Source AMA - Soc.

1995

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	$ 189.3	Ch	$ 221.9
GP	$ 116.8	Surg.	$ 262.7
IM	$ 180.8	Pedi	$ 135.4
		Radi	$ 259.8
		Psych	131.3
		Anesth	224.1
		Path	197.3

American Medical Association
Physicians dedicated to the health of America

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July 31, 1996

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

Many times over the last four years you have spoken out in support of antitrust policy changes to facilitate the introduction of physician sponsored networks as pro-competitive alternatives to commercial insurance plans. You have acknowledged the savings that can be achieved by eliminating the insurance middleman and the benefits of physician sponsored networks that put patient needs ahead of generating profit margins for Wall Street investors. There is a growing consensus among antitrust experts regarding the need to adjust the analysis of physician sponsored organizations. Clark Havighurst, of Duke University, and a frequent critic of organized medicine, states that "...the antitrust agencies seem trapped in a time warp that keeps them fearful of physician conspiracies that are much less likely to prosper -- and thus to be attempted -- today than in an earlier era." Therefore, we request that you personally urge the Department of Justice and the Federal Trade Commission to include the attached statements in the upcoming revisions in antitrust enforcement policy for physician sponsored organizations.

As you know, antitrust enforcement policy changes have been a high priority for physicians. The attached additions will give greater weight to the revised guidelines. Interpreting arcane and complicated antitrust policies is a tricky and high-risk business. The 1993 and 1994 guidelines failed to have a significant impact because the policies did not fully acknowledge that antitrust analysis should be adjusted to reflect major changes in the health care market and that physician-controlled networks can offer important benefits, efficiencies, and value to consumers, including networks that do not assume insurance risk. Clark Havighurst argues in the attached paper that he believes that "networks designed and controlled by physicians themselves might sometimes offer consumers more desirable products than networks controlled by other interests."

Finally, it is imperative that the upcoming guidelines include a revised statement on a more reasonable percentage of physicians who participate in non-exclusive networks in competitive markets. We recognize the caution in establishing limits for purposes of a safety zone. However, an affirmative statement that antitrust agencies are unlikely to raise objections to non-exclusive networks of 50% or 60% of physicians in a **competitive market** sends a clear and unmistakable message to physicians, and their attorneys, that the 30% safety zone limit is not

absolute. Such a statement could acknowledge that if the network fails to operate in a non-exclusive fashion or if the market ceases to be competitive, antitrust enforcement agencies may reconsider their previous approval of the network arrangement.

Your support for the proposed additions to the revised antitrust enforcement guidelines will go a long way towards promoting a more competitive and patient-friendly health care market. Without these changes, it will be difficult to support claims that the revised guidelines represent real relief for the medical profession.

Sincerely,

P. John Seward, M.D.

P. John Seward, MD

AMA Proposed Changes to pending DOJ/FTC Antitrust Guidelines for Health Providers

1. An affirmative statement acknowledging that the health care market has rapidly changed with large purchasers demanding competitive prices; large, well financed managed care organizations are exercising considerable leverage in negotiations with health providers, etc. DOJ and FTC have adjusted their analysis of antitrust issues to reflect these changes in the health care market.

2. An affirmative statement in the introduction to the rule of reason, that physician organizations can expand patient choice and inject greater competition in the marketplace. Provider sponsored organizations, even those that do not assume insurance risk, offer potential benefits, efficiencies and value to consumers and purchasers. These revised guidelines are based on the belief that antitrust enforcement policies should facilitate the introduction of new alternatives to existing commercial insurers to promote greater competition in the health care market.

3. Physician networks that are nonexclusive, operate in a competitive market, are in good faith attempting to compete by delivering a good value to the market, are not attempting to fix prices or restrict output, and which have 50%-60% of the physicians in any given specialty in the market are not likely to be anticompetitive and therefore are likely to be found legal under a rule of reason analysis. Larger networks may also be legal, but the agencies become increasingly concerned about the anticompetitive potential of networks as they increase beyond the 50%-60% range. Physician organizations seeking initial approval must recognize that decisions by the Department of Justice and the Federal Trade Commission are subject to reconsideration if the network does not operate in a non-exclusive fashion or subsequent evidence that the market has ceased to be competitive.

4. Expand messenger model discussion to allow the messenger to present an initial fee schedule proposal to purchasing groups. The messenger would develop a fee schedule to present to payers that reflects fees that the messenger has authority to accept. This fee schedule is not shared with physicians. Counter offers within the authority given to the messenger would be accepted. Those that were not within authority would be messengered to the physicians.

[forthcoming in LOYOLA CONSUMER LAW REPORTER]
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ARE THE ANTITRUST AGENCIES OVERREGULATING PHYSICIAN NETWORKS?

Clark C. Havighurst*

When the antitrust laws were first applied seriously to the medical profession following the Supreme Court's 1975 decision in *Goldfarb v. Virginia State Bar*,[1] a principal objective of antitrust enforcers was to contest organized medicine's control of health care financing. In the ensuing years, most health care markets evolved under antitrust protection so that they now feature a variety of financing entities that are not only independent of professional control but also highly aggressive in forcing physicians to sell their services on competitive terms. Although competition has not yet come to every local market, concerted action by physicians is no longer a ubiquitous obstacle to its emergence. Indeed, in mature markets for medical services, antitrust enforcers may do more harm than good if they continue to view concerted action by physicians with the skepticism that was appropriate in earlier years.

The thesis of this comment is that antitrust enforcers today are too quick to presume anticompetitive results when physicians organize so-called network joint ventures for the purpose of contracting with competing health plans or with employers purchasing health services for their employees. As a species of joint selling agency, a physician network joint venture certainly deserves close antitrust scrutiny since it may entail some agreement concerning the price and other terms on which otherwise independent competitors sell their services. But unless such a venture qualifies as a sham rather than as a legitimate effort to reduce marketing and other transaction costs, it is not an appropriate candidate for condemnation under the venerable principle that price fixing is illegal per se.[2] Yet current antitrust enforcement policy appears to give too little credence to the possibility that a physician network controlled by physicians might yield marketing efficiencies that more than offset any loss of competition among the joint venturers themselves. In one of nine joint statements of enforcement policy regarding antitrust issues arising in the health care field, the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) have specified certain conditions that any network joint venture must meet before they will view it as anything other than a per violation.[3]

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*William Neal Reynolds Professor of Law, Duke University. The author is grateful to Charles D. Weller of the Ohio bar for calling his attention to the problem addressed in this article, for other insights, and, in particular, for pointing out the extent to which current antitrust policy ignores the special needs and circumstances of self-insured employers as purchasers of physician services.

[1]423 U.S. 886 (1975).

[2]E.g., United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940); United States v. Trenton Potteries Co., 273 U.S. 392 (1927).

[3]Statement 8 -- Physician Network Joint Ventures, in U.S. Department of Justice & Federal Trade Commission, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, Sept. 27, 1994, reprinted in 3 Health Law Rptr. (BNA) 1391 (1994).

These conditions are too restrictive and should, for both doctrinal and policy reasons, be relaxed.

To say that the current policy of the DOJ and the FTC toward physician networks is overregulatory is not to say that Congress or the enforcement agencies should accede to demands by organized medicine that ordinary antitrust principles be bent to accommodate physician collaboration. The problem identified here is not a problem with antitrust law as such. Instead, the agencies have simply made a doctrinal error, adopting a rule of thumb when they should have applied the rule of reason. Regrettably, this error gives added ammunition to organized medicine in its continuing battle for legislative relief from antitrust strictures -- relief that would inevitably shelter more than just procompetitive activity by professional groups.[4] By the same token, giving collaborating physicians a chance to demonstrate that their joint venture poses no ultimate threat to competition, despite its failure to pass the agencies' objective test, would weaken the policy argument for softening antitrust rules applicable to physician collaboration.[5] Moreover, it would do so without sacrificing antitrust principles or authorizing anticompetitive conduct. Most importantly, it would remove an impediment that currently forces innovation in the delivery of medical services into narrow channels, with adverse consequences for the range of consumer choice and possibly also for the quality of care provided.

Origins of Current Enforcement Policy Concerning Physician Collaboration

The successful antitrust campaign against physician control of the financing and delivery of health services in the 1970s and 1980s was one of the great victories in the history of antitrust law. Beginning in the 1930s, the medical profession created a panoply of Blue Shield and other profession-controlled health care financing plans that enabled physician interests to dictate the economic conditions of medical practice. To be sure, independent financing programs also existed in the marketplace. But these plans were subject both to legal restrictions imposed at the behest of professional interests and to the threat of coercive boycotts by professional groups, and consequently also played by the profession's preferred rules.[6] In addition, even after Blue Shield and similar plans were freed from direct professional control, many of them protected their dominant market positions by serving local providers as their principal marketing agent. In return for marketing provider services on noncompetitive terms, a dominant Blue plan could count on providers collectively to deny competing plans discounts of the kind the Blues themselves typically enjoyed, to resist incursions by alternative financing and delivery

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[4]See text at notes 50-54 infra.

[5]On the appropriateness of accommodating political pressures of this kind in antitrust enforcement and even in antitrust doctrine itself, see infra note 20 and text at notes 53-54.

[6]See, e.g., Lawrence E. Goldberg & Warren Greenberg, *The Effect of Physician-Controlled Heath Insurance: U.S. v. Oregon State Medical Society*, 2 J. HEALTH POL,. POL'Y & L., Spring 1977 at 48. For examples of provider boycotts and similar restraints aimed at payers, see FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); In re Mich. State Medical Soc'y, 101 F.T.C. 191 (1983).

systems, and to stonewall efforts by commercial insurers to introduce competition by selectively contracting with providers.[7]

The health care marketplace began to show signs of competitive life in the 1970s, however, as alternative financing and delivery mechanisms began to get a foothold. In self-defense, physician groups in many local markets organized a second generation of profession-controlled entities. So-called foundations for medical care (FMCs) and individual practice associations (IPAs) served the profession well for a while as effective defenses against both independent health maintenance organizations (HMOs) and innovative purchasing practices by conventional health insurers. In the *Maricopa County Medical Society* case,[8] for example, FMCs in two Arizona counties established maximum prices for physician services and performed utilization review for health insurers that agreed to pay physicians under their fee schedules. The apparent purposes of the Arizona doctors in creating the FMCs were to set collectively a limit-entry price for their services (thus making the market less attractive to independent HMOs) and to induce health insurers not to embark on independent paths in procuring physician services on competitive terms. More recently, dominant physician interests have sought to use preferred-provider organizations (PPOs) or other network joint ventures to maintain solidarity in the face of purchasers' new efforts to break the profession's ranks. Antitrust enforcers have been appropriately alert to these collective efforts.[9]

The success of the medical profession in controlling the economic environment of physicians from the 1930s to the 1980s -- particularly in delaying the emergence of corporate middlemen able and willing to act as purchasing agents for consumers in procuring physician services on competitive terms -- was arguably the most successful restraint of trade ever perpetrated by private interests against American consumers.[10] By the same token, the antitrust battles that hastened the breakup of medical cartels paved the

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[7]For cases in which Blue plans acted, not as aggressive purchasers, but as marketing agents for provider cartels (but escaped antitrust penalties because courts failed to recognize the monopolistic character of their conduct), see Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); Travelers Ins. Co. v. Blue Cross of Western Pa., 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093) (1973). See generally Clark Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in HEALTH CARE IN AMERICA 221, 245-54 (H. Frech ed. 1988).

[8]Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982).

[9]See, e.g., Southbank IPA, Inc., 114 F.T.C. 783 (1991). See also Richard D. Raskin, *Antitrust Issues for Independent Health Care Providers: "Integration" and the* Per Se *Rule*, in ANTITRUST AND EVOLVING HEALTH CARE MARKETS 73 (19) (discussing recent enforcement efforts with respect provider networks); Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507 (1994); John J. Miles, Provider-Controlled Networks, Market Power, and Price Fixing (National Health Lawyers Ass'n, Managed Care Law Institute, Chicago, Dec. 4-6, 1995).

[10]See Clark C. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303.

way for the revolution that is occurring in American health care today.[11] Indeed, without uncompromising antitrust enforcement against physicians, the nation would have had to wait much longer for private innovations that make providers effectively accountable to consumers for the cost as well as the quality of medical care.[12] More likely, without antitrust enforcement clearing the way for private innovation, government would have assumed a dominant role in financing and regulating health care, as it has in other countries.

To be sure, the danger of physician collaboration to suppress competitive developments in local markets has not disappeared, and continuing antitrust vigilance is still warranted. Nevertheless, there are many markets in which doctors can no longer reasonably hope to forestall unwanted developments by banding together. Too many large purchasers -- including Blue Cross and Blue Shield plans finally forced by competition to use their market strength on behalf of consumers rather than providers,[13] commercial health insurers, and large self-insured employers -- now have the incentives, the tools, the bargaining power, and the independence they need to prevent doctors from exercising market power. Selective contracting and discounting of physician fees in return for assured patient load are now common practices. In addition, integrated health care systems, combining in various ways the functions of financing and delivery, are being constructed by many players and are now significant factors in most local markets. Although there remain some places where the doctors' old strategies may still be capable of heading off unwanted change, the market forces that have been unleashed in most communities cannot easily be reversed by counter-revolutionary professional action. In most circumstances, antitrust enforcers should no longer presume that physician collaboration that is not certifiably innocuous is intended to restrain trade rather than to achieve efficiencies or to offer purchasers a fuller range of health care options. Suspicions that were well justified when physicians possessed the means of controlling their economic environment are not generally justified today.

Networks under Today's Enforcement Policy and the Rule of Reason

Although the health care industry is undergoing a remarkable transformation, the one group of players that might develop the most efficient systems for delivering high-quality personal health care at reasonable cost are somewhat constrained in doing so by the way antitrust law is currently applied to their undertakings. Specifically, physicians

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[11]See, e.g., Clark C. Havighurst, The Antitrust Challenge to the Professional Paradigm in Medical Care (Center for Health Admin. Studies, U. of Chicago, 1990); Clark C. Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697 (1986).

[12]Accountability remains a problem in the current market, however. See note 46 infra.

[13]See, e.g., Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins. Inc., 784 F.2d 1325, 1337 (7th Cir. 1986) (quoting a 1983 memorandum by a Blue Cross plan proposing a new strategy, novel for the plan and many others like it -- namely, that the plan "use its market position and its control over substantial sums of health care dollars to negotiate lower fees for provider services").

organizing joint ventures for the purpose of marketing themselves to major purchasers are being forced by unrealistic antitrust standards into arrangements that may serve consumers less well than arrangements that such standards foreclose. The problem lies principally in the insistence by the antitrust enforcement agencies that any physician-controlled network have objective features that make it distinguishable on its face from anticompetitive arrangements appropriately condemned in the past.

The joint DOJ/FTC enforcement policy states that physician network joint ventures "will be reviewed under a rule of reason analysis and not viewed as per se illegal either if the physicians in the joint venture *share substantial financial risk* or if the combining of the physicians into a joint venture enables them to *offer a new product* producing substantial efficiencies."[14] These requirements are not laid down merely as conditions that must be met to qualify for a so-called "safety zone" in which private parties are promised freedom from government attack. To be sure, the guideline does delineate two "safety zones" -- one for exclusive networks, which are the sole marketing agents for participating physicians, and one for nonexclusive networks, which do not preclude their members from marketing themselves through other networks as well. In each case, the cited conditions, plus a market share screen relating to the percentage of physicians engaged, must be met to satisfy the agencies. The guideline goes on to state (in the quoted language), however, that networks not meeting these requirements, while not necessarily unlawful, can satisfy the rule of reason only if the two stated conditions are met. Although the context of the guideline suggests that the drafters had in mind only networks that fail the market share tests (20 percent for exclusive networks and 30 percent for nonexclusive ones), the guideline is written in such a way that the two conditions apply even to very small joint ventures. Moreover, a footnote underscores that the rule of reason will apply only if "the joint venture is not likely merely to restrict competition and decrease output, such as, for example, an agreement among physicians who do not share substantial financial risk that fixes the price that each physician will charge." Subsequent statements and applications of the guideline by agency personnel confirm that even very small joint ventures are expected either to impose financial risks on participating physicians or to integrate their practices so thoroughly as to yield "a new product."

Thus, current enforcement policy declares specific conditions that must be met if any physician network joint venture is to avoid being classified as a violation per se, making it conclusively indefensible by reference to conditions in the marketplace, to efficiencies it might achieve, or to other procompetitive features or consequences of the undertaking. To be sure, the policy statement is only a guide to the prosecutors' policy and not a regulatory rule, and one might wonder whether or not enforcement policy is as restrictive in fact as it seems to be on paper. Nevertheless, because antitrust counselors report that the agencies are taking their policy statement at face value, collaborating physicians must be advised that, to avoid a risk of litigation, they must comply with the agencies' dictates until enforcement policy is modified in some authoritative way.

The guidelines put the government on record as conclusively deeming any physician network joint venture of any size to be unlawful unless it is demonstrably something more than a joint selling agency wholesaling the services of the doctors in the group. A group of physicians would thus be absolutely barred from appointing an agent

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[14]Supra note 3 (emphasis added).

to negotiate on their behalf with sophisticated purchasers, such as insurers, employers, and other prepaid health plans, if the agent, rather than the individual physicians, had authority to set prices. Yet the practical difficulties that individual physicians face in finding secure places in the world of managed care are such that efficiencies in the form of saved transaction costs, not the elimination of competition, may easily be their principal objective in organizing such a sales agency. Purchasers, too, may realize significant cost savings from arrangements that spare them from having to bargain with numerous physicians individually. A proper application of the rule of reason would allow a physician network a chance to show that procompetitive effects predominate, whether or not the physicians "share substantial financial risk" or "offer a new product." Although many proposed arrangements would fail a rule of reason test, some joint ventures representing significant subsets of practitioners and not satisfying the guideline requirements might be found in particular circumstances to have more positive than negative effects.

As a doctrinal matter, only certifiably "naked" restraints of trade -- those having no object other than suppression of competition -- are or should be subject to per se rules. To be sure, the Supreme Court's opinion in the *Maricopa* case seemed to say that per se rules may be applied to certain kinds of conduct even though there may be some question concerning the nakedness of the restraint.[15] But the Court's method in that case demonstrated the excessiveness of its rhetoric justifying the arbitrary use of per se rules. Indeed, a careful reading of the majority opinion by Justice Stevens reveals that he actually applied the rule of reason (taking what has come to be called a "quick look" at all the circumstances) before finding unsupportable the FMCs' claim that their fixing of maximum prices was procompetitive -- specifically, that it made costs more predictable for both insurers and insureds, thereby lowering the cost and improving the quality of health insurance coverage. Indeed, Justice Stevens showed notable insight in his appraisal of the challenged practice. For example, he observed that, to achieve the efficiencies claimed, "it is not necessary that the doctors do the price-fixing."[16] He thus focused on the availability of a less restrictive, more procompetitive way in which better insurance coverage could be provided -- namely, by having an insurer itself set the fee schedule and contract with those physicians who were willing to abide by it. Since such selective contracting with physicians was practically unheard of at the time (indeed, it was precisely what the doctors hoped to discourage), his prescience was particularly commendable.[17]

Thus, despite what Justice Stevens said in *Maricopa* about having no choice but

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[15]E.g., 457 U.S. at ("The anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some.").

[16]457 U.S. at 352.

[17]At 457 U.S. at , Justice Stevens cited *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), for the proposition that insurers could obtain binding contractual fee commitments from physicians. That case upheld an insurer's selective contracting with low-price pharmacies against an antitrust challenge. Its citation in this context is noteworthy because, at the time, selective contracting and insurer-initiated price competition had not yet emerged in medicine.

to apply a per se rule to maximum price fixing, the Court did not in fact find a violation until after it had discredited the physicians' claim that their maximum fee schedules were procompetitive. Thus, Justice Stevens stated that "the limited record in this case is not inconsistent with the presumption that the respondents' agreements will not significantly enhance competition";[18] such consulting of the record to see whether a presumption of illegality might be successfully rebutted demonstrates that the presumption was not conclusive -- as a per se rule would be. Likewise, the Court said, "It is entirely possible that the potential or actual power of the foundations to dictate the terms of such insurance plans may more than offset the theoretical efficiencies upon which the respondents' defense rests";[19] obviously, the question whether market power offsets efficiencies would not come up if the Court were truly bent on applying a per se rule. Although the *Maricopa* opinion is certainly confusing to anyone who follows Justice Stevens's rhetoric rather than his footwork, the Court's ruling was in no way inconsistent with the generally respected principle that only naked restraints of trade (and, apparently, not all of them[20]) are appropriate candidates for per se treatment.[21]

In any event (and despite the tendency of antitrust lawyers to dichotomize between

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[18]457 U.S. at 333.

[19]Id. at 354

[20]Neither courts nor commentators have ever made it clear why a per se rule does not apply to all naked restraints, applying instead only to certain categories of such restraints. The best rationale (arguably underlying Justice Stevens's seemingly extreme rhetoric in *Maricopa*, supra note 15) is that, in many imperfect markets, there is more than a negligible chance that a restraint addressed to a matter other than price or output might actually yield an outcome closer to that which would result if the market were efficiently competitive. Wisdom might counsel, of course, against creating a doctrinal loophole for naked restraints of any kind, since competitors rarely, if ever, restrain trade solely in the interest of consumers. Nevertheless, a conclusive presumption that competitor cooperation aimed at limiting some aspect of competition in the market as a whole is always anticonsumer would be politically unwise, especially in professional fields. Possibly for this reason, courts have been "slow to condemn rules adopted by professional associations as unreasonable per se." FTC v. Indiana Federation of Dentists, 476 U.S. 447, (1986). And the enforcement agencies themselves have been circumspect in such matters -- as in the *IFD* case itself, supra, where the FTC fully (though arguably unnecessarily) investigated the dentists' claims that the naked restraint in question enhanced the quality of dental care. Agency and judicial willingness to listen to defenses based on an alleged market failure (even if such defenses are rarely accepted) has the virtue of weakening the ability of professional interests to appeal to Congress for antitrust relief. See text at notes 50-54 infra.

wo later cases, the Court appeared to apply per se rules too readily, without even a ook that would probably have changed the outcome in one case but not the other. v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411 (1990) (overlooking objection that market power could not be presumed -- as it usually is, implicitly, in price-fixing cases -- solely on the basis of defendants' attempt to fix prices, since defendants had alleged a plausible objective other than restraint of trade); Palmer v. BRG of Georgia, Inc., 498 U.S. 46 (1990) (per curiam) (treating restraint, easily condemnable as overbroad, as a per se violation without regard to its plausible business purpose).

"per se" and "rule of reason" cases), per se rules are not at war with the rule of reason, but are instead products of its application to particular facts.[22] Such rules should therefore never be applied without first applying the rule of reason -- that is, without lawyerly factual analysis to ensure that the case does indeed call for invoking the policy inherent in past rulings condemning comparable practices as indefensible restraints. The antitrust agencies, however, are apparently unwilling to look at the whole picture in judging physician network joint ventures. Indeed, if one takes the guidelines literally (and there is no reason one should not), a joint venture representing, on a nonexclusive basis, no more than a modest proportion -- say, ten percent -- of community physicians in each specialty would be condemned as a per se violation. Physicians are thus barred by the threat of antitrust attack from forming joint selling agencies that do not meet government specifications. Although antitrust prosecutors are not chartered to wield prescriptive powers, they have in this instance, by publicly committing themselves to exercise their prosecutorial discretion in a particular way, become regulators de facto.[23]

There is no mystery about the source in case law of the agencies' insistence that physician-controlled networks, to escape antitrust challenge, must either impose financial risks on the joint venturers or integrate the doctors' practices so substantially as to "offer a new product." In the *Maricopa* case, the Supreme Court rejected the FMCs' claim that they were engaged in price fixing "only in a 'literal sense'" by stating that "their combination in the form of the foundation does not permit them to sell any different product."[24] The Court went on to distinguish the FMCs from "joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss . . . ."[25] The Court concluded its analysis as follows:

> If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper. But the fee arrangements disclosed by the record in this case are among independent competing entrepreneurs. They fit squarely within

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[22]See Nat'l Soc'y of Professional Engineers v. United States, 435 U.S. 679, (1978) (describing rule of reason and how it yields "two complementary categories of antitrust analysis").

[23]Other have observed the increasingly regulatory character of antitrust enforcement -- not only in the health care field. See, e.g., Thomas L. Greaney, *Regulating for Efficiency in Health Care Through the Antitrust Laws*, 1995 UTAH L. REV. 465, 486-89; Thomas E. Kauper, *The Justice Department and the Antitrust Laws: Law Enforcer or Regulator?*, in 1 THE ANTITRUST IMPULSE: AN ECONOMIC, HISTORICAL AND LEGAL ANALYSIS 435 (Theodore P. Kovaleff ed., 1994). The Greaney article, although observing the agencies' regulatory role in health care, does not observe the particular instance of overregulation that is the subject this article. Indeed, Greaney raises a quite different (and equally valid) concern -- namely, the possibility that "assumption of financial reisk by physicians will trump most concerns about anticompetitive risks." Greaney, supra, at 479 n.57.

[24]457 U.S. at 356, quoting Broadcast Music, Inc. v. CBS, 441 U.S. 1, (1979).

[25]457 U.S. at 356.

the horizontal price-fixing mold.[26]

The agencies' position is thus seemingly supported by clear dicta in a Supreme Court opinion (for a four-Justice majority), and might easily carry the day in another court even though *Maricopa* involved a market very different from most of those one finds today. But the agencies' job is not to prosecute every case they might win on the basis of questionable dicta or precedent. It is instead to employ their expertise and fact-finding capability to prevent true restraints harmful to competition and consumer welfare while encouraging arrangements that create efficiencies.

Certainly, risk sharing and integration are appropriate requirements in defining safe harbors for certain physician collaborations. But they should not be made mandatory in all joint ventures by denying noncomplying ones a hearing under the rule of reason even when the parties make a plausible claim that their purpose is procompetitive and that their agreement on prices is ancillary to that purpose. In fact, absence of the features specified by the agencies does not unerringly identify a naked restraint deserving automatic condemnation -- without proof of the parties' anticompetitive purpose, of their power to affect competition in the market at a whole (not merely *inter se*), or of the actual or probable effect of their arrangement. Thus, a correct analysis of a physician-sponsored network falling outside the guidelines' safety zones would walk sensitively through the elements of purpose, power, and effect, condemning it only if there is a probable net harm to competition or if the parties have employed unreasonable means to achieve their legitimate objectives. Such an analysis of physician network joint ventures -- which could often be completed with only a "quick look" -- might sometimes result in a clean bill of health rather than a decision to prosecute.

Physician Networks as Joint Selling Agencies

Physician network joint ventures are best viewed for antitrust purposes, not as naked restraints of trade, but as joint selling agencies (JSAs), a type of arrangement that has not generally been condemned as a per se violation.[27] In a passage quoted with approval by the Supreme Court in the *NCAA* case, Professor Philip Areeda has observed that "joint buying or selling arrangements are not unlawful per se."[28] Likewise, Professor

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[26]Id. at 357.

[27]E.g., Appalachian Coals, Inc. v. United States, 288 U.S. 344 (1933) (treating some very minor and otherwise attainable benefits of joint selling in a difficult market as justifications for allowing a high percentage of sellers of coal to market through a single agent). The *Appalachian Coals* case is generally understood to be an aberration in the law, occasioned by the Great Depression. Nevertheless, even though more recent precedent places a heavy burden on JSAs, e.g., Virginia Excelsior Mills v. FTC, 256 F.2d 538, 539-41 (4th Cir. 1958), elementary principles entitle them to be evaluated under the rule of reason if their sponsors' purposes are not obviously anticompetitive.

[28]National Collegiate Athletic Ass'n v. Board of Regents of the Univ. of Okla., 468 U.S. 85, 109 n.39, quoting PHILIP AREEDA, THE "RULE OF REASON" IN ANTITRUST ANALYSIS: GENERAL ISSUES 37-38 (1981) (observing that in some circumstances the power of the combining parties might be so obvious that "the rule of reason [could] be applied [to condemn the joint-selling arrangement] in the twinkling of an eye"). See also 7 PHILIP AREEDA, ANTITRUST LAW ____ (1986).

Lawrence Sullivan has opined that

> some joint arrangements to buy or sell will not be summarily held to be unlawful . . . because summary analysis does not suggest a degree of market power which clearly demands that integration benefits be forbidden because price competition will be reduced. Joint agency cases such as these must be analyzed under the rule of reason, fully blown.
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> . . . . If the proposed selling or buying agency would materially increase concentration and if as a result the balance of forces would shift significantly away from rivalry and toward accord, the arrangement should be rejected as unreasonable. Just as surely, if competition could be expected to continue unabated, or even to improve, the rule of reason will mandate that the market's manner of striving for efficiency not be choked off.[29]

The Supreme Court cited Professor Sullivan's observations with approval in *Broadcast Music, Inc. v. CBS*,[30] overturning a decision condemning per se, as price fixers, two performing-rights societies that jointly marketed musical compositions on behalf of their composer-members. The Court held that the composers, through the societies, were engaged in price fixing only "in a literal sense" and that their pooling of compositions for licensing purposes was "not a 'naked restrain[t] of trade with no purpose except stifling of competition.'"[31]

Despite the favorable treatment of joint selling arrangements in *BMI*, however, that case is the ultimate source of much of the reasoning in the *Maricopa* case that apparently led the DOJ and FTC to insist that physician-controlled networks must either force the doctors to share financial risk or enable them to "offer a new product." To be sure, the Court praised the procompetitiveness of the performing-rights societies in making it easier, in a complex market, for composers to market their music and for users to hire it. But the Court's overall analysis, by emphasizing that the arrangement involved more than joint selling alone, may appear to justify hostility to less integrated physician joint ventures. Thus, the Court stressed that the societies each offered users of copyrighted music a particularly convenient form of blanket license, which it characterized as "to some extent, a different product."[32] Moreover, it went on to say that "to the extent that the blanket license is a different product, [a performing-rights society] is not really a joint selling agency offering the goods of many sellers,"[33] thus implying that a mere JSA would not qualify for rule of reason treatment. The *Maricopa* Court cited this discussion in rejecting the FMCs' claim that they, too, were engaged in price fixing "only in a literal sense."[34]

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[29]LAWRENCE SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 104 (1977).

[30]441 U.S. 1 (1979).

[31]Id. at 2, quoting ...

[32]Id. at 21.

[33]Id. at 22.

[34]*Maricopa*, 457 U.S. at 356.

It is a mistake in judging physician networks, however, for the enforcement agencies to focus so minutely on these two cases and on others blurring the line between naked and ancillary restraints[35] rather than consulting general antitrust principles, under which per se rules apply only to certain categories of the former. In *BMI*, the Court needed to find very strong procompetitive features in the arrangements because the societies, between them, dominated the licensing of musical compositions and were highly vulnerable to condemnation in the absence of a strong business justification.[36] Thus, if all the facts are considered, a physician network representing only a fraction of the physicians in an area, especially on a nonexclusive basis, might be able to make as persuasive a case for joint marketing as the *BMI* defendants. Certainly the efficiencies they could point to, based on the high transaction costs that both physicians and bulk purchasers would face in creating relationships by individual negotiation and in administering those relationships, would be similar in kind, and probably in magnitude, to the efficiencies achieved by performing-rights societies.

Moreover, a significant fact noted by the Court as favoring application of the rule of reason in the *BMI* case was the retention by the composers of the right to license their respective compositions on an individual basis.[37] As a practical matter, however, that alternative method of marketing was highly inefficient. It also did little to offset the market power of the societies, especially since the composers were not free to license their works through competing agents.[38] Nonexclusive physician networks, on the other hand, would permit physicians not only to service individual patients on a fee-for-service basis but also to join other networks, thus posing much less of a threat to competition. Such nonexclusivity should, in fact, save any network (whatever its size) that exists in a market where large employers and other payers have, and exercise, real opportunities either to organize their own networks or to patronize other existing physician groups. Of course,

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[35]See note 21 supra. See also United States v. Topco Assocs., 405 U.S. 596 (1972) (applying the per se rule condemning market-division agreements to a minor limitation on joint venturers' freedom despite its value in protecting the parties against each other's opportunistic conduct and thus in facilitating formation of the procompetitive joint venture in the first place). Unfortunately for coherence in the law, this holding, although effectively discredited in Rothery Storage & Van Co. v. Atlas Van Lines, 792 F.2d 210, 227-29 (D.C. Cir. 1986), was cited favorably by Justice Stevens in *Maricopa*, 457 U.S. at ____.

[36]Indeed, the Court should probably have broken up the societies themselves in any event, since as the only two licensors of musical compositions they wielded undue market power and engaged in suspiciously parallel conduct. The private plaintiff, however, for reasons of its own did not seek such relief, asking only for the invalidation of blanket licenses (which served the interests of its competitors more than its own) and not for the restoration of unbridled competition (which would have benefitted its competitors more than itself). See *Broadcast Music*, 441 U.S. at 16-18 (Court's discussion of CBS's theory and desired remedy).

[37]441 U.S. at 20-21. ("The individual composers and authors have [not] agreed not to sell individually in any other market . . . .").

[38]The arrangement was comparable in this respect to the more restrictive ("exclusive") type of physician networks identified in the DOJ/FTC policy statement.

the enforcement agencies might reasonably require network physicians to show that they are participating in competing ventures in fact, not merely that they are free to do so on paper. In addition, sponsorship of the venture by a local medical society, rather than by a subset of competing physicians, should defeat any claim that it is a procompetitive, rather than a defensive, undertaking.

There is no good reason in antitrust doctrine or policy why the antitrust agencies should not, in proper cases, be willing to treat physician-sponsored networks as JSAs and their attendant limitations on price competition as ancillary restraints subject to the usual test of reasonableness. Under the appropriate analysis, the authorities would give due recognition to the severe practical difficulties that physicians in solo or small group practices face in marketing their services to numerous large buyers. Lacking appreciable business experience and the staff resources necessary to negotiate and to keep track of their relationships with multiple payers, physicians should be free, within normal limits imposed by antitrust law, to form and operate JSAs. In mature markets for medical care, purchasers are generally capable of looking out for themselves and should be free to do business with physician networks that do not follow the current prescriptions of the antitrust authorities. In such markets, physicians are more likely to form JSAs as vehicles for competing on a price-discounted basis for particular contracts than as cartelizing devices.

Less Restrictive Alternatives?

To be sure, the evaluation of ancillary restraints of trade does not end with their classification as such. Even if the parties' purposes are unexceptionable, there must still be an inquiry into the probable state of competition if the collaboration is allowed. Such an inquiry begins with an estimate of the parties' market power -- that is, their ability to affect market price and overall output by their collaborative decisions. If the parties turn out to possess market power in fact (even though they do not need such power to accomplish their ostensible procompetitive purpose), the net effect of their collaboration could easily be more harmful than beneficial to consumers.

A case can frequently be resolved, however, without finally balancing procompetitive against anticompetitive effects -- by asking whether the parties could achieve their legitimate purposes in a manner less dangerous to competition. If such a "less restrictive alternative" was available and was not adopted by the collaborators, the antitrust enforcers might conclude either that their purpose was actually anticompetitive (thus justifying application of the per se rule after all) or that, despite their lawful purpose, the parties' choice of the more restrictive method of achieving it can itself be penalized. In reviewing physician-sponsored networks possessing a degree of market power, therefore, antitrust agencies must determine whether the anticompetitive features of the arrangement are reasonable in the sense that they are well-tailored to achieve their procompetitive purposes with minimal harm to competition.

Because the less-restrictive-alternative requirement is an element of a rule of *reason*, it should not used by the antitrust agencies simply as a warrant for closely second-guessing the way the parties have chosen to structure their relationship; thus, it should be invoked only if the methods chosen betray an anticompetitive motive or materially increase the threat to competition. Before antitrust enforcers require a physician joint venture to restructure itself in a way that sacrifices available efficiencies, therefore, they should have substantial reasons to fear that the arrangement jeopardizes

competition in the market as a whole. For reasons similar to those already discussed, an agency should not, without at least a quick-look power analysis, invoke the less-restrictive-alternative requirement to force the joint venturers to meet its prescriptions regarding risk-sharing or the nature and extent of their integration. It is not enough to say, as the *Maricopa* Court did, that "it is not necessary that the doctors do the price fixing." Even though an enforcement agency can imagine less restrictive methods by which the doctors could market themselves, it should not require use of such methods unless to do so would avert an unreasonable threat to competition in the larger market.

Reflecting the demands of antitrust authorities, the current practice in forming physician-sponsored networks is to design arrangements that avoid the noncompetitive fixing of prices for the services of the individual physicians in the group. Lawyers for physician JSAs have developed so-called "messenger" models in an effort to obtain some of the efficiencies of joint marketing while preserving a semblance of price competition.[39] Indeed, the apparent frequency with which networks are formed using some kind of messenger mechanism demonstrates that physicians set up JSAs primarily to achieve efficiencies, not to fix prices. It is not obvious why antitrust policy requires that they adopt cumbersome marketing methods that purchasers themselves do not insist upon. The enforcement agencies have uncharacteristically exalted form over substance in their analysis, ignoring valid efficiency considerations that normally would be given weight.

Messenger arrangements do not so obviously qualify as less restrictive alternatives that every physician-sponsored JSA should be required to use them. To be sure, they are *theoretically* less restrictive than letting the joint venturers agree on price. But because they are cumbersome to operate, they are not equally satisfactory as alternatives for getting the marketing job done. Their use therefore sacrifices some of the efficiency that JSAs can otherwise create. Indeed, antitrust authorities apparently insist that physician JSAs employ a particularly cumbersome mechanism called the "pure" messenger model. Under these arrangements, the marketing agent must communicate offers back and forth between bulk purchasers and individual doctors without disclosing to the latter the price terms that others are quoting. Because the pure messenger model is unwieldy, some networks employ "modified" messenger arrangements, which may take the form of a standing offer of individual physicians' services on uniform terms that a purchaser is free to accept or reject. Such arrangements have never been approved by enforcement officials, however, and have sometimes been rejected. Thus, if a physician-sponsored network provides neither for risk sharing nor for enough integration to create a "new product," the antitrust authorities will apparently deem it unlawful unless it takes maximum precautions – at whatever cost in inconvenience to both doctors and purchasers – to eliminate all price-fixing features. Although it is hard to judge the relative efficiency of all the possible messenger arrangements, the antitrust agencies might somewhat improve the situation by tolerating modified versions whenever competition in the market as a whole is not specifically in danger.[40] The better approach, however, would be to

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[39]See generally Raskin, supra note 9, at 86-91; *Law Firm Warns of FTC's and DOJ's Increased Focus on Messenger Models*, 4 HEALTH LAW RPTR. (BNA) 603.

[40]It is not known whether anyone has studied the actual operation of various messenger models to see what costs they incur or whether purchasers benefit in fact from the price competition they seemingly preserve. Although the doctrinal basis for doing so

apply the rule of reason.

Insistence on a second-best alternative is appropriate in antitrust enforcement and under the rule of reason only if a specific risk to competition outweighs the efficiencies forgone. To be sure, use of a messenger model should be required in many circumstances, often identifiable with only a "quick look." But in instances where the danger of anticompetitive harm is unclear, a more extensive evaluation is required. Such an analysis would consider such factors as sponsorship of the JSA by physicians in an aggressive competitive posture rather than in a defensive, anticompetitive one (that is, by interests other than a local medical society); the percentage of competing physicians engaged in the effort; their freedom to participate in competing ventures; their actual participation in other marketing schemes; the sophistication, effectiveness, and preferences of the purchasers with which they deal, and the overall vigor of competition in the market being served. Even if a network was the exclusive marketer for its member doctors, there would still be no threat to competition if the market featured a variety of other plans. In such a mature market, purchasers can decide for themselves whether to patronize JSAs in which physicians have not expressly undertaken to share financial risk, to integrate their practices, or to maintain any kind of independent pricing. Indeed, the availability of meaningful purchaser options itself puts the collaborating physicians at risk of contract nonrenewal and should go far toward satisfying government officials that competition is not in danger.[41]

The Danger of Prejudging Market Outcomes

As already demonstrated, the hostility of the antitrust agencies to physician network joint ventures results in part from their looking backward to the time when it was reasonable to presume that physicians collaborated only for anticompetitive purposes. Like many a wayward golf shot, however, the current enforcement policy suffers also from looking ahead, away from the object at hand and toward an intended goal. Thus, the agencies appear to be anticipating where they think the health care marketplace is headed and attempting to steer physician-sponsored networks in that foreordained direction. Thus, their prescription of the form that such networks must take reflects a prejudgment of the way physician services should, and will eventually, be bought and sold in the future

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would be highly artificial, the agencies might obviate some of the inefficiency by expressly letting joint venturers agree on nonprice terms, using the messenger model only for price terms (which may be more amenable to individual negotiation).

[41]Another kind of risk that should reassure antitrust enforcers concerning the compatibility of a JSA with competition in the larger market is the risk of "deselection" faced by individual physicians participating in the network and subject to periodic "profiling" of their practice patterns. Although the agencies are reported to take a narrower view, a joint venture might argue that it is offering "a new product" if it reserves, and occasionally exercises, the power to exclude doctors who overuse resources or provide care of doubtful quality. On the other hand, a state "any-willing-provider" law, mandating that a network include any physician willing and able to meet its terms, would diminish the risk of deselection. In states where such inclusiveness is mandated by law, the antitrust agencies could reasonably take the position that any joint venture should satisfy their requirements with respect to risk sharing or integration.

health care marketplace. In writing such a prescription, however, the agencies run the risk of choking off (in Professor Sullivan's words) "the market's manner of striving for efficiency."

To be sure, the antitrust agencies are not alone in assuming that all health care will eventually be provided by integrated health plans.[42] Many other observers also believe that physicians must bear financial risk if they are to be induced to provide health care efficiently and without the chronic excesses that have characterized much fee-for-service medicine. It is dangerous, however, for regulators to dictate market outcomes on the basis of *a priori* assumptions about what is and what is not efficient or responsive to the needs and preferences of purchasers.[43] Current antitrust enforcement policy with respect to physician networks is an exercise of prosecutorial discretion that, in attempting to provide guidance to the industry, has become overly regulatory and prescriptive, foreclosing options that might attract followers in a competitive market. It should after all be the province of purchasers, not the antitrust authorities, to decide whether a particular incentive arrangement achieves the right balance between spending and economizing.

The American Medical Association (AMA), in advocating greater freedom for physicians to create their own networks, has been somewhat careful about challenging directly the conventional view that physicians will ultimately either be put under managed-care arrangements operated by third parties or be organized in competing groups with explicit individual or collective incentives to control costs. Thus, AMA officials have sought to persuade antitrust enforcers that physicians need more freedom to collaborate only so that they can take incremental steps toward fuller integration or can explore new methods of payment without having to take the plunge all at once.[44] Citing physicians' lack of the capital, experience, and management skills necessary to organize a fully integrated plan, the AMA argues that physicians need an opportunity to test the waters and to evolve gradually toward full-blown integration of their practices. Observing that simple networks and management service organizations (MSOs) could either serve

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[42]See, e.g., Greaney, *supra* note 9.

[43]Although it is often assumed that fee-for-service practice is inherently inefficient, physician practice styles may be changing as physicians become more accountable for their competitive performance (see note 41 supra), as cost-consciousness becomes pervasive, and as changes in the prevailing standard of care reduce legal pressures to overtreat patients. Indeed, efficient practices have often been observed in some multispecialty groups treating patients under traditional indemnity insurance. See also Jeff C. Goldsmith, *The Illusive Logic of Integration*, HEATLHCARE FORUM J., Sept.-Oct. 1994, p. 26 (questioning the presumed benefits of much of the organizational integration sweeping the health care industry).

[44]See generally Letter from James S. Todd, M.D., Executive Vice President, AMA, to Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, May 11, 1994 (discussing antitrust issues addressed by certain legislative proposals). See also Edward B. Hirshfeld, *Antitrust Reform and Physician Groups*, in HEALTH CARE ANTITRUST: A MANUAL FOR CHANGING PROVIDER ORGANIZATIONS ¶¶1000-89 (Thomas Campbell & Daniel D. McDevitt eds., 1995) (authored by the AMA's Vice President Health Law).

as building blocks for larger plans to incorporate in their systems or evolve into physician-sponsored entities capable of bearing financial risks or offering "new products," it advocates antitrust relief that would facilitate physician experimentation with new ways of organizing themselves. This article argues more explicitly than does the AMA that some JSAs may have immediate procompetitive value in their own right and should therefore survive antitrust scrutiny without regard to the speculative (though probably valid) claim that they are also valuable as half-way houses on the way to fuller integration. Whereas the AMA hopes for some legislative relaxation of antitrust requirements, agency application of the rule of reason would alone be enough to give physicians all the freedom of action that is compatible with effective competition.

The AMA has also argued that impeding the creation of doctor-controlled plans fosters the unnatural growth of health plans operated by large corporate sponsors, which it alleges are less attuned than physician groups to patient welfare and the quality of care. Although granting legislative relief to physician collaboration would be a serious policy error,[45] antitrust enforcers should not, without good reason, deny physician-designed arrangements a fair chance to compete against lay-controlled entities in finding efficient ways to cope with disease at reasonable cost. In competitive markets, some such plans might prove attractive to many consumers. Able to rely on professionalism, collegiality, and consensus rather than exclusively on rules and regulations imposed from the corporate top down, physician-sponsored plans should have a comparative advantage in finding and implementing cost-saving methods that maintain essential quality and preserve intangible values that are at risk in many of today's managed-care systems.[46]

In any event, putting doctors at financial risk in treating their patients is not so obviously a wise and prudent policy that all physician-sponsored health plans should be forced into that mold. Financial risk creates interest conflicts, diminishes loyalty to patients, and may undermine professionalism, with consequences that some consumers would find objectionable. Not only do the incentives employed in many integrated plans engender *sub rosa* rationing of care that consumers have no way to monitor, but consumers and their agents lack other kinds of reliable information permitting them to compare the overall performance of competing plans. Thus, they have much to worry about in purchasing health care today and might therefore feel safer in dealing with plans that did not put physicians at financial risk.[47] Physician-sponsored JSAs, if they do not

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[45]See text at notes 50-54 infra.

[46]One physician sophisticated in health policy and generally appreciative of the role of antitrust law in medicine has argued that doctors must have a larger role in decision making and management if health care quality is not to suffer in the brave new world of managed care, "gatekeepers," and capitation. See Robert A. Berenson, *Do Physicians Recognize Their Own Best Interests?*, HEALTH AFFAIRS, Spring 1994, p. 185.

[47]The author has recently argued at length that the failure of health plans to write subscriber contracts saying anything meaningful about the degree to which the plan and its providers will ration services and balance health benefits against costs is a severe impediment both to offering consumers meaningful options in the marketplace and to holding providers and plans accountable for complying with any but a generally applicable (poorly defined but relatively expensive) standard of care. See CLARK C. HAVIGHURST,

dominate their local market, might add usefully to the competitive mix precisely because they do not feature direct financial incentives to withhold care, corporate control of medical practice, or integration and income pooling that lessen productivity incentives. A marketplace lacking arrangements designed by physicians themselves and not by antitrust authorities could easily fail to serve consumers well or to be fully reliable, from the standpoint of society as a whole, as a place for working out the difficult trade-offs with which health care necessarily abounds.

One consequence of the current and emerging problems with managed care could be a rising tide of regulation. Already, a combination of physician criticism, rumor, unverified consumer complaints, and occasional press reports of beneficial care denied is causing increasing skepticism and critical comment about the new generation of health plans. This discontent could easily ripen into a further backlash of regulation and litigation. Although designed to protect consumers, such legal developments would raise health plan costs and limit the ability of plans to adopt innovations responsive to the wishes of consumers and their agents. Indeed, overregulation is already a problem in many states, and only the fortuitous presence of the federal Employee Retirement Income Security Act (ERISA) as a barrier to intrusive state regulation and judicial oversight of employee benefit plans[48] has permitted the market to make as much progress as it has toward bringing costs under appropriate control. ERISA is under constant challenge, however, and may eventually give way as a defense against heavy-handed state regulators. For federal antitrust authorities to mandate risk sharing that in turn invites either relaxation of ERISA preemption or new state regulatory controls could be highly destructive of the market's ability to achieve efficiency.

In this connection, it should be noted that the National Association of Insurance Commissioners has recently declared its members' intention to treat any network of physicians that contracts with an employer to assume any degree of financial risk as an insurer requiring state licensure as such.[49] Thus, the antitrust requirement that physician-sponsored networks be structured to impose financial risks on physicians is driving such plans directly into the arms of state insurance regulators. State insurance regulation would increase the difficulty of creating new network joint ventures, would raise their costs, and would limit their ability to meet purchaser needs and expectations, thus undermining the efficiencies that such networks might otherwise achieve. Physician JSAs, on the other hand, would escape such regulation and would thus greatly enhance the freedom of self-insured employers and other purchasers to obtain the services they require without

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HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995).

[48]29 U.S.C. § 1001 et seq. (19). See, e.g., Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) (holding that ERISA preempts state mandated-benefit laws); Pilot Life Ins. Co. v. Dedeaux, U.S. (1987) (holding that ERISA preempts state law remedies for bad faith in administration of employee health benefits plans).

[49]See *NAIC Bulletin to Address Application of Insurance Laws to Provider Groups*, HEALTH LAW RPTR. (BNA) 1177 (discussing NAIC bulletin issued Aug. 10, 1995). See also *Storm Warning*, HEALTH SYSTEMS REV. (Federation of Am. Health Systems), Sept.-Oct. 1995, pp. 26-37 (series of articles discussing state insurance regulation of provider networks).

encountering the delays, obstacles, and costs that state regulators impose.

The assumption that competition will eventually induce virtually all Americans to enroll in some form of managed-care organization fails to take account of the fact that nearly 100 million Americans are currently covered by self-insured ERISA plans. This is roughly twice the number who receive their employer-purchased benefits through entities that integrate financing and delivery in ways that would satisfy the antitrust authorities in a physician-controlled arrangement. To be sure, there are some markets such as California where the market penetration by conventional HMOs and managed-care organizations is impressive, but there are many others (large parts of the Middle West, for example) where competition has operated for some time without inducing employers to rely heavily on corporate middlemen or integrated or risk-bearing physician networks. In these markets, many large employers do not require either that physician networks assume financial risk or that physicians integrate themselves in some formal fashion. Instead, they have employed either in-house benefit managers or third-party administrators to contract with physicians or physician networks directly at negotiated prices and work with them, often in highly creative ways, to control costs. Such employers apparently prefer the cost savings achieved through careful selection of physicians and through cooperation with them in addressing cost problems over the savings they might gain by contracting out the business on a capitated basis. Antitrust enforcers should not deny employers the option of dealing with physician JSAs, which they can hold responsible for selecting physicians who provide appropriate care without overcharging for their services.

Self-insured employers should therefore be free to work directly with physician-designed JSAs and not forced instead either to form their own networks or to hire independent entities to assume risk, to manage care, or to form fully integrated health plans. Such entities naturally expect to profit both from investing the employer's advance payments and, most importantly, from economizing on the provision of health care to employees and their families. Many employers might prefer to eliminate the middleman and to take direct responsibility for both the cost and the quality of medical care that their employees receive. In this effort, physician networks organized by physicians themselves could be valuable allies. Antitrust enforcers are simply wrong to insist that, when physicians organize a network joint venture, the only issue is whether the sponsors have either preserved a semblance of price competition among themselves or followed the agencies' prescriptions in allocating risks or integrating their practices. Ironically, the question they should ask is whether the market features *other* plans that meet the agencies' conditions. Once a market has matured to this extent, purchasers should be allowed to choose for themselves how they want physicians to be organized and compensated for their services.

An Invitation for Congressional Intervention?

Agency obtuseness on the issue addressed in this article comes at a particularly inopportune time -- as Congress is considering major reforms of the Medicare program. The version of the reform legislation that passed the House of Representatives in the Fall of 1995 included two provisions relating to antitrust law applicable to physicians. One would have explicitly required application of the rule of reason rather than a per se rule to "physician-sponsored networks" (PSNs) contracting with "physician-sponsored organizations" (PSOs) to deliver Medicare services under a PSO's capitation contract with

the government.[50] Thus, the House bill opted for letting physicians deal with "MedicarePlus" contractors through JSAs to the same extent that, under the analysis in this article, physicians could employ JSAs in dealing with ERISA plans and other private or public purchasers. The need for the House provision would therefore be obviated if the antitrust agencies were to relax the policy criticized in this article. Indeed, that outcome would be highly preferable to a legislative fix precisely because it would extend to physician networks of all kinds, not just to those organized to serve Medicare beneficiaries. In addition, it is always preferable to solve problems in the administration of antitrust law by refining doctrine so that it better promotes competition rather than by turning to Congress.

A more troubling provision in the House bill would have created a sweeping antitrust exemption for so-called "medical self-regulatory entities,"[51] rolling back twenty years of painstaking development (since *Goldfarb*) of antitrust principles applicable to concerted action by professional groups. Physician interests have long contended that antitrust enforcers misconstrue their motives in taking collective action in the marketplace. The agencies have successfully (and wisely) maintained, however, that the law requires the uncompromising maintenance of competition in professional fields, even when professionals can plausibly claim that their anticompetitive actions are motivated by concern for the public interest.[52] Thus, the antitrust movement has successfully brought to bear in medicine the wholesomely objective principle -- which the House bill would have converted to an impractical, and much too forgiving, subjective test -- that parties with a conflict of interests ought never to exercise coercive powers that are subject to anticompetitive abuse. Experience under the antitrust laws since the 1970s has generally vindicated the premise that competitive markets are preferable to professional control precisely because they are more hospitable to innovations responsive to consumer interests.

Unfortunately, unwise administration of the antitrust laws, either by the agencies or by the courts, invites Congress to intervene on behalf of politically powerful physician interests and to enact confusing, possibly overbroad correctives or destructive immunities like the ones in H.R. 2425.[53] The agency policy discussed in this article is thus doubly

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[50]H.R. 2425, 104th Cong. 1st Sess. § 15021 (1995).

[51]Id. at § 15221.

[52]E.g., FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986); National Society of Professional Engineers v. United States, 435 U.S. 679 (1978). But see note 20 *supra*.

[53]Congress last modified the application of antitrust law to the health care industry -- also at the behest of organized medicine -- in the Health Care Quality Improvement Act of 1986. 42 U.S.C. §§ 11101-51 (19). Because courts had been unable to find in antitrust doctrine any reasonable and expeditious basis for distinguishing between meritorious and nonmeritorious private antitrust challenges to staff privileges decisions in hospitals, see, e.g., Patrick v. Burget, U.S. (1988), Congress felt compelled to provide qualified antitrust immunity for hospital-based peer-review (and other similar professional) activities. On the other hand, if courts (perhaps with wise and balanced guidance from the antitrust agencies) had focused their efforts on distinguishing between actions of hospitals themselves and actions of medical staffs empowered by hospitals finally to decide the fate of their

unwise. In addition to being wrong as a matter of antitrust doctrine, it may prove a political disaster. Precisely because it has been based more on hostility toward physicians and suspicions about their motives than on reasoned application of antitrust policy, it has given medical interests a wedge with which to get Congress into the act, creating the potential for legislation virtually repealing antitrust law as it affects organized medicine. Antitrust is ultimately a political enterprise on which turns the fate of competition in the economy as a whole.[54] If competition is not to be undercut by congressional tinkering, antitrust enforcement must reflect astute political judgment as well as sound legal and economic analysis. An overly aggressive trust-busting mentality, such as the attitudes manifested by the agencies toward physician-sponsored JSAs, can easily have political repercussions harmful to competition in health care.

Conclusion

This article has argued that Americans are currently being denied access -- by antitrust authorities, of all people -- to a variety of doctor-sponsored physician networks that could perform useful services for some purchasers in some health care markets. In particular, the current policy of antitrust enforcers, in requiring all such networks to meet certain organizational or financial requirements, neglects at least three realities. One is that self-insured ERISA plans have very different needs than other purchasers of health care and that physician networks are capable of responding directly to these needs. Second, the antitrust agencies fail to recognize the heavy regulatory burdens and litigation threats facing the kinds of health plans they visualize as the wave of the health care future; precisely because ERISA plans and physician JSAs both escape many of these burdens, they may be jointly capable of efficiencies that are difficult for other plans to achieve. Finally, the antitrust agencies seem trapped in a time warp that keeps them fearful of physician conspiracies that are much less likely to prosper -- and thus to be attempted -- today than in an earlier era.

The Sherman Act's rule of reason was designed specifically to ensure that antitrust authorities consult the realities of actual markets in making judgments about whether competition is in jeopardy or is operating in healthy though possibly unpredictable ways. Conscientious antitrust analysis should enable the DOJ and FTC to recognize, often with only a "quick look," whether specific physician joint ventures or joint selling arrangements are more likely to suppress competition or to serve efficiently the needs of both their members and sophisticated purchasers, especially large employers and their employees. The threat that current enforcement policy poses to all physician network joint ventures that fail to meet the agencies' own prescriptions should be removed, either by a new policy statement or by an official clarification prominently announced. It would be a terrible reflection on the performance of the antitrust agencies if Congress had to put them on the correct doctrinal path in evaluating physician networks.

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competitors, there would probably have been no need for congressional intervention. See Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1108-42.

[54]See note 20 supra.

AMA "plan was a "blueprint" for much of [Republican] House Medicare package"

Dear Democratic Colleague:

In its July 1st Report to Members, the American Medical Association boasts of their victories in this Congress and says

> "Rep. William M. Thomas (R-Calif.), acknowledged that our plan was a "blueprint" for much of the House Medicare package"

and then lists its victories and quotes for its members the New York Times of October 11, 1995

> "The association--with shrewd lobbyists and a political action committee that donates tens of thousands of dollars to Congressional candidates--sways votes on Capitol Hill."

Not seniors, not the consumers, not the public, but the AMA was the "blueprint" of the Republican plan. The AMA, which fought the passage of Medicare with every ounce of its strength in the '60s, is whom the Republicans wrote their Medicare package for.

Hope you will share with your constituents in this year's campaign who was the source of the Republican Medicare ideas.

The AMA boasts are reprinted on the back. It is pretty accurate--except for their reference to "patient protections." The Republicans weakened patient protections--they didn't strengthen them.

Sincerely,

Public Policy

ADVOCATING FOR OUR PATIENTS AND THE BEST MEDICAL CARE POSSIBLE IN A CHANGING WORLD.

The Voice of Medicine: Advocacy in Action

AMA physicians, reversing a long trend of negative Washington action, in the current Congress so far have won eight of 10 floor votes that are important to medicine.

As a result, no major additional regulatory restrictions are being placed on the medical profession.

This is the AMA's best Washington record in at least 20 years. It is the result of advocacy that combines intensive one-on-one lobbying with a new physician grassroots network and the sophisticated use of advanced communications technologies.

Our overall strategy is two-pronged:

- "Constructive engagement" that keeps us on the inside of the process, fighting for our vision.
- "Stay the course" as long as it takes, regardless of the political environment.

Our strategy is working. On important floor votes in the 104th Congress' first 18 months, we were four for four in the House, four for six in the Senate. Following the same strategy, we expect more victories in the 105th Congress.

Major actions:

- Malpractice reform passed the House by a vote of 247-171, and is considered the closest step toward real reform in a generation.
- Medicare reforms vigorously sought by the AMA passed the House 231-201. Further action by Congress is expected early next year.
- Health insurance reforms in the Kassebaum-Kennedy bill that will help maintain access to care for more than 25 million working Americans and their families passed the Senate with a rare 100-0 unanimous vote. The final bill's anti-fraud provisions will require a "willful intent" standard.
- Antitrust relief advanced when the House Judiciary Committee voted 20-4 in favor of AMA's position. The bipartisan action came this spring after testimony from AMA Board Chair Nancy W. Dickey, MD, an AMA grassroots home district campaign and Capitol Hill visits by hundreds of physicians attending the National Leadership Conference. The bill has more than 150 sponsors.

This is the AMA's best Washington record in at least 20 years.

Doctors Emerge As Big Winners In GOP Plan
Washington Post, 9/22/95

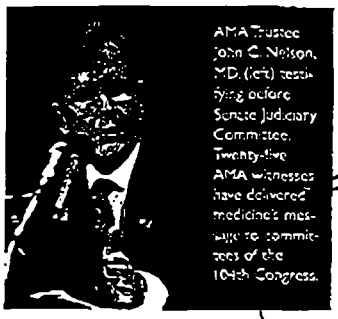
Doctors May Get Leeway To Rival Large Companies
New York Times, 4/8/96

House OKs $250,000 Ed on malpractice punitive damages
Washington Times, 3/10/95

Leaders of AMA Critical of Plan to Alter Medicaid
New York Times, 12/5/95

AMA wins concessions on Medicare
Chicago Tribune, 10/11/95

The day after the AMA ad appeared in Washington, the House of Representatives voted 247-171 for the medical liability reforms we advocated.



AMA Trustee John C. Nelson, MD, (left) testifying before Senate Judiciary Committee. Twenty-five AMA witnesses have delivered medicine's message to committees of the 104th Congress.

- "The doctors won huge. They got everything they wanted."
  - *Washington Post*, Sept. 22, 1995
- "The AMA's support is thought to be critical to public acceptance of the reforms."
  - *Baltimore Sun*, Oct. 11, 1995
- "The AMA has gotten other concessions from House Republicans, including a cap on malpractice damages and removal of antitrust restrictions on doctors."
  - *USA Today*, Oct. 11, 1995
- "The association — with shrewd lobbyists and a political action committee that donates tens of thousands of dollars to Congressional candidates — sways votes on Capitol Hill."
  - *New York Times*, Oct. 11, 1995

Medicare: Round Two

The AMA's strategy to "stay the course" and keep pushing medicine's agenda in Congress will pay off as the debate over Medicare reform continues into next year.

Our 100-page plan to strengthen Medicare is the only comprehensive Medicare plan put on the table by any group outside of government. Although the AMA differed with the House leadership on Medicaid, Rep. William M. Thomas (R-Calif.), acknowledged that our plan was a "blueprint" for much of the House Medicare package.

Key AMA provisions approved by the House included:

- Improvements in the reimbursement of traditional Medicare over current law.
- New choices for patients, such as medical savings accounts.
- Patient protections.
- Physician-sponsored networks and antitrust relief.
- Liability reforms.
- Reform of Stark I and II laws and easing of CLIA rules.
- A new trust fund for graduate medical education.

The House vote — called a "stunning victory" by AMA President Lonnie R. Bristow, MD — came after a major AMA public advocacy campaign.

Highlights:

Thousands of physicians mobilized through the AMA grassroots network.

AMA leaders appeared on major television news shows on NBC, ABC, CBS, CNN and PBS.

Full-page ads ran in *The New York Times*, *Washington Post*, *Washington Times* and *Los Angeles Times*.

AMA officials met with editorial writers and appeared on local radio and TV news shows in 30 major cities.

Grassroots Advocates

AMA members dramatically are increasing their personal involvement in AMA national advocacy.

At the heart of the effort: The new Physicians Grassroots Network, which now numbers 100,000 doctors.

About 70,000 already are linked by fax to the AMA, where a single action alert prompts a deluge of physician calls to Congress.

Just added is a high-tech telephone patch that with a single telephone call links AMA physicians and Alliance members to their elected representatives in Washington. The impact on the legislative process can be enormous.

To join the Physicians Grassroots Network, call 800-833-6354. Punch in your AMA ID number and you are part of this powerful physician movement.

LOOKING AHEAD

AMA's issues will top the agenda as the Medicare debate goes into 1997.

Gag clause and drive-through delivery legislation will make progress as popular election issues.

Long-sought CLIA reform will begin moving through the House Commerce Committee later this year.

American Medical Association

Physicians dedicated to the health of America

James S. Todd, MD
Executive Vice President

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

Identical letter sent to: Senate Leadership, Senate Finance, House Leadership, and House Commerce Committee

March 8, 1996

The Honorable Newt Gingrich
Speaker
House of Representatives
Capitol H-232
Washington, DC 20515

Dear Mr. Speaker:

The American Medical Association (AMA) is vitally concerned that under any restructuring, the nation's Medicaid program provides reasonable access to quality health care services for the nation's poorest and most vulnerable populations.

As Congress continues its work to develop Medicaid reform legislation, the AMA urges consideration of the following principles. These principles are intended to strike a balance between state flexibility to design and administer their Medicaid programs and the very real needs of the people the Medicaid program is intended to serve, most of whom have no other means of access to health care coverage.

Eligibility

The AMA applauds provisions of the National Governors' Association Medicaid proposal that would ensure coverage for some of the nation's most vulnerable populations by establishing income-based eligibility with a national floor and requiring maintenance-of-effort for certain populations.

At a minimum, the AMA also believes that states should phase in coverage for low-income children under age 19, as required under current law. With respect to the disabled population, we recognize that there have been some problems, even certain abuses, that have caused states to experience unacceptable growth rates in this population. However, this is a beneficiary group with extremely complex needs that need to be addressed. Therefore, we recommend that current coverage requirements be maintained for one year following the effective date of the reform and that HHS be directed to establish a task force to study the current disabled population and their medical care costs, as well as the impact of restricting SSI eligibility or changing disability criteria. This task force should be comprised of representatives from the governors' associations, organizations in the health care industry and advocacy groups for the disabled. The task force should be charged with developing national uniform disability criteria to be reported back to Congress within one year.

Benefits

The AMA strongly supports the NGA's vote to guarantee a set of benefits for covered Medicaid populations in every state. We also urge some minimum federal guidelines that would balance a state's flexibility to define the amount, duration and scope of services with the goal of providing beneficiaries with reasonable access to medically necessary services.

Access and Health Plan Standards

Although the AMA supports flexibility in the design of state Medicaid programs, we are concerned that a lack of federal standards or oversight with regard to access, quality or provider reimbursement will negatively impact beneficiaries and their ability to access appropriate health care services. The need for such oversight mechanisms was recognized in The Medicaid Transformation Act of 1995, which gave HHS oversight authority over state programs.

- Access Standards--We believe that HHS should have authority to monitor states' progress in meeting standards designed to measure patients' access to providers and covered health care services. If HHS finds that a state has failed to meet such standards, an oversight process should be established whereby a state will be required to engage in certain corrective activities to rectify problem areas.

- Health Plan Standards--There also should be standards for health plans that participate in Medicaid to ensure that beneficiaries are protected from practices that are unfair or impair the quality of care they receive. These standards should address: coverage, quality management, marketing, enrollment, physician involvement, utilization review, grievance procedures and incentive plans.

Public Notice and Input

The AMA believes that states should be required to comply with processes for public notice and input prior to implementing changes in their Medicaid programs, such as the processes outlined in The Medicaid Transformation Act of 1995 or those called for by HHS in its September, 1994 Federal Register notice. These processes will help to ensure that as states assume more control over Medicaid, they are accountable for policies that affect Medicaid beneficiaries and providers.

Private Right of Action

The AMA opposes eliminating the private right of action for providers and also opposes limiting the right of action for Medicaid beneficiaries. Providers should have redress against arbitrary and capricious processes, and they should have the authority to exercise assigned rights of action to protest actions that may result in harm to their patients.

Provider Taxes

The AMA strongly opposes any provision that would give states incentives to increase reliance on so-called provider taxes. Historically, many states have utilized provider taxes,

assessments, donations and intergovernmental transfer programs to "game the system" and draw down larger amounts of federal funds while expending fewer state dollars. We firmly believe that the Medicaid program and any efforts to expand eligibility should be financed in an equitable manner that spreads the cost over the entire state, not just to providers who are actually providing necessary health care services.

The AMA is committed to working with the Congress to bring necessary reforms to the Medicaid program while ensuring reasonable access and quality health care for our patients.

Sincerely,

James S Todd MD

James S. Todd, MD

November 2, 1995

1~
2~
3~
4~

Dear 5~:

The American Medical Association (AMA) feels the need to respond to recent attacks by the Administration and some in Congress on provisions in the House "Medicare Preservation Act" which would allow health care providers to form provider sponsored networks (PSNs) as an alternative to insurance industry products. We are especially puzzled by these attacks and the lobbying efforts against these provisions since the Administration supported similar provisions as part of health system reform in the 103rd Congress.

A "Congressional Health Care Workshops" document distributed by the Administration to Congress in September, 1993, stated that "eliminating the barriers to forming provider networks will promote efficiency and coordination of services." A Congressional Research Service analysis of the President's health reform bill commented that "an antitrust exemption would be provided for provider negotiations with regional alliances on fee schedules." The bill also established federal programs to provide technical and financial assistance for provider network development.

The President squarely addressed the PSN and antitrust issue in a satellite teleconference with the California Medical Association on March 23, 1994:

> **"But I agree that there must be some changes in the antitrust law so you can clearly get together without fear of legal repercussions. Otherwise, you are consigned to dealing with a middleman that will only add to the cost of you providing your services and undermine the choice that the consumer gets."**

In addition, the "Health Security Act" included provisions on other important issues addressed in the "Medicare Preservation Act," including professional liability reform and modifications to CLIA. The AMA supports these items, as well as the entire package of reforms included in the House "Medicare Preservation Act," as important and necessary steps to incremental health system reform.

We believe President Clinton had it right in his Address to a Joint Session of Congress on September 22, 1993:

> **"We propose to give every American a choice among high-quality plans. You can stay with your current doctor, join a network of doctors and hospitals, or join a health maintenance organization. If you don't like your plan, every year you'll have the chance to choose a new one."**

We could not agree more with respect to the Medicare program.

The AMA looks forward to working with you and the Administration as progress continues on expanding choices for beneficiaries, strengthening protections for patients, and ensuring Medicare's long-term viability for our nation's seniors.

Sincerely,

Lee J. Stillwell

Statement of Gerald E. Thomson, MD
President, American College of Physicians
Senate Democratic Leadership
October 5, 1995

PROPOSED MEDICARE BUDGET REDUCTIONS

Good morning Senator Kennedy, Senator Rockefeller and Senator Sarbanes. Thank you for conducting this important hearing today. I am Dr. Gerald E. Thomson, President of the American College of Physicians and Professor of Medicine at Columbia University. I am pleased to have the opportunity to share with you the College's very serious concerns about proposals to cut deeply into Medicare. Joining me is Dr. Christine K. Cassel, President-Elect of the College and Chairman of the Department of Geriatrics at The Mount Sinai Medical Center

Let me first remind you that the American College of Physicians is the nation's largest medical specialty society with 85,000 members trained in internal medicine and its subspecialties. We are dedicated to continuing medical education -- we publish the *Annals of Internal Medicine* -- and to high standards in medical practice and advocacy of responsible public policy.

Let me say in all seriousness that this group of physicians -- internists who provide more care for Medicare patients than any other physicians -- are *not* on board with the proposed budget reductions in the public insurance programs. We think that cuts of this magnitude call into question our ability to provide the world class medical care enjoyed by many, but not nearly all, Americans. Further, these cuts move us away from, not towards, assuring health care for all Americans, which remains an overarching goal of the American College of Physicians.

The College is concerned about an approach to Medicare restructuring that starts from a target number driven by the demands for a balanced budget and tax cuts, and then tries to engineer changes to meet that target. We believe in the opposite approach: start with changes that derive from health care system goals, and then estimate the savings that would be produced. The College was one of the first physician organizations to commit itself to cost containment, but we have insisted that cost containment not be the starting point for proposed changes. Rather, well conceived and carefully implemented reforms, designed to reduce excess capacity and utilization of services, promise savings based on a real reduction in costs rather than arbitrary budget cuts. In sum, we have to change the growth curve in health care costs and forego budget cuts that produce short term savings but no lasting cost containment or reform.

Neither Medicare patients nor the health delivery system can absorb the magnitude of budget cuts proposed, even with a large-scale transition of Medicare patients to managed care plans.

We do not believe that the health care system can absorb the loss of half a trillion dollars in public spending in the next seven years. We believe that the appropriate goal at this time is to extend the solvency of the Medicare trust fund, with savings estimated by the HCFA actuary at $89 billion, and to create the public/private mechanism necessary to plan for long-term savings in the entire health care system, including the public insurance programs.

Medicare patients already spend as much as 21 percent of their incomes on out-of-pocket costs, and the vast majority of patients are at relatively low incomes. The median income of Medicare beneficiaries is about $18,000. Nor do the elderly have substantial assets. The typical household in pre-retirement years has assets of $17,300; the comparable figure for African-American and Hispanic households is $500. Income-related premiums may make sense for the small number of beneficiaries at higher income levels, but that will produce only modest revenue.

It is proposed that reimbursements to health care providers be reduced through both government caps and market forces. There is a limit to what can be taken from the health care system in a given period of time. We suggest that proposed approaches to cost containment may prove to be very costly in terms of access to care and impact on the private sector.

Health care providers have paid more than their fair share towards deficit reduction. Physicians have absorbed 32 percent of recent budget reductions while they account for only 23 percent of Medicare spending. Medicare payment to physicians averages fully one third less than private sector payment. To ratchet down reimbursement further will threaten the ability of both doctors and hospitals to treat current and especially new Medicare patients. Particularly vulnerable are the poor, with disproportionate numbers of African-Americans and other minority groups, the very old, the disabled, and those living in rural and urban poverty areas -- all groups whose access problems have been documented (Physician Payment Review Commission, 1994, 1995).

Another significant cost of the proposed 'cost-cutting' effort will be steep increases in out-of-pocket expenses and lost wages for all Americans. A recent study by Lewin/VHI, commissioned by the National Leadership Coalition on Health Care -- a nonpartisan group that includes large corporations -- showed that more than $90 billion in costs would be shifted to the private sector from the $450 billion cuts proposed for both Medicare and Medicaid. This cost shift takes place even under assumptions of large numbers of Medicare patients moving into managed care plans and sizable reductions in reimbursement to providers; significantly, only a portion of the reimbursement reduction is included in the cost-shift amount.

This $90 billion cost shift is a tax increase. What's worse, it is a hidden tax increase, and it will fall on America's employers and families.

As distasteful and harmful to the economy as the cost-shift is -- it is not the greatest cost of proposed budget cuts. The highest price, paid by those least able to afford it, will be an increase in the number of uninsured. Already, one-sixth of the non-elderly population lacks health coverage. The Lewin/VHI study projects an *additional half-million people* will lose coverage as a result of the cost -shift. Just over a year ago, the American College of Physicians appeared before this and other committees to support efforts to bring America closer to universal coverage -- a goal that had bipartisan support. Today, we struggle to avert a cost-cutting proposal that will move the country backward from the goal of health care for everyone.

As in Medicare, the proposed cuts in Medicaid also are of grave concern. We strongly object to the slashing of Medicaid spending and the elimination of the guarantee of coverage. These proposals will take a program which has always been inadequate--covering only about half of people below the poverty level--and cut it back further.

We do not believe that a four percent growth rate can be achieved in the near term, as proposed. Some states would be limited to annual increases of 2 percent, a preposterous figure. Although the claim has been made by those supporting this cut, no one has shown how states, "freed" from federal requirements, can maintain the current level of service with severe reductions in funding. Cuts of this size will force states to move ahead with poorly conceived managed care plans, instead of implementing a careful transition that early experience, such as TennCare, suggests is essential. In contrast to Tennessee, the experience in Arizona tells us that savings are achieved only with a long term investment in a managed care infrastructure, especially in information systems that analyze the cost of care. The College believes that standards of access, capacity, quality, benefits, and other criteria of the Medicaid program must be maintained.

We believe that low income individuals who are eligible for Medicaid coverage should be guaranteed that coverage when they require it. If we face another recession, thousands will lose jobs and employer-provided coverage. States will face enormous pressures to provide coverage but will not have the funds to do so under these proposals. The expansion of Medicaid in recessionary periods is a critical component of the social safety net that should not be discarded.

Patients will have no recourse but to show up in emergency rooms and rely on the ability of financially vulnerable hospitals to absorb the costs of their care.

I would like to summarize our reactions to several major elements of the legislation proposed by the Senate Finance Committee:

Increased patient out-of-pocket costs: It is astonishing that additional beneficiary costs are contemplated in the face of figures that show the average Medicare patient already pays as much as 21 percent of their limited incomes for medical care. Every doctor can report to you patients living only on Social Security incomes, who forego medications because they cannot afford the costs of prescription drugs. Proposals to increase deductibles and set the premium at 31.5 percent of program costs may raise out-of-pocket spending to more than a quarter of the median income. This is an unacceptable level.

Diversion of public money to private use: Proposals that allow a beneficiary to withdraw money from a Medicare-funded medical savings account, even with a penalty, and use the balance for non-health purposes, are taking public tax dollars and diverting those amounts to private use. Proposals that allow a rebate for health plan premiums that are lower than the premium paid by Medicare divert tax dollars to private use. Finally, proposals that move aggressively and without ground rules from a publicly controlled program whose administrative costs are estimated in the single digits and turn over tax dollars to private control with much

higher percentages diverted to administrative costs, marketing, and profits in investor-owned plans, also put public dollars into private hands. We think that the first two of these initiatives are wrong. The third, while a more complicated issue because we support the gradual transition of Medicare to a system of increasingly available health plan options, should be undertaken only with careful thought about its implications and with constraints on the amounts of money not used directly for health care services.

Hospitals and Graduate Medical Education: The Committee package jeopardizes the viability of hospitals, many of which already operate on slim margins. The combination of cuts in updating the Prospective Payment System for hospitals and in reimbursement for graduate medical education will push many hospitals into a financially untenable situation, resulting in cutbacks in care and elimination of services and institutions. We are particularly concerned about the leading teaching centers that play a unique and precious role in developing and delivering high technology medicine and caring for the most difficult patients. These institutions also shoulder a large proportion of care for the uninsured. We oppose the cut in payment for so-called indirect graduate education costs--which in reality helps to provide services to uninsured patients--down to an adjustment of 4.5% for every 10% increase in the ration of interns and residents to beds. We also oppose the sharp reductions in disproportionate share payments. Without any kind of transition funding, teaching hospitals will not be able to fulfill their missions.

The House bill goes further than the Senate proposal. and would eliminate Medicare reimbursement for training residents in subspecialty medicine and for training international medical graduates. While we recognize the current imbalance between generalists and specialists, surely that does not imply the total elimination of training funds for the education of cardiologists, gastroenterologists, neurologists, and other physicians. The elimination of funding for residency slots filled by international medical graduates will severely impact the ability of hospitals in states like New York, New Jersey, and Illinois to provide services.

Price controls: One of the most ominous developments in this package is the use of arbitrary budget limits that dictate future payment amounts and impose price controls. The proposals make the simplistic and incorrect assumption that spending increases, regardless of cause, should be recouped by lowering payments to hospitals, physicians, and other providers. The right way to achieve cost containment is to address long-term factors that contribute to excess capacity and inappropriate utilization of services. The wrong way is to control prices through arbitrary limits.

Physician payment: The College supports the adoption of a single conversion factor for the Medicare fee schedule, but opposes the setting of a conversion factor that is below the current level. With the support of Congress, initiatives are underway that promise to improve payments for the evaluation and management services that are at the core of primary care. These initiatives include the five-year review of physician work values, adoption of a resource-based calculation of overhead costs, and hopefully, the single conversion factor. If Congress turns around and reduces

the size of the Medicare pie, these steps taken to assist physicians struggling to provide primary care will become empty promises. In light of widespread recognition of the need to redress the imbalance between subspecialists and generalists, negating the potential gains of these ongoing efforts would be a significant setback.

In sum, Senators, the American College of Physicians cannot support short-term budget cuts that target patients, physicians, hospitals, and others, bring about no meaningful change, and risk serious harm to patient care.

We urge the Congress to forego the inclusion of these programs in this budget cutting exercise and explore and eventually enact Medicare and Medicaid reforms that are consistent with, and indeed may lead the way to, more fundamental health system changes. We must reduce excess capacity and utilization if we are to achieve meaningful, lasting cost containment. I will summarize briefly the ACP recommendations for long term reforms.

First, the College supports managed care plans that are comprehensive and assure coordinated quality care. We think that this approach to delivery of services potentially can improve access and quality for Medicare and Medicaid patients and, at the same time, control spending by reducing excess capacity and utilization. Federal standards for high quality care are essential, and the ACP's Task Force on Aging has made recommendations on what Medicare managed care should look like. We have also proposed standards for Medicaid managed care.

Second, recognizing that Medicare patients now have complete and open choice of physicians and hospitals -- a point sometimes lost in the current debate -- the College supports the gradual transition of Medicare and Medicaid to systems which offer beneficiaries, on a voluntary basis, a variety of options among different types of health care plans, including traditional plans. We have real concerns about the ability of more vulnerable elderly patients to adjust to such a system, and believe that an administrative mechanism such as a purchasing pool is a necessary component of this approach. However, we have reservations about the medical savings account option. This approach contradicts the principles served by quality managed care. MSAs may discourage comprehensive care. Moreover, they have the potential of draining the healthier and wealthier beneficiaries from the rest of the Medicare risk pool, undermining the ability of Medicare to survive. The College recommends MSAs be tried on a demonstration basis to gather more information about their effects on the health status of those who use them and on the health coverage of those who do not.

Third, ACP believes that a national debate should be undertaken to address the difficult issue of prioritizing health care services for all populations, not simply the elderly or poor. A national consensus must be reached on how to decide when care becomes futile, at any age, and when other care options should be chosen to preserve individual dignity and comfort. Alternatives to acute care treatments are critical, so that patients are not forced to choose between high tech care and no care.

Fourth, the potential for savings through administrative simplification remains to be exploited. Strategies for savings include uniform claims forms and electronic processing, utilization review based on patterns of care rather than case-by-case review, and incentives to promote economies of scale.

Fifth, Medicare and Medicaid should evaluate and adopt, as appropriate, prudent private sector purchaser initiatives such as quality indicators and service performance standards, use of centers of excellence, specialized services contracting, and case management for high cost services.

To summarize, the American College of Physicians believes that the goal of Medicare and Medicaid changes should be quality care for those in need and the long-term solvency and viability of those programs. Restructuring must be considered in light of its effects on the larger health care system. We recognize that the changes we recommend may not be quantifiable by CBO for short-term deficit reduction, and we know we are bucking the tide to insist that deficit-reduction is not the appropriate goal for changes in these programs. Many proposals which are so easily scored by CBO are arbitrary program cuts that harm patients, health care professionals and institutions, and the larger health care system. We hope that Congress and the Administration establish the private-public mechanisms to plan for long-term reforms in these vital public programs.

Thank you for the opportunity to share our views with members of the Senate.

THE AMERICAN MEDICAL ASSOCIATION AD

After being criticized for making a backroom deal with Speaker Gingrich, the American Medical Association (AMA) placed a full-page advertisement in several papers last week defending their support of the House Republican Medicare plan. The AMA makes five points about the Republican plan, and all of their points are wrong.

1. Republicans ARE cutting Medicare

Republicans are cutting Medicare by $270 billion. The AMA and the Republicans claim that this isn't a cut because spending per beneficiary will rise from $4,800 to $6,700 in 2002. However, people on Medicare will not get what they get today with $6,700. To give older Americans what they are getting today, Medicare spending will rise to $8,400 per beneficiary in 2002. In other words, Republicans would spend $1,700 less than is needed just to maintain today's benefits. To a person on Medicare, that's a cut.

2. People on Medicare may have to give up what they have today

The AMA and the Republicans claim that beneficiaries can keep traditional Medicare. However, Medicare benefits will be cut by $1,700 in 2002. People on Medicare will be forced to pay more and get less. Both the House and Senate plans increase premiums, and the Senate plan also doubles deductibles from $100 a year to $210 a year in 2002 and raises the eligibility age from 65 to 67. It is difficult to imagine how Medicare beneficiaries -- 75% of whom have incomes less than $25,000 a year -- will be able to afford these increases.

3. People on Medicare may be forced into managed care if they can no longer afford traditional Medicare

Again, the AMA and the Republicans claim that people can keep what they have today. However, many beneficiaries will not be able to afford to stay in traditional Medicare and will be forced to join managed care plans that limit their choice of doctor. In addition, the legislation applies uneven rules to traditional Medicare and new "MedicarePlus," making traditional Medicare much less attractive to health care providers. With these incentives, people on Medicare may have fewer, rather than more, choices.

4. Republicans admit that beneficiaries will pay more under their plan but understate the amount

The AMA says that under the Republican plan premiums will rise on average only $6 a year. Today, people on Medicare pay about $46 a month in Part B premiums. Under the House plan, people on Medicare would pay $87 per month in 2002. The calculation in the AMA advertisement is simply wrong.

In addition to premium increases, there are hidden costs in the plan as well. Today, when Medicare pays for physician services it sets the payment rate and limits the amount above the rate that the doctor can charge the beneficiary. This limitation on so-called "balance billing" protects Medicare beneficiaries from paying too much. Under the Republican plan, this protection will be eliminated and doctors will be able to charge beneficiaries whatever they want in new private fee-for-service or high deductible medical savings account plans.

5. Quality and access to care may be put at risk

The AMA and Republicans claim that patients will be protected because plans can't discriminate if they have a pre-existing condition and patients can appeal denials of treatment. While these are important protections, the larger question is what will happen to access and quality with a cap in place on Medicare spending. The House bill constrains Medicare spending growth to an average rate of about 5 percent per person each year from 1996 to 2002 -- about 30 percent less than the private sector. The amount spent does not vary with changes in enrollment, medical inflation or technology. Capping Medicare spending may place access and quality of care at risk.

Washington Times 10/18/95

Dr. Lonnie Bristow Speaks To America's Patients About Medicare Reform:

I'm a practicing physician and I want my patients to know that Medicare will go broke by 2002 unless it's fixed now. The AMA has been working 10 years on ways to improve Medicare. Now Congress is about to act, and you need the straight story about what is really going on. Here are answers to questions patients ask me the most about the Medicare mess.

1. Does anyone have an answer?

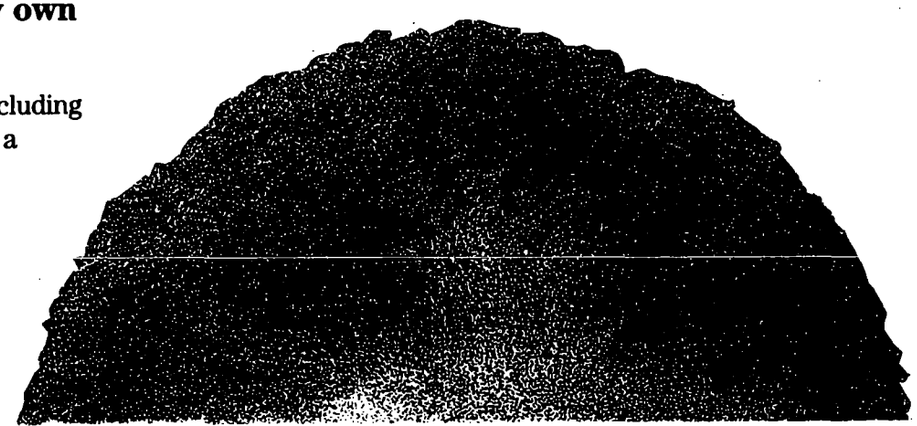
The House Leadership has a plan that makes sense, tackles the hard financing problem and is good for patients. Most important, spending per person will *still* rise from $4,800 to $6,700 in 2002.

2. Will I have to give up what Medicare already gives me?

No. You can keep the security of traditional Medicare if you want. You won't have to do anything different.

3. Can I choose my own doctor and my own health plan?

Yes. In fact, patients will have more choices, including traditional Medicare, private insurance plans or a tax-free medical savings account.



4. How much more will it cost me?

You will pay a little more, but not a lot more. On average, monthly premiums will rise only $6 a year over the next seven years. If you

On average, monthly premiums will rise only $6 a year over the next seven years. If you choose a private sector health plan, there may be expanded benefits and lower out-of-pocket expenses.

5. Will patients be protected?

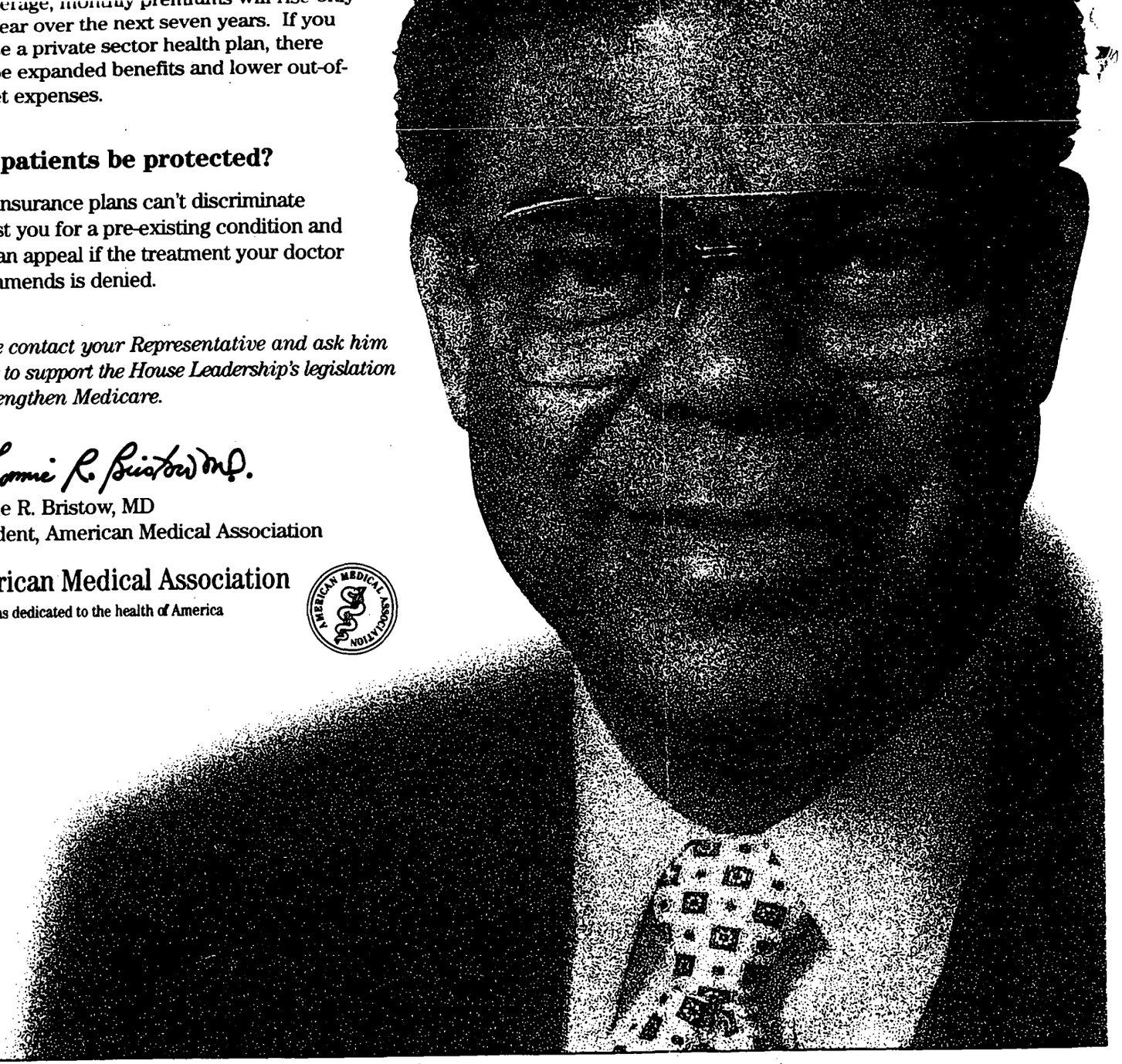
Yes. Insurance plans can't discriminate against you for a pre-existing condition and you can appeal if the treatment your doctor recommends is denied.

Please contact your Representative and ask him or her to support the House Leadership's legislation to strengthen Medicare.

Lonnie R. Bristow M.D.

Lonnie R. Bristow, MD
President, American Medical Association

American Medical Association
Physicians dedicated to the health of America



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The AMA and the Republicans claim that beneficiaries can keep traditional Medicare. However, Medicare benefits will be cut by $1,700 in 2002. People on Medicare will be forced to pay more and get less. Both the House and Senate plans increase premiums, and the Senate plan also doubles deductibles from $100 a year to $210 a year in 2002 and raises the eligibility age from 65 to 67. It is difficult to imagine how Medicare beneficiaries -- 75% of whom have incomes less than $25,000 a year -- will be able to afford these increases.

3. People on Medicare may be forced into managed care if they can no longer afford traditional Medicare

Again, the AMA and the Republicans claim that people can keep what they have today. However, many beneficiaries will not be able to afford to stay in traditional Medicare and will be forced to join managed care plans that limit their choice of doctor. In addition, the legislation applies uneven rules to traditional Medicare and new "MedicarePlus," making traditional Medicare much less attractive to health care providers. With these incentives, people on Medicare may have fewer, rather than more, choices.

4. Republicans admit that beneficiaries will pay more under their plan but understate the amount

The AMA says that under the Republican plan premiums will rise on average only $6 a year. Today, people on Medicare pay about $46 a month in Part B premiums. Under the House plan, people on Medicare would pay $87 per month in 2002. The calculation in the AMA advertisement is simply wrong.

In addition to premium increases, there are hidden costs in the plan as well. Today, when Medicare pays for physician services it sets the payment rate and limits the amount above the rate that the doctor can charge the beneficiary. This limitation on so-called "balance billing" protects Medicare beneficiaries from paying too much. Under the Republican plan, this protection will be eliminated and doctors will be able to charge beneficiaries whatever they want in new private fee-for-service or high deductible medical savings account plans.

5. Quality and access to care may be put at risk

The AMA and Republicans claim that patients will be protected because plans can't discriminate if they have a pre-existing condition and patients can appeal denials of treatment. While these are important protections, the larger question is what will happen to access and quality with a cap in place on Medicare spending. The House bill constrains Medicare spending growth to an average rate of about 5 percent per person each year from 1996 to 2002 -- about 30 percent less than the private sector. The amount spent does not vary with changes in enrollment, medical inflation or technology. Capping Medicare spending may place access and quality of care at risk.

Wilmington Times 10/18/95

Dr. Lonnie Bristow Speaks To America's Patients About Medicare Reform:

I'm a practicing physician and I want my patients to know that Medicare will go broke by 2002 unless it's fixed now. The AMA has been working 10 years on ways to improve Medicare. Now Congress is about to act, and you need the straight story about what is really going on. Here are answers to questions patients ask me the most about the Medicare mess.

1. Does anyone have an answer?

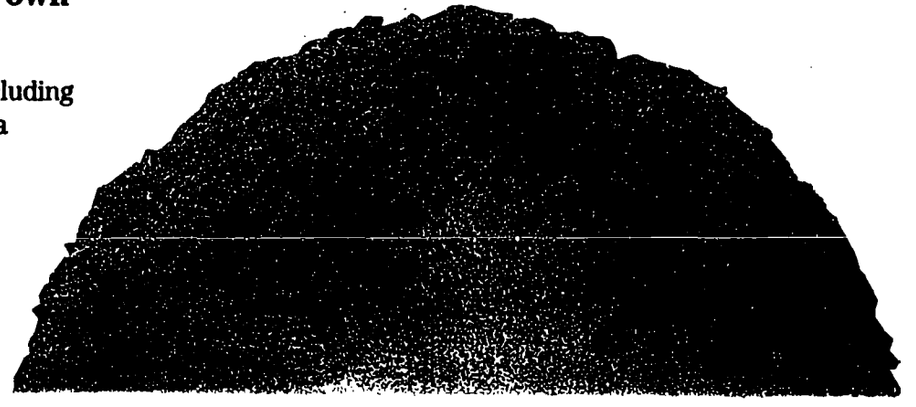
The House Leadership has a plan that makes sense, tackles the hard financing problem and is good for patients. Most important, spending per person will *still* rise from $4,800 to $6,700 in 2002.

2. Will I have to give up what Medicare already gives me?

No. You can keep the security of traditional Medicare if you want. You won't have to do anything different.

3. Can I choose my own doctor and my own health plan?

Yes. In fact, patients will have <u>more</u> choices, including traditional Medicare, private insurance plans or a tax-free medical savings account.



4. How much more will it cost me?

You will pay a little more, but not a lot more. On average, monthly premiums will rise only $6 a year over the next seven years. If you

$6 a year over the next seven years. If you choose a private sector health plan, there may be expanded benefits and lower out-of-pocket expenses.

5. Will patients be protected?

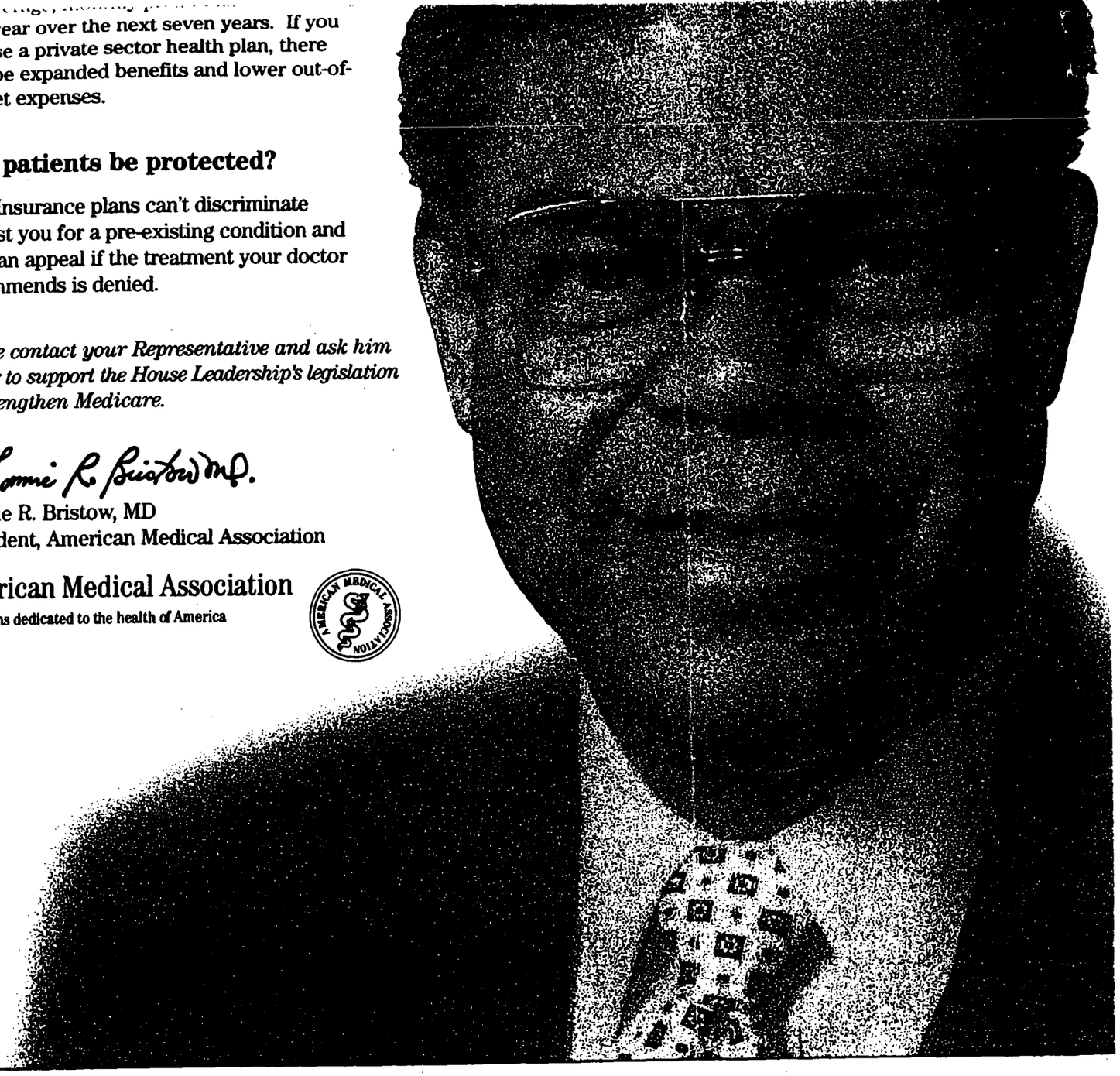
Yes. Insurance plans can't discriminate against you for a pre-existing condition and you can appeal if the treatment your doctor recommends is denied.

Please contact your Representative and ask him or her to support the House Leadership's legislation to strengthen Medicare.

Lonnie R. Bristow M.D.

Lonnie R. Bristow, MD
President, American Medical Association

American Medical Association
Physicians dedicated to the health of America



AMA Agreement with Speaker Gingrich

- Last night, in a closed door meeting, the American Medical Association (AMA) reached an agreement with Speaker Gingrich on the House Republican Medicare restructuring proposal. Although the details have not been shared with the public, it is clear that they have succeeded in placing their interest above that of their patients.

- The deal they cut shows their true vision for Medicare. They want to push Medicare beneficiaries into their so-called "Medicare-Plus" plans. It is actually going to be Medicare "Minus."

- So what did the AMA get to sign on to such unprecedented Medicare cuts?

  -- **Number One.** They secured a provision to permit doctors and health insurance plans to overcharge beneficiaries as much as they want in the new Republican managed care plans.

  -- **Number Two.** They reduced the physician cut by about $3-5 billion dollars which will simply shift a greater proportion of the cuts to beneficiaries and other health care providers who are already being unfairly burdened.

  -- **Number Three.** They got a cap on medical malpractice damages, so that victims of 'bad apple' doctors cannot be adequately compensated.

- So who are the losers?

  -- The losers are the patients of the AMA physicians.

  -- The losers are health care providers who are going to bear a greater share of the cuts.

  -- The losers are the entire health care system and the patients it serves.

- It is ironic that this deal was struck when, according to the AMA, the average physician's income is $189,000 a year, while the average Medicare beneficiary's income is $13,000.

- It is also clear that the AMA does not represent all doctors, many of whom continue to fight against the dramatic and excessive Republican cuts in Medicare and Medicaid. This is exemplified by the fact that the percentage of doctors and medical students in the AMA has dropped from 70% to 40%.

Klein

October 11, 1995

TO: Interested Parties

FROM: Chris Jennings

SUBJECT: Likely Details of AMA's Deal with Speaker Gingrich

The AMA's deal has not been released. However, preliminary reports indicate that the AMA obtained several significant provisions in exchange for their support of the House Medicare plan, including the following:

(1) Balance Billing. Medicare beneficiaries who enroll in the new private fee-for-service or high deductible MSA plan would lose their current law "balance billing" protection (i.e., limits on how much physicians can charge beneficiaries). This is particularly a problem because there is not requirement that physicians stay in fee-for-service (i.e., physicians could abandon regular Medicare and only see beneficiaries in plans where they can balance bill).

(2) Medicare Payments. Press Reports are unclear about the concessions that the AMA obtained last night, but reports are that AMA received $3 to $5 billion less in savings and was protected against decreases. Since the Medicare physician payment savings in the House bill was scored by CBO at $26 billion, the savings would now be scored at $21 to $23 billion.

(3) Malpractice Reform. Establishes numerous medical malpractice liability reforms including placing stringent limits ($250,000) on non-economic damages.

(4) Anti-Trust Exemption. Creates a broad anti-trust exemption for medical self-regulatory entities and substantially relaxes the anti-trust exemption for provider service networks. (The FTC and the Justice Department strongly object to these provisions and believe that they would encourage anti-competitive conduct and raise health care costs to consumers).

(5) Physician Service Organizations. Allows physicians and other providers to form managed care arrangements under Medicare, but does not subject them to same rules as HMOs (also supported by the Administration).

(6) CLIA Exemption. Exempts physician office labs from quality requirements despite the fact that to date more quality problems have been identified with physician office labs than other settings.

(7) Referrals. Virtually eliminates the prohibitions on referring to facilities in which the physician has ownership interest or other financial relationship.

(8) Anti-Kickback. Makes it more difficult to prosecute abusive kick-back arrangements (which creates double whammy with the changes in referrals).

One possibility to obtain "scored savings" while being spared the "real" cuts would be some type of fall-back mechanism. The fallback mechanism would be "scored" off the higher (CBO) baseline but would be "spared" the cuts because they would never materialize off the Administration baseline. All the provider groups seem to be trying to cut deals for fall-back mechanisms scored from the higher CBO baseline instead of traditional real cuts.

The AMA deal with the House is incredibly sweet.

- AMA has obtained extensive "real" concessions that they have long wanted and which would fundamentally change Medicare's relationship with physicians and create plenty of opportunity for physicians to improve their financial status at the expense of beneficiaries.

This analysis is obviously preliminary. As we get mor specifics, we will give you updates. Hope you find this helpful.

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(202) 789-7400

MEMBERS: Approximately 296,000 members—"43 percent of U.S. doctors and medical students" (*The Washington Post*, December 6, 1993). "While the number is higher than ever, the percentage is well down from the 70 percent level the organization enjoyed before dues were increased sharply in the 1970's..." (*The New York Times*, June 11, 1993).

REPRESENTS: Federation of 50 state medical associations and the District of Columbia, county, metropolitan societies and over 80 national medical specialty societies.

POSITION ON PLAN: Uncertain. AMA's position has varied between tepid cooperation, as represented by AMA executive vice president James Todd, and outright hostility, as represented by AMPAC, the AMA's more reactionary wing.

REFORM PROS: Universal coverage, Medicaid reforms, malpractice reforms, consumer choice of doctors. Until recently, the AMA favored an employer mandate.

REFORM CONS: Price-controls, global budgets, loss of professional autonomy.

SUMMARY OF POSITION: Universal access to medical care through an unspecified mandate and Medicaid reform, insurance market reforms, particularly community rating, and elimination of preexisting condition restrictions.

Want the right for organized medicine to negotiate with federal agencies and regulatory programs at the local level with managed competition entities.
Want professional liability reform; freedom of patients to choose their physician and system of health care delivery; quality assurance through practice parameters and outcomes research; administrative cost reduction; establishment at the federal level of a minimum benefits package (with repeal of state mandates); and decreased regulation.

DR. JAMES S. TODD

Dr. James S. Todd
388 Beechwood Road
Ridgewood, NJ 07450

Biography

Since the time he was eight years old, Jim Todd wanted to be a doctor (*The Washington Post*, October 8, 1991) and over the last 30 years, Dr. James S. Todd has lived his boyhood dream by involving himself in medicine and politics. Now, as the executive vice president of the American Medical Association, Dr. Todd is in the eye of the political tornado that has swept through this country, bringing the promise of medical reform.

Dr. Todd was born in 1931 and grew up in Cape Cod. He graduated cum laude for Harvard and Harvard Medical School. Later he interned and served his residency at Columbia Presbyterian Medical Center, becoming their Chief Resident in 1963. Dr. Todd then moved on to Ridgewood, New Jersey where he lasted 22 years as a surgeon, working at The Valley Hospital.

The political career of Dr. Todd is as impressive and diverse as his medical career. He has served as Trustee and Chairman of the Board of Trustees of the Medical Society of New Jersey, Chairman of the New Jersey Delegation to the AMA House of Delegates, and Chairman of the Ad Hoc Committee to Review the AMA's Principles of Medical Ethics. Also, in his hierarchal climb o the top of the AMA, Todd was a member of the AMA Board of Trustees (July 1980 to June 1984), Senior Deputy Executive Vice President (February 1985 to February 1990) and was elected to the Executive Vice President slot on June 19, 1990 (AMA Bio Sheet, October 5, 1993).

Todd principle expertise in medical politics is in medical liability. From 1977-85 he was Chairman of the Board of the New Jersey State Medical Underwriters, Inc. and is a Past President of the Physician Insurers Association of America. He has been a prolific commentator on the subject and has been published in numerous journals on medical liability (AMA Bio Sheet, October 5, 1993).

The rather successful life of Dr. James S. Todd has also been touched by tragedy. In May of 1988, Dr. Todd and his wife Pat lost their son Christopher J. Todd, who died at the age of 22.

> CHRISTOPHER J. TODD, 22, of Washington, D.C., formerly of Ridgewood, died May 24. He was a research assistant at Robert R. Nathan

Associates Inc., Washington. He graduated magna cum laude from Brown University, Providence, R.I., in 1987 and was a member of Phi Kappa Psi Fraternity. He was a graduate of Ridgewood High School. Surviving are his parents, Pat and Dr. James Todd of Ridgewood; and a brother, Kendall of Ridgewood.

(*The Record*,Northern New Jersey, 05/31/88)

Todd currently splits his time between his Ridgewood, New Jersey home and AMA offices in Washington and Chicago.

In an era where doctors and special interest groups are constantly assailed for their salaries, it is hardly suprising that James Todd, chief AMA executive, earns twice the average salary of a doctor or a health interest group executive.

Todd Makes More Than DoubleThe Average Doctor's Salary.

In 1991 the average doctor made $170,600 dollars a year (*AP Wire*, 3/25/93). In 1990, Dr. Todd's salary was reported to be $411,000 (*The National Journal*, December 15, 1990), which is more than double what the average doctor makes. Currently, Dr. Todd is earning an income of $421,542 (*The Washington Post*, February 4, 1993) and owns a two-story Ridgewood home that is estimated to be worth $ 465,300 (*TRW REDI Property Data*, 1993).

Todd's Income Ranks In Top Ten For Special Interest Group Executives.

Dr. Todd's 1990 income from the AMA ($411,000) ranks him in the top ten for special interest group executives (*The National Journal*, December 15, 1990). Also, the average health interest group executive earned $ 215,203 in 1990 which is a little more than half of Todd's salary (*The National Journal*, December 15, 1990).

PUTTING PATIENTS FIRST?

The American Medical Association and Dr. Todd in particular have continually repeated their mantra of "Putting Patients First." However, over the course of his career, Dr. Todd and the AMA have had made or endorsed policy decisions that diverge from their current stated goal.

"These are the kinds of things that can be eliminated. You're not doing violence to anybody."

The Washington Post, March 4, 1993

"If we're busting the budget, let's look at it and see why," he said. But, Todd warned, "anything that translates into price fixing and reducing compensation is unacceptable."

Chicago Tribune, March 4, 1993

Between 1983 and 1991, the mean income of doctors has gone from $88,000 to $170,000 per year, according to the AMA's own figures. The lowest-paid doctors are family physicians, making $111,000 per year; the highest are surgeons, at $234,000 per year.

The Washington Post, June 12, 1993

One frequently cited Harvard Universitystudy calculated that 80,000 people are killed each year and another 230,000 injured by physician negligence.

The AMA estimates that doctor and hospital malpractice premiums will total $ 9.2 billion this year.

Chicago Tribune, June 21, 1993

Dr. James Todd, the medical association's top staff member, lives in New Jersey and divides his time among that state, Washington, Chicago and road trips to visit state medical organizations.

Chicago Tribune, September 14, 1993

But he warned: "Without the tacit approval and support of the medical profession, health-care reform is not going to go very far."

Todd also held out an olive branch, saying doctors would be willing to see "reasonable" controls on their income, including a shrinking in payments to some specialties, in return for a fair plan to let them take care of patients with fewer bureaucratic hassles.
