August 7, 1996

Mr. Gene Kimmelman
Ms. Cathy Hurwit
Suite 310
1666 Connecticut Avenue, N.W.
Washington, D.C. 20009-1039

Dear Cathy and Gene:

Thank you for writing to express your opposition to H.R. 2925, the Antitrust Health Care Advancement Act of 1996. It's always good to hear from you, and I appreciate knowing your views on this legislation.

While I believe that health care providers need clarification on antitrust law so that they can establish competitive alternatives to traditional insurance plans, I am concerned that statutory changes could have unintended consequences. I share your strong support for the development of new guidelines by the Federal Trade Commission and the Department of Justice, and while the FTC and the Department have yet to release such guidelines, it is my hope that they will strike an adequate balance between addressing providers' need for clarification and avoiding interventions that undermine competition in the marketplace.

I welcome your involvement in this important issue, and I'm glad you took the time to write.

Sincerely,

BILL CLINTON

BC/SEM/JFB/RSM/ws-lynn-ws-emu (Corres. #3042799)
(7.hurwit.c)

cc: Chris Jennings, OEOB, 212R,ODP
cc: Sandy Bublick-Max, ODP
cc w/copy of incmg. to Jen Klein, WW

Consumers Union

Publisher of Consumer Reports

Citizen Action

June 18, 1996

The Honorable Bill Clinton
President
The White House
Washington, D.C. 20500

Dear Mr. President:

On behalf of health care consumers, we write to express our opposition to H.R. 2925, the Antitrust Health Care Advancement Act of 1996, sponsored by Representative Henry Hyde (R-Il.). This legislation would significantly weaken consumers' protection against anti-competitive practices in the health care industry. This legislation is likely to increase health care costs, reduce competition, and reduce choices for American consumers.

The legislation would harm consumers by exempting physicians from the *per se* standard (which determines that certain practices, like price-fixing, are themselves evidence of anti-competitive behavior), and substituting instead a weaker standard that would make it significantly more difficult to prevent price-fixing and other anti-competitive practices. Elimination of the *per se* standard would inevitably result in increased consumer costs as enforcement of pro-competitive rules becomes more difficult. The legislation would also preempt state law, making it more difficult and costly for states to pursue anti-competitive practices.

It is very unlikely that these costs will be offset by benefits to the public at large. There is absolutely no evidence that antitrust enforcement has inhibited the legitimate development of physician networks. Indeed, as many of 20% of all preferred provider organizations (PPOs) and 15% of all health maintenance organization (HMOs) are owned by physicians. In addition, physicians already receive significant assistance from the Federal Trade Commission (FTC) and the Department of Justice (DOJ) in determining what practices are illegal. The FTC and DOJ both recognize that all circumstances, including the availability of services in rural areas, must be considered in evaluating specific activities. Finally, both the FTC and the DOJ's Antitrust Division are developing new guidelines outlining acceptable methods of delivering medical services that will further accommodate the legitimate concerns of physicians . We support these efforts, which will more than accomplish the stated purpose of H.R. 2925.

Recent cases of anticompetitive behavior demonstrates the need to preserve the *per se* antitrust standard. These cases involve efforts to shut non-physician medical professionals out of markets, efforts to stifle new health care delivery methods such as HMOs and PPOs, and efforts to create monopolies of specific services.

For example, as recently as April 12, 1996, the Department of Justice proposed a settlement with the Women's Hospital and Woman's Physician Health Organization in Baton Rouge, Louisiana regarding their efforts to prevent the development of competition among facilities offering obstetrical care and with dictating higher prices for physician services. Woman's Hospital delivers approximately 94% of the privately insured newborns in Baton Rouge. The Antitrust Division's actions will ensure that consumers do not face higher obstetrical costs in the Baton Rouge area. This is the sort of case that could become much more difficult and expensive to resolve if H.R. 2925 becomes law.

We are committed to ensuring that consumers of all goods and services are adequately protected by our nation's competition laws. We believe that H.R. 2925 would result in considerable erosion of that protection in the area of medical services. In light of the serious concerns this legislation raises, we urge you to oppose this legislation.

Sincerely,

Gene Kimmelman
Co-Director, Washington Office
Consumers Union

Cathy Hurwit
Legislative Director
Citizen Action

JON KYL
ARIZONA
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August 1, 1996

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Robert Pitofsky
Chairman
Federal Trade Commission
Pennsylvania Avenue At Sixth Street, NW
Washington, DC 20580

Dear Chairman Pitofsky:

I write to request the opportunity to review the antitrust guidelines governing provider sponsored organizations (PSOs) that are now in draft form at the Federal Trade Commission (FTC).

I am aware that the FTC recently completed a comprehensive evaluation of the law and regulations governing the operation of PSOs in the rapidly evolving health-care market place and concluded that a change in the regulations was in order. In testimony before the House Judiciary Committee, you recently stated that the purpose of H.R. 2925, Chairman Hyde's Antitrust Health Care Advancement Act (also designed to address changes in the medical market place) would be rendered moot by FTC's pending antitrust regulations. As you know, H.R. 2925 would mandate that the FTC and the Department of Justice replace the per se rule with the "rule of reason" analysis in determining whether a specific PSO is pro- or anti-competitive in a particular market.

I would support a Senate companion to H.R. 2925 in the absence of federal regulations that achieved the same objective. Where competing providers voluntarily integrate to create a joint venture, I believe that agreements on prices and market allocation, and on other aspects of competition that are reasonably necessary to enhance competitiveness and efficiency, should not be per se unlawful, but should be judged on the basis of the facts and circumstances unique to each case.

For this reason, I would appreciate reviewing the proposed guidelines prior to issuance so that I might have the opportunity to offer comment.

Sincerely,

JON KYL
United States Senator

JK:ta

Additional DOJ/FTC Antitrust Guidance on Health Care Provider Networks

The Department of Justice and the Federal Trade Commission plan to issue additional guidance on the agencies' antitrust law enforcement policy with respect to health care provider networks. This action is designed to clarify and expand upon the agencies' earlier guidance regarding health care provider networks contained in the joint DOJ/FTC Statements of Enforcement Policy Relating to Health Care and Antitrust, issued in 1993 and revised in 1994. In developing revisions to the Statements, the agencies consulted with a broad spectrum of the health care industry (including self-insured employers, purchaser coalitions, physicians, hospitals and other providers, attorneys who advise providers seeking to form networks, insurers, and managed care plans) and with state antitrust officials. The agencies intend to issue the revised Statements by August 1996.

The revisions, which cover both physician networks and the broad range of "multiprovider" networks, address the following areas:

Rule of Reason/Per Se Treatment: The revisions clarify that a wide range of arrangements that offer efficiencies will justify analyzing price agreements among network participants under the more expansive "rule of reason" antitrust analysis, rather than the "per se" rule of illegality that applies to naked price fixing agreements. The revisions also include several additional examples of networks that would receive rule of reason treatment, including (a) networks in which the participants do not share financial

risk, and (b) networks in which participants share financial risk in ways not described in the earlier Statements.

Applying the Rule of Reason: The revisions elaborate on factors for evaluating networks that are subject to rule of reason analysis, particularly through the use of additional hypothetical examples that include both physician networks and one common type of multiprovider network, the physician-hospital organization (PHO).

Analysis of Networks in Rural Areas: The 1994 Statements discussed how market conditions in rural areas may justify certain health care arrangements that might raise antitrust concerns in other areas. The revisions provide further guidance on this issue through an analysis of a PHO in a rural area.

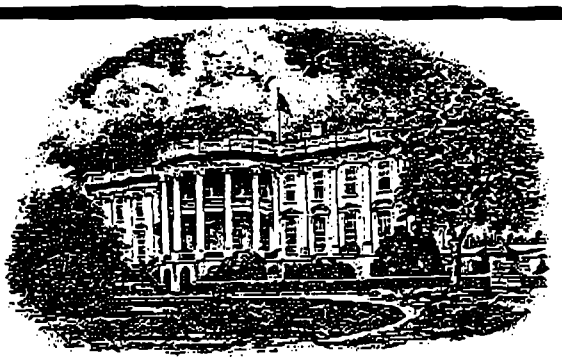
Safety Zones: The 1993 and 1994 Statements established "antitrust safety zones" for certain physician networks. Because some in the industry have misinterpreted these as defining the only physician networks that the Agencies would consider lawful, the revisions emphasize that networks falling outside the safety zones may be lawful.

Network Arrangements that Avoid Price Agreements: The revisions provide additional guidance on ways that unintegrated networks can employ a "messenger" to facilitate contracting while avoiding any agreements among competing providers on price terms.

FAX COVER

Health and Personnel Division

Executive Office of the President
Office of Management and Budget
OEOB, Room 262
Washington, D.C. 20503



DATE: July 31, 1996

TO: Chris Jennings
Jennifer Klein

AGENCY: _____

FAX NO: _____

cc: John Richardson (FYI)

FROM: Nancy-Ann Min
Associate Director for Health and Personnel

Phone Number (202) 395-5178
Fax number (202) 395-9119

Number of pages (including cover) _____

COMMENTS: I just received this info from AMA – it looks as though it will be relevant to tomorrow's meeting.

NM

c:\work\wp\faxcover

American Medical Association
Physicians dedicated to the health of America

P. John Seward, MD
Executive Vice President

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

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

[forthcoming in LOYOLA CONSUMER LAW REPORTER]
[Final Prepublication Draft--Feb. 22, 1996]

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.

[21]In two later cases, the Court appeared to apply per se rules too readily, without even a look that would probably have changed the outcome in one case but not the other. See FTC 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.

CC: Antitrust
for Medicare
Notebook

EXECUTIVE OFFICE OF THE PRESIDENT

08-Jul-1996 09:54am

TO: Christopher C. Jennings
TO: Jennifer L. Klein
TO: Marilyn Yager

FROM: Nancy-Ann E. Min NEM
Office of Mgmt and Budget, HP

SUBJECT: Positive Movement on Antitrust

Attached is a copy of the actual article from the AMA News about the FTC/DOJ antitrust policy changes afoot (last week, I sent you a wire story about this). I spoke with Chairman Pitofsky about this last week--they are planning to issue the new guidelines in August. The guidelines are currently under review by the other FTC Commissioners; he doesn't expect there to be a problem. He says that they will give us 2 weeks notice when they have gotten approval from the others and are ready to release the guidelines; since they are an independent agency, we do not review or comment on their decisions. He said they have met informally with a number of provider groups, including the AMA, and everyone was positive--though he said the AMA reps wanted them to go even further. (But note the attached article is fairly positive, even so). He also says they have met with a number of folks on the Hill, including Hyde, who like where they are headed.

I think we should get together and talk about how we might make the most of this.

Reactions?

American Medical
NEWS

AMERICAN MEDICAL ASSOCIATION • JUNE 24, 1996 • VOLUME 39 • NUMBER 24

Prescription for **change**

Drug firms expand into patient care

Drug firms are diversifying in response to the pressures of managed care. This story, the second of a two-part series, examines industry interest in disease management.

By Greg Borzo
AMNEWS STAFF

Can drug companies assume a role in managing or even providing care?

Many drugmakers say "yes," that they can apply their formidable resources — including the medical expertise derived from decades developing drugs — to help providers manage specific diseases.

The new approach, called disease management, takes a comprehensive, integrated view of disease. It focuses on chronic, high-ticket conditions where pharmaceuticals play a big part, such as diabetes, asthma and depression.

While traditional medicine treats an illness in one setting and specialty at a time, disease management treats a disease across the continuum of care, from wellness to critical condition; from prevention to tertiary care; from home to hospital.

Disease management intervenes aggressively to head off acute episodes. It works proactively to educate patients and assure compliance — in sickness and in health.

In fact, proponents say it fulfills the promise of managed care by managing the quality and process of care, not just controlling costs.

"Disease management re-engineers the entire physician care process," says John Byrnes, MD, chief executive officer of Lovelace Healthcare Innovations in Albuquerque, N.M., which is developing 30 disease management programs. "These tools then become the primary tools for medical groups and integrated delivery systems."

What disease management means for physicians

- Less autonomy.
- More accountability, outcomes measurement.
- More teamwork with nurses, midlevel practitioners, nutritionists, etc.
- Fewer office visits, hospitalizations, high-cost procedures.

Attacking asthma

Some 9 million Americans suffer from asthma. Treating it costs $6.2 billion annually, 30% of which goes for 1% of patients with the most severe conditions, and 70% for the top 10%.

Last year, Mid-Atlantic Medical

See DRUG FIRMS, page 7

Partisan split on MSAs could derail health insurance bill

By Sharon McIlrath
AMNEWS STAFF

WASHINGTON — Pushed by retiring Senate Majority Leader Robert Dole, House and Senate Republicans finally reached agreement on a health insurance reform bill.

The agreement includes several AMA-sought modifications in the fraud-and-abuse section, and would make medical savings accounts available to about a third of the American workforce. But Democrats had called for a far more modest MSA pilot program, setting the stage for further congressional stalls or a presidential veto.

Both the House and the Senate had adopted insurance reform bills before the end of April. But efforts to iron out significant differences between the two measures have been long and contentious.

Senate Democrats delayed the naming of an official conference committee because they believed Dole wanted to stack the deck with conferees who favored the MSA provision included in the House plan but rejected by the Senate. But even Republicans, who held unofficial conferences without Democratic participation, had a hard time finding common ground on some issues.

Dole, who is giving up a 35-year congressional career to concentrate on his presidential campaign, had hoped to leave the Senate with a record of achievement that included enactment of a health insurance bill. The delays in hammering out a compromise between the two bodies have denied him that feat.

But his last-minute intervention did wring out an agreement between Republican factions and enabled the former majority leader to take some credit for moving the process along.

Malpractice, mental health gone

As expected, negotiators abandoned medical-malpractice reforms and a mental health provision favored by the AMA and many other medical organizations. But a determined AMA campaign that culminated in a barrage of letters and phone calls from physicians prompted the negotiators to alleviate

See MSAs, page 30

Inside this week

Federation reform redux

Delegates to the AMA Annual Meeting will consider a proposal to increase specialty society representation without diluting state society strength.
Page 4

Caveat vendor

To get the best price for your practice, it helps to know your rights — and what buyers are looking for. Business.
Page 13

The profession's voice

Since its first Annual Meeting in 1889, the AMA house has served as medicine's forceful and unifying representative body. Editorial.
Page 17

Liability insurance

An Arizona thoracic surgery group learned this lesson the hard way: Read the fine print in notices from your insurer. Medicolegal Decisions.
Page 23

Savings may be FTC test in hospital, doctor mergers

By Julie Johnsson
AMNEWS STAFF

WASHINGTON — A proposed shift in federal antitrust policy could give hospitals and physician organizations that merge with competitors a new defense against enforcement action.

The Federal Trade Commission said it wants to give greater weight to the potential cost savings that would be produced by mergers in determining whether such deals were anti-competitive.

The commission outlined how it would approach this new analysis of merger efficiencies earlier this month in a 300-page report on global competition. That report also called for an FTC-Justice Dept. task force to examine the issue as a first step toward changing federal policy.

All of this signals an important new direction in antitrust enforcement — and a possible gain for physicians later this summer when federal officials release their revisions to the health care antitrust guidelines, experts say.

The FTC report is "groundbreaking," said Marilou M. King, executive vice president of the National Health Lawyers Assn. It's unprecedented for the commission's staff to produce a detailed analysis of the competitive effect that merger efficiencies can create in today's health care markets, she added.

Antitrust about-face

In fact, it's unprecedented for the FTC to acknowledge that such efficiencies could spur, not hinder, competition.

A key attraction for hospitals and other providers considering a merger is the savings they can gain by sharing high-technology equipment and eliminating duplicative services. Such savings can lead to lower-cost care, forcing competing institutions to seek similar savings — healthy market dynamics.

But until this report, federal antitrust officials were loath to acknowledge the full competitive benefit that such new efficiencies can bring to markets.

"Historically, the [antitrust enforcement] agencies have been very hostile to efficiency claims, and have taken the position in litigation that efficiencies are no defense to a merger," noted Tom

See MERGERS, page 28

Merger

Continued from page 1

Campbell, partner with the Chicago law offices of Gardner, Carton & Douglas.

FTC and Justice Dept officials would consider efficiencies in their antitrust analysis only if the merger partners could precisely quantify the savings a deal produced — a Herculean task, said Ed Hirshfeld, vice president for the AMA's health law division.

"You had to run the numbers and not just demonstrate the potential for it, but show that efficiencies are there," he added. "No data exists for that kind of analysis."

Competitive dynamics

The FTC report would broaden the enforcement agencies' analysis to focusing on whether a merger's potential efficiencies would positively affect the competitive dynamics of its marketplace.

"This is a much more positive, flexible way to approach it," Hirshfeld said. "It allows for the evolution of a market, as opposed to a bean-counter way that just looks at how much money would be saved if you have this joint venture or merger."

The report establishes a simple framework for determining whether the proposed efficiencies would justify antitrust exemption. The agencies would focus on two questions:

- Is the merger likely to result in credible efficiencies?
- If so, how are those efficiencies likely to change the merged firm's abilities and incentives to deter the likelihood of lessened competition after the merger, or to increase competition in a relevant market?

For example, federal officials would bless a deal where "if merger-related efficiencies would enable a firm to lower its costs, those lowered costs may disrupt market conditions so as to make collusion less likely or to disturb terms by which firms previously were able to coordinate their conduct," the report noted.

However, proving merger efficiencies doesn't guarantee that a deal will pass muster with the enforcement agencies, the report said. Federal officials will still challenge deals where the market power amassed by hospitals or physician organizations outweighs the benefits created by potential efficiencies.

Such analysis already factors into the FTC's merger investigations, Robert Leibenluft, assistant director of the commission's Bureau of Competition said at the National Health Lawyer Assn.'s annual meeting, June 6.

"This reflects a lot of what we do already," he added. The document merely provides a "more explicit suggestion" by the FTC as to how staff analysis should look for the competitive effect of efficiencies.

See MERGER, facing page

Crackdown on coding ahead

WASHINGTON — Federal authorities are poised to crack down on miscoded claims by hospitals and physicians.

In the months ahead, providers with a pattern of coding abuses could face enormous penalties, noted Len Homer, an attorney with the Baltimore law office of Ober, Kaler, Grimes and Shriver.

That's because officials intend to prosecute errant doctors and hospitals under the federal False Claims Act. Violators will be penalized with treble damages and fined between $5,000 to $10,000 for each miscoded claim.

Unlike federal fraud statutes, the false-claims law doesn't require authorities to prove that providers intentionally acted wrongfully — but merely show that doctors or hospitals filed incorrect documents.

"Yesterday's billing error is today's false claim," Homer said at the National Health Lawyers Assn.'s annual meeting here, June 6. Physicians could be especially vulnerable to false-claims charges under new evaluation and management codes that take effect July 1, he added.

In its June 1 instructions to Medicare carriers, the Health Care Financing Administration establishes lengthy new recordkeeping requirements for these codes. Attending physicians will be required to document that they were present during key parts of a patient's history evaluation, physical exam and assessment and diagnosis.

"It will be a tremendous job for physicians to bill E&M codes accurately," Homer said. "You can't blame doctors for being upset and outraged."

Hospitals, meanwhile, may pay heavily for past efforts to illegally upcode patient visits under Medicare's diagnosis-related groups, he added. At least one East Coast prosecutor is planning a major crackdown on "payment enhancement" programs often installed at hospitals by consultants.

James Sheehan, a Philadelphia-area assistant U.S. attorney, plans to investigate hospitals that systematically code respiratory and cardiac illnesses at unusually high case-mix levels in order to gain more money from Medicare, Homer said.

Sheehan, it should be noted, is known for his innovative enforcement in this area of law. Last December, he gained an unprecedented $30 million false-claims settlement from the University of Pennsylvania Hospital over its billing for physician services.

—Julie Johnsson

AZT, other drugs cut AIDS risk to health workers

ATLANTA (AP) — Health workers splashed with HIV-infected blood or pricked by needles tainted with the virus significantly lower their chances of infection by taking a mix of AZT and other anti-viral drugs, the government says.

Workers with open wounds who are exposed to infected blood should immediately be offered a combination of AZT and lamivudine, the Centers for Disease Control said.

And workers accidentally stuck with tainted needles should get a three-drug combo: AZT, lamivudine and indinavir, according to the CDC.

The recommendation, issued in May, follows a CDC study published in December that found nurses and others who took AZT after they were stuck by needles reduced their risk of infection by 79%.

Combining AZT with lamivudine and indinavir, new anti-viral drugs, boosts the chances of preventing infection because they fight the virus' ability to resist AZT, said Dr. David Bell, chief of the CDC's HIV infection branch.

CDC recommends AZT, lamivudine, indinavir combination therapy.

"These are newer drugs, and we know that they are stronger than just AZT alone so we recommended they be added," Bell said. "This is good news because now there is something workers can be offered to lower their risk of infection."

The CDC study — on 710 health workers in the United States, the United Kingdom and France — was the first one conducted on health-care workers given AZT to prevent infection after exposure to the AIDS virus.

Public health experts then met to discuss the effectiveness of combining AZT with other anti-viral drugs. After reviewing the evidence, the CDC decided to recommend the drugs be taken together.

The drug combinations cause side effects in HIV-positive patients, such as nausea, fatigue and headaches. In rare cases, indinavir has caused jaundice and kidney stones, the CDC said.

"We don't know what side effects there will be in healthy people, but at least workers will be offered the drugs and will be able to make an informed decision," said Dr. David Rimland, an infectious-disease expert at Emory University School of Medicine.

Merger

Continued from facing page

However, the policy shift suggested by the report isn't the result of some new revelation by FTC staff, noted Campbell. In fact, the courts have repeatedly rejected the agency's argument that efficiencies aren't a defense against antitrust allegations. "They've almost been forced to address this in a more positive way," he said.

Guideline changes

The FTC report could also prove beneficial to physician joint ventures that fall short of full risk-sharing, Hirshfeld said.

The 1994 antitrust guidelines establish rule-of-reason treatment for physician networks that produce significant efficiencies. But there's a catch, Hirshfeld added: "The references to efficiencies were made in language that antitrust lawyers recognize as the traditional view — you have to quantify savings before you have any significant impact in persuading the agencies to allow your network."

Now, there's a good chance that the FTC's more flexible approach to efficiencies will wind up in the guideline revisions it's due to release by August.

If so, it could enable a broader range of physician ventures to qualify for rule-of-reason analysis, rather than being dismissed by federal authorities as illegal per se.

"Hopefully, the FTC's report will be positive, not only for mergers of corporations, but for physician joint ventures," Hirshfeld said.

Leibenluft didn't address this potential link between the report and the guideline revisions. But he said FTC and Justice Dept. staffs were working to ensure that standard antitrust analyses are applied to physician networks and other provider activities.

He acknowledged the medical community's concerns that the current guidelines are "chilling" physician joint ventures by restricting rule-of-reason analysis only to networks that share significant financial risk, negotiate contracts through a cumbersome messenger model, or create significant new efficiencies.

"Physicians shouldn't get stricter, or more lenient, scrutiny under the antitrust laws," Leibenluft said.

Current staff discussions on the guideline revisions are focusing on identifying other forms of significant financial risk-sharing for physician ventures besides capitation and withholds, and exploring how to provide rule-of-reason treatment to physician plans without financial risk-sharing.

AMA's Hirshfeld hopes the guideline revisions will spur physicians to explore opportunities in their markets, rather than moving towards collective bargaining and unions.

"With a fuller and richer description of networks doctors have a realistic chance of creating, [the revisions] hopefully will stimulate doctors to take advantage of opportunities as we see the markets evolve."

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

12-Jul-1996 08:33pm

TO: Jennifer L. Klein

FROM: Christopher C. Jennings
Domestic Policy Council

CC: Nancy-Ann E. Min
CC: Marilyn Yager

SUBJECT: RE: Antitrust

I am glad you brought this up. I think this does have great potential for interest/support, but does have some potential for elite media criticism as well.

Before we go to the folks inside, I would like to get a briefing from Marilyn about the status of the groups on this one. (I've heard from the insurers and HMOs who are none too happy.) Also, do we have a time for a FTC briefing yet? It would be interesting to hear what they are picking up. One person I know we need to get to is Joe Stiglitz. He did that Op Ed arguing strongly against anti-trust changes (statutory ones to be sure, but still may be a problem.)

Let's talk...

cj

cc: Chris J
Jennifer K
Marilyn Y
I spoke w/
P. tofsky last
week & he says
things are going
well & they
might have
something ready
by
Memorial Day.
They
are negoti-
ating w/
Justice
now.
Nan

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF
THE CHAIRMAN

April 8, 1996

The Honorable Henry J. Hyde, Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Hyde:

I wish to report on the progress that we have made in our efforts to develop additional guidance concerning the antitrust review of physician networks.

The staff is now nearing the end of its information gathering effort, a process that began in December and which already has provided valuable input from over 50 knowledgeable individuals representing all areas of the health care sector, including provider groups, employer coalitions, payers, law firms, consulting firms and academia. Based on this input, staff at the FTC and the Justice Department are now working on revisions to the current joint agency statements on physician and multi-provider networks. According to staff, these guideline revisions will clarify that there is an expanded range of types of integration which warrant rule of reason treatment under the antitrust laws for joint pricing by physician networks. In addition, I anticipate that the staff proposal for revised guidelines will clarify that network arrangements that contribute substantially to controlling costs or assuring ality of care, but which may not involve financial risk-sharing, also will be evaluated under the rule of son.

In moving to clarify the standards for rule of reason treatment, I believe that the proposed guidelines the staff shortly will present to the Commission for its consideration will achieve the goals of your proposed legislation -- that of expanding the range of physician networks that receive rule of reason treatment and ultimately expanding consumer choice in this rapidly changing market. In addition, the proposed guidelines may provide for even more flexible treatment than that envisioned in the current legislation.

I am pleased to report that the project is on schedule, and indeed we are optimistic that we may be able to even beat the timetable that I discussed in my testimony last month. I am confident that these efforts will furnish providers with more certainty concerning the types of ventures that will receive rule of reason review, as well as assure that they have the flexibility to develop a wide variety of network arrangements.

Sincerely,

Robert Pitofsky
Chairman

c: ibers of the Judiciary Committee

THE NEW YORK TIMES
TUESDAY, APRIL 9, 1996

Clear Antitrust Rules for Doctors

The Federal Trade Commission plans to revise antitrust guidelines that dictate what types of joint ventures doctors will be permitted to create. The chairman, Robert Pitofsky, says the commission, in cooperation with the Justice Department, will not relax the antitrust laws but will simply spell out how existing rules apply to health care. If Mr. Pitofsky delivers on that pledge, the commission will do consumers some good. But if, as some fear, the commission gives doctors special protections, it will do serious harm.

The rapid growth of managed-care plans has forced an increasing number of doctors to sign up with the plans under terms that reduce their pay and autonomy. Managed-care plans have also forced hospitals to treat their enrollees at steeply discounted rates. One way for doctors to strike back is to band together, forming their own plans, joint ventures or loose associations.

Patients are best served if some of the doctors and hospitals in a region form their own plan, thereby giving H.M.O.'s and traditional insurance companies a run for their customers. A doctor-created health plan would assume the financial risk of treating patients, which stops doctors from overcharging and thereby driving customers into rival plans. For this reason, the antitrust rules already permit doctors to form their own health plans.

The doctors want more. They seek the freedom to band together to discuss prices and services in ventures that would leave the individual doctors financially independent of each other, thereby avoiding the joint financial risk assumed by a full-fledged health plan. The danger is that doctors would conspire to jack up their prices to H.M.O.'s, traditional insurance companies and individual patients.

The right antitrust approach for health care is the same two-step approach that the courts and Congress are applying elsewhere in the economy. The Government would first ask if the proposed joint venture amounts to nothing more than disguised price-fixing by doctors. If so, the Government would instantly prosecute. But if the venture offers consumers innovative services, then the Government would undertake a review to check whether the likely benefits outweigh the potential harm, such as higher prices or excessively costly treatment practices.

Mr. Pitofsky believes that the medical profession has misinterpreted current law, needlessly steering away from ventures that the Government would in fact approve. The F.T.C. will serve a useful function if it translates current rules into clear instructions when it issues the revised guidelines, probably this summer. It will set back medical reform if it lowers the antitrust crossbar for doctors so that they win legal clearance for putting their financial well-being above their patients'.

The Limits of Openness in Vietnam

Vietnam eagerly welcomes foreign investment these days. But the American businessmen who rushed in after Washington finally normalized ties with Hanoi last year are discovering that Communist hard-liners still grip the reins. Tight ideological controls and a maze of bureaucratic regulations make Vietnam a difficult place to do business and imperil its continued economic advance.

The latest blow to foreign businessmen is a nationwide campaign that targets foreign commercial advertising as a "social evil" to be eradicated, along with prostitution, narcotics and gambling. All over Vietnam, billboards for products like Coca-Cola and Esso gasoline are being blocked out by new coats of paint.

While technocrats in the ministries of Trade and Finance draw up plans for modernizing taxes and tariffs and the central bank prepares for the opening of a stock exchange, hard-liners in the military and Communist Party politburo worry that foreign investment threatens to undermine Vietnamese traditions, Ho Chi Minh's Socialist legacy and continued tight political control by the Communist Party. "We are not afraid of capitalist enterprises, but of not being able to supervise and control them," the party's general secretary said last December. Indeed, the Government expects to keep the most important industries in its own hands.

A showdown between Vietnam's modernizing and hard-line factions could occur as early as this June's Communist Party Congress, when a new set of top national leaders is expected to be named.

Six years of market-oriented economic reforms have already brought impressive results. Foreign investors have thus far committed $18 billion. The economy is expanding rapidly, average incomes are rising and inflation has been tamed.

But no Communist Government anywhere, China's included, has yet established the rule of law and climate of predictability that businesses require for serious long-term investment. When Secretary of State Warren Christopher spoke in Hanoi last summer, he rightly emphasized that sustained economic development depends not just on legal protections for property but also on due process for all citizens, free exchange of information and a free press. Vietnam's hard-liners are headed in the opposite direction. They are not just cracking down on foreign advertising, they are also arresting Vietnamese intellectuals who argue that continued economic reform requires more, not less openness to outside ideas.

Capitalist development may be compatible, in its early phases, with authoritarian rule. But longer-term progress will be stunted by insistence on Leninist ideological puritanism. Further, the United States Congress will rightly resist extending most-favored-nation trading privileges to Vietnam until it commits itself more firmly to due process and human rights for all.

Sooner or later, Vietnam, like China, will have to choose between its hopes for rapid development based on international investment and its fears of foreign ideological pollution.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

09-Apr-1996 11:25am

TO: Christopher C. Jennings
TO: Marilyn Yager
TO: Jennifer L. Klein

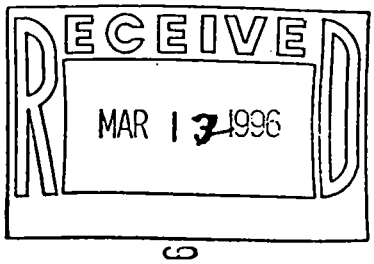
FROM: Nancy-Ann E. Min
Office of Mgmt and Budget, HP

SUBJECT: Letter from Stark, Dingell et al on Antitrust

Wanted all of you to see the attached letter. Apparently it sat around in Leg Affairs for several months and then they sent it to me to draft a response from the Director on behalf of the POTUS. (I'll share it with you when I have a draft).

Also attached, in case you haven't seen it, is the New York Times editorial on this today.

Congress of the United States
House of Representatives
Washington, DC 20515



95 DEC 28 A8:19

December 21, 1995

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

We understand that provisions that would have granted physicians special exceptions under federal and state antitrust laws and which were stricken from the final budget reconciliation conference report may reemerge as part of the current round of budget negotiations. As the Ranking Members of the House Judiciary Committee, House Commerce Committee, House Health Subcommittee and Senate Antitrust Subcommittee, we strongly oppose these efforts to grant medical providers special antitrust preferences. Such provisions are unrelated to debate over how best to balance the budget, are not necessary to the development of provider sponsored organizations and networks, and will likely result in less competition among physicians and increased medical costs for American health care consumers.

In our view, efforts to provide special antitrust preferences to medical providers represent little more than a special interest give-away designed to entice certain elements in the medical community to support the Republicans' ill-conceived efforts to cut Medicare protections. In a recent editorial entitled "Bribes for Doctors," the New York Times wrote that easing antitrust rules for provider groups would "invite doctors to engage in blatantly anticompetitive behavior and allow doctors who have no intention of going into business together to conspire among themselves to impose high fees and needlessly expensive treatment practices."

The special preferences would not only exempt physician service organizations from the usual "per se" rule against price fixing, but would extend the same treatment to loose groups of physicians and other health care providers. Current antitrust guidelines already allow physicians jointly to set prices so long as they share "substantial financial risk." The rationale for this is that significant financial risk-sharing leads physicians to operate in a manner akin to a single economic entity, thereby fostering an incentive for the group to provide health care services efficiently.

H9511

However, under the provisions that have been proposed, physicians as well as other health care providers would be able to set prices and avoid scrutiny under the per se rule against price fixing, even where financial risk sharing does not exist. Instead, enforcement agencies would be required to apply the far more costly "rule of reason" analysis to strike down anti-competitive price fixing activity. Both the Department of Justice and Federal Trade Commission agree that such an exemption from the per se rule is "unnecessary to protect any legitimate activity; would immunize a broad range of anticompetitive activities that could harm consumers and raise health care costs; and could seriously undermine the cost containment goals of medicare reform efforts."

Legislation dealing with the antitrust status of physician service organizations has no business being brought into the current budget debate. The Senate recognized this fact when these special antitrust preferences were stripped from the reconciliation bill because they violated the "Byrd Rule." More importantly, we believe altering our nation's antitrust laws should not be undertaken without serious study, deliberation and justification.

Sincerely,

John Conyers, Jr.
Ranking Member
Committee on the Judiciary

Patrick J. Leahy
Ranking Member
Subcommittee on Antitrust, Business Rights and Competition
Committee on the Judiciary

John Dingell
Ranking Member
Committee on Commerce

Fortney Pete Stark
Ranking Member
Subcommittee on Health
Committee on Ways and Means

cc: Leon E. Panetta
Alice M. Rivlin
Hon. Thomas A. Daschle
Hon. Richard A. Gephardt
Hon. J. James Exon
Hon. Martin Olav Sabo

Department of Justice

FOR IMMEDIATE RELEASE
FRIDAY, MARCH 1, 1996

AT
(202) 616-2771
TDD (202) 514-1888

JUSTICE DEPARTMENT WON'T APPROVE NEW JERSEY PEDIATRICIANS' NETWORK PROPOSAL CITING IT COULD RAISE PRICES TO CONSUMERS

WASHINGTON, D.C. -- The Justice Department today advised a group of southern New Jersey pediatricians that it would not approve their proposal to form a physician network because it is likely to be used to raise prices to consumers without countervailing procompetitive benefits.

The Department's position was stated in a business review letter from Anne K. Bingaman, Assistant Attorney General in charge of the Department's Antitrust Division to counsel for Children's Healthcare P.A.

"Children's Healthcare P.A. would achieve substantial power in several significant local markets sufficient to enable it to increase prices to consumers and deprive consumers of competitive health care choices," said Bingaman.

Bingaman's letter pointed out that the Department firmly supports the formation of properly structured physician-controlled networks that offer the prospect of cutting costs and improving patient care.

(MORE)

Bingaman said, "Unlike many physician networks that have received favorable business review letters, this proposed network is not likely to achieve substantial cost or other efficiencies that would benefit consumers."

The proposed network would be formed by 65 to 70 southern New Jersey pediatricians to negotiate and contract with managed care plans to provide basic healthcare for children. The network would comprise approximately 50 to 75 percent of the primary-care pediatricians in at least several important local markets for pediatric services in southern New Jersey.

Bingaman said the investigation concluded that basic healthcare for children is provided in local markets and that family practitioners and other physicians are not effective substitutes for pediatricians in the establishment of marketable managed care networks.

"Undoubtedly this network could be structured in a way to avoid anticompetitive effects on consumers. The Department remains flexible to consider revisions to the structure of the network and to provide guidance about how to do this to eliminate our competitive concerns," said Bingaman.

Among the many business review letters in the health care area issued in the last two years, 10 involved physician networks. All 10 were approved by the Department because the networks were structured to avoid anticompetitive harm to consumers.

(MORE)

After a thorough investigation that included many discussions with payers, hospitals, large employers and physicians, the Department rejected Children's Healthcare P.A.'s contention that the antitrust effects of its proposal should be tested in a market including all pediatricians and family practice doctors in the Greater Delaware Valley which includes, southern New Jersey, southeastern Pennsylvania, and northern Delaware.

Bingaman said, "Our investigation confirmed that insurance plan enrollees want pediatricians in their local areas to provide basic health care for their children. Parents do not want to drive long distances to obtain basic pediatric care."

The business review letter also noted that while Children's Healthcare stated that its members would maintain independent practices and would be permitted, with some restrictions, to participate in other networks or to contract individually with payers, the investigation revealed a real danger that its members would seek higher prices and other anticompetitive contract terms. Documents strongly suggested that a primary objective of Children's Healthcare was to obtain and exercise enhanced bargaining power in negotiations with health plans by presenting a united front.

Under the Department's business review procedure, a person or organization may submit a proposed action to the Antitrust Division and receive a statement as to whether the Division will

challenge the action under the antitrust laws.

A file containing the business review request and the Department's response may be examined in the Legal Procedure Unit of the Antitrust Division, Room 215 North, Liberty Place, Department of Justice, Washington, D.C. 20530. After a 30-day waiting period, the documents supporting the business review will be added to the file.

###

96-082

U. S. Department of Justice

Antitrust Division

Main Justice Building
10th & Constitution Ave., NW
Washington, DC 20530

Date:

FACSIMILE TRANSMISSION

TO: Jennifer Klein

Telephone: Fax: 456-2878

FROM: Robert A. Potter
Chief
Legal Policy Section
Telephone: (202) 514-2512 Fax: (202) 514-9082

COMMENTS: Jen,

I think total numbers since 9/93 are 34 Health Care Reviews; 31 positive. On physician network joint ventures specifically, before this one, we had ~~e~~ issued 10 straight positive ones on ~~[redacted]~~ physician network joint ventures. (10 positive, 1 negative) as subset.

TOTAL NUMBER OF PAGES BEING TRANSMITTED, EXCLUDING COVER: 4

FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

THE CHAIRMAN

March 8, 1996

Nancy-Ann Min
Associate Director
Office of Management and Budget
OEOB - Room 262
17th and Pennsylvania Avenue NW
Washington, DC 20503

Dear Nancy:

Joel Klein and I thought it would be useful to summarize some of the key points relating to antitrust treatment of physician networks. I hope the attached two pages does that job.

If there is anything further we can do to assist in this area, please give me a call.

Best regards.

Sincerely,

Robert Pitofsky

cc: Joel Klein

SUMMARY OF KEY POINTS WITH RESPECT TO ANTITRUST TREATMENT OF PHYSICIAN NETWORKS

-- Further guidance under existing laws, rather than statutory directives being considered by Congress, is the best way to aid development of procompetitive provider-directed health plans.

-- The market for financing and delivery of health care services has been rapidly changing. Antitrust law does not seek to drive market developments such as these in any particular direction, but rather seeks to deter private restraints that raise prices or limit the range of choices available to consumers.

-- We have been consulting with a broad cross-section of industry representatives and state antitrust law enforcers to assess whether current antitrust law enforcement standards are interfering unduly with the development of potentially procompetitive provider-sponsored network arrangements. We expect to conclude this review and provide additional guidance to the industry within six months.

-- My personal view (I can't speak for other Commissioners) is that the guidelines will be adjusted to clarify that less drastic antitrust treatment of some physician networks is appropriate.

-- The antitrust laws, as they currently stand, are sufficiently flexible to permit this type of reevaluation and any necessary adjustments, without the need for statutory changes. Such an approach permits continued flexible adjustment over time.

-- H.R. 2925 mandates that certain actions of health care provider networks possessing various enumerated characteristics will be subject to "rule of reason" analysis under the antitrust laws. Experience convinces us, however, that health care markets are changing too rapidly to assess the potential efficiencies of provider networks on the basis of any single set of fixed criteria like that contained in the legislation.

-- Adopting legislative criteria would rigidify the development of physician networks by encouraging organizers to establish networks that meet the technical requirements of the law, rather than ones that ensure maximum patient benefit. The legislation also risks immediate consumer harm by making it more difficult to prohibit certain forms of highly anticompetitive conduct -- such as hard core price fixing -- which sometimes has been undertaken by provider-sponsored networks.

Call Bob Potter

EXECUTIVE OFFICE OF THE PRESIDENT

20-Mar-1996 01:00pm

TO: John M. Richardson
TO: Mark E. Miller
TO: Anne W. Mutti
TO: Timothy B. Hill

FROM: Farooq A. Khan
Office of Mgmt and Budget, HD

SUBJECT: ANTITRUST RULING: Feds kill physicians' pediatric network.

ANTITRUST RULING: FEDS KILL PHYSICIANS' PEDIATRIC NETWORK

"In a highly unusual move," the U.S. Department of Justice has refused to give antitrust approval to Children's Healthcare P.A., a proposed New Jersey-based pediatric network. AMERICAN MEDICAL NEWS reports that the decision is the first time "a physician venture with substantial financial risk-sharing [was] denied approval under a 'rule of reason' analysis by federal antitrust authorities." It is also the first physician network to be rejected by the department "under the current antitrust guidelines, which took effect in 1994."

NO GO: According to Assistant Attorney General Anne Bingaman, the Justice Department decision was made because the proposed network "would likely raise prices to consumers without providing any countervailing pro-competitive value." She added that the network would not likely have achieved "substantial cost or other efficiencies that would benefit consumers."

WHY?: Federal antitrust officials came to their decision "after narrowing the network's product and geographic markets to services and areas dominated by Children's physicians." Under the 1994 antitrust guidelines, a "safety zone" was established, whereby the government would not pursue antitrust actions against any network that comprised less than 30% of an area's physicians. The officials found that Children's would represent between 50% and 75% of pediatricians in "several key markets -- far above the safety zone's 30% threshold." Further, "in a highly controversial move," antitrust officials ruled that "family practice doctors don't provide the same services as pediatricians, and thus constitute a separate product market." This finding went against the network's contention that family practice physicians in the area "provided more pediatric care there than pediatricians." In the end, federal officials determined that the network's doctors "had potential market power far beyond the safety zones for physicians set in the 1994 guidelines."

INCRIMINATING EVIDENCE: In addition to the guideline violations, federal officials found evidence of "anticompetitive intent" in the proposed network. The investigators found documents suggesting that one of the network's "prime objectives was to gain bargaining clout with health plans." The government also found that network physicians declined to sign individual contracts with managed care companies until Children's could negotiate the terms. The government also discovered that a prospective network member told managed care officials that pediatricians in the area were organizing "and would soon be in a position to dictate terms to managed care health plans." American Medical Association Vice Pres. for Health Law Ed Hirshfeld said that the ruling should serve as a warning to doctors "who view potential ventures solely as a way to improve payer rates."

PRECEDENT SETTING: AMNEWS reports that the decision comes as the Justice Department and the Federal Trade Commission "are considering loosening some restrictions on physician ventures in the antitrust guidelines." Earlier reviews of physician ventures have focused more on a proposed network's risk-sharing mechanisms. However, the Children's decision is the "first case that demonstrates how federal officials evaluate the reasonableness of a venture in light of its effect on competition" (Johnsson, 3/18 issue).

ANOTHER PRECEDENT?: An Iowa provider sponsored network (PSN) could become the first PSN to receive a HCFA Medicare risk contract, MODERN HEALTHCARE reports. HCFA Office of Managed Care Director Bruce Fried said that "possibly clearing the way" for the approval is the fact that Iowa is the only state to license organized delivery systems. Fried said that the discussions with the PSN are "very preliminary," but that HCFA is "interested in testing the variety of delivery systems." He added that if HCFA approves the Iowa contract, he "'would expect other states to follow Iowa's lead' and license" PSNs (Kertesz, 3/18 issue).

===== MARKETWATCH =====

Commissioners, shall restructure, as needed, those standard benefit packages.

(2)(A) Section 1882(p) (42 U.S.C. 1395ss(p)) is amended by adding at the end the following:

"(11) The groups or packages of benefits (including the core group of basic benefits) under paragraph (2) shall be modified by any changes made by the Secretary under section 11209(b)(1)(B) of the Balanced Budget Act of 1996 for Economic Growth and Fairness.".

(B) The amendment made by subparagraph (A) applies to services provided after 1997.

SEC. 11210. ANTITRUST RULE OF REASON STANDARD.

In any action under the antitrust laws (or under any State law similar to the antitrust laws)—

(1) the conduct of an organization that provides health care services in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians) under part C of title XVIII of the Social Security Act (as enacted by section 11202(a)(2) of this Act), and

(2) the conduct of any member of such an organization in carrying out such a contract,

shall not be deemed illegal per se if each member of the organization shares, directly or indirectly, substantial financial risk in connection with the organization's operations.

MARK-UP REPORT

Committee: House Judiciary Committee

Subject: H.R. 2925, Antitrust Laws for Health Care Provider Networks

Hearing Date: March 12, 1996

Key Points:

By a vote of 20-4, with five Democrats voting "aye", the Committee favorably reported the bill. Democrats voting "aye" were: Frank, Boucher, Reed, Lofgren, and Jackson-Lee. All Republicans present voted "aye".

Hyde explained that the bill would make one change in current antitrust laws -- it would replace the use of a "per se" standard with a "rule of reason" standard when judging activities of providers. He said that the Chairman of the FTC had testified before the Committee in support of the goals of the bill, but had said that the goals could be achieved through changes in regulations by the FTC, which would take several months.

Conyers said that there is no need for a change in antitrust law because the regulations could be changed. He said that the proposal is dangerous, and that physicians are fully authorized under current law to act together to compete against HMOs; however, they must show that their actions would lead to increased efficiency. This bill would eliminate the "per se" rule for physicians, while the "per se" rule would remain in place for all other members of society. He said that approval of the bill would interfere with enactment of the Kennedy/Kassebaum bill, and it would interrupt the work of the FTC to establish new rules for physicians.

Conyers offered the only amendment (attached), which would remove the provision in the bill that would preempt State laws on this issue. He said that there is no evidence of inappropriate behavior by States.

Hyde opposed the amendment and cited a series of bills that had changed the "per se" standard to a "rule of reason" standard. He said that Conyers had voted for every one of these bills, although all of them had included a preemption of State laws.

Frank opposed the amendment, and supported the bill. He said that all Representatives support having decisions made at the level of government at which they like the outcome. A consistent approach would not be desirable. He said, however, that Republicans who vote for preemption of State laws for those who provide medical services, should also vote for preemption of State laws for those who receive medical services.

Frank said that there is currently a major conflict between providers and the insurance industry, and that the position of providers needs to be strengthened.

The Conyers amendment failed 7-17, with Frank and Reed voting against it (along with all Republicans).

Analyst: Carl Taylor **Date:** 3/12/96

ONE HUNDRED FOURTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON THE JUDICIARY

2138 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6216

(202) 225–3951

GENERAL COUNSEL
ALAN F. COFFEY, JR.

MINORITY STAFF DIRECTOR
JULIAN EPSTEIN

FULL COMMITTEE MEETING

AGENDA

DATE	TIME	PLACE
Tuesday, March 12, 1996	**10:00 A.M.**	**2141 Rayburn HOB**

Markup of

H.R. 2925	**"Antitrust Health Care Advancement Act of 1996"**
---- ---	**Committee Views and Estimates on FY 1997 Budget pursuant to §301(d) of the Budget Act and House Rule X, clause 4(g)**
H.R. 2937	**Reimbursement of certain legal expenses and related fees incurred by former employees of the White House Travel Office**
H.R. 2511	**"Anticounterfeiting Consumer Protection Act of 1995"**
H.R. 1861	**Technical Corrections to the Satellite Home Viewer Act of 1994**
H.R. 1734	**"National Film Preservation Act of 1995"**
H.R. 2977	**"Administrative Dispute Resolution Act of 1996"**
H.J.Res. 129	**Granting the consent of Congress to the Vermont-New Hampshire Interstate Public Water Supply Compact**
H.R. 2604	**To authorize the appointment of additional bankruptcy judges**
	Private Claims Bills (H.R. 1009, H.R. 2765)

104TH CONGRESS
2D SESSION

H. R. 2925

To modify the application of the antitrust laws to health care provider networks that provide health care services; and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 1, 1996

Mr. HYDE (for himself, Mr. ARCHER, Mr. WELDON of Florida, Mr. MCCOLLUM, Mr. GEKAS, Mr. COBLE, Mr. SMITH of Texas, Mr. HASTERT, Mr. SCHIFF, Mr. THOMAS, Mr. CANADY of Florida, Mr. INGLIS of South Carolina, Mr. GOODLATTE, Mr. BOUCHER, Mr. CRANE, Mr. SHAW, Mrs. JOHNSON of Connecticut, Mr. MCCRERY, Mr. CAMP, Mr. CAMPBELL, Mr. SAM JOHNSON of Texas, Mr. CHRISTENSEN, Mr. GANSKE, Mr. LIPINSKI, and Mr. HANCOCK) introduced the following bill; which was referred to the Committee on the Judiciary

---

A BILL

To modify the application of the antitrust laws to health care provider networks that provide health care services; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Antitrust Health Care Advancement Act of 1996".

SEC. 2. APPLICATION OF ANTITRUST RULE OF REASON TO HEALTH CARE PROVIDER NETWORKS.

(a) RULE OF REASON STANDARD.—In any action under the antitrust laws, or under any State law similar to the antitrust laws—

(1) the conduct of a health care provider in exchanging with 1 or more other health care providers information relating to costs, sales, profitability, marketing, prices, or fees of any health care service if—

(A) the exchange of such information is solely for the purpose of establishing a health care provider network and is reasonably required for such purpose, and

(B) such information is not used for any other purpose,

(2) the conduct of a health care provider network (including any health care provider who is a member of such network and who is acting on behalf of such network) in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a health benefit plan, and

(3) the conduct of any member of such network for the purpose of providing such health care services under such contract to such extent,

shall not be deemed illegal per se. Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) ANTITRUST LAWS.—The term "antitrust laws" has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(2) HEALTH BENEFIT PLAN.—The term "health benefit plan" means—

(A) a hospital or medical expense-incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a multiple employer welfare arrangement or employee benefit plan (as defined

under the Employee Retirement Income Security Act of 1974).

Such term includes a contract to provide health care services under section 1876 or 1903(m) of the Social Security Act.

(3) HEALTH CARE PROVIDER.—The term "health care provider" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(4) HEALTH CARE SERVICE.—The term "health care service" means any health care service for which payment may be made under a health benefit plan, including services related to the delivery or administration of such service.

(5) HEALTH CARE PROVIDER NETWORK.—The term "health care provider network" means an organization that—

(A) is organized by, operated by, and composed of members who are health care providers and for purposes that include providing health care services,

(B) is funded in part by capital contributions made by the members of such organization,

(C) with respect to each contract made by such organization for the purpose of providing a type of health care service to individuals under the terms of a health benefit plan—

(i) requires all members of such organization who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

(ii) receives the compensation paid for the health care services of such type provided under such contract by such members, and

(iii) provides for the distribution of such compensation,

(D) has established a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in such health benefit plan, along with internal proce-

dures to correct identified deficiencies relating to such methods and such services,

(E) has established a program to monitor and control utilization of health care services provided under such health benefit plan, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

(F) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in such health benefit plan, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

(G) has established a grievance and appeal process for such organization designed to review and promptly resolve beneficiary or patient grievances and complaints.

(6) STATE.—The term "State" has the meaning given it in section 4G(2) of the Clayton Act (15 U.S.C. 15g(2)).

SEC. 3. ISSUANCE OF GUIDELINES.

Not later than 180 days after the date of the enactment of this Act, the Attorney General and the Federal

Trade Commission jointly shall issue guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of section 2.

O

F:\JH\HR2925\CONYER.001

Amendment to H.R. 2925

Offered by Mr. Conyers

Page 2, beginning on line 4, strike ", or under any State law similar to the antitrust laws".

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Vol. 8, No. 41 **Thursday, February 29, 1996**

TODAY'S NEWS

Antitrust scrutiny of PSNs too quickly presumes anticompetitive effect; attitude change, not legislation, may be all that is needed — Duke's Havighurst ..... **Story below**
Rep. Conyers questions AMA trustee Dickey on support for bypassing Judiciary Committee review of antitrust changes in GOP Medicare reform plan ..... **Page 2**
HIAA group market member endorses S 1028, diverging from association stance; Sens. Kassebaum, Kennedy to announce "major" endorsements Feb. 29 ..... **Page 3**
MSAs, portability, malpractice reform among candidate Dole's top health priorities; presidential hopeful is quiet on broad Medicare reform proposals ..... **Page 4**
Health care providers consider Sen. Dole a moderating force; health consumer groups view presidential candidate as unpredictable ..... **Page 5**
State flexibility on amount, duration and scope of services should be limited by "adequacy standard," HHS Secretary Shalala testifies Feb. 28 ..... **Page 5**
Medical prices rise 0.4% in first month of 1996, consistent with 12-month 1995 changes; overall Consumer Price Index also increases 0.4% ..... **Page 6**

FTC/DoJ VIEW OF PHYSICIAN NETWORKS PRESUMES ANTICOMPETITIVE EFFECT, but a change in attitude, not legislation, may be all that is necessary for more "sympathetic" treatment, Duke University Professor Clark Havighurst advised the House Judiciary Committee Feb. 28.

The Federal Trade Commission and Department of Justice have been too quick to apply rules that certain types of arrangements are presumptively anticompetitive, giving "too little credence to the possibility that a physician-controlled network might yield marketing efficiencies that more than compensate for any loss of competition among the joint venturers themselves," he said. But, Havighurst added, "I am not yet persuaded that the needed policy change requires legislation and cannot be achieved through a modification of attitudes in the enforcement agencies."

The law professor is the author of an as yet unpublished but widely circulated article entitled "Are the Antitrust Agencies Overregulating Physician Networks?" His conclusion that the answer is sometimes yes is seen as especially credible because, as Havighurst acknowledged, he has been an "advocate for aggressive enforcement against doctors."

Havighurst made it explicit that he does not yet not call for new antitrust legislation because groups such as the American Medical Association have cited his article in their endorsement for legislation such as HR 2925. The bill, sponsored by Judiciary Committee Chairman Henry Hyde (R-Ill.), would require antitrust agencies to apply the

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"rule of reason" analysis to health care arrangements, rather than applying rules that certain arrangements are "per se" anticompetitive. Citing recent FTC suggestions that the agency will look at its analytic methods, Havighurst said he has "some confidence" that FTC will address the issue and allow a fuller range of health care delivery options.

Havighurst suggested that enforcement agencies be more flexible in "mature markets," areas where there are a variety of plans already available and many sophisticated purchasers. In such cases, providers should have more opportunity to try new approaches, which would be scrutinized to see if they specifically pose a "hazard to competition" and not presumed to be anticompetitive based on their formal structures.

The agencies' "safe harbor" guidelines as applied to physician-sponsored networks tend to require that physician participants be integrated financially and share financial risk. But this creates a potential conflict of interest with a physician's duty to give priority to the needs of the patient, Havighurst noted. In his article, Havighurst states: "I am critical of antitrust policies that permit antitrust enforcers to dictate the nature and character of such plans even when overall market conditions are reliably competitive." Agencies should prohibit certain forms of arrangements only if physicians "seem truly capable of exercising market power."

Supporting Hyde's legislation, AMA Trustee Nancy Dickey, MD, said she wanted to "set the record straight" that AMA does not want "special treatment" but rather the same treatment as joint ventures in other industries. She noted that, for example, The National Cooperative Research Act of 1984 provides a rule of reason standard for joint research and the standard was extended to production ventures in 1993. Chairman Hyde emphasized that he intends his bill to establish the rule of reason for health care but not "immunize" health providers or any anticompetitive practices.

Two provider groups testified against the bill — the American Association of Health Plans and the American Association of Nurse Anesthetists, the latter representing several other nonphysician provider groups as well. AAHP is the new name of the entity formed by the Group Health Association of America and the American Managed Care and Review Association. On behalf of AAHP, Tufts Association Health Plan Senior VP Margaret Metzger said HR 2925 does not distinguish between different types of health arrangements and would make it more difficult to combat "genuinely pernicious" situations. Plans such as Tufts that have procompetitive goals are able to work within existing rules, she contended. Many physicians still resist arrangements such as HMOs and antitrust enforcement, rather than hindering such plans, was needed to help make them possible, Metzger argued. AMA's Dickey contended that current antitrust policies have made some physicians afraid to even discuss new delivery arrangements.

House Ways and Means Committee Chairman Bill Archer (R-Tex.) called HR 2925 a "modest step in the right direction." He was the bill's first cosponsor. Opposing the bill, Rep. Pete Stark (D-Calif.) emphasized that the concern in antitrust is protecting consumers, not providers. While his physician friends, "all three of them," say HR 2925 is needed, Stark said, new types of health plans are "blossoming" without it.

REP. CONYERS QUESTIONS AMA TRUSTEE DICKEY OVER ANTITRUST BYPASS OF JUDICIARY COMMITTEE, of which Rep. John Conyers (Mich.) is the ranking Democrat. AMA has developed a close rapport with House Speaker Newt Gingrich (R-Ga.), but Conyers questioned whether the two sides inappropriately traded AMA support for Republican Medicare reform and the speaker's pledges of favorable treatment in the areas of antitrust and medical malpractice.

Conyers' objection is that antitrust and other matters of legal practice were included in the Medicare legislation without any hearings in the House Judiciary Committee. The panel has begun examining these legal issues only because the legislation was unsuccessful in the Senate. During the committee's Feb. 28 hearing on health care antitrust legislation, Conyers used his time allotment to question American Medical Association Board of Trustees Chair Nancy Dickey, MD, not about the substance of pending proposals but rather about AMA's political strategies.

Conyers cited an October *New York Times* editorial against AMA activities and a July letter from top AMA officials to Gingrich. Conyers adopted a prosecutorial approach, allowing Dickey only "yes-or-no" answers to his questions, and cutting off her attempts at elaboration. Dickey answered no to Conyers' numerous questions about "concessions" or "trade-offs" on malpractice award caps, antitrust changes or smaller cuts in Medicare payments. Dickey eventually said AMA did discuss these topics "as an important issue to patients, yes."

Reading from the July AMA letter, Conyers highlighted a portion stating: "Committee jurisdiction need not be an obstacle to a comprehensive Medicare reform package. Antitrust issues should be resolved through the Republican leadership's task force designed to deal with cross-cutting issues." Noting the lack of earlier Judiciary Committee hearings, Conyers said he would "presume that was a result of your precise and very pointed advice."

Dickey responded that AMA was pleased that Gingrich has taken some of its advice, but the association has not obtained everything it prefers in the new Congress. She said AMA has not presumed to take a stance on House procedural rules. When Conyers asked whether AMA offered such advice in the letter, Dickey said it was important to get the Medicare legislation moving and antitrust change was a needed part of the legislation. Rep. George Gekas (R-Penn.) later maintained that the Judiciary Committee in Democratic congresses had fully aired health care antitrust issues, but came up with no remedies.

HIAA MEMBER BUCKS ASSOCIATION LINE IN SUPPORTING KASSEBAUM/KENNEDY health insurance legislation (S 1028) on Feb. 28. However, while the Health Insurance Association of America is chiefly opposed to the bill's individual market guaranteed issue provisions, Phoenix Home Life would be unaffected by this portion of the measure; it insures only the small-group market. Robert Fiondella, president and CEO of the Hartford, Connecticut-based firm, acknowledged that "I'd feel differently" if Phoenix sold individual market insurance. He spoke at a press conference with S 1028 co-sponsors Sens. Nancy Kassebaum (R-Kan.) and Edward Kennedy (D-Mass.)

Nevertheless, Fiondella asserted that "we hurt ourselves as an industry when we continually oppose everything." In response, HIAA said Feb. 28 that this statement was untrue, since the association "believes it is vital" to enact group-to-group insurance reform, specifically legislation introduced by Rep. Bill Thomas (R-Calif.). On the other hand, Fiondella claimed that current corporate downsizing trends mean many workers end up not in other companies but self-employed, and "group-to-group doesn't address this issue."

HIAA, which represents about 220 member companies, downplayed Phoenix's divergence from the trade group's position. The firm's stance, a spokesman said, is "very analogous to the fact that some Democrats and some Republicans may oppose" S 1028. Fiondella said that "there are a number" of additional HIAA members "who probably agree with" Phoenix stance. The association is the chief opponent of the bill.

Phoenix is not the first insurance firm to formally endorse the bipartisan legislation. On Feb. 27, the Healthcare Leadership Council backed it as "the last chance in the near future to enact health care reform that is thoughtful and bipartisan." HLC members include the insurance giants Aetna Life & Casualty, CIGNA HealthCare, and the Prudential Insurance Company of America.

Fiondella noted that assumptions used by HIAA and the independent American Academy of Actuaries to predict individual market premium increases under S 1028 "are very wide apart." HIAA predicts premium increases of at least 15%, while AAA believes a 2%-5% increase is the maximum. According to Fiondella, while HIAA assumed that all new entrants to the market would be "substandard" risks, AAA assumed a "much better

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mix" of entrants. HIAA is conducting a Feb. 29 media briefing to present its characterization of the differences between the two groups' assumptions.

Sens. Kassebaum and Kennedy will hold another media briefing on Feb. 29 to "announce major new endorsements" of the bill from associations and individual health policy experts, aides said. Participants will include the American Medical Association, which said Feb. 28 that it has been "supportive right along" but is "concerned about amendments that might weigh S 1028 down." The American Hospital Association also plans to provide a statement for the briefing. S 1028 has 49 Senate co-sponsors.

CANDIDATE DOLE SUPPORTS MSAs, PORTABILITY, MALPRACTICE REFORM and opposes "federalization" of the health care system, according to issue papers developed by the Bob Dole for President Campaign. Dole bills himself as a long-time opponent of national health care, unlike President Clinton. "Sen. Dole believes that a more rational approach, rooted in the private sector and market-based solutions, will go a long way toward improving access and affordability," campaign documents say.

Dole, a Republican from Kansas who now serves as Senate majority leader, has long been a member of the Finance Committee, which has primary jurisdiction over the Medicare and Medicaid programs. Dole's chief of staff, Sheila Burke, is a registered nurse and Dole's chief advisor on health issues.

The MSA approach most recently outlined by Dole was included in a health care reform bill developed last July but never introduced. The proposal would have established a tax deduction for medical savings accounts linked with catastrophic insurance policies. The plan offered deductibility for employer, self-employed or employee contributions to MSAs that did not exceed $2,000 for single coverage and $4,000 for family coverage. MSA disbursements would be tax and penalty free under the proposal if used for "medical expenses covered by the catastrophic insurance contract" and defined in the tax bill.

The proposal also supports portability of health insurance, including a regulatory structure and penalties for noncompliant plans. In the area malpractice reform, Dole has urged capping noneconomic damages at $250,000. He also has advocated 100% deductibility of health insurance premiums for the self-employed.

Dole has suggested requiring insurers to offer to self-employed individuals and small employers (those with fewer than 50 employees) the same benefit plans available to federal employees through the Federal Employee Health Benefits Plan at the same premium level plus an administrative fee. Plans would be required to renew coverage except for failure to pay premiums, fraud, noncompliance with plan requirements or an insurer's withdrawal of all benefit plans from a market. In addition, there would be limits on pre-existing condition exclusions.

Dole's July proposal would have required HHS to develop a system for ensuring insurance plan compliance. The Labor secretary would enforce self-insured employer plans requirements, and penalties would be imposed for noncompliance. Long-term care insurance would be treated as medical expenses under the tax law, with payments limited to $150 per day. Payments would not be taxable when received, and there would be no annual cap on indemnity policies.

Advanced last July, the proposal was significantly scaled back from a health reform measure developed by Dole with former Sen. Bob Packwood (R-Ore.), also a Finance member, in the heat of the 1994 health care reform debate. The Dole/Packwood measure, considered to be one of the more moderate of the reform measures then surfacing, would have, in addition to the proposals included in the July measure, offered subsidies to low-income individuals for the purchase of health insurance; established voluntary purchasing cooperatives; expanded the federal employees health benefits program; pre-empted "anti-managed care" laws; and established a budget fail-safe mechanism that would have effected tax deductions and subsidies if federal health spending exceeded a predetermined baseline.

Lately, Dole has refrained from talking about sweeping Medicare proposals, choosing instead to focus on moderating program spending by reducing provider payments. In the early 1980s, however, Dole was a force behind implementation of the Medicare prospective payment system. With respect to Medicaid, Dole proposed in 1994 that states be subject to a federal cap on Medicaid payments. He later modified that position after consultation with governors, who objected to it. The modified proposal would have enrolled Medicaid recipients into a federally financed acute care subsidy program.

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No Special Interest Exceptions -- Antitrust Laws Should Apply to All

Tucked in the recently passed House bill that cuts Medicare are two troubling special interest provisions: one would exempt doctors from certain antitrust laws and the other would bend the rules in their favor. These provisions are bad policy. They would encourage other industries to seek their own antitrust sweeteners; and they would reduce competition in health care, at a time when providing effective and low-cost health care is of utmost concern.

Antitrust laws exist for a reason -- to protect competition. Competition is central to the success of our market economy. It spurs producers to contain costs, to be responsive to consumer demands by offering innovative products, and to deliver these products at low prices. In short, competition promotes efficiency and delivers the resulting benefits to consumers. But because competition so effectively transfers the gains from producers to consumers, producers will often seek to curb it. Adam Smith -- the patron saint of free enterprise -- once observed that "people of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in some contrivance to raise prices."

in the Medicare program

The value of antitrust has been widely acclaimed. The Supreme Court has called the antitrust laws "a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade." Over the years, antitrust enforcement has enjoyed strong bipartisan support. A major strength of antitrust is that it is not riddled with special industry exemptions, but rather is applied broadly and consistently across most sectors. The House Medicare bill proposes an unfortunate departure from this principle.

Support, w/ approp. safeguards, provider-sponsored networks, to increase competition and choices for all consumers

The bill would grant an exemption from antitrust to medical self-regulatory bodies -- such as medical societies -- when engaging in "any activity ... relating to standard setting ... designed to promote the quality of health care." The words sound innocuous, but hide a wolf in sheep's clothing -- excluding competitors ostensibly to protect quality is one of the oldest tricks in the book. To be sure, professional associations such as medical societies have legitimate roles in policing industry conduct that would harm the industry's overall reputation. Present antitrust law,

Reps have gone over line — in guise of competition they actually limit choice & competition.

however, permits such legitimate activities, including standard-setting, certification, and peer review.

What it does not permit -- and what the House Medicare bill would -- is use of standard setting and quality control as excuses to stifle legitimate competition, through activities such as price fixing and group boycotts. These are not idle concerns. Medical societies have invoked "professional conduct" standards to justify blanket bans on alternatives to traditional fee-for-service medicine. The grounds: such activities *inherently* lead to lower quality of care. And, medical societies, medical staffs, and other physician groups are not shy in exercising their muscle. In the last few years they have attempted to boycott insurers to obtain higher fees and coerce hospitals not to introduce managed care plans, under threat of group boycott and through their control of the hospital staff credentialling process.

The House Medicare bill would provide broad exemption to pursue such tactics with renewed vigor. Though the bill purports to include certain safeguards related to "quality" of health care, the safeguards are simply inadequate. As the above examples and many others demonstrate, upholding quality has often been a smokescreen for classic anticompetitive conduct. Who determines if quality has increased? And shouldn't consumers, not self-interested providers, be the judges of whether any extra quality is worth the cost?

In short, the exemption would permit groups of doctors, under the guise of "self-regulation of quality," to impose higher fees on insurers, and to stifle the growth of HMOs and other alternatives to fee-for-service practice. Such alternative organizations can greatly contribute to containing health care costs, by acting as gatekeepers to prevent inefficiently high use of doctor services. This, of course, the specialist-dominated American Medical Association (AMA) opposes. But letting the AMA have its way by curbing HMOs and similar entities would undermine the goal of containing the explosion of health care costs.

There is another troublesome provision. Ordinarily, price fixing by competitors is judged as illegal per se. However, the courts and enforcement agencies recognize that, in certain cases, the apparent "competitors" may be cooperating in providing a superior package at a *lower* price; for example, a regional group of doctors markets its plan to HMOs and must offer a standard fee schedule for all its members. Such potentially pro-competitive alliances are judged on their merits under the antitrust rule-of-reason. To screen out such alliances from sham "alliances" that disguise collusive price increases, the courts and enforcement agencies have laid down minimal requirements that alliances must satisfy for their price fixing to qualify for rule-of-

reason treatment. The bill eases these requirements for certain alliances controlled by doctors, overruling the judgment of courts and enforcement agencies.

This is a technical area, requiring difficult judgment calls. Barring clear evidence that existing rules are inadequate, intervention by Congress seems unwise as a matter of preserving an efficient antitrust process. This country has developed a highly successful antitrust jurisprudence that incorporates checks and balances. Statutes articulate broad principles, which are interpreted through case law, and enforced by private plaintiffs and federal and state agencies subject to review by the courts. Why not allow this antitrust process to work also for medical groups?

Failing to do so raises at the very least troublesome issues about the ability of special interests to carve out exemptions to our antitrust laws. Every industry can articulate reasons why it is "special." If this precedent is followed our antitrust laws will be greatly weakened. And so too will competition and the vitality of the American economy. These provisions help explain why the AMA supports the House bill that cuts Medicare and why consumers -- and all those who believe in a competitive market economy -- should not.