



# Federal Trade Commission

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## **“Clinical Integration in Antitrust: Prospects for the Future”**

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**American Health Lawyers Association, ABA Antitrust Section  
and ABA Health Law Section’s  
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My remarks today will concern the antitrust issues that arise when competing physicians get together and collectively bargain with health care payors over their fees. I’m sure you know that this type of conduct by physicians can amount to price fixing, or something very close to it, and has been held to be *per se* unlawful by the Supreme Court in *Arizona v. Maricopa County Med. Soc’y*.<sup>2</sup>

This type of conduct has also been a longstanding problem for antitrust enforcers. For several decades the Federal Trade Commission has taken enforcement action against physicians who engage in conduct tantamount to price fixing or a group boycott. The Commission has entered into a number of consent agreements with physician IPAs that enjoin price fixing.<sup>3</sup>

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<sup>1</sup> The views stated here are my own and do not necessarily reflect the views of the Commission or other Commissioners. I would like to express my appreciation to my attorney advisor, Holly Vedova, for her invaluable contributions to these remarks.

<sup>2</sup> 457 U.S. 332 (1982).

<sup>3</sup> See, e.g., *In the Matter of San Juan IPA, Inc.*, Docket No. C-4142 (consent order issued June 30, 2005), <<http://www.ftc.gov/opa/2005/07/fyi0548.htm>>; *In the Matter of White*

Some of these consent agreements include orders of dissolution.<sup>4</sup> Additionally, the Commission has a litigated case currently on appeal before the 5<sup>th</sup> Circuit, the *North Texas Specialty Physicians* case.<sup>5</sup>

I focus on this area today because I am concerned that, notwithstanding all of these enforcement efforts, the message we have been trying to send does not appear to be getting through. Physicians still engage in conduct that we consider to be illegal. To deter this type of conduct it may be necessary for the enforcement agencies to undertake stricter remedies, such as disgorgement, than they have in the past.<sup>6</sup> In the meantime, I'd like to provide some background

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*Sands Health Care System, L.L.C.*, Docket No. C-4130 (consent order issued Jan. 11, 2005), <<http://www.ftc.gov/opa/2005/01/fyi0504.htm>>; *In the Matter of Piedmont Health Alliance, Inc.*, Docket No. 9314 (consent order issued Oct. 1, 2004), <<http://www.ftc.gov/opa/2004/10/fyi0457.htm>>; *In the Matter of Southeastern New Mexico Physicians IPA, Inc.*, Docket No. C-4113 (consent order issued Aug. 5, 2004), <<http://www.ftc.gov/opa/2004/08/fyi0445.htm>>; *In the Matter of California Pacific Medical Group, Inc.*, Docket No. 9306 (consent order issued May 10, 2004), <<http://www.ftc.gov/opa/2004/05/fyi0431.htm>>; *In the Matter of Carlsbad Physician Association, Inc.*, Docket No. C-4081 (consent order issued June 20, 2003), <<http://www.ftc.gov/opa/2003/06/fyi0339.shtm>>.

<sup>4</sup> See, e.g., *In the Matter of New Millennium Orthopaedics, LLC*, Docket No. C-4140 (consent order issued June 13, 2005), <<http://www.ftc.gov/opa/2005/06/fyi0543.htm>>.

<sup>5</sup> *In the Matter of North Texas Specialty Physicians*, Docket No. 9213, Commission Opinion issued Nov. 29, 2005, <<http://www.ftc.gov/opa/2005/12/ntsp.shtm>>.

<sup>6</sup> There has been one instance where the Commission obtained restitution in a matter involving a physician boycott. *In the Matter of College of Physicians-Surgeons of Puerto Rico*, FTC File No. 9710011, Civil No. 97-2466-HL (D. Puerto Rico, October 2, 1997), <<http://www.ftc.gov/os/caselist/9710011.htm>>. The Commission and the Commonwealth of Puerto Rico filed a final order, stipulated permanent injunction, and complaint in the U.S. District Court in Puerto Rico against the College of Physician-Surgeons of Puerto Rico (comprised of 8,000 physicians in Puerto Rico), and three physician independent practice associations. The complaint charged that the defendants attempted to coerce the Puerto Rican government into recognizing the College as the exclusive bargaining agent for all physicians in Puerto Rico through cessation of all non-emergency physician services. Among other things, the order called for the College to pay \$300,000 to the catastrophic fund administered by the Puerto

on how the agencies' analysis of this type of conduct has evolved over the last 10-15 years and to share with you my own personal view about what may be in the offing.

Before the mid-1990s, antitrust guidance respecting the legality of physician joint bargaining ventures was twofold. To begin with, if the members of a physician group constituted such a large percentage of the physician population in a locality that the group had market power, the group's negotiation of fees for its members was suspect under the antitrust laws, regardless of whether the physicians were integrated in any fashion. I will call this the "market power concern."

Conversely, regardless of whether the physician group had market power, if its competing members were not financially integrated, the group's negotiation of fees for its members was viewed as nothing more than *per se* unlawful price fixing. Financial integration (including capitation programs, or significant withholding of reimbursement) was the only clearly recognized way a group of competing physicians could get together and jointly negotiate fees with payors without facing *per se* illegality. I will call this the "price fixing" concern.

These two concerns are reflected in a host of FTC and DOJ Staff Advisory Opinion letters. My remarks today will consider only the second or "price fixing" concern. In other words, they will assume that there is no "market power" concern – that the competing physicians on whose behalf fees are being jointly negotiated do not constitute such a large percentage of the physicians in the market that they can exercise market power.<sup>7</sup>

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Rico Department of Health.

<sup>7</sup> Often times when physicians jointly negotiate they have market power – but it doesn't matter if the conduct amounts to *per se* unlawful price fixing. FTC enforcement actions focus on cases where there is consumer harm.

There has been some blurring of the lines between what is considered *per se* unlawful price fixing by competing physicians and something closer to a rule of reason analysis. This is due to the fact that sometimes when physicians jointly negotiate fees, there may be some form of integration, and the antitrust inquiry must determine whether the integration is likely to achieve significant efficiencies before determining the legality of the joint negotiation of fees. If there is no efficiency-enhancing integration, the conduct can be summarily condemned as unlawful price fixing. If there is an efficiency-enhancing integration, and the joint negotiation of fees is reasonably necessary to achieve the efficiencies, the conduct is evaluated under a rule of reason analysis.

The Commission's 2005 *North Texas Specialty Physicians* opinion dealt with issues of integration. Although the Commission concluded that NTSP's conduct was similar to conduct that had been summarily condemned as *per se* unlawful in the past, it utilized the more flexible analytical framework in its *Polygram* opinion,<sup>8</sup> and considered each of Respondent's defenses in depth before condemning the conduct.

The agencies should initially examine any claims of legitimate integration when they investigate joint negotiation of fees by competing physicians. But if, as in *North Texas Specialty Physicians*, it turns out that there is no efficiency-enhancing integration among members of the bargaining group or the joint negotiation of fees is not reasonably necessary to achieve the efficiencies, the conduct can be summarily condemned as unlawful price fixing under *Polygram*.

In the 1994 version of the agencies' Statements of Antitrust Enforcement Policy in

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<sup>8</sup> *Polygram Holding, Inc.*, 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003), available at <<http://www.ftc.gov/os/2003/07/polygramopinion.pdf>>, *aff'd*, *Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005) [hereinafter *Polygram*].

Health Care<sup>9</sup> there were two clearly recognized ways for groups (and their member physicians) to avoid price fixing concerns. The first was to employ a pure “messenger model” pursuant to which the entity representing the physicians avoids a horizontal agreement on price by simply acting as a “messenger” shuttling back and forth between individual physicians and payors with the fee proposals of each. The second was by *financial* integration of the individual physicians.<sup>10</sup>

Statement 8 describes examples of what can satisfy the requirements of financial integration for purposes of the Statements (I’ll use Statement 8 from the current version of the Health Care Statements):

- (1) an agreement by the physician group to provide services to a health plan at a “capitated” rate;
- (2) an agreement by the group to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;
- (3) use by the group of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:
  - (a) withholding from all physician participants in the group a substantial amount of the

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<sup>9</sup> U.S. Dep’t of Justice & Fed. Trade Comm’n, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, *reprinted in* 4 Trade Reg. Rep. (CCH) ¶13,152 (Sept. 27, 1994), Statements 8 and 9 [hereinafter 1994 Statements]. (The first version of the Statements were released in 1993.)

<sup>10</sup> The 1994 Statements also identified a third way to avoid price fixing concerns, through development of a new product that produces substantial efficiencies. 1994 Statements at 71.

compensation due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost-containment goals of the group as a whole; or

(b) establishment of overall cost or utilization targets for the group as a whole, with the group's physician participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and

- (4) agreement by the group to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary substantially due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors.

Statement 8 explains that the safety zones are limited to financial integration because the risk sharing that occurs in financial integration provides strong incentives for the physicians involved to cooperate in controlling costs and improving quality by managing the provision of services by group physicians. Put differently, financial integration incentivizes efficiencies.

When the 1994 Statements were released, the agencies were criticized for limiting the type of integration in the safety zone to financial integration. There was a perception that the agencies would only consider financial risk sharing as a means of integration worthy of saving a physician group (and the member physicians) from *per se* illegality. Physician groups felt that this would constrain their ability to initiate innovative new methods of patient care that would

enhance the quality of their medical services.

Rapid changes occurring in the industry reinforced the perceived need by physicians to develop innovative methods of care. Managed care companies (MCOs) were becoming increasingly powerful as health care payors, and this changed the balance between health care providers (physicians) and payors (insurers). In an attempt to provide further guidance to the industry based on the collective experience of the agencies, the Statements were revised and expanded in 1996.<sup>11</sup>

A new expanded Statement 8 discussed a different type of integration, one that falls outside the “financial integration” safety zone contained in the 1994 Statements, but also protects against *per se* illegality. More specifically, in an effort to more closely conform the statement to general joint venture law principles, the agencies identified the concept of *clinical* integration to the 1996 Statements as an additional means for physician groups to avoid antitrust liability for joint negotiation of fees.

New Statement 8 explains that where physician integration through the group is likely to produce significant efficiencies, agreements on price reasonably necessary to accomplish the venture’s efficiencies will be analyzed under the rule of reason. Key to the concept is that the integration involve an “active and ongoing program to evaluate and modify practice patterns by the group’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.”<sup>12</sup> Revised Statement 8 says that this

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<sup>11</sup> U.S. Dep’t of Justice & Fed. Trade Comm’n, Statements of Antitrust Enforcement Policy in Health Care (1996), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,153 (Sept. 5, 1996) [hereinafter 1996 Statements].

<sup>12</sup> 1996 Statements at 26.

effort may be evidenced by:

- establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care;
- selectively choosing group physicians who are likely to further these efficiency objectives; and
- the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

Statement 8 makes clear that these are not the only types of arrangements that can create sufficient integration to warrant rule of reason analysis. But critical to any qualifying clinical integration arrangement by a physician group is that agreements on price must be reasonably necessary to the group's achievement of efficiencies.

The underlying justification for clinical integration as described in Statement 8 is the same as that for financial integration: the potential for efficiencies. However, financial integration achieves efficiencies through direct monetary incentives with a system of monetary rewards and punishments providing a strong incentive for efficient integration. Unlike financial integration, clinical integration achieves efficiencies through organized, cooperative activity among the physicians; there is no strong financial incentive that, on its face, is likely to directly encourage achieving efficiencies.

Commission staff have attempted to provide guidance in specific situations about how proposed programs purporting to involve clinical integration are analyzed under the antitrust laws. Two advisory opinion letters issued by Commission staff consider the issue – the 2002



*MedSouth* letter,<sup>13</sup> and the 2006 *Suburban Health Organization* letter.<sup>14</sup> The *MedSouth* letter was the first time that a staff advisory letter addressed a physician group with no (or trivial) financial risk sharing, relying instead on clinical integration. The proposal involved a multi-specialty physician practice association that included competing primary care and specialist physicians practicing in Denver. Commission staff advised that they did not intend to recommend a challenge to the organization's proposed clinical integration program.

The *MedSouth* clinical integration program was designed to promote the coordinated delivery of services by primary care and specialist physicians, to improve quality and reduce cost both in the treatment of individual patients and in the overall modification of practice patterns. It consisted of two major parts. First, the *MedSouth* physicians would use an electronic clinical data record system that would permit them to access and share with one another certain kinds of clinical information relating to patients. Second, the organization would adopt and implement clinical practice guidelines and measurable performance goals relating to the quality and appropriate services provided by *MedSouth* physicians. *MedSouth* would collect and analyze information on individual physicians' performance and on the performance of the group as a whole relative to the benchmarks, and *most importantly in my view*, *MedSouth* would discipline or terminate physicians who did not fully participate in the program and adhere to its standards. *MedSouth* would also operate as a nonexclusive group, meaning its physicians would be

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<sup>13</sup> Advisory Opinion Letter from Jeffrey W. Brennan, Esq., FTC, to John J. Miles, Esq., Ober, Kaler, Grimes and Shriver 4 (Feb. 19, 2002), <<http://www.ftc.gov/bc/adops/medsouth.htm>> [hereinafter *MedSouth*].

<sup>14</sup> Advisory Opinion Letter from David R. Pender, Esq., FTC, to Clifton E. Johnson, Esq., Hall, Render, Killian, Heath & Lyman (Mar. 28, 2006), <<http://www.ftc.gov/opa/2006/03/shor31.shtm>> [hereinafter *Suburban Health Organization*].

available individually to negotiate and contract with customers not wishing to purchase the group's services.

Commission staff concluded that, considered as a whole, MedSouth's program "appears to involve partial integration among MedSouth physicians that has the potential to increase the quality and reduce the cost of medical care that the physicians provide to patients."<sup>15</sup>

Commission staff concluded that the collective negotiation of payor contracts appeared to be reasonably related to the physicians' integration through the group and reasonably necessary to the accomplishment of the group's objectives. This conclusion was based on two rationales. First, staff concluded that "doctors need to be able to rely on the participation of other members of the group in the network and its activities on a continuing basis,"<sup>16</sup> and joint contracting assures this. Second, staff found that the joint contracting would assure a more equitable distribution of returns among the physician members. Commission staff also noted that they would closely monitor the group's activities.

In June of this year Commission Staff issued a follow-up letter to MedSouth, making good on their promise to closely monitor the group's activities.<sup>17</sup> Staff reviewed updated information provided by MedSouth concerning various aspects of its operation, and found no reason to rescind or modify the earlier opinion. The letter states that MedSouth has continued efforts to integrate, and that MedSouth believes that its efforts have had success in achieving efficiencies. The letter also states that nothing reported by MedSouth suggests that it has

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<sup>15</sup> *MedSouth* at 1.

<sup>16</sup> *Id.* at 5.

<sup>17</sup> Letter from Markus H. Meier, Esq., FTC, to John J. Miles, Esq., Ober, Kaler, Grimes & Shriver (June 18, 2007), <<http://www.ftc.gov/bc/adops/070618medsouth.pdf>>.

exercised or increased its market power.

The letter gives some additional insights on clinical integration, stating:

Successfully achieving clinical integration in a physician network requires the establishment and operation of active and ongoing processes and mechanisms to facilitate, encourage, and assure the necessary cooperative interaction. It may necessitate selectively restricting participation in the network, both initially and as the program continues, including even expelling persistently uncooperative members. It may require significant investment in the venture by the physician participants, either monetary or in terms of human capital (*i.e.*, investing time and effort by committing to active participation in the mechanisms and processes by which the network hopes to achieve its efficiencies), in order to assure that all participants are committed to working together to achieve the venture's goals. It also requires having the capability to collect and evaluate information relating to practice performance, in order to determine whether the integration is effective and achieving the network's goals, and to identify where changes need to be made to improve individual and collective performance. Finally, there must be an appreciation by employers, patients, and payers of the potential benefits of such programs, and the willingness to contract for what the programs offer. . . . The test of that integration is what the participants, through the network, actually do – *i.e.*, how they use those tools to create cooperation and interdependence in their provision of medical care, thereby facilitating their efforts to jointly reduce unnecessary costs, improve quality of care, and otherwise increase their efficiency in the provision of medical care.<sup>18</sup>

Two points about the followup letter to MedSouth bear special mention. First, the letter highlights the fact that MedSouth has lost 32.5 percent of its physicians since the issuance of staff's 2002 letter. MedSouth stated to staff that it expected to have a decrease, and did not intend to add physicians to its network, though it acknowledges that it is smaller in size than what was initially anticipated. The letter states that:

The reduced number of physicians participating in the program since MedSouth's inception may well be indicative that a program of clinical integration requires very serious commitment and effort by physicians to engage in the activities that are necessary to achieve the beneficial objectives of such a program, as well as physicians' weighing of the economic costs and benefits of participating in such a program. This may be instructive for other provider networks, particularly ones involving large numbers of physicians, regarding the practical realities and potential difficulties inherent in

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<sup>18</sup> *Id.* at 3.

coordinating and clinically integrating the care provided to numerous enrollees through a network comprising many independent physicians.<sup>19</sup>

Second, the letter notes that MedSouth reported that many payors are not interested in contracting with MedSouth for its programs.

In *Suburban Health Organization*, issued last year, Commission staff concluded that the proposal involved some potentially beneficial integration among the participants, but that the reasons given for collective bargaining did not justify that elimination of competition. Under that proposal, Suburban Health Organization would be the exclusive bargaining and contracting agent with most insurers for 192 primary care physicians employed at Suburban Health Organization's eight member hospitals which surround Indianapolis, Indiana. Suburban Health Organization hospitals would deal only through Suburban Health Organization at prices set by the group when selling their employed physician's services to insurers. The proposed program eliminated price competition that would otherwise exist among the hospitals for the employed physician's services. The collective bargaining did not involve other services sold by the Suburban Health Organization member hospitals, such as hospital inpatient services, or the services of any specialist physicians, who were not employed by the hospitals, or participants in Suburban Health's program.

Suburban Health Organization's purported clinical integration involved joint development of practice protocols and disease-specific treatment parameters regarding a limited set of medical conditions; centralized collection and use of data to monitor physician behavior and outcomes with respect to the treatment protocols and parameters; jointly produced

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<sup>19</sup> *Id.* at 8.

educational materials for the participating physicians; and a commitment by the Suburban Health Organization hospitals to have their physicians abide by the program requirements, reinforced by a bonus pool to reward financially desirable behavior and results.

The staff advisory opinion letter concluded that Suburban Health Organization's program involved some integration that had some potential to improve care and create efficiencies in the delivery of physician services, but that the program's limited nature and scope diminished significantly its potential benefits. Because it only involved the Suburban Health Organization hospitals' *employed* primary care physicians, it would not apply to the full range of medical services that a patient might need. So anyone referred to a specialist physician would lose the benefits of the program. And most of the program's integration and efficiencies were informational in character – relating to developing and disseminating information, and collecting data regarding performance. They did not involve integration or interdependence among the participating physicians in *actually providing* their medical services. The letter concluded that the price agreement in Suburban Health Organization's proposal was not reasonably necessary to achieve any of the potential efficiencies or consumer benefits.

The main lessons respecting clinical integration that I take from *MedSouth* and *Suburban Health Organization* are as follows:

- The legitimacy of a clinical integration program, or the bona fides of its participants, do not alone determine the legality of the program's competitive restraints. Even if there is integration that is likely to create efficiencies, the analysis still must consider whether the proposed competitive restraint is *reasonably necessary* to create the integration and achieve the efficiencies. Without such an integral connection between an ancillary

restraint and the achievement of the venture's efficiencies, the restraint is viewed as unnecessarily eliminating competition, and therefore as not permitted by the antitrust laws.

- Where multiple groups are involved, there must be an explanation why it is not reasonably practicable for each group to achieve the efficiencies on its own. In Suburban Health Organization's case, it did not show why the individual hospital members on their own could not develop educational materials, adopt practice protocols for its employed physicians, monitor compliance with those standards, and encourage participation. (Indeed, some or all of them were arguably already trying to do this.)
- The group itself must include a mechanism for dealing with compliance and cooperation with the program requirements – it cannot just rely on the individual members themselves (or in Suburban Health Organization's case – its hospital members) to motivate and discipline the participants.
- There must be a detailed explanation how the participating physicians will or can work collaboratively to attain the program's goals. It is not acceptable merely to have development of quality management programs, outcomes measurement, and professional peer review, with little interaction occurring between or among the participating physicians. The integration cannot just be “informational” in this respect.
- It is acceptable for a group to determine the prices to be charged for one or more of the educational, monitoring, data collection, and other potentially efficiency-enhancing services – the “products” that the group is actually creating via the integration. This is different from jointly setting *the physician fees* and involves little or no antitrust concern.

- If the group already employs a legal and effective “messenger model” (as Suburban Health Organization did), and is providing the same programs to improve services as it proposes to offer under its clinical integration program, that undercuts the arguments as to the necessity for joint negotiation of fees.
- If a group enhances the attractiveness to patients and payors of the physician’s medical services, and arguably even improves the quality and efficiency of the services, *but does not otherwise fundamentally alter the nature of the services to patients or to payors*, there is not a “new product” that would justify the collaboration of competitors on pricing of the physician fees, as was the case in *Broadcast Music, Inc. v. Columbia Broadcast. Sys., Inc.*<sup>20</sup> It is still the same product that competing physicians offered – it may be somewhat better, but it is not a “new” product. (The *Maricopa* opinion makes this distinction.)
- If the group does not allow its participants individually to sell their services outside the group (as was the case with Suburban Health Organization),<sup>21</sup> that may further undercut any argument that there is a “new” product akin to *Broadcast Music*. There, the blanket license offered by the group of musicians was an efficient joint sale arrangement that added a new alternative, otherwise unavailable in the market. That alternative was in addition to what previously existed, and continued to exist in the market. Thus, the arrangement increased total output, without reducing either price competition or output in

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<sup>20</sup> 441 U.S. 1 (1979).

<sup>21</sup> In *Suburban Health Organization*, the proposal largely eliminated the members as individual competitors outside the group; with certain limited exceptions, they weren’t allowed to sell their employed physicians’ services separately outside the group.

the market outside the group. But non-exclusivity does not itself establish that a group has created a new product. It just avoids an output reducing elimination of competition among the group's participants.

- In a situation involving “employees” of a hospital – such as the physician employees of the Suburban Health Organization hospitals, they can already be expected to be responsive to their employers’ quality and other practice related requirements. The argument that the clinical integration is necessary to align their incentives with those of their employer is not a powerful one in those circumstances.
- Virtually all joint ventures may have to address problems relating to inequitable sharing of costs and benefits by members. Most of them are able to address this problem without resorting to horizontal price fixing. Thus, it is not enough for a group to assert that collective bargaining is necessary because of this problem. That said, in *MedSouth*, staff did credit this concern as one reason for considering collective bargaining on fees to be “reasonably necessary” to achieving the potential efficiencies.
- In any attempt at integration, the views of MCOs are important. Quite apart from antitrust considerations, MCOs are the buyers of the product that any physician group attempts to put together, and if MCOs do not think it is valuable or needed, then the product is not likely to be accepted in the marketplace. Thus, anytime a group of competitors attempts to provide a new service that involves joint negotiation of prices, vetting by customers may be a prudent business strategy. Customers are the ones who can best tell whether the product is indeed one that is likely to achieve efficiencies and that they would be willing to pay for in the marketplace.



-- Physicians should not underestimate the difficulty of establishing an effective clinical integration program. This stems from the time, expense, and commitment required, as well as difficulty in attracting customers willing to purchase the program.

As is evident from the foregoing legal analysis, meeting the clinical integration requirement spelled out in Statement 8 has turned out to be an extremely difficult and expensive task for physician groups, notwithstanding the efforts by Commission staff to provide guidance in the *MedSouth* and *Suburban Health Organization* advisory opinion letters. I think part of the reason why clinical integration that passes muster is so hard is because the incentives for physicians to create efficiencies with clinical integration are not nearly as obvious or direct as the incentives with financial integration. Those incentives are what makes financial integration work. If a clinical integration program includes a very strong system of rewards and punishment, I personally think it could be successful. Part of the reason Commission staff rejected Suburban Health Organization's proposed clinical integration proposal was because the compliance mechanism was implemented by each participant hospital individually – not jointly through Suburban Health Organization. Since there was no integration in this regard, there was no need for joint negotiations to implement it.

But I think it is extremely difficult for a physician group to create a strong enough system of rewards and punishment to create the proper incentives for successful clinical integration. Indeed, physician groups appear not to have made significant progress in fashioning clinical integration programs that meet the “reasonable necessity” requirement. MedSouth is one of a handful of physician joint ventures currently in operation, and of which we are aware, that has

made progress in this regard.<sup>22</sup> Staff's recent followup letter to MedSouth highlights some of the difficulties in establishing clinical integration, and from it I take that even though MedSouth may be successful in achieving clinical integration, it doesn't appear that it has been so successful in the marketplace.

As a result, my main message to you today is that I think the safest and most realistic form of integration that a physician joint venture can undertake is meaningful *financial* integration.<sup>23</sup> I am not proposing that the Agencies revoke Statement 8 of the 1996 Statements. I am still open to innovative efforts by physician joint ventures to integration. But I was on the other side of the fence when the Agencies introduced the concept of clinical integration in the 1996 Statements, and I viewed it as an enormous loophole. I think the agencies have acted

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<sup>22</sup> We are aware of several additional networks that are exploring or developing clinical integration programs (both through requests for advice, and also Commission order compliance notification provisions). For example, Advocate Health Partners in Chicago and Brown & Toland in San Francisco have developed clinical integration programs after the Commission took enforcement action against those IPA for price fixing. *In the Matter of Advocate Health Partners, et al.*, File No. 031 0021 (Consent Order, Dec. 2006); *In the Matter of California Pacific Medical Group, Inc.*, Docket No. D-9306, letter from Dan Ducore, FTC, to Richard Feinstein, Esq., Boies, Schiller & Flexner LLP, dated April 5, 2005, <<http://www.ftc.gov/os/adjpro/d9306/050405cpbresponsetbnotice.pdf>>. While not specifically addressing their clinical integration programs, Commission staff did not recommend enforcement action against either of these new clinical integration programs, and it is possible these programs are having some success.

<sup>23</sup> Even with financial integration, the integration must be sufficient enough that the proper incentives are created. Some attempts at financial integration have been found by Commission staff to be insufficient, while others have passed muster. *Compare* Advisory Opinion Letter from Mark J. Horoschak, Esq., FTC, to Paul W. McVay, President, ACMG, Inc., dated July 5, 1994, <<http://www.ftc.gov/bc/adops/007.shtm>>, *with* Advisory Opinion Letter from Mark J. Horoschak, Esq., FTC, to George Q. Evans, Esq., Wise Carter Child & Caraway, dated July 5, 1994, <<http://www.ftc.gov/bc/adops/006.shtm>>; *see also* Advisory Opinion Letter from Richard A. Feinstein, Esq., FTC, to Paul E. Levenson, The Rufus Choate House, dated July 27, 2000, at n.7, <<http://www.ftc.gov/bc/adops/neletfi5.shtm>>.

properly in trying to insure that that is not what it is.

## **Conclusion**

Let me conclude by emphasizing that my thinking about this entire subject is evolving. There are several reasons for this. First, as guardians of competition and members of an antitrust law enforcement agency, I am convinced that we must be concerned any time that competitors, including providers of health care, join together to jointly set their rates. Second, I am also convinced that that can be justified when it is reasonably necessary for the competitors to provide a new service or product, as was the case in *Broadcast Music*, or otherwise to achieve significant efficiencies. And I am convinced that there must be significant incentives in order to achieve those results.

However, I am uncertain about three related things. The first is what can or should be considered "significant efficiencies" in the health care industry. This is a peculiar industry on the demand side of the equation. There are three different sets of stakeholders here – the payors, the employers with whom they contract, and ultimately the consumers to whom the services are provided. I am inclined to think that the demand by payors and employers is what economists call "derived demand," meaning that their interests ultimately reflect the demands of the consumers, but I am not certain about that.

Second, assuming that it is derived demand, what do consumers really want in today's world? Generally, consumers want the lowest possible prices, and that may be true to some extent in a world in which substantial co-payments and deductibles are frequently required. But I am not at all certain that is true with respect to health care because the payors (and employers)

pick up such a large part of the tab. Generally, many consumers are also interested in quality. But perhaps the reported indifference of payors to MedSouth's offering, which ostensibly enhanced quality, is telling us that that is not at the top of the list here either. Perhaps we are being told that consumers cherish choice above all else – they do not want to be told to go to any particular provider group and that is being reflected in employer and payor behavior.

Finally, what incentives are reasonably necessary to give consumers of health care (or whoever else is responsible for the demand curve in this industry) what they want? In the end, when we see health care providers who are competitors jointly setting rates, we should look for incentives that will justify the joint rate-setting. My view that financial incentives are the safest way to proceed is a placeholder unless and until there are answers to those three questions.