PHYSICIAN IPAs; MESSENGER MODEL

Oral Statement of
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Good afternoon. My name is Edward Hill. I am the immediate past Chairman of the Board for the American Medical Association and a board-certified family physician from Tupelo, Mississippi. I am pleased to be here today to offer the perspective of practicing physicians on the application of the "messenger model" under the antitrust agencies' Statements of Enforcement Policy.

As we testified at the FTC Workshop last September, the AMA believes it's time to take a fresh look at some of the core principles that have guided antitrust enforcement in the health care sector. In our view, some of these principles don't hold up to close examination. They are simply assumptions which have never been proven and which, in our view, have outlived any purpose they once may have served and are now counterproductive.

Today, we discuss one of these assumptions in detail –it involves use of the messenger model. I will also identify some of the other assumptions and explain why we believe the Commission and the Justice Department should revisit them.

Our central message is this: When physicians create a network to market their services jointly to payers, the Rule of Reason rather than the *per se* rule should generally apply. The physician network should not be **required** to do risk contracting, to "clinically integrate," or to use the so-called "messenger model" in order to avoid charges of price-fixing. We believe that the Rule of Reason is capable of distinguishing between physician networks that are truly harmful to competition and those which offer procompetitive benefits such as greater flexibility, more innovation, and ultimately a better health care system.

Core Principles Worth Re-Examining

There are a few assumptions, sacred to antitrust enforcers, that I want to address before I get to the messenger model. The first is the agencies' position that **"capitation and other forms of risk contracting are 'more efficient' than fee-for-service medicine."** The agencies believe that capitation and withholds promote

efficiency by giving physicians an incentive to contain costs. By contrast, the agencies believe that joint contracting on a fee-for-service basis creates no efficiencies, and is illegal *per se.*

As a factual matter, it is far from clear that risk contracting is really "more efficient" than fee-for-service. To the extent this question has been studied, the results have been inconclusive.

To determine this question of efficiency, it would be necessary to gather and compare data on the overall costs and quality of care of both types of physician networks. This would be a truly overwhelming task. A number of factors would need to be considered – such as administrative costs of risk contracting, including the costs of legal and regulatory compliance. In addition, the effects of risk contracting on quality would have to be considered. This alone is a highly controversial, and unsettled, question.

An additional cost is the numerous physician bankruptcies that have resulted from inadequate capitation rates. Since 1999, numerous medical groups and IPAs in many states, have declared bankruptcy or are on the brink. These bankruptcies have caused enormous disruptions in care, jeopardizing the continuity and quality of care for millions of patients. Every time a medical group or IPA goes under, patients lose access to their treating physicians and must scramble to get their medical records. Patients are forced to try again to establish a new therapeutic relationship with a physician they hope they will retain, assuming they can find any physician who can see them.

But even if it were demonstrated that one form of contracting is "more efficient" than another, there's a more fundamental question to address: **Is it the proper role of antitrust officials to state a preference for risk contracting versus fee-for-service?** Competition policy ordinarily does not take sides on this sort of question. It usually lets the market decide. To quote Clark Havighurst:

"Antitrust enforcers should not, without good reason, deny physician designed arrangements a fair chance to compete against lay-controlled entities in finding efficient ways to cope with disease at reasonable cost"

Havighurst added that physicians should gain a competitive advantage because they are able to rely on professionalism, collegiality, and consensus, rather than exclusively on rules imposed from the corporate top down.

Another assumption that the AMA disagrees with is that **"joint contracting by physicians on a fee-for-service basis offers no potential for transactional or other efficiencies."**

Independent practice associations, or IPAs, were discussed in great detail this morning. We believe that joint contracting by physician sponsored IPAs and networks that don't share financial risk can offer great benefits in the form of

transactional efficiencies that can result in significant cost savings both for the payer and for the physicians. For payers, efficiencies can be achieved as a result of contracting with networks that have already been developed by physicians. Because physicians still practice predominantly in solo practice or in small groups, creating a physician panel can be a very time consuming and expensive task for a payer seeking to enter or expand its place in a market. For physicians, a network would enable them to pool their resources to afford the necessary expertise to evaluate contract proposals – just as large health plans do. This would lower costs and rationalize pricing – without restraining competition.

To illustrate, I'll describe a fairly typical physician-sponsored network. It includes a large number of physicians in the community. All of the physicians' credentials have been pre-approved by the network's credentials committee. The network is also truly non-exclusive. Payers thus have an option: They can build their own network by approaching physicians individually, or they can approach the physician-sponsored network and obtain ready access to a panel of qualified physicians. Assume, too, that payers have the additional option of acquiring a physician panel by going to a national or regional PPO that is not sponsored by physicians, but that has contracts with many of the same physicians in the physician-sponsored network.

No threat to competition is posed by this physician network. Because it is non-exclusive, the physicians actively and independently consider contracts presented to them outside the network. A payer who is unable to reach a "package deal" with the network can go directly to its physicians or to the competing PPO. Rather than restraining trade, the physicians' have created an additional option for purchasers – which is procompetitive. In this sense, these types of networks can be viewed as a "new product" under Supreme Court decisions.

Ironically, while enforcement policy continues to favor risk contracting, the market appears to be shifting away from it and towards discounted fee-for-service networks. Many employers and patients want to eliminate financial incentives for physicians to withhold care. **Should antitrust policy stand in the way of physicians responding to this consumer demand? Should our hypothetical physician network be prohibited from competing on an even keel with the national or regional PPO?** We don't think so.

The next assumption that should be reexamined is that **"Physician networks that want the flexibility to contract on a fee-for-service basis can simply become clinically integrated."** This concept holds great promise, but the only guidance offered by the agencies so far is discouraging. Although *the MedSouth* letter represents an attempt by the Commission to encourage an innovative effort by physicians to provide new services within the confines of antitrust restrictions, it sets a very high bar. For most physicians, the significant investment in capital and other resources necessary to establish the level of clinical integration in *MedSouth* is simply not an option. In addition to requiring the purchase of sophisticated information technology, the MedSouth project required the physicians to hire numerous advisors, including lawyers, health care consultants, and an information technology firm.

In addition, the physicians declared that they intended to contract on a non-exclusive basis – so they would continue to make their services available outside the network. One might have thought that this fact alone – even without clinical integration – would have substantially alleviated any concern about the physicians' ability or desire to harm competition. It also appears that MedSouth planned to wall off its physicians from direct involvement in contracting. The physicians proposed to use an outside consultant to develop a fee schedule and, if necessary, gather information from each physician on a confidential basis. This approach sounds like a modified version of the "messenger model" (which we get to later).

Yet, despite the cautious and creative approach taken by MedSouth, the FTC letter is laced with caveats that seem to indicate the IPA will continue to be exposed to significant antitrust risk. After years of work and a very substantial investment of time and resources, the IPA walked away with a lukewarm, conditional go-ahead.

Unless the antitrust enforcement agencies lower the bar on what is acceptable clinical integration, such as the approach described by Al Holloway this morning – where adoption and adherence to practice protocols is considered sufficient clinical integration, most physicians will not be able to meet this challenge. We hope the agencies will rethink the approach they have taken on this concept.

That leaves us with a final flawed assumption regarding physician network joint contracting: **"when all else fails, the messenger model represents a viable alternative for physician networks that are not financially or clinically integrated."** Under the messenger model, a third party – the messenger – receives offers from payers and conveys them to each physician practice in the network. It then surveys the practices, and conveys the individual response of each practice to the payer. If the payer is not satisfied with the level of acceptance in the first round, the parties start over and do it again…and potentially again…and again.

The messenger model is an inefficient apparatus invented for the sole purpose of maintaining antitrust compliance, with no independent business justification. It is cumbersome and difficult to administer. It's not surprising that the messenger model is often despised by physicians, hospitals, and – to our understanding – even payers.

Moreover, the messenger model leaves physicians exposed to charges of boycott whenever a large number of physicians in the network independently view a payer's offer as inadequate. Consider the following scenario: A payer offers a contract to the network messenger. The messenger takes the contract to the individual physicians, each (or many) of whom reject it as unacceptable. The payer, who views its offer as eminently reasonable, incorrectly concludes that the physicians must have colluded – so it contacts the FTC.

The lawfulness of the physician's conduct should not depend on whether they accept the payer's proposal. As a practical matter, however, whenever a payer's offer is rejected by a significant number of physicians, a factual question will arise as to whether the physicians acted in a truly independent fashion. The presence of that factual

question creates antitrust risk for the physicians. And it gives the payer an upper hand in the contracting process, regardless of whether the Commission agrees to bring a complaint or even to open an investigation.

In the end, the messenger model provides little in the way of antitrust protection for physicians while imposing significant administrative costs on all parties. Because fee-for-service contracting is not inherently anticompetitive – and because the Rule of Reason can sufficiently guard against competitive abuses – the messenger model is at best unnecessarily restrictive and at worst an obstacle to competition by legitimate physician networks. It doesn't provide physicians with what they need to counter the enormous power wielded by health plans with which they contract.

Conclusion

In conclusion, the AMA commends the Commission and the Justice Department for holding these hearings to reexamine antitrust enforcement policies and competition in the health care industry. We are hopeful that you will reconsider your policies regarding joint contracting by physician networks, taking serious consideration of our recommendations. We look forward to a continuing dialogue with the agencies on these and other important issues. Finally, I'd like to thank you for the opportunity to present the AMA's views today.