PHYSICIAN INFORMATION SHARING

Statement of

American Medical Association
to the
Federal Trade Commission and Department of Justice

Hearings on Health Care Competition Law and Policy
Washington, D.C.

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The American Medical Association (AMA) appreciates the opportunity to present to the Federal Trade Commission (FTC) and the Department of Justice (DOJ) our views on physician information sharing. We are pleased that the agencies included this issue for discussion in the last set of hearings on health care competition law and policy.

Physicians should be entitled collectively to gather and compare information about health plans' reimbursement rates. Fairness and efficiency in the contracting process demand no less. This is procompetitive, not anticompetitive.

In recent months, antitrust enforcement agencies have provided guidance on the extent to which physicians may gather and disseminate data on insurer activities. Since last September, the agencies have issued one business review letter and two advisory opinions on physician information sharing.[1] Although they differ, each of the letters involves a request on behalf of physicians for a third party to conduct a survey and disseminate the results on, among other things, insurer reimbursement for physician services. We are pleased that in each of the letters, the agencies have indicated, with important caveats, that they do not intend to bring an enforcement action regarding the proposed information exchange. [2]

Before discussing how the letters differ, the AMA would like to make a few observations. As we have testified previously, the reality is that physician reimbursement rates are often contractually imposed by powerful health plans in a take-it-or-leave-it manner. This imbalance in the market results from a significant disparity between the information available to payers, and the information available to the typical physician practice. Because physicians tend to practice in small groups with limited resources, they often

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[1] Letter from Charles A. James, Assistant Attorney General, to Jerry B. Edmonds (Sep. 23, 2002) ("*WSMA*"); Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to Gregory G. Binford (Feb. 6, 2003) ("*PriMed Physicians*"); Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to Gerald Niederman (Nov. 3, 2003) ("*MGMA*").

[2] *See* transcript of hearing, Physician Information Sharing, Federal Trade Commission and Department of Justice Hearings on Health Care Competition Law and Policy, September 24, 2003, page 175, line 22 – page 185, line 25.

lack the information to evaluate a payer's rates, compare those rates against others in the market, and determine whether they are adequate.

The imbalance in the health care marketplace is due in part to the demographics of medical practice. Small group and solo practices remain the most common forms of physician practices in the United States (56.1%). More than half of all self-employed physicians practice in a group that has fewer than 5 physicians; for physicians who practice in physician-owned groups, more than half practice in a group with fewer than 10 physicians.[3] These small group practices are at a severe disadvantage compared to the resources of large health plans when attempting to negotiate a contract for physician services.

One negative outcome of the market imbalance is that many health plans adamantly refuse to provide fee schedules to physicians with whom they contract. Those plans that do not refuse outright to disclose their reimbursement rates typically provide rate information only on a small number of CPT codes. However, this data on CPT codes typically does not reflect the coding edits that health plans use, and therefore, the data does not reflect what physicians are actually paid.

As a result of this complex system, physicians frequently do not know what the payment for a given service will be at the time they are providing service. Physicians merely bill their normal rates, or charges, and the health plan then determines payment after the fact. The physician is left with little or no recourse to challenge the payer's determination.

Yet, even when physicians do get some payment information, it is not feasible from an administrative standpoint for small physician practices to calculate and extrapolate the data necessary to determine their reimbursement, even when it is based on a percentage of Medicare's resource-based relative value scale. These practices do not have the capability to conduct a thorough analysis of contract terms or payment data because they do not have the resources to monitor, aggregate and calculate this information.

It is even harder for physicians to conduct an adequate comparison of fee schedules among different health plans. Some plans negotiate discounted rates; others use withholds or incentives that are not realized until the end of the year, if at all; some follow Medicare's resource-based relative value scale and payment rules; while others do not. In some plans, differences in the way services are bundled for payment or otherwise adjusted precludes accurate comparison with Medicare.

Another negative outcome of the market imbalance is that dominant health plans reserve the right to change reimbursement rates during the course of the year as contracts are

[3] Kane, Carol K., The Practice Arrangements of Patient Care Physicians, 1999, Figure 2 "Distribution of Self-Employed Physicians and Physicians Employed in Physician Owned Groups by Practice Size, 1999" (http://www.ama-assn.org/ama/upload/mm/363/practice200102.pdf). See also Kane, Carol K. "The Practice Arrangements Of Patient Care Physicians, 2001," AMA Center for Health Policy Research (forthcoming on the AMA website www.ama-assn.org).

altered or renewed. Health plan contracts often contain terms that allow the health plan to unilaterally change payment rates during the term of the contract, sometimes with little or no notice to the physician.

In this environment of uncertainty and potential instability, it easy to understand why there is a growing interest by physicians to obtain this type of information through means other than the contracting process or informal dealings with health plans. At the hearing on this topic, it was not disputed that physicians should have information on reimbursement and be able to compare rates among potential insurers with whom they may contract.[4] What is widely misunderstood, however, is that physicians cannot easily obtain this information because of the complexities identified above, and because the contracting process is so imbalanced. Physicians therefore, have no ability to demand this information from large dominant health plans.

Safety Zones For Physician Information Sharing

Under the 1996 Statements of Enforcement Policy, Statement 6 describes a Safety Zone involving exchanges of price and cost information among providers that will not be challenged by the Department or the Commission under the antitrust laws, absent extraordinary circumstances. The Safety Zone applies to provider participation in written surveys of prices for health care services if the following conditions are satisfied: the survey is managed by a third-party (e.g., a health care consultant or professional association); the information provided by survey participants is based on data that is more than 3 months old; and at least five providers report data upon which each disseminated statistic is based; no individual provider's data represents more than 25 percent on a weighted basis of that statistic; and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

The three recent letters issued by the agencies involve requests to gather some information that fits squarely within Statement 6 and some that does not. The requests for insurer payment information (as distinguished from physician fee information) fall outside of the safety zone. When the agencies receive requests for information sharing that fall outside of the safety zone they are evaluated under the Rule of Reason. On the whole, the agencies must determine whether the information exchange may have an anticompetitive effect that outweighs any procompetitive justification for the exchange.

The DOJ seemed to understand the reality that many physicians face when it issued its September 2003 business review letter to Washington State Medical Association ("WSMA").[5] And the FTC also seemed to understand that reality in its Advisory letter to PriMed Physicians in Dayton, Ohio. In both cases, the AMA believes it was appropriate for the agencies to approve the collection and dissemination of insurer specific data. Providing information to physicians, employers and patients, so that they may make

[4] *See* transcript of hearing, Physician Information Sharing, Federal Trade Commission and Department of Justice Hearings on Health Care Competition Law and Policy, September 24, 2003, page 176 – 178.
[5] WSMA, supra, n. 1.

informed decisions that will ultimately increase competition among insurers, is clearly a procompetitive justification that outweighs any potential harm.

The health insurance industry has been very aggressive, however, in criticizing these two letters, with the WSMA business advisory letter coming under particular condemnation. The health insurers are adamant that physicians should not be able to collect data on physician payment by individual insurers in the market. They contend that any data collection must be in the aggregate. The industry's attack on these actions of the agencies shows how determined they are to prevent the dissemination of information.

The AMA was very disappointed to learn that ultimately WSMA was thwarted in its efforts to move forward with the data gathering project outlined in the business review letter because of concerns expressed by the Washington state attorney general. This illustrates the kind of uncertain landscape physicians frequently face: a project that was given a green light by the DOJ is later doomed by a state attorney general.

Moreover, moving beyond the recent advisory opinions, there continues to be a common misconception that physicians can easily present information or act jointly to improve patient care without additional help under the antitrust laws. Yet the reality is that the information sharing safety zones in the 1996 Guidelines are full of landmines for physicians.

Merely by jointly presenting information specifically permitted under Statements 4 and 5, physicians place themselves at serious antitrust risk. And ironically, the health plan is under no obligation to even consider the information. After the information is presented, if some of the physicians in the network independently choose not to contract with the health plan, the physician network leaves itself vulnerable to allegations by health plans that it is somehow signaling a boycott. Health plans have proven quite adept at using the antitrust laws as a hammer against physician groups.

Information Sharing on Non-Price Related Terms

Physicians continue to face serious roadblocks when attempting to share non-price related information as well. The FTC continues to dismiss these concerns. The Chairman of the FTC recently stated that physicians "can do a lot of things collectively, as long as they are designed to improve quality."[6] However, health plans and regulators have long taken a very broad view of what they consider price-related terms, thus creating much ambiguity around this safety zone and leaving very little on which physicians may lawfully collaborate.

For example, the June 2003 decision of the U.S. Court of Appeals for the Ninth Circuit in *International Healthcare Management v. Hawaii Coalition for Health* illustrates the perverse realities physicians face in this environment. While the decision of the Ninth

[6] Sage, William, *Protecting Competition and Consumers: A Conversation With Timothy J. Muris*, Health Affairs, vol. 22, no. 69 November/December 2003, at 105.

Circuit was a victory for the Hawaii Medical Association (HMA) and the other plaintiffs because it dismissed the defendant's lawsuit alleging price-fixing and boycott, this victory came at a substantial cost.

The important facts are as follows. International Healthcare Management (IHM) sought to enter the Hawaii marketplace and developed a provider network to accomplish this. HMA and other advocacy groups had concerns about non-price provisions in the provider contract provided by IHM. HMA and the other defendants communicated these concerns to their physician members and to IHM.

Over 500 physicians signed up with IHM, including 70 physicians that joined after the communications from HMA and others. Fewer than a dozen physicians withdrew altogether – before and after the communications. Nonetheless, IHM chose to quit marketing in Hawaii and instead filed an antitrust action against HMA and others. IHM alleged that the communications from HMA and others to their members and to IHM constituted price-fixing and a threatened boycott. IHM characterized every provision that HMA and others expressed concerns about as a price-related term.

The federal district court dismissed the lawsuits and the Ninth Circuit agreed. The Ninth Circuit completely rejected IHM's claims that the conduct was anticompetitive in any way. It cited *U.S. v. Alston*, 974 F. 2d 1206 (9th Cir. 1991), for the proposition that in health insurance, "in light of departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price-fixing) to level the bargaining imbalance and provide meaningful input into the setting of fee schedules."

The outcome was welcomed by the physician community. But HMA incurred substantial legal bills in defending this action over three years and, like any antitrust defendant with limited resources, feared potential financial devastation.

Conclusion

The AMA appreciates the thoughtful response that the DOJ and FTC have given to the recent requests from physician groups to collect certain data. More is needed, however.

We want to impress upon the FTC and the DOJ the importance of encouraging the dissemination of more information among physicians to provide a balance in the current marketplace, especially where physicians face take-it-or-leave-it contracts that impact patient care. Such efforts, when properly structured and monitored, pose no anticompetitive threat and serve an important procompetitive purpose: providing contracting parties with better, more reliable information about market conditions.