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FEDERAL TRADE COMMISSION

I N D E X

P R O C E E D I N G S

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MS. KOHRS: This is day two of the final session of the joint hearings of the Department of Justice and Federal Trade Commission on Health Care and Competition Law and Policy. Today we're going to be talking about IPAs: Patterns and Benefits of Integration.

There are a number of distinguished panelists on here and I'm only going to be giving one-line introductions. We have a biography book that is available outside, so please take a look at that for more complete information on all the speakers.

We're going to start in order from my right. Dr. Larry Casalino is a professor in the Department of Health Studies at the University of Chicago, following extensive experience as both a practicing physician and active researcher.

Albert Holloway is the head of the IPA Association of America, which he founded after heading up several IPAs.

Dr. Bartley Asner is a board-certified pediatrician who heads CAPG which is the largest organization of physician groups in California.

Curt Hawkinson came today, I believe, from

Oregon, right? He's a physician assistant who works in an IPA.

And Markus Meier is a Deputy Assistant Director of the Health Care shop at the Federal Trade Commission where he works on a spectrum of health care and antitrust matters.

I'm joined by a moderator from the Department of Justice, Rich Martin. Rich and I will be facilitating the question and answer period which is going to go on after everyone's had an opportunity to speak. So, without further ado, we'll go ahead and start.

Dr. Casalino, your presentation is on the computer right up here.

(Tape malfunction.)

DR. CASALINO: -- for an IPA in Northern California that I was vice president of for many years in the '80s. These are not really the happiest moments, but they were some of the more interesting.

That IPA was one of the oldest in California, but it is not still in business, unlike most IPAs in California, which are.

The enjoyment of the board meetings was far surpassed by the enjoyment of the general meetings, however, at one of which the president of the IPA threatened to call the police to evict a few of the

physicians in the back who were disagreeing with him rather vehemently.

Well, this is probably elementary for most, if not all of you. But just briefly, what is an IPA and how is it different than a medical group, an integrated medical group? A lot of IPAs call themselves medical groups now, but there are important differences.

I think the easiest way to understand it is to look at three different contracting models or really two, with the second one having two variations. One, which is the predominant model in a lot of the country still, is with an HMO contracting directly with individual physicians. The HMO may do this simply directly with individual physicians, or especially in the early days of HMOs, HMOs would sometimes set up their own, what they called an IPA, but it was really just HMOs contracting with individual physicians. And in that model, the HMO does all the utilization management, such quality improvement as there may be and the HMO usually takes most of the financial risk as well.

In the other model, the HMOs contract with an intermediate group of physicians. So, an HMO may contract with a medical group, an integrated medical group, typically a partnership or professional corporation, which the physicians are all part of a group

-- they're owners or employees of owners -- and the group has employment contracts with its own physicians.

This becomes important especially in the antitrust part of the discussion later and for some other reasons as well. And the variation on that model is for an HMO to contract with what I'll call a true IPA, which is a separate organization composed of often hundreds of physicians, each in their own small or solo group of practices. So, the HMO will contract with the IPA and then the IPA contracts with its member physicians, but the physicians are in their own independent offices and in medical groups of various sizes, usually relatively small because the large groups will contract directly with HMOs.

Now, how many IPAs are there in the United States? Al Holloway may have something to say about this, but I think the answer is that nobody really knows. There probably were 1,000 or even a bit more. The number has gone down a bit, it's safe to say, during the last few years. In something called the National Survey of Physician Organizations, which I worked on with colleagues in Berkeley, we identified about 463 IPAs nationally, but we know there -- and we worked pretty hard to do that, but we know that there are more.

The reason that there has been -- we'll get to

the reasons why there's been a decline in the number of IPAs in a moment. The median age of the 463 we identified was six years and the median size about 233 physicians. The reason that the number of IPAs is declining is really due to the changes in managed care from the expectation, if not the reality, of what I would call tight managed care with a lot of risk contracting to loose managed care.

So, when it was thought that medical care in the United States was going to be delivered mostly through HMOs and that HMOs would utilize primary care gatekeepers and that risk contracting, capitated contracting would become the predominant mode of contracting, and by that I mean you'd have physician groups, plus or minus allied hospitals, would be taking on the financial risks, not only for their own services, but for many other services, for example, hospital services and various ancillary services. When it was thought that that was going to be the model, there was a proliferation of IPAs as well as medical groups and PHOs and various other kinds of organizations.

But without risk contracting, the IPAs have to seek a reason for existence and we'll come back to this in a minute, but the reason is that -- let me leave that and come back to it.

Just to clarify a little bit, I don't think there's as much confusion about this as there used to be, but HMOs, for many years, have been classified into staff models, group models, and so-called IPA models, extremely confusing. The IPA model is really the first model that I showed in this slide here where the HMO contracts with individual physicians. As you can see, that's quite different from what I would call the true IPA model, which is where there actually is an organization that's an IPA, typically owned by physicians, sometimes by physicians and a hospital or occasionally by a physician practice management company and it's the HMO contracting with that.

So, the so-called IPA model HMOs -- that classification doesn't really mean much and is not what we're talking about today. We're talking about actual physician organizations, IPAs. And as I say, usually they're owned by a physician, some or all of their physician members, but there are other forms of ownership as well or others kinds of owners.

In the classic payment method, an HMO would capitate the IPA for prominent care physician and specialist services; that is, give a certain amount of money per member per month to the IPA and then there would be a risk pool for other services, such as hospital

or diagnostic services. At the end of the year, depending on how much money was spent by the IPA's patients on those hospital or ancillary services, the HMO and the IPA would split the profits or in theory, at least, split the losses.

Now, where there is risk contracting being done, that still is the predominant model with some modifications basically to make the IPAs a little bit safer in terms of downside risk. It is important to understand, although we won't be getting into this today -- at least I won't -- that although the IPAs are capitated, they can pay their physicians any old way. They may pay them all a fee-for-service; they may pay primary care physicians capitation. The IPA may capitate some primary care physicians and pay specialists fee-for-service. Or some IPAs, for example, the Hill Physicians IPA, one of the most successful in the country, actually tends to pay its primary care physician fee-for-service and tries to capitate many of its specialists.

So, the fact that the HMO capitates the IPA does not mean that the IPA capitates its own physicians. But it may.

There was a move toward global capitation in '96, '97, '98, especially in California, but in some other places, and this is where an IPA, sometimes in

conjunction with a hospital or hospital system, would really take financial risks for virtually all services provided to patients, both physician services and hospital services and also ancillary services. So, basically the HMO would pass on the premium amount that was supposed to pay for those things, keep money for whatever other expenses the plan had and profits, give the rest to the IPA. The IPA often would pay claims. At the end of the year, if the IPA had money left over, made a profit; if it ran out of money, this was a problem.

Now, this is an extraordinarily brief history of IPAs and doesn't really go back to the early IPAs, some of which were formed in the '50s for other reasons. But I think it's safe to say that the IPAs formed in the '80s and early '90s, especially, and to some extent, even in the late '90s in some parts of the country where managed care was slow to come, they were really more of a defensive strategy against managed care. Sometimes physicians and hospitals were getting together and saying, let's get our own organization here and we'll try to reduce the impact of managed care and of HMOs as much as we can. And the idea really was to keep things as much like they had been in terms of modes of practice and in terms of levels of income for physicians and ways of getting paid to keep things as much as possible as they

had been, so very much a defensive strategy.

But there have been some IPAs and there are, I would say, more and more as the years go by, which have actively embraced their own form of managed care or a more physician-friendly form of managed care that they would say, I think, and are actually kind of proactively trying to manage care to control costs and to improve quality, and we'll probably hear a bit about that today from some of the other speakers.

Now, in California where I did most of my research and practiced until three years ago -- and Bart will probably talk about this -- this is still a great deal of capitation and IPAs have a strong reason to exist. But in a lot of the rest of the country, not all but much, where physicians and health plans have retreated from capitated contracting, either it never really ever got there or it was there and there's been a pullback, IPAs are casting around for a reason to exist.

And the reason is this. The other reason, I guess, is that a lot of patients have moved, as you know, from HMOs into PPOs and that seems to be an accelerating movement at present. Now, if you're a true medical group, an integrated medical group, you can negotiate contracts with PPOs, if you're big enough to have the negotiating leverage to do that, and not be violating the

antitrust laws because you're a group of physicians, you're not competing physicians getting together to try to "set" prices.

But if you're an IPA, you really only can negotiate as a group with a health plan if you're taking significant financial risks or if -- with the new guidelines that the FTC and the DOJ put out about six or seven years ago, you can negotiate with a health plan if you're clinically integrated and very few IPAs have sought that status or received it. The FTC gave an advisory letter, I believe it was called, to an IPA in the Denver area called MedSouth last year, in which the FTC said, even though you're not taking risk anymore, this IPA has been, you look like you're clinically integrated and we're going to watch you, but as long as you look like you're clinically integrated, you can negotiate collectively with an HMO.

But absent that, if you -- and this was, you can negotiate collectively with an HMO, to the best of my knowledge, MedSouth has not been negotiating with PPOs. But absent the ability to somehow show clinical integration with PPO patients, an IPA really can't negotiate with a PPO. And, therefore, if a lot of the patients in an area are in a PPO, the IPA loses a lot of its reason for existence. If it's not getting risk from

HMOs either, the IPA really can be in trouble. And I'm sure we'll probably talk more about this as the panel goes on today. So, I shouldn't belabor the point right now.

But in some areas of the country, this has led to a crisis of IPAs and it is a major reason for the decline in the number of IPAs in the country as a whole. The other reason being some of them just didn't do very well financially in trying to manage risk.

Now, briefly about some of the possible advantages of IPAs. For consumers, they do offer a broad choice of physicians and hospitals, but let's just stay on the physician side here. In other words, if you're a medical group, even if you're quite large, even if you have 100 physicians, which is a big medical group, that still is a pretty limited network of physicians for patients to be able to see in terms of geographic location, specialty types, ethnicity. But an IPA can have hundreds of physicians at many locations and so can offer a lot of choice. Also, since most IPA physicians practice in solo or small group practices, many consumers prefer that to going to a Kaiser-like center. So, that's a possible advantage of IPAs.

Insofar as IPAs can manage care to lower costs, that can be an advantage if you assume that those lower

costs will be passed on to consumers. And similarly, if IPAs, as some probably can do, can manage care in such a way to improve quality, that can be a benefit for consumers compared to what they might get from physicians just in solo or small group practices who don't have any larger organization giving them various organized processes with which to improve quality.

Now, there are some advantages of IPAs for HMOs as well. For one thing, if you're an HMO trying to get started in an area, you basically have one-stop shopping to get a physician network. If you sign a contract with the IPA, all of a sudden you have hundreds of physicians. You don't have to go out and recruit them and sign contracts with them one-by-one. They're relatively inexpensive to create for the HMO, for the reason I just gave. And if it's an IPA which is really trying to manage care in a beneficial sense, then the HMO can get probably more physician cooperation with utilization management and quality improvement than an HMO would that is just contracting with lots of individual physicians.

And it can also be very uncomplicated for the HMO if it delegates credentialing utilization management, quality improvement and financial risk to the IPA. The HMO doesn't actually have to do very much. That's assuming the IPA can actually handle these things well

and doesn't blow up. In the latter case, it's not good for the HMO at all.

For physicians there are also possible advantages of IPAs. One is a way to get HMO contracts, which in some cases, especially when networks were narrower than they are right now, if you're a small practice, you might be left out of HMO contracts, but in a large IPA, you're not likely to be. You can get some negotiating leverage with HMO by being part of this larger organization which you'd never have by yourself. Yet you get to stay in your own small practice, which you may want for lots of reasons.

In IPAs, the physicians, since they own their own practices, tend to be very productive and to pay a lot of attention to the costs of operating their practices. I remember Al Barnett at Friendly Hills in California, which was a large medical group, but also operated an IPA. He'd say when they would have a meeting for all their physicians that was supposed to start at 6:00, he'd say at quarter to 6:00, our own physicians from our medical group, who are mostly on salary, would be sitting there waiting for the meeting to start and the IPA physicians would come running in from their offices about quarter of 7:00, an hour later, late for the meeting because they had been squeezing in every last

patient they could see and taking care of everybody who called.

It's also a benefit for physicians that IPAs are inexpensive to create compared to creating a large medical group, which is expensive.

Another thing that's not generally recognized by non-physicians, but if you're in a solo or small group practice and contracting directly with HMOs, you may have contracts with six or seven HMOs, they each have their own utilization management process, they each have their own network of physicians and hospitals you have to use, it's very difficult.

If instead you have contracts with those six or seven HMOs through your IPA and your IPA has been delegated utilization management, then you only have to deal with one utilization management system for those six or seven HMOs. That may sound like a small thing, but I can tell you, if you're a practicing physician, that's huge.

And the other thing is, although individual physicians may not recognize this that much, having an IPA -- and this would be true of medical groups as well -- that is managing care is actually a way to keep physicians at the center of medicine. In other words, if one thinks that in the long run, people who are going to

be most valued by purchasers, corporate purchasers, government purchasers, are the organizations that can add value by managing care in a beneficial way, if HMOs do that or health plans, they're going to be at the center of the system. If physician groups do it, they can be at the center of the system.

Now, IPAs versus medical groups. I've given some advantages of IPAs. There are some disadvantages. Physicians are typically much less committed to the IPA than they are to their own medical group. They may be members of multiple IPAs. They only get a certain percentage of their patients through the IPA whereas the medical group is their whole life. So, it's much easier for a medical group to get its physicians' cooperation and attention to what the group wants done than it is for an IPA to do that.

At the physician office level, there can be a lack of scale economies. In other words, if you have one large medical group, it has one information technology system, one CEO, one accounting firm and so on and so forth, whereas an IPA will also have one of all those things, but then all the dozens, if not hundreds of physician practices in the IPAs will each have its own IT system and so on, office managers, accountants, billing officers and so on. So, it's expensive at the individual

physician level.

As I mentioned, you don't really have command and control in an IPA compared to a medical group. They can be much more difficult to govern. However, they are easier to create and maintain.

Now, just to conclude, which it probably is getting time for me to do, I just want to briefly touch on a few important issues. One thing I should say is if you asked the question, how good are IPAs at decreasing the costs of medical care or are they as good as medical groups, and the answer is, there isn't really a lot of data on any of the things I'm going to talk about here, at least there isn't a lot of definitive data.

So, what I'm saying are generalizations based on the studies that have been done and on my own work, which includes now nearly 1,000 interviews around the country with people who run health plans, IPAs, hospital systems and so forth, medical groups. Generally speaking, everything else being equal, a large medical group can probably lower utilization of care, inappropriate utilization, more than an IPA which can do it more than the other model where HMOs contract with individual physicians.

Now, there are exceptions. A good IPA will do better than a so-so medical group at managing

utilization. But in general, I would say it's fair to say that this would be the way it would go, and I should add immediately that many IPAs in California, and in some other places of the country as well, have been extremely successful at managing utilization.

There is the extra layer of administrative expense in an IPA that's -- in a delegated IPA compared to HMO individual contracting. In other words, an HMO has its own administrative set-up. It deals with individual physicians, there's nothing in between. But if there's an IPA in between, somewhere the money has to come from to pay for that administrative structure. So, there's the question, does that administrative structure of the IPA lower costs enough more than the HMO could do it itself to make it worthwhile for the HMO essentially to pay for that administrative structure?

Costs can go up, also, from IPAs, if the IPA has sufficient negotiating leverage to raise physician payment rates, which some people may think is a good thing. But in any case, it makes costs a bit higher. And as I said, compared to large medical groups, IPAs don't have the scale economies at the physician practice level. On the other hand, the physicians and the IPAs are highly, highly motivated to run their practices well and work really hard compared to physicians in a large

medical group practice.

Effects on quality. For patients, physicians and staff who prefer to practice in the familiar old small practice setting, IPAs make it possible to do that yet still get negotiating leverage with HMOs on the physician side and also still be part of an organization which can develop organized processes to improve quality.

IPAs definitely have a lot more trouble getting good information technology systems at the physician office level than a medical group. Obviously, a medical group, even if it has 20 sites, can have the same IT system at all its own sites. An IPA really can't impose an IT system on all the multiple physician practices that comprise the IPA, any of whom may only get 10 percent, 20 percent, at the most, of their patients from that IPA.

So, again, you'd expect everything else being equal, that medical groups, large medical groups, would be able to improve quality better than IPAs which would probably be able to do it better than the HMO individual physician contracting model. But there isn't great data about this. Probably the best data there is, I think, is from the national survey of physician organizations that I mentioned at the beginning, which I did with colleagues in Berkeley.

We looked at 1,040 physician organizations

nationally. About two-thirds of them were medical groups of 20 or more physicians and the rest were IPAs and we -- one of the things we did was compare their use of what we call organized care management processes. We looked at 16 processes for four chronic diseases and said, okay, how much do you use these? These are good things to do, how do you do them? How much do you do them?

We found that in general they didn't get done much, only about five out of 16 were done on average by these large medical groups and IPAs. Small groups, I'm sure, would be less. But we found no difference if we adjusted for all factors. Everything else being equal, there wasn't actually no difference between IPAs and large medical groups in the number of these processes that were used.

Now, I wouldn't want to say too much during this study. This is just a crude way of measuring it. But it makes it look pretty good for IPAs and actually belies a little bit what I was just saying.

Just to conclude a little bit on antitrust, I've basically already said this. IPAs can't negotiate fees with -- or really anything else practically speaking, with health plans unless they in some way have some financial risk or are clinically integrated. And, again, insofar as HMOs move away from risk contracting,

insofar as PPOs don't do risk contracting with physician organizations and don't delegate the functions to physicians that would make it possible for an IPA to at least -- I don't want to say possible. It would make it easy for an IPA to clinically integrate. It calls the very existence of IPAs into question. If all patients were in PPOs, would there be any IPAs?

I already mentioned the MedSouth situation in Denver where MedSouth really spent quite a bit of money and did a lot of planning, did a lot of work to persuade the FTC that processes were in place for their HMO patients. I don't believe there were PPO patients involved in this, though I'm not certain of that, to show clinical integration.

But the other thing that the FTC said in their advisory letter -- and this is something that would be dismaying perhaps to proponents of IPAs -- is MedSouth did not ask its physicians to sign exclusive contracts. In other words, a physician could contract with an HMO either through MedSouth or just directly on his or her own yet still be a member of MedSouth, and a lot of IPAs think it's hard to do business that way.

So, I will stop with that and we'll take questions later.

(Applause.)

MS. KOHRS: Thanks, Dr. Casalino. Mr. Holloway, you can either sit here or you can go up to the podium.

MR. HOLLOWAY: I'll stay here.

On behalf of the more than 2,000 physician organizations in the United States, representing three-fourths of the physicians practicing in America, I would like to commend the Commission for its efforts to provide detailed guidelines to physician organizations on the degree of clinical and financial integration necessary for them to bargain with payers as a group.

I am encouraged that the Commission has created a venue by which open and meaningful discussion can take place on the implication of the FTC's growing emphasis on health care as it relates to clinical and financial integration and for your colleagues to hear about the potential impact that the Commission's efforts are having on patient care.

I am eagerly anticipating that the Commission will further provide definitive definition and guidelines on what is the required degree of clinical integration and financial integration from the physician's point of view and how physician organizations can effectively operate within the confines of those guidelines.

TIPAAA recognizes the importance of the 1996

statement of enforcement policy that outlined the framework for physician organizations negotiating economic contracts as a joint entity. TIPAAA's legal committee provided a great deal of input to the FTC on these issues as they relate to community practice. TIPAAA was very encouraged to have had the opportunity to work with the FTC in developing revised guidelines.

We are also pleased to have had the opportunity to play a role in educating the physician community about the guidelines. In the latter part of 1996 and the early part of 1997, TIPAAA, in conjunction with the FTC and the Department of Justice, conducted approximately 24 four-hour educational programs around the United States on the revised guidelines.

TIPAAA realizes that the 1996 statements were a major step in enhancing the concept of shared contracting. We are very pleased to have had the opportunity to work with the FTC in clarifying the framework for the physician organizations.

At this point, however, we are very concerned that the lack of clear, concise, definitive direction to physician organizations on what is permitted under the messenger model for non-integrated IPAs as well as the related question of the degree of shared clinical and financial information necessary to achieve integration is

significantly interfering with the ability of physician groups to effectively deliver quality care to our communities. To effectively deliver quality care to our communities.

We're currently aware of several IPAs who have slowed down or stopped altogether their negotiating on behalf of physicians because of the uncertainty as to what they can and cannot do. Left unresolved, this will lead to further problems for physicians to remain in practice that will result in access issues in many communities. We are already aware of many communities where they cannot attract physicians because of the low reimbursement rate. That cannot continue.

The historical role of the IPA has been one of ensuring that the health care needs of our communities are met in a cost-effective manner while delivering quality care. The IPA has proven that it is a structure that reduces duplication and rewards quality of care. The structure of an IPA that bears financial risk is one that requires it to establish overall -- in part, overall clinical protocols and to insist that its provider members adhere to those protocols.

It is important to recognize that there is a growing national consensus around evidence-based guidelines that have begun to establish a common set of

protocols and clinical guidelines.

These protocols or guidelines are not unique to HMO patients. They are the clinical guidelines for all patients served by a physician regardless of their payment source. It is not functionally feasible for an IPA to have its provider members operating under two distinct sets of protocols or guidelines that are unique to an individual payer or insurer.

The FTC should consider allowing flexibility in the acceptance of common evidence-based guidelines to help simplify the clinical management task of physicians and acknowledge that adoption and adherence to evidence-based guidelines is clinical integration. IPAs have historically implemented active and ongoing programs aimed at evaluating and modifying physician practice patterns to create a higher degree of interdependence and cooperation among the physicians resulting in cost control and quality management. Those IPAs who adopt these guidelines should be able to negotiate with payers as a group.

On a more general note, financial risk sharing has been declining in most markets in the United States while efforts at clinical integration have been increasing. This is particularly attributable to the introduction of electronic medical records and other

forms of online clinical data exchange. The ready availability of health information online greatly aids patient care and is something to be fostered. IPAs are ideally suited to provide these kinds of networks.

As the FTC recognized in its advisory letter to the MedSouth IPA in Denver, development of clinically integrated services may require a single price offering to payers so that participation of physicians can be assured. Physician participation is crucial. In this way, rewards from the program flow equitably among the participating physicians. It may also be necessary to enable the IPA to pay for expensive computer systems.

What is desirable is for the FTC to issue definitive and clear guidelines as to what level of clinical integration and oversight is required to allow the IPA to price the products, guidelines as to what spectrum of services, what level of information sharing and oversight procedures should the IPA implement are requested.

TIPAAA is very encouraged that the Commission is willing to engage in dialogue which will hopefully lead to the establishment of definitive guidelines, thus enabling physician organizations to offer the benefits of information sharing and clinical integration without the present uncertainties.

Thank you.

(Applause.)

MS. KOHRS: Thank you, Mr. Holloway. Dr. Asner?

DR. ASNER: Thank you. I'll try and keep my throat clear here, having gotten over a cold recently.

I'm Bart Asner. I'm representing the California Association of Physician Groups and what I'll do this morning is give you, I think, a very unique California perspective to add to the comments that you heard from Larry and Al.

The California Association of Physician Groups, known as CAPG, represents 122 integrated medical groups and IPAs in the State of California. These physicians provide coordinated care, and that word is going to be very important as I continue this morning, to nearly 17 million Californians. The members of CAPG are dedicated to providing cost-effective, high-quality care in an organized manner. CAPG represents the most prestigious and well-known medical groups and IPAs in California.

As a framework for the comments I'm going to make this morning, I just want to give you a little anecdote about workers compensation in California. Many of you may know there is a crisis in workers compensation costs in many parts of the country and California has

faced that. Costs have ballooned in 1995 from $9 billion to about $29 billion in 2003. The L.A. Times had a comment recently about the legislation that was passed to reform several aspects of the system.

First of all, there was a proposal to put in place fee schedules for outpatient surgery centers. Prior to this, outpatient surgery centers could charge whatever they wanted and the worker's comp system would pay. There would also be fee schedules for pharmaceuticals. The workers comp system was paying enormous drug costs and we all know that that's a problem nationwide.

The number of visits to chiropractors was going to be capped at 30 visits per year. Up to that point, there were unlimited visits to chiropractors and surprisingly, the number of visits to chiropractors in California was twice that of anywhere else in the country. I know that's probably shocking to all of you. And the recommendation was made in the legislation to put guidelines in place for how much care is appropriate for any given injury. Depending on which doctor you went to, which hospital you went to, the care varied dramatically within the State of California under workers comp.

These are really novel solutions to those of us who practice managed care. Who would have thought that

we should put in place these types of solutions?

What this really is is an excellent example of unmanaged, uncoordinated health care and what would happen if IPAs and medical groups did not exist in this country.

The California model is a little bit unique in terms of the way IPAs are structured, but I think you'll see many similarities to what Larry described. These are multi-specialty organizations, as opposed to a single specialty IPA consisting of just anesthesiologists or radiologists. These are organizations that have multiple specialties represented. In fact, all specialties are represented.

These are physicians in private practice, as you heard, who are responsible for financial and clinical management of a population of patients. This is different than taking care of one patient at a time. These are hundreds of thousands of patients that the IPA is responsible for. And there are contractual arrangements, as Larry alluded to, between the IPA and the health plans.

In terms of the perspective of the California model, I think it's important to understand how this impacts consumers and the marketplace. IPAs are clearly beneficial for the consumer. This model provides a large

choice of physicians in private practice. Also, there's quality oversight within an IPA for the delivery of care.

Many of you know that hospitals have programs in place whereby physician committees exist that review procedures and processes that happen in the hospital. But 95 percent or more of health care is delivered in private offices. Up to this point, no one was looking at what doctors were doing in their offices. IPAs do that. We can avoid medical errors not only in hospitals, but in the offices as well.

IPAs are beneficial for the marketplace as well. IPAs manage the utilization of expensive services. They also negotiate for volume discounts in a local community for these expensive services. So, clearly, this has a marketplace advantage.

And IPAs compete with medical groups and with Kaiser Permanente. This provides a balance of power in the marketplace. In the State of California, Kaiser represents six million patients. So, there is the 800-pound gorilla in the room.

Why were IPAs created? This in California started probably in the mid-'80s. At that time and today the majority of physicians practiced as individuals or in very small groups. In simplistic terms, the physicians needed to be able to compete. They wanted patients in

their office. As you heard earlier, the physicians in private practice will work as long and as hard as they have to because they're incentivized to make their practices successful. Well, they need patients in that waiting room to do that and they were very concerned about the patients going to competing medical groups and to Kaiser.

Health plans favored a single contract, as you heard from Larry. Under that single contract, they can contract with large numbers of physicians, and probably most importantly from their perspective, they could transfer financial risk to the IPA and reduce their costs. They don't provide as much clinical or administrative support in the IPA model as they do in the direct contracting model.

Physicians found a value in creating IPAs because they can provide a full complement of coordinated health care services to their patients. They can share infrastructure, share clinical programs, information systems that the IPA can provide, and this was very valuable for them.

So, why did California physicians and still do California physicians join an IPA? And I might say parenthetically, IPAs are still a very successful model in the State of California. The number one issue for

most physicians is security, the security of gaining access to patients in competition, again, with those large medical groups. The employers contract with the health plans, the HMOs, and those plans are offered to the IPAs, the medical groups, and the patients are accessed by the individual physician through the IPAs.

The IPAs also provide technology, clinical and population management programs to improve patient care and outcomes and physicians truly do care about this. The access to care management nurses at an IPA, not in the physician's office, but at an IPA, and to programs help guide their patients through a very complex health care system, what I refer to as the continuum of care, the patients that move from the outpatient setting to the inpatient setting to skilled nursing facilities. The IPA manages those patients on behalf of their physicians through that continuum. This avoids silos in health care and the patients dropping through the cracks.

A couple of other points, and you've heard some of this. There's a lot of efficiency for the physician in that small private practice, or mom and pop shop in many cases, to joining an IPA. Claims are sent to one organization rather than 10 or 15 different health plans. They face uniform clinical guidelines from an IPA as opposed to all the different health plans. And they have

one local medical director to deal with when there's a clinical discussion to take place. So, this is extremely convenient. They're not calling an 800 number in Connecticut or wherever to have a discussion with a medical director that they don't know.

There's one credentialing process. Their office faces one audit to make sure they're compliant, and clearly it's important to the physicians, who are very ill-equipped to do this on their own, that the IPA can negotiate the complex financial and operational terms of health plan contracts. If anyone's ever looked at a health plan contract, it is very difficult to understand those terms, and the IPA provides that value to its physicians.

What is the alternative to the IPA for physicians? Well, maybe contracting with multiple plans, with all those different rules I alluded to. They would have limited ability to coordinate the care of chronically ill patients. The patients would be going to different doctors and different facilities on their own and that is not a good thing.

The IT sophistication in the physician's office is, again, more like a mom and pop shop and the physicians in a non-IPA model would have very limited feedback on how they're doing compared to their peers.

So, these are all very important for physicians to avoid.

How about patients? Well, what's it like in a private practice situation without an IPA? The patient has to navigate the complex health care system by themselves and there's no guarantee for that patient that they're going to have access to best clinical practices.

Think about a patient -- and this happens all the time -- who has cancer. Where do they find the right facility, the right doctor? Who do they go to, what do they do? It is an extremely frustrating experience for a patient in a private practice setting without someone to guide them. So, an IPA does that very, very well. In fact, most of the time they ask their friends and neighbors, well, how do you think I should go to. I don't think that's really the ideal way to do it.

For patients without an IPA, there would be no coordinating effective disease in population management programs and they would face higher medical costs -- patients pay co-pays, deductibles, co-insurance. If there's no utilization of you to reduce unnecessary services and no longer contracting to bring down the cost, the patient -- the consumer -- actually is paying more, and that happens today in the PPO model.

I want to give you a little validation of the IPA model by talking about pay for performance. I call

this a business case for quality.

Starting in 2003 -- and frankly in many years to come -- there's an industry-wide effort that began in the State of California, initiated by the Integrated Health Care Association, with the participation of the six major health plans in California, to award financial payments to the top performing medical groups and IPAs in the State. And this is based upon a common set of quality performance metrics; hence, pay for performance.

The performance metrics break down into clinical, patient satisfaction and IT infrastructure and the percentage values are on the right side.

The clinical measures are preventative care measures and chronic disease care.

Patient satisfaction is based on access -- the ability to get in to see your physician -- and communication -- the patient's perception of how well the physician is communicating with them.

And IPA infrastructure is self-explanatory.

The importance of mentioning this, from my perspective, is that the integrated IPA model is uniquely designed to achieve these quality and performance metrics on behalf of a large population of patients across multiple health plans, and this is an extremely successful program that is now being emulated across the

country. There are 25 other programs that are starting up across the country that are using the pay-for-performance model from California. You cannot do this with physicians in individual private practices.

I was asked to answer a few questions, and I'll try my best to do this in the time remaining. There are challenges and benefits to financial integration. First, let me talk about the challenges. And, again, you heard the comment made that IPAs need to be financially integrated and/or clinically integrated to be able to perform their functions from the FTC's perspective.

In the HMO context, where an IP is at financial risk -- and let me explain that -- the IP must monitor, profile, educate and influence its physicians' behavior. This means determining what's appropriate care in the appropriate setting at the appropriate cost.

The rising cost of health care, which we all are acutely aware of, directly impacts their IPA, and that's an enormous challenge, because the IP is paying those bills -- new technology, pharmaceutical costs, the aging population and patient expectations contribute to this rising cost of care.

One that may not be as evident is that there is an adverse selection of the HMO product, which is what the IPAs in California are doing -- they're performing

HMO care, by sicker patients. Sicker patients choose an HMO. If you're young and healthy, you're more like to choose a PPO product because it has a high deductible, high co-pays and you don't think you're going to go to the doctor very often.

That means that you'll pay less for that. The premiums will be a little lower because the care is pushed onto the patient. Well, I'm young and healthy, that's fine. So, the young, healthy patients are often choosing the PPO product, leaving a larger percentage of ill, chronically ill and particular patients in an HMO where the costs are covered by the managed care organizations.

What are the benefits of financial integration? The delivery of quality care at the most cost effective price, I think, is the number one benefit. An individual practicing physician in that office is so worried about managing their small practice that they cannot focus on the cost versus quality equation.

I actually had a friend recently who said that he was in need of a treadmill, and his doctor sent him to the local hospital to get the treadmill. The cost he said was going to be $1,300. He, on his own, started looking around, as would be intelligent, to see where else he could get this done and found an outpatient

facility where it's $300. His physician never told him that. His physician probably didn't even know the difference in the cost.

Another benefit, the IPA pays the bill and it needs to avoid certain things: Unnecessary duplication of expensive services. It doesn't want the patient to go for three or four of the same tests because they see three or four different doctors who ordered the same test.

It wants to avoid excessively high-priced facilities, and all you need to do is read the Wall Street Journal to understand that there are plenty of those around. And it needs to avoid inappropriate testing or procedures. Not only are they financially harmful, but they can be personally and clinically harmful.

The other side of the coin is clinical integration. And clearly there are challenges to clinical integration. Approximately five percent of patients generate somewhere between 60 and 80 percent of health care costs. And, of course, these are the chronically ill patients who spend a lot of time in hospitals and having expensive procedures done.

The challenges here are to first of all identify those patients by their diagnosis, by

utilization patterns, by pharmacy data. And, then, the IPA needs to develop and implement programs to manage the care of these patients -- not a simple process and certainly not an inexpensive process. The IPA provides a care management team to coordinate -- again, that key word "coordinate" -- the epiotic here that's provided by individual physicians in their office.

Also, the challenge is to implement evidence-based clinical guidelines to reduce the variation in care. Going back to what's going on in Worker's Comp in California, patients receiving different care for the same diagnosis. The Dartmouth Studies have shown across the country dramatic differences in the care and cost for the same diagnosis, with no difference in patient outcome. We need to reduce that variation.

So, what are the benefits of integration? Practice guidelines can be put in place which will reduce this variation and improve outcomes; under clinical integration there can be monitoring and managing chronic patients, and this will ensure high-quality, cost-effective care; and coordinating and authorizing the care -- which an IP does -- coupled with quality improvement programs which exist in the IPA, at the health claim level and at the Department of Managed Health Care in California, to ensure neither over nor under utilization

of expensive, high-tech procedures, emergency room costs and hospital costs. And that is an enormous benefit to society.

So, I have five points in my final message as I wrap up.

First of all, the California Multi-Specialty IPA is a financially and clinically integrated model under the HMO context. Physicians join in IPA to receive security, efficiency, collaboration and both clinical and technology investment that's unattainable in a private-practice setting. And I hope I made that point clearly to you.

Financial integration delivers quality care at the most cost-effective price; clinical integration provides coordination -- again, that key word, "coordination" -- throughout the health care continuum, resulting in high-quality, cost-effective care.

And I think it's very clear to those of us practicing in California that IPA provides value to the consumers and the marketplace.

I will say that in California in 2002 the health care premiums were the lowest in the country -- number 50 out of 50 states. And it's no coincidence that the IPA medical group model is in California and has been very successful there. That is one of the key drivers in

bringing health care costs down.

So, with that I will wrap up. Thank you very much.

(Applause.)

MS. KOHRS: Thank you, Dr. Asner. Mr. Hawkinson?

MR. HAWKINSON: Thank you and thank you for having me this morning. My name is Curt Hawkinson and I am a full-time, practicing physician assistant from Salem, Oregon. And although I am here as a member of the American Academy of Physician Assistants, I think it's important to remember the views I express today are mine and not their's.

As I was leaving the house yesterday morning, in my sort of half-awake state and my wife's sort of half-awake state, I asked how I could limit this to 10 minutes and she rolled over and sort of mumbled, speak slowly. So, we'll see how it goes here.

I think if we're going to talk a little bit about PAs, I think we have to talk a little bit about what a PA is, and so that's what we're going to start out with here, and then at the very end I'm probably going to pose more questions than I do answers.

But first of all I think we need to talk about a definition of what a physician assistant is. Many of

you may be familiar with this and some of you may not. PAs are licensed health care professionals who practice medicine with physician supervision. I think it's important to remember that supervision is determined by the state regulatory agencies, and although some payers -- Medicare being the most prominent -- require a certain level of supervision, for lack of a better term, in order for you to be reimbursed for services, it's really the state regulatory agencies that determine that level of supervision, and that varies widely depending on the state.

PAs exercise some autonomy and medical decision making. I say that and sometimes people look at me a little strangely, but what that means is that when I'm conducting a lab test, I don't have to walk down the hallway and ask my supervising physician to look at every urinalysis that I get back.

We provide a broad range of diagnostic and therapeutic services and I think the easiest way to point to that is how PAs work virtually in every specialty; again, much like physicians, obviously.

A fair number of PAs are now starting to perform educational research and administrative activities. There are over 130 PA programs and there are a large number of PAs on faculty of those programs.

One of the reasons that we say that PAs practice medicine is they do many of the functions that physicians do; granted they do it with physician supervision. They perform physical exams, take histories, they diagnose and treat illnesses, they order and interpret laboratory tests, they also order imaging studies and sometimes provide the initial interpretation.

You may order a chest x-ray in your office, take a look at it, decide that patient has pneumonia and still ending up sending that, of course, to a radiologist for review or speaking with your supervising physician about it, obviously.

They assist in surgery and this is, obviously, something that a fair number of PAs do cardiac surgery, orthopaedic surgery, and so forth.

In 47 states and here in the District of Columbia, physician assistants are authorized to write prescriptions and in many of those state they can write for controlled substances.

And, finally, one thing PAs have always done is provide a fair amount of patient education and counseling.

One of the things that the profession has often prided itself on is how well we do with under-served and rural populations. And, as you can see from this quote

from the Seventh Report to the President and Congress on the Status of Health Personnel in the United States, PAs, particularly in rural areas, seems to match the population of the country more evenly than other health care providers would.

As I said, I think it's important to not only understand a little about the definition but the education process that PAs go through. The physician assistant program is really competency-based rather than degree-based. Each degree can vary; some award certificates, some award bachelor degrees, although there's a growing movement toward master's degrees, and I personally thought for years the PA education program is really taught at a master's degree level, but now we're at the point where many programs are offering that.

First nine to 12 months in the classroom with the didactic phase are similarity in many ways to the first two years in medical school though, obviously, shorter and not near as in depth and include a variety of basic science subjects that you can see there.

There's also, of course, a clinical phase and for physicians in the audience probably the easiest way to think of this is the similarly between this and the clinical clerkships in years three and four in medical school. There are standards, obviously, that have to be

met for accreditation and in addition to what you see there could be typical core rotations are also electives that can be tailored to the students' needs or preferences.

There's an independent certifying body, the National Commission on Certification of Physician Assistants that certify PAs. In order to be licensed in a state, you have to pass what's known as the initial certifying examination. To be eligible to take that examination, you have to have graduated from an accredited program, and to be certified, obviously, you need to pass the examination.

There also is a re-certification process which is somewhat different from what physicians go through in that their's is typically board certification. For physician assistants the national certification requirements are in front of you. We're the only health care profession requiring certification by exam every six years. Nineteen states require that you keep a current certification in order to maintain a license in that particular state.

Now, moving along more to getting towards looking at IPAs and the practice of medicine more specifically, I think it's important to take a look at the specialties that PAs are in.

Thirty-two percent are still in what we consider a family or general internal medicine. I think we are starting to see a growing number of PAs in specialties, and if you look in the surgical subspecialties and that category there is the all-important other, you'll see that over time those percentages have grown as we've seen more PAs working in fields such as dermatology, for example.

I think one of the important things to remember about PA practice, unlike physician practice, is that PAs are not trained in any single specialty; they're trained as generalists. You can work in more than one specialty, you can have more than one specialty, although in my 15-year career I spent most of my time in family medicine, for example, but for two years I worked for a neurosurgery group at the medical school in Portland.

Moving along, if you're going to speak about IPAs, I think it's really important to look at where PAs are practicing much like someone alluded to earlier that 95 percent of health care is delivered in physician offices as opposed to large HMOs. I think you're seeing that the employment of PAs really sort of mirrors that. Fifty-five percent are either in solo or group practices, with a small percentage in HMOs and some are employed by hospitals. I think that's sort of a growing role for

PAs. Now that residency hours have been cut back, we're seeing PAs substitute and replace house officers in some settings.

Now, the profession continues to grow. As I said earlier, there are over 130 programs now with approximately 2,500 graduates yearly and we're going to see these numbers continue to rise and it will near 70,000 by the year 2005.

Basically, to come more to the questions that I bring to you more than the answers, and as a profession that has a large percentage of its members that practice in rural areas, there are several questions I would pose that would pertain to the rural areas.

For example, what if the supervising physician's main practice site is several miles from the site where the PA practices? This is common in many western states where the supervising physician may actually be 60 or more miles away from where the PA is. If there is an IPA, how does this come into play? Can that PA be a member of an IPA in that area? If the physician is out of the area that the IPA typically contracts in, how are they going to serve the needs in that community if neither the physician nor the PA can be a member of that IPA?

In certain states it's permitted for the PA and

the supervising physicians to have different specialties. Again, I think this is most common in rural areas and an example would be, perhaps, a general surgeon who might supervise a physician who provides family medical care.

Why would that happen? Well, if there's a shortage of a physician in under-served areas, certain states have provided that as long as the physician is willing to accept the responsibility and supervise that PA, this is possible, although I think that also presents some other interesting questions when you look at IPAs and the percentage of physicians in a certain specialty that could belong in an IPA.

Finally, what if the PA works in more than one specialty? And this is becoming more and more common. What if you have two part-time jobs? For example, one in dermatology and one in orthopaedic surgery, or what if you work full time in family medicine and moonlight in the emergency room?

How would contracting with IPAs work with that, if your supervising physician is a member of one IPA and not a member of another, for example, how would that come into play? And I don't necessarily have the answer to that, again. Again, I think I come with more questions than answers for you.

Finally, some additional questions. As we look

at integration and IPAs, I think it's important to remember that with PAs the supervisor versus the employer may be different. You may have a supervising physician who is a salaried position with a large medical group as opposed to one of the owners or one of the partners in that group, and in any setting you always have to ask, what is the PA's duty to the supervising physician versus the employer? And if you bring an IPA into the play, I think that brings another question in. What duty do you have to one of those four groups; including, of course, the most important person of all, the patient?

Who and what determines the PA's legal standing in an IPA? In other words, is that practice going to be reimbursed for the services that you provide? Is that determined by state law? Is it determined by the contract between the IPA and the physician? Is it determined by the payer and the IPA?

Does a physician or practice employing several PAs have any effect on antitrust? For example, if you had a community that had four gastroenterologists in town and one of them employs four PAs and the other employs none, how does that have an effect on the community? Does antitrust come into play? And if we're looking simply at the percentage of physicians that belong to an IPA, are we really looking at the amount of care that's

delivered by other providers, other medical providers, PAs, of course being the best example?

And how does this come into play if the PAs are IPA members? Are there some antitrust issues that could snag an IPA?

That's really most of what I have to present today. Again, with more questions than I do answers. And I'm sure there will be some questions for me later on and I'll take those during the question and answer period.

Thank you.

(Applause.)

MS. KOHRS: Thanks very much. We're going to go ahead and take a short break, about 10 minutes. When we come back, we'll hear from Markus Meier.

(Whereupon, a brief recess was taken.)

MS. KOHRS: We're ready to reconvene. We're going to go ahead with Markus Meier.

MR. MEIER: I want to start by thanking the people for putting on the health care hearings and inviting me to come talk. We're all part of the same agency, but I'm actually in a different area than the people putting on the health care hearings. I'm in what's known as the Health Care Shop, colloquially around here, and what I do is, I'm a law enforcer, and I'm

bringing to you today a law enforcement perspective on the things that we talk about.

The hearings are being run out of our General Counsel's Office and they are, in part, to help educate the Commission, help us understand what's going on, help us figure out what's going on out there, and, of course, they are a help to me to get information and to learn more and to maybe think more deeply and more broadly about the kinds of things that we're seeing. But, like I said, today I'm speaking primarily from the perspective of a law enforcer.

I, of course, have to give the general disclaimer that the things I'm saying are not the opinions of the Commission or the views of the Commission or anybody else here at the Commission. I do bring, however, a staff perspective.

It's not secret, I think, that health care is an important area for the Commission. Currently the Chairman has made it very clear, through speeches, through articles in the newspapers, that this is going to be an area that he's very interested in and, of course, that's exactly what these hearings are all about. But also, on the law enforcement side, he's made it very clear to us that he wants us to go out there and look at what's going on and find cases and bring cases to the

extent that those cases are out there.

And, again, that's a matter of public record. You can read that in the New York Times, you can read that in the Wall Street Journal and many other places.

Turning now a little bit more to what my goals are for the session before I really get going.

I need to start by explaining or making sure we're all on the same page with respect to what the basic purposes of the antitrust laws are and the background of the antitrust law, because I think it's important to understand a little bit about the history and the development to see where we're coming from when we start applying those same principles to IPAs and to physician conduct.

The biggest point I'm going to make, when we look at that, is to make it clear to you that I'm not making this stuff up. This is stuff that's coming down from the Supreme Court; the Supreme Court's telling us this, as are the other courts, and we're trying to apply that to the particular circumstances that we see when we look at the health care market.

So, after we talk a little bit about the background of antitrust laws, we'll move on to talk about the application of those laws specifically to the physician area, then we'll talk a little about -- we'll

set out the concepts of clinical and financial integration and show you how that fits into the analysis, and at the end I'll try to highlight at least what I think are some of the recent trends that we're seeing in the cases that we've been investigating and that we've been bringing.

First thing, though, what I want to do is make a real quick pitch for our website. You can't possibly cover everything that there is in a session like this, and we have an incredible amount of information on our website and, in fact, a number of people have come up to me during the break and complimented us on that, and so I always make that a part of my pitch -- www.ftc.gov.

If you'll look down the left-hand column, there's something called Antitrust Resources, that's where you want to look. You want to go to Antitrust Resources. If you go there, it looks like this: public documents; then you go down the public documents and there's something called Health Care, you go to Health Care and you find where I want you to be, which has things like statements of our Antitrust Enforcement Policy in Health Care.

It has an overview of every case we've ever brought in the health care area, with a discussion and a description of it and with additional information where

you can find more information about it; not just physician cases, pharmaceutical cases, hospital cases -- anything in the health care area that resulted in some kind of a law enforcement action. That means we either settled the case or we went into litigation. It's not every investigation we've done because sometimes we investigate things and we don't find a problem and we go away. So, that doesn't describe that.

Also, we put out a lot of advisory opinions. We've talked a little bit here today about the MedSouth and we'll probably talk more about that in a little while. We have a compendium of all the advisory opinions -- organized by year, by topic -- that's on the website, too.

And, then, of course, the advisory opinions themselves, like the MedSouth letter, are available on the website. You can pull them up, read them and see what's there.

And then there are speeches by the Chairman and other Commissioners and sometimes by people in the Health Care Shop, too.

Of course, the health care hearings are also on the website, but at a different location, because -- like I said -- this is really the part that takes it to the stuff that we do in the Bureau of Competition as opposed

to what the General Counsel's Office is doing with these hearings.

Quickly, now, to talk a little bit about the purpose of the antitrust laws, and, again, this is, probably for a lot of people here, if not boring, a review, and if not a review, probably something that they work with all the time, but nonetheless it's important to understand that what we're really talking about -- what the whole body of antitrust laws is trying to do is it's trying to prevent private business practices that unreasonably restrain competition. And I've underlined the word "unreasonably," because that's the crucial word -- what is reasonable and what is unreasonable? And that is what we grapple with every day -- we grapple with it as enforcers; people on the other side grapple with it as advisors and counselors -- we're trying to understand what that means.

The antitrust laws were written -- and I'll show you in a few minutes what some of the language is -- they were written purposely to be very broad, to be not that well defined, to give the courts an opportunity to opine and to give the marketplace an opportunity to develop and see where things were going. Congress, when they wrote most of the antitrust laws, didn't really know exactly what they wanted, they had a general concept and,

as a result, that's sort of the way the law has developed -- case by case, investigation by investigation.

There is a general agreement, though, what the general purpose of the antitrust laws are, and they're for the benefit of consumers, and the thought is, if you promote competition, if you get competitive marketplaces, in general, what you would expect to occur as a result of that are lower prices, better quality products and services, increased choice, selection, convenience, innovation -- nothing anybody could really be too upset with -- those are good things.

The point is, though, it's for the benefit of consumers, okay? It's not for the benefit of producers. Now, there's some good news in that and there's some bad news in that.

The good news is for most of the things in life we are all consumers. So, in our capacities as consumers, they are supposed to promote our interests. But we are also producers -- producers of our labor, producers of our efforts, and on that side the law is not there for you, as a producer.

So, a doctor, as a producer of medical services, the antitrust laws come to bear on that; the doctor as a consumer of automobiles, office space, PA services, office supplies, et cetera, et cetera, you're

supposed to be the beneficiary of the antitrust laws just like everybody else.

Statutory provisions -- not to give you a quick law lesson, but it's more to point out a couple of things. One is, if you notice, I put the year that these laws were passed. The Sherman Act, 1890; the Federal Trade Commission Act, 1914. These are the same laws that were passed back then that apply today, and these same laws apply whether you're General Electric, General Motors, Microsoft or you're two doctors in rural West Virginia.

Section 1 of the Sherman Act says it prohibits every contract combination or conspiracy in restraint of trade. Well, that's where that word unreasonable that I underlined a few minutes ago comes in, because the court quickly realized that when Congress passed that law and said, every contract combination or conspiracy in restraint of trade is illegal, the court said, hey, they couldn't really have meant that. If we're talking about every contract that restrains trade, you have a partnership -- two people used to compete, now they form a partnership, they're restraining at least some level of competition between the two of them -- they used to each do it independently, now they're a partnership, that can't possibly be illegal. Maybe/maybe not.

So, the question became, what is reasonable and what is unreasonable, and that's where the phrase "unreasonable restraint of trade" came in.

Section 2, which we're not going to talk a lot about today, is not that applicable to most of the cases we've had involving IPAs, but that's the part that says it's unlawful for a company to monopolize or attempt to monopolize or combine or conspire to monopolize trade. It doesn't come up that often in the context of physician cases.

The Federal Trade Commission Act, it basically prohibits unfair methods of competition. That's actually the Act under which we at the FTC bring our cases. The Department of Justice, where Rich Martin works, they bring their cases under the Sherman Act, Section 1 or 2. But a while back the courts told us that the FTC Act encompasses everything that's encompassed in the Sherman Act, Sections 1 and 2. So, everything that's in those two Acts falls into those same words of "unfair methods of competition." It also just goes right into there. So, those are the laws that we're starting with.

Now, you see, there's not a whole lot of meat there; there's not a whole lot of description as to what that means, and that's where the courts have come in and that's where some of the concepts that I'll be talking

about in a few minutes come in.

What are the real concerns now? Breaking that down to physician collective negotiations. Now, notice, I don't say antitrust concerns related to IPAs, because there is no antitrust concern related to an IPA, as such. It's related to the concept of collective negotiations; that is to say, that a group of otherwise competing people come together and start negotiating contracts collectively, that's when antitrust may have something to say about it. And I would break the problem down into two different types of problems.

One is what we call the cartel problem -- or at least, I call the cartel problem. The other is the monopoly problem. Of the two, the one that's of most interest here today is the cartel problem.

That's the problem that would come under Section 1 of the Sherman Act which says, every contract corporation or conspiracy in restraint of trade is illegal.

What are we talking about when we're talking about the cartel problem? We're talking about agreements among otherwise competing physicians on price or collective refusals to deal without integrating their members' activities. It's a lot like if you think about the OPEC Cartel or any other -- the Diamond Cartel --

it's a group of people who would otherwise be competitors and they're coming together and they're fixing the price, and that's all they're really doing is setting the price. Otherwise, they're out there running their own businesses.

This is where the concepts of financial integration and clinical integration come in, which, again, we'll talk about in a little more detail in a few minutes.

And the monopoly problem, that's derived from Section 2 of the Sherman Act. Here we're talking about a group -- it's integrated, no question -- financially/clinically, they're okay. But they probably have substantial market power because maybe they're very, very large in a given area, and in a relevant market they are a very, very large group -- they have power over the price, they have power over the marketplace.

So, they didn't run into the problem of the cartel because they are really actually integrated, but they're simply too big relative to the market.

Again, we're not going to get into anymore detail about that today, unless it comes up during the discussions.

Where does this all come from? Where am I bringing these concepts from? Well, it actually goes

back -- the entire view of the physician IPA cases, I would say, trace their history back to Arizona v. Maricopa County Medical Society, a case from 1982, where the Supreme Court made clear that physicians in independent practices are supposed to compete.

Now, I know, having gone and spoken before enough different doctor groups, most doctors don't think of themselves as competitors. Now, I'm not using the term competitor in the lay sense of two rivals going at each other, trying to steal each other's business or chase down business and heavily engaging in marketing practices and promotion. I'm using it more in the economic sense, in the sense we use most of the time around the Commission, as two people who are reasonable substitutes for one another.

If I were ill, I could go to this doctor or I could go to that doctor; I could go to this practice group; I could go to this HMO. I have substitutes, I have the substitutes that are available to me, and from that standpoint they are, in fact, competitors.

Now, when they don't compete -- and the Supreme Court made this very clear -- by collectively setting the prices at which they sell their individual services, they can be guilty of illegal price fixing, no different from if Burger King and McDonald's got together and decided

how much to charge for a hamburger; no different than if General Motors, Ford and Chrysler got together and decided how much to charge for an automobile. They would be just as guilty of price-fixing as any of those other companies would be.

Now, this is the operative language -- where I'm taking that from, in the Maricopa case the Supreme Court said the agreement under attack is an agreement among hundreds of doctors concerning the price at which each will offer his own services to a substantial number of consumers.

The fee agreements are among independent, competing, entrepreneurs who fit squarely into the horizontal price-fixing mold. The Court had very little difficulty seeing that.

However, they went on and said a little bit more, and this is where financial integration has its birthplace. They did say, at a later part of the opinion, to avoid condemnation as an illegal price-fixing conspiracy, the Supreme Court said, the agreement needs to be, and I quote, "Analogous to partnerships or other joint arrangements in which persons who would otherwise be competitors hold their capital and share risk of loss as well as opportunities for profit."

This is what we lawyers would call dicta, it

wasn't part of the holding of the decision, but the Supreme Court intimated that if these groups getting together and collectively setting their price are more in the nature of a true partnership or some kind of a joint arrangement where there is some risk-sharing going on, where there's financial integration going on, then maybe we would have given it a different analysis -- maybe we wouldn't have condemned it so quickly -- maybe we would have looked at it a little more in depth and maybe come to a different conclusion.

So, let's move on to talk a little bit about financial integration. There are some examples that we've outlined in the statements of enforcement policy are things like capitation, percentage of premium or revenue, withholds global fees, all-inclusive case rates and those kinds of concepts.

At the time of the guidelines, people weren't talking about pay for performance, which very well could be another example of financial integration -- it may or may not be, but it's an interesting development.

Now, the important thing to keep in mind about the concept of financial integration -- and you'll hear me say the same thing about clinical integration -- is that it's not an end in itself. The goal is really just like the goals of the antitrust laws themselves, it's to

create a meaningful prospect of improving efficiency in the delivery of care, reducing costs, better managing utilization, or improving the quality of care.

What you find, oftentimes, when a group gets together and really does share risk in a meaningful way, they bring to bear a lot of systems that help manage the care. All of a sudden the decisions that I would make as a doctor and the decisions that you would make as a doctor suddenly we realize that your decisions affect my income and my performance, my performance affects you, we develop some systems to try and take care of that, and we have at least, possibly, the potential for improving efficiency, reducing costs and the kinds of things that Dr. Asner and Dr. Casalino were talking about: Clinical integration. What we've put in the definition that we use in the statements is an active and ongoing program to evaluate and modify the practice patterns of physicians and create a high degree of interdependence and cooperation to control costs and ensure quality.

So, again, the idea of ultimately controlling costs, ensuring quality, those goals are important. So, similarly, the goal is to create a meaningful prospect of improving efficiency, reducing costs, better managing utilization, including quality of care. Like I said, the goals of the antitrust laws themselves.

Here's where we really get into trouble, though, and here's where you really have to focus and really have to pay attention to the guidelines and to the types of analysis we've done in the MedSouth case and in some of our other cases.

Even if there is some clinical integration, any price agreement, any joint negotiation must be reasonably necessary to realize those efficiency goals. So, when somebody says, oh, is this enough clinical integration? How many of these things do we have to do? How many of these systems do we have to put in place? We're not talking the same language. That's not what I'm here about. I'm not here to say you need these 10 items off of list A and these five things off of list B and then you'll be clinically integrated.

The question is, are those things you're doing that are clinically oriented necessary in some reasonably necessary way to actually achieve those efficiency goals? That's a tough question. That's a tough issue.

Now, I've actually been throwing around the words "unreasonable restraint" and "reasonable" and "significant" and "substantial" a lot, and again that's language of the courts, that's language of the legislation, but when lawyers use that kind of language, it means we don't really know exactly or precisely. We

want to have a little bit of wiggle room. But I notice that lawyers aren't the only ones who use that kind of language because a few minutes ago when Dr. Asner was speaking he had the line -- and I wrote it down, because I really liked it -- "appropriate care, in appropriate setting, at appropriate cost." I think he's kind of doing the same thing. We don't really know exactly what that means, so we want some flexibility, we want to be able to look at things case by case, and we want to see what's really going on.

So, it has to be -- going back to the point, though -- even if there's some clinical integration -- and again it's not a master list that we have and we secretly hide and we pull it out and we look at your organization and we say, hmm, it doesn't stack up, but we're not going to share that list with you. We're looking at what's going on and we're asking ourselves, does this have a meaningful prospect of promoting those goals and is the promotion of those goals reasonably necessary to the joint price-setting behavior?

So, I would encourage any group to go out there and do as much clinical integration as it wants, but it has to be careful about engaging in the joint price negotiations, because those negotiations and that price-setting has to be reasonably necessary. And we can talk

about that a little bit more, what some of the guidance on that is from the MedSouth letter, probably during the discussion period.

Some recent trends -- and I put a question mark there because my economist friends tell me that just because it happens a couple of times doesn't necessary make it a trend. It's, you know, maybe we don't have sufficient data points to really call something a trend, but the kinds of things we've been seeing in the last couple of years in the cases we've been bringing -- and we've brought a number of them -- I think something to the extent of 15 physician cases that have been a matter of public record since the beginning of 2002 -- we're seeing larger physician groups than we used to see.

Now, that doesn't mean we're not still looking at some small groups, because we have looked at some very small ones. I think Napa Valley was a physician group of eight, but at the same time we've looked at some very big ones in Texas involving 1,200 and in other areas even larger groups. So, we're seeing quite a bit larger groups forming, and that's been a trend.

What we're also seeing is that these groups are often aligned with hospitals in things called physician/hospital organizations or if you're the hospital, hospital/physician organizations, and so that makes the

analysis somewhat more complex, but we're seeing that trend.

We're seeing a growing trend of relying on agents -- people to come in and help establish the group, put the group together and go out and do negotiations on behalf of the group. And on the front we've actually, in some of our cases, we've named the agents individually for their behavior, as well as the group, and in a number of cases, I think four so far, some of these agents are lawyers; some of these agents are just business people; and there are people who are going out, I believe, at least in the cases I've looked at, who are pretty much going out and letting everybody know that they've figured out all this stuff -- they've figured out this clinical integration stuff, they've figured it out, and here's all they have to do and we can start doing some collective negotiation.

So, when we find a case where an agent is, I think, giving really, really, really bad guidance, we might be interested in putting that agent under order, too, so they don't go around the country and keep spreading their gospel.

The last thing we're seeing is a movement away, to some degree with some of our cases, that there has been movement away from the PPOs, HMOs -- Dr. Casalino

was talking about that -- to broader panel, less-restrictive PPOs, and that may be creating certain problems, and the problem is that in the past the IPA was doing it -- clearly doing risk sharing, clearly involved in a capitated agreement. Now the HMOs are moving away from that, drawing broader panels. They want to do negotiation with PPOs where there's no risk sharing, where we're not safe on the risk-sharing front. Now we have to develop a clinical integration model instead, and instead of building the organization from the ground up and thinking: "How do we really do this clinical integration and how do we really make the joint negotiations ancillary to that clinical integration? How do we really show that it's reasonably necessary in order to create these efficiencies to do this joint negotiation?"

Not enough thought is going into that and instead they're just saying, "hey, we used to do risk sharing, now let's just go ahead and try to seek some contracts here without worrying about anything else, because we used to be good to go." It's a problem and it's something that we're looking at and we're trying to understand better and then there may be the possibility that some guidance on that will come out in one form or another in the months to come.

That is all I have at this moment.

(Applause.)

MS. KOHRS: Thank you very much, Markus. As you saw, Markus had the advantage of listening to the other speakers, so we're going to give the earlier speakers an opportunity to make comments about the later ones. So, we'll go, again, in order of the speakers.

Dr. Casalino, do you have anything about anybody's presentation that you'd like to comment on?

DR. CASALINO: Not as a question, but as a comment not directly related to antitrust but something that's possibly not so obvious to everybody here, it would be good to understand, I think. If you want to pay for physicians for performance -- either quality performance as Bart was talking about, or even cost performance, it's very hard to do that for most individual physicians, for statistical reasons.

In other words, you have to have enough cases of a physician treating a particular condition that you can reliably estimate how well is the physician really doing in treating that condition.

And it turns out that if you're looking at a physician who does the same thing all day long, like in cardiac surgery, who does primarily just by-pass surgery, you probably can do that pretty well at the individual

physician level.

But for most other physicians, the vast majority of physicians, you can't. If you want to see how good is Dr. Casalino or Dr. Asner at caring for diabetes, we're not actually going to have enough diabetic patients for you to get a good estimate. There's a very good articular written about that published in JAMA by one of my colleagues at the University of Chicago, Will Manning, a few years ago, which is just really devastating. It shows that even if you use the most sophisticated techniques to adjust for how sick the diabetics are, and other factors that aren't under the physician's control, you still can't really get a good estimate of how well an individual physician is taking care of a diabetic patient, unless they have a very large number of patients -- probably over 100 -- which very few physicians do, certainly very few primary care physicians.

And I found that, actually, if you wanted to score well on these quality measurements, even, again, using the best techniques of trying to adjust for how sick your patients were compared to other doctors, the best way to score well, even after that, is just get rid of your two sickest diabetics and you'll score really well, as opposed to really doing good things.

So, the point of this long digression that I just made is that if you're a health plan or if you're Medicare or if you're a General Motors and you want to pay physicians for quality, you can't do it for most physicians at the individual physician level. Therefore, the unit of analysis has to be some kind of physician group -- it can be a medical group of sufficient size or it could be an IPA.

And that it's no accident that, I think, it's California which has, compared to other states, a relatively high percentage of physicians that are in either large medical groups or IPAs that there has been this pay-for-performance initiative put into place, which most people in the country, I think, think is really a great thing to give physicians incentives to improve quality, which they haven't really had very much, and it can be done there because there are enough medical groups and IPAs to do it with. So, these organizations are potentially of value for that reason.

MS. KOHRS: And, Dr. Casalino, thanks for that. One of the key issues that we've been looking at is how antitrust can actually look at quality issues and how do we factor that in to the equation. So, I'm sure we'll come back to that further as we go through the discussion.

Mr. Holloway?

MR. HOLLOWAY: First of all, Dr. Casalino, it's nice to see you again. I knew I recognized you from California. Unfortunately, we have all these California people here. We need more people from other parts of the United States, and I mean that because we hear a lot about California being a leader and California is, there's no doubt about it, a leader.

But in my organization we represent IPAs in 40 states and we see a lot of innovative -- very, very innovative approaches happening in states outside of California that in many cases California is behind the scene. Wisconsin is one state, Upstate New York, part of Texas, Southern Oregon -- and I can go on and on and on and name some states where there are some very fascinating things happening that haven't even made it to California yet.

There are approximately 2,000 IPAs in the United States. New York is the only state that we can go to and get from New York exactly how many IPAs are in the United States. In New York, if we develop an IPA, you have to have IPA in your name when you incorporate. So, I can go to the Department of Corporations and they tell me, there are 424 IPAs in the State of New York. I know that. That's the only state I know that. The rest of

the states I have no idea how many IPAs are there.

Markus, I really think it's important for us to recognize the health care community and high competition may be a little different in the health care community than it is in the rest of our society, and I sincerely believe that. I think that competition does not function as effectively in health care as it does in other parts of our society.

We have two major players other than the physician in the health care -- we have the hospital and the insurer. So, how do we have competition when we look at the hospital and insurer perspective, at the same time looking at what role the physician may play in this whole scenario?

I firmly believe that the physician is the only part of our society -- the only part of our society -- that can play a very meaningful role in helping us control the quality of care that comes to our respective communities.

We need to recognize that when we deal and look at all our policies and procedures as it relates to competition. We really need to understand that -- that uniqueness.

Health Care is in a crisis -- we know that. Health Care is in a tremendous crisis. How do we -- how

does this regulatory agency -- the FTC -- help us get from the crisis that we're in right now to something that we can live with and understand? When we all leave here, we're going to get in some kind of a vehicle. You're either going to drive, you're going to get in a taxi -- well, let's take those two. You may get in a subway, but I don't want to go there.

If you get into a taxi or if you drive, you're going to see a sign that says the speed limit is what? Twenty-five? Thirty-five? It's going to give you some direction, and if you drive above the speed limit or if the taxi goes above the speed limit, something can happen -- we expect something to happen. We have a system that gives us direction. We need a system that gives physician groups direction -- definitive direction -- on what is clinical integration, what is financial integration? If they do something in excess of what is outlined, then what are the penalties?

Thank you.

MS. KOHRS: Thank you, Mr. Holloway. Dr. Asner?

DR. ASNER: I think the comments that were made were excellent. I would just add that it's important to recognize that we are all, myself included, consumers of health care. We're all either patients or going to be

patients at some point, and I think it's extremely important that we know that when we go into a doctor's office, regardless of who that doctor is or what type of insurance you have -- HMO, PPO or the little bit of remaining fee-for-service indemnity -- that you're going to get the same quality of care regardless. And today that does not exist in this country. It doesn't even exist in individual physician's offices, and when you compare one physician to another, which, as you heard, is difficult to do, clearly you see that the care that's delivered is different.

We need to have the ability to aggregate physicians and organizations like medical groups and IPAs and then be able to monitor and influence that care. Physicians are a challenge. Anyone who's managed physicians has heard the expression it's like herding cats -- they don't want to be managed, they were trained as individuals but we're able to do that and the IPA model has been very successful at that.

So, in the end what we want to do is regardless of the type of insurance that you or I have we want to make sure that the patients receive excellent, high-quality care and we need some help and some guidance, frankly, from the FTC to accomplish that. I think everybody on this panel wants the same outcome.

MS. KOHRS: Thank you. Curt?

MR. HAWKINSON: Yes, Markus, actually I have a question for you, so it's kind of nice that you're sitting at my left going next, and it was something that I wanted to make sure that I understood was the PPO model because we all know in that situation there's no risk being shared, that if you integrate clinically enough, do enough clinical integration as an IPA, would you, then, in theory, at least, hypothetically speaking, be ruled as not violating antitrust in that situation?

MR. MEIER: Well, do I have to answer his question or say whatever I want to say?

(Laughter.)

MS. KOHRS: Answer his question first.

MR. MEIER: I thought I addressed that. I mean, I think it's important, again, sort of almost implicit in your question is this idea that there's this certain amount of clinical integration and then everything is okay, and I hope I can make clear the point that that's not the test.

MR. HAWKINSON: I understand.

MR. MEIER: And that the test is what is the relationship between the potential for that clinical integration to create certain efficiencies and the need, in order to realize those efficiencies, to engage in

collective negotiation, and that's really sort of the tough issue. We did, however, provide some guidance for that in the MedSouth decision, and I guess I might as well turn to that in order to make sure I'm not saying it the wrong way, I'm going to have to look at my notes.

MR. HAWKINSON: I understand your point that there has to be a reason -- that negotiating prices has to be essential to the clinical integration that you're doing or the clinical integration doesn't count. But the way you're saying it is you can't give a list of things that say, okay, if you go this, this and this, you're clinically integrated and, therefore, it's okay.

I mean, it sounds a little bit like each case is totally unique, but that's not really the case. I mean, there are only, you know, "X" number of forms of clinical integration and it should be, I would think, hypothetically, possible to look at each form and say, well, you know, this is a form, you really don't need to negotiate prices to get physicians together to integrate clinically in this way, but for this form, you know, generally speaking, you really do.

In other words, if you want to give physicians financial incentives to comply with some quality-improving process, well, you have to have some financial glue and the glue is that you're negotiating prices

together and distributing the money together.

So, I guess I'm just trying to understand why is it so difficult to say that, you know, "X" forms of clinical integration really hardly ever, if ever, require negotiating prices together, but these other type of forms of clinical integration offering -- although perhaps not always -- do require negotiating prices together to keep the physicians integrated.

MR. MEIER: One of the themes here is we need to provide more guidance, and, quite frankly, you're suggesting that you have some ideas about how to structure that guidance, and, quite frankly, I'd love to have you outline for us sometime, if you can, put together these things that you believe say, hey, these are things that say, really, there's simply no legitimate joint negotiation activity going here, if you're doing these things, but these are things that you might consider. That would be useful guidance to us; that would be useful, I think, to these hearings and to the FTC in consideration, and I would, you know, really welcome somebody putting that down on paper and providing it to us.

We look at the cases that we see. I get complaints, I go out and I do investigation. That's not necessarily always the best way to systematically attack

one of these problems. But, again, that's part of the point of these hearings to try to bring more of a systematic approach to something that doesn't always happen so systematically.

So, if you really think that there is some guidance out there that's that clear for us to take into account, I would be happy to hear about that.

You know, a theme of Mr. Holloway's comments and, again, some of this discussion is this idea of more guidance. Let me say a couple of things about that.

One is, we put out quite a bit of guidance. Probably it's fair to say that in the health care area we put out more guidance than in any other single industrial sector in America -- maybe all of them combined. Health Care is the only area where we have statements of enforcement policy jointly put out by the DOJ and the FTC in one sector of the economy. It's the only one. We write more advisory letters in the health care area than the entire rest of the Commission combined. We probably go out and give more speeches and more talks to more different groups in health care than all the other speeches by the Bureau combined.

DR. ASNER: Why would you say this is?

MR. MEIER: I would say probably part of the reason is the cases, because it's still local phenomenon,

there's a lot of different things going on. I mean, Mr. Holloway made the point: Don't just look at California, there's a lot of other stuff going on in different parts of the country. It's such a local and regional thing and there are so many differences. I mean, if you're competing in California and there's Kaiser there, that's a very different world than if you're competing in West Virginia, presumably, and in other places. So, I think that's part of the reason for it.

But let me get back to the point about the guidelines. The trick is if we really put out some really clear guidelines, nobody is going to be happy with that. You know, I could put out a clear guideline that says, look, anything other than absolutely financial risk sharing is illegal. Now, do you want to hear that? Probably not. And we could probably find some faults in that.

Where we start developing a total rule-based system, you're going to limit yourself and you're going to possibly create losses of innovation development. What if I put out a guideline that said, it's only financial integration -- and by that I mean capitation and withhold -- and you come along years later with this idea of pay for performance and we say, well, that's not in the list. That's not going to cut it. No, we have to

be a little more analytical than that.

That's the way the antitrust laws developed. Remember I went back and I showed the actual language of the law. The natural language of the law is very broad and encompasses a lot of potential, but that's also a lot of potential to do good, a lot of potential to innovate, a lot of potential to develop new systems and new ideas and new approaches, and if we come up with a complete rule-based -- this is the guidelines, this is the line -- we're talking about squelching innovation, we're talking about squelching opportunities to develop and we're talking about becoming a very regulatory organization. And maybe I'm fooling myself, but we like to think that we're not that regulatory here at the FTC.

MR. HOLLOWAY: Markus, I think you have to really recognize that there's something called the American Spirit and that I guarantee that if you put definitive guidelines and if those guidelines are too tight, then Americans will figure out a way around it.

(Laughter.)

MR. MEIER: Okay. So, then, what's the point of a guideline?

MR. HOLLOWAY: But I think you should give direction, you shouldn't default on the defense that I cannot give definitive direction because it would be too

tight.

MR. MEIER: Okay.

MR. HAWKINSON: I don't think that's --

MR. MEIER: Well, perhaps I went too far to suggest that we haven't provided quite a bit of guidance. And, again, the word definitive, I'm not comfortable with that because I can't give the definitive word. I don't know. I mean, Dr. Casalino suggested that he has, at least in his mind, a model of something that could say, hey, here's some lines that might be drawn that we haven't even considered. So, it's not my place --

DR. CASALINO: Don't the MedSouth decision and the 1996 Guidelines -- how are those inadequate for you?

MR. HOLLOWAY: I'd like to tell you without the FTC listening.

(Laughter.)

DR. ASNER: One of the problems is all we have to go on right now is MedSouth. That's the only time that the FTC has said that it's okay, and we'll watch it, but it's okay. And you allude to the fact that you're going on a case-by-case basis, and that puts us all in a very difficult position trying to see how we can get along this path. We're looking for somewhat of a road map. It can be very broad, but not as broad as exists in the current guidelines. It doesn't have to be specific,

a list of things that you have to do. There is something in between. There are concepts of clinical integration that I clearly believe would allow us to move along a path that would be reasonable and acceptable and in the end beneficial for consumers. And that's what we're looking at, and we're happy to participate in that process with you.

We recognize this is very difficult for you to understand and to come forth with, and you're caught in the problem that you don't want to be in and we don't want you in of looking on a case-by-case basis, saying, this is okay; this is not okay. Then the rest of us look at what was okay and what was not and see how close we can get to that.

Frankly, I don't propose to be an expert on the MedSouth decision, but from having looked at that, I don't think that's the answer. In fact, I know that's not the answer, and I think there are things that we do in the California model that are far better, far more clinically integrated and far more beneficial for consumers, and we could do that in the non-HMO, non-financially integrated model, but everyone's really tiptoeing through this, and we need to move along. The industry is moving very quickly and we need some help.

MR. MEIER: Okay. Well, if you understand

MedSouth to be the answer, than that's a misunderstanding, because that's certainly not the way we put it out there. In fact, I'm trying to say that's not the way we think about it. It's not the answer, it's an answer, it's a system that we've now had enough time to look at and review and we can say with some degree of confidence that it's probably okay. You have the opportunity to seek advisory opinions to the extent that if you want to put together a model and put together some concept that you think you want to implement and bring to bear in the marketplace, and we can look at that.

But you're asking me to do something that we can't do. We can't just make this stuff up. I mean, there are guidelines and there's guidance that the courts tell us that we follow and we try to apply that. That was the thesis or the theme of what I was trying to put forth a little while ago. We're bound by certain parameters, too, and the guidance there isn't always as clear as one might hope, but we're trying to work with it as best we can.

But if we keep our eyes focused on the goal, if you keep your eyes focused on the goal and you can develop a system that you feel comfortable can reach those goals, it should withstand antitrust scrutiny.

DR. CASALINO: Bart, if I can jump in. When

you said you don't see MedSouth as the answer, I interpreted that as not saying you didn't think it was the FTC giving a good answer, you were saying you weren't impressed by MedSouth's clinical integration.

DR. ASNER: Exactly.

DR. CASALINO: And that if you were the FTC, you might not have thought that MedSouth is so clinically integrated as compared to what you would consider clinically integrated.

MR. MEIER: I actually understood him to mean that. I wasn't understanding it as a criticism. I was saying that you think you can do better than that. That's fine.

DR. ASNER: But the definition of better is challenging because there is no other guidance as to what's better, and I think we all agree that you don't have the answers, and we may have some of them and together we could formulate that. And we, frankly, would like that opportunity. I think that would be great for you and great for us.

MS. KOHRS: I think that that's part of the reason for these hearings. There are a lot of situations that we just don't have sufficient information about and that's why -- I'm going to remind people in the audience and people listening at their offices -- that we do take

public comments, that we encourage those. Those will be considered as we work on writing the report of these hearings. So, if you have more answers than the panelists, please, by all means, do submit public comments. And to just get a little heat off Markus for just a moment I'm going to turn the microphone over to Rich Martin.

MR. MARTIN: I would just add along the lines of what Markus was saying. I wanted to underscore one thing which is that we are not business people. We do not know markets individually. We know some things work in some markets, some things don't work in other markets. We're not capable of saying, this is -- you know, or giving you something that we say, this is good. We don't even know if it would work.

Often in a business review context, not just in health care, people will come in for a business review and we'll have a problem with something. We can identify a problem and they say, well, what should we do. And we're in a no-win situation because we're not competent to design something that will work in their particular area, industry, or market. We can react to things, but we don't presume to know the kinds of innovations that you think will work with physicians in a particular area.

So, I think that's what's really the crux of

our position about not being able to give more guidance than you think we should be able to give. At least that's one thing.

Now, let me ask you, this brings me to a question, I've gotten some mixed signals on the future of risk-sharing IPAs and I hear they're doing wonderfully in California, and that's not the only type of IPA, but they're ones that are integrated, they're also doing well. But I also get the impression that they have an uncertain future in other areas of the country and I'm just wondering, why is this? Why are they doing so well in California? Is it something about the market or did they get so deeply rooted there and not elsewhere or do I just have a mis-impression and are they doing very well -- risk-sharing ones -- elsewhere?

MR. HOLLOWAY: No, you do not have a misunderstanding, but that's historical. It's nothing that just happened last week. It's been like that from the formation of IPAs. And by the way, the first IPA, I think, was in Oklahoma City back in the late '60s. So, IPAs have been around for sometime.

But the California model never played well outside of California and you have models outside of California that are doing extremely well, IPAs that are doing extremely well, on all different types of

structures. You name a structure, an IPA has it and that's part of the problem for the industry. There's no uniformity in structures. But the risk model that you find in California never played well throughout the United States.

MR. MARTIN: Do you have any notion as to why that is or any of the other gentlemen?

MR. HOLLOWAY: Well, because most people, when you travel outside of the boundaries of California and you say, I'm from California, you're looked upon like you are from Mars. Its just a California concept, the rest of the United States didn't buy into, for whatever reason. I can't tell you it's the HMOs didn't contract with the provider groups, provider groups didn't accept capitation. That's not true, because in certain markets they accepted capitation; certain markets, they didn't.

I think the general issue is that it's a California phenomenon, we're going to do something different.

DR. ASNER: I'd like to add to that. I think it is a very fair question. In California, the IPA model is certainly very deeply rooted. It goes back a long way. There is a great deal of experience amongst the leadership, and there's consistent leadership. I actually had dark hair when I started in this business.

So, it goes back quite a ways.

What I think is important is that managing financial risk and providing clinical services is not an easy task. It requires a very sophisticated leadership, it requires collaboration between physician leadership and non-physician leadership. You need financial people who really understand the business and California IPAs have made that commitment and have done very well. As I alluded to, the premiums are lower in California despite the fact that we have put in place this additional layer of administration and clinical leadership, clinical guidance.

So, California has, I think, the experience that's made this work. Also, the health plans do like the model. They actually are more successful because of the model. In other parts of the country, health plans did not like the model. They chose not to follow through with that model. They actually, in other parts of the country, didn't like the fact that they'd have a strong IPA that could negotiate with them. That was not necessarily attractive to them. Whereas in California, that's been successful for both parties.

So, it is different in different parts of the country. I have seen many IPAs in other parts of the country that are very successful. But, clearly, in

California, there have been more success stories. There have also been a number of failures. As most people know, a number of IPAs went out of business in California in the last four or five years because they did not have the competency to financially manage the cost of care and that was what drove them out of business. Those that are in business still have been able to manage that cost of care and those challenges very successfully.

DR. CASALINO: Rich, I agree with what Bart just said. I think the ability to make money or not go bankrupt, to put it the other way, in taking financial risk is dependent -- it's really dependent on two factors. One is premium levels have to be high enough so that there has to be enough money flowing to the physician organization that's taking risk to have some chance of not going bankrupt, and the other thing is the physician organization has to be able to manage care effectively.

And it is true that in most of the country -- I mean, mostly what we've heard today is all the good things IPAs can do and I strongly agree that a good IPA can do all those good things. But I would equally strongly say that the majority of IPAs nationally are not anywhere near that level of being able to manage care on the cost and quality side.

I work with another organization which some of you in Washington are probably familiar with, the Center for Study in Health System Change. I am the senior academic on their provider team that every two years goes out to the same 12 randomly selected metropolitan areas, one of which is the Orange County area in California, and interviews in each area about 90 people, people who run health plans, hospitals, employers, people who run medical groups and IPAs. And I can tell you in this last round of visits, which we just completed a few months ago, in 11 of the 12 metropolitan areas, IPAs hardly even come up in the discussion. The exception was Orange County where they're very important in the discussion.

I think the reason why in 11 out of these 12 randomly selected areas you don't see much about them is because, again, absent risk contracting, IPAs are struggling to find a reason to exist and also that in these areas, the majority of IPAs did not do well, they didn't manage care well, for whatever reason, and they just blew up and they gave everybody, the health plans and the physicians involved a bad feeling.

Indeed, this risk-sharing model is so discredited in most areas of the country that when people talk about California, they exactly talk about California as this kook model that, oh, these are just the

Californians and nobody would want to do it the way they do it.

And, also -- and this is largely to do with the California Medical Association, which really has gone around the last couple of years making a lot of noise about the enormous numbers of medical groups and IPAs that are failing in California, very exaggerated statistics to serve a political purpose. But in the rest of the country has really given the impression that this California model is a disaster. I think as Bart has explained to us somewhat, it really isn't.

We're about to publish a paper from this national survey of physician organizations, it will be in Health Affairs in a few months, where we compare medical groups and IPAs in California to medical groups and IPAs in the rest of the country as a whole, and lo and behold, the California groups are doing at least as well financially even though premium levels are much lower in California. So, they're getting lower payment rates, and they score much, much higher on the quality processes that we measure than other places in the country.

So, the model there, of which IPA is a part, has actually worked pretty well. But IPAs in the rest of the country, there are notable exceptions, but by and large, they, at this point, fall far short of managing

care in the way that, Bart described in some detail.

MS. KOHRS: Dr. Casalino, I'd like to follow up on that just a little bit. You said that in the 1950s, IPAs first began and I'd kind of like to know what the motivation for that was, because, obviously, at that point, it wasn't just push back to get into a negotiating position with payers. I'm wondering, is that where we've gotten to now? Is that really the sole motivating factor for forming the IPAs today?

DR. CASALINO: Cecile, let me not talk about the '50s so much because I think that's actually probably not that relevant. But when you look at when IPAs started to form really in the '80s, more than these just couple of exceptions that formed for somewhat idiosyncratic reasons in the '50s, '60s, whenever it was, the motivation primarily, yes, was we need to be able to get health plan contracts, not be left out of them and we need to be able to negotiate them. We can't be up against health plans, just one doc against multiple.

And for the majority of physicians -- physicians do care about quality, there's no question, okay? But most physicians, and this is true even in California, I would say, they have a traditional view of quality which I would call the individualized view of quality. Physicians think that quality is what I do for

whatever patient happens to be in front of me for however long that patient is in front of me and the buck stops with me. That's what you're trained to do during your medical training, and that is indispensable. You have to have that. You don't what physicians saying, well, the buck doesn't stop with me, it's her fault that something bad happened.

But there is another view of quality which is the one that's being espoused here today, again, most notably by Bart, called the organized process or the organizational view of quality, and that's quality is what a group of doctors can do for a population of patients, not just the patients who are in front of them and happen to come in, but the patients who don't come in. So, the patient who doesn't even know that he or she has diabetes or needs a mammogram or whatever. Groups developing organized processes to see that these patients get the kind of care they need. And this is not just a cost thing, but a quality thing.

Now, people like Bart and people who run medical groups and IPAs in California and some other places understand this very well. Most physicians don't. So, I think it would be an exaggeration to say that physicians in any IPA just about, even in California, that the average physician is saying, oh, this is really

great, I'm a member of this IPA and we have all these great processes to improve quality and that's really why I'm a member of the IPA. It mostly is about leverage but that's because two reasons. One is health plans are so big that doctors feel like they need to have some leverage, and the other is that there aren't much in the way of rewards for quality for doctors in the United States. So, of course, they're focused on the cost side and the payment side. If they were getting paid based on quality, they'd be more interested in developing organized processes to improve quality.

Not to talk forever, but just one last point. In this same national survey that we did where we found that physician groups, medical groups and IPAs on average used only five of the 16 processes to improve quality for chronic diseases that we looked at, we found that -- we also looked to see if they had incentives from the outside to improve quality, basically if they got rewarded for it. And we found that mostly they didn't. The average group had 1.7 out of 7 incentives we looked at and about 40 percent of the groups had no incentives at all to improve quality.

But we found that if they did have incentives, two incentives, they used 40 percent more processes to improve quality. So, yes, it's mostly about negotiating

leverage for both medical groups and IPAs and that's because that's where the money is. If it were about getting a reward for quality, you'd see much more attention to the kind of things Bart is talking about and Al, that IPAs would pay more attention to, hey, we're going to do all these good things to improve quality.

MS. KOHRS: Markus you wanted to make a comment?

MR. MEIER: I wanted to throw out an additional hypothesis -- and I don't know that it's correct or not, and I'd be interested in any responses to it -- in response to Rich's question about whether there is, in fact, this trend of movement away from risk-sharing HMOs to PPO type arrangements and what might account for that.

My hypothesis is as follows: That capitation and risk-sharing I think largely grew up in an environment of selective contracting where you would have fairly narrow panels of providers and the idea was you'd shift a certain amount of volume there and you'd get a better price for it. And, of course, there's -- you know, everybody's familiar with the fact that there's been a fairly big managed-care backlash going on in this country and people just don't like it in general.

And as a result of that, to be responsive to the market place, the response of demand, you're seeing

the growth of more open panel type HMOs or less restrictive HMOs or open panel PPOs where people have lots of choices and can go to lots of different doctors.

Now, why is some of that going on? One is a response to the fact that people don't really like to be managed in managed care and another, I think, is because employers have recognized that it actually gives them a way of shifting more costs onto their employees. A lot of times HMOs, in particular California's as I understand it, are very heavily regulated. They have a lot of mandated benefits that they have to provide. You shift out of an HMO to a PPO and suddenly you can get out from under all that regulation and you can shift more of the costs of the program to your patients.

So, the health plan in that environment is not looking for risk-sharing with a group of physicians anymore. What it's really looking for is simply, do I have enough doctors to take care of the patient population that I have at a price that I'd like to pay. And at that point, there's questions about what would a group of doctors really be providing.

So, I throw that out as a hypothesis that might explain this trend, whether the trend exists or not.

MS. KOHRS: I'm going to go back to Mr. Holloway. You wanted to make a comment.

MR. HOLLOWAY: Markus, I must admit, I agree with you to your last statement. I hate to do that, but I do agree with you.

I would like for the FTC, in particular, to consider what is happening in our society, in that the physician -- the focus of the IPA, you're absolutely correct, was put forth to gain some clout. How do you gain some clout with the HMOs?

An individual physician has zero clout with the large, financially well-funded HMO. So, how does a physician even the playing field, so to speak? So, you join these groups to hopefully try to have some ability to negotiate. Why? Because in some communities, the HMOs are receiving double-digit increases in premiums and are passing zero on to providers.

I really get very, very upset when I hear a term that's called "medical loss ratio." In our society, when is it a loss to take care of patients? Shouldn't that be what our health care system is all about? A large amount of the dollars we spend in our society should go to providers for taking care of patients, not to the HMO so that their stock can look better.

In one large community in the Midwest -- and this actually is going on right now as we speak -- for the past seven years, all of the insurers in this

community have received double-digit increases in premiums and they've passed zero on to providers. So, the business community came to us and wanted us to work with them to look at direct contracting.

We have a crisis out there in our health delivery system. We need the FTC to help us out of this crisis.

MS. KOHRS: Thank you, Mr. Holloway. Dr. Asner, you had a comment?

DR. ASNER: Yeah, I have a few comments, one of them to follow up on what Mr. Holloway just said because I think it's very important. There's clearly a crisis in health care and the cost of health care has exploded the last few years, but I think it's important to recognize that there the national studies. This is not from crazy California. There are national studies that have shown that the largest percentage of the premium increase the last few years has gone to hospitals, particularly outpatient services because they've been smart enough to move services in the outpatient setting, and pharmaceuticals, not to physician services.

I don't think there's anyone in the room that would like to have their health care decided by hospitals or by drug companies. We all depend on our individual physicians.

And to your point, Al, the money has not gone to physicians. Despite the integration that the FTC is concerned about and the negotiating clout and leverage, there really is no leverage with the health plans on behalf of the medical groups and the IPAs that's of any significance. The money has gone to the hospitals and we all know how they've integrated -- I use the word "integrated" loosely there. They've grown larger over the last few years, and the drug companies and drug costs.

The second point I wanted to make is with regard to PPOs, which were alluded to, and the premium issue. I think it's very important to recognize that the premiums in PPOs have come down to where in certain markets they're very close to the premiums for HMOs. But that doesn't reflect the cost to consumers because the way that those premiums have come down is through very high deductibles.

The most common PPO plan in California is a $5,000-a-year deductible. So, patients will choose that product, pay very little per month, and that's wonderful as long as you don't need health care. When you have to go to the doctor, they pay high copays and a $5,000-a-year deductible. That is a disaster for a young person, in particular, who thinks that they're omnipotent,

they're never going to need health care. Well, you know what? They do. And they, all of a sudden, find out they have diabetes and the cost is very, very significant to the consumer in that case.

The last point, as I've thought a little more about the difference between California and the rest of the country in terms of the IPA model that you asked about, one of the things that the health plans did not do well in the rest of the country is allow the IPAs to pay the claims.

When the IPA pays the claims, then it has the information about the services that are delivered and then can act on those services to make sure that the doctors are doing "the right thing." And in many parts of the countries where there was an IPA, the claims were still paid by the health plans and the information flow wasn't really there for those IPAs. So, that definitely was a differentiating factor in the success of California IPAs and IPAs in the rest of the country. You need to know what's going on within the delivery system to be successful.

MR. MARTIN: Dr. Casalino, I wanted to ask you about group practices. You mentioned them in your talk and made some comparisons between the ability of IPAs and group practices to affect practice patterns and things

like that. I'm wondering, historically, of course, doctors have been slower than any other profession, even lawyers, to amalgamate into efficiently operating units and I'm wondering whether that has changed substantially in the last 10 or 20 years and whether -- to the point where we have fewer and fewer solo and small practices and more practices where you can do things like have practice parameters that would be effective. And a related question is, whether the experience with IPAs and doctors with IPAs, does that, in any way, pave the way for larger practices to develop or are those two concepts just unrelated?

DR. CASALINO: These are terrific questions. I don't know if you're asking them based on knowledge or just because you've --

MR. MARTIN: That couldn't be the case.

DR. CASALINO: Okay. They're very good questions. Let me answer your second one first. It was thought and frequently said in the '80s and '90s that IPAs were a transitional step to get physicians used to managing care and working together in some way, but that they really weren't as effective for controlling costs or improving quality as medical groups, they couldn't be, and, therefore, what would happen is eventually physicians would transfer from their small practices and

being members of IPAs to being part of larger medical groups through mergers of smaller groups or however it would happen.

I don't think that too many people would argue for that viewpoint now. I think that even medical group leaders, integrated medical group leaders -- when I say medical group, I mean medical group, not IPA.

I think that even medical group leaders would concede that there probably is a place for IPAs and for some of the reasons I mentioned. That there are a lot of physicians and patients who really prefer to not practice or be seen if you're a patient in a facility of a 500-member medical group or a bigger medical group like the Kaiser Permanente medical group and that IPAs are not just a transitional step, and if they can find a reason to exist, absent risk contracting and then show some value in managing care, that they might continue to exist and not just be a step toward large medical groups.

Now, the first question was, I think, are physicians moving into large medical groups more rapidly? I hate to bringing myself up again, but it just happens that this month, September, a group that I worked with from the community tracking study has published a paper in the archives of internal medicine in which we examine exactly this question. And we used both survey data and

data from our sight visit interviews.

Basically, what we say is that ever since the '30s really there's been progressives in medical care that have pushed for all the reasons why doctors should be in medical groups, and those reasons are kind of the ones we're talking about today. That you can come together and be a group of doctors developing organized processes to improve quality for a population of patients.

Well, that concept really wasn't understood by most doctors. Like I say, it still isn't today and it certainly wasn't during the '50s, '60s, '70s and '80s. But there were some reasons to be in groups, like sharing call, some kind of collegiality, little economies of scale. And so, there has been a movement really since the '40s, a slow movement into groups away from solo or two-physician practice into groups of four, five, six, seven, eight and that movement continues. Most of the physicians in the country now practice in groups between, say, three and eight. And insofar as they're dealing with managed care, lots of these physicians are then members of IPAs, although some in areas where there aren't IPAs contract with HMOs directly.

Now, in the '90s, there was more movement into large groups. Managed care gave physicians new reasons

to be in large groups. Getting negotiating leverage was one, but there are potentially others. One would be to serve as a unit of analysis to take risk or to be measured for quality. Another is to have economies of scale in management to deal not only with managed care but with an increasingly complex regulatory environment, some of which surrounds managed care, and to get economies of scale in IT and so on and so forth.

So, there seem to be, actually, overwhelming reasons for physicians to join large groups. But, in fact, we haven't seen that much of that. There was some push of it in the mid to late '90s. What we found in the last three years is that some of the large multi-specialty groups in California and elsewhere have actually disappeared, including some very well-known ones, and we find no movement at all to create large multi-specialty medical groups now, or really very many large multi-specialty IPAs. And the reason for that really is the managed care backlash, move away from risk, move back to paying fee-for-service, move away from primary care gatekeepers, move toward open access to specialists.

In a situation like that, there's no reason to form a large multi-specialty group. If you're a specialist, why would you want to share revenues and

governance with primary care physicians? Under tight managed care, where it looked like there were going to be narrow physician networks, all patients had to come through primary care gatekeepers, that was the only way they were going to get to be specialists, specialists were clambering to work with primary care physicians. Now, they don't want to because specialists have gone from being the cost centers they were under risk contracting to, once again, along with hospitals, being the primary revenue centers in medical care.

So, what we found is no more large multi-specialty groups being formed, some dissolving, but lots of single specialty groups being formed. A single specialty group, it doesn't have to be that large. You can be 20 orthopedists and have pretty good negotiating leverage. So, we're finding a lot of these groups being formed and you can also own an ambulatory surgery center and buy an MRI scanner. So, we're finding a lot of formation of single specialty groups for those reasons. They all talk a lot about quality. I can't say that we've seen that they're actually doing much in terms of organized processes to improve quality because, again, they don't really get rewarded for that. They get rewarded for generating as much revenue as they can now that we're back to fee-for-service.

And just the last thing, why aren't more physicians in groups, period, in larger groups? Basically, they don't want to be. It's hard to form them and -- there's a lot more to be said about it, which we do say in the article, but I'll stop there. But we're not seeing large multi-specialty group formation. We are seeing single specialty. This is a potential issue for the FTC, especially with the hospital-based specialties, anesthesia, emergency medicine where we actually may be getting not so much into the cartel problem, but the monopoly problem.

MS. KOHRS: I do want to come back to the single specialty IPAs in just a moment.

DR. CASALINO: Certain groups, not IPAs.

MS. KOHRS: Sorry. Groups. But I do want to take advantage of Curt's presence. We've talked a lot about, during the course of these hearings, new entrants and market barriers that are presented and alternative types of health care that we don't necessarily think about. And so, having Curt here, I just wanted to ask a little bit about how IPAs are including people like physician assistants, nurse anesthetists, dental hygienists, those sorts of things. Are IPAs dealing with any of those issues and how so? Curt, do you want to like just tell me a little bit about where you practice?

MR. HAWKINSON: Sure. Well, first of all, I can only speak to the PA experience. Unfortunately, I don't have any expertise in those other areas for you. Where I'm at, for example, there is an IPA which is, I guess for where I'm at, relatively large with a metropolitan area of probably 250 or 300,000 potential patients. There are probably 400 plus physicians in this IPA. It's multi-specialty. I would probably say that 90 plus percent of the physicians in town belong to that. When I say "town," I really don't mean a single town, it's a rather large area.

MS. KOHRS: Can you tell us where it is?

MR. HAWKINSON: Actually, Salem is probably considered part of the Portland metropolitan area, I'm sure, for most purposes and that's why that number is higher than most people would realize. When you say 90 percent, it usually raises some eyebrows, but we're considered part of that metropolitan service area of Portland.

From my standpoint of view, I have not had any problems as far as being paid for services and I think that PAs certainly can help improve access to health care, which is obviously a very important thing. PAs cannot be members of the IPA where I'm at and I think that's probably just a generalization and it's very hard

to get data on that. That's a hard concept sometimes to get across to PAs when you would try to survey them because I think so many of them it's invisible to them. But anecdotally, I don't think there are physician assistants who are out there having trouble getting paid for their services. That, of course, is because we practice with physician supervision. So, if those physicians hire a PA, they want to be paid for those services, obviously.

Again, I think where so much of that comes in were the questions I alluded to earlier, were the rural areas. What happens in that setting where it's not traditionally where you think of a patient going in, a physician may not be available, they see a PA or they tend to see a PA for most of their care in that practice. What if that physician isn't there readily? And I think sometimes there are some access questions for patients. I'm not saying that the access isn't available, but when a patient walks into an office a lot of times they expect to see their physician or they expect to see the physician who's on call.

And for those patients that I care for, primarily, they see me for the majority of their visits. One of the questions that frequently comes up is, well, your name is not on my health plan, how does this work?

And I think it creates just a level of confusion for patients. I don't think that's unique to IPAs. I think that's unique to managed care and I think the move to PPOs will probably take us away from that a little bit.

We're also seeing, where I'm at, that movement towards the PPO system. The major payer is Regents Blue Cross-Blue Shield, which is basically Blue Cross-Blue Shield of Washington, Alaska, Oregon and Idaho, I believe, and they're going to move away from their HMO product as of the start of 2005. So, I'm not sure if that answers your question entirely or not.

MS. KOHRS: That's a good start at it. Dr. Asner, did you want to comment on that?

DR. ASNER: Yes, I was going to comment on that. I think there are two levels which nurse practitioners or physician assistants interact with an IPA. One is what Curt was talking about and that is, as employees of the physicians who are members, and that's clear. The other is, as employees of the IPA. The nurse practitioners and physician assistants are part of the clinical team that the IPA employs to provide these organized programs and coordinated care. If we're going to set up a diabetes clinic or chronic care clinic of some sort, we use nurses, we use nurse practitioners, we use physician assistants to do that, and that's a level

of expertise that we provide.

This goes back to the difference between an individual physician in their practice who cannot do that versus an IPA structure which can. So, that's the infrastructure that the IPA puts in place that exists on the managed care side of the equation that, frankly, doesn't exist on the non-managed care or PPO side of the equation and it brings real value.

MS. KOHRS: Thank you. Mr. Holloway.

MR. HOLLOWAY: Yes, I agree with Dr. Asner. Many IPAs have ancillary services providers who are in varying states of relationships, employees who are contracted, and in some cases, members.

I'd like to go back to what Larry stated and your question about medical groups. There's been a crisis in medical groups and I'm sure that your research -- you alluded they haven't been growing. But most of the medical groups that grew for a period of time, they grew through wrap-around IPAs and I think it's important for you to understand that, that these fully integrated medical groups that we look at as a system that is more capable of providing coordinated care are in a crisis just like IPAs.

If it hadn't been for a lot of them developing wrap-around IPAs, more of them would have failed than

what has failed.

MS. KOHRS: Can you define "wrap-around" for me? I'm sorry, I'm not familiar with that term.

MR. HOLLOWAY: Let's take the 601 New Jersey medical group. That 601 New Jersey medical group has 75 full-time, paid physician members. That group would have a difficult time sustaining itself, and so, what the group did was form a 601 New Jersey IPA with physicians in the community and those physicians refer to whatever specialties are in the 601 medical group and that feeds the medical group. That concept has kept a lot of medical groups alive.

DR. ASNER: It's the law of large numbers. You're managing a larger population of patients, so if you're taking financial risk, you're spreading it across a larger population by doing that than a medical group could by itself.

MR. MARTIN: Let me ask an unfair question. So maybe you could just put your sign up or down if you don't want to answer it. The question basically is, do you think that -- and I'll preface it by saying once I was working on a case where a pediatrician was a potential witness in a case and after the interview I said, is there anything else you want to ask me? He said, yeah, what does Footnote 16 in the Maricopa

decision mean? And I was just stunned. I have never, in any industry, found people who were so interested in the law that governs their industry.

And so, the question is, with respect to the health care guidelines that both agencies put out jointly and with respect to all the information, for example, that's on the websites, do you think doctors are aware of the amount of guidance that is out there, or is it kind of ho-hum, but it's not very helpful to my specific situation or -- and I mean that as a sincere question.

Do you think it's just at such a level that it does not help providers?

MR. HOLLOWAY: Well, I'm glad you brought that up. I have your statement of Antitrust Enforcement Policy and I'd like to know, what is Section 2? What does that mean? I'm sincere about this. Section 8, the Rule of Reason, Section 2, Physician Networked Joint Ventures Involving Risk Sharing and Non-Risk Sharing Contracts. What does this mean?

MR. MARTIN: I'm sorry?

MS. KOHRS: We're somewhat handicapped by not actually having a copy of that in our hands.

MR. MARTIN: Markus, since you have that, why don't you help us out?

MR. MEIER: I'm not qualified to answer it.

MR. MARTIN: I'm just a moderator.

MR. HAWKINSON: Actually, Cecile, if I can go back to your question, I'd be happy to try to answer that for you.

As someone in full-time clinical practice, I think that the leadership in our local IPA -- and I suspect it's true for most IPAs in general -- are very aware of what is out there, at least what's available. Are they aware of particular guidelines? That I can't answer because I'm not part of that.

I think, however, the rank-and-file physicians who provide the care in this country probably don't know, they probably don't care. They want to join a group. They want someone else to do all that for them. They want to see patients. They want to be reimbursed at a reasonable rate and they don't want to have to deal with this. And I think that if the managed care and HMO structures hadn't come into place, would we see so many of them bound together to collectively negotiate? I dare say not. I certainly don't have data to back that up as so many colleagues do. I think most physicians don't really care and they don't know that it's out there.

DR. CASALINO: Before Markus gives the definitive FTC answer to Al's questions, I just want to also use your question, Cecile, to, again, hammer at the

point of organized groups, whether they be IPAs or medical groups. I agree with what Curt said. I think the physician leadership of IPAs and large medical groups, not of small medical groups, is fairly sophisticated, by and large, about these kind of things. So, I'm not surprised to hear what Richard said.

But the average physician has no clue. And this is why we also don't see more organized processes to improve quality. The average physician, you have to understand, they get to work very early in the morning. They go as fast as they can doing multiple things at once until late at night.

When I practiced, I would get into the office at 8:00. I may or may not have been on call all night the night before, and if I was, I may or may not have slept. And I would go as fast as I could until about 9:00 that night. I would eat lunch at my desk. I wouldn't have had supper by the time I went home and that entire time I would be seeing patients, answering phone calls, dictating charts, whatever, the whole time. Probably about an hour of that 11 hours or whatever it was, 13 hours, was spent dealing with various kinds of managed care things, which the IPAs actually made easier for me.

But the point is, at 9:00 at night, I'm not

going to sit around and think about, now, how can my 5-physician group develop organized processes to improve quality. And if I did, which actually I did -- I was unusual that way. I couldn't get the other -- there's no way the other people are going to listen, you know what I'm saying?

So, unless you have groups that are big enough to actually be able to pay physicians and non-physicians to think about these things and put these processes in place, you aren't going to get them. You really need two things to get better quality in health care. You need groups that can hire people like this and that can serve as units of analysis for measurement and you need -- or I should say organizations, medical groups or IPAs, and you need to reward them in some way for doing it.

It isn't a form of reward really to say -- well, I'll leave it at that.

MS. KOHRS: Well, that leads into one of the issues that we also wanted to address, which is, you were talking about giving incentives to the doctors to increase quality. My question is, is there some way IPAs can give greater incentives to the patients to greater manage their own health care and to get better quality and lower prices for themselves? Because we've talked about that in terms of for the IPAs.

MR. MARTIN: But I jumped in on Al's question to Markus.

MR. HOLLOWAY: I'd like to discuss this with Richard.

MS. KOHRS: We're still busy ducking that one.

MR. MARTIN: That was a nice try.

MR. HOLLOWAY: No, I will discuss this with you because in reading your guidelines, it looks like you're absolutely correct in one of your earlier statements. Boy, this is twice today I'm agreeing with you. That you have given a lot of guidelines and directions, and if I read this correctly, then we may not have the issue that we think we have. I just need to understand and I need you to explain to me what it means. So, I'll discuss it with him.

MR. MEIER: If that's an acceptable solution, I'll go with that. Otherwise, I have three other arguments to dump in.

MS. KOHRS: You can take that one in the hall later. I was told no fisticuffs during my panel. I'm sorry. Dr. Asner, could you go?

DR. ASNER: Sure, you wanted an answer to getting the patient involved in the incentives?

MS. KOHRS: We are kind of concerned about quality and care from the consumer's perspective.

DR. ASNER: Sure, sure. I think that that's actually a very interesting question and quite timely. One of the frustrations -- and by the way, I'm a pediatrician. I did not read that footnote, so it's probably not typical of pediatricians. I was too busy doing 11-hour days and didn't have time at 9:00 at night either. Usually, in fact, as a pediatrician, I was taking my phone calls at 9:00 at night from the mothers.

I think the issue of getting the patient involved, the consumer involved, is very important. One of the things that a consumer advocate once told me is, no one asked the patients, the consumers, if they wanted to be in managed care. They were just basically told, this is the new system and the employers basically said, this is what you've got. I think that, obviously, has created a lot of backlash against managed care because they didn't like what they were told they had to have.

That being said, I think there are a number of studies that are coming out and will be coming out showing that the quality is going to be better. The question is how to reinstate the doctor/patient relationship. That's really been lost. The doctors have been frustrated, the patients have been frustrated, and so, one of our challenges as an industry and, frankly, as an IPA model, is to recreate and reinvigorate that

doctor/patient relationship.

I just recently attended a meeting of a consumer advocacy group that is proposing something called healthy incentives, where the patients would actually be paid for performance along with the doctors. If the patients were to go for their pap smears, were to go for their mammograms, they would actually get $10 or $15 for doing that. And that actually is in place in some IPAs in Northern California and it works with varying degrees of success.

So, there are some programs to incentivize the patients to do the same things that the doctors are incentivized to do, so everyone is on the same page.

Now, I wish it wasn't necessary to pay people to do those things, but that, to some degree, is a reality and so, there are efforts to align the incentives right down the line so that in the end we have the delivery of quality care.

DR. CASALINO: Can the patients negotiate collectively with the IPA?

DR. ASNER: I'm sure that will happen and then we'll be back to you complaining about that.

MR. HOLLOWAY: I can't leave this like this. I'm sensitive about speaking a lot. The structure of an IPA is a vehicle that passes dollars through. The IPA

does not keep money. In order to have a good educational program, the IPA needs to have funds to do that. So, you can't just say, why isn't an IPA not actively involved in education of a patient? There need to be funds associated for the IPA to do those things. If an IPA is functioning appropriately, it should have zero dollars at the end of its reporting period. All of the funds should go to the doctor. That's the purpose of the IPA, to pass money through to the providers who have taken care of patients.

DR. ASNER: And I'll agree with that and respectfully disagree with that on one level. In any business, you need to retain some earnings for the future to be able to put those programs into place. So, if you're going to have a successful IPA structure, what our experience has been in California is not that you're trying to earn a profit. You're trying to retain enough earnings so that you can successfully put in place programs for the future.

So, I think one of the reasons IPAs failed in California is they did not retain earnings. Typically, in an individual doctor's office, the goal is exactly that, get the money out at the end of the year so you don't pay taxes. That's the way doctors work. So, when doctors formed IPAs, initially that's what they did.

They said, get the money out, it's the doctors' money, and it is. But if you're going to be successful, you need to make investments in technology, in infrastructure and programs and so there really does need to be some retention of those earnings for the good of the delivery of health care.

MS. KOHRS: There's a big difference between -- well, not big, but there's some difference in enforcement when we were looking at multi-specialty IPAs versus single specialty IPAs, and I wanted to find out -- we were talking a little bit about trends. You said that there's a trend toward more group practices that were single specialty but not toward single specialty IPAs, is that correct?

DR. CASALINO: There is definitely a trend away from formation of large multi-specialty groups and toward formation of single specialty groups, especially in specialties that can either achieve a monopoly-like status, like the hospital-based specialties that I just mentioned, anesthesia, emergency medicine, or specialties that can make a lot of money from ambulatory surgery and/or from high-end diagnostic imaging.

So, cardiology and orthopedics are two big specialties in which a lot of single specialty groups are being formed, even to the point of owning their own

hospitals, as is happening in Indianapolis for example, either alone or jointly with a national company or sometimes with a local hospital, their own specialty hospitals, an orthopedic hospital, a cardiac hospital.

Our research, honestly, wasn't designed to look at single specialty IPAs. I don't know if Al or Bart would have a comment on that. So, I can't say more than just kind of hearsay. I think there's some slight movement toward it, but I don't see it as an overwhelming trend.

Frankly, I think from an antitrust point of view what I've seen, I'm less concerned about single specialty IPAs as I am about groups of specialists in a specialty, like orthopedists, for example, who don't form an IPA and who aren't in a medical group together, but who, nevertheless, in effect, negotiate jointly with some poor IPA. And this, in fact, happened in the IPA that I was a vice president was, an IPA that lasted for 20 years. It was a pretty successful IPA.

But one of the factors that killed it was a group of orthopedists -- I shouldn't say a group -- about 15 orthopedists that were in about 11 different groups in our particular area of the country got together, in my opinion, completely illegally and said to the IPA, pay us this or we're not seeing your patients anymore. In other

words, give us more of the money, don't give it to the other doctors. And it was a form of joint negotiations, collective negotiations, even though these people were not members of a group, and they got away with it.

And I think actually a lot of that goes on below the radar screen of the FTC. I know the FTC, in fact, didn't know about this case. But I think there's probably a whole lot where it doesn't know. But, Al and Bart, I'd be interested to see what you have to say about single specialty IPAs.

MR. HOLLOWAY; First of all, I agree with Bart. My earlier comment about IPA is a pass-through. There needs to be some retained earnings. My organization worked with the IRS several years ago to get the IRS to relax the tax laws to permit IPAs to retain more of their earnings for these purposes. But the mission of the IPA still is to pass money through to providers.

In the Southeast about eight years ago, an insurance company, one of the large HMOs, fostered the development of single specialty IPAs and that model grew real fast in the Southeast. It lasted for about five, six years and it disappeared and you don't find a lot of single specialty IPAs anymore.

DR. ASNER: I think there's really no difference from my perspective between a single specialty

IPA, a single specialty medical group or a bunch of doctors who just come in to negotiate that happen to be in the same specialty. I vividly recall an orthopedic meeting where 25 orthopedics came into the room to negotiate with an IPA and they had never spoken to each other before, they hated each other. But all of a sudden, they're best buddies because what they were doing was getting together to negotiate a rate in the interest of all of them. So, that clearly happens.

There are a number of instances, and the FTC is aware of this, where some hospital-based groups have gotten together to try and negotiate price and, again, this is not just with the health plan. It's with the IPAs and the medical groups who are paying those bills. And that has been a problem and the FTC has appropriately stepped in and dealt with that and I think that is very appropriate because there is no true financial integration. They're just being paid fee-for-service and there is no clinical integration. They just are trying to get the best price that they can for their services.

So, there's a very big difference between single specialty groups or IPAs and multi-specialty IPAs, which is why in my definition I underlined the term "multi-specialty IPAs."

MS. KOHRS: I'm sorry, did you say that the FTC

was or was not aware of that?

DR. ASNER: I think you are. You've come down on what you call single specialty IPAs in some of your decisions.

MS. KOHRS: I'm sorry, I was talking to Dr. Casalino, his early comment.

DR. ASNER: Oh, I'm sorry.

MS. KOHRS: Dr. Casalino had said that you believe the FTC was aware where the individuals came into the group -- got together as a group.

DR. CASALINO: Yeah, I probably shouldn't talk so much about this specific case. No action was ever taken. But I have reason to believe that this kind of thing goes on -- Bart just confirmed it -- fairly commonly around the country and is a problem not just for health plans, but especially for IPAs.

I don't want to be in a position of being part of single specialty medical group or single specialty IPA bashing. I mean, I should say the progressive model in health care since the '30s has been that reformers have advocated so much but physicians haven't bought that much -- was the formation of multi-specialty medical groups, okay? That was considered what would lead to the best quality. And as a primary care physician, I have always believed that and I'm very sympathetic to that.

There is another viewpoint, which I think should be expressed and that's the focused fact review point or the Herzlinger viewpoint, the Harvard Business School professor which says, no, no, no, a multi-specialty group can't provide higher quality than 20 orthopedists who come together and say, we're going to form a medical group or an IPA and we're just going to focus, focus, focus on orthopedic conditions and we're a tight group. We're going to be able to give such higher quality for orthopedic conditions, much higher than five orthopedists in part of a big multi-specialty medical group could do. And similarly, that a specialty hospital, an orthopedic hospital can give better orthopedic care than a general hospital to orthopedic patients.

And, again, as a primary care physician and for various other reasons, I am sympathetic to the multi-specialty side, but the jury is still out. There really isn't data to show whether, in the end, multi-specialty or single specialty is going to be able to do a better job on quality and costs or whether they both can do pretty well. We still don't know that.

But I would say that single specialty groups', like multi-specialty groups, negotiating leverage has been a prime reason for formation. But, now, with the

move to loose managed care, I think the prominent reason really is to have a big enough group that you can, as I say, buy an ambulatory surgery center or create one, buy a CT scanner, buy an MRI scanner and just run through as much revenue as you can, which is basically back to the '60s again except with higher technology.

DR. ASNER: And I would add that you're absolutely right. I don't mean, by any means, to bash single specialty organizations. I think within an IPA structure, when the orthopedists get together, they actually help us define the better quality of care. As a pediatrician, I have no idea what goes on in orthopedics that will really enhance quality of care.

What we were talking about was getting them involved. Once they're involved, there is excellent cooperation in terms of delivering higher quality care. Some of my best friends are orthopedists.

DR. CASALINO: And they're as strong as an ox and twice as smart.

DR. ASNER: That's right.

MS. KOHRS: I wanted to go back to quality one more time just because I'm kind of curious about how you all define it. Customer satisfaction, how does that equate to quality? How does that factor in?

DR. ASNER: Well, maybe I can answer that from

the California pay-for-performance model. As I showed on my slide, 40 percent of the funding of the pay-for-performance initiative will be for patient satisfaction as patients perceive quality. And the questions that are being asked of the patient are very general. There's something called a CAS survey, the consumer assessment survey that is a standard tool in California and the questions go something like, how did you feel about your waiting time in the doctor's office, was it too long? Not how many minutes, but how do you feel about that? How did your doctor communicate with you? Did you have a good experience? I mean, these are the kind of questions that are being asked.

So, whether I agree or not that that's the definition of quality, that's the definition of quality from a patient. How long did it take you to get to see your doctor? How long did you wait in the waiting room? In general terms. Are you satisfied with that? Not a time, but was it reasonable? And that's what's being used to measure quality from a patient point of view and that's how the physician groups and IPAs are going to be paid, which is very interesting when you think about that.

MS. KOHRS: Well, it's very interesting when you're considering that the antitrust agencies are trying

to factor quality into how we analyze competition. So, Dr. Casalino, ideas?

DR. CASALINO: Well, I agree with what Bart was saying. I doubt that there would be disagreement about this. Obviously, patient perceptions of what they perceive as quality is important. We don't want doctors or health plans or employers just being paternalistic about what is quality.

On the other hand, we all know -- and I had this experience to my dismay when I was in medical school and my father was seriously injured. We all know that just because a doctor is nice doesn't mean they provide good care. And patients aren't really in a good position and sometimes physicians aren't because they don't actually have the data.

As a primary care physician, I face this problem all the time on knowing who's really giving high quality care. Also, I don't really have an idea of, gee, does my medical group or does my physician, part of an organization that uses organized processes to improve quality. So, I think what patients' perceptions are is important and we need to keep eliciting more and more about what patients perceive as quality. But I think there has to be room for other input, too. And the pay-for-performance model, obviously, has that. It's only

somewhat based on patient perceptions.

DR. ASNER: Just to expand on that, 50 percent is based on clinical quality and the first year, as an example, it's, did the patient get their test, did the diabetic get the hemoglobin A1C test to see that at least that testing's being done? Next year it's going to be, what was the result of that test and did it improve? Now we're starting to talk about quality.

MR. HAWKINSON: Cecile, an additional comment. I think when you start to look at quality indicators, particularly for providers other than physicians, particularly physician/PA teams, which is how we practice, one of the questions is, can you mine the data out of what is different from individual provider versus the team and can you separate that out? That's always an important question that we've tried to ask, but it's really hard to get that data unless you treat those two individuals as sort of two separate providers when you're looking at indicators of the quality of the care they provide.

MS. KOHRS: Well, I think we're just about to wrap up so I'm going to let people make concluding comments. For a radical change, we'll start with Markus.

MR. MEIER: I think we've heard the word "crisis" used a number of times today and I imagine

probably that concept has come up a lot during the hearings. I don't know. I haven't gone back and read all the transcripts of all the sessions that I've missed.

I've only been in this business of looking at antitrust in health care since 1990, so I guess I have about 13 years now and I remember people talking about crisis back then, too. I wonder if one went back and tried to do a Lexis/Nexis search of the leading newspapers and magazines and put the words "crisis in health care" whether we wouldn't find that they've been talking about it probably as long as there have been newspapers and magazines.

And I guess that reflects the fact that there are a lot of different views as to how we deal with the problem that health care costs are clearly very, very high by any measure, and certainly, when you compare it internationally, when you look at what different countries have, America, by far, pays more than any of the other OECD countries and those are the most, you know, modernized Western countries.

In preparing for coming here today, I sort of went back and looked at some old speeches at the Commission. One of the big health care speeches that our current commissioner, current Chairman has given was called Everything Old is New Again: Health Care and

Competition in the 21st Century, which is available on the website. I went back to test the hypothesis -- somebody in my office dug this up -- to test whether everything old is really new again and we went back 20 years when Chairman Muris was actually the Bureau Director of the Bureau of Competition and found a speech that he helped write for the current chairman of the FTC at that time and I just think it kind of plays into this crisis theme and whether competition can really work or not. So, bear with me as I read a couple lines from it.

The health care sector -- now this is 20 years ago. This was written October 24th, 1982. "The health care sector is at a crossroads with two ways to go. The first road is competitive private enterprise with dentists, physicians and other health professionals playing by the rules of competition within the framework of legitimate state licensing laws and regulations.

The second road is increasing government control and even ownership, not general oversight by the two or three dozen health care attorneys at the FTC, but genuine control by bureau after bureau of real regulators, genuine pointy-headed bureaucrats, that someday could be directed by a frustrated Congress to take charge of the nation's health care system. That is why I believe that supporters of the proposed exemption

within the professions are being short-sighted. Passage of the exemption would sow very ominous seeds that someday could sprout into a much larger and more fearsome government bureaucracy, a regulatory monolith that would become the new nemesis of the health care professionals.

Dentists and physicians may then come together and recall fondly the days when all they had to worry about was that bunch of crazies at the FTC." That's all.

MS. KOHRS: Gee, I hate to make you follow that, Curt.

MR. HAWKINSON: I'm not sure I can one-up him on that. Well, first of all, thank you very much for having me here today. I really appreciate being able to present the non-physician perspective, for lack of a better term. I think one hallmark of the PA profession has always been flexibility and I hope that's been a little bit evident today. I think one thing is the FTC continues to look at IPAs and so forth; also to remember to take a look at how that particular structure affects health care providers other than physicians.

And I think Mr. Holloway, as he mentioned earlier, and to not take words from his mouth, but when you've seen one IPA, you've seen, well, one IPA, and I think that's an important thing to remember.

MS. KOHRS: Thanks. Dr. Asner?

DR. ASNER: I guess the message that I'd like to leave you with is that I'm happy that I was invited here to give you some education on the provider perspective because in the end what's going to help address the crisis in health care that we seem to constantly be going through, but today's crisis, is going to be collaboration and cooperation. And I appreciate the opening of this opportunity, and others that I heard you say, to work together.

I also wanted to make sure that we continue to recognize the value of organized medicine. You heard a lot about that today, the term "organized medicine" and the value that that brings to the marketplace and the consumers, the ability to provide innovation, to provide coordination of care for patients. I don't want that to get lost, not only because I believe in this firmly, that's why I do it every day of my life, but someday I'm going to be an older patient in this system and I want to make sure the system can provide the kind of care that I want for myself and my family and all of you.

MS. KOHRS: Thank you. Mr. Holloway?

MR. HOLLOWAY: Markus, I really appreciate your comments. Like I say, health care is in a crisis. Physicians are in the best position to improve the problem. We need the FTC to be part of the solution.

Competition does not function effectively in health care because there is, at least, one and sometimes two middlemen, the insurance company and the hospital, between the seller and the consumer who have a fiduciary duty to the shareholders.

I welcome an opportunity to work with the FTC to try to provide more guidance to the community.

MS. KOHRS: Thank you. Dr. Casalino.

DR. CASALINO: I don't think I have any further comments. Thanks for having me, though. I enjoyed it.

MS. KOHRS: I'd like to ask everyone to give the panelists a round of applause and remind you that we will be back at 2:00.

(Whereupon, at 12:30 p.m., a lunch recess was taken.)

AFTERNOON SESSION

MR. KELLY: Again, I would like to welcome everybody to this afternoon's session of the health care and competition law and policy hearings. We'll be talking about the messenger model this afternoon. On behalf of the DOJ, and the Federal Trade Commission, we welcome you. The panelists this afternoon, and I will just introduce them very briefly, because there are biographies available, are: In order from right to left, Dr. Edward Hill, Douglas Ross, Jeff Miles, Richard Raskin, David Marx and last, but not least, Art Lerner, and my co-moderator from the FTC this afternoon is Sarah Mathias.

Before we get started, I would just like to remind the audience that we really appreciate your being here, but in terms of time and fairness to everybody, we would ask that there not be any direct participation from the audience during the hearings. Thank you. And the speakers will be speaking for approximately 10 to 15 minutes, and after all the speakers have had the opportunity to speak, we will take a brief break, then we will come back and we will have a moderated discussion on the presentations.

Okay, without further ado, I would introduce Dr. Edward Hill, representing the American Medical

Association. Dr. Hill?

DR. HILL: Thank you very much and good afternoon. I'm Edward Hill, as you've heard. I'm an immediate past Chairman of the Board of the American Medical Association and a board certified family physician from Tupelo, Mississippi. I'm very pleased to be here today to offer the perspective of practicing physicians on the application of the messenger model under the antitrust agency's statement of enforcement policy.

As we testified at the FTC workshop last September, the AMA believes it's time to take a fresh look at some of the core principles that have guided antitrust enforcement in the health care sector. In our view, some of these principles don't hold up to close examination. They are simply assumptions which have never been proven and which, in our view, have outlived any purpose they once may have served and are now counterproductive.

Today we discuss one of these assumptions in detail, it involves the use of the messenger model. I will also identify some of the other assumptions and explain why we believe the Commission and the Justice Department should revisit them.

Our central message is this: When physicians

create a network to market their services jointly to payers, the rule of reason, rather than the per se rule, should generally apply. The physician network should not be required to do risk contracting, to clinically integrate, or to use the so-called messenger model in order to avoid charges of price fixing. We believe that the rule of reason is capable of distinguishing between physician networks that are truly harmful to competition and those which offer pro-competitive benefits such as greater flexibility, more innovation, and ultimately a better health care system.

There are a few assumptions sacred to antitrust enforcers that I want to address before I get to the messenger model. The first is the agencies' position that capitation and other forms of risk contracting are more efficient than fee-for-service medicine. The agencies believe that capitation and withholds promote efficiency by giving physicians an incentive to contain costs. By contrast, the agencies believe that joint contracting on a fee-for-service basis creates no efficiencies and is therefore illegal, per se.

Now, as a factual matter, it's far from clear that risk contracting is really more efficient than fee-for-service. To the extent this question has been studied, the results have been inconclusive. To

determine this question of efficiency, it would be necessary to gather and compare data on the overall costs and quality of care of both types of physician networks. This would be truly an overwhelming task.

A number of factors would need to be considered, such as administrative costs of risk contracting, including the costs of legal and regulatory compliance. In addition, the effects of risk contracting on quality would have to be considered. This alone is a highly controversial and somewhat unsettled question. An additional cost is the numerous physician bankruptcies that have resulted from inadequate capitation rates. Since 1999, numerous medical groups and IPAs in many states have declared bankruptcy or are on the brink.

These bankruptcies have caused enormous disruptions in care, jeopardizing the continuity and quality of care for millions of patients. Every time a medical group or an IPA goes under, patients lose access to their treating physicians and then they have to scramble to get their medical records. Patients are forced to try again to establish a new therapeutic relationship with a physician that they hope they can retain, assuming they can find a physician who can see them.

But even if it were demonstrated that the one

form of contracting is more efficient than the other, there's a more fundamental question to address, and that is, is it the proper role of antitrust officials to state a preference for risk contracting versus fee-for-service.

Competition policy ordinarily does not take sides on this sort of question, it usually let's the market decide. And to quote Clark Havighurst, "antitrust enforcers should not, without good reason, deny physician-designed arrangements a fair chance to compete against lay-controlled entities in finding efficient ways to cope with disease at a reasonable cost."

Havighurst added that physicians should gain a competitive advantage because they are able to rely on professionalism, collegiality, and consensus rather than exclusively on rules that are imposed from the corporate top down. And another assumption that the AMA disagrees with is that joint contracting by physicians on a fee-for-service basis offers no potential transactional or other efficiencies.

Independent practice association, or IPAs, were discussed, of course, in great detail this morning. We believe this joint contracting by physician-sponsored IPAs in networks that don't share financial risk can offer great benefits in the form of transactional efficiencies that can result in significant cost savings

for both the payer and for the physicians. For payers, efficiencies can be achieved as a result of contracting with networks that have already been developed by physicians.

Because physicians still practice predominantly in solo practice or in small groups, creating a physician panel can be very time consuming and very expensive task for a payer seeking to enter or expand its place in a market. For physicians, a network would enable them to pool their resources to afford the necessary expertise to evaluate contract proposals, just as large plans do. This would lower costs and rationalize pricing without restraining competition.

To illustrate, I'll describe a fairly typical physician-sponsored network. It includes a large number of physicians in a community. All of the physicians credentialed have been pre-approved by the network's credentials committee. The network is also truly nonexclusive. So, payers thus have the option, they can build their own network by approaching physicians individually, or they can approach the physician-sponsored network and obtain ready access to a panel of qualified physicians.

Assume, too, that payers have the additional option of acquiring a physician panel by going to a

national or regional network PPO that is not sponsored by those physicians, but that has contracts with many of the same physicians that are in the physician-sponsored network.

No threat to competition is posed by this physician network. Because it is nonexclusive, the physicians actively and independently consider contracts presented to them outside the network. A payer who is unable to reach a package deal with the network can go directly to its physicians or to the competing network PPO. Rather than restraining trade, the physicians have created an additional option for purchasers, which is pro-competitive.

In this sense, these types of networks can be viewed as a new product under the Supreme Court's decision. Ironically, while enforcement policy continues to favor risk contracting, the market appears to be shifting away from it and towards discounted fee-for-service networks. Many employers and patients want to eliminate financial incentives for physicians to withhold care.

So, the question is, should antitrust policy stand in the way of physicians responding to this consumer demand? Should our hypothetical physician network be prohibited from competing on an even keel with

a national or the regional PPO? We don't think so.

The next assumption that should be re-examined is that physician networks that want the flexibility to contract on a fee-for-service basis can simply become clinically integrated. Now, this concept holds great promise, but the only guidance offered by the agency so far has been discouraging. Although the MedSouth letter represents an attempt by the Commission to encourage an innovative effort by physicians to provide new services within the confines of antitrust restrictions, it sets a very high bar. For most physicians, a significant investment in capital and other resources necessary to establish the level of clinical integration of a MedSouth is simply not an option.

In addition to requiring the purchase of sophisticated information technology, the MedSouth project required the physicians to hire numerous advisors, including lawyers, health care consultants, and information technology firms. In addition, the physicians declared that they intended to contract on a non-exclusive basis so they would continue to make their services available outside the network.

One might have thought that this fact alone, even without clinical integration, would have substantially alleviated any concern about the

physician's ability or desire to harm competition.

It also appears that MedSouth planned to wall off its physicians from direct involvement in contracting. The physicians proposed to use an outside consultant to develop a fee schedule, and if necessary, gather information from each physician on a confidential basis. Now, this approach sounds very much like a modified version of the messenger model, which we'll get to next.

Yet, despite the cautious and creative approach by MedSouth, the FTC letter is laced with caveats that seem to indicate the IPA will continue to be exposed to significant antitrust risks, and after years of very substantial investment of time and resources, the IPA walked away with a somewhat lukewarm and conditional go ahead.

Unless the antitrust enforcement agencies lower the bar as to what is acceptable clinical integration, such as the approach described by Mr. Al Holloway this morning, where adoption and adherence to practice protocols is considered sufficient clinical integration, most physicians will not be able to meet this challenge. We hope that the agencies will rethink their approach on this concept.

Now, this leaves us with a final flawed

assumption regarding physician network joint contracting.

Now, that assumption is, when all else fails, the messenger model represents a viable alternative for physician networks that are not financially or clinically integrated. Now, under the messenger model, as you know, a third party, the messenger, receives offers from payers and conveys them to each physician practice in the network.

It then surveys the practices and conveys the individual response of each practice to the payer. If the payer is not satisfied with the level of acceptance in the first round, the parties start over and do it again, and potentially again and again.

The messenger model is an inefficient apparatus invented for the sole purpose of maintaining antitrust compliance with no independent business justification. It is cumbersome, it's difficult to administer, and it's not surprising that the messenger model is often despised by physicians, hospitals, and to our understanding even payers.

Moreover, the messenger model leaves physicians exposed to charges of boycott whenever large numbers of physicians in a network independently view a payer's offer as inadequate. Consider this scenario: A payer offers a contractor the network messenger; the messenger

takes the contract to the individual physicians, each or many of them reject it as unacceptable. The payer who views its offer as eminently reasonable, incorrectly concludes that the physicians must have colluded, so it contacts the FTC.

The lawfulness of the physician's conduct should not depend on whether they accept the payer's proposal. As a practical matter, however, whenever a payer's offer is rejected by a significant number of physicians, a factual question will arise as to whether the physicians acted in a truly independent fashion. The presence of that factual question creates antitrust risk for the physicians, and it gives the payer an upper hand in the contracting process, regardless of whether the Commission agrees to bring a complaint or even to open an investigation.

In the end, the messenger model provides little in the way of antitrust protection for physicians, while imposing significant administrative costs on all parties. Because fee-for-service contracting is not inherently anticompetitive, and because the rule of reason can sufficiently guard against competitive abuses, the messenger model is at best unnecessarily restrictive, and at worst, an obstacle to competition by legitimate physician networks. It doesn't provide physicians what

they need to counter the enormous power wielded by health plans with which they contract.

In conclusion, the AMA commends the Commission and the Justice Department first for holding these hearings to re-examine antitrust enforcement policies and competition in the health care industry. We are hopeful that you will reconsider your policies regarding joint contracting by physician networks, taking serious consideration of our recommendations, and we look forward to a continuing dialogue with the agency on these and other important issues.

And, finally, I would like to thank you personally for the opportunity that I have to present the AMA's views today. Thank you.

MR. KELLY: Thank you, Dr. Hill.

Doug?

MR. ROSS: I have a PowerPoint, should I do it from up there?

MR. KELLY: Yeah. Thanks very much.

MR. ROSS: I'm Doug Ross, and what I thought I would do as a preface for what you are going to hear from some of the others is go over the basics of the messenger model, some of the variations, some of the more creative variations, and some of the problems that people have seen in it and provide that as a framework from which we

can follow with discussion later.

The traditional model, of course, is that you have physicians who are in different groups in the community, payers negotiate or simply pay each of the physicians or small physician groups directly. The messenger model presupposes that physicians come together in a network -- and by the way, when I speak of physicians, you could, of course, transpose this analysis to a group of hospitals or other providers as well.

They come together in a network, for sake of argument, let's talk about an independent practice association, an IPA, and that IPA then contracts or facilitates contracting on behalf of its members with payers.

As Dr. Hill pointed out in the traditional messenger model, the classic messenger model, the notion is that the payer submits a fee schedule to the messenger, who messengers that to individual physicians, they look at the offer and say, yes, I'll accept this, or no, I won't, and that is taken back to the payer and you can have as many rounds as either side will tolerate, or as are set up in the underlying ground rules. The payers then ultimately contract with the physicians who have accepted its offer.

That is cumbersome and I don't know that any

IPAs are contracting on that basis today, other than perhaps very, very small ones.

A typical variation is to have each physician in an IPA provide the messenger in advance with a fee level at which that physician agrees to be bound. That means that if an offer comes in from a payer, that meets or beats that fee level, then the physician will be automatically signed up by the messenger to the program, to the product.

The messenger will in the typical model, when this is used, send the offer that a payer makes to all physicians whose rates were above what the payer had offered.

Now, you can have some variations on this, and a variation which the Federal Trade Commission commented on just a day ago in a new staff advice letter is one which is actually fairly common among IPAs. The notion that underlies this is this: You can set up an IPA, spend a lot of your time and money putting a network together, and then a payer comes in, provides you with an offer, and that offer is acceptable only, let's say, to a quarter of your membership. Why should you facilitate contracting by that payer? What if one quarter of your membership expend the entire membership's monies on administering that contract which only ends up

benefitting a small number of your members?

So, a number of IPAs have come up with a rule such as the one that's discussed in this staff advice letter, the Bay Area physicians letter, which suggests -- which says the following: If more than half of the physicians have on file -- have given pre-approval to a certain fee level to the fee level which the payer offers, then the IPA will contract on their behalf, but if, in fact, the physicians who are willing to contract with that given payer are fewer than one half of the physicians in the IPA, the IPA will not contract on their behalf.

In the Bay Area letter, the way, in fact, it was set up or the way the Bay Area physicians group is set up is the payer makes an offer to the IPA, the IPA looks and says that will satisfy X number of doctors, we'll transmit it to the remaining members of our panel, and if at the end of that process we've got 50 percent or more signed up, then we will contract on their behalf and administer this contract. But if fewer than 50 percent accept, the IPA declines to contract.

An interesting twist mentioned in this Bay Area physicians contract was that if fewer than 50 percent accepted at the end of this process, the IPA would still contract with the payer, but only if the payer would

agree to absorb the administrative costs for that contract.

The Commission staff looked at this and asked a number of very good questions. The first question they asked and on which there was no answer, because context, it was just a business review letter, was are there legitimate reasons for this rule? As I say, I think frequently there are, it is a fairly common rule that you see among IPAs using a messenger model. The FTC didn't opine whether or not the business reasons were legitimate in this particular case, because they didn't conduct that kind of a searching inquiry.

The second thing that the FTC questioned and spoke about in the letter is what would the effects be of this rule, because if you are a network that has this rule, and you're one of the doctors in the network, and you all of a sudden have a payer that comes directly to you and is knocking at your door and submitting its contract to you, that's going to give you some information. That is going to tell you that this payer who presumably first went to the IPA, had an offer which was not accepted by one half of the members of the IPA, and now the payer is going directly to the physician members to see if any of them will sign up.

That is potentially valuable information for

you as a physician, it is telling you what your colleagues are doing. You know of course what the payer's offer is, by definition you have it in front of you, but you also know that this offer or something very much like it, you presume, was rejected by over half of your colleagues. That may or may not be information which has an effect in the marketplace.

Let's move on, since I just want to touch on a number of issues and not go into depth into many of them. With a problem that I have seen and a number of the groups with whom I have worked have experienced with the messenger model, let's assume this messenger model that I spoke about a moment ago where the physicians give the messenger authority, standing authority on which is the basis on which the messenger is permitted to contract on their behalf. So, all the physicians give the messenger a conversion factor or a percentage of Medicare rates that they will accept.

Now, each physician, of course, makes the decision individually as to what that level is. But it's not enough simply to tell a messenger, I will accept 150 percent of Medicare rates, or I will accept conversion factor of X, Y or Z, you've got to have a context in which that rate is promulgated.

You may be willing to accept 150 percent of

Medicare rates if the other non-priced terms in the contract line up in a certain way. But if you have a contract into which you'll be paid very slowly, under which the definitions of the kind of care you have to provide are broad, and that has other terms that you consider to be onerous, at that point, you may not think that 150 percent is enough, you want 160 or 170 percent.

The point is, you can't make a price offer in a vacuum, you need to have some context, contractual terms around that.

And the way in which IPAs, some IPAs, do this, and a way which has, to my knowledge, at least, not been blessed in any of the statements or business review letters that are out there, is to come up with a standard contract which the IPA has, and then sends to its doctors and says to the doctors, based on this contract, what would your offering rate be, the rate at which you're willing to be bound?

Then when a payer comes to the IPA, the IPA can say to the payer, if you use this contract or something substantially similar, here are the rates and we can use this messenger model with power of attorney to bind doctors, if you choose. Alternatively, we can use your contract form and just messenger the entire contract and all of your rate proposals to the physicians in the

network. That takes us back to the messenger model classic that I had up there a moment ago, the going back and forth potentially forever.

And the question, of course, is can the IPA develop standard non-priced terms for this purpose? The agencies will tell you, and it is obviously and clearly the law, that it isn't simply an agreement on price which may offend the Sherman Act, agreements on other terms that have an effect on competition, other competitively significant terms, may also run afoul of the antitrust laws.

The Department of Justice some years ago in a business review letter, Midwest Behavioral Health Associates, suggested that a certain amount of agreement among members of a physician network on non-priced terms could be tolerated. It's not at all clear that the Federal Trade Commission takes the same view or that the Federal Trade Commission agrees that the items that DOJ listed as non-price items on which doctors could negotiate would be items on which the FTC would think they could negotiate. I think David Narrow pointed that out in an ABA brown bag that was held a few months ago on the messenger model.

So, that is certainly an unknown and a serious one to take into account if you're contemplating a

messenger model.

Let me just talk about a couple of other variations. One problem that networks have is that you ask doctors to give you the price at which they will be willing to be bound, and you find that they give you very, very high, unrealistic rates, just because they're not quite sure what they're getting into. They may give you rates that are far above, in fact, what they use for their own contracts. And if you're going to have a competitive network that is attractive to payers, those rates aren't going to work.

So, you tell your doctors, give us your opening set of rates at which you're willing to be bound, but here's a rule, from now on, every time we get a payer contract, if it doesn't meet your specifications, we send it to you, once, and you can agree to it or not agree to it, as you choose. If you agree to it, we will take those rates as your new standing authority rates that we can use in the future when additional contracts come in from payers.

It is a way of trying to expand the size of the network, and one can start to think of ways in which that will be pro-competitive, and undoubtedly one can think of ways in which it might not be. But it is something that a number of IPAs use, and it is something to think about.

Unacceptable variations: Offers transmitted only after an IPA committee, the fee committee, the negotiating committee, the whatever you want to call it committee, in the view of the agency's price fixing committee approves it. That's clearly unacceptable.

Offers that are transmitted by the messenger only if they meet a level preset by the IPA, that is not acceptable. And that is very different from saying that we won't transmit offers unless they meet or beat what 50 percent of our physicians have said individually they're willing to take.

Another idea, sometimes called the black box, is that you go and you hire a third party to set a fee schedule for you, perhaps even after surveying the market and trying to come up with something that that third party consultant thinks is a competitive rate. There is still an agreement among the physicians to hire that person and to authorize that person or agent to set the rates. That's the agreement you need for antitrust purposes, that can get you into trouble.

And it doesn't excuse you from the trouble that you get into, to say that, in fact, it's up to the physicians to either opt into that, or conversely, to opt out. Either system does not excuse the practice.

When we talk about IPA -- when we talk about

messenger models, we're usually talking about a physician network. We're talking about a group that is somewhere, perhaps in the middle of the spectrum, of integrations, the spectrum of running from solo practitioners through shared lease staff arrangements to PPOs, IPAs, group practices without walls, and then finally fully integrated group practices.

Something that goes hand in hand but may not always be thought of that way is -- should you agree more in order to avoid the problem of having to adopt what may be a cumbersome messenger model. And of course one answer isn't just to engage in risk contracting, as Dr. Hill suggested, one answer is to integrate more, perhaps go all the way and form a group practice, you can then by definition set your rates. An interesting question is can you go halfway? Can you move to something like a group practice without walls, will that give you enough integration so that you can now negotiate with payers collectively and avoid the messenger model?

The term "group practice without walls" is not a legal term, and it encompasses many, many different ideas. I think what's fundamental to all of them is that physicians are in different locations and contract jointly with payers. But some are very loosely integrated, others might be very tightly integrated. You

might look and ask how many different clinic sites do they have, how large are the clinic sites? The fewer the sites and the more physicians in them, the more integrated this looks.

Does the group clinic have separate employees in each site? Do they have common employees? Do they have governance at the level of each site, or is it corporate governance from the top down? How is their compensation determined? Is it determined by each site or do they pool their compensation and have a common arrangement as to how they pay themselves out of that? Do they all arrange for services on their own or do they obtain their services through the group? What is the degree of clinical integration?

You should keep your eyes on this model, the FTC is challenging a group which, as I understand it, is arguing in partial defense of what they're doing, the Brown & Toland group in the Bay Area, that they are sufficiently integrated to set price, and therefore when they come together and misuse a messenger model or jointly negotiate price, they're not price fixing. But that will be an issue for people to think about on a going-forward basis, if the messenger model is cumbersome, do we move towards more integration? If we do that, how much integration is enough to get us over

the hump of an agreement in violation of Section 1 of the Sherman Act?

With that, let me conclude and turn it over to the next speaker.

MR. KELLY: Thank you. Jeff, you're next.

MR. MILES: Thank you. Well, good afternoon. It's a pleasure to be here. I'm going to try to do two or three things. I want to talk very briefly about the history of messenger arrangements, and then I want to try to be practical, I suppose, and try to look at the costs and benefits of messenger arrangements, and the problems that messenger arrangements have made that the agencies are particularly interested in. In other words, the types of conduct that can get you in trouble.

All this with the ultimate goal, I suppose, of asking are messenger arrangements worth the time, effort, and cost? And I'll give you my conclusion, and you can draw your own conclusion.

I think probably everybody is aware that messenger arrangements effectively resulted from the Supreme Court's 1982 decision in Maricopa County Medical Society, where the court held that a maximum price-fixing agreement among a foundation for medical care, which is very similar to an IPA, constituted a per se illegal horizontal price-fixing agreement.

At that time, for some of you who are as old as I am, or hopefully older, you might remember that PPOs, whether they were provider controlled or otherwise, typically were using fee schedules. That's the way they established fees. And so after the Maricopa case, the question became, gee, what do we do now?

And several interesting things happened. Many simply continued on as they had before with their fee schedule, and I suppose people from both the FTC and DOJ would argue that indeed that continued to a large extent up through or to 2003 and goes on today. But the lawyers got involved and the consultants and there were all sorts of contortions trying to come up with new models by which provider-controlled networks could somehow establish the fees at which they would sell services.

There was some confusion, I suppose, in several respects. The district court injunction in the Maricopa decision itself, which came down in 1983, was a little bit unclear. Some attorneys read that to permit networks to have fee schedules as long as some third-party payer -- some third party, independent party came up with the fee schedule. If you read the decree a little more closely, that's not quite what it says. In addition, there seemed to be in the -- in the mid and late 80s, a philosophical difference between the antitrust division

and the Federal Trade Commission, particularly on the issue of how much integration was necessary in a network before the rule of reason, instead of the per se rule, applied.

In fact, in 1985, the Assistant Attorney General in charge of the Antitrust Division, Paul McGrath, said the following: "As a threshold matter, physician-controlled PPOs entail some degree of innovation and produce efficiencies. Although providers typically do not share risk, there are a number of aspects of PPO agreements that militate in favor of concluding that an efficiency-enhancing integration may be present. These may include an agreement to treat patients on a fee-for-service basis at reduced or discounted levels, or pursuant to some fee schedule with no balance billing. An agreement to abide by some limitation on their practice in the form of utilization review, an agreement to administer claims and jointly market their venture and an agreement to select a group of limited size to engage in bidding for contracts against other panels." The implication being that if your PPO had these characteristics, a fee schedule would be tested under the rule of reason.

And then in 1988, the then Assistant Attorney General in charge of the Antitrust Division, Rick Rule,

in a speech said, "While the competitive benefits of HMOs and PPOs are generally recognized, some have at times been far too hostile, in my opinion, to provider-controlled organizations that do not entail a very high degree of integration. For example, it's been suggested that in order to form a legitimate PPO, the providers must contribute capital and share a substantial degree of risk of adverse financial results. The department believes that PPOs can achieve substantial pro-competitive benefits through integration that falls far short of financial participation and sharing risk. For example, integrative efficiencies can be realized through an agreement among physicians to give up some are their freedom in setting the terms of billing and treatment in order to reduce transaction costs and to offer discount fee levels. In addition, provider control PPOs may jointly market their ventures to insurers or small employers unable to organize their own panels. In both cases, PPOs can generate pro-competitive benefits, despite the fact that financial risk is not shared."

A relatively lenient view, certainly in terms of the way the agencies interpret the law today. Now, on the other hand, at the Commission during this time, there were a number of advisory opinions on networks coming out that simply were much more strict in their interpretation

of the necessary degree of integration. But this was just exemplary of some of the confusion that existed over the network price-fixing issue at the time.

As far as messenger models are concerned, some of us took a look at the literature and really the first reference we could find to an arrangement that looked like a messenger model was a 1982 speech that one Art Lerner gave as assistant director. And so one of the things that I hope Art will address is whether indeed he is the father of the messenger arrangement, or if not, to whom he would like to shift blame.

When the first iteration of the health care statements came out in '93, my memory is there was nothing in the Statements about messenger arrangements, but then when Statement 9 was added in 1994 for the first time, we see some discussion of messenger arrangements in the Health Care Guidelines.

So, in any event, that's sort of a little bit of history, and I suppose I should throw this up there. From a practical standpoint, in my own practice, I suppose there are three ways I sort of get involved in messenger arrangements. Sometimes you're simply called in by a network to do an audit, an antitrust audit of their operations. And in a number of situations, you walk in and you see potential antitrust problems, and you

advise the network to shift to some other type of arrangement from that it's using, and very often that arrangement will be a messenger arrangement.

The other situation I run into a lot is working with networks who were originally established to take on risk, and of course risk has dried up significantly and the question the network has is, well, what do we do now? And you really have three choices: number one, go out of business; number two, come up with some sort of unilaterally imposed risk sharing arrangement such as a withhold; or number three, look into some form of clinical integration, which raises its own set of issues.

But to some extent these networks are treading water. They need an interim measure so that they're not engaging in an antitrust violation simply while they decide sort of what they want to do when they grow up, or what they want to be when they grow up.

And then the third situation, and the one that is certainly the most fun, is the one where you get a call from a network that says, boy, I've got this really nice letter from somebody named staff attorney at some place called the Federal Trade Commission, and they're not -- they didn't hit me with a subpoena or anything, but they're asking me to produce some documents, do you think I should do this? And of course usually the answer

is yes. Usually there is already a problem that you cannot obviate, sometimes you can help to alleviate the problem, but usually the attorney's strategy there is what I call B&P, that is go in and beg and plead.

The costs and benefits of messenger arrangements, I'm not -- I'm not a fan of messenger arrangements, and that's going to become pretty clear. I look at messenger arrangements and I really see three benefits. The first is the arrangement certainly can simplify contracting and contract administration for both providers and payers. Transactional cost efficiencies basically, and this especially true in the case of standing offer messenger arrangements, where you can have a situation where the members sign one participation agreement with the network and then they do not sign individual contracts with different payers, but after the messenger process is completed, the network signs a contract on behalf of the participants who were chosen for the network.

Messenger networks can help market their provider's services, hopefully increasing provider volume. That, at least in my experience, is not an overwhelming benefit. And, frankly, I think maybe the best benefit they can have is simply educating their physicians and particularly the physician staffs to make

more rationale contracting decisions. The lack of business acumen among physicians is simply amazing. It will boggle your mind to see some of the things they do. And in certain situations, the network itself can work with these physicians and their offices, not in an anticompetitive manner, but simply to educate them, to manage care, how managed care works, different contracting strategies, et cetera, et cetera.

And from my standpoint, I really think from a physician perspective, that's the biggest benefit messenger arrangements can generate, and certainly you don't need a messenger arrangement to do that. In fact, there's an FTC staff advisory opinion about a group I think out in Texas that basically was an educational forum for physicians.

The disadvantage: If you're a physician, I'm looking at the disadvantages from the physician standpoint, and the first is the one I would emphasize the most, and that is unless you're smarter than I am, I do not know any way a messenger arrangement can operate lawfully and increase its provider members' leverage. And of course the precise reason for a messenger arrangement is to prevent that from happening.

Almost none of the physicians that I work with initially realized this. They look at the messenger

arrangement as simply a different way for them to get together and try to aggregate their bargaining power in dealing with third-party payers. My own feeling is, if the attorneys and the consultants were honest with these people on the front end, they would save a fortune in consulting fees and attorneys fees, because they would very quickly determine that this type of arrangement simply isn't worth while.

Secondly, and others have mentioned this, messenger models are definitely cumbersome. I don't know how many of you have had the pleasure of either helping to establish them or work with them, but to put it mildly, they are a pain in the butt to operate.

Third, providers and payers have got to be educated to the process. This is really fun. Physicians have to change their mind set to understand how a messenger arrangement works, especially if they've been part of a network using a fee schedule for a number of years. They have trouble grasping the idea that decisions have to be made individually and independently. And payers, and by payers I want to limit this to medium and small TPAs and self-insured employers. The big managed care plans don't have any problem understanding messenger models, but it's very difficult to explain messenger model -- the messenger model concept to TPAs

and employers. And at least initially, they don't like messenger arrangements. It's not just the physicians who don't like them, the employers and TPAs don't like them, because they put the onus on the customer to educate itself about what prices are reasonable and what prices are not. And a lot of self-insured employers simply don't have that capability.

And let me just emphasize, these things are just the tip of the iceberg. These are the primary superficial disadvantages that you see when you work with these groups.

Customers also can't understand why the network can't force particular groups to participate in their panel. You have a group of specialists with market power, and they've submitted a very high standing offer, and they won't come down on their offer. And the TPA or the self-insured employer will come to the network and say, get these guys in line, force them to participate, we can't pay them that much. And the network is trying to explain, no, no, under the messenger concept, we can't make them do that, they've got to make their own decision. And it leads to hard feelings.

Messenger arrangements are difficult to operate lawfully, especially over a long period of time. You can give messenger arrangements all the antitrust advice in

the world, but when they go out into the real world, into the payer's office to talk about a contract, subjects come up, questions get asked, in some situations the messenger person is sitting there thinking, well, I heard the antitrust advice, can I answer this question, or can't I? What can I say in this situation? In two situations, I might add, I've gotten cell phone calls from messenger network representatives who were in a meeting with a payer who called up to say, what can I tell this guy and what can't I tell this guy?

Frankly, the network needs to have an attorney on call 24 hours a day to be able to ensure that it operates the network lawfully. Establishing a panel can take forever. In other words, offer, counteroffer, counteroffer, offer. One thing a messenger network has got to do is limit the rounds of contracting offers and counteroffers that take place, else it will take you a year and a half just to put a panel together.

Not all providers participate in all contracts. This is under messenger arrangements, this is a hard idea to get over to both the networks and the provider themselves. The providers don't understand that not only -- not everybody is going to participate in every messenger panel. And this can raise cross coverage issues when my group participates, but I always use group

X to cover me and group X doesn't participate, what do I do?

And it can also lead to referral problems. If you're a GP, and the specialist to who you refer doesn't participate in the particular panel, what do you do then? Messenger arrangements, at least in my judgment, really are not a network in the usual sense of a network at all. You think of a network as being an interdependent group that works together, typically not the case in messenger arrangements.

If you've got a large number of members, you're going to have to put in place an information system infrastructure. You can't do messengering by hand. Typically, and as I mentioned before, you need an antitrust attorney on call, simply because you would not believe the little specific questions that arise that you would have never anticipated as you worked to put the network together itself.

So, with that, it appears my time is up, and so I'll turn the program over to Richard.

MR. KELLY: Thank you, Jeff.

MR. RASKIN: Good afternoon.

Recently I pulled out my copy of Section 1 of the Sherman Act and discovered to my amazement that it made no mention of the messenger model. So I looked

through the cases, including Maricopa, and I found that there wasn't any reference to the messenger model there either. I kept looking, and finally when I got to the Statements of Antitrust Enforcement Policy, 1994 and 1996, there it was in Statement number 9.

Of course, the messenger model has also been described in scads of agency advisory letters, apparently including the pro-to-messenger model network that Jeff Miles has discovered through dogged research, and which we will soon learn whether Art Lerner will claim responsibility for or not.

But there's also vast nonpublic literature, I assure you, of lawyer's advice explaining the risks, I hope, in most instances, as well as any conceivable benefits of doing network contracting on a fee-for-service basis without following -- well, I should say the risks of doing fee-for-service contracting without following the messenger model.

One thing in all of those materials that I have never found, though, is any business person, any administrator or health care professional in any segment of the industry who advocates the use of the messenger model for any business purpose. I should probably qualify that last statement. The few people who I have heard promote the use of the messenger model almost

always have had a false conception of what the messenger model really requires and some of them have ended up signing consent orders with one or the other of our cohosts at today's hearing.

Now, the messenger model was never really intended to achieve a business purpose, so perhaps it shouldn't be measured by that standard at all. The messenger model was devised by antitrust lawyers solely as a vehicle to permit network contracting while at the same time avoiding any agreement on price among the network participants.

And that phrase "devised by antitrust lawyers", I think, ought to raise a red flag, because devising things is not something that we antitrust lawyers usually do. What we do is pass upon the legality of things devised by others, or we defend them after the fact. But we rarely devise a business model. When we do, as with the messenger model, we ought to face a particularly heavy burden of justifying to our clients why a model with such a dubious lineage ought to be followed.

I would like to suggest, at least for purposes today, a return to first principles, and perhaps that suggestion is not the first that you've heard today. Let's suppose that we did not have 25 years or more of health care antitrust law and that we were able to write

on a clean slate. Clean, that is, except for the general antitrust principles that are applicable to participants in any industry. And then let's consider whether the messenger model really is necessary to avoid harm to competition posed by a physician network seeking payer contracts on a fee for service basis.

Now, you might say that harm to competition isn't quite the right standard, because a failure to follow the messenger model may represent a per se violation under Maricopa, so harm to competition doesn't matter. I think most antitrust lawyers would not find that response very satisfying. An application of the per se rule that condemns business conduct, that does not harm competition, is one that probably ought to be re-examined.

Even apart from that, we all know that agreements on price by competitors may be sustained in certain circumstances. In particular, price agreements that are ancillary to a legitimate joint venture, are examined under the rule of reason. And I think as you heard from Jeff Miles' comments regarding some of the Department of Justice speeches in the 80s, there have been times when government antitrust enforcers have viewed those principles as the principles that ought to be called into play here.

Even today, in the policy statements, the agencies recognize that when a physician network meets the standard of so-called financial integration or clinical integration, a physician's use of a fee schedule to price their joint product is not price fixing.

Now, financial integration and clinical integration are concepts that are a bit like the messenger model itself. That is, they are doctrinal concepts that have been devised to fit the health care context, but for purposes of my thought experiment today, we're returning to first principles, so we're going to set those concepts aside.

Let's consider a hypothetical that is perhaps not so hypothetical. Suppose a network of independent physicians wants to offer the physicians' services as a package to self-insured employers. I think, and a comment was made earlier today to the same effect, I think that's generally when you will see the messenger model arise as a realistic product to market, if ever, is not to large payers, but to smaller payers.

The network in this example intends to provide some administrative services such as credentialing and perhaps some soft core utilization review, but not to accept financial risk. And the principal function of the network's administrative office is to analyze contracts,

to collect financial information and the like, to lease office space, and to purchase office equipment for the employees there, but not to establish the sort of virtual group practice or even a group practice without walls that Doug Ross described earlier, that appears to be called for by the concept of clinical integration.

Now, let's suppose further that this network is approached by a payer, for a price quote, and it really does happen that way. And the network representative responds that the physicians will accept the Medicare fee schedule. That, my friends, is a per se violation. If a physician organization asked me what to do in that situation, I would strongly counsel them not to go there, and I would tell them that under these facts, their only choice is to have the network representative act as a messenger and to have some poor soul shuttling the offers back and forth or to do the up-front work required to create what has been referred to as a standing offer messenger model.

But I'm not at all sure that that's really the right advice from an antitrust standpoint as opposed to a risk avoidance standpoint. So, let's consider what really is the threat to competition here in this example. I think we would all agree that there are some payers and some self-insured employers who are interested in

contracting with a physician network of the type I've described, if the price is right. But the messenger model is based on the premise that this network may not, cannot establish a network price at any level without committing a per se violation.

A network price, a fee schedule, even if it's based on an existing schedule offered by another payer in the market, is deemed to be the product of a group agreement, and hence, the need for the messenger model's unique brand of shuttle diplomacy.

Getting back to our hypothetical, let's make it perhaps a little more realistic and say that the network says to the payer that it will accept 150 percent for the Medicare fee schedule. If the payer accepts, and there are no additional facts out there suggesting a threat of boycott by the physicians, presumably the payer is accepting it because it views the proposal as competitive and appropriate. If the payer rejects the proposal, it can still pursue other options for getting a network, either by building its own, or by contracting with another network in market.

Has competition been harmed in this scenario? I think not, but I see at least two potential threats that have been raised in discussions about the messenger model, neither of which, in my view, requires the strong

preventive medicine offered by the messenger model.

First potential problem is the boycott problem. The physicians in the example might refuse to contract with the payer, except at the agreed-on level. This is a legitimate concern that the antitrust laws have long evaluated these types of situations based on the facts. The messenger model doctrine builds in an assumption that a boycott will occur if certain procedures are not followed. And the question I would ask is why not approach the question as antitrust law usually does and do a case-specific examination of the facts, rather than relying on a presumption. If there is a boycott, there is a problem. If there is not, there probably isn't.

Now, the second problem that sometimes gets brought up is the so-called spillover problem. In other words, the physicians might adopt the network fee schedule for use in their own individual practices. Now, the first point I would make about the spillover problem is that while it's been much discussed over the years, I'm not sure that we've ever seen this problem in real life. I don't know that it's ever even found its way into a concept order or a complaint. It's certainly never been proven to have occurred. But even if it did occur, it's far from clear to me whether this should be viewed as an anticompetitive result, especially since

billed charges, which is what we're talking about here, often have little relationship to what payers pay.

In other words, even if some physicians who were in the network and did adopt the network fee schedule, questionable possibility in its own right, but even if that were to occur, that might have little or no impact on their actual collections, depending on the market circumstances. In any event, that ought to be a rule of reason question, rather than a per se question.

And that points out, you know, one of the basic problems, I think, with the per se approach to these types of network scenarios. It simply stops all discussion of the more subtle questions that could be considered if we had an active and vibrant rule of reason to apply to these types of situations. And it leaves antitrust counselors and antitrust enforcers uninformed as to what the competitive effects of these types of scenarios really are.

In that regard, you know, I would point out that last year Commissioner Leary gave a speech followed by an article in which he discussed the MedSouth advisory letter in some detail, and he noted that in physician cases, the Commission really does not have much experience at all in applying anything other than a per se rule. With all the dozens of consent orders, advisory

letters, and policy statements that we've got out there, the rule of reason has only rarely made its way into the analysis in physician cases.

Most arrangements, virtually all arrangements that have been considered in health care antitrust cases brought by the agencies deal with the per se rule, and that has been in effect the end of the analysis. I think if we had a re-invigorated rule of reason for these types of cases, the messenger model would probably be unnecessary. It seems to me to represent a sort of prophylactic fencing-in approach that was designed for an earlier era when any physician network activity was in effect assumed to be inherently suspect, or probably intended for an unlawful or anticompetitive purpose. And I don't think that sort of assumption is appropriate today. I think we see that there is a demand for these types of networks, and it's a demand that a free market ought to permit.

The messenger model provides, I think, and as the health care policy statement suggests, really a form of safety zone, although I don't believe the statements describe it that way. But it's also a somewhat odd safety zone in the world of antitrust. If you meet its strictures, you are very likely to be considered to be lawful. Not just within the rule of reason, but out of

trouble. Of course, it's been discussed meaning its strictures in real life may be an unlikely or even impossible scenario.

But if you fall outside of that safety zone, you're within the per se rule. And now you've fixed prices, the highest form of antitrust defense. It sounds to me like there's something wrong here in an analysis in which there's essentially no middle ground, essentially no rule of reason to fall back on, and I think that's what we ought to try to develop to deal with these sorts of situations.

Perhaps the messenger model has some value, I would suggest, in a couple of situations, pretty limited. One is for the very conservative network that doesn't want to take virtually any risk of having to be found to have violated the antitrust laws, or even to be exposed to a relatively serious rule of reason analysis. It provides that opportunity for a relative safety zone. And even though we might, many of us, agree that the messenger model is very difficult to police and to ensure compliance with, over time, in real life, at least a good strong effort to come close will make it more likely that under the rule of reason, you can be safe.

So, it may have some use for that very conservative network out there. The second place I think

it may be appropriately used is in a consent order for a network that is found, perhaps under a rule of reason, to have violated the antitrust laws. And that's where the messenger model also made some of its early appearances and became a little bit more well known to the antitrust bar and to the health care world.

I think in those situations, fencing in can be appropriate and a prophylactic rule to prevent problems before they might occur has something to recommend it. Other than that, those two very limited suggestions, I think I would join in what seems to be a mounting chorus, but perhaps one that will diminish, of people who will suggest that perhaps it's time to shoot the messenger.

MR. KELLY: Thank you, Richard. We will now hear from David Marx.

MR. MARX: Thank you very much. I appreciate the opportunity to speak on the same panel with all my distinguished colleagues and friends addressing an issue that I think is an interesting one and a difficult one for providers, for payers, and in many respects for those of us who have to counsel both sides.

I want to try and build on what the people speaking before have talked about and create a hypothetical physician network structure that I think goes to an issue that Richard has raised, but that as

best I can tell from the state of enforcement actions that have come down recently, the agencies really haven't addressed. Virtually all of the cases that the agencies have brought recently have involved allegations of price fixing, horizontal price fixing by physicians in a network.

I think there's a problem out there that's gone -- that exists that has gone unenforced, and I want to try and create that hypothetical and hopefully elicit some discussion from the panel members today on whether or not they really think it's a problem, although Richard sort of prestaged that even he might agree that it is.

Let's talk about a network that's been formed as an LLC, and frankly the structure really doesn't make any difference, to provide three types of services to its members. First, it's going to serve as the exclusive contracting agent for certain fully integrated noncompeting specialty physician practice groups, and just for the sake of argument, let's call these the division A providers. And this network is really going to be almost exclusively specialists, but division A will be distinguished from division B by virtue of their exclusivity.

The network is going to serve as the agent via a messenger model for certain competing physician groups.

And to the extent that, of course, the division A physicians are noncompetitors, there's a real issue as to whether or not, if they all agree on the price, you've got a horizontal price fixing problem at all. This is one of the reasons that they want to distinguish between the division A and the division B providers. If the division A providers are all noncompeting specialty physician groups, and to the extent that they agreed on the price that they were going to charge, and they said we want the network to be our exclusive contracting agent, do we have a horizontal price fixing problem there? And I suspect the answer is probably not, but hopefully we'll hear.

In the meantime, though, in order to minimize the risk that there would be a per se price fixing problem, they've got this second division of specialists, these division B physicians, who may be competitors of each other and certainly would be, in some cases, competitors of the division A providers. As to them, the network is going to serve as a messenger and contract on their behalf as a messenger model. And then to the extent that there are -- there may be in this hypothetical network physicians who don't belong in division A or division B, the network wants to provide some value to them, and it may well provide MSO types,

management service organization type services, not just to the division A physicians, also to the division B physicians, and maybe as well to other physicians who don't fall within division A or division B, but want to contract independently.

Now, let's talk a little bit more specifically about who's in division A and what the network is going to do for them. Let's assume that these division A providers are individual physicians or fully integrated practice groups that practice, as I've said, in a specialty area. Let's also assume that the division A specialist physicians are among the most desirable in the community.

A network would want to have these physicians -- a payer would want to have these physicians in their panel. And with respect to some of these physicians, it may have to have them in order to be able to provide the full range of services to the payer's members.

Let's also assume, for the sake of argument, that some of these division A groups were competitors at one point, but combined to actually truly merge their practices prior to the formation of this LLC so that they could contract together as a single economic entity, to avoid the price fixing problem that would have existed had they not merged their practices.

We want to assume, as I've said, that the division A providers or groups don't compete with each other in a material kind of way. Now, as we'll see in a minute when we start talking about what types of specialties are in division A, it's not as -- may not be as clear as you might think. Neurosurgeons compete with orthopedic surgeons, I think, at least with respect to some kinds of procedures, and some surgical groups, general surgery and maybe even specialty surgery groups may compete on the fringes as well.

So, there may be a touch of overlap, but maybe not a lot. Now, the key to division A, of course, is that those providers must execute exclusive contracting agreements authorizing the network to be their sole agent for negotiating nonfinancial and financial contract terms with managed care payers. If the network doesn't reach an agreement with the payer, the division A providers are not going to contract individually with the payer. They're not going to participate in that payer's plan.

Specialties included in division A, our hypothetical network, there are going to be some internists, some orthopods, some neurosurgeons, you can see the list. For the most part, as I say, you don't really have what I would consider to be competing specialties here. They have maybe some competition at

the fringe, but not in a material type of way.

Now, there may be other specialists in the community who can provide some or all of these services, but I think for purposes of the hypothetical that I want to raise here, you should assume that there are not alternatives for all of the specialties that are going to be included in division A.

Who is in division B? Well, division B includes providers, specialists who compete with the division A providers, as well as who might compete among themselves. They enter into these nonexclusive contracts with the network, authorizing the network to serve as their messenger for purposes of contracting with managed care payers.

Now, the optional MSO services that I talked about, and I want to stress that they are optional, the network can't require the providers to participate in them, may include things like group purchasing and malpractice insurance, may include shared management activities, integrated information systems, corporate compliance, maybe clinical path ways, medical management, some practice management services, maybe some shared office locations, the kinds of things that begin to look like they might constitute clinical integration if they were actively pursued. But I don't want to suggest here

that clinical integration exists with respect to any of the providers, either the division A or the division B providers. And as I've said, the physicians in the network wouldn't be required to participate in any of these activities.

Now, those are the ones that were actually in development. There may be other MSO-type services that would be offered in the future, financial accounting, analysis reporting and planning, maybe billing and collection, group purchasing, utilization review, risk management, some claims administration, maybe credentialing, further refinements in information systems and technology, but again, for purposes of this network, no one would be required to partake of those services.

The types of division B specialists that are included in our hypothetical network, plastic surgeons, colo-rectal surgeons, general surgeons, cardiothoracic surgeons. We've really got most of the specialties covered, I think, in division A and B.

How does this network operate? On behalf of division A providers, the network attempts to negotiate nonprice terms first with the payer. This network is going to engage in what I would call stage negotiations with payers. First, it's going to attempt to negotiate the nonprice terms of the contract, and it's not even

going to talk about price unless and until, unless and until it has reached an agreement with the payer on nonprice terms.

If they don't reach an agreement on nonprice terms, then the network is going to terminate its discussions with the payer, and the division A providers will not be able to participate because they have this exclusive contracting arrangement on the payer's panel. If the network and the payer agree on nonprice terms, the network attempts to negotiate price terms with the payer and ultimately if they're successful, we have a deal.

If they don't, they can't reach agreement, then all contract negotiations are terminated, and again, the division A providers don't participate on the payer's panel.

Where is the problem? The payer seeks to contract with the network's providers, both division A and B. The network declines to negotiate price terms with the division A providers until there's an agreement reached on nonprice terms, it won't messenger a proposal to the division B providers until a contract is negotiated with the network's division A providers.

Now, that doesn't preclude, of course, the payer from going to the division B providers independently and trying to negotiate a contract. That's

not really where the issue is going to arise. The issue is going to arise if the network and the payer can't reach agreement on the nonprice terms on behalf of division A. Where would that -- how would that impasse be caused? Well, suppose, for example, the network said, we want most favored nations pricing. We're not talking about specific pricing yet, but on behalf of our specialists, if you're going to contract, Mr. Payer, with other specialists who compete with the specialists in our group, we want most favored nations treatment.

Now, I'm not going to argue whether that's a price term or a nonprice term. It's close enough to a price term, I guess, that you could say that it is, but I think the network might say, look, we're not talking about price here, we're just talking about we don't want to be discriminated against. And if we can't reach agreement on that, there's no deal, and none of our division A providers will participate in your panel. The issue, of course, that I'm going to raise is, is this a boycott and does this constitute an antitrust violation? But that's not the only issue that might cause an impasse in the negotiations.

Suppose the network says to the payer, look, I don't want you to provide an incentive, financial or otherwise, to any of our competitors or any primary care

doctors, particularly primary care doctors, to refer patients to my network's competitors. Payer may well have contracted with other specialty groups that compete with the specialists or some of the specialists in this network. And the network says to the payer, look, don't incentivize the primary care doctors to send their patients some place else. If you do that, if we're discriminated against in that way, then we won't contract with you.

And there may well be good reasons why a payer, particularly a vertically integrated payer, may well want to provide incentives to primary care physicians to steer their patients to perhaps specialists who are willing to accept less reimbursement to provide the same services. If they can't do that, then they may have a problem.

Another issue, nonprice issue, that might come up in the negotiations could be that the physician network doesn't want to be required to participate in payer's hospital cost containment programs. You know, to the extent that you've got a multi-provider network here where the payer has hospitals as well as physicians under contract, it may well be working with the hospitals to try and develop clinical protocols, cost containment programs, the physicians may not want to be forced to participate in those.

Well, if the payer can't force them to participate, then it may have a problem containing some of the costs. Well, that could be another reason why there would be an impasse and why division A providers may never be able to contract with the network. There might not be a contract reached.

And then there may be one other issue, and that is that the network might not want to be prohibited as the payer might want them to, particularly, again, if it's vertically integrated, from holding fiduciary positions in hospitals that compete with hospitals within the payer's network. There may be a lot of information that's being exchanged in the context of this payer network relationship that the payer doesn't want the network to disclose to competitors of its hospital providers. And in fact, we have seen situations where that's resulted in an impasse.

Now, suppose the network is unable to reach an agreement with the payer, and now the payer is unable to contract at all with the division A providers. Not based on price, but simply based upon their inability to reach agreement on the nonprice terms. Does this constitute a per se unlawful considered refusal to deal or boycott in violation of the antitrust laws? I think this problem is out there, I haven't seen any or all of these cases where

this issue has been specifically addressed. All of the cases have been price fixing cases.

I will tell you, you know, my view is I don't think this is a per se problem. Most boycotts aren't analyzed under the per se rules anymore. So, then we come to Richard's point, he wants to do rule of reason analysis. I'm happy to do rule of reason analysis on this. I think you can analyze it under the rule of reason, and you say, well, does this constitute a violation of the antitrust laws applying the rule of reason? You know, you've got a payer out there who may not be able to offer certain specialties because it was confronted with the situation where in order to get one or two, you have to take us all. And depending upon what the network's motivation is, I mean, what's their purpose? Why wouldn't they contract with the payer? Did they have legitimate business reasons for not doing it. If there was a legitimate business reason, it seems to me that you may well have a boycott, an unlawful boycott here. You know, what are the pro-competitive benefits that flow from the network saying, in order to get one of these division A providers, you have to take them all. I'm not sure I necessarily see anything there, one way or the other.

One question, a fair question may be, well,

what percentage of the physicians, the specialists do the division A providers represent? If there really are alternatives out there for virtually all of them, then maybe we don't care about this, maybe there isn't any anticompetitive effect, maybe it doesn't violate the rule of reason.

I guess this issue is more likely to arise in what I characterize, so that I don't offend too many people, as a non-urban area, sort of a small city. I don't think the issue is going to come up, maybe it will, I don't think it's going to come up in Chicago, but I think it's -- I'm pretty certain it's come up in some other cities that aren't anywhere near as big as Chicago. It's not an issue that I think has attracted as much attention and I guess I would like to hear what it is that my colleagues have to say about it when we get an opportunity.

MR. KELLY: Thank you. And last but not least we will hear from Art Lerner, the purported father of the messenger model.

MR. LERNER: Good afternoon.

I'll tell you, there's so much to say. I'll tell one brief story, though, I recall that when I was assistant director in the health care shop at the FTC, roughly 1984, late '84, early '85, we got a request for

an advisory opinion in from California, home of all great new ideas. Who asked -- I think it was Michael Duncheon, who wrote an advisory opinion request that framed it very squarely and he said we want to put together a network, a PPO type thing. It would be providers in no specialty where we have more than 10 percent of the specialists, so you don't need to worry about market power. We're not going to organize any boycotts, and we want to be able to -- but we do want to be able to negotiate price. What do you think of that? Well, I left the agency, because I didn't know how to answer that question.

So, if you look back, I think you will find a letter that was written by the FTC staff shortly after my departure which basically said something like, well, we have some questions and it sort of left that for another day.

So, that issue was raised then, and it still bothers us all together to one degree or another. I will just respond to a couple of things. The notion that antitrust laws don't devise things. I got a yuck out of -- antitrust lawyers devise things all the time, virtual mergers, group practices. So, the basic question of the messenger model not appearing in the Sherman Act, basically if you don't want to fix prices, don't -- if you don't want to be guilty of fixing prices, well, don't

fix prices. That's in the Sherman Act. Or since 1911 that's been true of the Sherman Act.

So, that aspect of the label may not have been there, but the concept that if you want to call it a safety zone, it says, if you don't want to be accused or guilty of fixing prices, don't fix prices, is not something that I think was invented at any particular point in time.

I think, though, that the discussion we've had today points up a fundamental question, which is, I think one of the payers. I think Richard flagged the question of, you know, what's the harm here in some of these instances? What's the harm? And I guess the question that brings you to is, should there be a per se rule against conduct, which if there weren't a per se rule, might in some instances not flunk the rule of reason?

In other words, in order to prohibit a physician network, should you have to prove as a prosecutor or as a plaintiff that, in fact, there's market power, and in fact, the group is negotiating for prices that are above the competitive norm and backing that up with a boycott threat. If you could prove all that, of course, there would be no need for the per se rule at all, because you would have proven a full-blown rule of reason violation.

The purpose of the per se rule is to say, I don't have to do all of that. In instances when I know that in almost all instances the conduct is pernicious, and there are no significant efficiencies to be given up, then it's per se. Even though there might be some situations where it's harmless. Nonetheless, there is value in judicial economy and value in education to let people know what things you should and shouldn't be doing.

So, I think the question then becomes: is this an area where either a mistake was made in logic years ago, or, with the evolution of the industry and evolution of our thinking today, we can look at this conduct and say, yes, there are plausible meaningful and significant efficiencies that can be achieved in this way, that it's difficult and impractical to achieve in some other way, but that can be achieved through these networks negotiating price such that we ought to put aside the per se rule and say, all right, let's analyze it under the rule of reason.

I think that's a very, very good question. I have not heard anyone today really come forward and back up what Rick Rule suggested in some of those speeches in the late 80s about all of the efficiencies associated with this. But if that showing could be made, you don't

need to depart significantly from antitrust 101 to say, if there are meaningful efficiencies, such that this is a real joint venture, such that the price negotiation is a legitimate ancillary restraint, then you're into rule of reason and go ahead.

And so, then the question comes to the Commission and the DOJ's role here in looking at the guidelines as they stand now in the policy statements and under what circumstances they have given some recognition to the potential for there to be significant or meaningful efficiencies. I think that's a legitimate area for consideration, and at one point it was, you know, clinical -- well, financial integration, risk sharing, and then the discussion of clinical risk sharing, with the issue on clinical, as I know is presumably discussed this morning, you might be clinically integrated, but what does the price fixing have to do with that? That's always an issue.

So, ultimately here we get down to the question of maybe there's an efficiency in the price fixing itself. I mean, that's sort of what the argument comes down to, so the efficiency is the price fixing. I mean, there's actually some pro-competitive benefit in the transactional efficiency, if you will, the efficient contracting process to do it this way. That would be the

argument, and I think it remains, in my view, to be made. I hear the argument, but I am not particularly persuaded by it yet.

I will say that in response to one of the comments that Dr. Hill made, that I think is trenchant, and I think Jeff picked up on it very well, is, if, however, what the networks really want is to be able to counteract perceived power by payers, if that's what they really want, the messenger model isn't going to do it for them. But that's not a reason to say, under antitrust as the law as we know it exists, to say, then we need to permit the conduct, because the messenger model doesn't help.

Under antitrust 101 as we know it, that's not a reason to move off of the existing approach. Because to say that doctors need to be able to gang up, if you will, or combine together to have more marketing, more contracting negotiation leverage over price, is simply not a cognizable argument under antitrust as we know it. It is a cognizable argument in Congress. Labor, fishermen, agricultural co-ops, all have gone to Congress and addressed that issue. Physicians and other health professionals have also gone to Congress and that's a legitimate topic for public debate, whether or not, in fact, third party payers have this power and doctors

should be able to join together and collectively bargain and not have to deal with the antitrust laws. I personally don't think so. I don't think that's good public policy change. But that's a legitimate public policy debate.

But antitrust as we know it, I don't think, recognizes that we need to get together to negotiate to have more power as a good argument. So, I think the question there is one of efficiency. I do think that there are times under the current policies where the lawyer is put in an almost ethereal position in trying to advise clients, and even calling up the agencies to try to get a little bit of seat-of-the-pants guidance is very frustrating. In situations where there's sometimes a disconnect between stated enforcement policy and what most practitioners probably assume is actual enforcement policy, where you have -- the one I had most recently a situation where I had an IPA that is capitated for HMO business. There's a payer who wants them to be their network for a point of service product, doesn't want it to be risk sharing on the doctor side but wants the doctors to be incentivized on the hospital side.

So, the doctors would be incentivized to keep the hospital costs down, there would be no risk sharing on the physician side, because the HMO has decided, in

fact, it's cheaper to work on a fee-for-service side than on a capitated basis. And they're actually going to also pay a bonus to the IPA if they can keep the doctors' fee schedule below a particular point. So, the IPA actually profits by negotiating a lower fee schedule.

I had a fascinating discussion with the staff at the FTC, at least one member of the FTC who said, well, gee, couldn't you add a withhold on the doctors' side, you know, or a 10 percent bonus. And so this is a situation where the payer in a free market and the customer and the doctors in a free market have come to this, and now we're sort of sitting here as lawyers sort of playing around with it trying to tinker with the incentives to say that would be okay. I think at some points it gets a little bit ethereal.

And I think the Brown & Toland case, and I'm not going to speak to the specific facts, because I only know what I read in the complaint and what people tell me. I don't know, you know, whether they deserve to be sued or not, I just know that that case, and what it's doing to IPAs and managed care plans who have bifurcated arrangements, that have both risk and nonrisk arrangements, they're all totally out at sea now about what they should be doing.

The current policy statement, for example,

says, well, if the network is using the same fee schedule for the capitated business as they do for the negotiated fee for service business, then that's sort of a good thing, when in fact it's not, because in reality you would not normally -- the managed care plan would not normally want to use -- you wouldn't expect to be using the same fee schedule on the nonrisk business as you do for the risk business. So, there's some disconnects there.

I'll also say that I thought the advisory opinion that came out very recently, today or yesterday, the day before, on the messenger model had a feature that we talked about a few minutes ago, which was that if less than 50 percent of the doctors were opting in pursuant to their standing offer language, then the IPA would not be obligated to take the deal. Nonetheless, the payer picked up admin cost.

I have advised clients that -- and I think I'm right in doing so -- that you shouldn't have to take such a deal, whether or not the payer wants to pick up the marketing costs, because when a doctor signs up to an IPA or PPO or PHO like that and agrees to a price, it's consistent with one of their accounts, the doctor is simply not agreeing to a price in the abstract, it's agreeing to take a particular price within a particular

network. The premise being that I'm in a network with the doctors that I normally practice with. And that I'm familiar with working with.

To say that that doctor is -- that the IPA is then obligated to accept a contract in that circumstance, when only a minority of the doctors are going to be in the network, I think would make it very inefficient, because then you're going to make it even less likely that the doctors are going to quote a reasonable fee in the first place. So, again, I think there are some ways in which a little more givingness would be worth considering. Of course the advisory opinion the FTC did, they didn't say that you have to do it the way the parties in this case are doing it; they just approved of the way the parties were doing it in this case. They didn't say that if you fall short in any particular respect it was necessarily bad.

I think the price and nonprice point that was made is an important one. The policy statements make it clear, I think, that a messenger model that avoids group collective negotiation of price and price-related terms is heading out to the "okay" land. There have been some discussion I have seen in some Justice Department pronouncements in the past that you're not really in a messenger model if you negotiate price or any material

nonprice terms. I think that was wrong, because the per se rule, of course, applies to price fixing, and not to nonprice fixing. And therefore absent market power, I wouldn't think that a PPO that negotiated nonprice terms would be particularly in any kind of trouble, or shouldn't be.

All of this said, though, I think you have to come back to basics, the basics are that there's a very good reason why price fixing is illegal. And therefore, we should be loath to relax the rule against price fixing, absent strong arguments as to what are the efficiencies that are being given up by applying the rule. So, I recognize that there are many situations that are fairly innocuous, where a PPO or an IPA that's sort of pushed off into the messenger model is doing a lot of dancing around. But the question is what kind of exposure do they have if they didn't. On the other hand, if you change the rules to say that you don't have to use a messenger model unless you have market power in some defined geographic market, unless you're threatening a boycott, et cetera, et cetera, then you've basically eaten up the per se rule completely and I don't think you're going to find much interest in that from the agencies or from large constituents in the industry.

I'll also say that if you went over to a model

said, let's make it all rule of reason, then you would need two lawyers on call, and not just one. That's all, thank you.

MR. KELLY: Thank you, Art. At this time I think we will take a brief break until perhaps five of 4:00 and then we will come back and have an animated panel discussion. Thank you.

(Whereupon, a brief recess was taken.)

MR. KELLY: Okay, while we're waiting for Mr. Miles to return, I would like to take this opportunity to thank all of you for turning out and to thank the panelists for giving of their valuable time and energy to help make this panel a success today.

Now, before we begin the questioning, we're going to give all of the panelists an opportunity to respond to the comments of other panelists for just a minute or two. It's only fair in that the people further to my left had more presentations to hear first that they could incorporate into their comments, poor Dr. Hill got to go first and didn't get to respond to anybody's remarks, so we will let him start the response in just a moment or two and go across again to the left.

DR. HILL: Actually, that's not a disadvantage, because half the stuff I didn't understand what they were talking about, but I would rather take care of heart

attacks and strokes than try to figure out some of the complexities here.

However, I was extremely pleased that some of the assumptions that we're asking to be relooked at got some support around the panel today, and I think that's very, very good for us.

The question I was going to ask, I think I already have the answer, from a couple of people, but I am going to ask it anyway, and the question was that under the per se rule, there is no opportunity, apparently, to analyze any of the potential efficiencies, so why have a rule where you can't analyze potential efficiencies? And under the rule of reason, you would always be able to do that. And I think I know the answer having to do with court decision, but I didn't realize that before, not being a lawyer. So, that's the only question that I have.

MS. MATHIAS: Art, do you want to try to answer that?

MR. LERNER: Yeah, I'll answer that one, and I think the answer is, in fact, that you can. And so I think the point would be that if one could demonstrate, I mean this is dancing on the head of a pin a little bit, but if you could demonstrate that there were significant efficiencies being achieved that were -- and that the

price setting activity was reasonably necessary to -- that they went together, then the per se rule should not apply.

If the same case comes up 25 times in a row, and I mean it's exaggerating, and it's been found that in none of those 25 cases could anybody come up with any efficiencies, then at some point the court is not going to spend much time looking at that question again. But if somebody could make that case that the per se rule shouldn't apply here because the activity is associated with significant efficiencies, then the per se rule would not apply.

MR. KELLY: Jeff?

MR. MILES: I really don't think there is any longer a per se rule in the strict sense of the term. I think everything these days really has turned to a truncated rule of reason type analysis, and my feeling is that if you had a network and you walked into court and you argued plausibly that there were efficiencies that the network generated, I think a court would listen to those arguments and you would typically be in a truncated rule of reason type analysis.

And I guess the other thing that I would emphasize is that I don't think there's any requirement in antitrust jurisprudence that a network exhibit either

financial integration or clinical integration before it can generate efficiencies, and I think the types of efficiencies that could be generated short of those types mentioned specifically in the guidelines a court would consider.

MR. RASKIN: Just one comment I would add. We can argue about, you know, what precisely is per se, what's rule of reason, whether it makes a difference. I think it does make a difference, but not in the way that you might imagine. I think it makes a difference because while Art is probably right that a network that could come forward and make this evidentiary showing of efficiencies would get it -- would have a good shot at getting itself outside of per se rule, to date, after many, many dozens or hundreds of these networks being formed, no one has taken on that fight. And maybe it's because it's not a winnable fight, but maybe it's because it's a fight that cannot economically be made in a way that's worth fighting.

And so, I think it makes a difference that we get this question right, you know, without waiting necessarily for that fight to be fought, because it makes a difference. It makes a difference in the negotiation of consent decrees, it makes a difference in the counseling of clients. And so put that burden at this

point out there, it's not necessarily the right solution.

I think we have this persistent question about whether the transactional efficiencies are out there, and to put all of that burden on that one network that happens to have gotten a CID, makes me think that we're never going to get an answer to it. On the other hand, if we consider it at a more abstract level, because of the fact that the question is persistent, and because physician networks do have a demand, and now do seem to have a recognized legitimate place within the marketplace, then maybe we ought to be asking, hey, maybe we ought to be doing this at the rule of reason level in the first place.

So, I think you have to take those dynamics of sort of negotiation and litigation into account before you come up with an abstract rule which simply points out what we all know to be true, which is, yeah, you can fight the efficiencies battle if you want to, and if you have the resources to take on that fight.

MS. MATHIAS: Did you have a follow-up comment from the other things that you've heard today?

DR. HILL: Well, the only other comment that I would make is that the messenger model is about price. I realize that, but that's not everything that we're interested in, at all. And I think that needs to be a

part of the discussion. Physicians want meaningful contracts, and the pricing is just one aspect of the contract. And we can't even get fee schedules. We can't even get a rate of all products clauses. We can't get payment, timely payments. So, there are a lot of other things besides the pricing and the messenger model involved as far as we're concerned and I just wanted to get that on the record.

MR. ROSS: A couple of things. Just following up on the discussion that the panelists were just having. It's one thing to say that if you can point to recognizable efficiencies that you can get yourself out of a strict per se rule into a rule of reason or truncated rule of reason, but how about the example that several people spoke about today. And Art, I think you spoke about with Michael Duncheon's request, if I understood it right, and if not, I'll change the facts, where you have a small network with no more than 10 percent of the physicians in a given market, who wish to come together and do nothing other than jointly negotiate on price with payers. And what if at the same time you have some relatively small payers who are interested in contracting with those physicians because it's a way of jump starting a network. And they can come into an area, they can get a network together, they're not being the

victims of gouging. Clearly there are no efficiencies, or the efficiencies are insufficient to justify the agreement on price under our current antitrust jurisprudence. That would be probably treated certainly by the agencies, and I think by the courts, as a per se violation.

And yet, this was a point that I think Richard was making, and Dr. Hill, that in that situation, if you applied a rule of reason, you would not find any harm to competition.

Now, taking one step back from all that, perhaps that's the case, and perhaps it makes good sense therefore to apply the rule of reason in that situation. The problem I don't think is with the agencies, the problem is with the law as the law currently stands, if this is a problem. Richard spoke about going back to first principles. Well, one of the first principles in this area is the Maricopa case, and in Maricopa, a network that was put together by physicians that intended to agree or did agree on maximum prices above which they would not contract with payers, which arguably had some pro-competitive benefits, was struck down.

And the agencies necessarily have to deal with that. And they can't go around changing policy on that front. So, much of the rule of reason, per se debate is

a quarrel with the law as the law stands as received from the Supreme Court. Rather than -- and but it is manifested in this forum as a quarrel with the agencies that then end up having to apply the law.

The only other thought I wanted to or point I wanted to make, and it expands on what I said when I was talking, is to try to get people away from the messenger model, and its many, many problems. You can lay out a series of options. Risk contracting is far less attractive today than it was a few years ago. Clinical integration, never a good solution if you're going to put all your eggs into that basket, unless you invest heavily in the clinical systems and heavily in Jeff Miles as your lawyer.

Beyond that, according to Dr. Hill. Beyond that, you start looking at a full practice integration, or some steps short of full practice integration. And I don't advocate the people enter into group practices without walls, but something like that with many indicia of integration could be sufficient to permit it. But we have very little to permit joint negotiation, price negotiation, what have you. But we have very few cases out there, very little case law, and very little guidance from the agencies on how much practice integration is enough, short of a complete merger.

And perhaps that is an area in which the agencies could give us more guidance, certainly if the Brown and Toland cases shapes up in one particular way, we may get guidance through that litigation. Again, I don't know enough about the case to know if that's the direction that it will take, but it looks as if it might have some promise there.

MS. MATHIAS: Jeff?

MR. MILES: I suppose my first question is to Art Lerner, and that is, are you the father of the messenger model?

MR. LERNER: A former collaborator has shown me a speech I made in 1983 where I did use the word "messenger." So, if that -- whether that was the first such use, I can't say.

MR. MILES: Okay. I guess the only thing I would add, and after this panel it's probably unnecessary, and that's I really think messenger models are worthless, except as interim tools, as networks decide what they want to do. I've seen networks use the messenger arrangement. And I can think in one case it was because this, again, was a network that had been taking risk, wasn't anymore. Its reason was it didn't want the network staff to lose its jobs, it wanted to stay in existence.

In another instance, the reason was that it was used was because the network was a PHO, and the hospital wanted to protect -- wanted to protect its referrals from those physicians and wanted to do something to bond them to the hospital. So, they continued with a messenger model.

But I don't know, in my work, I certainly have had no group come to me and say we want to form a new network and we think a messenger model presents a viable, long-term business strategy and that's why we want to do it.

MS. MATHIAS: Richard?

MR. RASKIN: I guess I want to get back to this question of the per se rule. We've had a lot of back and forth on it, and I was surprised to hear a defense of the over breadth of the per se rule. What I mean by that is, there is a sort of an old school, old style argument that says that, well, the per se rule is worth it in the end, even if it ends up shooting down some pro competitive or competitively neutral practices, because they're judicial in administrative efficiencies and having the rule out there. I think that's a classical defense of the per se rule and it's a defense that is particularly applicable to price fixing cases.

However, the question we're asking here is not

whether price fixing ought to be legal, the question is whether the conduct we're describing is price fixing. And I think, you know, there is no -- there is no countering the fact that we do also have doctrines that allow for more flexible consideration of price agreements that are ancillary to arrangements that may have pro competitive benefits.

So, I don't think it's helpful to say, well, the question is, is price fixing legal?

In terms of Maricopa, just a quick response, now I'm responding to responses to what Doug brought up, which is, hey, Maricopa is out there, and Maricopa said that a physician network not too terribly unlike some of the ones we're positing today, despite the use of a maximum price schedule, was per se unlawful.

I guess there's a couple of things that I would say about that. First of all, the agencies have shown themselves most willing to forget about decisions that they don't like in the antitrust field. I mean, just sticking with joint ventures alone, there are Supreme Court cases like Sealy and Topco that are, you know, honored in the breach more often than in reality. That's because there's an been an evolving understanding of the antitrust laws over the years, and I think what we're talking about now is, has there been such an evolution

here that ought to call for a reconsideration of enforcement policy? And I don't think the agencies' hands are tied at all in that area. In fact, I think they've recognized that they are not tied and they have shown themselves an ability and a willingness to evolve the policy statements, to develop the concepts of financial and clinical integration.

So, the question we're asking, I think, is not whether they have the authority to go a little further, but whether it makes sense as a policy matter to go further. You know, there may be issues about whether Maricopa itself ought to be considered to be strong law today and a lot of folks have debated that over the years. And one of the problems that is Maricopa is ambiguous in a variety of ways. You could read it in many ways as a rule of reason decision. As Jeff Miles just stated, the per se rule and the rule of reason in many ways have moved together over the years, and the Court in that very decision did consider the possibility of potential efficiencies.

And just, you know, quickly in response to Art's comment earlier that nobody here, he didn't hear anybody here really making the case that there were strong efficiencies presented for these -- for the kinds of networks we're talking about that might do a messenger

model. You know, I don't know that that's necessarily entirely the right question. I mean, the way I phrase the question is: is there any showing of harm to competition?

And usually in a rule of reason analysis, which is what we're proposing here, or that many of us have been discussing, in a rule of reason discussion you do a balance, and you only need so much efficiency as is required to counterbalance the threat of harm.

So, you can't just put the entire burden, the entire evidentiary burden on the side of these networks to show efficiencies, which is a notoriously difficult thing to do. I mean, in large merger investigations where great companies have great amounts of money to spend on proving efficiencies, they often fail in that effort and yet nevertheless have mergers approved.

Efficiencies are very, very difficult to prove in litigation, or in negotiation. And so, what we're left with is the abstract arguments of antitrust lawyers like everyone on this panel. And that's why it's appropriate to address these types of issues I think in this type of environment and not simply to put the burden on respondents and defendants to litigate these issues to the bitter end.

MR. MARX: I guess one of the things that I

find about this is, almost all of the cases where there's been a challenge, the conduct has been pretty egregious, at least as it's been alleged. And I understand that there are always going to be two sides to the story, but we're not dealing with many cases where it's just a question of 10 percent of the doctors trying to negotiate price and I think there are a lot of cases out there where the rule of reason is being applied, either by the agencies without anybody having said so and they don't bring an enforcement action because there hasn't been a real perceptible adverse effect on competition, or because payers don't really feel like they've been hurt by conduct that if the agencies got a chance to look at it in detail they might say constitutes per se unlawful price fixing.

But I think, Richard, in response to your question, I think a lot of the cases have involved very egregious conduct, whether it's been a large group of majority of the physicians being part of the network agreeing to contract only on an exclusive basis, threatening to boycott, demanding that payers sign waivers to their right to file private antitrust claims based on the negotiations. That conduct is pretty egregious. I don't think it's going to pass muster under the rule of reason. I just don't think it will.

So, again, I recognize that just because the agencies file the complaints and they get a consent agreement where the respondents haven't admitted that they have engaged in any of that unlawful conduct, I mean I think there's probably at least some reason to believe that at least some of that conduct has gone on, and under those circumstances, I'm not sure that I think that most of these cases would pass muster under the rule of reason.

So, I mean, and I think that the cases that aren't being brought are like the cases that a lot of people have talked about where maybe it's just no harm no foul, but nobody is going to talk about the fact that there was an investigation and there was no enforcement action that ultimately resulted. I don't think you're likely to see payers raise the question unless they really feel like they've been taken advantage of. You know, it may well be that you've got payers out there saying that I understand that this isn't exactly the way the messenger model is going to work, don't worry about it, you know, if we can reach an agreement on a price that's acceptable to me, I'm not going to go to the FTC or the Department of Justice and complain about it. And I think that happens a lot.

So, I guess in the end, it's not clear to me

that the rule of reason isn't being applied, but people aren't just talking about it very much.

MR. MILES: Sarah, can I just comment on the no harm no foul?

MR. RASKIN: I want to comment, too.

MS. MATHIAS: Jeff and then Richard.

MR. MILES: I think David is right in two of the three things that he says, that the agency -- you know, I mean, they go to the hall of fame for that.

I think it's right when you read these cases that the agency brings, it appears from the complaints at least that the facts are egregious and I would assume that it's correct that when the facts aren't, when they see the 10 percent IPA that was fixing price but has absolutely no effect on competition, that they don't bring those cases. I guess the third question is, is that good enough?

If that 10 percent network hires a lawyer that doesn't know much about antitrust law, and that lawyer gives the network advice, sure, you can go ahead and do this, don't worry about it. Then the network goes ahead, does it, never is found, no payer complains, or somebody does complain but the agency looks at it and says there's no harm here, we're going to spend our scarce resources elsewhere, and so nothing happens.

But if that network hires you as their lawyer and says can they do this, you're not going to say to them, no, it's against the law, but no harm, no foul. You're going to say, you know, you may never be found, but this is against the law, you're not going to want to do it.

And so the problem is that a well counseled IPA in that situation is not going to engage in it, so this sort of informal rule of reason is going to benefit only those that have no legal counsel or incompetent legal counsel.

MR. LERNER: That's pretty much what I would say. I agree with David about the egregiousness, at least in the allegations of the cases brought by the government. I don't think anybody could seriously disagree, but that's just the tip of the iceberg. The question then becomes the extent to which the potential for application of the rules in a technical manner chills advice and the formation of other ventures that on balance might have pro competitive effects, which I think is just the point you were making.

MR. ROSS: I want to respond on a couple of points. Our focus today is on the messenger model, and so it's all about whether or not insistence upon compliance with the messenger model is problematic or

not. That's sort of broadly speaking our topic. It presupposes that it's a very important question. And I guess what David was getting at was in the grand scheme of problems in antitrust enforcement, I'm not sure how big a problem this is one way or the other. And in that respect, I want to -- and by that I mean, the principal things that the doctors often say to me that they want to accomplish, getting rid of the messenger model and just leaving them with the rule of reason, they could not accomplish either, because if they want a cartel, they're not going to get a cartel under the rule of reason.

On the other hand, if what they want to do, and this is responsive to Jeff's comment, about whether the messenger model is really of any use to anybody, I have had provider groups that come and say, we want to be a place through which health care can be accessed where we're going to be involved in certain quality improvement activities, we want to be involved in doing the case management, rather than the health plan. We think we can do that in house, and they want to do a bunch of things and they think that they can do a better job of it. And I say, okay, do you want to take risk and do you meet this clinical integration threshold, and the answer is maybe not. And then I say, how important is it to you to negotiate price? And they say, frankly that's not the

big issue.

Okay? And so the messenger model works well there. If they can negotiate the contract and they can get rid of the all products clause, and they can negotiate all the other quality issues that are of concern to them, and absent them being a monopoly, you know, kind of problem, there's no problem at all in that kind of situation and if they're not particularly interested in negotiating the fee schedule. And I've had a number of clients where that's just fine. They'll say, we'll take the market rate, you know, the doctors will sign whatever it is, and whether we use the black box or the advanced approval or whichever model, because price is not what they're all about.

If you come with a client who comes at you from the beginning, price is what it's all about, well of course the messenger model is a problem, because that's an organization that wants to be a cartel. They're going to have a problem whatever we do on this issue.

The only other thing, going back to Richard's point, just it's that old kids game we played behind school of, you know, burden, burden, whose got the burden in antitrust. And I think it is an important question. Richard stated the question as being we certainly allow various agreements related to price to not necessarily be

deemed price fixing, where they are ancillary to some pro-competitive benefit. Fair enough. But then he moved along a couple of minutes later to, well, why should it be my burden to have to prove the pro-competitive benefit.

I appreciate that argument. I think if the case could be made here, or in the economic literature, or in studies or in an extended FTC analysis and DOJ analysis, that the current view is too stingy. I agree, we shouldn't make some poor IPA in Texas be the one to have to spend the $5 million approving it. I'm just saying I hear the argument being made, but I haven't seen here today or anywhere else yet a strong pitch to me that convinces me of that. As if my opinion mattered or anything. But I think that's a legitimate thing, if that argument can be made, I think the agencies should listen to it and adopt it as part of their enforcement view, just like they have risk sharing and clinical integration.

But I think you also have to remember the flip side, which is a case that I'm looking at now where you have a group of providers, not physicians, who have decided that they have adopted some clinical practice protocols to govern their behavior, and having done so, now think they can fix prices.

There doesn't seem to be any real connection between the fact that they have clinical practice protocols and why that means they should be able to fix prices. But if one were to say, well, you know, is the geographic market these two counties or these six counties, and how exactly do we define the markets, and do they have -- what share of the market do they have or there are barriers to entry. I don't think antitrust really wants to have to go there, and that's the problem with the 10 percent hypothetical, which is that if it was always that easy to say it's 10 percent, and not have to worry about it, that's the one where the tree falls in the forest and nobody is listening, so nothing happens.

The problem is that the antitrust agencies, I don't think, are going to want to give up the classical per se rule to have to litigate over all these geographic market and product market definition issues, unless there is some threshold showing that can be made on the truncated rule of reason that gets you out of the per se rule.

MR. KELLY: I would like to follow up on that quickly with a question to Dr. Hill. Doctor, you spoke earlier how you felt that price was only a small part of it and that the physicians weren't that concerned with price.

DR. HILL: I didn't use the word small. I did not use the word small, I'm sure I didn't. Because price is an issue with anybody, and anybody that denies that. But I was very interested in what you just said, because it could be that that group you're talking about, nonphysicians you said, providers, who wanted to -- obviously were using protocols and profiling performance management. Well, if they were reducing cost significantly, which we know happens when you use proper quality controls, then I question whether they shouldn't have the right to have a lot more to do with setting prices. That may be heresy, I don't know, but I don't think it is, at all.

But no, what I meant was the frustration and anger that I hear all over this country, and I don't come from a managed care market. So, there's no managed care in Mississippi to speak of. So, we're on a fee for service market. It's like heaven. But anyway, and many other ways like heaven, also. But I hear anger, all over the country, not just in California, everywhere. And the anger and frustration has just as much to do with prompt payment issues, with the contracts that are coerced upon physicians and they don't feel like they have any ability to negotiate anything in the contract, take it or leave it. And that's what I'm hearing, and that's what I meant

by pricing certainly not being the -- not a small thing, but it's one of the many things that physicians have to deal with.

The other thing you've got to remember is, I don't know any physician who cares very much or thinks very much about their contracts. And maybe that's bad, I'm sure it is, but the point is, that's not what they're trained to do, that's not what patients want them to do, and that's not what you want them to do. Yet they're forced into this position where they have to go looking for "experts," and the experts out there that understand this whole issue are so few and far between it's frightening. And those experts are expensive and they give bad advice, as you have all said today, and I heard that this morning, also.

So, that's what I meant, that pricing is important, but there are many things just as important.

MR. KELLY: Well, you've helped me set up the hypothetical that I am going to ask you, and before I do this, I would like to say that this is my own imaginative hypothetical, it's not a precursor to a change in any policies of the antitrust division.

If the agencies were to take the approach that following up on what Art said, that we're not going to view nonprice term negotiations as per se violations, and

you can negotiate on those terms, but you're going to have to go to a strictly blind black box negotiation on price, and everybody treat price independently, do you think that would address the concerns of the physicians that you're hearing if you were allowed to negotiate the other terms and then have price be the true messengered genuinely not jointly negotiated feature? Do you think that would appease those concerns?

DR. HILL: I think there are a large number of physicians that would actually like that. And I know that people probably don't believe that, but I think a lot would go for that, yes.

The other thing is that as we begin to implement clinical policies and guidelines and protocols at work, physicians are slowly but surely catching on to the fact that they can reduce their costs tremendously. And I don't think that the capitations -- the issue didn't work very well -- but I think it's going to come into a new era, the era of really truly addressing quality which we didn't do in the capitation era. We talked about it, but it never happened. We all dreamed about it, but it never happened. We didn't have the information to do it, we didn't have the data system to do it, and we still don't, but when we get those data systems, I think that then physicians will become very

amenable to wanting and getting those efficiencies that are going to help patient care and not worry so much about pricing.

MR. MARX: Can I respond to your hypothetical for just a second?

MR. KELLY: Certainly.

MR. MARX: It seems to me that if we add one more assumption, which is that if the group isn't able to successfully negotiate the nonprice terms, that the payer will be able to contract and in fact the members of that group will contract independently with the payers, then I think that the hypothetical that you have just posed, I certainly would view as the state of law today. Because I think if you look at the consent decrees, I think if you look at the informal agency advice, it seems to me that the network is in a position to do a fair amount of negotiation on nonprice terms and if it's able to reach agreement, then go ahead and black box the prices and as long as it's not exclusive and as long as there's no boycott by the physicians if it doesn't work. I'm not sure that I wouldn't say in appropriate circumstances that you can do that.

MR. MILES: I think it might depend on what you mean by the term negotiate.

MR. KELLY: Yeah, and it might also go to the

concern that Jeff raised about the quality of the antitrust counsel and whether or not those -- what I stated was a theoretical hypothetical, but that's not the situation that people are actually giving legal advice in.

MR. MILES: And I guess the other issue that's obviously going to come up is where is the line between a price term and a nonprice term.

MR. ROSS: And you don't think most favored nations clauses are nonprice terms?

MR. MILES: I think most favored nations clauses are price terms.

MR. RASKIN: Timeliness of payment?

MR. MILES: Price term.

MR. RASKIN: Utilization review?

MR. MILES: Probably not. But you can make the argument either way.

MR. RASKIN: Choice of law?

MR. LERNER: But leaving aside the fine line there, I'll just say that the FTC policy statement already says that the messenger model can be run messengering price and price-related terms. So, as far as I'm concerned, the existing agency guidance is that you're able to -- that you don't need to messenger nonprice and price related terms, and on to Jeff's

comment --

MR. MILES: I thought you just said it could be messengered.

MR. LERNER: No, no, that price and price related are the terms that could be messengered, other terms do not need to be messengered.

MR. ROSS: Which now resembles the California debate last night.

MR. LERNER: And on the negotiation point, I believe that absent market power and a threat to boycott by a group with market power, that negotiation and even refusal to deal over even a concerted refusal to deal over nonprice terms by a group without market power is not illegal.

MR. MILES: That's a boycott.

MR. LERNER: It's not per se unless it's --

MR. MILES: No, but I mean you just said short of a boycott.

MR. LERNER: No, I didn't.

MR. MILES: Only short of a boycott by a group with monopoly power. If you had a group that didn't have a monopoly or didn't have market power but said, we're going to negotiate this nonprice term and that's the term in dealing, I think it's a rule of reason case and absent market power, you're not in violation.

MR. LERNER: And they can boycott?

MR. MILES: If you want to use that word, absent market power.

MR. LERNER: I agree with you, by the way.

MR. MILES: Thank you.

MR. ROSS: Well, it's clear to see why physicians have no problem following the advice they get.

(Laughter.)

MS. MATHIAS: To kind of take a tack on some of the things that we've been hearing, I mean Jeff has been saying that messenger models are fairly worthless, except in maybe two circumstances, and one of them included PHOs using messenger models, and actually that's a situation where I heard that maybe messenger models are actually usable and efficient for the PHO to do their contracting.

I was wondering if there's any agreement with that statement, and I don't know if Jeff agrees with that, and then I was also wanting to throw onto the deck whether we see any difference in the perception of the benefits or the costs of messenger models, depending on whether you're in an urban market or whether you're in a more rural market, and does that affect the prospective of the benefit or cost of messenger models. So, I'll open that up to the table if there's anybody who is interested in that question.

MR. MILES: Well, I'm not sure how to answer it. I think Art has provided the only even plausible justification for using a messenger model that I've heard, and that is that it might be a mechanism through which you can -- a group can do its efficiency work. I don't know why a messenger model would be any more efficient or any more beneficial in the PHO context than it would be in any other. In the context I've seen it, it has simply been used as a bonding tool by the hospital to try to keep the physicians referring patients to the hospital. Which from an economic standpoint, I guess is neutral.

MR. ROSS: I think of PHOs to some extent as one of these constructs that Richard and Art were talking about earlier created by antitrust lawyers. They weren't entirely created by lawyers. They were also created by hospital administrators in large part not for real business reasons, but as Jeff says, to bond with their physicians and they've met the same fate that the messenger model has met among many IPAs, which is that they've crashed and burned.

So, I think PHOs themselves are not very prevalent anymore, those that are aren't doing a lot of work. They certainly never satisfied the promise that they had back in the mid or late nineties when they were

being put together.

MR. LERNER: A comment I was going to make is in terms of when might it make sense more rather than less, would it be worth more rather than less. It's interesting that the larger national payers or the strong regional payers generally have their networks. The argument that I think sometimes is made, and I think Dr. Hill even mentioned it, about circumstances where you may have a small payer, a newer payer wants to come into a market, and therefore if you had some kind of pre-existing network there, that it might meet that need.

The point I was going to make is that you have a system like Kaiser on the one hand where you have an entirely integrated system. They have the provider capacity, the insurance capacity, the utilization management, all the whole system is self contained. Then you can have a system like Aetna or a large company where the insurance function, the claims processing and all of that is all self contained, but they don't own the providers, the providers are off separate.

And then you have other situations where it's all unbundled. You have an insurance company on the paper, but it rents a network from somebody. There's a TPA that processes the claims, okay? So it's all very much unbundled. In that circumstance, if you were trying

to put together a product in a local community, there is -- it's more obvious that at least a possibility that a preformed provider network on the shelf, ready to go, available to be purchased by a payer who -- or a TPA who wants to be able to put together the modules necessary for a health plan, that's an appealing argument. The question is, and what I find, is that in that circumstance, using the standard offer model, where basically you survey the doctors and you basically find out, you know, what kind of fee schedule would be ready to go, and then the payer can just say what fee schedule, it's like a clearinghouse, you can move forward on that basis.

If that weren't feasible, if for whatever reason that aspect of the messenger model wasn't feasible, then you could have an interesting discussion about whether or not the pro-competitive benefits of facilitating entry by the new payer by having a network ready to go and all set up, and having it be able to have a preset fee schedule, that's an interesting debate, but I would want to hear why the messenger model couldn't work there. But I think that's a possibility.

The irony of it, though, is that the circumstance that some physicians will give you as to why we need to not have the messenger model is so we can

counteract the market power of the payers. Well, of course, that's not the negotiation with that small new entrant, that's the large payer for whom the alleged efficiency doesn't exist.

MR. RASKIN: Can I make a quick comment on that?

MS. MATHIAS: Sure.

MR. RASKIN: Art is creating another straw man.

Let's set aside the situation where we've got the physicians who are saying, we want to fix prices, or we just want to raise our prices. And we think we will achieve that more effectively if we band together in a network. And let's agree for the moment that that ought to raise a significant problem.

I think the more nuanced question, though, is, is there any more that physicians can do, lawfully, to address some of the concerns that I think Dr. Hill raised, which is that they genuinely often do feel rather helpless, particularly in small practices, to bring the resources to bear to effectively analyze and effectively negotiate managed care contracts. Now we can all recognize that they've got the option of creating a large group practice. They have the theoretical option of creating a large group practice, and that is one of the efficiencies that a large group practice is able to bring

to bear. I mean, what you will see in the large group practices that are out there is the building of an administrative infrastructure that allows people to consult with fancy antitrust lawyers, that allows people to do fancy analyses of coding, to do better collection, to go back to payers and say, for example, you know, you agreed to pay me 120 percent of Medicare, how come I've been collecting 95 percent from you?

Now, I think we would all agree that that sort of push back is, you know, absolutely competition at work, and there's nothing anticompetitive at all about that. And that is the kind of leverage that a group practice can develop that is entirely lawful and appropriate, even though payers don't like it. And even though they don't experience it on a daily basis, because it is very much the exception rather than the rule.

And so it seems that the harder question that we ought to be asking, that we ought to be looking at under the rule of reason is, what else can the physicians who are in these smaller practices, what else, if anything, can they do to develop some of those same administrative efficiencies that would have allowed them to, in fact, negotiate more effectively? Because I don't think we should just make the assumption that negotiation is bad.

The question we have to ask -- or that leverage is bad. The question has to be: is it lawful; is there just simply an agreement on price here, purely to leverage up prices? And I don't think much thought has been given to what can be done to really, again, build up that administrative infrastructure on an entirely lawful basis, collectively, in order to bring information to bear in ways that address these persistent concerns of physician organizations.

MR. KELLY: I'm going to throw this question out for anybody on the panel who wants to pick it up. There's been several enforcement actions by both agencies in the last year or so, and yet when you look at the resultant private antitrust litigation that typically follows agency action, it seems in these messenger model cases that have been brought that there has been less private antitrust litigation than might have been expected under ordinary circumstances. Why is that?

MR. MARX: I'll start, I guess, you know, although Doug may be in a better position at some point to answer this. But I think the answer is that payers have to deal with the providers after the consent orders are entered into, and you see this in other industries all the time. Distributors don't sue their suppliers and remain as distributors for very long. It just sours the

relationship. And I think you've got a situation where payers are not likely to sue the providers, because if they do, they're not going to have a provider panel in the future. Providers simply won't deal with them.

So, there may be where's the long-term benefit from that? You know, I guess this raises an issue that if you guys would stop filing a new case every day I could finish the paper that I'm trying to write about it. It raises the issue it seems to me as to whether or not you ought to be considering remedies other than the remedies that you have pursued. And let me preface my comments by saying, you've got to analyze those things I think on a case by case basis. I do not think that a standardized or a template consent order is necessarily the right way to go in every single case. They're all that specific.

But having said that, it seems to me that the fact that you have had to bring 12, 15, 16, you know, I've lost track, cases in the last 13 or 14 or 15 months, after the litigation that you did in 1999, after the revised agency guidance in the '96 policy enforcement statements, and all of the business review letters and advisory opinions that have come out since then, says that whatever it is that you have done apparently is not having a sufficient deterrent effect, and if it's not, I

think one of the things that the agencies need to consider is are there alternative remedies out there that we ought to be considering?

Now, I understand and it seems to me that there are several that you can pick from and relatively few that you have chosen. You know, I say this with great trepidation, because I typically represent the respondents in these cases, and that's why I implore you, should you be pursuing this against any of the clients that I represent, that you should consider each case on a fact basis and stick with the -- go-forth-and-sin-no-more consent decree if that's where we have to go.

But it seems to me that you've got dissolution, which you have only used a few times. You've got structural relief, which was used as recently as we saw, I guess yesterday, but has only been used a couple of times to try and address the issue. You've got the ability to do better fencing in, require more affirmative reporting by the networks of contracts that they have entered into to make sure that they don't slip back into doing what they have done before, which has not been done as best as I can tell.

You've got disgorgement as a potential remedy that as best I can tell from the policy statement has essentially been written off by the agency for pursuit in

cases like this. Frankly, it seems to me that there are at least one or two cases out there that probably would have been appropriate vehicles to seek disgorgement. What, a million dollars worth of measurable overcosts in one of the cases? Why wasn't disgorgement pursued in that kind of a case? It seems to me it meets the three criteria.

And then of course there's the last alternative remedy that was pursued back in the early nineties and hasn't been pursued as best I can tell since just about then, which was referral by the FTC to you guys at the Division for possible criminal investigation. My sense was that after the criminal investigation -- after the Alston case, after the criminal investigations that I still remember, the anesthesiologists in Massachusetts, the OB/GYNs in Savannah --

MR. RASKIN: Allergists.

MR. MARX: Allergists, I'm sorry. The allergists in Massachusetts, there weren't a lot of problems for a few years. And I think that may have been because the criminal investigations actually served to have somewhat of a deterrent effect. Again, I'm not endorsing all of these in every case, what I am suggesting is that there may be alternative remedies out there that you should consider under appropriate

circumstances.

It's not clear to me, and because it's not clear to me that cease and desist orders are having the requisite deterrent effect, and frankly, from my perspective as a counselor, trying to explain to networks why they should do it right, if there's no potential downside for them, other than having to pay my fee, which isn't as much as Richard's for sure, there's not much deterrent effect for them. The physicians, the networks, whether they're physicians or hospital networks, it doesn't matter, they just don't see, I don't think they don't perceive there to be much of a downside risk. Because, in part, the payers aren't going to act against them.

MR. RASKIN: David, you know that it's volume rather than prices that drives cost?

MR. LERNER: I would just add one comment, which is on the question of whether or not the agency should seek restitution or disgorgement, I think you've got comments back from both the defense bar and the plaintiff's bar that the enforcement agencies should not do that. I think that says something about whether, in fact, it would be a good idea. I won't say what that is, but if you've got the defense bar and the plaintiff's bar agreeing that you shouldn't do it, then I would think

about it pretty long. I would give it a good look.

MR. ROSS: To answer the question or try another answer to the question, it's a really good question, and it's one I've asked myself a lot recently, the question being why haven't there been more private actions? And I've asked it of myself because I represent an IPA which has been the subject of a -- I should change that, I represent a group that has been the subject of a private action and the subject of an FTC enforcement action, and I looked around the country and asked myself how frequently has that occurred, and I can't really find that it has occurred maybe more than once or twice.

I think perhaps that David's comments certainly make good sense, that payers are unlikely to want to go sue physicians with whom they do business. I don't think it's necessarily because they're worried about the retaliation. There's a whole host of reasons as to why they may not, and that might be part of it, but there can be other reasons as well.

But then you ask the question, why haven't there been class actions? There certainly are enough class action lawyers out there. And that's the case that I'm defending, and I don't know why there haven't been others. I guess I can simply say in this particular

case, when the court ended up certifying a class several months ago during the summer this year, it ended up certifying an extraordinarily narrow class, and thereby gutted the economics of the case from the plaintiff's counsel's point of view.

So, maybe other plaintiffs' counsel have figured out that's what would happen, I just don't know. All I know is I think the observation is entirely accurate. There are very few private cases, there are very few class actions, unlike other antitrust areas, or other areas where the agencies take antitrust enforcement actions. And the one case in which I have experienced hasn't worked out very well from the point of view from a plaintiff who is looking to make it into an economic success story. But beyond that, I can't comment.

MR. RASKIN: Can I just add a quick thought on that? I agree with Doug's comments. You know, I'm personally aware of one from my own experience where there was a follow-up to an FTC consent decree in the physician area, and it was a class action, and while it purported to be on behalf of consumers, there was essentially a competitor behind it.

So, you know, I think you're right that it's not simply a matter of asking about the payers' issues, because they've got a complex set of considerations that

they would take into account. But, I mean, you've got consumers and patients out there who would presumably have copays at stake and we've got a plaintiff's class action bar, that has certainly discovered health care generally that is very active in the pharmaceutical sector right now in seeking to recover, you know, alleged overpays through copayments in class action cases. Many of them following up on the FTC's activities, you know, very broad activities, in the pharmaceutical sector. So, I think the question of why we have, you know, certainly the plaintiff's class action bar knows how to follow the money.

And I think it's a very legitimate question to ask why are they perceiving that there is no money here, or as appears to be the case. And I think that raises a real question as to, you know, leading back to competitive harm. Are there consumers out there who have been harmed by the activities that are the subject of the physician network consent decrees? And I think it's an interesting test to ask whether the plaintiff's class action bar perceives it as such and sees dollars there. Now, there may be a variety of legal barriers that would come into play and issues of standing and direct purchasers and everything else that could play a role in that analysis, too, but I think that's one hypothesis

that ought to be considered.

MS. MATHIAS: Real quick. We do like to value everybody's time and we told you we would be done by 5:00, and so actually I'm going to allow everybody to have one final statement and then we will wrap up. So, I could tell Art was itching to go, so we will let him start and we will proceed this time from left to right.

MR. LERNER: Just think that most of these cases are too small to be attractive to the plaintiff's bar. That's all.

MS. MATHIAS: And this is also your time to wrap up if you have any other final comments.

MR. LERNER: I've rapped enough.

MR. MARX: I'm going to concur with Art, I think I've rapped enough, too. I appreciate the opportunity and I think it's been an interesting discussion and I will frankly be really curious to see what comes out of all of this.

MR. RASKIN: Same here, we've all had plenty of opportunity to air our views, I think it's been a really interesting discussion.

MR. MILES: No more except to say thank you for another good time.

MR. ROSS: I have about 20 minutes worth. Thanks very much.

MS. MATHIAS: Dr. Hill?

MR. HILL: Well, I represent the Eagles that nobody can get to fly in formation. So, I've felt like a duck out of water here, but I appreciate the opportunity for sure, and the educational opportunity that I have had. I certainly don't want to continue it, I don't want to get a master's or a Ph.D. in it, I'll tell you that, but we really do appreciate the hearing and hopefully some reconsiderations coming out of the hearing. Thank you.

MR. KELLY: Once again, on behalf of both agencies, I would like to thank our panelists for giving so generously of their time and energy to help make this panel a success. Thanks to everyone for coming and I'd like to remind everyone that tomorrow morning we'll get under way at 9:15 with the physician unionization discussion, and tomorrow afternoon at 1:30, which is different than our usual 2:00 start, we'll be starting at 1:30 with the group purchasing organizations. Thank you.

(Applause.)

(Whereupon, at 4:55 p.m., the workshop was concluded.)

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C E R T I F I C A T I O N O F R E P O R T E R

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: SEPTEMBER 25, 2003

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the notes taken by me at the hearing on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: OCTOBER 16, 2003

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DAN WILSON

C E R T I F I C A T I O N O F P R O O F R E A D E R

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

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