American Medical Association
Physicians dedicated to the health of America

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Mr. Donald Clark, Esq.
Office of the Secretary
Federal Trade Commission
600 Pennslyvania Avenue, N.W.
Washington, D.C. 20580

Re: Comments of the American Medical Association to the Consent Agreement and Order Entered In *In Re Alaska Health Network, Inc.,* File No. 991-0103

Dear Mr. Clark:

On September 20, 2000, the Federal Trade Commission (FTC) entered its proposed Consent Agreement and Order (Consent Agreement) in *In re Alaska Healthcare Network, Inc.,* File No. 991-0103. The American Medical Association (AMA) files these Comments in response to the terms of the proposed Consent Agreement.

I. INTRODUCTION

In addition to penalties aimed at AHN's conduct, the Consent Agreement contains penalties intended to restructure AHN. The Consent Agreement permits Alaska Health Network, Inc. (AHN) to, *inter alia*, act as a messenger to qualified financial or clinically integrated "joint arrangements", provided the participating physicians in AHN constitute no more than 30% of physicians in the relevant physician market. AHN may be messenger to "any other arrangement", provided the participating physicians in AHN constitute no more than 50% of the relevant physician market. Further, the proposed decree includes a "grandfathering" provision, which permits AHN to exceed the market share limits set by the FTC, in order to accommodate any single physician, or any one pre-existing practice group.

Two dissenting commissioners note the anomalies created by the structural element of the proposed settlement. In light of the sparse physician population in Fairbanks, the grandfathering provision allows AHN to exceed the 30% and 50% caps set by the Consent Agreement, rendering those caps, and any presumed procompetetive benefits emanating from the caps, meaningless. Conversely, the grandfathering provision may discourage

nascent competition among certain medical specialties in Fairbanks, by allowing potential competitors to AHN to join AHN, instead. In sum, the dissenters contend, while the structural component of the settlement may be appropriate in some areas of the country, the small physician population pools typically found in thinly populated areas like Fairbanks make such schemes impractical for all but urban locations.

The AMA agrees with the dissenting commissioners that a structural settlement should not be used. The AMA believes that the use of a structural settlement is unnecessary, because settlement terms aimed at adjusting conduct can better achieve the FTC's goal of restoring true balance to the marketplace. The AMA also believes that the presumptions underpinning structural settlements demonstrate a misunderstanding of the economic power wielded by physicians in the marketplace. Structural settlements are inappropriate for any physician joint venture that attempts to contract with managed care organizations (MCOs), and particularly inappropriate for joint ventures located in lightly populated communities.

II. THE FTC SHOULD NOT IMPOSE STRUCTURAL REMEDIES ON PHYSICIAN JOINT VENTURES ATTEMPTING TO CONTRACT WITH MANAGED CARE ORGANIZATIONS.

A. Structural Settlements for Physician Joint Ventures Undermine the Aims of the FTC

The AMA finds the structural element of a consent decree, as applied to a physician joint venture that attempts to contract with MCOs, unnecessary and antithetical to the stated goals of restoring balance to the health care market place. In 1996, the FTC issued its Statements of Antitrust Enforcement Policy in Health Care (Statements). The Statements identify conduct by physician joint ventures that the FTC finds violative of antitrust laws. The Statements indicate that, while the government notes the portion of the physician market place held by a physician joint venture, the FTC places greater emphasis on whether, on balance, joint ventures exhibit other anti-competitive behavior:

> "For example, physician network joint ventures in which the physician participants share substantial financial risk, but which involve a higher percentage of physicians in a relevant market than specified in the safety zones, may be lawful if they are not anti-competitive on balance. Likewise, physician network joint ventures that do not involve the sharing of substantial financial risk also may be lawful if the physicians' integration through the joint venture creates significant efficiencies and the venture, on balance, is not anti-competitive."

Further, in a 1998 address, "Antitrust Issues Raised By Rural Healthcare Networks"[1] then-FTC counsel Robert Liebenluft stated that the FTC "focus[es] not on the form that networks

[1] Presented at a meeting of the Network Development Grantees sponsored by the Federal Office of Rural Health Policy, U.S. Dept. of Health and Human Services, Washington, D.C., February 20, 1998.

take, but on their potential for providing real efficiencies in the particular marketing context in which they operate, and on the relationship of any price agreement among competing providers to the production of those efficiencies." In the absence of evidence of market restraint, according to the FTC, the presence of presumptively anti-competitive practices or forms are not *a fortiori* unlawful.

In *In Re AHN*, the FTC has proposed settlement terms directed to AHN's allegedly anti-competitive conduct. Pursuant to the settlement, AHN cannot enter into any agreement with physicians to: negotiate on behalf of any physicians; deal with payors or providers; or restrict the ability of any physician to deal with a payor or provider. The agreement also curtails activity by AHN as a "messenger" between physicians and payors. This behavioral correction goes to the heart of restoring the balance the FTC seeks to return to the market place. By these measures, the FTC will achieve the goal that it has previously stated is of paramount importance to the FTC, namely, achieving pro-competitive harmony in the market. Thus, the additional structural measures imposed on specialist participation in *AHN* are entirely unnecessary.

Additionally, the limit set on the number of physicians allowed to participate in AHN is remarkably similar to the caps on physician participation set forth in the 1996 Statements' "safety zones". While the FTC has cautioned that the safety zones are merely a starting place for antitrust analysis, and that they do not, alone, establish the parameters of competitive conduct, the use of the same numbers in this case belie the FTC's promises of flexibility in its scrutiny of physician joint ventures. Whether it is merely convenient to apply a formula already used as an example by the FTC, or whether the FTC truly intends to use the safety zones as absolute limits of lawful conduct, the fact remains that the FTC, by incorporating these limits into a consent decree, is using supposedly illustrative and voluntary safety zones in a mandatory fashion.

B. Health Plans Pose A Greater Threat to Consumer Choice Than Physician Joint Ventures

The application of a structural element in the AHN proposed settlement also indicates a continuing misapprehension by the FTC of the power physician joint ventures can wield in the marketplace. The focus on physician joint ventures is unwarranted and unfair, when compared to the consolidation of, and resources available to, the managed care entities with which they must contract. As the AMA has previously observed, the federal government has failed to adequately scrutinize the obviously anti-competitive practices embraced by the managed care industry. See, e.g., Testimony in Support of H.R.1304, the Quality Health Care Coalition Act of 1999, presented by E. Ratcliffe Anderson, Jr., M.D., to the House Judiciary Committee, June 22, 1999; American Medical Association Discussion Paper on Aetna/U.S. HealthCare Acquisition of Prudential Health Care, January, 1999. One of these practices is consolidation among managed care providers. Since 1994, the 18 largest health plans in the country have, through mergers and acquisitions, thinned down to just six – Aetna, Cigna, United HealthCare, Foundation Health Systems, Pacificare and Wellpoint

Health Networks. A review of market shares of health plans in 25 states found that the largest five insurers have more than 50% of the covered lives in 23 states, and in 16 of those states, more than 70%.[2]

As a consequence of this unchecked consolidation, physicians and managed care entities do not play on a level field. By allowing these health plans to so thoroughly dominate the market, the FTC robs physicians of real bargaining power with the health plans. Consequently, physicians are subjected to "take it or leave it" contracts that dictate reimbursement and coverage terms to the physicians. These same contracts frequently contain non-negotiable "gag" and all product clauses, and fee schedules subject to unilateral change by the health plan. These contracts are the product of coercion, not genuine bargaining. They unreasonably constrict the physicians' choices and, inevitably, threaten the quality of patient care and the physicians' livelihood.

Similarly, the vast majority of physician groups lack the resources, expertise and legal sophistication to negotiate effectively with MCOs and other health plans. A mere 200 of the group practices nationwide exceed 100 doctors. As noted by Professor Clark Havighurst of the Duke University School of Law, most physicians in solo or small group practices face "severe practical difficulties... in marketing their services to numerous large buyers." Havighurst, *Are the Antitrust Agencies Overregulating Physician Networks?* at 5 (Draft Paper, forwarded to FTC, November 16, 1995). Thus, in part because of the current antitrust laws, these entities have little power compared to the monolithic health plans:

> "[T]here are many markets in which doctors can no longer reasonably hope to forestall unwanted developments by banding together. Too many large purchasers...now have the incentives, the tools, the bargaining power, and the independence they need to prevent doctors from exercising market power. Selective contracting and discounting of physician fees in return for assured patient load are now common practices. In addition, integrated health care systems, combining in various ways the functions of financing and delivery, are being constructed by many players and are now significant factors in most local markets. Although there remain some places where the doctors' old strategies may still be capable of heading off unwanted change, the market forces that have been unleashed in most communities cannot easily be reversed by counter-revolutionary professional action. In most circumstances, antitrust enforcers should no longer presume that physician collaboration that is not certifiably innocuous is intended to restrain trade rather than to achieve efficiencies or to offer purchasers a fuller range of health care options. Suspicions that were well justified when physicians possessed the means of controlling their economic environment are not generally justified today." *Id.*

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[2] MCO consolidation in Alaska is even worse. According to ASMA, "[t]he dominant participants in the [Alaska] market are Aetna and Premera Blue Cross represent well over 50% of the entire Alaska health plan market."

Physicians also generally lack the ability to participate in development of MCOs or other health plans that could compete with the highly consolidated commercial managed care players. High barriers to entry include, for example, the fact that states often require HMOs to demonstrate a net worth of one to two million dollars and to deposit with the state cash or securities amounting to several hundred thousand dollars.

Despite the obstacles to meaningful physician bargaining power in the market place, the FTC has left health plans virtually untouched, while aggressively targeting physician groups for alleged antitrust violations. An insistence on enforcing a structural settlement, where the parties have already agreed to correct the supposedly unlawful conduct, would be one more example of this misplaced enforcement attention.

III. STRUCTURAL SETTLEMENTS ARE INAPPROPRIATE FOR THE SMALL TOWN AND RURAL MARKETPLACE

Even if the FTC concludes that structural settlements serve, as a general proposition, a valuable purpose in the enforcement of antitrust laws against physician joint ventures, such structural settlements should not be employed in sparsely populated areas. The enforcement of a structural settlement in Fairbanks is contrary to opinions previously expressed by the FTC about appropriate responses to anti-competitive behavior in rural areas. It is also a method that the FTC has not used in locations with similar demographics.

A. Structural Settlements Are Contrary To The FTC's Goals For A Market With A Small Population

In his speech "Antitrust Issues Raised by Rural Healthcare Networks", Mr. Liebenluft expressed concern about the "participation of a substantial proportion of providers in a network:"

> "One [concern] is that the joining together of most or all providers in a market, as a practical matter, may make formation of other networks unlikely, in a situation where operation of competing networks might be feasible and beneficial to consumers. This can occur because cooperation of competitors in even a legitimate joint undertaking may dull the incentives of the participants to continue to compete vigorously with one another outside the joint venture. Another concern flows from the possibility that the venture may result in the exchange of competitively sensitive information that facilitates implicit collusion among the participants to limit competition outside the venture. The higher the proportion of available competitors represented in the joint venture, the greater is the potential impact of these effects on the market as a whole."

The FTC's decision in this case seems squarely at odds with the concerns expressed in the preceding paragraph. As noted by the dissenting commissioners, the grandfathering provision of the structural element would allow the vast majority of physicians in certain specialties to join a single joint venture. In the words of the FTC, the grandfathering provision will inhibit the growth of other networks, or facilitate collusion among network participants. This result, in turn, will inhibit the growth of potential competitors, and thereby jeopardize the goals sought to be achieved by the conduct-altering settlement terms.

Even in the absence of the grandfathering option, the cap on physician participation is ill-conceived. As explained in the prior section of these Comments, the structural element is a superfluous addition to the conduct-oriented terms of the Consent Agreement. Additionally, the comments submitted by the Alaska State Medical Society (ASMA) on October 17, 2000, demonstrate that a structural settlement will do more than just encourage a non-competitive health care environment. The structural element could exact a personal toll on physicians and patients in the Fairbanks area. As ASMA explains, the number of physicians practicing in Alaska is comparatively low. Thus, any impediments to practice that discourage needed specialists from relocating to Alaska can quickly lead to burn-out of physicians already in the state. Poorly performing physicians can, in turn, pose a danger to the public health.

B. Prior FTC Settlements In Rural And Small Markets Did Not Employ Structural Settlements

Further, the majority's assurances that structural settlements have been employed before are unpersuasive. The two prior consent agreements on which the majority relies are readily distinguishable from the present facts. In *In re Home Oxygen & Medical Equipment Co.*, 118 F.T.C. 661 (1995), 60% of the pulmonologists in Alameda County, California, owned an interest in Home Oxygen and Medical Equipment Company (Home Oxygen), a company that supplied oxygen delivery systems to patients in need of supplemental oxygen. Alameda County includes the City of Oakland, California. The FTC alleged that Home Oxygen created a barrier to entry in the market and inhibited free and open competition. In pertinent part, the consent agreement in *Home Oxygen* decision prescribed a 10 year prohibition on granting or acquiring an ownership interest in any entity that sold, leased or treated oxygen delivery systems, if more than 25% of the pulmonologists in the relevant area were affiliated with the entity.

In the present matter, the relevant market is a town of 30,000, with a "metropolitan" region of only 80,000. The nearest city of any notable size is over 300 miles away. Further, as the FTC admits, of the few physicians practicing in the market, not all are year-round residents. Presumably, therefore, at certain times of the year, the physician population is even smaller than the numbers described in the Consent Agreement. Thus, the structural element of the proposed settlement in this case will have a much greater impact on the relevant provider population in Fairbanks than in a large urban market like Oakland, California. Indeed, one

of the dissenters to the *Home Oxygen* remarked that an urban population dilutes a market share that might otherwise raise a suspicion of anti-competitive conduct.

> "Assuming *arguendo* that the alleged product and geographic markets are relevant antitrust markets, these market shares alone do not justify an inference of market power. In addition to the respondents, the evidence indicates that there are nine competing sellers of home oxygen in Alameda County and eight competing sellers in Contra Costa County. Some of these firms have market shares of about 10%."

In *Physicians Group, Inc.*, 120 F.T.C. 567 (1995), the FTC ordered dissolution of an IPA located in Pittsylvania County and Danville, Virginia, for alleged conspiracy to prevent or delay the entry of third party payors into the area. Assuming that the affected market included a relatively small population (and the order gives no indication that it did), the FTC neglected to describe the market share allegedly held by the IPA, and how many physicians in the area were not affiliated with the IPA. Therefore, any comparison with the structural settlement imposed in this case is meaningless, since comparable data is unavailable for the *Physicians' Group* case.

The scenario existing in Fairbanks is more like the fact patterns in *In re Mesa County Physicians Independent Practice Association, Inc.*, 1999 F.T.C. Lexis 67 (May 20, 1999) and *In re Montana Associated Physicians, Inc.*, 123 F.T.C. 62 (1997). Both cases emanated from rural areas and involved IPAs that, like AHN, employed a "messenger" model. Nonetheless, the FTC did not cite either decision in its analysis of the Consent Agreement.

In *Mesa County*, the Mesa County IPA served the city of Grand Junction, Colorado (population 37,600). The IPA's physicians constituted 85% of the physicians in Mesa County, including 90% of the primary care physicians. The FTC charged that Mesa County IPA contracted with Rocky Mountain HMO but discouraged its physicians from contracting with other third party payors, or encouraged them to do so only on terms approved by Mesa County IPA. As a result of Mesa County IPA's conduct, a large number of third party payors were allegedly excluded from doing business in Mesa County.

The consent decree subsequently entered against Mesa County IPA ordered penalties directed to the IPA's conduct that were similar to conduct–oriented penalties proposed in this case. For example, Mesa County IPA could not negotiate on behalf of any participating physicians with any payor or provider, nor could Mesa County IPA deal or refuse to deal with any payor or provider or determine any terms upon which providers and payors could deal with each other. However, the *Mesa County* consent decree contained no structural elements. Apparently, the FTC believed that it could restore equanimity to the health care market in Mesa County by correcting anti-competitive conduct alone without adding a layer of structural sanctions. See also *In re Montana Associated Physicians, Inc.*, 123 F.T.C. 62 (1997)(IPA comprised of 43% of all Billings physicians, and 80% of all physicians not part of a specialty practice or employed by a hospital. IPA was punished for

alleged anti-competitive conduct with third party payors, but no structural penalties were imposed by the FTC).

Adequate Oversight of the Proposed Settlement May Be Achieved Without a Structural Settlement

Finally, the majority contends that the structural element of the consent decree is necessary to avoid "detailed oversight" by the Commission. The FTC's contention lacks merit. The Consent Agreement already incorporates stringent oversight by the FTC, in the form of frequent and detailed reporting requirements for AHN to prove that it is in compliance with the Agreement. AHN must, for instance, file reports every 60 days, for five years, identifying payors contacted by AHN, demonstrating shared financial risk by participating physicians, and providing minutes of annual meetings. AHN must also, for a period of 10 years, notify the FTC of actions furthering qualified joint risk sharing arrangements between physicians and any other arrangement involving third party payors and AHN acting as agent for two or more Fairbanks physicians.

IV. CONCLUSION

The AMA urges the FTC to reconsider the terms of the proposed Consent Agreement. The attempt to restructure AHN according to arbitrary market shares is unnecessary at best and, at worst, will so constrict the Fairbanks physician population as to undermine the aims intended by the sanctions.

Sincerely,

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