis with the work of that individual. It cannot be bought and sold separately from that individual. To treat reputation as if it were an asset, thus allowing one class of practitioner to be distinguished from another, demeans the very concept of the labor of these individuals, which, as the Clayton Act reminds us, is not an article of commerce.

Further, given the complicated nature of medicine and the inherently subjective experiences of patients, and all the issues involved with severity of illness, co-morbidity, heredity, outcomes, and pain thresholds, subjective statements of consumers have no relevance for antitrust analysis purposes. Indeed, although tremendous effort is being spent to create such measures, there is still no reliable mechanism to fully risk-adjust physician outcome data, such as would be necessary for an accurate, objective comparison.

Moreover, it is impractical, anecdotal, and far too speculative to try to make decisions upon personal statements. Thus, courts have typically discouraged testimony of not only competitors, but also consumers in an antitrust analysis. See, e.g., *FTC v. Freeman Hospital,* 911 F.Supp. 1213, 1220 (W.D.Mo. 1995) explaining that, "informal, off-the-cuff remarks and anecdotal

evidence concerning the marketplace are no substitute for economic analysis." The appellate court in the *Freeman Hospital* case elucidated upon that remark. See *FTC v. Freeman Hospital* 69 F.3d 260 (8th Cir. 1995). There, an action was brought seeking a preliminary injunction to prevent two hospitals from merging. The Court of Appeals held that a relevant market was not established, notwithstanding the submission of statements from various market participants addressing the question of where consumers would likely go if the merger was consummated. Since the issue of market definition involves substitutability, the court discounted the importance of the testimony since, "the views of market participants are not always sufficient to establish a relevant market, especially where their testimony fails to address the practicable choices available to consumers." (*Id*. at 270.)

Courts similarly have rejected speculative statements concerning anticompetitive effects for the purposes of establishing an antitrust injury. See *HTI Health Services, Inc. v. Quorum Health Group, Inc.*, 960 F.Supp. 1104 (S.D.Miss. 1997) (stating, "It is clear from the case law that speculative statements about anticompetitive effects will not satisfy the narrow standard for establishing anti-injury, e.g., *Anago*, 976 F.2d at 249, *Doctors Hospital of Jefferson, Inc. v. Southeast Medical Alliance, Inc.*, 897 F.Supp. 290, 293 (E.D.La. 1995) (experts' speculative statements about increased health care costs and an environment conducive to increased prices for inpatient and outpatient hospital care fell short of the strict Fifth Circuit standard for antitrust injury"), *id.* at 1111-1112, affirmed on appeal 123 F.3d 301 (5th Cir. 1997).)

GEOGRAPHIC MARKET

As the agencies' "Statements on Health Care Enforcement" suggest, like product market, a geographic market depends upon substitutability. While the scope of the relevant geographic

market may vary, depending upon a physician's specialty, "a properly defined geographic market reflects the commercial realities of the industry at issue and when it is economically significant." (*HTI Health Services, Inc., supra* at 1120.)

In rural areas in particular, CMA is concerned that the statistical analysis of market concentration loses all meaning in the context of small markets composed of individual human beings. When a market goes from a statistically highly concentrated to an unconcentrated one because a single physician has moved to the suburbs, CMA questions the use of trying to do a Herfindahl-Hirschman Index based upon who happens to live where at the moment, or who happens to put his/her office where at the moment. The courts have recognized the impracticality of a harsh antitrust analysis in rural areas, recognizing the injury to consumers which will befall in the event physicians are not able to move freely. See *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, supra*, (stating, "Similarly, if the practice of medicine in some sparsely populated county of north central Wisconsin is a natural monopoly, consumers will not be helped by our forcing the handful of physicians there to affiliate with multiple HMOs.")

In *HTI Health Services, Inc. v. Quorum, supra,* a subsidiary of Columbia/HCA HealthCare Corp. opposed a merger of the two largest physician clinics in Vicksburg, Mississippi. The court there refused to find that the merger would have an anticompetitive effect, relying on practical, common sense reasons that justified a combined practice. The court's discussion of the provision of urology services is instructive on this point. Since the entire market in Vicksburg consisted of two urologists, the post-market share became 100%. Placing aside the monopoly share, however, the court found that the combined practice between these two physicians was justified. The court understood the concerns of the physicians regarding backup coverage and

the need to take a vacation or weekend off. Considering that evidence, the court stated as follows:

> Considering the specific character of this two-person market that exists within a relatively small medical community, this court finds it inconceivable that Congress intended the Clayton Act to prohibit two urologists in Vicksburg, Mississippi, from practicing together under the same roof. The practical effect of such an impractical statutory interpretation would be to deprive two physicians from taking alternative weekends off or an occasional family vacation.

(*Id*. at 1128.)

As a result, the court found there was no probable anticompetitive effect as a result of the merger.

The 1996 Agency Statements of Antitrust Enforcement Policy grant a small hospital a safety zone for hospital mergers. CMA requests that the agencies consider a small physician group merger and joint venture safety zone so that when physicians wish to create efficiencies together in a small town they are not threatened with prosecution. While we believe that courts will be sympathetic to any prosecutions, when they occur against a small group of physicians, the physicians simply cannot afford to defend these cases.

BARRIERS TO ENTRY AND PHYSICIAN MARKETS—MANAGED CARE PENETRATION

As a general principle, if entry into a market by new competitors is sufficiently easy, the merger guidelines and court cases provide that the market will remain competitive whatever the market

shares of the existing competitors. Notwithstanding any speculative "physician barriers to entry," courts have recognized that entry by physicians is easy. See *Hassan v. Independent Practices Associates*, 698 F.Supp. 679, 696 (E.D.Mich. 1997) (stating, "Even if the plaintiffs were to leave the tri-county market, there would be no reason to believe that they would not be easily replaced so that the market would be served by enough allergists.")

To the extent that barriers to entry exist for physician services in California, at least, they exist due to the severe concentration of and underfunding by managed care organizations.

Health care in California is so dramatically underfunded that many physician organizations, both large and small, have become insolvent in recent years. The majority of physician groups and those that remain are struggling to survive and risk closure in the near future. In September of 1999, CMA released a report entitled, "The Coming Medical Group Failure Epidemic," which estimated that "as many as 90% of California's physician organizations in the state are posed for bankruptcy or closure." While commentators have disputed that number (most likely due to differences in methodology), it is universally recognized that CMA's report conveyed the overall message properly. See Casalino, *Canaries in a Coal Mine: California Physician Groups and Competition*, (July/August 2001) 20 Health Affairs 97, noting that the report "accurately conveyed the sense of financial crisis among California physician groups"; see also Bodenheimer, M.D., *California's Beleaguered Physician Groups—Will They Survive?* (April 6, 2000) 342 N. Engl. J. Med. 1064. *See* Lentz, *Closure Count: Report Enumerates California Medical Group Failures*, (August 01, 2001) Modern Physician, (setting forth a summary of an independent report on how many California medical groups have closed for financial reasons). Further, with the collapse of these physician groups, many physicians have started new careers, moved out of state, or retired early.

The nearly universal insolvency problem for physician groups and individual physicians points to the fundamental factor that a competitive market does not exist in California. To the contrary, given the fact that approximately five health plans control nearly 90% of California's HMO market and three plans now represent 67% of all patients,[4] these HMOs wield enormous bargaining power, leaving physicians unable to negotiate reimbursement rates which are adequate to cover the cost of providing the medically necessary care promised to enrollees by their health plans and the law.

Even with these low rates, physicians that stay in California have no choice but to contract with these plans. Indeed, a San Francisco Superior Judge, in an order filed on August 22, 2001, recognized the anti-competitive conditions for physicians at least insofar as Blue Cross of California is concerned, emphasizing the practical reality that physicians can't say no:

> Physicians who wish to survive economically in California participate as providers in Blue Cross's Prudent Buyer [health] plan ("PBB"), one of the fastest and largest growing preferred provider organizations in California. . . .

See Order Granting Plaintiff's Motion For Class Certification in A*nesthesia Care Associates Medical Group, et al. v. Blue Cross of California* (San Francisco Superior Court No. 986677). The Court went on to note that Blue Cross's contracts with physicians are, in fact, "contracts of adhesion." (*Id.*)

This inability to negotiate with health plans has led even the largest physician organizations to accept inadequate capitation rates—rates that are not actuarially based as required by law (see,

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[4] *See* Bodenheimer, *id.* at 1064.

e.g., 28 C.C.R. §1300.75.1) to assure that they cover the costs of care, but are driven by whatever the market will bear. See Robinson, *Physician Organization in California: Crisis and Opportunity*, (July/August 2001) 20 Health Affairs 81, 85 stating, "Low payments, expressed most clearly in dismal per member per month capitation rates, are the proximate cause of the difficulties afflicting medical groups and IPAs in California."[5] Yet, the very survival of physician organizations depends upon adequate capitation rates from health plans.[6]

The end result for these physician groups in this unfair and anti-competitive environment is a Darwinian struggle to survive between contracting with health plans, competing with other physician groups, and competing for treating physicians and other suppliers with whom they employ or contract with to provide necessary medical services. Physician groups may have no bargaining leverage with any of these entities. As was recently described:

> The largest groups did enjoy some gains in bargaining leverage but have been dismayed to encounter even more effective resistance both up- and downstream. The limited

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[5]These concerns regarding inadequate capitation payments have been substantiated by an independent financial report. In 1999, PriceWaterhouseCoopers (PWC), an independent financial consulting firm, reported California capitation rates ranging between $29-36 pmpm—$32.50 average. The Warren Survey published a report, *Physician Capitation and Benefits*, which showed that in 1999 the national mean capitation rate was $42.50 pmpm. A more recent national capitation survey conducted by *Capitation Management Report* demonstrates capitation rates (year 2000) nationally are averaging $44.15 for physician services only. Thus, in the instance of the Warren Study, California rates are 31% below the national average and in the instance of the second survey, 36% below average. The Capitation Management Report further states that while provider organizations are beginning to receive higher capitation rates they ". . . are by no means out of the woods in negotiating and managing actuarially sound capitation contracts . . ." They also report that health care premiums have increased during the past year but "health plans have not raised cap rates commensurate with those increases . . ." Health plans have, however, recorded record profits.

[6]*See* Bodenheimer, *supra* at 1065.

> leverage against health plans stem from the simple fact that health care is local, and even the largest medical groups never built anything approaching monopoly power in any particular submarket. Scale typically has been achieved through mergers with groups in adjacent communities, not by absorption of all local competitors. The vast supply of physicians attracted to the California lifestyle and the lack of entry barriers to establishing practices produce an abundance of upstart IPAs, specialty carve-outs, and expansion-minded entrepreneurs always willing to undercut rate increases demanded by the local incumbents. Payment rates have now declined to levels that equilibrate supply and demand in the most brutal fashion, as enough specialists and subspecialists simply walk away from the table.[7]

Under these circumstances, we believe that the agencies would better protect consumer welfare if they focused upon the monopsony power of health plans. The Department of Justice has previously recognized the problems with monopsonies and that they can create decreased input because of price reductions which result in reduced quantity. As the DOJ stated, the exertion of monopsony power by Aetna would have had severe effects on the purchasers of HMO products in those markets, "likely leading to a reduction in quantity or degradation in the quality of physician services" to patients. Under those circumstances, the consent decree entered allowing Aetna to proceed with the acquisition required it to divest its HMO business in certain markets.

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[7]Robinson, *Physician Organizations in California: Crisis and Opportunity*, *supra* at 91.

CONCLUSION

In conclusion, CMA again would like to stress the important role the antitrust laws play in preserving a marketplace which benefits the consumer. We believe, however, that taking overly narrow and statistical approaches to physician markets will benefit no one, particularly in this era of underfunding. We respectfully request that the agencies reevaluate the situation and take a serious look at competition on the payor side. Thank you for the opportunity to participate in these proceedings.

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