COMPETITION IN HEALTH INSURANCE AND PHYSICIAN MARKETS:

A REVIEW OF "COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF US MARKETS" BY THE AMERICAN MEDICAL ASSOCIATION

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Executive Summary

Since representative Thomas Campbell (R-CA) introduced the "Quality Health Care Coalition Act of 1999" (H.R. 1304) during the 106th Congress, attempts to enact physician antitrust waiver legislation at both the federal and state levels have generated considerable debate. The American Medical Association recently commissioned an evaluation of concentration in health insurance markets as part of an attempt to regenerate interest in waiver legislation.

Although the report purports to be "A Comprehensive Study of US Markets,"[1] the scope of the report is actually quite limited. Review of the competitive concerns raised by the AMA report reveals that it has misinterpreted or ignored important market dynamics. A more complete analysis demonstrates the effectiveness of the market in ensuring competition among insurers both as sellers of insurance and purchasers of physician services. In addition, regulatory intervention is available to correct any weakness in the market. The concentration measures reported by the AMA are misleading or inappropriate for several reasons:

- **Market Definition:** The AMA reports concentration measures using overly narrow product and geographic market definitions, leading to an exaggeration of health insurance concentration levels.

- **Inaccurate Depiction of Merger Guidelines:** The AMA report ignores important determinants of competition described in the Department of Justice (DOJ)/Federal Trade Commission (FTC) Horizontal Merger Guidelines such as potential entry, merger efficiencies, and factors hindering anticompetitive behavior.

- **Failure to Measure Competition in Physician Services:** The AMA report omits any analysis of the market for physician services, instead drawing inappropriate connections between health insurance concentration levels and competition by managed care organizations in the purchase of physician services.

In focusing solely on market concentration among HMOs and PPOs, the AMA's analysis ignores a number of significant characteristics of the market dynamics that shape current interactions between managed care plans and physicians. These include:

- **Fierce Competition in Health Insurance:** Competition among health insurers remains fierce, characterized by multiple large competitors with marginal profits. Ease of entry into new markets and expansion in existing markets by health insurers assures that such competition is maintained.

[1] "Competition in Health Insurance: A Comprehensive Study of US Markets." American Medical Association, November 2001.

- **Changing Healthcare Environment**: The shift in consumer preferences toward broad provider networks and decreased utilization controls has given physicians the upper hand in contract negotiations.

- **Alternative Revenue Sources for Physicians:** Physicians have alternative sources of revenue that remain unaffected by negotiations with managed care organizations (MCOs). The average physician practice derives less than half its revenues from managed care contracts, and revenues that are derived from such contracts are spread across multiple insurers.

- **Must-have Physicians:** Physicians can engage in a variety of legitimate behaviors to make themselves a crucial part of any physician network, thereby enhancing their negotiating position. These "must-have" physicians possess market power of their own in negotiations with insurers.

- **Physician Consolidation and Negotiating Power:** Consolidation among physicians has produced large health care provider groups that enjoy significant leverage in negotiations with managed care organizations. Several of these provider groups have successfully negotiated rate increases or other conditions with insurers.

- **Adequacy of Existing Antitrust Laws:** Existing antitrust laws allow physicians substantial leeway in their negotiations with insurers. A review of DOJ and FTC actions indicates that a variety of coordinated arrangements among physicians have been allowed. At the same time, antitrust scrutiny of insurers continues to ensure that competition is maintained.

Fundamentally, the debate regarding physician antitrust waivers requires consideration of two questions. First, what justifies physician antitrust waivers? The AMA study provides no answer, relying only on insurer concentration levels while ignoring existing regulatory scrutiny of health insurers, indications of competitive managed care behavior, and increasing health care provider consolidation. Second, what is the likely outcome of granting antitrust waivers to health care providers? Since such waivers are designed to increase physician leverage over health plans, it is reasonable to infer that health care costs to insurers would rise. Given the recent substantial increase in health insurance premiums, any policy that threatens to add another source of cost increases to already spiraling health care inflation should be considered with extreme caution.

Introduction and Background

The American Medical Association (AMA) continues to advocate for physician antitrust waivers despite continued consolidation by health care providers, and opposition to such legislation by the Department of Justice (DOJ), the Federal Trade Commission (FTC), and the Antitrust Section of the American Bar Association (ABA), among others. To support its contention that physicians require exemptions from Federal and State antitrust regulations, the AMA recently commissioned an evaluation of health insurance markets.[2,3,4] A more rigorous approach than any the AMA has commissioned in the past, this report presents compelling sound bites regarding the concentration of local health insurance markets. However, by focusing primarily on purported concentration levels, the AMA report presents a misleading assessment of competition among health insurers.

The concerns raised by the AMA are related to two distinct markets,: the market for health insurance, and the market for physician services. In the market for health insurance, competing companies provide insurance products (e.g., HMO, PPO, and indemnity coverage) to employers and individuals. These insurers compete for enrollees by offering products with an attractive mix of quality and price. In the market for physician services, physicians sell their services to insurers, patients, and publicly-funded health care programs, such as Medicare and Medicaid. Physicians often sign contracts with insurers to provide services at negotiated prices in return for increased patient volume.

While the insurance and provider markets are clearly interrelated, the competitive characteristics of each must also be analyzed individually if correct inferences about competition are to be made. The AMA report instead draws inappropriate conclusions about the market for physician services based on the structure of the market for health insurance. These conclusions lead directly to misguided policy prescriptions, such as physician antitrust waivers.

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[2] "Competition in Health Insurance: A Comprehensive Study of US Markets," American Medical Association, November 2001. Subsequent references to the "AMA study" refer to this publication.

[3] See *Modern Healthcare*, December 3, 2001, pp. 14–15.

[4] In 2000, the initial federal initiative (H.R. 1304 passed the House by a 276-136 margin, although it was not introduced in the Senate, and was introduced in neither chamber in 2001. On the state level, by June 1, 2001, 12 states had introduced or reintroduced legislation to secure antitrust waivers for physicians: Alaska, California, Connecticut, Florida, Louisiana, Massachusetts, Missouri, Montana, New York, Pennsylvania, Rhode Island, and Tennessee. Texas introduced legislation to amend its implementation of physician antitrust waivers. Similarly, other states, such as Florida and Utah, have witnessed increased activity from physicians' unionization efforts. On January 28, 2002, New Jersey became the third state (after Washington and Texas) to pass physician collective negotiation legislation (see http://www.ama-assn.org/sci-pubs/amnews/pick_02/gvsa0128.htm); similar legislation is under review in Ohio. Most recently, Representatives Barr, Conyers et al. introduced H.R. 3897, the "Health Care Antitrust Improvements Act of 2002" in the U.S. House of Representatives on March 7, 2002.

Absent from the discussion of physician waivers is evidence of demonstrable harm to physicians. Through focusing solely on market concentration measures for health insurers, the AMA study ignores physician market characteristics and resulting opportunities for physicians that provide powerful and legal methods to strengthen their negotiating position with health insurers. Physician groups can consolidate to increase their bargaining power. Physicians can capitalize on their good reputations or powerful presence in local geographic areas to achieve leverage with health insurers. Finally, physicians can employ messenger models or other agreements to reject untenable contract offers without violating competition regulations. Given the options already available to physicians, and the dearth of evidence suggesting any need for change, little justification exists to alter current antitrust policy, which is designed to promote competition in all sectors.

This report addresses the competitive concerns raised by the AMA report and identifies market dynamics that have been misinterpreted or ignored by the AMA analysis, providing appropriate counterpoints to arguments made therein. It provides a competitive analysis of both the market for health insurance and the market for physician services, and discusses the relationship between the two. This report does not attempt to verify or contradict the AMA's empirical findings. Rather, it critiques the methodologies, interpretations, and conclusions of the AMA effort. A more complete market assessment, combined with a proper interpretation of the AMA's findings, leads to different policy prescriptions than those suggested by the AMA. More specifically, this report, along with the findings of the DOJ, the FTC, the ABA, and others, concludes that vigilant enforcement of existing antitrust policies, applied to both physicians and managed care organizations, is most likely to ensure desirable competitive outcomes.

Constraints on fee increases and a perceived loss of autonomy associated with the rise of managed care have caused physicians to seek increased negotiating power in their dealings with insurers. In response, with the support of the AMA, Representative Thomas Campbell (R-CA) introduced the "Quality Health Care Coalition Act of 1999" (H.R. 1304). According to the rhetoric of the Campbell bill, large health insurers representing millions of patients held undue influence over health care providers. Advocates of the Campbell bill claimed that an antitrust waiver would allow health care providers to negotiate on a "level playing field" and thus ensure that they received fair payment for services rendered.

Since the initial introduction of the Campbell bill, the health care landscape has changed substantially. After rising to 8.3 percent in 2000, double-digit health care inflation is anticipated. In fact, the prediction of 11 percent increases in the cost of employer-provided health insurance for 2002 preceded September 11, 2001, and the economic fallout that followed. At the same time, health care providers have continued to consolidate. Antitrust authorities should continue to scrutinize consolidation among insurance companies and health care providers. Providing antitrust exemptions for

physicians would undermine competition in the market for physician services, which will ultimately increase health care costs and harm consumers.[5]

Competition in Health Insurance

The most thorough empirical analysis provides little policy guidance without the proper context and interpretation of its results. Despite increased statistical rigor, the AMA study still suffers from fundamental misunderstandings and misinterpretations of antitrust policy and legal precedents.[6] Antitrust principles are not altogether ignored; the AMA study includes discussions of market definition and market entry, two components of the *Horizontal Merger Guidelines* ("the Guidelines").[7] The Guidelines form the analytical framework used by the antitrust authorities to gauge the competitive effects of mergers and provide a useful framework for studying the state of competition in the health insurance industry.

An analysis of competition based on the Guidelines consists of five fundamental components: product market definition, geographic market definition, analysis of competitive entry, examination of efficiencies, and consideration of other conditions that facilitate or hinder the exercise of unilateral market power or coordinated conduct. Concentration measures, which are only one part of the analysis, provide a snapshot of the current industry structure that is, in some situations, a useful baseline from which to assess existing and potential competition. However, the AMA study focuses almost solely on the measurement of concentration and, as a result, is seriously incomplete.

Product Market for Health Insurance

As the AMA study notes, there has been considerable debate over the relevant product market for health insurance products. As purchasers (employers and individuals) gain experience with the available products, and insurers adjust their product lines to meet consumer demands, the traditional distinctions between HMO, PPO, point of service (POS), and indemnity (fee-for-service) have blurred as nearly all health insurance products have addressed factors such as flexibility, network size, physician autonomy, and price.

In response to consumer demands and government controls, insurers are being forced to relax network restrictions associated with HMO products and to expand their POS and

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[5] See Monica G. Noether, "The National Cost of Physician Antitrust Waivers," Charles River Associates, March 2000.

[6] See "AMA Uses Flawed Report to Support Anti-Consumer Bargaining Powers," American Association of Health Plans, for methodological or statistical limitations of the AMA report (http://www.aahp.org/Content/NavigationMenu/About_AAHP/News_Room/Press_Releases/AntitrustAMARebuttal2001.pdf).

[7] U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines ("the Guidelines"), 4 Trade Reg. Rep. 13104 (1992).

PPO networks.[8] Patients in HMOs are increasingly granted access to specialty care without a referral, a feature traditionally available only in PPO and indemnity insurance. Employers are mixing aspects of HMO and PPO products in order to obtain the desired balance between cost savings and flexibility, and open access plans are gaining popularity in many markets.[9] At the same time, pricing of various managed products is converging. The Community Tracking Study by the Center for Studying Health System Change recently concluded: "The distinction between HMO and preferred provider organization (PPO) products is becoming less clear as HMOs increasingly offer broad provider networks and no gatekeeper. Premium differences between HMO and PPOs are shrinking as well."[10] In fact, price convergence was observed in the majority of communities surveyed.

As products have become more similar in both features and price, it has become clear that all forms of health insurance products compete with each other as employers and individuals choose among HMO, POS, PPO, and indemnity insurance.[11] Insurance brokers provide information to employers about the benefits and prices of each product as well as assist them with decisions about self-insurance options. Brokers generally sell various types of insurance products, making switching from one plan type to another relatively easy.[12]

The AMA report considers three product market definitions: a "broad" product market that includes both PPO and HMO insurance, and narrower definitions that focus separately on PPO or HMO plans. Each of these approaches excludes other financing mechanisms, such as indemnity insurance, self-pay, and in some analyses, workers' compensation, CHAMPUS (military), Medicare, or Medicaid.[13,14] The AMA agrees that,

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[8] Debra A. Draper, Robert E. Hurley, Cara S. Lesser, and Bradley C. Strunk. "The Changing Face of Managed Care," *Health Affairs* 21(1), January/February 2002, pp. 13–14.

[9] "Open access" describes plans that allow enrollees access to specialists without a referral from their primary care physician (gatekeeper).

[10] Draper *et al.*, p. 14.

[11] For example, from 1993 to 1997 employees of the University of California system could choose among four and seven health insurance options, depending on their geographic location. At minimum, each employee had access to two HMO plans, an indemnity plan, and a PPO/POS plan. See Bruce A. Strombom, Thomas C. Buchmueller, and Paul J. Feldstein, "Switching Costs, Price Sensitivity and Health Plan Choice," *Journal of Health Economics* 21(1), January 2002.

[12] According to survey data collected in 2000, more than one-third (34 percent) of small employers (from 2 to 50 employees) switched health plans in the previous year, and nearly two-thirds (63 percent) had switched within the last five years. See Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits.
Survey, Employee Benefit Research Institute, Washington, D.C., October
2000.

[13] The AMA report claims that "HMO includes HMO point-of-service, and PPO includes PPO point-of service plans for the purposes of this study." However, actual treatment of point-of-service (POS) enrollments is not clear, because InterStudy, AIS, and Harkey data use different POS definitions.

[14] The AMA report notes that indemnity insurance accounts for only 8 percent of commercial insurance, though their source for this information actually specifies that indemnity insurance represents 8 percent of employer provided health insurance. We do not expect the difference to be substantial. InterStudy data

if data were available, all forms of insurance products should be considered.[15] However, lack of data sufficient to perform the ideal analysis does not justify policy decisions based on inappropriate measures of concentration. At the very least, the likely effect that inclusion of other insurance types would have on concentration measures should be considered.

The AMA study uses data from several sources to calculate Herfindahl-Hirschman Index (HHI) concentration measures of the insurance "market." Regulatory agencies, such as the FTC and DOJ, are sensitive to HHI estimates that suggest high levels of concentration.[16] Inclusion of self-insurance in the product market would certainly reduce measured concentration, and as long as indemnity insurers are not also dominant in the combined HMO, PPO, and POS segments, their inclusion would further reduce the concentration levels. The AMA results themselves indicate that, in general, broadening the product market causes concentration measures to decline. In all but four of the 44 MSAs where the AMA produces separate HMO and combined HMO and PPO results, the HHIs are lower with the broader market definition. In general, including all the appropriate insurance options in the product market definition (including indemnity and self-insurance) further reduces the measured HHIs, and associated concerns over managed care concentration. Therefore, the AMA's overly narrow product market definition results in exaggerated measured concentration levels.

Geographic Market for Health Insurance

The AMA report concludes that because of limits on the distance patients and physicians are willing to travel to facilitate health care delivery, the relative geographic market for insurance products is local. However, the AMA confuses the market for health insurance with the market for physician services. The behavior of insurers is constrained not by the distance a patient is willing to travel to see a doctor but by the ability of competing insurers to offer products that vie for that patient's business. As long as competitors are able to offer provider networks that meet the needs of patients in a particular area, they will prevent any single insurer from raising premiums above competitive levels to subscribers or employers in that area. Health plans are regulated at the state level, and insurers that are licensed to operate in a state can often develop statewide provider networks. As a result, in many circumstances it is reasonable to conclude that all insurers in a state can compete for the enrollees in the state. Furthermore, indemnity insurance is not tied to a provider network and can easily be purchased from a nonlocal insurer.

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include managed Medicare and Medicaid enrollees in HMO totals. It is not clear whether the AMA study removed these enrollments in its calculations.

[15] AMA report, p. 4.

[16] The HHI is calculated as the sum of squared market shares, usually multiplied by 100 to avoid decimals. Regulatory guidance provided by the FTC and DOJ suggest that HHI levels less than 1,000 are "unconcentrated;" levels from 1,000 to 1,800 are "moderately concentrated;" and levels exceeding 1,800 are "highly concentrated." See Merger Guidelines, Section 1.5. Characterizations of concentration are not indicative of market power, but are instead used as a first-order approximation to identify market circumstances that might require further regulatory scrutiny.

Indemnity insurers can compete for customers living in any state in which the insurer is licensed.

Appropriate geographic market definition may vary in different locations. Ideally, the scope of existing managed care provider networks and the potential to expand them, combined with the relevant regulatory structure, should be examined in each geographic area to determine the boundaries of geographic competition in that area. The AMA study uses the smallest market identified in available data (either the Metropolitan Statistical Area (MSA) or state) and suggests that it would use even smaller market definitions if possible.[17] In fact, according to the AMA results, only four of 26 states for which both state and MSA-level information was produced had higher HHI estimates for the state market than for the MSA market.[18] As a result, it seems likely that the AMA study has overestimated actual concentration levels by defining the geographic markets too narrowly.

Analysis of Potential Market Entry

The AMA considers the possibility of market entry as remote, given what it deems as entry barriers—financial resource and regulatory compliance requirements. In reality there are three types of market entry that constrain the behavior of local insurers: *de novo* entry, entry from current health insurers operating in other geographic markets, and expansion by fringe suppliers.

De novo entry refers to entry from "new" firms—those firms that do not operate in the health insurance or closely related industries. Despite the AMA's allegations, both industry analysts and academics recognize that entry into managed care markets is relatively easy. For example, Geoffrey E. Harris, managing director for Salomon Smith Barney, noted that the number of HMOs competing in local markets grew from 550 in 1993 to 800 by the end of 1998.[19] Professors Deborah Haas-Wilson and Martin Gaynor also found that, "potential entrants into the market for insurance do not appear to be scarce."[20] Growth has been very rapid during profitable periods. Any current absence of growth is more indicative of a lack of profits at this time, not barriers to entry.
De novo entry has been especially common among provider groups and large health systems. Many large health systems possess resources that allow them to vertically integrate into health insurance markets, such as a stable provider network, financial resources, knowledge of the local health care market, a reputation for providing quality

[17] A geographic market built from an aggregation of county or zip code data (based on patient flow calculations) could provide an accurate market assessment; it is highly unlikely that any reasonable geographic market is contained in a single county or zip code.
[18] Two of these states (Massachusetts and Michigan), along with Florida, effectively demonstrate no difference between state and MSA estimates, with HHI differences of 11 points or less (based on combined HMO/PPO market definition).
[19] "Wall Street Comes to Washington: Analysts' Perspectives on Health System Change." Issue Brief, Center for Studying Health System Change, No. 17, December 1998.
[20] Deborah Haas-Wilson and Martin Gaynor, "Increasing Consolidation in Healthcare Markets: What Are the Antitrust Policy Implications?" *Health Services Research* 33, December 1998, Part II.

health care, and long-standing relationships with patients. Health care providers have consistently demonstrated that they can successfully ramp up their health insurance business, providing a valuable check against attempts by large insurers to exert market power.

Health insurers operating in certain geographic areas can often expand rapidly into new markets if a lack of local competition presents a profit opportunity. The new entrants can be national managed care firms, large indemnity insurers, or regional plans operating in nearby metropolitan areas. Because health insurance is regulated at the state level, once a license is obtained to operate in one locality within a state, it is relatively easy to expand into other areas within the state. Generally, insurers simply need to notify the state insurance department of their intentions. Similarly, firms in an area can easily expand by offering additional product lines, e.g., an HMO initiating a PPO. Furthermore, many of the fixed costs associated with market entry, such as product development, information systems, regulatory approval, and corporate infrastructure have already been incurred in other geographic areas. Many of the national managed care firms have expanded one market at a time, providing a steady supply of new entrants into markets where excess profits are available. The Kaiser Permanente expansion path, starting in California and spreading to other geographic markets, provides a good example of competition injected by current insurers that expand geographically.
Finally, and perhaps most significantly, fringe suppliers of health care insurance services with low enrollments provide an important restraint on the activities of large competitors. With a provider network in place, a license to operate in the state, and local expertise, any attempt to exert market power would be quickly punished by smaller firms. Given the lack of capacity constraints in insurance, the marginal cost of adding one new enrollee or employer enrollee group is relatively small, allowing for rapid expansion without incurring substantial additional costs. Local employers can facilitate such expansion by signing contracts with smaller firms if a dominant firm tried to raise price or reduce services.

Conditions that Hinder the Exercise of Market Power by Insurers

While the AMA study documents concentration levels in select health care "markets," it assumes a link between concentration and market power. Concentration measures are only useful to the extent that they provide information regarding the state of competition. This is only the case when the market is relatively static and when other conditions do not prevent the exercise of market power. In fact, competition remains intense among health plans. In most geographic areas, no single insurer is in a position unilaterally to increase the price of health care coverage above the competitive rate. Any attempt by a single plan to increase prices above the competitive level would be offset by competitors that would seize the opportunity to grow their businesses at the expense of the plan attempting to raise its rates. Similarly, any attempt by a single plan to decrease the rates it pays providers below the competitive level would be offset by its competitors taking the opportunity to augment their preferred provider panels and thereby grow their businesses at the expense of the plan attempting to reduce its fees paid to providers.

There is also no evidence that managed care plans have colluded in the past, or would be able to collude in the foreseeable future. Economic theory suggests that as the number of firms decreases, the likelihood of successful collusion increases, because it is easier for a cartel to agree on what price to charge and/or who may sell the restricted quantity when it has fewer members. There are a number of factors that protect against anticompetitive behavior among managed care plans:

- As the number of purchasers (in this case, employers and individuals) increases, the likelihood of successful collusion declines.[21] With many buyers making independent purchase decisions, collusive pricing agreements break down because it is difficult to determine whether increased sales by a particular firm (plan) occurred randomly or if those sales should be viewed as evidence that the firm is "cheating" on its fellow cartel members by offering lower prices (or higher quality) than that agreed upon by the cartel.

- Given the varying characteristics of health plan offerings, it is difficult for other health insurers to monitor the particular price-service packages that competitors sell. As a result, any efforts to coordinate activity would be difficult to police. Instead health insurers would have strong incentives to "cheat" and provide higher-quality or lower-cost plans.

- Repeated purchases and plan switching by health insurance purchasers provide constant information and incentives for health insurers to deviate from any collusive arrangements. For example, many employers switch the plan or plans they offer to their employees relatively often. Any attempt to collude in this market would be extremely difficult.

- The low profit margins experienced by many managed care organizations in recent years hardly suggest successful collusion, either explicit or implicit.[22]

Research conducted by Pauly *et al*.[23] is consistent with the hypothesis that managed care markets have remained competitive even during periods of rapid consolidation. He explains that in a competitive market, any excess profits earned by managed care

[21] Collusive behavior is further limited when the purchasers have some method of sharing information and experiences regarding health insurance purchases. Employer coalitions, such as the National Business Coalition on Health, aggregate employer concerns and provides a forum to discuss and recommend particular insurers, providing additional constraints on potential anticompetitive behavior.

[22] According to InterStudy, in 1998, in over two thirds of the MSAs, HMOs, as a group, were unprofitable. That is, in 213 MSAs, the HMOs, as a group, had negative operating margins. InterStudy MSA Profile Database, data from January 1998. Operating margins equal premium revenues minus medical and administrative expenses. In that same year, Business Insurance reported that stock prices of the HMOs it tracked declined 1.82 percent. By March 1999, the group's stock price had declined another 5.45 percent. "Analysts Predict Improved HMO Stock Performance," Business Insurance, March 22, 1999.

[23] Mark V. Pauly, Alan L. Hillman, Myoung S. Kim, and Darryl R. Brown, "Competitive Behavior in the HMO Marketplace," *Health Affairs* 21(1), January/February 2002, pp. 199- 201.

companies would not persist because competition from local competitors or new entrants would eliminate them. Pauly tests his hypothesis by comparing HMO profits in 1994 and 1997 (in between which substantial consolidation occurred) and concludes that during the study period, profits did not persist, suggesting that competitive forces prevented HMOs from exerting market power. That is, on average, profits earned by HMOs in 1994 were competed away by 1997. Pauly explains:

> If producers cannot immediately expand volume, prices and profits may rise temporarily. But the hallmark of competition is that these aberrations do not last. Cutting of price to achieve market share eventually erodes them…profits declined much more for firms in MSAs in which profits were initially high than in those in which they were low…In a period of substantial change, the HMO markets we studied displayed some of the key characteristics of competitive markets…In addition, they generally exhibited behavior consistent with competition.
>
> Why do HMO markets generally seem to become and remain competitive? First, the HMO enrollment at which administrative costs per enrollee are minimized appears to be small relative to the overall potential market in MSAs; there is little chance of natural monopoly for health insurers in many of them. Second, the presence of such close (according to some) substitutes as indemnity and PPO plans in every market puts competitive pressures on HMO prices and profits. Third, large employers are perfectly capable of making managed care-type arrangements directly with health care delivery systems if local HMOs try to raise profits by increasing prices, relative to the competitive level.

Efficiencies Due to Size

Although the AMA report expresses concern over the size of insurers, managed care companies operate most efficiently at some minimum efficient scale.[24] While such economies of scale in health insurance are likely modest, in some smaller markets only a limited number of firms will be able to operate efficiently. In many cases, concentration levels greater than 1,800 may be desirable in order to allow local competitors to operate cost-effectively. Firms that achieve greater efficiency (lower costs) can offer products at lower prices and compete more effectively. Preventing the consolidation of two firms that would achieve greater efficiency combined would lead to higher prices for consumers by preventing the formation of a new firm that could reduce its costs and compete more effectively. Thus high concentration rates in some markets might indicate

[24] See, for example, Douglas Wholey, Roger Feldman, Jon B. Christianson, and John Enberg, "Scale and Scope Economies among Health Maintenance Organizations," *Journal of Health Economics* 15(6), December 1996, pp. 657–684; and R. S. Given, "Economies of Scale and Scope as an Explanation of Merger and Output Diversification Activities in the Health Maintenance Organization Industry," *Journal of Health Economics* 15(6), December 1996, pp. 685–713.

that the competitors in the market operate most efficiently and compete most effectively at high enrollment levels.

Summary: Health Insurance Competition

As the preceding discussion indicates, HHI estimates greater than 1,800 do not by themselves indicate a lack of competition. In most markets considered "highly concentrated," multiple firms compete for enrollees and providers, the threat of entry is constant, firms have been unable to maintain persistent profits, and there has been no evidence of collusion. Contrary to what the AMA suggests,[25] the antitrust authorities consider multiple factors that affect competition. In fact, concentration levels generally provide only the starting basis from which to consider the likely competitive effects of a particular transaction or behavior. Recent activity in other industries demonstrate that the DOJ and FTC do not base their decisions on concentration measures alone, precisely because there are many other factors to consider. Cable television, defense contracting, DRAM semiconductor computer chips, college textbooks, job recruitment Web sites, and wireless phones describe a few of the industries that have consolidated to five or fewer large firms within the oversight of federal regulators.[26]

Examples of prosecution against health insurers for issues related to market power are scarce. The lack of activity, however, is not attributable to a lack of scrutiny. In addition to the national antitrust enforcement agencies (FTC and DOJ), state Attorneys General (state AGs) have become increasingly active in the last 10 years. Where state AGs once waited for federal enforcers to address issues of competition, they now often seek out and prosecute anticompetitive behavior in advance or in tandem with their federal counterparts.[27] In addition, while the AMA report is quick to identify the entry barriers erected by state licensure requirements, it fails to mention the review capabilities available to state departments of insurance or health that provide administrative oversight of insurers, and follow up on concerns expressed by customers, competitors, or contractors.

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[25] Although the AMA report does concede that other factors (such as barriers to entry) are considered by the antitrust authorities, the focus of the report is on concentration, which also forms the basis of the AMA's policy prescriptions.

[26] Yochi J. Dreazen, Greg Ip, and Nicholas Kulish, "Oligopolies are on the Rise as the Urge to Merge Grows," *Wall Street Journal*, February 25, 2002, p. A1.

[27] Seven states have pursued actions against HMOs since 1998. See Laura B. Benko, "Attorneys General Take On HMOs," *Modern Healthcare*, February 18, 2002, p. 24. In addition, the Texas Attorney General worked in collaboration with the DOJ to contest the Aetna-Prudential transaction, resulting in divestitures in Dallas and Houston; see Revised Competitive Impact Statement, *United States of America and the State of Texas v. Aetna Inc. and The Prudential Insurance Company of America*, Civil Action No. 3-99CV1398-H, p. 1 (at http://www.usdoj.gov/atr/cases/f2600/2648.pdf).

Competition in Physician Services

The AMA study expresses substantial concern over the potential for insurers to exercise "monopsony power"[28] in the market for physician services. However the AMA study is inconclusive on this issue for at least three reasons:

- The AMA analysis never provides a meaningful measure of monopsony power and ignores evidence indicating that monopsony power is absent.
- The AMA report disregards recent changes in the health care market that have enhanced the negotiation position of health care providers.
- Omitted from the AMA study is the success of existing antitrust law in preserving a competitive balance in the market for physician services.

Measuring Monopsony Power

The AMA report relies on links between the market for health insurance and the market for physician services to infer conclusions regarding insurer market power. It states that "those physicians whose practices depend most heavily on patients covered by a particular insurer are most exposed to the potential for unreasonable contract terms and anticompetitive reimbursement rates."[29] While some connection may exist between an insurer's position in the market for health insurance and its ability to negotiate with physicians, such a connection does not imply that the two are the same. Furthermore, to the extent that seller and buyer market power are related, the preceding discussion of competition in health insurance suggests substantial competition in the purchase of physician services.

There are a number of reasons why, even if managed care organizations possessed market power in selling health insurance, they may not have any purchasing power for health care provider services. First, physicians have other significant sources of income (e.g., Medicare). Second, since plans must offer a network with full specialty and geographic coverage, many specialty physicians in local areas possess their own market power. As Pauly notes, "Market power in selling insurance need not imply monopsony power since market-level input supply curves might be highly elastic…So it is quite possible for local health plans to have seller (monopoly) power but not buyer (monopsony) power…measuring the concentration of buyers in the market is not, in itself, sufficient to

[28] "Monopsony" is an industry structure characterized by a single *purchaser* of a good or service (a "monopsonist"). Standard economic models predict that a "monopsonist" will reduce the amount of the good or service purchased in order to avoid driving up its price, thereby increasing its costs. In the present context, the AMA is concerned that dominant insurers will reduce the amount of physician services purchased and depress physician fees below competitive levels.

[29] AMA study, p. 12.

establish the existence or extent of monopsony power."[30] Therefore, the HHI, measured in a market limited to HMOs or HMOs and PPOs, is clearly not the appropriate measure of monopsony power.

The AMA argues that the HHI is meaningful because "if the health insurer has both a high percentage of the overall market and a high percentage of the individual physician's practice, the physician will have great difficulty replacing lost business from that health insurer."[31] However, the AMA never measures concentration in "the overall market," instead focusing on select managed care product lines. More relevant to the monopsony discussion, the AMA report does not measure the "percentage of the individual physician's practice" revenues received from a single insurer. Without analyzing the universe of purchasers of physician services, the AMA report cannot measure monopsony power.

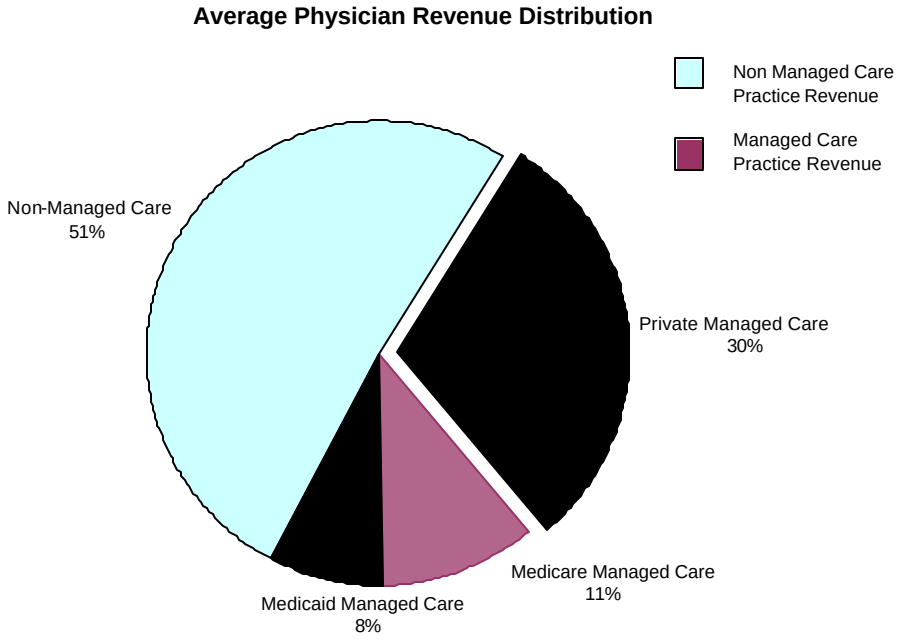
A simple stylized example illustrates the lack of connection between insurer concentration and negotiating ability. Consider an MSA with only three HMOs, one with a 50 percent HMO enrollment share and the other two each with a 25 percent share. The HMO HHI in this town is 3,750, exceeding the threshold of "highly concentrated" under the Merger Guidelines. However, suppose also that local physicians obtain 50 percent of total practice revenue from managed care, and only half of that from the three HMOs. A typical physician practice that contracts with all three HMOs would only rely on the "dominant" HMO for 12.5 percent of its revenue, or for less than the 30 percent figure suggested by the AMA to be overly burdensome. Without even considering whether the physicians might have unique characteristics that enhance their negotiating leverage, this example illustrates that there is no direct connection between concentration in the selling market and monopsony power.

Other measures shed greater light on the ability of physicians to negotiate with insurers. For example, as Figure 1 indicates, in its Physician Socioeconomic Statistics, the AMA estimates that, on average, physicians obtain less than half of practice revenues from managed care contracts.[32] These revenues are divided between multiple private plans, including:

- HMOs, PPOs, and POS plans (30.4 percent),
- Medicare+Choice plans (10.5 percent),
- Medicaid managed care plans (7.7 percent),

[30] Pauly, Mark V. "Managed Care, Market Power, and Monopsony," *Health Services Research*, December 1998, Part 11, p. 1443.
[31] AMA study, p. 12.
[32] Of course, the percentage of practice revenues from managed care is likely to vary from MSA to MSA, but there is no reason to expect it to be higher in highly concentrated MSAs. In fact, to the extent that MSAs with high HMO concentration also have low HMO penetration, the effect of concentration rates on physician negotiating ability will be mitigated.

making it unlikely for the vast majority of physicians that a substantial share of revenue comes from any single plan. Moreover, the AMA report demonstrates that multiple private managed care firms exist in almost all local areas. Physicians have the ability to tailor their patient mix to attract Medicare, Medicaid, PPO and indemnity patients, allowing them to credibly threaten nonparticipation in any single plan's provider network. Several examples of successful negotiation by physicians are noted below.



Source: American Medical Association. Physician Socioeconomic Statistics 2000-2002.

Physicians' Negotiation Position

The AMA report suggests that in MSAs with high managed care concentration, physicians are unable to negotiate effectively with dominant insurers, yet the report fails to note situations when physicians possess substantial negotiating clout. Physicians employ several methods to make themselves indispensable to health insurers. Some physicians are trained in certain specialties that are often in short supply and high demand, such as cardiology or oncology. In many rural areas, where managed care penetration is low and there are few choices of physicians, physicians routinely refuse to accept managed care payment rates, often preventing the development of low-priced managed care products. Some physicians, often those with academic affiliations, cultivate reputations for high-quality care, regardless of specialty area. As a result, each health insurer that intends to offer coverage in relevant specialties or geographic locations must have an agreement in place with these influential physicians in order to be competitive with other plans: "Indeed, after years of consolidating market share and

strengthening their brand names, some providers now enjoy "must-have" status in plans' networks."[33] While independent physicians cannot discuss acceptable contract terms collectively, under existing antitrust laws they can independently reject untenable offers and can even employ a messenger model to achieve efficient negotiations with health insurers.[34]

Changes in consumer demand and increased sophistication of providers have improved physicians' ability to negotiate effectively with health plans.[35] In order to compete for enrollees, plans have been forced to offer less restrictive managed care products, and restrictions on existing products are being reduced. As a result, insurers' ability to exclude specific physicians or physician groups is declining, and they are forced to pay higher fees in order to maintain network stability. Recent interviews with managed care plans conducted as part of the Community Tracking Study provide insight into the changing nature of managed care.

> Consumers are becoming more active health care participants and are demanding more choice, greater flexibility, and fewer restrictions on access and service delivery. Employers (purchasers) are demanding less restrictive managed care to appease employees and at least so far have been willing to absorb most of the higher ensuing costs. Consumers' and purchasers' preferences for broad and stable networks give providers the upper hand in contract negotiations with plans.[36]

Furthermore, "the drive to offer new, less restrictive products is especially noteworthy in markets with high HMO penetration rates,"[37] suggesting that physicians' negotiating positions are improving in those areas where they are most dependent on managed care revenue.

An area of notable success for providers has been the rejection of risk-sharing arrangements. Although managed care plans attempted to pass some risk onto providers, these efforts have been largely abandoned as physicians resisted. Many of the remaining at-risk agreements between physicians and insurers remain in place only because insurers are paying higher rates in order to maintain an adequate provider network.[38]

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[33] Bradley C. Strunk, Kelley Devers, and Robert E. Hurley. "Issue Brief No. 40: Health Plan-Provider Showdowns on the Rise," Center for Studying Health System Change, June 2001. http://www.hschange.org/CONTENT/326/.

[34] "Messenger models," described below, offer physicians a method or organizing negotiations with managed care without running afoul of competition regulations.

[35] The abandoned use of 'all products' clauses (which requires health care providers to participate in all or none of an insurers plans) demonstrates both the declining leverage of even large health insurers as well as the availability of current relief mechanisms to address health provider concerns. See "'All Products' Clauses Fade from Physician Contracts," *Managed Care*, August 2000 (http://www.managedcaremag.com/archives/0008/0008.states.html) for a description of all products clauses.

[36] Draper *et al*., p. 11.

[37] *Ibid*, p. 14.

[38] *Ibid*, p. 17.

Finally, competition and the difficulty in constructing and maintaining health care provider networks prevent any health plan from being able to earn excess profits by reducing fees to physicians below competitive rates. If a health plan attempted to pay less than the competitive fee to its providers, physicians would facilitate the expansion of both alternative existing firms and new entrants. Since very few physicians sell their services exclusively to a single managed care plan, physicians would easily encourage their patients to switch their coverage to a plan where the physician earned higher fees. Patients are far more loyal to their doctors than to their managed care plans.

There are numerous other examples of providers refusing to accept the terms of managed care contracts, resulting in serious harm to the insurer's bottom line. In October 2000, Saint Joseph's Health System in Orange County, California solicited bids from insurers to determine which five of fourteen contracts would retain access to St. Joseph's. As a result of the aggressive bidding strategy, St. Joseph's canceled its contract with Pacificare, leading Pacificare to predict losses of 100,000 patients to alternative insurers. Similarly, Regence Blue Cross in Seattle was forced to delay and adjust introduction of a new reimbursement schedule after more than 150 specialists decided not to renew their contracts as of January 1, 2000. These incidents are not isolated; similar instances were reported in the majority of communities surveyed.[39]

The Community Tracking Study also found that many sources of contention between insurers and providers are being addressed within the confines of existing policy, due in large part to physicians' ability to negotiate desirable contracts. For example, preauthorization requirements are becoming less burdensome for patients, referral processes are becoming more streamlined, and managed care companies are focusing on consumer-driven quality improvement initiatives.[40] According to the survey findings, insurers are recognizing the importance of keeping providers satisfied, as lengthy contract negotiations are costly, unpredictable, and may cause dissatisfaction with consumers. In every community surveyed, providers are pushing back against managed care practices and are successfully demanding higher fees, more autonomy, and prompt payment.

These examples provide support for two fundamental themes. First, physicians and other health care providers have been able to negotiate quite effectively with managed care organizations and have become increasingly savvy in negotiating favorable contracts. Second, these successes for health care providers have come *without* any regulatory or legislative antitrust reform. State and federal efforts to ensure quality of care for consumers have addressed many of the concerns that may have been a source of contention between insurers and providers. Moreover, quality is often aggressively pursued by insurers as a dimension of competition. Physicians' continued interest in antitrust waivers, therefore, appears to be primarily related to their desires to increase fees.

[39] Strunk *et al*., http://www.hschange.org/CONTENT/326/.
[40] Draper *et al*., p. 15.

Trends in Physician Consolidation

In recent years, physicians are increasingly joining large groups in order to negotiate more effectively with insurers.[41] For example, the merger of two large IPAs in Arlington, Texas, in June 2000 was indicative of a trend of consolidation in the area. The stated purpose of the merger was to improve physician negotiating clout: "We both realized there was really no point in competing with each other…" explained the network manager of the new IPA.[42] From 1995 to 1999, the proportion of physicians engaged in practices with one to three physicians declined by 5 percent, while the proportion involved in a group practice with more than 8 physicians increased by 24 percent.[43] The majority of physicians now belong to group practices with at least three physicians.[44] While three may seem an insufficient number to provide much bargaining leverage, in many situations, a group of three specialists may represent a "must have" group in the community. Moreover, many physician groups are substantially larger.

The recent consolidation among health care providers has increased physician negotiating leverage with managed care companies. As noted in several recent studies,[45] consolidation by health care providers has resulted in significant and immediate increases in both physician reimbursement and health insurance premiums. For example, Sutter Health, a health care provider with 26 hospitals and 5,000 physicians servicing Northern California, demanded a 25 percent payment hike from insurer Health Net in fall 2001. After pulling employees from Health Net and implementing an aggressive marketing strategy, Sutter Health's approach convinced 20,000 members to leave Health Net before the insurer conceded to the payment increase. Immediately after reaching a two-year agreement, Health Net increased insurance premiums by about 15 percent.[46]

Partners HealthCare recently capitalized on its "must-have" status in a contract dispute with Tufts Health Plan, a Massachusetts HMO. Tufts initially informed nearly 200,000 enrollees that HealthPartners facilities would be excluded from the Tufts network. Patient response was critical; according to Tufts' general counsel, so many enrollees "would drop us that we wouldn't have a health network anymore."[47] Tufts relented, committing to a 30 percent fee increase over three years to secure access to Partners HealthCare facilities and personnel.

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[41] *Ibid*, p. 11.
[42] Dallas Business Journal, "Merger in Arlington illustrates trend in IPAs," June 2, 2000.
[43] AMA Physician Socioeconomic Statistics, 2000-2002, p. 110; AMA Physician Marketplace Statistics, 1995, p. 134.
[44] AMA Physician Marketplace Statistics, 1997/1998, p. 134.
[45] See, for example, Dreazen *et al.*; Joseph Weber, "The New Power Play in Health Care," *Business Week*, January 28, 2002; and California Association of Health Plans, "Four Managed Care Myths," April 20, 2000 (http://www.calhealthplans.com/PDF_Files/4myths.PDF).
[46] Weber, p. 90.
[47] Dreazen *et al.*, p. A1.

Similarly, concerns have been raised with much smaller numbers of physicians in less populated areas. For example, in an evaluation of Yellowstone Physicians LLC, the FTC noted that the proposed physician group would have significant percentages of certain specialties due to the small number of total physicians available in the market (14 general surgeons and 15 obstetricians/gynecologists). While noting concern regarding these concentration levels, the FTC found plausible business justifications for the network and did not oppose it.[48] Federal regulators recognize unique characteristics of rural markets and monitor competition accordingly: "while the demands of the antitrust laws, and the competitive values on which they are based, need to be kept in mind by those who develop and operate provider networks and health plans, antitrust should not be a barrier to efforts by rural providers to combine in ways that improve the efficiency or marketability of their services."[49]

Large physician groups are especially effective when bargaining with managed care companies. In many geographic areas, it is nearly impossible to offer a plan that does not include particular physician groups.[50] This fact enhances the bargaining power of these (and other) large physician groups, counterbalancing any power that a health plan might attempt to exert over doctors. It is in physicians' interests to sign contracts with every managed care company willing to pay competitive fees. In this way, they can offer their existing and prospective patients the maximum flexibility possible.

Current Antitrust Enforcement of Provider Networks

As with horizontal consolidations of firms in any industry, antitrust authorities scrutinize physician mergers and joint ventures to ensure that competition is maintained. In practice, physician groups are able to engage in collective negotiations under certain conditions. The analytical framework used by the antitrust agencies to evaluate collective negotiation by physicians over price and price-related terms is primarily set forth in Statements 8 and 9 of the joint FTC and DOJ (*Statements of Antitrust Enforcement Policy in Health Care)*, most recently updated in 1996 ("Statements").[51]

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[48] "Advisory Opinion – Yellowstone Physicians LLC," Federal Trade Commission, May 14, 1997. http://www.ftc.gov/bc/adops/yelltone.htm.

[49] "Antitrust Issues Raised by Rural Health Networks," Robert F. Leibenluft, Federal Trade Commission, February 20, 1998. http://www.ftc.gov/bc/ruralsp.htm#N_3_.

[50] The dispute between another Dallas-area physician group, Genesis Group, and Aetna that occurred prior to Aetna's merger with Prudential illustrates the power of a single physician group. Genesis Group, and its 748 doctors, terminated its contract with Aetna. Thus, despite Aetna's size, the Company learned it was far from the "only game in town." Indeed, the Genesis Group had contracts with over 80 other managed care companies. This abundance of contracts permitted Genesis to encourage its doctors' patients to switch health plans so that they would not have to switch physicians. The press documented the group's success, for example, noting that one human resources director acknowledged that, rather than wait for employee complaints, she added another plan that included the Genesis Group. The papers also reported that Dr. Shouse, vice chair of the Genesis Physicians Practice Association, noted that a physician could expect to drop Aetna with little or no change in cash flow. In contrast, Aetna lost enrollment and revenues from the Genesis departure.

[51] While health care is the only industry in which the antitrust agencies have issued industry-specific guidelines, the agencies emphasize that the Health Care Statements are meant only to clarify the application

As former FTC chairman Robert Pitofsky noted, the Statements "have been widely cited for reducing uncertainty and recognizing that wide range of joint activities by health care providers potentially can be procompetitive and benefit customers."[52]

The analytical principles set out in these Statements as well their practical application to current antitrust policy enforcement are explored below. Overall, many types of physician networks are regarded as lawful by the agencies, provided these organizations also create value for their customers and do not pose a substantial threat to competition.

The Health Care Statements

The Statements first describe those types of physician networks in which collective fee negotiation will not be challenged by the agencies absent extraordinary circumstances. The Statements strongly emphasize that these safety zones do not define ceilings on the types of physician activities that are considered lawful, but rather establish floors below which collective negotiation by physicians will not be challenged.

Two criteria must be met in order for physician network joint ventures to qualify for these so-called "safety zones." First, all physician-owned organizations that wish to engage in collective fee negotiation must "share substantial financial risk." To qualify, the risk sharing arrangements must have each participant's compensation tied to the performance of the entire group.[53] Such financial risk sharing should affect incentives to encourage participating physicians to engage in a broad range of efficiency-generating activities relating to clinical as well as business operations. In this situation, collective control over the financial terms at which the group sells it services can be justified.

Safety zone treatment also limits the maximum market share of the venture. When a network is exclusive, and meets the financial risk-sharing criterion discussed above, the network must encompass no more than 20 percent of the providers in the relevant market(s) to qualify for safety zone treatment. On the other hand, if the financial risk-sharing criterion is met and the network is nonexclusive, a 30 percent threshold applies.[54]

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of standard antitrust principles to the health care area and are not meant to indicate there is more lenient or more strict application of the antitrust laws in such markets.

[52] Robert Pitofsky, Prepared Statement of Federal Trade Commission Concerning H.R. 4277, The Quality Health-Care Coalition Act of 1998. July 29, 1998.

[53] The Statements also emphasize that the examples of financial risk sharing enumerated therein are not meant to be an exhaustive list and that it is not the agencies' intention to drive the form or structure of physician networks. Indeed, in 1996, the Statements were revised to list several forms of financial risk sharing not included in the previous versions.

[54] Because physician networks may represent themselves as nonexclusive while behaving in an exclusive manner, the agencies lay out several criteria that must be met beyond a simple declaration of nonexclusivity. However, it may be difficult to establish the fact of nonexclusivity when managed care has not yet penetrated an area. The Statements recognize this dilemma and lay out several scenarios where a physician network can establish the fact of nonexclusivity. For example, the sixth example regarding physician network joint ventures discusses an IPA with more than 30 percent of the physicians in a rural area where managed care has not yet entered, which appears, nonetheless, to be nonexclusive.

The Statements make it clear that physician networks that do not qualify for "safety zone" treatment are often also lawful. Thus, the Statements indicate that physician joint ventures that share substantial financial risk, but fall outside the market share thresholds, even significantly so, may be procompetitive depending on a number of factors. Such factors include the number of physicians in an area, the circumstances surrounding the formation of the venture (e.g., whether the venture formed at the initiative of payors rather than providers), the degree of exclusivity, steps taken to prevent anticompetitive spillovers, and the number of competitors to the proposed venture.

Similarly, the Statements also emphasize that a venture that does not share financial risk may also be lawful, if it creates significant efficiencies. This can be true even when its membership exceeds the market share thresholds. Indeed, the revised versions of the Statements issued in 1996 significantly expanded the list of examples of the types of arrangements that can establish such efficiency potential.

The Statements also describe how physician organizations that do not wish to share substantial financial risk or otherwise integrate can still lawfully offer their services to employers and third-party payors using one of several types of "messenger models." The key ingredient underlying these messenger models is that the messenger must not negotiate on the providers' behalf nor should it in any way facilitate an agreement among competitors on prices or price-related terms.

Physician Antitrust Policy in Practice

The application of antitrust policy to the health care area is manifested in various consent agreements negotiated by the agencies with physician organizations and through the agencies' Business Review and Advisory Opinion processes. These suggest that enforcement actions have only been brought against organizations whose structure and conduct indicated they posed a substantial threat to competition without any significant offsetting efficiency potential. As evidenced by the agencies' Business Review and Advisory Opinion processes, many types of physician network arrangements are lawful.

Consent Decrees

The agencies have prosecuted only a handful of physician network joint ventures through the years. These entities involved physician groups with extremely high market shares that were involved in arrangements that indicated they were cartel devices aimed solely or primarily at increasing prices and that held out very little prospect of efficiency benefit. These situations were resolved by consent decrees in which the named party agrees to modify its activities or organization without formal acknowledgment of anticompetitive behavior.

For example, in 1996 the FTC took action against Montana Associated Physicians Inc. (MAPI). According to the FTC's complaint, the approximately 115 physician-shareholders in MAPI comprised approximately 43 percent of all physicians in Billings, Montana and over 80 percent of all "independent" Billings physicians (those who were not part of a large multispecialty physician practice known as the Billings Clinic or employed by a hospital). The physicians agreed to settle charges that MAPI acted as a group to delay the entry of managed care into Billings and to raise the prices its members would accept from insurers. Among various actions, the FTC complaint alleged that, when a PPO sought to collect fee information from MAPI members in order to devise a proposed fee schedule, MAPI urged its members to submit prices higher than they currently were charging.

A 1999 consent order involved the North Lake Tahoe Medical Group, Inc. The physician membership of this organization comprised at least 78 percent of the physicians in a market designated as the North Lake Tahoe area of California and at least 70 percent of the physicians in a market designated as the South Lake Tahoe area of California. This complaint alleged that the IPA organization encouraged its members to cease participating in a Blue Shield PPO, threatened area employers that few of its members would continue to participate in Blue Shield, and that these employers should contract with other payors that had agreed to contract with the IPA.

As these examples illustrate, in some situations physician networks have been little more than cartel devices and continued antitrust enforcement in this area appears warranted.

Advisory Opinions and Business Review Letters

In order to reduce the inevitable uncertainty associated with antitrust enforcement, the agencies have indicated that persons seeking guidance regarding the legality of their conduct can take advantage of the DOJ's "Business Review Letter" procedure or the FTC's "Advisory Opinion" procedure. These processes do not appear particularly burdensome[55] and generally provide quick turnaround.

Since the 1996 version of the Statements was issued, the agencies have issued 21 opinions involving proposed horizontal agreements among physicians; they approved all but one.[56] These business letters and advisory opinions attest to the numerous types of lawful physician organizations forming in the marketplace, including multispecialty and single-specialty networks of various sizes (ranging from 11 physicians to more than 400), and networks in rural as well as all sizes of urban areas. Almost all of the networks addressed in these opinions were nonexclusive in nature, and almost all involved financial risk sharing of some type.[57] Many of the review letters described numerous other ways proposed joint ventures would seek to control costs and generate value for their customers.

In addition, most of the organizations approved by the agencies exceeded the market share thresholds established in the safety zones, often by a substantial amount. For example, in its May 14, 1997, advisory opinion for Yellowstone Physicians L.L.C., the FTC approved a venture that proposed to contract with 39 percent of the active physicians in the Billings, Montana, area and considerably higher percentages in some specialties. Indeed, Yellowstone proposed to include 64 percent of the general surgeons

[55] For a list of the materials required, see Judith Moreland, "Overview of the Advisory Opinion Process at the Federal Trade Commission." Speech presented at the National Health Lawyers Association, Antitrust in the Healthcare Field, Washington, DC, February 13–14, 1997.

[56] The following opinions specifically involving horizontal networks involving physicians (as opposed to horizontal agreements among providers in general) were issued during this time period: Sierra CommCare, Inc. (8/15/96); Cincinnati Regional Orthopedic and Sports Medicine Association (10/4/96); Home Care Alliance, Inc. (10/4/1996); Anne Arundel Medical Center Anesthesiologists (10/17/1996); Orthopedic Associates of Mobile, P.A. and the Bone Joint Center of Mobile (4/16/1997); CVT Surgical Center (CVT) and Vascular Surgery Associates (VSA) of Baton Rouge (4/16/1997); Allentown, Pennsylvania Gastroenterologists (7/7/1997); New Jersey Pharmacists Association (NJPA) (8/12/1997); Santa Fe Managed Care Organization ("SFMC") (2/12/97); Southwest Orthopedic Specialists (6/10/97); Vermont Physicians Clinic (7/30/97); First Priority Health System ("FPHS") (11/3/97); Heritage Alliance/Lackawanna Physicians' Organization (9/15/98); Yellowstone Physicians LLC (5/14/97); Phoenix Medical Network, Inc. (5/19/98); Associates in Neurology, Inc. (8/13/98); Orange Pharmacy Equitable Network ("OPEN") (5/19/1999); MedSouth, Inc. (2/19/2002); Preferred Physicians Medical Group ("PPMG") (7/23/1999); Midwest Behavioral Health Care LLC ("MBH") (2/4/2000); and Rio Grande Eye Associates, P.A. (8/29/2001). The only unfavorable letter concerned the proposed formation of Allentown, Pennsylvania Gastroenterologists. The combined entity would have had a very high market share (63 to 86 percent depending on the geographic market definition), and no merger-specific efficiencies were demonstrated.

[57] Two exceptions were Sierra CommCare, Inc. and Santa Fe Managed Care Organization, which indicated that for contracts not involving risk, the messenger model would be utilized.

as participants, although those surgeons practiced in three different practice groups. If the AMA's concerns about a relationship between market share and undue negotiating power are applied to physician markets, these levels would raise red flags. Yet the FTC allowed its formation.

More recently, the Federal Trade Commission approved a large IPA's request to negotiate with managed care organizations on behalf of its member physicians. Over 400 physicians participate in MedSouth, Inc., a physician independent practice association located in Denver. In a number of specialties, they constitute half or more of the physicians with admitting privileges at the three hospitals in south Denver. The advisory opinion acknowledges that "access to some significant number of MedSouth doctors is necessary for health plans to have adequate networks to support a marketable product and to have enough conveniently located doctors to care for their current enrollees."[58] Nonetheless, the FTC concluded that "The proposed program appears to have the potential to improve the quality and effectiveness of health care services that are delivered to patients, and thus to provide important benefits to consumers…. We have concluded that we would not recommend a challenge to MedSouth fully implementing the program and then offering it to payers on a collective basis."[59]

Current antitrust policy appears to offer physicians substantial scope to form organizations that can engage in collective negotiation. Indeed, as seen in the agencies' business letters and advisory opinions, such organizations can be viewed as lawful even when they exceed the market thresholds laid out in the Statements by a substantial amount. Nevertheless, as evidenced by the agencies' enforcement actions, physician-controlled networks can also be cartel devices whose sole purpose is to increase prices or forestall the entry of managed care. Thus, continued vigilance is warranted to ensure that innovative cost and quality assurance efforts in the physician services area will continue. Such vigilance is also appropriately applied to managed care plans.

Conclusions

The AMA report represents a significant effort in documenting concentration levels (measured using the HHI) for various product and geographic market definitions. However, the reported concentration measures are misleading because they fail to define relevant product and geographic markets appropriately for the questions at hand. Instead, they use incomplete data sources that do not permit measurement that reflects the economic realities of the health care system. Rather they ignore many sources of health insurance for consumers and sources of payment for physicians. Moreover, they rely on overly narrow geographic areas.

[58] Federal Trade Commission, February 19, 2002. http://www.ftc.gov/bc/adops/medsouth.htm
[59] Ibid

More importantly, the AMA's sole focus on concentration levels leads to misleading conclusions. A more complete analysis of competition in health care markets (both provider and financing) considers such other factors as ease of entry on the insurer side and the unique (indispensable) position that many physician groups hold. In addition, the AMA review ignores recent trends including more flexible managed care network organizations and consolidation among physicians.

The market for health care financing remains vigorously competitive and is therefore highly responsive to patient and physician needs. Managed care firms have been unable to exert market power in order to earn excessive, persistent profits; rather, competition has ensured that profit margins have been razor thin for many years. The market for physician services also benefits from healthy competition, with multiple purchasers generally competing for services from multiple providers. The vigilant enforcement of existing antitrust legislation has contributed to keeping these markets competitive and, in general, has been equitably applied to both providers and insurers.