September 30, 2002

The Honorable Timothy J. Muris, JD
Chairman
Federal Trade Commission
600 Pennsylvania Ave., NW
Washington, DC 20580

RE: Comments regarding the Federal Trade Commission (FTC) Workshop on Health Care Competition Law and Policy.

Dear Chairman Muris:

On behalf of the 64,000 Fellows of the American College of Surgeons (ACS), I would like to commend the Commission for its efforts to provide a detailed perspective on the future of its analysis, enforcement, and compliance efforts at the AHealth Care and Competition Law and Policy Workshop@ hosted earlier this month. I think this was a good opportunity to discuss the implications of the FTC=s growing emphasis on health care and for your colleagues to hear about the potential impact of the Commission=s efforts on our patients. I was hoping we might use this opportunity to provide some insight for the record on a regulatory trend that we find frustrating, if not problematic, for American medicine.

The College recognizes the importance of the 1996 antitrust guidance which outlines the framework within which a practice or group of physicians may negotiate economic contracts as a joint entity and we encourage our Fellows to observe the letter and spirit of the document. In light of the clarification we received at the workshop and in the recent settlement agreements and advisory opinions, we also plan to remind them of the importance of observing the intent of the Amessenger model@ requirements and the necessity of receiving and reviewing all offers.

We realize the 1996 antitrust regulations were a major step in helping flesh out options for shared contracting. The FTC should be congratulated for clarifying the framework for these Asafety zones.@ However, there is a growing concern that Ashared economic risk@ as

outlined in the 1996 ruling is no longer sufficient to protect physician joint ventures from antitrust liability.

For example, does the expanding Commission emphasis on Ashared clinical and quality improvement efforts@ and the Aefficiencies@ that they might produce pose a potential problem of interpretation in the years to come? Could the Commission find itself in a situation where it must become more prescriptive and be asked to define quality and verify the value of integrated clinical systems which are evolving and vary in their ability to deliver the efficiencies and apparent consumer benefits?

We are particularly troubled that in several of the most recent settlement opinions there are references that imply that Aa qualified risk-sharing joint arrangement@ must ***both*** share economic risk ***and*** also prove that it has achieved quality and financial efficiencies. This interpretation, if correct, raises at least two serious concerns. First, incorporating a quality or clinical integration component into the shared risk requirement would hold physicians to a higher standard than others who are subject to the antitrust laws. Second, it would create considerable uncertainty as to whether a group of physicians can qualify for the so-called rule of reason analysis because of the inherent difficulty in judging the adequacy of quality and clinical integration systems.

As you know, insurance companies of all kinds have been allowed to consolidate, concentrating their market power and leverage. They have done so without the FTC applying to them anything comparable to a quality/clinical integration requirement. Moreover, they have had the freedom to make business decisions based on economics in the marketplace. For example, medical liability companies can simply make a business decision to withdraw from states, leaving countless physicians scrambling for coverage and creating a significant access crisis in more than 13 states.

Yet, in the most recent Denver settlement, the FTC seems to be saying that groups of physicians, many of whom are small businesses representing fewer than five members, are not allowed to make comparable Abusiness decisions@ and decline certain contracts that don=t keep pace with the cost of providing patient care unless they ***both*** share substantial financial risk ***and*** achieve some degree of clinical integration. In our view, application by the FTC of this additional requirement solely to physicians would constitute a double standard and further skew the already Aunlevel playing field@ between physicians and health plans.

The prime concern of the College and its Fellows is preservation of the patient-physician relationship. Consequently, the FTC=s focus on physician practices is troubling. That, coupled with the increased market consolidation of insurance companies, presents an inordinate disadvantage to physicians who ultimately are responsible for their patients= health care. But, when we add the additional focus of the Commission suggesting that the only way to pursue joint contracting is by sharing financial risk (and emphasis is being placed on capitation rather than fee for service) ***and*** integrated quality improvement efforts, we pause and ask whether the degree of the Commission=s emphasis and resources may be misplaced and could present problems of interpretation in the future.

The Commission=s apparent policy of requiring Ashared risk@ physician joint ventures to meet additional clinical integration and quality requirements runs the risk of involving the FTC in regulating the types of quality and clinical integration systems that are put in place - something that it is ill-suited to do. There are countless efforts and voices calling for tracking the quality of care and integrating those measures with appropriate monitors to detect trends that can improve care and provide economic and clinical efficiencies. As an organization that was founded on the need to establish standards for high-quality patient care, the College supports and encourages clinical quality improvement. However, we believe that the best place for this to occur is at the site of care, not through the FTC or through health insurers that have a vested interest in controlling cost and access to care.

Finally, we also fear that because the areas of quality improvement and clinical integration are so complex, somewhat subjective, and rapidly evolving, an FTC requirement for Arisk sharing@ physician joint ventures to have quality and clinical integration systems in place could create significant uncertainty about whether specific business arrangements will withstand antitrust scrutiny. This in turn may invite insurers and other payers with which they negotiate to call for antitrust investigations of wholly legitimate physician groups - further depleting physician resources that have already been severely constrained by significant cuts from federal and state health programs, such as Medicare and Medicaid.

While we know that the Commission=s initial involvement in the quality and clinical integration issues was in an attempt to create an alternative Asafety zone@ for the purposes of allowing joint contracting, the incorporation of a clinical integration and quality component into the shared risk Asafety zone@ introduces an undesirable element of uncertainty about who will qualify for its protections. This casts a significant pall on physician groups and poses a very real threat for these small businesses.

In essence, we believe the FTC in its recent settlement agreements and the advisory opinion to Med South has warned American medicine that if collective efforts to increase quality and reduce duplication result in higher costs, there is a likelihood of adverse action. We are troubled by the suggestion that, absent proof that substantial efficiencies (defined by who) have proven beneficial to patients (interpreted by whom), the FTC would recommend action. What are

the triggers that would deem these efficiencies Aworth@ the rate increase? Who is making those decisions B regulators, insurers, attorneys general, or qualified/practicing health providers? And, with this contraction of the zone of safe conduct for joint contracting, could the FTC be systematically boxing physicians into a very narrow Abusiness model,@ one that is not applied to other industries or organizations that it regulates?

We are most encouraged by the Commission=s willingness to engage in this important dialogue with representatives of all components of the health care delivery system in this fine workshop. This is an important step in the overall process of achieving a necessary balance between delivery and payment for care.

I appreciate the opportunity to reflect on the problems that this trend presents to surgeons and their patients.

Sincerely,

Thomas R. Russell, MD, FACS
Executive Director

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