"Why Physician Cartels Do Not Need a "Fresh Look" – a Response to the AMA's Testimony at the FTC Health Care Competition Workshop

In its statement submitted in connection with the Federal Trade Commission's Workshop on Health Care Competition Law and Policy, the American Medical Association ("AMA") argues that doctors should get special treatment under the antitrust laws so that physician networks that are neither financially nor clinically integrated would be evaluated under the Rule of Reason. [1]/ The AMA urges that we abandon settled antitrust case law, including a Supreme Court decision [2]/ that squarely addresses the issue, and jettison longstanding enforcement agency policy and guidelines. There are sound reasons, however, for the existing antitrust approach that condemns as *per se* illegal physician networks that amount to little more than price-fixing cartels. The approach that the AMA recommends – while it may serve to increase physician incomes – will benefit neither patients nor the employers who are largely responsible for paying for employee health care costs.

THE AMA ATTACK ON FIVE "CORE PRINCIPLES"

The AMA argues that five "core principles" underlying antitrust treatment of physician networks should be re-examined. But a closer look reveals that the AMA has misconstrued these principles, and that granting physicians special treatment under the antitrust laws would be seriously misguided.

Capitation vs. fee-for-service medicine. First, the AMA constructs a "straw man" argument, asserting that antitrust treatment of physician networks is based on the assumption that "capitation and other forms of risk contracting are "more efficient than fee-for-service medicine." [3]/ The AMA Statement then launches into a discussion of which form of arrangement – risk contracting or fee-for-service medicine – is preferable.

This discussion entirely misses the point because, contrary to the AMA's assertion, antitrust policy is *not* based on a preference of one form of

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[1]/ "Statement to the Federal Trade Commission Workshop on Health Care Competition Law and Policy re "Integration, Physician Joint Contracting and Quality: Taking a Fresh Look at Some "Settled" Questions," presented by Catherine Hanson, J.D., September 9, 2002 [hereinafter "AMA Statement"].

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

[3]/ AMA Statement at 2.

contracting over the other. [4]/ Rather, the crux of the antitrust analysis is whether the price-fixing that occurs with joint physician contracting is reasonably ancillary to an enterprise that may have the potential to achieve substantial efficiencies. Accordingly, the antitrust analysis of capitation and risk-based contracts is based on two important assumptions. First, such arrangements – because they involve financial incentives that encourage physicians to work with each other to reduce inappropriate utilization and improve quality – may result in more efficient care than would be the case if the physicians were not collaborating. In short, the "whole may be greater than the sum of the parts," and what the physicians are "producing together" may be more efficient (lower costs and higher quality) than what they would have "produced" in their separate offices without any financial or clinical integration. Second, capitation and risk-based contracting, by their very nature, require that the physicians engage in some collective negotiations so the doctors can set a price for what they produce through their joint efforts. Therefore, Rule of Reason treatment is given to this joint contracting that is ancillary (*i.e.* reasonably necessary) to such efforts.[5]/

Thus, the antitrust laws do *not* assume that capitation or risk-based contracting is better than fee-for-service arrangements. Instead, the difference between these two forms of contracting is that physicians can contract on a fee-for-service basis without agreeing on their prices, so there is no justification for them to engage in price-fixing. Moreover, the "product" that physicians provide under jointly contracted fee-for-service contracts is no different than what they would furnish under independently set fees. What is disfavored under the antitrust laws is not fee-for-service medicine, but joint negotiations for fee-for-service contracts that offer the potential of few efficiencies, while presenting significant risks of higher prices and other anticompetitive effects.

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[4]/ *See Health Care Statements* at § 8.B. (It is not the intent of the FTC and DOJ "to treat [physician] networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumes may desire. Rather, their goal is 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").

[5]/ *See Rothery Storage & Van Co. v. Atlas Van Lines*, 792 F.2d 210, 224 (D.C. Cir. 1986), cert. denied, 479 U.S. 1033 (1987) ("The ancillary restraint is subordinate and collateral in the sense that it serves to make the main transaction more effective in accomplishing its purpose. . . . [T]he restraint imposed must be related to the efficiency sought to be achieved."); *General Leaseways, Inc. v. National Truck Leasing Association*, 744 F.2d 588, 595 (7th Cir. 1984) (There must be an "organic connection between the restraint and the cooperative needs of the enterprise that would allow us to call the restraint a merely ancillary one. . . . ").

Joint contracting and transactional efficiencies. Apparently acknowledging that fee-for-service networks offer no promise of clinical efficiencies in the form of lower cost or higher quality care, the AMA argues in its second point that such networks can offer significant "transactional" efficiencies. The AMA suggests that physician joint contracting could reduce the cost of a health plan in developing a physician network. It also could reduce physicians' costs in evaluating whether, and on what terms, they wish to participate in a particular health plan.

But such "transactional efficiencies" are given little weight under traditional antitrust analysis if there are other ways that the efficiencies can be achieved with much less risk of anticompetitive effects. Thus, while there may be some potential efficiencies associated with providing a fully-developed physician network that is available for health plans to contract with, there are third-party national and regional PPO companies that specialize in putting together such networks and "renting" them to health plans.[6]/ These efforts, unlike a physician-sponsored network, do not raise antitrust issues since the third-parties have an incentive to set fees at a competitive level. And, as discussed below, if physicians wish to put together their own networks without raising antitrust issues, they can do that under existing antitrust law through use of the so-called "messenger model."

As to the potential efficiencies for doctors, few would argue that the negotiation process would be more efficient if physicians could fix their prices. But that would be the same as saying that cartels should be legalized since they are more "efficient" at setting prices than a competitive market. Furthermore, physicians who wish to pool their resources to obtain objective evaluations of complicated contract terms are free to do so under existing antitrust laws.[7]/ Such efforts can enable them to make more informed decisions – but those decisions must be independent, and not coordinated through a joint negotiation process.

Finally, in arguing that transactional efficiencies should be given more weight, the AMA asserts that the risk of anticompetitive harm would be small since the physician network could be non-exclusive, and health plans would be free to contract with physicians independently outside of the network arrangement if they so wished. But this ignores entirely the anticompetitive

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[6]/ *See Maricopa*, 457 U.S. at 352 (Even if it is desirable to establish a fee schedule for physician contracts, "it is not necessary that the doctors do the price fixing.").

[7]/ *See e.g.* Letter from Charles A. James, September 23, 2002, to Jerry B. Edmonds re: Washington State Medical Association, *available at* <http://www.usdoj.gov/opa/pr/2002/September/02_at_542.htm> (Press Release) (allowing medical society to disseminate survey results containing information about the average reimbursements paid by individual insurers).

"spillover" effects that would occur. For example, consider a physician network that develops a fee schedule that it offers to, and is prepared to negotiate with, health plans. If the health plans decide, however, that they would prefer to contract with the physicians independently it likely will be too late – all of the physicians already would know what they had collectively agreed on as an "acceptable" rate, and it is doubtful that the independent negotiations would result in competitive fees. Moreover, it would be very difficult to determine whether the physician network was really non-exclusive and that the physicians were making truly independent decisions. For example, if most of the physicians subsequently rejected health plan contracts, a reasonable inference might be that they had used the previously agreed on "acceptable" rate in helping them coordinate their so-called independent responses.

Clinical integration. The AMA's third point apparently is that it may not be simple for physicians to form "clinically integrated" networks. This is true, and there are ample reasons for it.

In the 1996 *Statements of Antitrust Enforcement Policy in Health Care*, [8]/ as well as in the FTC's recent advisory opinion involving the MedSouth IPA in south Denver, [9]/ the antitrust enforcement agencies acknowledged that physician arrangements can receive Rule of Reason treatment even if they are not financially integrated. But this does not mean that simple window dressing will allow a cartel to escape *per se* antitrust condemnation. Instead, where there is no financial risk-sharing, the agencies and courts rightfully should be skeptical that the physicians will achieve any substantial efficiencies that would justify their joint price-setting. What the agencies have said, however, is that notwithstanding that justified skepticism, where an arrangement such as the one in *MedSouth* reflects a substantial investment in time, effort and expense to suggest that it has the potential to result in more efficient (lower cost or higher quality medicine), it deserves to be assessed under the Rule of Reason.

The Messenger Model. The AMA Statement then attacks the "messenger model" for physician contracting as "cumbersome and difficult to administer." [10]/ Under the messenger model, a third-party receives contract offers from payers and conveys them to physicians, who then communicate their independent decisions, through the messenger, back to the payers as to whether they wish to participate in the contracts. The crucial aspect of the

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[8]/ U.S. Dep't of Justice & Federal Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (1996), available at < http://www.ftc.gov/reports/hlth3s.htm > [hereinafter Health Care Statements].

[9]/ Letter from Jeffrey W. Brennan to John J. Miles, February 19, 2002 re: MedSouth, Inc., *available at*: < http://www.ftc.gov/bc/adops/medsouth.htm >.

[10]/ AMA statement at 15.

messenger model is that the physicians do not communicate with each other as to what terms they are willing to accept, and the messenger does not engage in negotiations with the payers. Thus, if properly administered, the messenger model reduces the risk of anticompetitive price agreements, while at the same time providing a payer with a "ready-made" network with which to contract.

It is true that the messenger model requires some administrative structure, and that it must be implemented carefully to ensure that it is not simply a cartel in disguise. But this is not an impossible task, and the agencies have clarified how the messenger can obtain information from the physicians at the outset so as to be able to respond promptly and efficiently to payer inquiries concerning how many physicians would be willing to participate at various fee rates.[11]/ Messenger models also have been approved by antitrust enforcement officials to negotiate (provided certain safeguards are in place) non-price terms, such as utilization review, credentialing, quality assurance standards, indemnity and hold harmless provisions, payment and billing arrangements, and termination procedures. [12]/

The AMA argues that the messenger model leaves physicians exposed to boycott charges if a large number of physicians independently reject a payer's offer as inadequate. Such charges should be of little concern if the physicians have followed the clearly articulated messenger model rules. Under such rules, the physicians will not have had the opportunity to communicate with each other as to an "acceptable fee," and therefore there should be (absent other evidence to the contrary) no basis for an antitrust challenge. In contrast, the AMA proposal to allow physicians to jointly negotiate fee-for-service contracts would raise much more serious concerns. If the network rejects a health plan's proposal, and then the individual physicians similarly reject the proposal when posed to them independently, legitimate questions could be raised as to whether the network's collective negotiation had facilitated illegal collusion.

The Importance of Quality. The AMA's last point is that antitrust enforcement in health care should give consideration to quality issues. Few would argue with this view. Indeed, the underlying premise of the antitrust laws is that competition will result not only in lower prices, but also higher quality goods and services. Moreover, as the antitrust agencies have made clear, the antitrust laws do not preclude physicians and other health care

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[11]/ *See Health Care Statements* at § 9.C.

[12]/ *See e.g.* Letter from Joel I. Klein to Jaye L. Martin, February 4, 2000, re: Midwest Behavioral Healthcare LLC, *available at* http://www.usdoj.gov/atr/public/busreview/4120.htm>.

providers from communicating among themselves, or with health plans, on quality issues. [13]/

CONCLUSION

As the above discussion indicates, a close look at some of the "core principles" underlying health care antitrust enforcement indicates that they are based firmly on sound legal precedent and policy. There is no justification for special rules that would legitimize physician cartels. The antitrust agencies should continue to vigorously enforce the antitrust laws to ensure a competitive health care market that will benefit all consumers.

[13]/ See *Health Care Statements* at § 4.A (provider activities related to mode, quality or efficiency of treatment, including development of practice parameters, are unlikely to raise significant antirust concerns).