Oral Statement

of the

American Medical Association

to the

Joint Venture Project of

the Federal Trade Commission

in Collaboration with

the United States Department of Justice

RE: IMPACT OF FEDERAL ANTITRUST LAW AND ENFORCEMENT POLICY ON PHYSICIAN NETWORK JOINT VENTURES

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July 1, 1997

INTRODUCTION

Members of Federal Trade Commission and staff, my name is Thomas "Tom" Reardon, MD. I am in family practice in Portland, Oregon. I also serve as Chair of the American Medical Association Board of Trustees. Today, I am pleased to offer our views on federal antitrust law and enforcement policies affecting joint ventures.

We commend the Federal Trade Commission (FTC) and the United States Department of Justice (DOJ) for undertaking this project. Joint ventures are frequently used by businesses that must respond to rapidly evolving markets. That is certainly the case in health care. It is important that antitrust laws facilitate and not impede competitive responses to evolving markets if consumers are to realize the maximum potential of innovations that drive change.

My comments today will focus on market trends and the effects of current antitrust laws and enforcement policies on physician network joint ventures. In that regard, the AMA commends the agencies for issuing the "Statements of Enforcement Policy in Health Care," on August 28, 1996. The Statements were a significant improvement over previous versions and we believe that they have facilitated the formation of physician networks.

The AMA will submit a written statement by August 1, 1997 that will address the questions listed in your Federal Register notice in more detail than I can provide in the time alloted here.

DEVELOPMENTS IN HEALTH CARE DELIVERY AND FINANCE

I will begin by describing trends in the health care industry that enhance the importance of physician joint ventures.

As you know, managed care health plans are widely credited with stabilizing the growth rate of health care costs. This has been accomplished primarily through reduction in the use of hospitals. Savings have also come from other sources, but the greatest amount has come from reduced hospital care.

Two factors are threatening this source of savings. One is limits on the extent to which hospital use can be reduced without endangering patients. There are more savings available here -- hospital use rates in many parts of the country are higher than in areas where managed care plans have long been dominant. But, it will not be long before the limits are reached. New efficiencies must be found if health care costs are to be stabilized over the long run.

The second factor threatening hospital savings is public concern about the effects of reduced use on the quality of care. For example, due to public outcry, federal legislation has been passed mandating minimum hospital stays for mothers giving birth. Public concerns may force managed care plans to be less aggressive in reducing hospital stays, thereby blunting it as a source of savings.

New sources of savings and ways to improve quality must be found. One way that substantial gains can be achieved in both areas is through the operation of physician organizations (POs) in a competitive market. POs are making substantial advances in providing high quality care to patients more efficiently by applying innovations in clinical management and medical information technology.

The main innovation in clinical management is continuous quality improvement (CQI), a process whereby PO physicians review detailed data about their own performance and that of their referral providers, and then determine how to enhance quality and efficiency. The innovation in medical information technology is new computer software and hardware that enables physicians to gather and analyze the data used to support the CQI process. These innovations allow physicians interactive access to detailed

information about the cost and quality impact of treatment decisions.

Improvements in quality and efficiency are implemented by making systematic changes in the way that medicine is practiced. Protocols are developed to achieve the best possible outcomes most efficiently, given the facilities and resources available. PO physicians follow the protocol unless, in their medical judgement, an element of the protocol should not be used due to the individual needs of a patient. Use of the protocol is monitored to determine what modifications should be made to further improve quality or efficiency.

Successful CQI requires participation by the physicians that deliver care in the review and analysis of data, and in the development, implementation, and monitoring of protocols. The physicians must cooperate and educate each other about the optimal methods to deliver care. This must be done at the local level by providers using detailed data about their own performance and having detailed knowledge and experience about the resources and equipment that are available to them in caring for patients. These innovations cannot be implemented from afar by health plan managers that are remote from patients, the physicians, and the process of rendering care.

Shifting medical management from health plans to POs will yield substantial benefits to patients. This is made evident by comparing CQI with the medical management techniques of health plans. The AMA believes that public concerns raised about quality are largely attributable to these health plan techniques.

The primary technique used is called "preauthorization". It requires a physician to call a reviewer and ask for authorization to hospitalize a patient or to continue a hospital stay. The reviewer is remote from the provision of care and does not have first hand knowledge of the patient. Reviewers generally rely on predetermined guidelines for hospital stays in making their decisions. As a result, there is risk of error.

Sometimes the risk of error is increased by inappropriate use of guidelines. For example, an actuarial firm, Milliman & Robertson, has used actuarial data to develop guidelines for hospital stays. These guidelines are based on stays achieved by the least costly cases. It is reported that the guidelines are based on the 90th percentile with the 100th percentile being the least costly cases.

In other words, in the data base used by Milliman & Robertson, 90% of the actual cases had hospital stays greater than the stays called for by the guidelines.

The guidelines offer no information on how to achieve the least costly cases. They present "best case" cost scenarios towards which providers can aspire. Meeting the guidelines is dependent on having the same kinds of patients and resources, such as adequate home health care services, as did the physicians who achieved these results. However, many payers are treating the guidelines as a standard as opposed to a target. The AMA hears regularly from physicians who are confronted with hospital stay requirements based on the Milliman & Robertson guidelines. Inappropriate use of these guidelines inevitably leads to errors.

Safeguards against error include reliance upon physicians to press the case for hospitalization if the physician feels that hospital care is essential for a patient. In addition, most health plans have appeal procedures available to patients. However, physicians are often fearful of termination from health plans if they challenge plan decisions, and the appeals procedures are cumbersome and time consuming. Under these circumstances, it is inevitable that the safeguards will not catch all errors.

Another technique is physician profiling. It involves comparing information about the hospital use rate of a physician with other physicians. Health plans create profiles to identify physicians who use more hospital services than others. Often these physicians are terminated from health plan participation. Sometimes the health plan gives the physician an opportunity to reduce hospital use prior to termination. However, these plans rarely provide the physician with information about how to reduce usage without endangering patients. This puts pressure on physicians to reduce usage without the informational tools neccessary to achieve it. Again, under these circumstances it likely that errors will result.

POs using CQI can avoid these problems. Physicians using interactive data can craft protocols for care using the facilities and resources available to them that will lead to improved quality and greater cost efficiency. They also have the ability to depart from those protocols when, in their judgement, it is necessary for the health of a patient.

In summary, the AMA believes POs using CQI can substantially improve quality and reduce costs. I should point out that the AMA

believes that other forms of health care delivery can also improve efficiencies, and that the AMA supports a pluralistic health care system in which patients have a wide choice of health plans and providers. POs should be a part of this mix.

THE IMPORTANCE OF FLEXIBILITY IN PO JOINT VENTURE ANALYSIS

The CQI process requires a high degree of cooperation among physicians, and that is often accomplished through joint ventures. If patients are to realize the benefits of CQI, it is important that PO joint ventures be facilitated.

Antitrust joint venture analysis needs to be flexible to facilitate POs. The AMA does not believe that it is possible to determine an optimal financial and operational structure for POs. On the financial side, many have argued that the best results occur when POs compete for capitation contacts. However, not all payers want that. For example, self-funded health plans face regulatory barriers to the use of capitation. Anecdotally, the AMA is aware of a number of major self-funded corporations that are looking for alternatives to capitated arrangements. The AMA believes that payers are likely to use a variety of financial schemes with POs and that POs will use a variety of methods to compensate their physicians.

On the operational side, many have argued that POs need to install multimillion dollar medical information systems. Certainly the key to CQI is access to interactive data, but a variety of ways are available to obtain it. For example, a PO can work with a service bureau and pay it to gather and aggregate the data needed. That kind of arrangement allows the PO to minimize its own investment in computer hardware and software.

Also on the operational side, many have argued that POs are most effective when fully integrated. However, recent studies of independent practice associations shows that they can be as effective at reducing costs as fully integrated multispecialty group practices. Further, not all multispecialty group practices use CQI or otherwise coordinate their care. It is the intent and will to engage in CQI that is determinative as opposed to the form of PO organization.

Finally, I should point out that the kind of POs that can apply CQI do not spring forth, fully formed, like Athena from the forehead of Zeus. Instead, these organizations are built over time as the

physicians gain the necessary experience and resources. Further, many payers are interested in POs that are in early stages of evolution as opposed to an advanced stage, since their employees want the kind of arrangements offered by those POs.

In summary, joint venture antitrust policy needs to be flexible enough to accomodate many different forms of POs, because it is impossible to determine what kind of PO is best for any market. In addition, policy must be flexible enough to accomodate the evolution of POs from simple organizations to those able to engage in CQI.

IMPACT OF THE STATEMENTS OF ENFORCEMENT POLICY IN HEALTH CARE

The AMA believes that all three sets of statements of antitrust enforcement policy for health care issued by the agencies, including the 1993, 1994, and 1996 versions, have facilitated the formation of certain kinds of POs. As you know, case law does not provide adequate guidance for the typical attorney advising a PO. The statements provide the guidance that POs and their attorneys need to have comfort that they are in antitrust compliance.

Each set of statements has provided additional assurance by clarifying the scope of POs said to fall within a safety zone or qualify for the rule of reason. Significant clarifications introduced by the 1996 version include additions to the definition of substantial financial risk, more guidance about the size of networks likely to pass a rule of reason analysis, introduction of the concept of clinical integration as a way that fee for service networks can qualify for rule of reason analysis, and provisions that allow messenger model networks to operate more efficiently.

It is too soon to determine the full impact of these clarifications. Early indications are that the greatest impact is from provisions that allow the messenger model to operate more efficiently, and increased guidance about when networks larger than the safety zone limits are likely to pass a rule of reason analysis. We have been informed by physicians that both of these provisions have allowed physicians to form networks with a higher degree of comfort than in the past. However, the issue of appropriate size limits remains unclear, and there is a strong need for more information about the agencies' views on this issue.

Unfortunately, there is substantial confusion about what constitutes sufficient clinical integration for a fee for service

network to qualify for rule of reason analysis. Well established networks with capitation arrangements generally feel that they have sufficient clinical integration to negotiate fee for service contracts with payers as an alternative to their capitated arrangements. However, physicians attempting to establish a new network, or to enhance the operations of a messenger model network, are not able to judge when they have attained sufficient clinical integration.

There appears to be substantial disagreement among attorneys about what constitutes sufficient clinical integration. Some feel that multimillion dollar investments in medical information systems and a high degree of coordination of the physicians is required. Others feel that the effort to use data about clinical performance to improve network performance is key, and that the data can be obtained from service bureaus or payers without making substantial investments.

Given uncertainty about what constitutes clinical integration, it appears that further clarification of this concept by the agencies will be necessary before it is widely relied upon in PO formation. This could come through advisory opinions and business review letters, speeches, or as a revision to the 1996 statements.

In addition, a few attorneys are making use of the new definition of substantial financial risk that allows physicians to establish cost or utilization targets for the network as a whole, with the physicians subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets. This is being used to structure arrangements with self-funded employers in ways that give the physicians an incentive to control utilization, but which do not require the network to obtain a state license to operate a health plan. However, the number of attorneys who understand and use this provision is limited. It appears that many experienced antitrust attorneys do not understand the meaning and potential use of this definition. Further clarifications of this definition would help the antitrust bar and physicians better understand this dimension of the statements, and result in wider choice to patients.

Further, a problem that existed with the definition of substantial financial risk in prior guidelines continues with the 1996 statements. It is uncertainty over when fee withholds are substantial enough to constitute substantial financial risk. The agencies have issued advisory opinions and business review letters

which provide some guidance on this issue, but it is still a frequently asked question.

Finally, the AMA has been told that the new examples appended to the 1996 statements have been helpful to attorneys, and are a substantial improvement over past versions of the statements. This is a technique that could be used in other communications that provide information about the agencies' views or in further revisions of the statements.

SUGGESTIONS FOR FURTHER CLARIFICATION OF THE STATEMENTS

The AMA regularly hears from attorneys and physicians that further clarification is needed to accommodate loosely integrated fee for service networks. A number of attorneys have told us that a gap in the statements interrupts the natural evolution in the market of POs from messenger model networks to more sophisticated organizations. Physicians starting out in network development find it easy to begin with a messenger model, but find it difficult to make the leap from messenger model to clinical integration or risk sharing. There is a middle ground where the physicians have increased their level of coordination and feel a need to engage in joint negotiations. The statements do not accommodate this stage of PO evolution.

A number of attorneys that work with physicians advocate that POs be allowed to negotiate fee for service arrangements without clinical integration, provided that their networks include no more than 20% to 30% of any specialty in the market. They have suggested that given the current market realities of contracting for groups of patients, it would actually enhance competition to allow these networks to exist. They would have to bid against each other for the business of payors. It is believed that this competition would spark the development of clinical integration, because a bidding network would have to find ways to differentiate itself from others by offering lower fees, better quality, or both. The AMA expects that the number of attorneys advocating this argument will grow.

SUGGESTIONS FOR JOINT VENTURE LAW

Our comments reveal the difficulty of drafting antitrust guidelines for POs. Each time the agencies issue new statements, questions arise about their meaning and lawyers argue that some kinds of procompetitive POs are erroneously considered to be illegal *per se*. Sometimes these questions and arguments are legitimate, so the agencies revise the statements. As a result, the statements have increased in size from 46 pages in the official 1993 edition to 141 pages in 1996.

The core problem is the regulatory nature of the approach to joint ventures by the agencies. This approach, and the problems that it causes, are aptly described by Clark C. Havighurst, a professor of law at Duke University, in an article entitled "Are the Antitrust Agencies Overregulating Physician Networks ?" Professor Havighurst points out that the agencies regulate physician networks by evaluating the merits of the products that they offer, and allowing only those networks with products perceived to be of sufficient value to be legal. In doing so, the agencies act in place of the market by determining which products have merit, rather than facilitating competition by allowing the market to determine the merits of the products that are offered.

Professor Havighurst traces this approach to the Supreme Court's decision in Topco Associates, Inc. v. United States, 405 U.S. 596 (1972). That case involved a joint venture among several independent grocery chains to develop a private brand of products to compete more effectively with national grocery chains. In aid of that effort, they agreed not to sell the private brand products in each other's territories, but to compete in all other respects. The Court found this to be an illegal horizontal division of markets. Professor Havighurst argues that this agreement was reasonably ancillary to a procompetitive purpose. He argues that the only plausible explanation for this result was a perception that the joint venture was a promotional gimmick and not a new or useful product for which antitrust rules could be bent. Professor Havighurst points out that this is a value judgement that the market, not antitrust enforcers, should make.

In his article, Professor Havighurst argues that the rule of reason should be of wider application to physician network joint ventures. He believes that networks should be viewed as joint selling agencies, and reviewed under the rule of reason to determine

whether they have a procompetitive or anticompetive impact on the market.

The AMA supports Professor Havighurst's views and commends them to the FTC as a way to avoid the problem of having to create and interpret concepts such as substantial financial risk and clinical integration. It would also allow a more natural evolution of POs that is based on the real demands of the market, and that is responsive to what payors and patients want as opposed to what is viewed as meritorious by the agencies. Clearly, the statements define what kind of POs are deemed of sufficient value to be offered to consumers. The market can make this decision for itself.

THE NATIONAL COOPERATIVE RESEARCH AND PRODUCTION ACT OF 1993

Finally, to the best of our knowledge, the National Cooperative Research and Production Act of 1993 (NCRPA) has not been a significant factor in the development of POs. Antitrust lawyers have not advanced it to their physician clients. This is probably due to the availability of the statements, and to questions about whether POs would qualify under the Act.

CONCLUSION

Thank you very much for this opportunity to comment on antitrust joint venture law and policy. I would be happy to answer any questions.