The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice

Lawrence P. Casalino
University of Chicago

Abstract This article examines Federal Trade Commission (FTC) policy—in particular, the agency's controversial 1996 statements on clinical integration—toward joint negotiations for nonrisk contracts with health plans by physicians organized into independent practice associations (IPAs) and (with hospitals) into physician-hospital organizations (PHOs). The article concludes that the policy is consistent with antitrust principles, consistent with current thinking on the use of organized processes to improve medical care quality, specific enough to provide guidance to physicians wanting to integrate clinically, and general enough to encourage ongoing innovations in physician organization. The FTC should consider stronger sanctions for IPAs and PHOs whose clinical integration is nothing more than a sham intended to provide cover for joint negotiations, should give the benefit of the doubt to organizations whose clinical integration appears to be reasonably consonant with the statements, and should clarify several ambiguities in the statements. Health plans should facilitate IPA and PHO efforts to improve care by rewarding quality and efficiency and by providing clinically integrated organizations with claims information on individual patients. Though creating clinically integrated organizations is difficult and expensive, physicians should recognize that clinical integration can help them both to gain some negotiating leverage with health plans and to improve the quality of care for their patients.

During the past decade, the Federal Trade Commission (FTC) has devoted considerable attention to physicians' attempts to negotiate fees jointly with health insurance plans. The agency has engaged in numerous actions

The research for this article was funded in part by an Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation. The author reports that he has served as a vice president of an independent practice association, as a board member of a physician-hospital organization, and as a consultant and expert witness for the Federal Trade Commission.

Journal of Health Politics, Policy and Law, Vol. 31, No. 3, June 2006
DOI 10.1215/03616878-2005-007

against physician price fixing and has prevailed in each (Pender and Meier 2005). The FTC has repeatedly emphasized that its goal in these actions is to support a competitive market in medical care while trying to avoid dictating the forms of organization of physician practice. Though the organization of *physician practice* is not defined by the FTC, in practice the agency uses the term, appropriately in my opinion, to mean two things: first, the types of organization in which physicians work—for example, medical group or independent practice association (IPA), large practice or small; and, second, the ways in which physicians organize their work, and particularly the extent to which they use organized processes to improve quality and/or to control the costs of medical care.

In this article, I concentrate on four questions relating to FTC antitrust policy regarding physicians, focusing on the agency's controversial clinical integration guidelines. I ask, (1) What is the FTC policy? (2) What have been the effects of the policy on the organization of physician practice? (3) Is the policy appropriate? (4) What actions should the FTC, health plans, and physicians take in relation to the policy?

What Is the Federal Trade Commission Policy?

Physicians who are owners or employees of a medical group—that is, who share staff and a single bottom line—are not considered to be competitors with one another and may legally jointly negotiate payment and other contract terms with health plans. However, physicians who work in separate practices are considered to be competitors; the FTC and the courts consider joint negotiations by these physicians to be a form of price fixing, unless they are integrated into a legitimate joint venture. Price fixing is so threatening to market competition that it is per se illegal under U.S. antitrust law. When competitors fix prices, the FTC need only demonstrate that they have engaged in the activity to have them found guilty of an antitrust violation. No analysis of benefits or costs of the activity to consumers is necessary.

The growth of managed care during the 1980s and 1990s gave physicians very strong incentives to negotiate jointly with health plans (Burns and Wholey 2000). Health plans sought to control payment rates to physicians by using the threat of *selective contracting*—that is, of excluding them from their provider networks (Draper et al. 2002). Physicians in small practices—even today, 75 percent of private physicians work in

groups of eight or fewer and 53 percent work in practices of one to three (Cunningham 2004)—had little or no negotiating leverage with health plans. They tried to gain leverage—as well as the size to manage financial risk—through creating IPAs and physician-hospital organizations (PHOs) (Burns and Wholey 2000; Robinson and Casalino 1996).[1]

Antitrust oversight of the thousands of IPAs and PHOs[2] created during the 1980s and the early 1990s was lenient (Haas-Wilson 2003; Marjancik 1998). In 1993, in response both to uncertainty within the industry about what forms of organization were permissible and to concern within the FTC and Department of Justice (DOJ)[3] about possible price fixing by physicians, the agencies issued the joint *Statements of Antitrust Enforcement Policy for the Health Care Areas*. They specified a "safety zone" for physician "joint ventures" (IPAs),[4] stating that they were unlikely to be challenged if the physicians shared "substantial financial risk" and if the number of specialty physicians in the IPA did not exceed 20 percent of the market for "exclusive" networks and 30 percent for "non-exclusive" networks.[5] At the time, substantial financial risk was thought of primarily in terms of capitation and/or of withholds by health plans on payments to physicians that would be refunded if cost-control targets were met (Horoschak 1996).

The agencies emphasized that they were focusing on risk sharing "not because [it] is a desired end in itself, but because it normally is a clear and reliable indicator that a physician network involves sufficient integration . . . to achieve significant efficiencies. Risk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality" (FTC/DOJ 1996: 24).

In 1996, the agencies released a revised set of statements that provided new examples of financial integration and created a new and controversial safety zone, stating that a joint venture that was sufficiently "clinically

1. A *physician-hospital organization* consists of one or more hospitals and numerous physician practices that contract with health plans through a PHO.

2. In the remainder of this article, *IPA* should be taken to stand both for IPAs and for PHOs, unless stated otherwise.

3. In March 2002, the FTC and DOJ formalized an antitrust division of labor; as part of this agreement, the FTC handles health care, hospitals, and professional services and the DOJ is responsible for health insurance.

4. In 1994, the FTC and DOJ issued a new statement that defined essentially the same safety zone for PHOs.

5. The statements define an exclusive network as one in which "the network's physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans" (FTC/DOJ 1996: Statements, 64).

integrated" might pass antitrust scrutiny even if its physicians did not share financial risk.[6] Clinical integration could be evidenced by the presence of organized processes to control costs and improve quality and by the significant investment of monetary and human capital in these processes. The statements provided one example: the hypothetical "Charlestown IPA" would, "prior to contracting [on a non–financial risk basis] on behalf of competing doctors":

- Implementsystems to establish goals relating to quality and appropriate utilization of services
- Developpractice standards and protocols to govern treatment and utilization
- Regularlyevaluate both individual participants' and the network's aggregate performance
- Modifyindividual participants' actual practices, where necessary
- [Subjectparticipants who] fail to adhere to the network's standards and protocols . . . to remedial action, including the possibility of expulsion
- Engagein case management, pre-authorization . . . and concurrent and retrospective review of inpatient stays
- [Invest]significant . . . capital to purchase the information systems necessary to gather aggregate and individual data . . . to measure performance . . . and to monitor patient satisfaction
- Providepayers with detailed reports on the cost and quantity of services provided
- Hirea medical director and support staff to perform the above functions and to coordinate patient care
- Involvenetwork physicians in investing appreciable time in developing the practice standards and protocols. (FTC/DOJ 1996: Statements, 83–84)

6. The statements also refined the definition of the *messenger model*, in which each physician in an IPA may, individually and without consultation with other physicians, inform a neutral messenger of the minimal fee she or he will accept. The messenger then communicates this information to the health plan but is not permitted to negotiate. In theory, the messenger model could reduce the transaction costs of contracting (though it does nothing for integration), but in practice it has frequently been used simply as cover for joint negotiations (Harrison 2004). It has been described, even by advocates for physicians, as a Rube Goldberg device "with no independent business justification" (Hanson 2002: 15).

What Have Been the Effects of FTC Policy on Physician Organization?

FTC policy is far from the only factor that affects the organization of physician practice, so assessing its effects is difficult. Nevertheless, two things seem reasonably clear.

First, the explosion in the number of IPAs and PHOs during the 1980s and 1990s would not have occurred if the FTC had not permitted these new organizational types to serve as vehicles for jointly negotiating financial risk contracts with health plans (Page 2004).

Second, during the nine years since the FTC identified clinical integration as a safety zone for joint negotiations, there has been very little overt "take-up" by physicians of this safety zone. Initially, many articles, from a variety of perspectives, claimed that the 1996 statements were a "breakthrough" for physicians (Harris 1996; Kuttner 1997; Pretzer 1997). However, only one organization—MedSouth, a 400-physician IPA in Denver—has requested and received an advisory letter from the FTC regarding the legality of its plans to negotiate nonrisk contracts using the clinical integration safety zone (Brennan 2002).[7] A second organization—the 1,500-physician Brown and Toland IPA—recently received conditional approval to negotiate nonrisk contracts (Ducore and Pender 2005).[8] The lack of interest in clinical integration has been especially surprising because, during this nine-year period, risk contracting has become much less common (Hurley et al. 2002). Absent risk contracting, IPAs and PHOs lose their safety zone for engaging in joint negotiations and thus lose their reason to exist—unless they are clinically integrated. In fact, the number of IPAs and PHOs has decreased considerably (FTC/DOJ 2004: chap. 2, 5; Lake et al. 2003).

Four factors likely explain the lack of take-up. First, it appears that some IPAs are negotiating nonrisk contracts with health plans on the assumption that the contracts will not be challenged by the FTC or, if challenged, will fall into one of the safety zones (Page 2004). In the nine years since the statements were published, the FTC has taken action against twenty-two IPAs and seven PHOs for price fixing, with most action occurring since

7. IPAs can minimize the risk of an FTC investigation by requesting an advisory letter from the agency before negotiating nonrisk contracts. MedSouth received an advisory letter stating that, given its degree of clinical integration, the FTC would be unlikely to challenge its negotiations, at least for the present.

8. Brown and Toland signed a consent order in 2004 that required it to cease negotiating nonrisk contracts; the IPA subsequently enhanced its organized processes for improving care for nonrisk patients and in 2005 requested and received FTC permission to resume negotiations.

2002,[9] when the agency made an explicit, public commitment to antitrust enforcement in health care (Abelson 2002). Most of these organizations claimed to be using the messenger model; a few claimed to be clinically integrated. All but one of these twenty-nine organizations agreed to sign consent orders to cease negotiating nonrisk contracts, to terminate existing nonrisk contracts, and to make frequent reports to the FTC. One IPA—the 500-physician North Texas Specialty Physicians (NTSP)—refused to sign a consent order; in this case, the FTC prevailed in court (the case is currently under appeal).

Uncertainty over what constitutes clinical integration is likely a second reason deterring some IPAs from attempting to negotiate nonrisk contracts using this safety zone (see section on enforceability and uncertainty below).

The third reason for the lack of take-up of the safety zone is that, under present conditions, the costs of trying to demonstrate clinical integration are immediate and certain, whereas the benefits are in the future and uncertain. An IPA may be uncertain about whether it will be able to reorganize effectively; uncertain about which of the myriad information-technology systems available is likely to be effective, enduring, and interconnectible with other physicians and hospitals (Miller and Sim 2004); and uncertain about whether the financial benefits of integration will balance the costs. Furthermore, it is difficult to develop organized processes to improve quality for patients in nonrisk (often preferred provider organization [PPO]) contracts. Keeping track of nonrisk patients is difficult because, in contrast to patients in a risk-based HMO contract, nonrisk patients do not enroll with a primary-care physician or an IPA and are permitted by health plans to seek services from a very broad network of physicians—including physicians outside the IPA. In addition, in a nonrisk contract individual physicians submit claims for payment to the health plan, which pays the physicians directly. Under these conditions, it is very difficult for an IPA to know who the patients are that it should consider to be the population for which it is responsible, which patients need special attention because of chronic illness, and which have not received preventive care. Lacking data on who the patients are and what physicians are doing for them, it is difficult for the IPA to measure and improve quality and to reward physicians for providing quality care. There are ways of dealing with this—Brown and Toland now requires its physicians to sub-

9. I have calculated these figures by referring to the FTC's *Overview of FTC Antitrust Actions in Health Care Services and Products* (Pender and Meier 2005).

mit copies of claims to the IPA—but health plans could help by providing data to IPAs; most, however, have been reluctant to do so.

At present, most physicians lack strong financial incentives to overcome these problems (Becher and Chassin 2001; Casalino 2003). In principle, clinical integration can increase an IPA's revenue in four ways: (1) by providing a safety zone for the negotiation of nonrisk contracts at higher rates than the physicians would otherwise receive, (2) by improving the IPA's scores on quality (and/or cost control) measures in contexts where health plan pay-for-performance programs reward better scores, (3) by reducing administrative costs of the IPA and/or its physicians, and (4) by increasing the volume of visits and/or procedures provided by the organization's physicians. At present, each of these potential sources of revenue enhancement must look questionable to the leaders of many IPAs. Even if the FTC gives the go-ahead to an IPA as clinically integrated, health plans may refuse to negotiate nonrisk contracts with the organization.[10] In most areas of the country, pay-for-performance programs provide extremely modest rewards (Rosenthal et al. 2004), and it is not at all clear that administrative costs will be reduced, or that an IPA's physicians will generate more services, as a result of clinical integration.

Physician attitudes are a likely fourth reason for the lack of take-up. IPAs and PHOs are composed mainly of physicians in small, independent practices. It is not clear that many of these physicians are familiar with the concept of using organized processes to improve quality or that, if aware, they believe that the processes are efficacious (Bodenheimer et al. 2004). Despite widespread dissatisfaction, physicians are doing reasonably well financially (Romano 2005). They might do better if they could jointly negotiate higher payment rates from health plans, but "many physicians feel that [clinically integrated] networks require a degree of investment, expertise, time, and political consensus that they cannot muster" (Hirshfeld 1997: 4).[11] Many of these physicians are likely to value being as independent as possible (Casalino, Devers, et al. 2003) and are not likely to

10. MedSouth initially experienced this problem but has recently been able to negotiate at least one such contract (Lowes 2005; Page 2003).

11. The AMA has lost its initial enthusiasm for the clinical integration safety zone and for the messenger model; it argues that physicians should be permitted to jointly negotiate nonrisk contracts in geographic areas where health plans have market power regardless of whether the physicians are clinically or financially integrated or using the messenger model (Hanson 2002). Despite opposition from health plans and the FTC, three states—New Jersey, Texas, and Alaska—as well as the U.S. House of Representatives (but not the U.S. Senate) have passed AMA-sponsored bills to this effect. Discussion of the pros and cons of this legislation is beyond the scope of this article (Ameringer 2002; Choudhry and Brennan 2001; Hellinger and Young 2001).

submit themselves to organized processes, much less to invest time and money in creating them, unless there are strong financial incentives to do so (Casalino 2003).

Is FTC Antitrust Policy toward Joint Negotiations Appropriate?

How might *appropriate* be defined in the context of FTC policy? The appropriateness of the policy may be evaluated in terms of its consistency with current antitrust principles, its enforceability, and its consistency with current thinking about the use of organized processes to improve quality and control costs.

Antitrust Principles

The FTC's financial integration safety zone has generally been considered to be consistent with the principles used by the FTC, the DOJ, and the courts to assess joint ventures in other industries (Marjancik 1998; Sullivan and Grimes 2000). Joint ventures reduce competition because they involve competitors cooperating and often setting prices. However, joint ventures can produce benefits to consumers that no party to the joint venture could produce alone. The task of the agencies and the courts is to determine, first, whether the joint venture is really an attempt to create a better product or is simply a sham—a cover for price fixing. If the parties to a joint venture invest significant resources in the venture and share substantial financial risk for the venture's success or failure, the agencies and the courts are likely to conclude that the joint venture is not simply a cover for price fixing. If they lack this financial integration, the joint venture is likely to be declared per se illegal. If they are deemed to have sufficient financial integration, rule-of-reason analysis is then applied in an attempt to determine whether the benefits to consumers from the joint venture outweigh the costs due to the decrease in competition.

Even if the benefits do outweigh the costs, the joint venture will not be approved unless the restraints on competition—for example, the joint setting of prices by competitors—are *ancillary*—that is, reasonably necessary—to the creation of the benefits. For IPAs that meet the FTC's financial integration guidelines, the agency has considered that the restraints on competition—physician joint negotiations—are reasonably necessary for the benefits (increased quality and reduced costs of patient care) to be realized. It has also tended to accept financial integration as a proxy dem-

onstrating, without further investigation, that the benefits to consumers of the joint venture outweigh the costs.

The FTC's clinical integration safety zone is much more controversial (Marjancik 1998; Sullivan and Grimes 2000). It means that IPAs that negotiate nonrisk contracts but show some degree of clinical integration will be evaluated under rule-of-reason analysis, rather than being declared per se in violation of antitrust law. Critics argue that, with rare and atypical exceptions, nonfinancially integrated joint ventures are considered per se illegal in other industries and that the *Arizona v. Maricopa Medical Society 1982* decision indicated that they should be considered per se illegal in health care. Additionally, they argue that it may not be necessary for physicians to negotiate jointly with health plans for them to work together to benefit patients through clinical integration (Greaney 2004).

Some critics suggest that financial integration gives physicians an incentive to work together to control costs but that clinical integration alone does not (Danzis 2001). They fear that therefore costs will increase as physicians both negotiate for higher payment rates and, absent financial integration, have a financial incentive to provide as many services as possible.

Critics also argue that the clinical integration policy is unenforceable. They claim that the financial integration guideline creates a bright line that makes it relatively easy for the FTC "to distinguish legitimate provider networks from sham networks formed to impede competition" (Marjancik 1998: 77). But, they argue, it is difficult to define clinical integration and, although it is relatively easy to examine contracts to determine whether they involve financial risk, extensive investigation is required to determine whether an IPA is functioning in a clinically integrated manner. The clinical integration guideline, critics fear, could lead to large numbers of IPAs jointly negotiating contracts with health plans while doing very little to improve quality or control costs.

Supporters of the clinical integration guideline claim that U.S. antitrust policy has been becoming more favorable to joint ventures that create a new product, even when they are not financially integrated (Oldham 2005). IPAs, they argue, are actually creating a new and desirable product—networks of independent physicians working together to improve quality and control costs (Havighurst 1996; Leibenluft and Weir 2004). Though it may be more difficult for IPAs than for large integrated medical groups to improve quality and control costs, they do provide a way for the large numbers of physicians in small practices to create efficiencies.

Contrary to critics' assertions, it is not necessarily correct to state that

financially integrated physicians have an incentive to work together to create efficiencies but physicians who are merely clinically integrated do not. This statement draws too sharp a line between clinical and financial integration—at least if clinical integration is defined, as the FTC does define it, as requiring that physicians invest both money and time in creating and maintaining organized processes to generate efficiencies. Though payment rates per unit of service may be higher when physicians negotiate jointly, overall costs may be lower if unnecessary care is reduced and higher-quality care reduces complications and keeps patients in better health. The distinction between financial and clinical integration also breaks down if an IPA gains higher payment rates from health plans because it is high quality and cost efficient, if it receives bonuses for quality and efficiency through pay-for-performance programs, and/or if it pays its own physicians, in part, based on measurements of the quality and efficiency of their care.

The question of whether it is reasonably necessary for participants in a joint venture to engage in activities that restrain competition (for example, jointly negotiating prices) in order to create the joint venture's benefits for consumers is typically a difficult one to answer. Supporters of the clinical integration statement argue that IPAs cannot create efficiencies unless large numbers of physicians are members and unless these members cooperate with the processes implemented by the organization to improve quality and control costs. Though most physicians are interested in quality, they, like other people, are responsive to financial incentives. They are highly unlikely to become members or to invest time and money in working together to implement these processes unless they have some hope of a financial return (Feinstein 2004).

Enforceability and Uncertainty

For the clinical integration guideline to be enforceable, the FTC staff and the courts must be able to know clinical integration when they see it. They must also be able to detect IPAs that are negotiating nonrisk contracts without being clinically integrated, to win in court when an organization refuses to sign a consent decree, to deter IPAs from trying to use weak clinical integration as a cover for joint negotiations, and to detect backsliding from clinical integration in an organization, like MedSouth, whose joint venture the agency has approved.

None of these tasks are easy, but this in itself is not an argument against the clinical integration guidelines: antitrust action in general is difficult,

and there are reasons to believe that the clinical integration guideline will be at least reasonably enforceable (Leary 2004: 26). Health plans can and often do notify the FTC when they believe that an IPA is trying to negotiate nonrisk contracts without being clinically integrated; this facilitates detection of both new cases and, potentially, backsliders.

One may question whether sanctions applied in consent decrees are strong enough to deter IPAs whose clinical integration is marginal at best from giving joint negotiations of nonrisk contracts a try, calculating that they may not be caught and that, if they are, the penalty will not be severe. Given that the IPA is not typically ordered to dissolve and that neither the IPA nor its leaders pay a fine, the sanctions might be considered weak (Greaney 2004). However, IPA leaders may still want to avoid placing the organization in a position where sanctions are possible—first, because it is expensive for an IPA to respond to an FTC investigation and, second, because IPA physicians may not be at all pleased with leaders who have led them down an unsuccessful path. Nevertheless, if experience over the next few years suggests that large numbers of IPAs are jointly negotiating nonrisk contracts by using messenger models or clinical integration that do not even approach compliance with the guidelines, the FTC might consider seeking more severe sanctions in egregious cases.

Uncertainty is the other side of the coin from enforceability. Physicians and some attorneys have pressured the FTC to provide more specific criteria for clinical integration (Asner 2003; Holloway 2003; FTC 2002). The FTC has consistently replied that it does not want to stifle innovation by providing a checklist or prescribing a particular kind of organizational structure "because of the risk that it would channel market behavior, instead of encouraging market participants to develop structures responsive to their particular goals and the market conditions they face" (FTC/DOJ 2004: Executive Summary [ES], 25). Furthermore, the FTC emphasizes that it welcomes requests for advisory letters and will try to respond to them within 90 to 120 days if the information provided is sufficient.

Though it is difficult to disagree with the FTC's reasoning, uncertainty over what the agency will consider to constitute clinical integration, and the delay and expense involved in reducing it through an advisory letter, probably have been acting as deterrents to IPAs making the choice to integrate clinically. This may change as the agency continues to provide precedents. The recent decision to permit the Brown and Toland IPA to negotiate nonrisk contracts provides a third example of what the agency will consider to be clinical integration, and the FTC's arguments and the

court's judgment in the NTSP case provide a fourth. The four examples are consistent: the same general organized processes are used by each of the IPAs (or, in the case of NTSP, are cited specifically for not being used), though they vary in detail.

Payment methods from health plans to IPAs, and from IPAs to their physicians, are likely to continue becoming more innovative and complex, especially given the accelerating movement to pay for performance (Robinson et al. 2004). The FTC could reduce uncertainty by providing guidance on three related questions that suggest the overlap between financial and clinical integration.

First, the agency has suggested that pay for performance may be considered a kind of risk contracting and therefore may qualify an IPA to negotiate jointly through the financial integration safety zone (FTC/DOJ 2004: ES, 25). How substantial must pay-for-performance payments be for an IPA that is not otherwise involved in risk contracting to qualify as being financially integrated?

Second, can an IPA that is paid on a nonrisk basis by health plans but that gives its own physicians incentives to control costs and/or improve quality be considered financially integrated? If so, how substantial must the incentives be? The FTC discussed this possibility in the 1996 statements but has not provided guidance since. The question is important, because "the extent to which a network realizes [cost] efficiencies or provides higher quality care will depend, in part, on the network's internal incentive structure" (Haas-Wilson and Gaynor 1998: 180).

Third, how will an IPA be evaluated if it has some degree of financial and clinical integration for patients in its nonrisk contracts but does not quite meet the "substantial" criterion for either (FTC 2002: 28)?

Clinical Integration and the Use of Organized Processes to Improve Quality

Numerous studies show that the quality of medical care in the United States is not nearly as high as it could be. In a much-cited national study that included 439 quality indicators for thirty acute and chronic conditions and preventive care, patients received appropriate care only 55 percent of the time (McGlynn et al. 2003). Yet there is ample evidence both that the use by physician groups of organized processes to improve quality is effective and that it is uncommon (Casalino, Gillies, et al. 2003; Institute of Medicine 2001). The processes suggested by the FTC's clinical integra-

tion policy are consistent with the literature on quality improvement yet are general enough to encourage innovation.

Conclusion

Overall, the FTC's policy toward physician joint negotiations appears to be reasonably clear, enforceable, and consistent with the literature on medical care quality improvement. Controversy persists over the degree to which the policy is consistent with current antitrust thinking regarding joint ventures; it is likely that the evolution of this controversy will be affected by the effects of the policy, and it is too soon to be sure of those. The agency could do several things to increase the likelihood of beneficial effects by further deterring IPAs from using sham claims of clinical integration as a justification for joint negotiations, on the one hand, and, on the other, by encouraging IPAs to make efforts to become clinically integrated:

1. Provide guidance on the three questions just discussed and, while doing so, explicitly recognize that, in IPAs that are truly integrated, financial and clinical integration are likely to be interdependent.
2. Consider stronger penalties for IPAs whose clinical integration (and/or messenger models) are found to have little or no substance. Stronger penalties would minimize the number of organizations that try to fly under the FTC's radar while doing little to improve care.
3. Do not be overly stringent. Give IPAs the benefit of the doubt if investigation suggests that an IPA is acting in good faith and that its degree of clinical integration is substantial. The need for clinically integrated physician groups is acute; if the FTC gives a green light to organizations that have made a good start, they are likely to continue to improve, particularly if, as expected, pay for performance increases.

As some health plans realize, a system in which they focus on driving down physician payment rates and on improving quality without physician cooperation is not stable. Health plans should welcome IPA partners that provide higher-quality, efficient care. They should reward them with higher payment rates and pay-for-performance bonuses and should assist them in organizing better care for their patients by providing the IPAs with claims data for individual patients seen by their physicians.

Since the advent of managed care, physicians have been mourning the

pressures on their incomes and on their central role in caring for patients. It may be time to recall the advice given long ago by Joe Hill to the International Workers of the World: "Don't mourn, organize!" In response to managed care, physicians have organized, through the American Medical Association (AMA) and their specialty societies, to exert political pressure on managed care. Perhaps they should also consider organizing physician practice. Clinical integration gives physicians the ability both to gain some negotiating leverage with health plans and to improve the quality of care for their patients. The per-physician cost of moving toward clinical integration need not be excessively large. For example, if it costs $120,000 per year in salary, benefits, and operational support for a three-hundred-physician IPA to have a nurse care manager to help patients with severe congestive heart failure and diabetes, the per-physician annual cost would be $400. Pay-for-performance bonuses might reduce this cost or generate a positive return on the investment.

Shortly after the 1996 statements were published, Dr. Lonnie Bristow, at the time the immediate past president of the AMA, remarked regarding clinical integration, "If doctors want to regain professional control, they will have to pay the price" (Kuttner 1997: 388). The fact that so few IPAs have attempted to use the clinical integration safety zone to negotiate jointly with health plans is not, in my opinion, because the policy is too demanding or too vague. The barriers, rather, are two: first, the loosely organized character of many current IPAs and, second, the lack of rewards for quality and efficiency. Physicians can seek to overcome these barriers by being part of large medical groups or, if they prefer to remain in smaller practices, by creating better-organized, clinically integrated IPAs. The alternative is to cede the task of improving the quality of medical care to others.

References

Abelson, R. 2002. U.S. to Step Up Antitrust Effort on Health Care. *New York Times*, August 9.

Ameringer, C. F. 2002. Federal Antitrust Policy and Physician Discontent: Defining Moments in the Struggle for Congressional Relief. *Journal of Health Politics, Policy and Law* 27: 543–574.

Asner, B. 2003. Statement by Bart Asner. Joint FTC/DOJ Hearings on Health Care and Competition Law and Policy. Washington, DC: Federal Trade Commission.

Becher, E. C., and M. R. Chassin. 2001. Improving the Quality of Health Care: Who Will Lead? *Health Affairs* 20: 164–179.

Bodenheimer, T., M. C. Wang, T. G. Rundall, S. M. Shortell, R. R. Gillies, N. Oswald, L. Casalino, and J. C. Robinson. 2004. What Are the Facilitators and Barriers in Physician Organizations' Use of Care Management Processes? *Joint Commission Journal on Quality and Safety* 30: 505–514.

Brennan, J. W. 2002. Advisory Opinion Regarding MedSouth. [Letter to J. J. Miles.] February 19. Washington, DC: Federal Trade Commission.

Burns, L. R., and D. R. Wholey. 2000. Responding to a Consolidating Healthcare System: Options for Physician Organizations. In *Advances in Health Care Management*, vol. 1, ed. J. D. Blair, M. D. Fottler, and G. T. Savage, 261–323. New York: Elsevier Science.

Casalino, L. 2003. Markets and Medicine: Barriers to Creating a Business Case for Quality. *Perspectives in Biology and Medicine* 46: 38–51.

Casalino, L. P., K. Devers, T. Lake, and J. Stoddard. 2003. Benefits of and Barriers to Large Medical Group Practice. *Archives of Internal Medicine* 163: 1958–1964.

Casalino, L., R. R. Gillies, S. Shortell, J. A. Schmittdiel, T. Bodenheimer, J. C. Robinson, T. Rundall, N. Oswald, H. Schauffler, and M. C. Wang. 2003. External Incentives, Information Technology, and Organized Processes to Improve Health Care Quality for Patients with Chronic Diseases. *Journal of the American Medical Association* 289: 434–441.

Choudhry, S., and T. A. Brennan. 2001. Collective Bargaining by Physicians: Labor Law, Antitrust Law, and Organized Medicine. *New England Journal of Medicine* 345: 1141–1144.

Cunningham, R. 2004. Professionalism Reconsidered: Physician Payment in a Small-Practice Environment. *Health Affairs* 23: 36–47.

Danzis, S. D. 2001. Revising the Revised Guidelines: Incentives, Clinically Integrated Physician Networks, and the Antitrust Laws. *Virginia Law Review* 87: 531–576.

Draper, D. A., R. E. Hurley, C. S. Lesser, and B. C. Strunk. 2002. The Changing Face of Managed Care. *Health Affairs* 21: 11–23.

Ducore, Daniel P., and David R. Pender. 2005. In the Matter of California Pacific Medical Group. [Letter to Richard A. Feinstein.] April 5. www.ftc.gov/os/adjpro/d9306/050405cpbresponsebtnotice.pdf.

Federal Trade Commission. 2002. Section of Antitrust Law, American Bar Association. Comments Regarding the Federal Trade Commission's Workshop on Health Care and Competition Law and Policy. Washington, DC: FTC.

Federal Trade Commission/Department of Justice (FTC/DOJ). 1996. *Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care*. Washington, DC: FTC/DOJ.

———. 2004. *Improving Health Care: A Dose of Competition*. Washington, DC: FTC/DOJ. www.usdoj.gov/atr/public/health_care/204694.htm#toc**.**

Feinstein, Richard A. 2004. In the Matter of California Pacific Medical Group. [Letter to Donald S. Clark.] December 2. www.ftc.gov/os/adjpro/d9306/041202letter.pdf.

Greaney, T. L. 2004. Chicago's Procrustean Bed. *Antitrust Law Journal* 71: 857–920.

Haas-Wilson, D. 2003. *Managed Care and Monopoly Power: The Antitrust Challenge*. Cambridge, MA: Harvard University Press.

Haas-Wilson, D., and M. Gaynor. 1998. Physician Networks and Their Implications for Competition in Health Care Markets. *Health Economics* 17: 179–182.

Hanson, C. 2002. On Integration, Physician Joint Contracting, and Quality: Taking a Fresh Look at Some "Settled" Questions. Federal Trade Commission Workshop on Health Care Competition Law and Policy. Washington, DC: Federal Trade Commission.

Harris, R. M. 1996. New Antitrust Guidelines for Physician Networks, Part 1. *Journal of the American Medical Association* 276: 1450–1451.

Harrison, J. L. 2004. The Messenger Model: Don't Ask, Don't Tell? *Antitrust Law Journal* 71: 1017–1032.

Havighurst, C. C. 1996. Are the Antitrust Agencies Overregulating Physician Networks? *Loyola Consumer Law Reporter* 8: 78–97.

Hellinger, F. J., and G. J. Young. 2001. An Analysis of Physician Antitrust Exemption Legislation: Adjusting the Balance of Power. *Journal of the American Medical Association* 286: 83–88.

Hirshfeld, E. 1997. Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks. *Annals of Health Law* 6: 1.

Holloway, A. 2003. Statement by Albert Holloway. Joint FTC/DOJ Hearings on Health Care and Competition Law and Policy. Washington, DC: FTC/DOJ.

Horoschak, M. J. 1996. The New Statements of Antitrust Enforcement Policy in Health Care: Antitrust Guidance for Health Care Providers Enters a New Phase. *Antitrust* 11: 28–32.

Hurley, R. E., J. M. Grossman, T. K. Lake, and L. Casalino. 2002. A Longitudinal Perspective on Health Plan-Provider Risk Contracting. *Health Affairs* 21: 144–153.

Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the Twenty-First Century*. Washington, DC: National Academy Press.

Kuttner, R. 1997. Physician-Operated Networks and the New Antitrust Guidelines. *New England Journal of Medicine* 336: 386–391.

Lake, T., K. Devers, L. Brewster, and L. Casalino. 2003. Something Old, Something New: Recent Developments in Hospital-Physician Relationships. *Health Services Research* 38: 471–488.

Leary, T. B. 2004. Special Challenges for Antitrust in Health Care. *Antitrust Magazine* 18(2): 23–27.

Leibenluft, R. F., and T. E. Weir. 2004. Clinical Integration: Assessing the Antitrust Issues. In *Health Law Handbook*, ed. A. G. Gosfield, 1–47. St. Paul, MN: West Group.

Lowes, R. 2005. For This IPA, P4P Pays Off. *Medical Economics* 82: 31–34.

Marjancik, N. 1998. Risky Business: Proposed Reform of the Antitrust Laws as Applied to Health Care Provider Networks. *American Journal of Law and Medicine* 24: 59–87.

McGlynn, E. A., S. M. Asch, J. Adams, J. Keesey, J. Hicks, A. DeCristofaro, and E. A. Kerr. 2003. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine* 348: 2635–2645.

Miller, R. H., and I. Sim. 2004. Physicians' Use of Electronic Medical Records: Barriers and Solutions. *Health Affairs* 23: 116–126.

Oldham, A. S. 2005. The MedSouth Joint-(Ad)venture: The Antitrust Implications of Virtual Health Care Networks. *Annals of Health Law* 14: 125–182.

Page, L. 2003. No Risk, No Takers: Clinical Integration Model Has Yet to Catch On. *Modern Physician* 7: 12.

———. 2004. How Physicians' Organizations Compete: Protectionism and Efficiency. *Journal of Health Politics, Policy and Law* 29: 75–105.

Pender, D. R., and M. H. Meier. 2005. *Overview of FTC Antitrust Actions in Health Care Services and Products*. Washington, DC: Federal Trade Commission.

Pretzer, M. 1997. Will the Big, Bad Antitrust Wolf Blow Your IPA Down? *Medical Economics* 74: 40–47.

Robinson, J. C., and L. Casalino. 1996. Vertical Integration and Organizational Networks in Health Care. *Health Affairs* 15: 7–22.

Robinson, J. C., S. M. Shortell, R. Li, L. P. Casalino, and T. Rundall. 2004. The Alignment and Blending of Payment Incentives within Physician Organizations. *Health Services Research* 39: 1589–1606.

Romano, M. 2005. Holding Steady: Specialists Are Still Seeing Biggest Paychecks, but Raises Are Flat, and Some Generalists Are Gaining Ground, Physician Compensation Survey Shows. *Modern Healthcare* 35: S1–S5.

Rosenthal, M. B., R. Fernandopulle, H. R. Song, and B. E. Landon. 2004. Paying for Quality: Providers' Incentives for Quality Improvement. *Health Affairs* 23: 127–141.

Sullivan, L. A., and W. S. Grimes. 2000. *The Law of Antitrust: An Integrated Handbook*. St. Paul, MN: West Group.