CHAPTER 2: INDUSTRY SNAPSHOT AND COMPETITION LAW: PHYSICIANS

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I. OVERVIEW

As Chapter 1 details, competition has spurred significant changes in the market for physician services in the past several decades. Chapter 2 discusses how many physicians have sought to use innovative joint ventures to provide consumers with higher quality care at lower prices, while others have sought to stifle competition through conduct such as price-fixing and restrictions on allied health professionals. Reflecting consumer concerns about the quality, availability, and price of physician services, we highlight the benefits to consumers of competitive markets and vigorous antitrust enforcement.

This chapter first considers two types of provider network joint ventures – independent practice associations (IPAs) and physician-hospital organizations (PHOs) – that are part of the rapidly changing marketplace for physician services. We then discuss physician payment arrangements, the messenger model, and physician collective bargaining. Next, the chapter evaluates the competitive impact of restricting physicians' and allied health professionals' market entry. Finally, we examine the application of antitrust law to certain aspects of the marketplace for physician services, including private antitrust litigation about credentialing, the Agencies' analysis to assess the financial and clinical integration of joint ventures, and the ability of physicians to share and use information relating to quality improvements.

Representatives from physician groups and organizations, attorneys, economists, and scholars testified on these matters over seven days of Hearings. Physician topic panels included Health Care Services: Provider Integration (September 9, 2002); Physician Hospital Organizations (May 8); Quality and Consumer Information: Physicians (May 30); Quality and Consumer Protection: Market Entry (June 10); Prospective Guidance (June 26); Physician Product and Geographic Market Definition (September 24); Physician Information Sharing (September 24); Physician IPAs: Patterns and Benefits of Integration (September 25); Physician IPAs: Messenger Model (September 25); and Physician Unionization (September 26).[1]

II. INTRODUCTION

Spending on physician and clinical services accounts for approximately 22% of the $1.6 trillion spent annually on health care services.[2] Total spending on physician services increased at an average annual rate of 12 percent from 1970-1993.[3] As Figure 1 reflects, the rate of increase in spending on physician services has varied in the intervening decade, but generally ranged

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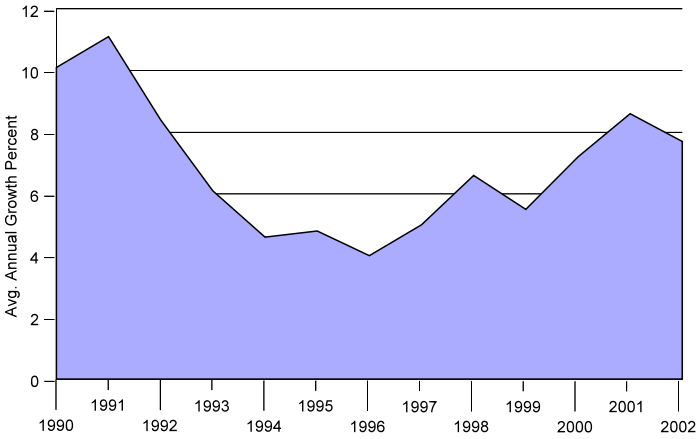
[1] Complete lists of participants on these and other panels are available *infra* Appendix A and in the Agenda, *at* http://www.ftc.gov/ogc/healthcare hearings/completeagenda.pdf.

[2] *See* Stephen Heffler et al., *Trends: Health Spending Projections Through 2013*, 2004 HEALTH AFFAIRS (Web Exclusive) W4-79, 80 ex.1 (2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.79v1.pdf.

[3] *Id.* at 81 ex.2.

between four and seven percent per year.[4] Spending on physician services is projected to increase approximately seven percent per year for the next decade.[5] Nevertheless, the percentage of national health spending devoted to physician services is likely to decline given "[t]he continued shift of care to other professional services, negative updates to the Medicare physician payment rates, and faster growth in other sectors such as prescription drugs."[6] Although physician services account for only 22 percent of total health care spending, the treatment decisions of physicians profoundly affect both the cost and quality of the other health care services that consumers receive.[7]

Figure 1: National Physician and Clinical Services Average Annual Growth From Prior Year



The cost and geographic distribution of physician services affect the accessibility of those services. For several reasons, including higher per capita incomes and economies of scale in complementary health care inputs, there are many more physicians per capita in metropolitan areas than in non-metropolitan and rural areas.[8]

[4] Centers for Medicare & Medicaid Services, *Health Accounts: National Health Expenditures 1965-2013, History and Projections by Type of Service and Source of Funds: Calendar Years 1965-2013*, *at* http://www.cms.hhs.gov /statistics/nhe/default.asp#download (last modified Mar. 24, 2004).

[5] Heffler et al., *supra* note 2, at 80 ex.1.

[6] Stephen Heffler et al., *Health Spending Projections For 2002-2012*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-54, 63, *at* http://content. healthaffairs.org/cgi/reprint/hlthaff.w3.54v1.pdf.

[7] Gail B. Agrawal & Howard R. Veit, *Back to the Future: The Managed Care Revolution*, 65 LAW & CONTEMP. PROBS. 11, 49 (2002) (stating that "reliance on medical judgment is inevitable in the complex cases that account for the majority of health care spending.").

[8] *See* GENERAL ACCOUNTING OFFICE, PHYSICIAN SUPPLY INCREASED IN METROPOLITAN AND NONMETROPOLITAN AREAS BUT GEOGRAPHIC DISPARITIES PERSISTED 6 (2003) (reporting that metropolitan areas have more of the facilities and equipment on which physicians depend than nonmetropolitan areas and that specialists prefer to practice in metropolitan areas because they handle less prevalent but more complicated illnesses), *available at* http://www.gao.gov/atext/d04124.txt; INSTITUTE OF MEDICINE, THE NATION'S PHYSICIAN WORKFORCE: OPTIONS FOR BALANCING SUPPLY AND REQUIREMENTS 69 (1996) ("[A]n abundance of physicians will not solve the problems of maldistribution by geographic area or specialty.").

III. COMPETITION AND THE MARKET FOR PHYSICIAN SERVICES

Provider network joint ventures have the potential to reduce costs and improve quality. Some physicians, however, have responded to changes in the market for physician services by engaging in collusive anticompetitive conduct, seeking collective bargaining rights, and manipulating licensure regulations. The following sections describe these developments and assess their implications for the cost, quality, and availability of health care. Some of these sections contain recommendations to enhance the performance of the physician services market.

A. Provider Network Joint Ventures

As Chapter 1 discusses, the Supreme Court's decisions in *Goldfarb* and *Maricopa* clarified the antitrust laws' application to health care, and spurred numerous market changes, including the development of managed care. Many physicians responded to managed care's growth by implementing network joint ventures to facilitate contracting with managed care plans. This section focuses on two joint venture types (IPAs and PHOs) and describes their key features and potential efficiencies.[9] These joint venture types are not immutable categories; as managed care organizations (MCOs) have reduced reliance on capitation arrangements, some joint ventures have dissolved while others have implemented messenger models or invested in clinical integration.[10] These joint ventures also compete with one another to recruit physician-members and to obtain MCO contracts.[11]

1. IPAs

a. Description of IPAs

IPAs are networks of independent physicians that contract with MCOs and employers.[12] IPAs may be organized as sole proprietorships, partnerships, or professional

[9] Some of the potential efficiencies discussed in this Section may not constitute efficiencies for the purposes of the Agencies' antitrust analysis of physician network joint ventures.

[10] For a discussion of the messenger model, see *infra* notes 110-132, and accompanying text. For a discussion of clinical integration, see *infra* notes 249-281, and accompanying text. As discussed in Chapter 1, capitation involves a physician assuming responsibility for a certain number of patients and receiving a fixed amount for each of these patients regardless of whether those patients seek care.

[11] Joint ventures employ varying payment options, including capitated contracts, fee-for-service payment, and pay-for-performance incentives. For a discussion of physician payment arrangements, see *infra* notes 97-109, and accompanying text, and *supra* Chapter 1. Joint ventures also employ varying strategies to make themselves more attractive to MCOs, including integrating financially, clinically, or both. For a discussion of integration, see *infra* notes 249-281, and accompanying text.

[12] Gordon D. Brown, *Independent Practice Associations*, *in* INTEGRATING THE PRACTICE OF MEDICINE: A DECISION MAKER'S GUIDE TO ORGANIZING AND MANAGING PHYSICIAN SERVICES 289, 290 (Ronald B. Connors ed., 1997); Peter R. Kongstvedt et al., *Integrated Health Care Delivery Systems*, *in* ESSENTIALS OF MANAGED HEALTH CARE 35 (Peter R. Kongstvedt ed., 4th ed. 2003); Kevin Grumbach et al., *Independent Practice Association Physician Groups in California*, 17 HEALTH AFFAIRS 227, 227 (May/June 1998). For a discussion of MCOs, see *supra* Chapter 1.

corporations.[13] Physician-members generally own IPAs, although individual doctors, hospitals or physician practice management companies also own some IPAs.[14] IPAs contract with physicians on both an exclusive and nonexclusive basis.[15] IPAs have historically included primary care physicians and specialists, although some commentators have noted a trend toward the formation of single-specialty IPAs.[16] Many IPAs are nonprofit.[17]

IPAs can be integrated (financially, clinically, or both) to varying degrees or not at all. Physicians participating in financially integrated IPAs share financial risks. Clinically integrated IPAs seek to improve the quality of care their member-physicians provide though varied strategies. Physicians who eschew financially or clinically integrating an IPA may use a messenger model to convey price and price-related information to the payor.

Most IPAs emerged in the 1980s as a reaction to managed care.[18] Panelists stated that some physicians in smaller practices thought that payors had the upper hand so they formed IPAs to gain bargaining leverage.[19] Physicians were also concerned about missing out on managed care contracts, particularly contracts that included capitation provisions.[20] One commentator stated that the Health Maintenance Organizations Act of 1973 spurred the growth of IPAs by recognizing them as an acceptable form of organized medical practice and providing funds for their development.[21] As MCOs have abandoned capitation arrangements with providers, the number of IPAs has declined in recent

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[13] *See* Brown, *supra* note 12, at 290-92.

[14] *See* Lawrence Casalino, *IPA Overview* 4 (9/25/02) (slides) [hereinafter Casalino Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030925lawrencecasalino.pdf; Robin R. Gillies et al., *How Different is California? A Comparison of U.S. Physician Organizations*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-492, 494 (observing that hospitals or HMOs own 18% of non-Californian IPAs, physicians own nearly 70%, and non-physician managers own about 12%. In California hospitals or HMOs own more than 20% of IPAs, physicians own approximately 50%, and non-physician managers own about 25%), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.492v1.pdf.

[15] Grumbach et al., *supra* note 12, at 230 (noting that 40 percent of Californian IPAs use exclusive contracts for some physicians).

[16] Lawrence Casalino et al., *Growth of Single Specialty Medical Groups*, 23 HEALTH AFFAIRS 82 (Mar./Apr. 2004); Kongstvedt et al., *supra* note 12, at 35; Ginsburg 2/26 at 67.

[17] Kongstvedt et al., *supra* note 12, at 35.

[18] Casalino 9/25 at 10 (stating that IPAs "were really more of a defensive strategy against managed care."); Asner 9/25 at 31-32.

[19] Casalino 9/25 at 15, 97; Holloway 9/25 at 100; Asner 9/25 at 126; Doran 2/27 at 217 (stating that physicians bargaining alone lack data and an understanding of the negotiating process); TIMOTHY LAKE ET AL., MEDICARE PAYMENT ADVISORY COMM'N, MPR NO. 8568-700, HEALTH PLANS' SELECTION AND PAYMENT OF HEALTH CARE PROVIDERS, 1999, at 120 (2000) (final report) ("Most of the entities were also formed to improve negotiating power or leverage with health plans (67 percent) and to protect market share (78 percent).").

[20] Casalino 9/25 at 15 (stating that "if you're a small practice, you might be left out of HMO contracts, but in a large IPA, you're not likely to be."); Asner 9/25 at 31; Kongstvedt et al., *supra* note 12, at 35.

[21] Brown, *supra* note 12, at 290.

years.[22]

Statistics on the number and size of IPAs vary.[23] A panelist representing an IPA trade association stated that there presently are approximately 2,000 IPAs nationwide.[24] One survey found that the number of IPAs decreased from 1223 in 1996 to 771 in 2002.[25] A national survey of physician organizations found that there were at least 463 IPAs that contained more than 20 physician members in 2002.[26]

One panelist noted that IPAs can vary in size from about a dozen to more than 1,000 physician members.[27] A national survey of physician organizations found the average number of doctors in an IPA was 233.[28] Another study calculated an average of 387 physicians per IPA nationwide, while in California the average was 418.[29]

[22] Casalino 9/25 at 7, 12-13, 93 (explaining that "absent risk contracting, IPAs are struggling to find a reason to exist"); Meier 9/25 at 70. *But see* Asner 9/25 at 32 (stating "IPAs are still a very successful model in the State of California").

[23] *See, e.g.*, Casalino 9/25 at 6.

[24] Holloway 9/25 at 74.

[25] HEALTH FORUM, LLC, AFFILIATE OF THE AMERICAN HOSPITAL ASS'N, HOSPITAL STATISTICS 8 tbl.3 (2000 ed.); HEALTH FORUM, LLC, AFFILIATE OF THE AMERICAN HOSPITAL ASS'N, HOSPITAL STATISTICS 10 tbl.3 (2004 ed.).

[26] Casalino Presentation, *supra* note 14, at 3; Casalino 9/25 at 6; Gillies et al., *supra* note 14, at 502.

[27] Meier 9/25 at 68.

[28] Casalino 9/25 at 7.

[29] Gillies et al., *supra* note 14, at 494.

b. IPA Efficiencies

(i) Costs and Related Efficiencies

Panelists and commentators disagreed about the impact of IPAs on the cost of care and whether IPAs can create efficiencies. Panelists stated that IPAs reduce contracting costs by lowering administrative and search costs for physicians and allowing payors to contract efficiently with pre-existing networks.[30] Additionally, they asserted that IPAs may generate efficiencies by integrating information technology and billing systems, using their collective purchasing power to receive volume discounts, and performing credentialing of physician-applicants.[31]

Others expressed concern that physicians may use IPAs to obtain increased fees from payors.[32] IPAs that engage in payor contracting and are not integrated run

[30] *See* Asner 9/25 at 32-34; Casalino 9/25 at 14-16; American Medical Ass'n, *Physician IPAs: Patterns and Benefits of Integration, and Other Issues (Sept. 25, 2003)* 4 (Public Comment).

[31] Asner 9/25 at 31-33; Peter R. Kongstvedt, *Primary Care in Managed Health Care Plans*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 12, at 92-93; Casalino 9/25 at 14-15. For a discussion of private antitrust litigation involving physician credentialing, see *infra* notes 241-247, and accompanying text.

[32] *See* Kongstvedt, *supra* note 31, at 90 (contending that "[i]f relations between the IPA and the health plan become problematic, the IPA can hold a considerable portion (or perhaps all) of the delivery system hostage to negotiations."); Casalino 5/28 at 126; Scott D. Danzis, *Revising the Revised Guidelines: Incentives, Clinically Integrated Physician Networks and the Antitrust Laws*, 87 VA. L. REV. 531, 535 (2001).

the risk of antitrust liability if they facilitate price agreements among their members.[33] IPAs also create an additional layer of administration, which can increase administrative costs – although physician-members in the IPA have an incentive to minimize these expenses.[34]

One panelist suggested that financial integration creates an incentive for physician-members to provide "quality care at the most cost effective price."[35] Another panelist suggested that "pay for performance" (P4P) strategies, which are described in greater detail in Chapter 1 may be a new form of financial integration.[36] A third panelist noted that P4P strategies have been adopted on an industry-wide basis in California.[37] One study found that IPAs in California use 35-50 percent more care management strategies than physician organizations in other parts of the country.[38] The study identified two factors that strongly correlated with this difference: IPAs in California have greater exposure to external incentives to improve services and greater access to information technology than non-Californian IPAs.[39]

Panelists also considered whether clinical integration can reduce the cost of health care and create efficiencies. One panelist stated physicians in clinically integrated IPAs can do a better job monitoring and managing patients with chronic illnesses.[40] Such patients typically comprise five percent of the patient population but generate between 60 and 80 percent of health care costs.[41] Another panelist stated that clinical integration allows physicians to share information more

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[33] *See*, *e.g.*, *In re* Physician Network Consulting, L.L.C., No. C-4094 (Aug. 27, 2003) (decision and order), *available at* http://www.ftc.gov/os/2003/08/physnetworkdo.pdf; *In re* Tex. Surgeons, P.A., No. C-3944 (May 18, 2000) (decision and order), *available at* http://www.ftc.gov/os/2000/05/texas.do.htm; *In re* N. Lake Tahoe Med. Group, Inc., No. C-3885 (July 21, 1999) (decision and order), *available at* http://www.ftc.gov/os/1999/08/northtahoe.do.htm; *In re* Mesa County Physicians Indep. Practice Ass'n, Inc., 127 F.T.C. 564 (1999); *In re* Southbank IPA, Inc., 114 F.T.C. 783 (1991).

[34] *See* Casalino 9/25 at 17, 19; JAMES C. ROBINSON, THE CORPORATE PRACTICE OF MEDICINE 148 (1999) (physician-members are "motivated to . . . hold down expenses.").

[35] Asner 9/25 at 38.

[36] Meier 9/25 at 64 (stating that pay for performance "very well could be another example of financial integration."); *see also* Casalino 9/25 at 97 (observing that if physicians were paid based on quality, they would "be more interested in developing organized processes to improve quality.").

[37] Asner 9/25 at 36-37 (also stating "[t]here are 25 other programs that are starting up across the country that are using the pay-for-performance model from California," which cannot be implemented "with physicians in individual private practices.").

[38] Gillies et al., *supra* note 14, at 496-98, 499. Care management strategies include disease management programs, use of guidelines and critical pathways, use of hospitalists, and the like.

[39] External incentives include outside reporting of patient satisfaction and outcome data, and recognition for quality such as receiving better contracts. *Id.*

[40] Asner 9/25 at 40.

[41] *Id.* at 39.

effectively.[42] Two panelists reported that some IPAs employ care management teams to coordinate patient care.[43] On the other hand, commentators noted that clinical integration is very expensive, and cautioned that physicians may prove unwilling to make the necessary investment.[44]

(ii) Quality of Care and Related Efficiencies

Some have stated that financial integration provides physicians with incentives to improve quality of care.[45] Nevertheless, many physicians state that financial incentives including capitation arrangements reduce quality of care.[46] One commentator observed that "[t]he degree to which capitation encourages organizations to compete on quality and efficiency depends on the market context within which it is used."[47]

Panelists stated that clinical integration can improve quality of care.[48] One panelist observed that clinically integrated IPAs can "provide technology, clinical, and population management programs to improve patient care and outcomes."[49] A capitated IPA that implemented certain clinical integration initiatives "exerted a dramatic impact on patterns of utilization and expenditure," noted one commentator.[50] One study found that, although many IPAs have implemented organized care management programs to improve the quality of care for their patients,

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[42] Burkett 9/9/02 at 144-45 (stating that his organization's clinical integration program provides "benefits for the patients, for the health plans and for the providers, all for different reasons, but much of it revolves around the ability to share the information that we use for patient care.").

[43] Asner 9/25 at 40; Casalino 9/25 at 11 (noting that some IPAs pro-actively try to manage care to control costs and improve quality).

[44] *See* Hill 9/25 at 145; Hoangmai H. Pham et al., *Financial Pressures Spur Physician Entrepreneurialism*, 23 HEALTH AFFAIRS 70, 75-76 (Mar./Apr. 2004); DEP'T OF JUSTICE & FEDERAL TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE § 8(B)(1) (1996) (holding that the Agencies require physician network joint ventures to make a "significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize" sufficient clinical integration efficiencies to enable collective price-setting) [hereinafter HEALTH CARE STATEMENTS], *available at* http://www.ftc.gov/reports/hlth3s.pdf.

[45] Peter R. Kongstvedt, *Compensation of Primary Care Physicians in Managed Health Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 12, at 118 ("[C]apitation eliminates the FFS incentive to overutilize"). *Id.* at 120 ("[A] very large body of literature shows that managed care systems have provided equal or better care to members than uncontrolled FFS systems.").

[46] *See, e.g.*, Kevin Grumbach, *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516, 1518-19 (1998).

[47] Lawrence Casalino, *Canaries in a Coal Mine: California Physician Groups and Competition*, 20 HEALTH AFFAIRS 97, 99 (July/Aug. 2001).

[48] Burkett 9/9/02 at 148; Asner 9/25 at 40 (observing that "under clinical integration there can be monitoring and managing chronic patients, and this will ensure high-quality, cost-effective care.").

[49] Asner 9/25 at 33.

[50] ROBINSON, *supra* note 34, at 147 ("Cardiology in the . . . region experienced a 30 percent drop in hospital utilization and a 20 percent drop in claims costs in the first year.").

the use of such processes is still "relatively uncommon."[51] Some experts contend that an integrated, or "closely knit" IPA may provide a good environment for testing whether quality programs can deliver hoped-for results.[52]

2. PHOs

a. Description of PHOs

A PHO is a joint venture between a hospital and physicians who generally have admitting privileges at the hospital.[53] Physician and hospital members of a PHO sometimes contract jointly with MCOs for providing care to a population of patients. PHOs typically vary along four parameters: exclusivity, integration, ownership/control, and organizational base.[54]

First, PHOs can accept hospital medical staff on an exclusive or nonexclusive basis. Open PHOs allow most medical staff to join and have minimum credentialing requirements; specialists usually dominate these PHOs.[55] Closed PHOs limit physician membership by practice profiling or specialty type and are more likely to form exclusive relationships with physicians.[56] PHOs that employ practice profiling seek to use objective practice data to determine which physicians they should invite to join the PHO.[57] PHOs that recruit physician-members based on specialty type reportedly focus on the number of patients that the physician-member will see.[58]

Second, PHOs are integrated (whether financially, clinically, or both) to varying degrees or not at all.[59] Many PHOs employ financial risk-sharing arrangements

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[51] Lawrence Casalino et al., *External Incentives, Information Technology, and Organized Process to Improve Health Care Quality for Patients with Chronic Disease*, 289 JAMA 434, 439 (2003).

[52] Thomas Bodenheimer et al., *Primary Care Physicians Should Be Coordinators, Not Gatekeepers*, 281 JAMA 2045, 2048 (1999).

[53] Lawton R. Burns & Darrell P. Thorpe, *Physician-Hospital Organizations: Strategy, Structure, and Conduct*, *in* INTEGRATING THE PRACTICE OF MEDICINE, *supra* note 12, at 352; Miles 5/8 at 6; Guerin-Calvert 5/8 at 15.

[54] *See generally* Marren 5/8 at 30 (remarking that "if you have seen one PHO, you have seen one PHO."); Guerin-Calvert 5/8 at 20.

[55] Kongstvedt et al., *supra* note 12, at 43; Burns & Thorpe, *supra* note 53, at 353; Alison Evans Cuellar & Paul J. Gertler, Strategic Integration of Hospitals and Physicians 9 (May 1, 2002) (unpublished manuscript), *at* http://faculty.haas.berkeley.edu/gertler/working_papers/hospital_VI_5_10_02.pdf.

[56] Cuellar & Gertler, *supra* note 55, at 10; Kongstvedt et al., *supra* note 12, at 43, 45 (mentioning the emergence in recent years of closed PHOs with only one type of specialist); Marren 5/8 at 37 (nothing that there are not many exclusive PHOs); Burns & Thorpe, *supra* note 53, at 353.

[57] Kongstvedt et al., *supra* note 12, at 43-44. Many PHOs have found it difficult to get the necessary information in a timely manner so as to profile physician-members comprehensively. An additional complication is dealing with physicians who refuse to adhere to profiling requirements after they become members of a PHO. For a discussion of the antitrust issues related to physician credentialing, see *infra* notes 241-247, and accompanying text.

[58] Kongstvedt et al., *supra* note 12, at 43.

[59] For a discussion of the antitrust issues associated with clinical and financial integration, see *infra* notes 252-281, and accompanying text.

with physician-members, such as partial or full-risk contracts, although PHOs, as a whole, appear to be moving away from full-risk contracts.[60]

Third, ownership, control, and capital structure vary. Physician-members and hospitals jointly own most PHOs, but some hospitals are sole owners.[61] Although hospitals generally provide a majority of initial capitalization, some PHOs strive for equal physician-hospital ownership.[62] Physicians may own interests in a PHO individually or through an entity such as an IPA.[63] PHOs can take the form of a limited liability company, a general partnership, a nonprofit corporation, or a general business corporation.[64]

Finally, PHOs can have different organizational bases. PHOs can have a hospital, multiple hospitals, or a hospital system as their organizational base.[65] Commentators often describe PHOs that involve multiple hospitals or joint ventures between multiple PHOs as super-PHOs.[66]

Panelists and commentators stated that PHOs emerged in the 1980s largely as "a defensive provider reaction to increasing managed care penetration."[67] PHOs subsequently became the most common form of vertical integration among physicians and hospitals.[68] Approximately 60 percent of PHOs are nonprofit and 40 percent are for-profit.[69] In 2002, 74 percent of PHOs were open and 26 percent were closed.[70]

Panelists noted that PHOs have changed substantially in recent years.[71] Many PHOs initially engaged in full or partial risk contracting. As insurers and providers abandoned capitated payment

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[60] *See, e.g.*, Guerin-Calvert 5/8 at 15, 18-20.

[61] Kevin J. Egan & Rebecca L. Williams, *Vertically Integrated Networks*, *in* HEALTH CARE CORPORATE LAW: MANAGED CARE § 5.12.2, at 5-105 to 5-107 (Mark A. Hall & William S. Brewbaker III eds., 1999 & Supp. 1999); Kongstvedt et al., *supra* note 12, at 42.

[62] Kongstvedt et al., *supra* note 12, at 42; Egan & Williams, *supra* note 61, § 5.12.2, at 5-105.

[63] Egan & Williams, *supra* note 61, § 5.12.2, at 5-105.

[64] Julie Y. Park, *PHOs and the 1996 Federal Antitrust Enforcement Guidelines: Ensuring the Formation of Procompetitive Multiprovider Networks*, 91 NW. U. L. REV. 1684, 1692 (1997).

[65] *See* Burns & Thorpe, *supra* note 53, at 353.

[66] *See* Miles 5/8 at 9; Burns & Thorpe, *supra* note 53, at 353; Weis 5/8 at 38-39 (describing the Advocate Health Care Network, which comprises eight PHO joint ventures, including 2,400 independently practicing physicians and eight Advocate hospitals).

[67] Burns & Thorpe, *supra* note 53, at 352; *see also* Weis 5/8 at 38; Miles 5/8 at 4; Kongstvedt et al., *supra* note 12, at 41-42; Egan & Williams, *supra* note 61, § 5.12.2, at 5-105.

[68] Burns & Thorpe, *supra* note 53, at 352.

[69] STEPHEN J. KRATZ, TAYLOR & COMPANY AND AMERICAN ASS'N OF INTEGRATED HEALTHCARE DELIVERY SYSTEMS (AAIHDS), PERSPECTIVES ON INTEGRATED DELIVERY SYSTEMS AND IDS EXECUTIVES 2 (1998/99).

[70] HEALTH FORUM (2004 ed.), *supra* note 25, at 10 tbl.3.

[71] *See* Guerin-Calvert 5/8 at 14-15; Miles 5/8 at 6-7.

arrangements in favor of preferred provider organizations (PPOs) and point of service plans (POS plans), many PHOs scrambled to identify a new role to fill.[72] Numerous PHOs have dissolved or failed in the last eight years.[73] One antitrust lawyer panelist stated that his recent experience with PHOs primarily involves converting them into messenger model networks.[74] PHOs that engage in payor contracting and are not integrated run the risk of antitrust liability if they facilitate price agreements among their members.[75]

b. PHO Efficiencies

(i) Costs and Related Efficiencies

Panelists and commentators differ on whether PHOs can reduce costs or otherwise result in efficiencies. Some contend that PHOs can reduce the cost of negotiating contracts between payors and physicians and hospitals by offering "one-stop shopping."[76] As such, PHOs may enable payors to contract more efficiently with physicians with whom they have no existing contractual arrangements. PHOs could also allow providers to contract directly with self-insured employers and certain Medicare and Medicaid risk or managed contracts.[77]

Commentators and panelists also stated that PHOs may deliver economies of scale by sharing administrative and integration costs among physician-members

[72] Miles 5/8 at 4; Guerin-Calvert 5/8 at 17-18 (establishing that fewer PHOs are involved in full-risk contracting); Weis 5/8 at 76; Ginsburg, 2/26 at 67-68 (noting "a sharp decline in physician hospital organizations"); Lesser 9/9/02 at 83-84 (stating that PHOs are less relevant following the decline in risk contracting). *But see* Babo 5/8 at 41 (describing Advocate Health Partners' use of full risk contracts with managed care). For a discussion of PPOs, see *infra* Chapter 5.

[73] *See* Miles 5/8 at 4-5; Marren 5/8 at 36-37; Nathan S. Kaufman, *Market Dominance of PHO Entities*, HEALTHCARE FIN. MGMT., Aug. 1998 ("Many PHOs are either unprofitable, unsuccessful at developing new business, or stalemates by politics"); Lawton R. Burns & Mark V. Pauly, *Integrated Delivery Networks: A Detour on the Road to Integrated Health Care?*, 21 HEALTH AFFAIRS 128, 128 (July/Aug. 2002).

One survey found that the number of PHOs declined from 1446 in 1994 to 1114 in 2002. HEALTH FORUM (2000 ed.), *supra* note 25, at 8 tbl. 3; HEALTH FORUM (2004 ed.), *supra* note 25, at 10 tbl.3.

[74] *See* Miles 5/8 at 6-7.

[75] The Agencies have brought a number of cases alleging that PHOs violated the antitrust laws. *See, e.g.*, *In re* Piedmont Health Alliance, Inc., No. 9314 (Dec. 24, 2003) (complaint), *available at* http://www.ftc.gov/os/caselist/0210119/031222comp0210119.pdf; *In re* S. Ga. Health Partners, L.L.C., No. C-4100 (Oct. 31, 2003) (complaint), *available at* http://www.ftc.gov/os/2003/11/sgeorgiacomp.pdf; *In re* Me. Health Alliance, No. C-4095 (Aug. 27, 2003) (complaint), *available at* http://www.ftc.gov/os/2003/08/mainehealthcomp.pdf; United States v. Health Choice of Nw. Mo., No. 95-6171-CV-SJ-6 (W.D. Mo., filed Sept. 13, 1995) (complaint); United States v. Healthcare Partners, No: 3:95CV01946 (D. Conn., filed Sept. 13, 1995) (complaint); United States v. Women's Hosp. Found., No. 96-389-BM2 (M.D. La., filed Apr. 23, 1996) (complaint).

[76] Egan & Williams, *supra* note 61, § 5.12.6, at 5-110; Kongstvedt et al., *supra* note 12, at 44; Burns & Thorpe, *supra* note 53, at 354; Weis 5/8 at 44; Park, *supra* note 64, at 1695.

[77] *See* Kaufman, *supra* note 73, at 3; Egan & Williams, *supra* note 61, § 5.12.6, at 5-110. Presumably, such PHOs are integrated sufficiently to avoid per se condemnation under the antitrust laws.

and hospitals.[78] They further said that PHOs may result in more efficient deployment of physician resources, because these arrangements allow physician-members to concentrate on practicing medicine.[79] Finally, they added that PHOs may reduce legal expenses for hospitals and physicians by enabling them to "present a unified front and a common defense in the event of malpractice claims."[80]

Others contend that the primary advantage for physicians and hospitals in forming a PHO is the increased bargaining power gained from "presenting a united front to payers."[81] They assert that providers can use this additional bargaining power to obtain higher prices from payors, particularly if providers "raise barriers to entry by forming exclusive relationships."[82] A panelist representing a health insurance plan stated that PHOs have given providers "greater negotiation leverage" and "contributed to some of the runaway inflation in health care costs."[83]

Empirical studies of PHO pricing have found mixed results.[84] A recent study of hospital and physician integration based on organizations in Arizona, Florida, and Wisconsin found that integration is associated with an increase in prices, especially when the integrated organization is exclusive and located in less competitive markets.[85] Other studies have concluded that physician-hospital affiliations generally do not result in higher hospital prices.[86]

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[78] Egan & Williams, *supra* note 61, § 5.12.6, at 5-110; Dalkir 5/8 at 68 (observing that efficiencies can be derived from physicians organizing as a group and from physicians and hospitals integrating).

[79] *See* Egan & Williams, *supra* note 61, § 5.12.6, at 5-110; Miles 5/8 at 10 (explaining that PHO physicians can refer their patients to other PHO participants, which has "obvious[] pro-competitive and efficiency justifications."). *But cf.* Buxton 5/8 at 50 (suggesting intra-organization referrals may result in overuse).

[80] Egan & Williams, *supra* note 61, § 5.12.6, at 5-110.

[81] Burns & Thorpe, *supra* note 53, at 353; *see also* Burns 4/9 at 70; Kongstvedt et al., *supra* note 12, at 41-42. *But see* Miles 5/8 at 79 (observing that managed care plans can have a phobia of dealing with provider networks because the plans assume the networks form only to obtain higher fees).

[82] Cuellar & Gertler, *supra* note 55, at 7; *see also* Guerin-Calvert 5/8 at 21-23; Dalkir 5/8 at 26; Buxton 5/8 at 51-52 (listing examples of physician groups demanding significant fees). For further discussion of physician collective bargaining, see *infra* notes 133-178, and accompanying text.

[83] Buxton 5/8 at 50; *see also* Hurley 4/9 at 18.

[84] STEPHEN M. SHORTELL ET AL., REMAKING HEALTH CARE IN AMERICA: THE EVOLUTION OF ORGANIZED DELIVERY SYSTEMS 26 (2nd ed. 2000).

[85] Cuellar & Gertler, *supra* note 55, at 25-26.

[86] Federico Giliberto & David Dranove, The Effect of Physician-Hospital Affiliations on Hospital Prices in California 1 (Nov. 30, 2003) (unpublished manuscript) (finding that highly integrated hospital and physician structures may slightly reduce prices); Kaufman, *supra* note 73, at 1 (discussing research that "showed no correlation between a hospital's physician integration strategy and its payments under managed care. There is, however, a high correlation between a hospital's payments under managed care and its institutional market position. Dominant hospital systems got paid better than marginal

Some commentators doubt whether PHOs actually lower the costs associated with contracting.[87] One commentator stated that PHOs have not resulted "in any meaningful improvement in contracting ability. In many cases, MCOs already have provider contracts in place and see little value in going through the PHO."[88]

(ii) Quality of Care and Related Efficiencies

Panelists and commentators differed on the ability of PHOs to improve quality of care. Some stated that PHOs can significantly improve quality by coordinating patient care delivered to consumers in the doctor's office and the hospital.[89] They also stated that PHOs can implement shared information systems.[90] As Chapter 1 reflects, many commentators state such investments in information infrastructures are a necessary first step in improving quality of care.

One panelist representing a PHO contended that financially integrated PHOs can reduce costs and improve quality by clinically integrating.[91] This panelist also suggested that physicians practicing individually or in small groups that are not financially or clinically integrated have limited ability to improve quality, reduce costs, and capture related efficiencies.[92] The same panelist suggested that physicians practicing in large groups do not readily cooperate with one another, and hospitals are the most likely entities to implement programs to improve health care quality and reduce costs.[93]

Another panelist noted PHOs must make significant investments in clinical integration to improve quality of care.[94] A third panelist suggested that clinical integration is improbable because of its high implementation costs and potential antitrust risks.[95] A panelist representing a health

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hospitals regardless of whether they had a PHO.").

[87] *See* Kongstvedt et al., *supra* note 12, at 44-45; Burns & Thorpe, *supra* note 53, at 354.

[88] Kongstvedt et al., *supra* note 12, at 44-45.

[89] Marren 5/8 at 34; Weis 5/8 at 46 (discussing the crucial role clinical integration can play in creating efficiencies and improving patient safety); Miles 5/8 at 79-80; Guerin-Calvert 5/8 at 23; Babo 5/8 at 60; Vogt 9/9/02 at 69; Park, *supra* note 64, at 1693-94 (stating that "PHOs may permit . . . consumers to obtain high quality at a lower price by conducting or developing systems for utilization review and quality assurance."); Cuellar & Gertler, *supra* note 55, at 4. *But see* Burns 4/9 at 77-78.

[90] *See* Cuellar & Gertler, *supra* note 55, at 4; Guerin-Calvert 5/8 at 18-19.

[91] *See* Weis 5/8 at 41-42, 60-62.

[92] *Id.* at 60-62.

[93] *See id.* at 60-62; Marren 5/8 at 31-32 (stating that physicians do not self-organize very well). *But see* Kaufman, *supra* note 73, at 2 (stating that "[h]ospitals . . . are less motivated than [physician practice management companies] to extract profit growth from the physician practices they purchase and/or manage.").

[94] Guerin-Calvert 5/8 at 17; *see also* Marren 5/8 at 34-35, 36-37; Weis 5/8 at 61 (observing that "some form of clinical or financial integration is necessary in order to achieve quality improvement, cost reduction and better patient safety."); Burns & Thorpe, *supra* note 53, at 354.

[95] Miles 5/8 at 5, 7 (citing antitrust concerns and the refusal of a state antitrust bureau to accept clinical integration for antitrust analysis purposes); *see also* Timothy S. Snail & James C. Robinson,

insurance plan stated that "there appears to be no difference in the quality of care offered by a PHO than that offered by physicians and hospitals that contract separately."[96] Although opinions regarding PHOs vary significantly, there is relatively little empirical research on PHOs, quality of care, and clinical integration with which to resolve these competing claims, and the available evidence is decidedly mixed.

3. Summary

Physicians have historically been solo or small-group practitioners, competing only with other such practitioners in their particular product and geographic market. As the market for physician services has evolved, and antitrust enforcement has addressed anticompetitive conduct, competition has emerged along multiple dimensions. IPAs and PHOs compete for physician-members and to contract with payors. The forms and modes of competition in the market for physician services will inevitably vary over time as conditions and preferences change. Competition helps deliver an optimum mix of physician services at the lowest cost and highest quality. The Agencies are committed to vigorous price and non-price competition and not to any particular model for delivering health care.

Organizational Diversification in the American Hospital, 19 ANN. REV. PUB. HEALTH 417, 423 (1998).

[96] Buxton 5/8 at 49-50 (suggesting also that intra-organization referrals may result in overuse).

B. Physician Compensation

1. Physician Payment Arrangements

Insurers and others typically pay physicians on an FFS, salaried, or capitated basis.[97] In FFS payment an insurer directly pays an individual provider based on the number and type of services that provider performs.[98] Some state that FFS improves quality by rewarding physicians who do more for their patients.[99] Other commentators are concerned that FFS payment creates incentives for physicians to over-provide healthcare resources because a physician's income is directly related to the volume and intensity of services rendered.[100]

Capitation involves a physician assuming responsibility for a certain number of patients and receiving a fixed amount for each of these patients regardless of whether

[97] Sherry Glied, *Managed Care*, *in* 1A HANDBOOK OF HEALTH ECONOMICS (Anthony J. Culyer & Joseph P. Newhouse, eds. 2000). The payment arrangement that insurers use to pay a physician network joint venture may be different from the arrangement those joint ventures use to pay their physician members. *See* James C. Robinson, *Blended Payment Methods in Physician Organizations Under Managed Care*, 282 JAMA 1258, 1258 (1999).

[98] *See* Academy for Health Management, *A Glossary of Managed Care Terms*, *at* http://www.aahp.org/glossary/index.html (last visited June 22, 2004).

[99] *See, e.g.*, Kongstvedt, *supra* note 45, at 123 (noting that sicker patients require more care and doctors practicing on a FFS basis get paid more for their time, energy and skills applied to such patients).

[100] *See, e.g.*, David Orentlicher, *Paying Physicians More To Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 158 (1996); GLIED, *supra* note 97, at 723-25.

those patients seek care.[101] Although some state that capitation reduces the incentive to provide excessive care,[102] others are concerned that capitation creates an incentive for physicians to increase the number of patients for whom they provide care and simultaneously decrease the services they actually provide.[103]

Physicians employed by the government, hospitals, or medical groups typically receive a salary.[104] Some commentators state that medical groups or organizations can align more carefully the incentives of the physician with those of the group by paying salaries.[105] Others are concerned that such arrangements also create an incentive for physicians to decrease the number of patients they are responsible for and the services they provide.[106]

Medicare reimburses physicians on an FFS basis, using the resource-based relative value scale (RBRVS).[107] The Centers for Medicare & Medicaid Services determine the RBRVS based on the cost of physician labor, practice overheads, materials, and liability insurance. The resulting figure is adjusted for geographical differences and is updated annually.[108] Many private payors and MCOs base their payment of physicians on this schedule.[109]

2. Messenger Model

a. Description of the Messenger Model

The messenger model is an arrangement that allows contracting between providers and payors, while avoiding price-fixing among competing providers.[110] *Health Care Statement* 9 provides that messenger models "can be organized and operated in a variety of ways."[111] One

[101] Orentlicher, *supra* note 100, at 158-159; Casalino 9/25 at 7; GLIED, *supra* note 97, at 714-16.

[102] Kongstvedt, *supra* note 45, at 118.

[103] *See, e.g.*, Orentlicher, *supra* note 100, at 158-59.

[104] *See* Carol K. Kane & Horst Loeblich, *Physician Income: The Decade in Review*, *in* AMERICAN MEDICAL ASS'N, PHYSICIAN SOCIOECONOMIC STATISTICS 7 (2002 ed.) (noting that approximately 35 percent of physicians are salary-based employees).

[105] Kongstvedt et al., *supra* note 12, at 48 (discussing the use of salaries to capture economies of scales and to apply capital resources most effectively).

[106] Orentlicher, *supra* note 100, at 159; Henry T. Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53, 57 (1997).

[107] *See generally* American Medical Ass'n, *RVS Update Process* (2002), *at* http://www.ama-assn.org/ama1/pub/upload/mm/380/rucbooklet.pdf. For a discussion of trends in Medicare spending on physician services, *see* GENERAL ACCOUNTING OFFICE, MEDICARE PHYSICIAN PAYMENTS (2004), *available at* http://www.gao.gov/new.items/d04751t.pdf.

[108] *See* American Medical Ass'n, *supra* note 107.

[109] Kongstvedt, *supra* note 45, at 127 (stating that private payors paid physicians 20 percent more than the Medicare amount in 1999).

[110] HEALTH CARE STATEMENTS, *supra* note 44, § 9(C); Raskin 9/25 at 174.

[111] HEALTH CARE STATEMENTS, *supra* note 44, § 9(C); *see also* Arthur N. Lerner & David M. Narrow, *PPO Programs and the Antitrust Laws*, *in* THE NEW HEALTHCARE MARKET: A GUIDE TO PPOS

panelist described the traditional messenger model as one involving a payor submitting fee schedules to an agent or third party, who transmits this schedule to the network physicians.[112] This panelist elaborated that each physician decides individually whether to accept or reject the fee schedule and the messenger or agent communicates those decisions to the payor.[113] The payor may then initiate another round of negotiations with the network physicians or enter into contracts with those physicians who accepted its offer, observed the panelist.[114]

Commentators have discussed a variation that involves the messenger conveying to payors information obtained individually from providers about the prices or price-related terms that those providers are willing to accept.[115] The messenger may aggregate this information into a comprehensive schedule and market the schedule to payors, and may receive authority from individual physicians to accept contractual offers on their behalf, commentators have noted.[116] They also stated that agents must convey offers that do not meet a physician's preferred rate to those physicians, because they are not empowered to reject offers.[117] Agents also may help physicians understand the contracts offered, for example, by providing objective or empirical information about the terms of an offer.[118] Messenger models can be used creatively to facilitate contracting between payors and providers, so long as they do not facilitate anticompetitive agreements on price or other terms.[119]

FOR PURCHASERS, PAYORS AND PROVIDERS 858 (Peter Boland ed., 1985).

[112] Douglas C. Ross, *Physician IPAS: Messenger Model* 5 (9/25) (slides) [hereinafter Ross Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030925douglasross.pdf; Ross 9/25 at 150-51 (also acknowledging that physicians infrequently implement the traditional messenger model).

[113] Ross Presentation, *supra* note 112, at 5; Ross 9/25 at 150; Kim H. Roeder, *The 1996 Antitrust Policy Statements: Balancing Flexibility and Certainty*, 31 GA. L. REV. 649, 671 (1997) ("The key to the Messenger Model [is] that the individual providers [make] independent, unilateral decisions irrespective of what other providers would do and regardless of the views of the agent acting as the messenger.").

[114] Ross 9/25 at 150.

[115] Edward Hirshfeld, *Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks*, 6 ANN. HEALTH L. 1, 29 (1997); Ross 9/25 at 151.

[116] Hirshfeld, *supra* note 115, at 29; Ross 9/25 at 151.

[117] Hirshfeld, *supra* note 115, at 29; Miles 9/25 at 170.

[118] Hirshfeld, *supra* note 115, at 29; Miles 9/25 at 167-68.

[119] Commission staff recently issued an advisory opinion that involved the messenger collecting minimum payment levels for certain procedures from each physician member. If a payor's offer exceeded these minimum payment levels for more than 50% of network physicians, then the messenger would contract on these physicians' behalf. If the payor's offer met the minimum payment level for less than 50% of physician members, then the payor would have to agree to bear contract administration costs before the messenger could enter a contract. Commission staff emphasized in the advisory opinion that this arrangement would be acceptable only if it were not used to facilitate price collusion. *See* Letter from Jeffrey W. Brennan, Federal Trade Commission, to Martin J. Thompson, Manatt, Phelps & Phillips, LLP (Sept. 23, 2003) (FTC Staff advisory opinion regarding Bay Area

Physician networks purporting to use the messenger model have given rise to considerable antitrust enforcement activity. In recent years, the Agencies have brought numerous cases alleging physicians involved in messenger models engaged in anticompetitive conduct.[120] These cases have involved a diverse array of allegations.[121]

b. Messenger Model Efficiencies and Antitrust Concerns

Panelists and commentators expressed differing views on whether the messenger model can reduce costs for providers and payors. Some stated that the messenger model simplifies contracting and contract administration, thereby reducing physicians' and payors' transaction costs.[122] Two panelists observed that an agent can significantly reduce physicians' transaction costs by educating them about the terms of a contract.[123] Panelists also explained that a properly implemented messenger model cannot result in higher prices for payors, because it is incapable of creating countervailing market power for physicians.[124] Finally, one panelist observed that networks risk incurring administration costs for limited gain if only a minority of network physicians accept a payor's offer.[125]

In contrast, some panelists and commentators stated that the messenger model is not a viable business strategy and can increase costs for providers and

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Preferred Physicians), *available at* http://www.ftc.gov/bc/adops/bapp030923.htm.

[120] *See, e.g.*, *In re* Physician Network Consulting, L.L.C., No. C-4094 (Aug. 27, 2003) (decision and order), *available at* http://www.ftc.gov/os/2003/08/physnetworkdo.pdf; *In re* Carlsbad Physician Ass'n, No. C-4081 (June 13, 2003) (decision and order), *available at* http://www.ftc.gov/os/2003/06/carlsbaddo.htm; *In re* SPA Health Org., No. C-4088 (July 17, 2003) (decision and order), *available at* http://www.ftc.gov/os/2003/07/spahealthdo.pdf; United States v. Fed'n of Physicians & Dentists, Inc., 2002-2 Trade Cas. (CCH) ¶ 73,868 (D. Del., 2002); United States v. Mountain Health Care, P.A., 2003-2 Trade Cas. (CCH) ¶ 74,162 (W.D.N.C. 2003).

[121] For example, so-called "messengers" in several instances allegedly negotiated prices with payors, refused to transmit price offers that were deemed insufficient, or orchestrated price agreements among network physicians.

[122] *See* Miles 9/25 at 167 (stating also that "messenger networks can help market their provider's services, hopefully increasing provider volume"); Lerner 9/25 at 235-36 (suggesting that the messenger model could facilitate a new payor's entry into local markets by creating provider networks with which the payor could readily contract); Robert Leibenluft, *Why Physician Cartels Do Not Need a "Fresh Look" – a Response to the AMA's Testimony at the FTC Health Care Competition Workshop* 5 (Public Comment) [hereinafter links to FTC Health Care Workshop Public Comments are available at http://www.ftc.gov/os/comments/healthcarecomments/index.htm].

[123] Miles 9/25 at 167-168 (stating that messengers can educate physicians and their staff "to make more rational contracting decisions"); Hill 9/25 at 228 (remarking that physicians are not trained to understand contracts and that many physicians have limited interest in such contracts).

[124] Miles 9/25 at 168-169; Lerner 9/25 at 200; Ross 9/25 at 223-224.

[125] Ross 2/25 at 150-151.

payors.[126] Panelists contended that such arrangements have high administrative costs because they are complex to implement and difficult to maintain.[127] They observed that agents frequently cannot determine the antitrust implications of a particular course of conduct and therefore require expensive legal advice.[128] Others noted that certain messenger model variations actually can prolong contract negotiations and increase provider and payor transaction costs.[129]

Panelists and commentators also differed on the messenger model's usefulness in avoiding antitrust concerns. Some stated that messenger arrangements are useful in preventing violations of the antitrust laws and lower the risk of being compelled to disband a network to settle an Agency investigation.[130] One panelist noted the model has been particularly useful for erstwhile financially integrated physician networks that need an alternative contracting mechanism as risk sharing arrangements have become less common.[131]

Others noted that physician networks purporting to use the messenger model have been the focus of multiple Agency investigations and consent settlements.[132]

3. Physician Collective Bargaining

Some physicians have lobbied heavily for statutory or other legal changes that would enable independent physicians to bargain collectively by exempting them from the antitrust laws.[133] Those who support

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[126] Raskin 9/25 at 173 ("I have never found . . . any business person, any administrator or healthcare professional in any segment of the industry who advocates the use of the messenger model for any business purpose."); Miles 9/25 at 214-215 (stating that "[m]essenger models are worthless, except as interim tools.").

[127] Hill 9/25 at 147 (declaring that the messenger model "is cumbersome, it's difficult to administer, and it's not surprising that the messenger model is often despised by physicians, hospitals, and to our understanding even payors."); J. Edward Hill, *Physician IPAs; Messenger Model* 4 (9/25), *at* http://www.ama-assn.org/ama1/pub/upload/mm/368/drhillftcstatement.pdf; Miles 9/25 at 169 (stating that the messenger model is so "cumbersome" to implement and maintain that it is "a pain in the butt"); Jack R. Bierig, *Physician-Sponsored Managed Care Networks: Two Suggestions for Antitrust Reform*, 6 HEALTH MATRIX 115, 122 (1996) ("The messenger model is universally recognized as inefficient and cumbersome, particularly given the thousands of medical procedures and the large numbers of physicians involved in physician networks."). One panelist noted the concern that physicians might adopt the network fee schedule for use in their own individual practices, thereby leading to increased prices for payors and consumers. This panelist further stated that such concerns have never been empirically established. *See* Raskin 9/25 at 179-80.

[128] Hill 9/25 at 228; Miles 9/25 at 169-71.

[129] Ross 9/25 at 156 (stating that some versions of the messenger model can lead to "going back and forth potentially forever"); Hill 9/25 at 147; Miles 9/25 at 157 (stating that physicians may provide "very, very high, unrealistic rates" under some messenger arrangements because "they're not quite sure what they're getting into"), 171.

[130] Raskin 9/25 at 182-83.

[131] Miles 9/25 at 166-7.

[132] Marx 9/25 at 193-94; Raskin 9/25 at 173-174; Miriam L. Clemons, *Don't Shoot the Messenger: Independent Physicians and Joint Payment Contracting Using the Messenger Model*, 32 U. MEM. L. REV. 927, 949 (2002).

[133] *See* American Medical Ass'n, Position Paper on Antitrust Relief Legislation [hereinafter AMA Position Paper], *at* http://www.ama-assn.org/ama/pub/article/5910-6004.html (Last

such exemptions contend that physicians need to bargain collectively to exercise countervailing market power against payors.[134] The Agencies have consistently opposed such exemptions because they are likely to harm consumers by increasing costs without improving quality of care. This section describes the legal landscape for physician collective bargaining, discusses the competitive impact of countervailing power, and considers the impact of collective bargaining on the cost and quality of health care.

a. Legal Landscape

Both labor and antitrust laws affect the ability of workers to bargain collectively.[135] Antitrust law prohibits competitors from price-fixing and engaging in group boycotts. Labor law provides exemptions from antitrust liability under certain circumstances.[136] Pursuant to the National Labor Relations Act (NLRA), employed physicians are generally allowed to unionize and bargain collectively.[137] Physicians who are self-employed or independent contractors generally may not collectively bargain without violating the

updated Oct. 6, 2003); Letter from Michael D. Maves, American Medical Ass'n, to Spencer Bachus & John Conyers, Jr., U.S. House of Representatives (Mar. 21, 2003) (regarding HR 1120, the "Health Care Antitrust Improvements Act of 2003") (asserting that "insurers are using these contracts to gain increased control over how medical care is delivered") [hereinafter AMA Letter], *at* http://www.ama-assn.org/ama/pub/article/5908-7508.html. *See generally* Foreman 5/7 at 20-26 (representing the AMA); Stephen Foreman, *Countervailing Market Power* (5/7) (slides), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507foreman.pdf; Donald Palmisano, *Taking the Payer Side Seriously: Why the Federal Trade Commission Should Redirect Its Efforts in Health Care Antitrust Enforcement* (9/9/02) [hereinafter Palmisano (stmt)], *at* http://www.ama-assn.org/ama/pub/article/5911-6710.html; Crane 5/7 at 34-40 (noting health plan consolidation and trend away from HMOs and capitation, and suggesting that the FTC and Justice Department revise Health Care Statement 8 of the Health Care Statements to allow more latitude to IPAs); Donald Crane, *Statement* (5/7), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507doncrane.pdf; Fred Hellinger & Gary Young, *An Analysis of Physician Antitrust Exemption Legislation: Adjusting the Balance of Power*, 286 JAMA 83 (2001).

[134] Levy 9/26 at 45; Connair 9/26 at 23 (stating that "insurers have been able to strong-arm physicians into signing one-sided contracts that give managed care insurers the legal right to deny care, compromise optimal care, and unfairly squeeze doctors financially."). Countervailing power involves sellers (or buyers) faced with buyer (or seller) market power acquiring their own market power (*i.e.*, by negotiating collectively and engaging in other behavior that would otherwise be prohibited by the antitrust laws) to offset that monopsony or monopoly power. See *infra* notes 150-165, and accompanying text.

[135] Sujit Choudhry & Troyen A. Brennan, *Collective Bargaining by Physicians – Labor Law, Antitrust Law, and Organized Medicine*, 345 NEW ENG. J. MED. 1141 (2001).

[136] *See, e.g.*, Marc L. Leib, *White Coats and Union Labels: Physicians and Collective Bargaining*, 42 ARIZ. L. REV. 803, 812-13 (2000).

[137] National Labor Relations Act (NLRA), 29 U.S.C. § 157 (2004); Leib, *supra* note 136, at 813 (stating that the NLRA creates "a legally enforceable right for employees to organize," requires "employers to bargain with employees through employee elected representatives," and gives "employees the right to engage in concerted activities for collective bargaining purposes or other mutual aid or protection."); Flaherty 9/26 at 30-31. Employee bargaining rights vary, depending on whether the physician works for a firm or the federal or state government.

antitrust laws.[138] A few states have passed legislation that exempts self-employed physicians from the antitrust laws and provides for state regulation of physician collective bargaining.[139] Other states and Congress have also considered such legislation.[140] Commission staff submitted competition advocacy letters commenting on three such bills in Ohio, Washington, and Alaska.[141]

Until recently, physician interest in unionization and collective bargaining was limited. Organized medicine long opposed physician unions.[142] According to one panelist, physicians began making more concerted efforts to unionize and bargain collectively in the 1970's in response to the emergence of large health care organizations and changes in physician fees.[143] The same panelist noted that many physicians believed that organized medicine was failing to respond to these changes.[144]

The AMA remained opposed to unionization until 1999 when it approved the formation of Physicians for Responsible

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[138] Jeremy Lutsky, *Is Your Physician Becoming a Teamster: The Rising Trend of Physicians Joining Labor Unions in the Late 1990's*, 2 DEPAUL J. HEALTH CARE L. 55, 78 (1997); Levy 9/26 at 41-42. Some commentators have suggested however that the National Labor Relations Board and the courts "may yet conclude that some physicians that contract with MCOs are de facto employees and thus should be entitled to bargain collectively under the NLRA." William S. Brewbaker III, *Physician Unions and the Future of Competition in the Health Care Sector*, 33 U.C. DAVIS L. REV. 545, 564; Leib, *supra* note 136, at 819-23.

In this Report, "collective bargaining" can refer to bargaining by union members, which is authorized by the NLRA, or non-unionized physicians' attempts to obtain the right to bargain collectively.

[139] *See* Flaherty 9/26 at 32 (stating that in certain states, including Texas and New Jersey, the state attorney general regulates physician collective bargaining); Ameringer 9/26 at 16; Tobey 5/7 at 47-52 (discussing Texas's experience); Mark Tobey, *Prepared Remarks* (5/7), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507tobeytestimony.pdf. For a discussion of the state action doctrine, see *infra* note 286, and accompanying text, and *infra* Chapter 8.

[140] *See* TODD J. ZYWICKI ET AL., FEDERAL TRADE COMM'N, NO. P011200, REPORT OF THE STATE ACTION TASK FORCE 67 (2003) (stating that legislatures in Ohio, Washington, and Alaska considered passing such legislation in 2002), *at* http://www.ftc.gov/os/2003/09/stateactionreport.pdf; Leib, *supra* note 136, at 830 (writing in 2000 that "Illinois, Delaware, the District of Columbia, New Hampshire, New Jersey, New York, and Pennsylvania have introduced bills to allow collective bargaining by physicians.") (footnote omitted); Quality Health-Care Coalition Act of 1999, H.R. 1304, 106th Cong. (1999) (sponsored by Rep. Tom Campbell); Health Care Antitrust Improvements Act of 2003, H.R. 1120, 108th Cong. (2003).

[141] Letter from Richard A. Feinstein, Federal Trade Commission, to Robert R. Rigsby, Government of the District of Columbia (Oct. 29, 1999), *at* http://www.ftc.gov/be/hilites/rigsby.htm; Letter from Joseph J. Simons, Federal Trade Commission, to Dennis Stapleton, Ohio House of Representatives (Oct. 16, 2002), *at* http://www.ftc.gov/os/2002/10/ohb325.htm; Letter from Joseph J. Simons, Federal Trade Commission, to Lisa Murkowski, Alaska House of Representatives (Jan. 18, 2002), *at* http://www.ftc.gov/be/v020003.pdf.

[142] Ameringer 9/26 at 10-12 (stating that organized medicine "saw unions as a threat to professional . . . turf, and as antithetical to professional values of individualism and autonomy.").

[143] *Id.* at 7-8.

[144] *Id.*

Negotiations (PRN).[145] Initially, PRN was "an AMA-affiliated labor organization dedicated to representing physicians in collective bargaining with employers."[146] Panelists primarily attributed the AMA's support for physician unionization to an ongoing decline in the AMA's total membership and a determined lobbying effort by the AMA's younger physician members.[147]

News reports indicate that PRN's membership in 2002 was "only a few hundred" individual members, its advocacy for two Chicago physicians' groups had stalled, and that "AMA leaders, who fear that union-management tensions would compromise patient care, ha[ve] stymied the group."[148] In March 2004, the AMA and PRN separated; PRN now operates as an independent physician labor organization.[149]

b. Countervailing Power

Some physicians claim they need countervailing market power to offset the market power they allege health care insurers possess. They contend that monopsony power enables health plans to approach "contract negotiations with a 'take-it-or-leave-it' attitude that puts physicians in the untenable position of accepting inappropriate contract terms."[150] The AMA asserts that these terms include unreasonably low fees and provisions that may harm quality of care.[151]

Some participants asserted that there are numerous markets in which health care insurers exercise monopsony power.[152]

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[145] The AMA also supported federal legislation that would allow physicians to bargain collectively, claiming it would "reduce the critical imbalance in the health care marketplace and restore some power to physicians so they can act in the best interests of their patients." AMA Letter, *supra* note 133. The Pennsylvania Medical Society has similarly suggested that "regulatory and countervailing power approaches may produce welfare-improving outcomes." Stephen Foreman & Dennis Olmstead, *Written Comments of the Pennsylvania Medical Society* 3 (9/9/02, dated Sept. 30, 2002), *at* http://www.ftc.gov/ogc/healthcare/pms.pdf.

[146] Flaherty 9/26 at 29.

[147] *See* Ameringer 9/26 at 15-16; Flaherty 9/26 at 29.

[148] Joseph Weber, *I Dreamed I Saw Dr. Joe Hill Last Night; Tensions are running high in the American Medical Assn. over a divisive question: Should doctors form labor unions?*, BUS. WEEK ONLINE, June 20, 2002; *see also* Lindsey Tanner, *Doctors Union Battles for Survival*, ASSOCIATED PRESS, May 9, 2002; Sara D. White, *For the Record*, CRAIN'S CHICAGO BUSINESS, May 13, 2002.

[149] News Statement, Michael D. Maves, American Medical Ass'n, *AMA separation from PRN* (Mar. 10, 2004), *at* http://www.ama-assn.org/ama/pub/article/1617-8441.html; Physicians for Responsible Negotiation, *at* http://www.4prn.org (last visited July 8, 2004).

[150] AMA Letter, *supra* note 133.

[151] *See, e.g.*, AMA Position Paper, *supra* note 133; AMA Letter, *supra* note 133 (asserting that "insurers are using these contracts to gain increased control over how medical care is delivered"); Catherine Hanson, *On Integration, Physician Joint Contracting, and Quality: Taking a Fresh Look at Some "Settled" Questions* (9/9/02), *at* http://www.ftc.gov/ogc/healthcare/hanson.pdf; Palmisano (stmt), *supra* note 133.

[152] *See* Foreman 5/7 at 54; Crane 5/7 at 35 (stating that California is a "a textbook example of monopsony power" because health care insurer mergers have left California with fewer, more dominant health care insurers); George Koenig, *Additional Testimony Subsequent to FTC Workshop*

Others disagreed, however, arguing that physicians, rather than insurers, often exercise market power.[153] Although there may be disparities in bargaining position between some payors and some providers, the available evidence does not indicate that there is a monopsony power problem in most health care markets.[154]

A proponent of countervailing power theory stated that providers need this power if health care insurers exercise monopsony power.[155] Nonetheless, those physicians seeking to bargain collectively have sought blanket exemptions from the antitrust laws. Several speakers opposed such exemptions.[156] As one panelist stated, "it's clear that a blanket exemption to the antitrust laws for the purpose of allowing the creation of countervailing power is inappropriate."[157] Another speaker similarly testified that allowing providers to acquire countervailing market power is unnecessary, impossible to implement, and bad public policy.[158]

The Agencies believe that antitrust enforcement to prevent the unlawful acquisition or exercise of monopsony power by insurers is a better solution than allowing providers to exercise countervailing power. Joel Klein, the Assistant Attorney General in 1999, noted that a "better approach [than allowing countervailing market power] is to empower consumers by encouraging price competition, opening the flow of accurate, meaningful information to consumers, and ensuring effective antitrust enforcement both with regard to buyers (health care insurance plans) and sellers (health care professionals) of provider services."[159]

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on Health Care and Competition Law and Policy (Sept. 16, 2002) 2 (Public Comment); Meghrigian 9/24 at 85; American Medical Ass'n, Competition in Health Insurance: A Comprehensive Study of U.S. Markets Executive Summary (2003), *at* http://www.ama-assn.org/ama/pub/category/12246.html.

[153] *See* Leibenluft 5/7 at 42-43; Noether 5/7 at 29, 32; MONICA NOETHER ET AL., CHARLES RIVER ASSOCIATES, COMPETITION IN HEALTH INSURANCE AND PHYSICIAN MARKETS: A REVIEW OF "COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF US MARKETS" BY THE AMERICAN MEDICAL ASSOCIATION (2002) (Public Comment) (Submitted by Robert Leibenluft).

[154] *See generally infra* Chapter 6.

[155] *See, e.g.*, Foreman 5/7 at 21-22.

[156] *See, e.g.*, Noether 5/7 at 138; Monica Noether, *Health Insurance/Providers: Countervailing Market Power* (5/7) (slides), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507noether.pdf; Gaynor 5/7 at 138; Greaney 2/27 at 221-222; Matthews 9/24 at 137; Carson-Smith 2/27 at 193; American Bar Ass'n, *Comments Regarding The Federal Trade Commission's Workshop on Health Care and Competition Law and Policy (Oct. 2002)* 10-13 (Public Comment) [hereinafter ABA (public cmt)].

[157] Gaynor 5/7 at 19; Martin Gaynor, *Countervailing Power in Health Care Markets* 12-13 (5/7) (slides), *at* http://www.ftc.gov/ogc/healthcare hearings/docs/030507gaynor.pdf.

[158] *See* Leibenluft 5/7 at 40-46; Robert Leibenluft, *Statement on Behalf of the Antitrust Coalition for Consumer Choice in Health Care* 1-2, 10 (5/7), *at* http://www.ftc.gov/ogc/healthcare hearings/docs/030507liebenluftt.pdf; Robert Leibenluft, *Letter to Member of Congress (Apr. 12, 2002)* (Public Comment) (On Behalf of The Antitrust Coalition For Consumer Choice in Health Care).

[159] *The Quality Health-Care Coalition Act of 1999: Hearing on H.R. 1304 Before the House Comm. on the Judiciary*, 106th Cong. 14 (1999) (Statement of Joel I. Klein, Assistant Attorney General, U.S. Department of Justice) [hereinafter

Former FTC Chairman Robert Pitofsky likewise remarked that "[f]rom a policy and enforcement perspective, the most effective response to the emergence of excessive buyer power is not to permit the aggregation of some form of countervailing power. Rather, the appropriate response is to try to prevent the aggregation of excessive buying power in the first place."[160] As Chapter 6 reflects, the Justice Department has investigated and challenged health insurer mergers that likely would have resulted in monopsony power and challenged health insurers' use of most favored nations clauses in contracts with health care providers.

Panelists agreed that it is preferable to use antitrust enforcement to address monopsony concerns than to allow physicians to accumulate countervailing market power. One panelist stated, for example, that the best policy response to the existence of market power on one side of the market is to remove it on a case-by-case basis.[161] Even a panelist who spoke in favor of allowing countervailing market power noted that restoring competition is the ideal solution to a health insurer's acquisition of monopsony power.[162]

Indeed, even if we assume physicians confront a monopsonist health plan that neither unlawfully acquired nor unlawfully exercised that power, authorizing physicians to engage in collusive conduct will not serve the interests of consumers.[163] A health insurer with monopsony power is likely to impose quantity restrictions that will increase prices for consumers. If providers were to acquire countervailing market power, the result is likely to be further quantity restrictions – increasing the prices paid by consumers above those already imposed by the monopsonist.[164]

Providers that obtain countervailing market power also likely will cause competitive harm to other market participants that do not possess monopsony power. One panelist suggested, for example, that physicians may use their countervailing market power to disadvantage non-physician competitors, such as nurse midwives and nurse anesthetists, or health care insurers other than the monopsonist health care insurer.[165]

The Agencies believe that statutory or other legal changes allowing countervailing market power are ill-advised and unnecessary. To the extent monopsony power exists in some markets, the Agencies and state Attorneys General should address such matters on a case-by-case basis.

DOJ, *H.R. 1304 Statement*], *at* http://www.usdoj.gov/atr/public/testimony/2502.htm.

[160] Robert Pitofsky, Thoughts on "Leveling the Playing Field" in Health Care Markets, Remarks Before the National Health Lawyers Association, Twentieth Annual Program on Antitrust in the Health Care Field (Feb. 13, 1997), *at* http://www.ftc.gov/speeches/pitofsky/nhla.htm.

[161] Gaynor 5/7 at 9; *see also* Noether 5/7 at 32.

[162] Foreman 5/7 at 22, 25.

[163] *But see id.* at 23-24.

[164] *See* Gaynor 5/7 at 12, 13, 16-17; Brewbaker 9/26 at 58 (stating that "it's just as likely that we would see an additional economic welfare loss from the addition of the second monopoly on the seller's side").

[165] Leibenluft 5/7 at 45-46.

c. Physician Collective Bargaining Harms Consumers

The Agencies have consistently opposed the creation of antitrust exemptions for physician collective bargaining. In congressional testimony, the Agencies have identified various ways in which physician collective bargaining likely will harm consumers and other participants in the health care system.[166]

These harms include: (i) consumers and employers facing higher prices for health insurance coverage; (ii) consumers facing higher out-of-pocket expenses as copayments and other unreimbursed expenses increase; (iii) consumers receiving reduced benefits as costs increase; (iv) senior citizens participating in Medicare HMOs receiving reduced benefits; (v) the federal government paying more for health coverage for its employees; (vi) state and local governments incurring higher costs to provide health benefits to their employees; (vii) state Medicaid programs incurring higher costs to provide health benefits, forcing them to increase taxes, cut benefits, or reduce the number of beneficiaries; and (viii) the number of uninsured increasing due to more costly health insurance. The balance of this section focuses on the impact of physician collective bargaining on cost and quality.

Collective bargaining is likely to increase substantially the price of health care services, because providers collectively are likely to demand higher fees and refuse to negotiate individually.[167] The Agencies have extensive experience with the consequences of alleged physician collective bargaining. For example, the Commission alleged approximately 500 physicians and 15 hospitals that comprised the vast majority of providers covering a large area of southern Georgia conspired to fix prices and not to deal with payors on an individual basis.[168] According to the complaint, respondents restrained competition among the providers and forced payors to pay higher prices to its providers, thereby increasing the cost of healthcare for consumers.[169]

In *United States v. Federation of Physicians And Dentists*, the Division alleged that the Federation had successfully recruited virtually all of the private practice orthopedic surgeons in Delaware, who ultimately agreed to designate the Federation as their exclusive agent to negotiate fee levels with a particular payor. The Federation then organized nearly all of its members to terminate their contracts with

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[166] *Prepared Statement Concerning the "Quality Health-Care Coalition Act of 1999": Hearing on H.R. 1304 Before the House Comm. on the Judiciary*, 106th Cong. 5 (1999) (Statement of Robert Pitofsky, Chairman, Federal Trade Commission) [hereinafter, FTC, *H.R. 1304 Statement*], *at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm; DOJ, *H.R. 1304 Statement*, *supra* note 159, at 5.

[167] FTC, *H.R. 1304 Statement*, *supra* note 166; Brewbaker, *supra* note 138, at 549-50 ("Legalized collective bargaining would permit physician unions to function as doctors' cartels, raising physician fees and organizing professional boycotts of MCOs and other institutions.").

[168] *In re* S. Ga. Health Partners, L.L.C., No. C-4100 (Oct. 31, 2003) (decision and order), *available at* http://www.ftc.gov/os/2003/11/sgeorgiado.pdf.

[169] *In re* S. Ga. Health Partners, L.L.C., No. C-4100 (Oct. 31, 2003) (complaint), *available at* http://www.ftc.gov/os/2003/11/sgeorgiacomp.pdf.

this payor with the expectation that this would force that payor to accede to their fee demands.[170] There are many other examples of such conduct.[171]

The Congressional Budget Office (CBO) estimated that proposed federal legislation to exempt physicians from antitrust scrutiny and allow collective bargaining "would increase expenditures on private health insurance by 2.6 percent."[172] The CBO also predicted that such legislation would increase direct federal spending on healthcare programs such as Medicaid by $11.3 billion and decrease tax revenue by $10.9 billion over ten years.[173] Other estimates of the cost of an antitrust waiver were substantially higher.[174] Physician groups have argued that the actual cost of physician collective bargaining is likely to be modest.[175]

Whatever the impact on costs, proponents of antitrust exemptions for physicians often suggest that collective bargaining will result in increased quality of care.[176] However, physician collective bargaining has historically focused on physician compensation and not on patient care issues.[177] Moreover, as Chapter 1 explains, current antitrust law already permits physicians to work collectively on legitimate quality of care issues. Given these considerations, physician collective

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[170] *See* R. Hewitt Pate, *Opening Day Comments* (2/26), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030226pate.pdf; *see also* United States v. Fed'n of Physicians & Dentists, Inc., 2002-2 Trade Cas. (CCH) ¶ 73,868 (D. Del., 2002).

[171] *See supra* Chapter 1.

[172] CONG. BUDGET OFFICE, 106TH CONG., H.R. 1304: QUALITY HEALTH-CARE COALITION ACT OF 1999, at 2 (Cost Estimate, Mar. 15, 2000), *at* ftp://ftp.cbo.gov/18xx/doc1885/hr1304.pdf.

[173] *Id.*

[174] *See* HEALTH INSURANCE ASS'N OF AMERICA, THE COST OF PHYSICIAN ANTITRUST WAIVERS (2002) (incorporating findings of CHARLES RIVER ASSOCIATES, THE NATIONAL COST OF PHYSICIAN ANTITRUST WAIVERS (2002) (5 percent to 7 percent increase)); H.E. FRECH III & JAMES LANGENFELD, THE IMPACT OF ANTITRUST EXEMPTIONS FOR HEALTH CARE PROFESSIONALS ON HEALTH CARE COSTS 3-4 (2000) (Prepared for the American Ass'n of Health Plans) (estimating "that H.R. 1304 will increase health care expenditures by $141 billion over a five year period, or 8.6 percent of private health care costs during its peak year" and "that by 2003 the bill would cause approximately 3 million more individuals to become uninsured."), *at* http://www.aahp.org/DocTemplate.cfm?Section=Antitrust&template=/ContentManagement/ContentDisplay.cfm&ContentID=1849.

[175] William S. Brewbaker III, *Will Physician Unions Improve Health System Performance?*, 27 J. HEALTH POL. POL'Y & L. 575, 597 (2002); *see generally* Jacqueline M. Darrah, *Perspectives on Competition Policy and the Health Care Marketplace* 11 (2/27) ("However you cut the pie, physician costs today are simply not a significant factor driving growth in overall healthcare costs."), *at* http://www.ama-assn.org/ama1/pub/upload/mm/368/febftctestimony.pdf.

[176] Monique A. Anawis, *The Ethics of Physician Unionization: What Will Happen If Your Doctor Becomes a Teamster?*, 6 DEPAUL J. HEALTH CARE L. 83, 87 (2002); Brewbaker, *supra* note 175, at 585-86; Jeffrey Rugg, *An Old Solution to a New Problem: Physician Unions Take the Edge Off Managed Care*, 34 COLUM. J.L. & SOC. PROBS. 1, 7 (2000); Levy 9/26 at 41, 44-46; Flaherty 9/26 at 74-75.

[177] *See, e.g.,* Brewbaker, *supra* note 175, at 588-594; Brewbaker, *supra* note 138, at 575-577 (noting that the principal purpose of unionization is to enhance the working conditions of the unionized employees, with salary a major bargaining point).

bargaining is unlikely to improve the quality of care that consumers receive.[178]

C. Licensure, Market Entry, and Practice Restrictions

Licensure impacts marketplace competition. Through licensure requirements, states may restrict market entry by physicians and allied health professionals (AHPs), and further limit the scope of authorized practice.[179] Most state licensing boards are primarily composed of licensed providers, although some states require broader representation.[180] The Commission recently initiated administrative litigation against a state licensing board, alleging that it had taken steps unlawfully to restrict AHPs from obtaining direct access to consumers.[181]

Many states have only limited or no reciprocity for licensing out-of-state physicians and AHPs seeking to practice in-state.[182] A number of state licensing boards have also sought to restrict the practice of telemedicine. This section considers each of these issues and recommends strategies for addressing the anticompetitive risks of state regulation of the nature and form of professional practice.

1. Mechanisms to Regulate Physician and AHP Market Entry

The states have traditionally assumed responsibility for regulating physicians and AHPs using three distinct mechanisms: (i) occupational licensing or licensure; (ii) certification; and (iii) registration.[183] Licensure, the most restrictive method of regulation, typically involves a mandatory system of state-imposed standards that practitioners must meet to practice a given

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[178] *See* Roger D. Blair & Jill Boylston Herndon, *Physician Cooperative Bargaining Ventures: An Economic Analysis*, 71 ANTITRUST L.J. 989, 1014-15 (2004).

[179] AHPs are individuals trained to support, complement, or supplement the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients. They include physician assistants, dental hygienists, medical technicians, nurse midwives, nurse practitioners, physical therapists, psychologists, and nurse anesthetists. PATRICIA FRANKS ET AL., UNIV. OF CALIFORNIA, ALLIED HEALTH: 1970S-2000S: A REVIEW OF KEY REPORTS 23-24 (2002) (citing U.S. DEP'T OF HEALTH, EDUCATION, & WELFARE, A REPORT ON ALLIED HEALTH PERSONNEL, DHEW NO. (HRA) 80-28 (1979)), *at* http://www.futurehealth.ucsf.edu/pdf_files/Allied%20Health%20Key%20Reports%207-30-02%20final.101502.doc. *See also* Ass'n of Schools of Allied Health Professionals, *Definition of Allied Health*, *at* http://www.asahp.org/definition.html (last visited July 8, 2004); Hawkinson 9/25 at 42-44 (describing the education, role, and expertise of physician assistants).

[180] INSTITUTE OF MEDICINE (IOM), ALLIED HEALTH SERVICES: AVOIDING CRISES 238, 241 (1989), *available at* http://books.nap.edu/books/0309038960/html/R1.html#pagetop.

[181] *See, e.g.*, *In re* S.C. Bd. of Dentistry, No. 9311, at 1 (Sept. 12, 2003) (complaint), *available at* http://www.ftc.gov/os/2003/09/socodentistcomp.pdf.

[182] U.S. DEP'T OF HEALTH & HUMAN SERVICES, TELEMEDICINE REPORT TO CONGRESS 21-24 (2001) [hereinafter HHS, TELEMEDICINE (2001)], *available at* http://telehealth.hrsa.gov/pubs/report2001/2001REPO.PDF; American Medical Ass'n (AMA), *Physician Licensure: An Update of Trends*, *at* http://www.ama-assn.org/ama/pub/category/2378.html#introduction (last updated Sept. 4, 2003).

[183] *See* IOM, *supra* note 180, at 235-37; Sue A. Blevins, *The Medical Monopoly: Protecting Consumers or Limiting Competition?* 7 (Cato Institute, Policy Analysis No. 246, 1995), *at* http://www.cato.org/pubs/pas/pa-246.html.

profession.[184] Autonomous boards, comprised largely of members of the regulated profession, determine applicants' eligibility requirements, develop standards of practice, and enforce disciplinary actions.[185] Physicians and other licensed professionals must satisfy these requirements to practice within the state.

Certification generally refers to a voluntary system of standards that practitioners can choose to meet to demonstrate accomplishment or ability in their profession.[186] Nongovernmental agencies or associations typically set certification standards.[187] Certified health professionals may use a predetermined title. Uncertified health professionals may still practice within the field but may not use the relevant title.[188] Certification can serve as a substitute for and a complement to licensure. Many physicians become board certified within a specialty, in order to establish that they have an appropriate level of knowledge, skills, and experience.[189]

Registration is the least restrictive mechanism for regulating health care professionals because individuals simply must file their name, address, and qualifications with a government agency to practice.[190] Professionals generally are not required to meet educational or experience requirements to practice under a registration system.[191]

a. Regulation's Impact on Cost, Quality, and Access

Commentators state that limits on

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[184] Morris M. Kleiner, *Occupational Licensing*, 14 J. ECON. PERSP. 189, 191 (2000). For a discussion of the state action doctrine issues that licensure raises, see *infra* note 286, and accompanying text, and *infra* Chapter 8.

[185] *See* BENJAMIN SHIMBERG ET AL., OCCUPATIONAL LICENSING: PRACTICES AND POLICIES 14 (1972) (stating that licensing boards "serve as gatekeepers to determine the qualifications and competence of applicants" and ensure "that standards are adhered to by practitioners and, when necessary, adjudicate disputes between the public and members of the regulated occupation."); CAROLYN COX & SUSAN FOSTER, FEDERAL TRADE COMM'N, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION 1, 3 (1990); National Council of State Boards of Nursing, Inc., *Comments Regarding Hearings on Health Care and Competition Law and Policy (July 31, 2003)* (Public Comment) (Submitted by Donna M. Dorsey).

[186] SHIMBERG ET AL., *supra* note 185, at9 (citing U.S. DEP'T OF HEALTH, EDUCATION, & WELFARE, REPORT ON LICENSURE AND RELATED HEALTH PERSONNEL CREDENTIALING (1971)).

[187] *Id. See also* Nat'l Council of State Boards of Nursing, Inc., *Comments Re: Letter from the National Boards for Certification of Hospice and Palliative Nurses (Jan. 8, 2004)* (Public Comment) (Submitted by Donna M. Dorsey).

[188] COX & FOSTER, *supra* note 185, at 43; Blevins, *supra* note 183, at 7; Kleiner 6/10 at 35.

[189] *See* American Medical Ass'n, *Becoming An M.D.*, *at* http://www.ama-assn.org/ama/pub/category/2320.html (last updated Dec. 4, 2003); Bureau of Labor Statistics, U.S. Dep't of Labor, *Physicians and Surgeons*, *at* http://www.bls.gov/oco/ocos074.htm (last modified Feb. 27, 2004).

[190] *See* Blevins, *supra* note 183, at 7; COX & FOSTER, *supra* note 185, at 49; MINNESOTA OFFICE OF THE LEGISLATIVE AUDITOR, OCCUPATIONAL REGULATION (99-05), at xii (1999), *available at* http://www.auditor.leg.state.mn.us/ped/pedrep/9905-all.pdf.

[191] COX & FOSTER, *supra* note 185, at 49.

entry increase health care costs.[192] However, commentators and panelists disagreed on the effects of licensing on quality of care. Several commentators contend that a state-enforced minimum quality standard is an efficient response to the "limited information patients have about quality and the relatively high costs of obtaining information."[193] Another commentator noted that "[o]ccupational licensure creates a greater incentive for individuals to invest in more occupation-specific human capital because they will be more able to recoup the full returns to their investment if they need not face low-quality substitutes for their services."[194] Others argue that licensure may not improve quality of care because the requirements do not correspond to the factors that influence quality.[195] Moreover, some maintain that licensure may decrease the overall quality of care that consumers receive by increasing prices, which can cause some consumers to forego care.[196]

Empirical studies have found that licensing regulation increases costs for consumers.[197] There are fewer studies on the impact of licensure on quality, and these studies have found mixed results.[198] One study found that licensure requirements can reduce the likelihood of adverse outcomes and increase quality of care.[199] Another study found that consumers in states with tougher licensure requirements do not receive higher quality care, because the resulting increase in the price of care limits consumer access.[200] A third study found that licensure benefits the segment of consumers who place more emphasis on quality.[201]

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[192] *See* Kleiner 6/10 at 42; COX & FOSTER, *supra* note 185, at vi ("Mandatory entry requirements and business practice restrictions increase the cost of providing professionals' services and, as result, increase prices as well.").

[193] SHERMAN FOLLAND ET AL., THE ECONOMICS OF HEALTH CARE 343 (2004); *see also* COX & FOSTER, *supra* note 185, at 4-16 (discussing rationales for licensure including asymmetric information on quality, externalities, and the dual role of professional as diagnostician and treatment specialist).

[194] Kleiner, *supra* note 184, at 191.

[195] COX & FOSTER, *supra* note 185, at vii; Kleiner 6/10 at 37-38.

[196] *See, e.g.*, Lawrence Shepard, *Licensing Restrictions and the Cost of Dental Care*, 4 J.L. & ECON. 185 (1978).

[197] *See, e.g.*, Kleiner 6/10 at 42; Morris M. Kleiner, *Occupational Licensing and Health Services: Who Gains and Who Loses?* 5-6 (6/10) (slides) (discussing study) [hereinafter Kleiner Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030610kleiner.pdf.

[198] *See* Kleiner 6/10 at 39-40; Kleiner, *supra* note 184, at 197.

[199] Kleiner Presentation, *supra* note 197, at 5-6.

[200] Morris M. Kleiner & Robert T. Kudrle, *Does Regulation Affect Economic Outcomes? The Case of Dentistry*, 43 J.L. & ECON. 547 (2000); *see also* Sidney L. Carroll & Robert J. Gaston, *Occupational Restrictions and the Quality of Service Received: Some Evidence*, 47 S. ECON. J. 959 (1981) (finding that licensure of electricians increased the number of electrocutions because consumers responded to the increased prices of licensed electricians by doing repairs themselves); Kleiner 6/10 at 42 (discussing the "Mercedes Benz effect" of licensure, which enables consumers to "get a high quality service . . . or no service at all because no other services are legally available.").

[201] *See* Kleiner Presentation, *supra* note 197, at 5-6; *see also* Lomazow 6/10 at 259-60 ("[T]his whole issue of lesser trained versus more trained . . . simply flies in the face of logic. I mean, and you can

Studies consistently have found that state-based licensure can harm consumer welfare by serving as a barrier to provider mobility.[202]

b. Certification's Impact on Cost, Quality, and Access

Some commentators state that certification, rather than licensure, is a better way to protect quality, increase consumer choice, broaden access to care, and enhance market competition.[203] They state that providing consumers with a choice of certified or uncertified providers allows consumers to receive care they might forego under a licensure regime.[204] Some commentators also contend that certification spurs competition and innovation by creating increased opportunities for market entry.[205]

Others argue, however, that certification does not adequately protect consumers from low quality care and suggest that consumers may not factor in certain externalities when they select uncertified health care providers.[206] Moreover, if health plans only choose to cover certified health care providers, a certification regime may not markedly increase the choices available to consumers.

There currently is insufficient empirical evidence to assess whether certification provides many of the benefits of licensure with fewer disadvantages.[207] The Agencies encourage further study of the advantages and disadvantages of these two methods for regulating physician and AHP market entry.

2. AHPs and Provider Control of Licensure Boards

Most state statutes delegate authority for establishing and enforcing licensure standards to state Boards of Medical Examiners.[208] These boards typically

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talk about studies and studies and studies, but it's just illogical. You want the best. You want the people that are best trained, the best qualified to do the thing. Do you want a certified plumber or do you want some guy next door to come over?").

[202] *See* Stanley J. Gross, *Professional Licensure and Quality: The Evidence* (Cato Institute, Policy Analysis No. 79, 1986) (citing studies on the effects of professional licensing arrangements on mobility in discussion of "Interstate Mobility"), *at* http://www.cato.org/pubs/pas/pa079.html; Kleiner, *supra* note 184, at 198; Kleiner 6/10 at 39, 49 (discussing the role of the Federal government and practitioners in monitoring provider mobility and licensure standards); Gingrich 6/12 at 16-17.

[203] *See, e.g.*, COX & FOSTER, *supra* note 185, at 44-45.

[204] *See generally id.*

[205] *See, e.g.*, *id.* at 45; Nat'l Board for Certification of Hospice & Palliative Nurses, *NBCHPN Response to Hearings on Health Care and Competition Law and Policy Regarding Advanced Practice Registered Nurse Task Force of the National Council for State Boards of Nursing, Inc. (Sept. 30, 2003)* 1-5 (Public Comment).

[206] *See* COX & FOSTER, *supra* note 185, at 45 ("[C]ertification may not lessen quality problems associated with externalities (footnote omitted). A consumer who chooses a noncertified doctor, for example, may not take into account the possible effect of his quality decision on others . . . .").

[207] *See* Morrisey 6/10 at 254.

[208] AMA, *supra* note 182; Blevins, *supra* note 183, at 7 ("Professional health care associations have been influential in setting the standards for licensure laws in the United States.").

promulgate regulations governing physicians and related AHPs.[209] Because most board members are industry participants with economic interests at stake, the potential exists for the board to make decisions that are contrary to consumers' interests.[210] Panelists and commentators have identified varying ways in which provider-controlled state-based licensure boards can limit competition and harm consumers.[211]

A panelist representing a dental hygienists' trade association described the efforts of certain Boards of Dentistry to prevent dental hygienists from obtaining direct access to consumers.[212] This panelist stated that such Boards determinedly seek to maintain control over dental hygienists and contended that this control denies consumers access to dental care.[213]

This panelist also asserted that the Boards of Dentistry in certain states have prevented dental hygienists from obtaining direct payment, despite those states' Departments of Health authorizing such hygienists to provide certain services to

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[209] Fed'n of State Medical Boards, *Getting a License - The Basics*, *at* http://www.ama-assn.org /ama/pub/category/2644.html (last updated Sept. 29, 2003); Byrd 6/10 at 67.

[210] *See* COX & FOSTER, *supra* note 185, at 1 ("Although the professions may seek to benefit consumers, the possibility of a conflict of interest exists. The regulators, in many cases, have a financial interest in the profession they are regulating. Since professionals' self-interest may not coincide with the public's best interest, many have come to regard self-regulation with growing skepticism."); IOM, *supra* note 180, at 241; Apold 6/10 at 119; Bauer 6/10 at 227; Carolyn Buppert, *Comments Regarding Competition Law and Policy & Health Care (Aug. 30, 2002)* (Public Comment); American Congress on Electroneuromyography, *Comments Regarding Health Care and Competition Law and Policy (July 15, 2003)* (Public Comment); Melissa M. English, *Comments Re: Anti-Competition Practives (July 22, 2003)* (slides) 1-2 (Public Comment).

[211] *See* Gross, *supra* note 202 (discussing empirical studies that have found "licensing has had a profoundly negative effect" on the utilization of paraprofessionals); Apold 6/10 at 119. Commentators and panelists also discussed other barriers to entry for AHPs. *See* Mallon 6/10 at 187-188; Newman 6/10 at 203-205; Lynne Odell-Holzer, *Comments Regarding FTC/DOJ Hearings Regarding Anticompetitive Practices in Healthcare Industry* (Public Comment); Joe Holzer, *Comments Regarding Hearings on Healthcare Competition Law and Policy (July 10, 2003)* (Public Comment); Christine A. Sullivan, *Comments Regarding Hearings on Health Care Competition Law and Policy (Sept. 19, 2003)* (Public Comment); Cathryn Wright, *Comments Regarding Hearings on Health Care Competition Law and Policy (July 22, 2003)* (Public Comment); American Ass'n of Nurse Anesthetists, *Comments Regarding Hearings on Health Care and Competition Law and Policy (Nov. 20, 2003)* (Public Comment) (Submitted by Frank Purcell); American Ass'n of Nurse Anesthetists, *New Economic Perspectives on the Market for Anesthesia Services: Achieving Desired Reforms Through Fair Competition, Nov. 2003* (Public Comment) (Presented by Jeffrey C. Bauer); American Chiropractic Ass'n, *Comments Regarding Health Care and Competition Law and Policy (Nov. 24, 2003)* (Public Comment) (Submitted by Donald J. Krippendorf & George B. McClelland). *But see* American Medical Ass'n, *Health Care and Competition Law and Policy – Quality and Consumer Information: Market Entry (June 10, 2003)* (Public Comment); Frank A. Sloan & Roger Feldman, *Competition Among Physicians*, *in* COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE: PROCEEDINGS OF A CONFERENCE SPONSORED BY THE BUREAU OF ECONOMICS , FEDERAL TRADE COMMISSION pt.2, at 57-131 (Warren Greenberg ed., 1978).

[212] *See* Byrd 6/10 at 67-70, 75.

[213] *See id.* at 69-70.

consumers without a dentist's supervision.[214] These arrangements, argued the panelist, increase dental costs and decrease consumers' access to dental care.[215]

The Commission recently alleged the South Carolina State Board of Dentistry "restrained competition in the provision of preventive dental care services by unreasonably restricting the delivery of dental cleanings, sealants, and topical fluoride treatments in school settings by licensed dental hygienists."[216] The Board contends that its challenged actions were necessary to protect school children from substandard care, including possible injury.[217]

Many commentators state that widening the membership of state licensure boards will decrease the probability that provider-dominated licensure boards will harm competition.[218] The Institute of Medicine (IOM) recommended that "states strengthen the accountability and broaden the public base of their regulatory statutes and procedures."[219] In particular, the IOM recommended that "[l]icensing boards should draw at least half of their membership from outside the licensed occupation; members should be drawn from the public as well as from a variety of areas of expertise such as health administration, economics, consumer affairs, education, and health services research."[220]

States should consider adopting the IOM's recommendation to expand the membership of state licensure boards. Such reform may reduce the possibility that these boards will engage in conduct that increases prices or decreases access to health care.

3. State Restrictions on the Interstate Practice of Telemedicine

Interstate communications between health professionals historically have not been subject to licensing requirements.[221]

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[214] *Id.* at 74.

[215] *Id.* at 74-75, 135 (stating that "the people that are suffering the most [from restrictions on direct payment] are our elderly and our underprivileged and our school children who don't have access to offices on Monday through Thursday from eight to five.").

[216] *In re* S.C. Bd. of Dentistry, No. 9311, at 1 (Sept. 12, 2003) (complaint), *at* http://www.ftc.gov/os/2003/09/socodentistcomp.pdf. For discussion of the state action issues this case raises, see *infra* note 286, and accompanying text, and *infra* Chapter 8. *See generally* Loeffler 6/10 at 79.

[217] *In re* S.C. Bd. of Dentistry, No. 9311, at 8 (Oct. 22, 2003) (memorandum to support motion to dismiss), *at* http://www.ftc.gov/os/adjpro/d9311/031021scdentmemoinsupdismiss.pdf.

[218] IOM, *supra* note 180, at 249 ("Widening the membership of regulatory boards has been one of the most consistent recommendations made by critics of state occupational regulation (e.g., Public Health Service, 1977; Begun, 1981; Cohen, 1980; Shimberg, 1982).").

[219] *Id.* at 256.

[220] *Id*.

[221] U.S. DEP'T OF HEALTH & HUMAN SERVICES, TELEMEDICINE REPORT TO CONGRESS § III.B. (1997) (noting that physician-to-physician communication can take varied forms including "the mailing of x-rays, clinical histories and pathological and laboratory specimens for evaluation and interpretation, and oral or written inquiries to another

As the Department of Health and Human Services (HHS) noted, "the consulted physician or other health professional [was] regarded either as practicing medicine only in his or her home state or as exempt from licensure under the 'consultation exception' in the patient's state."[222] Developments in technology have facilitated the practice of telemedicine, which involves the use of electronic communication and information technologies to provide or support clinical care at a distance.[223]

Telemedicine can benefit consumers in at least three ways.[224] First, telemedicine can give physicians and other health care professionals the ability to provide high quality medical services to rural or other underserved areas.[225]

Second, telemedicine can significantly reduce a range of health-care-related costs, including travel expenses and costs arising from the duplication of services, technologies, and specialists.[226] With telemedicine, for example, a single pathologist can provide services to a number of locations. Finally, telemedicine networks can enhance training and education in new technologies for health care professionals, particularly for those located in rural areas.[227] After surveying empirical studies on the costs and benefits of telemedicine, HHS observed "there may be real cost savings to be realized from telemedicine."[228]

Telemedicine can harm consumers in at least four ways. First, telemedicine can subject consumers to substandard care,

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out-of-state physician involved in the patient's care or in the form of a specific consultative request to a physician with special expertise") [hereinafter HHS, TELEMEDICINE (1997)], *available at* http://www.ntia.doc.gov/reports/telemed; AMA, *supra* note 182.

[222] *See* HHS, TELEMEDICINE (1997), *supra* note 221, § III.B.

[223] *See* HHS, TELEMEDICINE (1997), *supra* note 221, § I.A.; *see also* INSTITUTE OF MEDICINE, TELEMEDICINE: A GUIDE TO ASSESSING TELECOMMUNICATIONS IN HEALTH CARE 16 (1996).

[224] Telemedicine is not subject to the risks of Internet fraud that have led the Commission to bring over 300 law enforcement cases involving auction fraud, investment fraud, "Nigerian scams," cross-border Internet fraud and identity theft. *See generally Prepared Statement on Efforts to Fight Fraud on the Internet: Before the S. Spec. Comm. on Aging*, 108th Cong. (Mar. 23, 2004) (Statement of Howard Beales, Director of the Bureau of Consumer Protection, Federal Trade Commission), *at* http://www.ftc.gov/os/2004/03/bealsfraudtest.pdf; GENERAL ACCOUNTING OFFICE, INTERNET PHARMACIES: SOME POSE SAFETY RISKS FOR CONSUMERS AND ARE UNRELIABLE IN THEIR BUSINESS PRACTICES (2004), *available at* http://www.gao.gov/new.items/d04888t.pdf.

[225] *See* HHS, TELEMEDICINE (1997), *supra* note 221, § I.A. ("Telemedicine also has the potential to improve the delivery of health care in America by bringing a wider range of services such as radiology, mental health services and dermatology to underserved communities and individuals in both urban and rural areas."); Waters 10/9 at 639-40; Parente 10/9 at 640-41.

[226] *See, e.g.,* Waters 10/9 at 617; Parente 10/9 at 640-41.

[227] HHS, TELEMEDICINE (1997), *supra* note 221, § I.A. ("[T]elemedicine can help attract and retain health professionals in rural areas by providing ongoing training and collaboration with other health professionals.").

[228] HHS, TELEMEDICINE (2001), *supra* note 182, at 41, 44-45; *see also* Parente 10/9 at 641; Waters 10/9 at 652-53.

possibly from unlicensed providers.[229] Individual states have a legitimate interest in ensuring that out-of-state health professionals meet the same standards as professionals licensed within the state.[230] Second, providers could use telemedicine to perpetrate fraud against consumers.[231] Third, "[t]elemedicine consultations might involve personal medical records being shipped over computer lines to other regions of the country," creating privacy and confidentiality concerns.[232] Finally, "[t]here is significant uncertainty regarding whether malpractice insurance policies cover services provided by telemedicine."[233]

The practice of telemedicine has thus crystallized tensions between the states' role in ensuring patients have access to quality care and the anticompetitive effects of protecting in-state physicians from out-of-state competition.[234] Many states have responded to telemedicine by enacting legislation to restrict such practices. HHS reported that 11 states had implemented laws restricting the interstate practice of telemedicine in 1997, and 26 states had implemented such laws by 2001.[235] These states mostly require a physician to obtain either a special license to engage in the out-of-state practice of medicine or a full unrestricted state medical license.[236] Some contend these laws may create a barrier to entry that significantly increases costs and decreases access without improving quality of care for physicians who want to practice telemedicine.[237]

Commentators have debated varied approaches to encourage the practice of telemedicine. Some have argued that

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[229] *See* FLA. STAT. ch. 456.065 (1) (2004); Gary Winchester, Executive Summary, Prepared for the Federal Trade Commission Office of Policy Planning, Public Workshop: Possible Anticompetitive Efforts to Restrict Competition on the Internet 3 (Oct. 9, 2002), *at* http://www.ftc.gov/opp/ecommerce/anticompetitive/panel/winchester.pdf; Winchester 10/9 at 624-25, 643-44.

[230] HHS, TELEMEDICINE (1997), *supra* note 221, § III.C.

[231] *See, e.g.*, Winchester 10/9 at 624-25; Stephen Parente, *A Review of the Internet-Enabled Medical Marketplace*, Written Statement Prepared for the Federal Trade Commission Office of Policy Planning, Public Workshop: Possible Anticompetitive Efforts to Restrict Competition on the Internet 2 (Oct. 9, 2002), *at* http://www.ftc.gov/opp/ecommerce/anticompetitive/panel/parente.pdf.

[232] Edward T. Schafer, *Telemedicine: An Emerging Technology With Exciting Opportunities for North Dakota*, 73 N. DAK. L. REV. 199, 204 (1997); Roman J. Kupchynsky II & Cheryl S. Camin, *Legal Considerations of Telemedicine*, 64 TEX. B. J. 20, 27-28 (2000).

[233] WESTERN GOVERNORS' ASS'N, TELEMEDICINE ACTION REPORT (1995); Parente 10/9 at 642-43.

[234] AMA, *supra* note 182; Parente, *supra* note 231, at 4-5.

[235] HHS, TELEMEDICINE (2001), *supra* note 182, at 21; *see also* AMA, *supra* note 182; Robert J. Waters, *Anticompetitive Efforts to Restrict Telehealth Services on the Internet*, Written Statement Prepared for the Federal Trade Commission Office of Policy Planning, Public Workshop: Possible Anticompetitive Efforts to Restrict Competition on the Internet 8-15 (Oct. 9, 2002), *at* http://www.ftc.gov/opp/ecommerce/anticompetitive/panel/waters.pdf.

[236] *See* AMA, *supra* note 182; HHS, TELEMEDICINE (2001), *supra* note 182, at 21; Waters 10/9 at 619-22 (discussing Oregon, Texas and Nevada).

[237] *See, e.g.*, Parente, *supra* note 231, at 4-5; Parente 10/9 at 619.

Congress should pass national telemedicine licensure laws to stop individual states from protecting the economic interests of their providers to the detriment of their citizens' access to healthcare.[238] Others contend that telemedicine should be regulated on a state-by-state basis.[239] The American Telemedicine Association (ATA) has proposed an alternative, which it argues is "a compromise between full national licensure and state-imposed unreasonable barriers" to telemedicine.[240] The ATA contends that states should regulate physical face-to-face encounters between physicians and patients within state borders, but not virtual consultations across state borders. They also recommend that states should not restrict a duly licensed physician from consulting a physician in another state.

When used properly, telemedicine has considerable promise as a mechanism to broaden access, lower costs, and increase healthcare quality. When used improperly, telemedicine has the potential to lower health care quality and increase the incidence of consumer fraud. To foster telemedicine's likely pro-competitive benefits and to deter its potential to harm consumers, states should consider implementing uniform licensure standards or reciprocity compacts. Uniform licensure standards and reciprocity compacts could operate both to protect consumers and to reduce barriers to telemedicine. State regulators and legislators should explicitly consider the pro-competitive benefits of telemedicine before restricting it.

IV. ANTITRUST ENFORCEMENT IN THE PHYSICIAN MARKETPLACE

This section examines the application of competition law to the marketplace for physician services. It first discusses the significance of private antitrust litigation involving physician privileges and credentialing. The section then discusses the Agencies' analysis of provider network joint ventures, focusing on market developments in financial and clinical integration. Finally, this section addresses the ability of physicians to share and use quality-related information and the application of the state action doctrine to licensure and physician collective bargaining.

A. Private Litigation Involving Physician Privileges and Credentialing

The most common type of private healthcare-related antitrust litigation raises physician privilege or credentialing issues.[241]

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[238] *See, e.g.,* Parente 10/9 at 615-616.

[239] *See* AMA, *supra* note 182.

[240] *ATA Policy Regarding State Medical Licensure: Hearings on Telemedicine Before the Subcomm. on Sci., Tech. & Space, S. Comm. on Commerce, Sci. & Transp.*, 106th Cong. (1999) (Attachment to Statement of Dr. Ronald K. Poropatich, Member, Board of Directors, American Telemedicine Association), *at* http://www.senate.gov/~commerce/hearings/0915por2.pdf; *see also* Waters 10/9 at 618-620.

[241] Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 568 (2002) (noting that 35 percent of health care antitrust disputes involving quality between 1985 and 1999 raised these issues). The Commission has brought enforcement actions involving physician privileging and credentialing issues. *See In re* Med. Staff of Mem'l Med. Ctr., 110 F.T.C. 541 (1988) (consent order) (alleging the

These cases usually involve physicians asserting that a hospital and/or its physician peer review committee denied them privileges for anticompetitive reasons.[242] Physicians with hospital privileges may also sue hospitals and/or their peer review committee because these privileges have been revoked or curtailed.

Commentators state that the courts largely have been "inhospitable" to these cases, except when there has been "clear evidence of bad faith by rival physicians on the hospital's medical staff[, which has] resulted in large damage awards."[243] An empirical study found that plaintiff physicians prevail in only seven percent of these cases.[244] One set of commentators are concerned, however, that these "staff privileges cases have had problematic effects on the legal analysis of quality-based competition" because the "courts began using quality to remove conduct from the purview of competition law, rather than factoring quality into an overall competitive mix."[245]

Congress created an antitrust safe harbor for peer review decisions involving quality that meet certain procedural requirements in the *Health Care Quality Improvement Act of 1986*.[246] This legislation also enabled prevailing defendants to seek recovery of attorney's fees. The number of physician privilege antitrust cases dropped by approximately 10 percent in the decade following the passage of this Act.[247]

B. Provider Network Joint Ventures

The antitrust analysis of joint ventures and multi-provider networks has received considerable attention from the Agencies and commentators in recent years.[248] This issue is not unique to health care; as the Commission recently stated, "no analytical exercise is more important to U.S. competition policy than defining the bounds of acceptable cooperation between direct rivals."[249] As noted previously, the Agencies

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medical staff of a hospital in Savanna, Georgia, acting through its credentials committee, conspired to suppress competition by denying a certified nurse-midwife's application for hospital privileges without a reasonable basis); *In re* Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order).

[242] For a description of physician peer review processes, *see* Hammer & Sage, *supra* note 241, at 619. *See generally* Meghrigian 9/24 at 83-84. *See also* American College of Nurse-Midwives, *Addendum of Cases and Articles For Statement of Lynne Loeffler for the American College of Nurse-Midwives* (Public Comment).

[243] Sage et al., *Why Competition Law Matters To Health Care Quality*, 22 HEALTH AFFAIRS 31, 37 (Mar./Apr. 2003).

[244] Hammer & Sage, *supra* note 241, at 575. The authors note that these figures raise questions about the extent to which private counsel inform clients of their dismal prospects before pursuing such cases. *See id.* at 601.

[245] Sage et al., *supra* note 243, at 37.

[246] 42 U.S.C. S. § 11151 (1986).

[247] Hammer & Sage, *supra* note 241, at 569, 597, 619. Although the number of cases dropped after this legislation's passage, the success rate for plaintiffs did not change. *Id.*

[248] *See, e.g.*, Thomas L. Greaney, *A Perfect Storm on the Sea of Doubt: Physicians, Professionalism and Antitrust*, 14 LOY. CONSUMER L. REV. 481 (2002).

[249] *In re* Polygram Holding, Inc., 5 Trade Reg. Rep. (CCH) ¶ 15,453 at 22,456 (FTC 2003), *available at* http:www.ftc.gov/os/2003/07/poly

have brought numerous enforcement actions against physician networks, and also issued statements, advisory opinions, and business review letters on this subject.

1. The Agencies' Antitrust Analysis of Provider Network Joint Ventures

Health Care Statement 8 describes how the Agencies evaluate physician network joint ventures. This statement sets forth antitrust safety zones for exclusive and non-exclusive physician network joint ventures that, absent extraordinary circumstances, the Agencies are unlikely to challenge. *Statement* 8 then outlines the analytical framework for joint ventures that fall outside the antitrust safety zones. It states that like transactions in other sectors of the economy, "physician network joint ventures will be analyzed under the rule of reason, and will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies."[250]

This statement further notes that financial risk-sharing and clinical integration may involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies. Finally, *Statement* 8 outlines the Agencies' rule of reason analytical framework and applies the principles set forth in the statement to seven examples of physician network joint ventures.[251]

2. Financial Integration

Statement 8 notes that financial risk sharing can generate significant efficiencies by providing physicians with incentives to cooperate in controlling the cost and improving the quality of services they render. It provides examples of arrangements through which participants in a physician network joint venture can share substantial financial risk, including capitation, global fee arrangements, fee-withholds, and cost or utilization-based bonuses or penalties.[252] *Statement* 8 also establishes that only those physician networks that share substantial financial risk can qualify for an antitrust safety zone on the basis of their financial integration.

As Chapter 1 outlines and the *Health Care Statements* acknowledge, financing and delivery arrangements for health care have changed substantially over the past several decades.[253] Some commentators and panelists state P4P arrangements may have important procompetitive benefits for consumers.[254] Chapters 1 and 3 describe

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[250] HEALTH CARE STATEMENTS, *supra* note 44, § 8(B)(1).

[251] Some panelists stated the Agencies may increasingly confront physician network joint ventures that require rule of reason analysis. *See* Wiegand 9/24 at 4-5; Guerin-Calvert 9/24 at 26; Feller 9/24 at 73.

[252] HEALTH CARE STATEMENTS, *supra* note 44, § 8.

[253] *Id.* § 8(A)(4).

[254] *See, e.g.*, Asner 9/25 at 36; *see also supra* note 36.

these arrangements and consider their potential to lower costs and increase quality.

In determining whether a physician network joint venture is sufficiently financially integrated to warrant rule of reason analysis, the Agencies will consider the extent to which a particular P4P arrangement constitutes the sharing of substantial financial risk among the members of the joint venture, whether that sharing is likely to produce efficiencies, and whether any price or otherwise per se illegal agreements among the members are reasonably necessary to achieve those efficiencies.

3. Clinical Integration

Health Care Statement 8 notes that clinical integration can be evidenced by a "network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[255]

This statement identifies three arrangements that a clinical integration program might include: (i) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (ii) selectively choosing network physicians who are likely to further these efficiency objectives; and (iii) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

This section discusses commentators' perspectives on clinical integration and presents a series of inquiries the Agencies are likely to pose when considering whether a physician network joint venture is sufficiently clinically integrated to avoid summary condemnation.

Commission staff stated in an advisory opinion to a proposed initiative involving clinical integration that the venture, as designed, did not warrant summary condemnation.[256] Commission staff also closed an investigation into a physician collaboration that created a substantial degree of market concentration, because the parties demonstrated the collaboration created considerable efficiencies (including improvements in the quality of care).[257]

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[255] HEALTH CARE STATEMENTS, *supra* note 44, § 8(B)(1).

[256] Letter from Jeffrey W. Brennan, Federal Trade Commission, to John J. Miles, Ober, Kaler, Grimes & Shriver (Feb. 19, 2002) (FTC Staff advisory opinion regarding MedSouth, Inc.) [hereinafter FTC MedSouth Letter], *at* http://www.ftc.gov/bc/adops/medsouth.htm. *See generally* Thomas B. Leary, *The Antitrust Implications of "Clinical Integration:" An Analysis of FTC Staff's Advisory Opinion to MedSouth*, 47 ST. LOUIS L.J. 223 (2003); Thomas B. Leary, The Antitrust Implications of "Clinical Integration:" An Analysis of FTC Staff's Advisory Opinion to MedSouth, Speech Before Saint Louis University Health Law Symposium (Apr. 12, 2002), *at* http://www.ftc.gov/speeches/leary/eicreview.pdf.

[257] Timothy J. Muris, Everything Old is New Again: Health Care and Competition in the 21st Century, Prepared Remarks for the 7th Annual Competition in Health Care Forum (Nov. 7, 2002), *at* http://www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf.

a. Indicia of Clinical Integration

Commentators and industry experts describe various techniques and programs for achieving clinical integration. Commentators primarily focus on four indicia of clinical integration: (1) the use of common information technology to ensure exchange of all relevant patient data; (2) the development and adoption of clinical protocols; (3) care review based on the implementation of protocols; and (4) mechanisms to ensure adherence to protocols.

Panelists and industry experts also have discussed other indicia of clinical integration including physician credentialing, case management, preauthorization of medical care, and review of associated hospital stays.[258] Some also have discussed the use of payment systems to collect clinical data.[259]

Commentators described varied information technology (IT) systems that can facilitate, monitor, and control the utilization of health care services.[260] The FTC MedSouth Letter discussed, for example, an IT system that included "a web-based electronic clinical data record system that will permit MedSouth physicians to access and share clinical information relating to their patients."[261]

Some suggest that these systems can significantly improve quality of care by enabling physicians to collect and track information about individual patients.[262] One industry expert noted the "management of information as it relates to promoting health, treating illness and managing disease" is a "major component of clinical integration."[263] Some have observed that clinical care information technology systems are expensive to implement.[264] One study

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[258] *See* California Ass'n of Physician Groups, *Clarifying the Health Care Statements' Policies of Clinical Integration and Ancillarity* 7-9 (Public Comment) [hereinafter CAPG (public cmt)]; Robert F. Liebenluft & Tracy E. Weir, *Clinical Integration: Assessing the Antitrust Issues*, *in* HEALTH LAW HANDBOOK (forthcoming 2004 ed.) (manuscript at 29-35, on file with the authors). For a discussion of private antitrust litigation involving physician credentialing, see *supra* notes 241-247, and accompanying text.

[259] *See, e.g.*, Bartley Asner, *An IPA Based Model for Clinical Integration in a PPO Setting*, *in* CAPG (public cmt), *supra* note 258, at i (discussing a system of payment from an insurance company to a PPO, which would enable the PPO to track claims and gather additional data).

[260] *See, e.g.*, SHORTELL ET AL., *supra* note 84, at 159.

[261] FTC MedSouth Letter, *supra* note 256.

[262] *See, e.g.*, Robert H. Miller & Ida Sim, *Physicians' Use of Electronic Medical Records: Barriers and Solutions*, 23 HEALTH AFFAIRS 116, 116 (Mar./Apr. 2004) (stating that electronic medical records have "the most wide-ranging capabilities and thus the greatest potential for improving quality."); STEPHEN M. SHORTELL ET AL., REMAKING HEALTHCARE IN AMERICA: BUILDING ORGANIZED DELIVERY SYSTEMS 40-41 (1996) ("It is not possible to create clinically integrated care . . . without certain functions such as information systems and quality management in places.").

[263] Teresa Mikenas Jacobsen & Maria Hill, *Achieving Information Systems Support for Clinical Integration*, *in* CLINICAL INTEGRATION: STRATEGIES AND PRACTICES FOR ORGANIZED DELIVERY SYSTEMS 129, 129 (Mary Crabtree Tonges ed., 1998).

[264] Miller & Sim, *supra* note 262, at 119 ("In most practices we studied, up-front costs [for electronic medical records] ranged from $16,000 to

found that California-based IPAs are among the most successful in implementing and using IT systems, in part because they employ more technical support staff.[265]

Commentators describe physicians' selection and adoption of care management protocols (CMPs) as another indicia of clinical integration.[266] A trade association representing Californian physician groups stated that these protocols can "delineate utilization and quality goals for various diagnoses."[267] This trade association also described the process by which an IPA might develop and revise clinical protocols.[268] MedSouth proposed to implement between 100 and 150 such protocols that would cover 80-90 percent of the diagnoses that were prevalent in their physician members' practices.[269]

Commentators have observed that the selection and implementation of CMPs can improve quality and generate efficiencies for physician networks and payors.[270] Several commentators contend, however, that clinical integration requires networks to monitor and ensure compliance with CMPs.[271]

b. Are Joint Negotiations on Price Reasonably Necessary to Achieve Clinical Integration?

A joint venture will escape summary condemnation when joint price negotiations are reasonably necessary to achieve substantial efficiencies arising from the clinical integration.[272] Panelists and commentators identified varying reasons

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$36,000 per physician. Some practices incurred additional costs (in the form of decreased revenue) from seeing fewer patients during the EMR transition period."); Liebenluft & Weir, *supra* note 258 (manuscript at 32).

[265] Gillies et al., *supra* note 14, at 494-96.

[266] *See, e.g.*, CAPG (public cmt), *supra* note 258, at 5; Liebenluft & Weir, *supra* note 258 (manuscript at 29-30); Brown, *supra* note 12, at 289. *See generally* ABA (public cmt), *supra* note 21, at 19-22.

[267] CAPG (public cmt), *supra* note 258, at 5.

[268] *See id.* at 5.

[269] FTC MedSouth Letter, *supra* note 256.

[270] *See* Liebenluft & Weir, *supra* note 258 (manuscript at 16-17).

[271] *See* Peter R. Kongstvedt, *Physician Behavior Change in Managed Health Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 12, at 425 ("Physicians, like all of us, have habits and patterns in their lives. Habits also extend to clinical practices that are not cost-effective but that are difficult to change."); Liebenluft & Weir, *supra* note 258 (manuscript at 30-31, 33-34); FTC MedSouth Letter, *supra* note 256 (proposing several steps to ensure compliance with CMPs).

See also CAPG (public cmt), *supra* note 258, at 5-6 (networks must review their "physicians' delivery of care to ensure compliance with efficiency and quality goals identified in clinical protocols"); Brian J. Anderson, *Values and Value: Perspectives on Clinical Integration*, *in* CLINICAL INTEGRATION, *supra* note 263, at 39, 54 (stating that "an integrated system must be able to apply performance measures across the span of care and service sites."); Susan A. Creighton, Diagnosing Physician-Hospital Organizations, Remarks Before American Health Lawyers Association Program on Legal Issues Affecting Academic Medical Centers and Other Teaching Institutions 2 (Jan. 22, 2004), *at* http://www.ftc.gov/speeches/other/creightonphospeech.htm.

[272] HEALTH CARE STATEMENTS, *supra* note 44, § 8(B)(1).

why joint negotiations may be reasonably necessary to implement and maintain a clinical integration program.

A trade association representing Californian physician groups contended that joint negotiation of contracts will ensure that sufficient physicians across multiple specialties participate in the venture.[273] Physicians participate in IPA networks, this association argued, because they can delegate "the time and hassle of negotiating contracts with payers" to the IPA.[274] Moreover, the trade association suggested that payors' overall costs may not necessarily increase, because a clinically integrated IPA will deliver cost-effective and efficient care. This trade association also argued that clinically integrated IPAs "can offer payers a single, comprehensive, and integrated network" and should therefore "be priced in the aggregate, not through individual contracts with physicians."[275]

Commentators similarly asserted that joint pricing is necessary to ensure the active and ongoing participation of an entire group's members.[276] These commentators also contend that joint negotiations are necessary to help physician members recover the substantial time and financial commitments that are necessary to implement a clinical integration program.[277] Finally, they argue that joint negotiations are necessary to prevent physician members from free-riding on the contributions of their colleagues.[278]

The extent to which joint contracting is reasonably necessary to achieve efficient clinical integration will vary, depending on the facts and circumstances.[279] The Agencies will consider multiple factors to determine whether collective negotiation is reasonably necessary to accomplish the goal of achieving clinical integration. Participants in a joint venture that is not sufficiently integrated (whether financially or clinically) face significant antitrust risk if they attempt to contract jointly.

c. Further Guidance on Clinical Integration

Commentators and panelists asserted that there is uncertainty regarding the nature and extent of clinical integration that would, in the Agencies' view, avoid summary condemnation of collective price setting or other horizontal agreements on competitive terms among physicians who participate in

[273] CAPG (public cmt), *supra* note 258, at 8.

[274] *Id.* at 9.

[275] *Id.* at 10. *See also* Liebenluft & Weir, *supra* note 258 (manuscript at 39) (explaining that a physician network that has implemented a clinical integration program "can sell a 'new product' – that is, an integrated package consisting of more than merely the individual physician services, but, rather, an integrated package of those services tied to the network's clinical program.").

[276] Liebenluft & Weir, *supra* note 258 (manuscript at 39).

[277] *Id.* (manuscript at 39).

[278] *Id.* (manuscript at 39).

[279] *See, e.g.*, Leary, *supra* note 256, at 16-17 (discussing the relationship between joint contracting and non-exclusivity).

clinically integrated joint ventures.[280] Several panelists and commentators requested that the Agencies provide additional guidance to address such uncertainty.[281]

The Agencies are committed to eliminating unlawful restraints on vigorous price and non-price competition in physician markets, but not to any particular model for financing and delivering health care. The Agencies do not suggest particular structures with which to achieve clinical integration that justifies joint pricing, because it would risk channeling market behavior rather than encouraging market participants to develop structures responsive to their particular efficiency goals and the market conditions they favor.

Nonetheless, to help further guide practitioners and counsel on the issue, below is a broad outline of some of the kinds of questions that the Agencies are likely to ask when analyzing the competitive implications of a physician network joint venture that justifies joint action involving price or other competitively significant terms on the grounds that it is clinically integrated. The Agencies emphasize that this list is not exhaustive, and that these questions may be more or less relevant, depending on factual circumstances. Other questions, not listed here, may be important, again depending on the facts at issue.

1. What do the physicians plan to do together from a clinical standpoint?

   - What specific activities will (and should) be undertaken?
   - How does this differ from what each physician already does individually?
   - What ends are these collective activities designed to achieve?

2. How do the physicians expect actually to accomplish these goals?

   - What infrastructure and investment is needed?
   - What specific mechanisms will be put in place to make the program work?
   - What specific measures will there be to determine whether the program is in fact working?

3. What basis is there to think that the individual physicians will actually attempt to accomplish these goals?

   - How are individual incentives being changed and re-aligned?
   - What specific mechanisms will be used to change and re-align the individual incentives?

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[280] *See, e.g.*, Liebenluft & Weir, *supra* note 258 (manuscript at 15).

[281] *See* Holloway 9/25 at 27 (stating that it "is desirable for the FTC to issue definitive and clear guidelines as to what level of clinical integration and oversight is required"); Asner 9/25 at 85 (remarking that "[w]e're looking for somewhat of a road map. It can be very broad, but not as broad as exists in the current guidelines. It doesn't have to be specific, a list of things that you have to do. There is something in between."); Section of Antitrust Law, American Bar Ass'n, *Comments on the Public Hearings on Health Care and Competition Law and Policy* 15-17 (Public Comment); American College of Surgeons, *Comments Regarding the Federal Trade Commission (FTC) Workshop on Health Care Competition Law and Policy (Sept. 30, 2003)* 3-4 (Public Comment) (Submitted by Thomas R. Russell). *See generally* ABA (public cmt), *supra* note 21, at 25-26.

4. What results can reasonably be expected from undertaking these goals?

    - Is there any evidence to support these expectations, in terms of empirical support from the literature or actual experience?
    - To what extent is the potential for success related to the group's size and range of specialities?

5. How does joint contracting with payors contribute to accomplishing the program's clinical goals?

    - Is joint pricing reasonably necessary to accomplish the goals?
    - In what ways?

6. To accomplish the group's goals, is it necessary (or desirable) for physicians to affiliate exclusively with one IPA or can they effectively participate in multiple entities and continue to contract outside the group?

    - Why or why not?

C. Physician Information Sharing

The sharing of information among physicians can have procompetitive benefits, but may also facilitate collusion or otherwise reduce competition on prices or compensation. *Health Care Statement* 6 sets forth a safety zone for provider exchange of price and cost information that the Agencies will not challenge, absent extraordinary circumstances.[282] The statement also outlines the Agencies' antitrust analysis of information exchanges that fall outside this safety zone.[283]

The Agencies have issued a number of business review letters and advisory opinions that apply the analytical framework in *Statement* 6 to evaluate the antitrust implications of physicians' collecting and disseminating information concerning insurer payments for physician services.[284]

In general, the sharing of quality-related information among physicians and consumers can reduce costs and increase quality of care. As Areeda and Hovenkamp note, "the great majority of exchanges of information that do not pertain to either price or output should be regarded as harmless, at least when concerted refusals to deal are not in issue."[285] The Agencies encourage such information sharing, as long as there are adequate safeguards to ensure information exchange is not used for anticompetitive ends.

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[282] HEALTH CARE STATEMENTS, *supra* note 44, § 6.

[283] *Id.* § 6.

[284] *See* Letter from Charles A. James, Department of Justice, to Jerry B. Edmonds, Williams, Kastner & Gibbs PLLC (Sept. 23, 2002), *at* http://www.usdoj.gov/atr/public/busreview/200260.pdf; Letter from Jeffrey W. Brennan, Federal Trade Commission, to Gerald Niederman, Faegre & Benson (Nov. 3, 2003), *at* http://www.ftc.gov/bc/adops/mgma031104.pdf; Letter from Jeffrey W. Brennan, Federal Trade Commission, to Gregory G. Binford, Benesch Friedlander Coplan & Aronoff LLP (Feb. 6, 2003), *at* http://www.ftc.gov/bc/adops/030206dayton.htm; American Medical Ass'n, *Physician Information Sharing* 1 (Public Comment).

[285] *See* XIII PHILLIP E. AREEDA & HERBERT HOVENCAMP, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 2111d1, at 49 (2nd ed. 2004).

D. Physician-Related Conduct Implicating the State Action Doctrine

As Chapter 8 describes in greater detail, anticompetitive physician conduct can be shielded from federal antitrust scrutiny if it constitutes state action. Through enforcement actions and competition advocacy, the Commission has recently addressed this issue.[286]

[286] *See supra* Chapter 1.

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Improving Healthcare
A Dose of Competition
Hyman, D. (Ed.)
2005, XV, 431 p., Hardcover
ISBN: 978-0-387-25751-8