PHYSICIAN NETWORKS AND ANTITRUST:
A CALL FOR A MORE FLEXIBLE ENFORCEMENT POLICY

AMERICAN MEDICAL ASSOCIATION WITH SIDLEY AUSTIN LLP

June 2008

EXECUTIVE SUMMARY

I. INTRODUCTION

Over the last thirty years, antitrust enforcement in health care has been a major priority of federal antitrust authorities. Both antitrust Agencies – the Federal Trade Commission (FTC) and the Department of Justice (DOJ) – have devoted considerable resources to actions involving health care services. Within health care, no group has received greater attention from the Agencies than physicians.

We believe that changes in health care markets warrant a shift in focus. When the Agencies charted their current course, payers did relatively little to manage the cost or volume of services provided. Today the landscape is far different. Governmental and private payers take a much more active role in regulating the price and volume of physician services. Further, consolidation among private payers has resulted in more powerful health payors and a substantial reduction in physician autonomy. These forces reduce both the practical and the economic risks of joint activity among physicians.

Equally important, professional, market and regulatory developments are encouraging physicians to collaborate in new ways. In particular, the federal government is encouraging physicians and other providers to invest in health information technology ("HIT") to facilitate the collection and sharing of clinical data. HIT "has the potential to significantly increase the efficiency of the health sector" and to "improve the quality of care."[1] However, the adoption of HIT requires a level of physician investment and network integration that pose significant barriers to implementation. At the same time, the emergence of new reimbursement mechanisms such as "pay for performance" -- *i.e.,* paying physicians in part based on their ability to meet or exceed quality or other performance benchmarks -- place a premium on physicians' ability to collect data and utilize HIT. For physicians, who still practice predominantly in small groups, network arrangements provide one way of achieving the economies of scale necessary to participate in these initiatives.

Despite these developments, enforcement policy – embodied today in the *Statements of Enforcement Policy in Health Care* developed jointly by the FTC and the DOJ during the 1990s – still casts a suspicious eye on physician collaboration through network arrangements. The AMA submits that the *Statements of Enforcement Policy* go too far in deterring the formation and operation of legitimate physician networks.

Joint contracting arrangements that are ancillary to the implementation of HIT or to the participation in innovative payment arrangements among other physician collaborations on quality improvement, ordinarily create plausible efficiencies and should not face summary condemnation. Accordingly, the AMA proposes a modification of the existing standards to reflect changes in the health care market and to provide greater flexibility for physicians to engage in procompetitive joint arrangements.

The AMA proposes the following specific modifications of the *Statements*:

1. Physician networks supported by plausible efficiencies should not face summary condemnation under the *per se* rule or the "inherently suspect" standard. The Agencies should explicitly recognize that joint contracting is ordinarily reasonably necessary to the attainment of the plausible efficiencies associated with implementing HIT or participating in P4P, among other physician collaborations on quality improvement.

2. Non-exclusive physician networks – those in which the physicians are genuinely available to contract with payers separately from the network – should almost always be found lawful under the rule of reason.

3. Exclusive physician networks should be evaluated under the rule of reason. Absent proof of market power or actual anticompetitive effects, such networks should be found lawful. If an exclusive network is shown to have market power or to result in anticompetitive effects, the network should be viewed under a full rule of reason analysis that balances the anticompetitive effects against efficiencies created by the exclusive network. Among the expected benefits of exclusivity that the Agencies should explicitly recognize are the elimination of free riding and the removal of obstacles to the acquisition and implementation of HIT.

[1] Congressional Budget Office, "Evidence on the Costs and Benefits of Health Information Technology," (May 2008) (hereinafter "*CBO Report")*, at 1.

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This paper begins by describing changes in the health care market since the Agencies adopted their current enforcement policy relating to physician networks. It then describes the *Statements* and considers whether antitrust law leaves room for a change in policy. Finally, the paper describes a more flexible approach based on the rule of reason.

II. CHANGES IN THE HEALTH CARE MARKETPLACE

Since the *Statements of Enforcement Policy* were last revised in 1996, health care market conditions have changed in significant ways. The principal changes include (a) increasing health insurer consolidation and market power; (b) a retreat from financial risk-sharing between health insurers and physicians; and (c) the emergence of HIT and new payment methodologies.

A. Health Insurer Monopsony Power

The Agencies adopted the *Statements of Enforcement Policy* shortly before a tidal wave of mergers swept through the health insurance industry. In the last decade, dozens of major health insurer mergers have resulted in an increasingly consolidated payer market. Premiums have steadily increased, even as patient co-pays and deductibles have expanded, effectively shrinking the scope of coverage. As a result of these mergers, health insurance markets throughout the country are at levels of concentration associated with monopsony power.

The AMA's most recent study of the health insurance industry shows that 96% (or 299 of 313) of the metropolitan statistical areas ('"MSAs") analyzed by the AMA, are controlled by a single insurer with a combined HMO/PPO market share of 30% or more.[2] The report further shows that 64% (or 200 of 313) of the MSAs were controlled by a single insurer with a combined HMO/PPO market share of 50% or greater.[3] In addition, 96% of the MSAs studied by the AMA are considered highly concentrated (with a Herfindahl-Hirschman Index above 1,800) under the Agencies' Horizontal Merger Guidelines.[4] The AMA's "study shows unequivocally that physicians across the country have virtually no bargaining power with dominant health insurers and that those health insurers are in a position to exert monopsony power."[5] Put another way, if physicians were to refuse the terms of the dominant health insurer, they would likely suffer an irrecoverable loss of revenue. Consequently, physicians can be forced

to accept inadequate reimbursement rates likely to lead to a reduction in the supply of physician services – despite the demand for such services by patients. Indeed, recent projections by the Health Resources and Services Administration suggest a looming shortage of physicians in the United States.[6]

It is a mistake to assume that, when insurers push down the cost of physician services, their interests are perfectly aligned with those of consumers.[7] Health insurers who exercise monopsony power by driving physician fees below the competitive level may cause patients to receive an inadequate level of service and quality.[8] Also, because health insurer monopsonists typically are also monopolists, lower input prices (for physician services) do not lead to lower consumer output prices (for health care premiums).[9] Indeed, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers.[10] Although compensation to physicians has been reduced, health insurance premiums have continued to increase rapidly.

In this environment, one of the key concerns historically animating antitrust enforcement policy in health care – preventing physicians' collective resistance to the entry of managed care – has only marginal relevance. Between the statutorily-fixed prices of Medicare and Medicaid in the governmental sector, and the negotiating leverage of private health plans that dominate commercial markets, there is only a narrow slice of the market left that is even theoretically vulnerable to a physician-orchestrated conspiracy.

B. Retreat from Risk-Sharing

In 1996, when the *Statements of Antitrust Enforcement Policy* were adopted, managed care was in its ascendancy. Many in health care expected to see continued growth in HMOs and other forms of risk sharing. Today, by contrast, employers and other purchasers of health care coverage have largely rejected payer-

provider risk-sharing arrangements.[11] Many IPAs that previously attempted to share financial risk experienced significant financial losses and ceased offering the model.[12] Consumers also resisted arrangements that placed physicians at financial risk. Contrary to early predictions, in most areas of the country physician capitation proved to be an unpopular and highly controversial payment methodology. Employers wanted broad networks that allowed patients a significant choice among physicians, but without any perceived incentives to ration care.

C. The Emergence of HIT and New Payment Methodologies

One of the more significant and promising developments in the health care market since the promulgation of the *Statements* in the mid-90s is the emergence of HIT. HIT has the potential, if adopted widely and used effectively, to save the health care sector about $80 billion annually (in 2005 dollars).[13] At the same time, by making it possible for physicians to collect and analyze vast numbers of patient encounters, HIT promises to drive advancements in medical science and clinical practice.

Notwithstanding the tremendous promise of HIT, its adoption has lagged.[14] To date, only 14% of physicians have minimally functional EMR systems.[15] Solo or single partner practices, accounting for about half of all doctors, had the lowest level of comprehensive EMR use – 7.1% of solo practitioners, 9.7% of those with a partner.[16] The Congressional Budget Office (CBO) attributes this disappointing response to challenges in implementing HIT systems and to physician inability to achieve financial returns from HIT sufficient to offset its daunting implementation costs.[17] Most of the benefits of HIT – such as less duplication of diagnostic tests or increased availability of patient data – accrue to health insurance companies or patients rather than to the physicians who incur the costs of implementation. This lack of symmetry leads the CBO to conclude that "[h]ow well HIT lives up to its potential

depends in part on how effectively financial incentives can be realigned to encourage the optimal use of the technology's capabilities."[18] Network arrangements provide one way for physicians in small practices both to spread the costs of HIT implementation and to internalize the potential gains from enhanced efficiency.

Closely linked to the adoption of HIT is the emergence of a new payment methodology known as "pay for performance" ("P4P"). The core purpose of P4P is to provide financial incentives for physicians to meet pre-established performance benchmarks. While P4P is in its infancy and has raised a host of methodological concerns – including errors in data used, over-reliance on cost measures, and lack of transparency and physician input in performance metrics – it is "now routinely used by both private and public payers in the U.S. health care system."[19] A majority of commercial HMOs use P4P, and the Center for Medicare and Medicaid Services has been directed by Congress to adopt value-based purchasing.[20] P4P depends upon accurate and medically appropriate performance measurement, which in turn depends upon HIT. If the adoption of P4P spreads and its use expands, physicians in small practices will face yet another force driving them into "integrated care networks that [will] allow the physicians to more seamlessly coordinate care."[21]

III. CURRENT ENFORCEMENT POLICY

A. The Statements of Enforcement Policy in Health Care

The initial version of the Statements was released in September, 1993. Issued in response to calls from the American Medical Association, the American Hospital Association, and other leading health care organizations, the Statements reflected a significant effort to provide heightened clarity to medical professionals and companies. The Statements articulated in a clear, accessible format policies that had emerged previously only in advisory letters, speeches, and consent decrees.

1. Financial Integration

As originally issued, the Statements contained eight separate policy statements. Statement 8, entitled "Physician Network Joint Ventures," identified two features of particular importance to the antitrust analysis of physician networks: (1) the size of the network, in terms of participating physicians, as a measure of potential market power; and (2) whether the physicians had integrated their practices by sharing "substantial financial risk." The AMA's focus is on the latter requirement.

As set forth in the initial version of the Statements, physicians in a contracting network could share "substantial financial risk" in either of two ways: (1) by accepting "capitated" or "per-member per-month" payments; or (2) by incentivizing physicians to contain costs through the use of a substantial withhold from payments. With capitation or substantial withholds in place, the network would be deemed to have sufficient financial incentive to enhance efficiencies. Otherwise, without such financial integration, a physician network that engaged in joint price negotiations with health insurers would be summarily condemned as a *per se* illegal price-fixing agreement.

The concept of integration as an antitrust guidepost did not originate in the Statements. Rather, antitrust law has long sought to distinguish between mere cartels and legitimate joint ventures. "Integration" is used as shorthand to describe attributes that make a joint arrangement sufficiently likely to generate efficiency that application of the rule of reason is appropriate. What was distinctive in the Agencies' approach was the suggestion that, in the specific context of physician contracting networks, only the sharing of "substantial financial risk" would suffice to allow the network to escape application of the *per se* rule. Other forms of integration – structural, functional, or transactional – would not carry the day.

With the rapid decline of risk sharing arrangements since the Statements'

inception, the requirement of financial risk-sharing as the defining feature of a legitimate physician network proved unduly restrictive.

2. Clinical Integration

In the 1996 version of the Statements, the Agencies recognized a second type of integration that could qualify a physician network for rule of reason treatment. "Clinical integration," as defined in the Statements, is evidenced "by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and to create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[22] Clinical integration as so defined represented a sort of "as if" standard: A physician network that acted "as if" its members shared financial risk – by instituting the types of cost containment techniques that would necessarily be in place for a capitated group – might qualify for rule of reason treatment despite the absence of "substantial financial risk."

For several years following the publication of the 1996 Statements, the Agencies gave no further guidance on the meaning of clinical integration. In 2002, however, the Commission issued a staff advisory letter to MedSouth, Inc., an IPA based in Denver, Colorado with over 400 physicians.[23] And in 2007, the Commission issued a staff advisory letter to the Greater Rochester Independent Practice Association, Inc. (GRIPA), a network based in Rochester, New York with over 600 physician members.[24] The MedSouth and GRIPA letters demonstrate how high the bar has been set for physician networks seeking to qualify for rule of reason treatment through clinical integration.

While the MedSouth and GRIPA arrangements are not identical, they bear significant similarities. Notably, both networks were originally built for capitation, but needed to be re-tooled in the face of market resistance. Thus, both MedSouth and

GRIPA were constructed "as if" the physicians would be sharing substantial financial risk. Only when risk contracting proved to be commercially infeasible did the networks seek Commission approval for their programs of clinical integration.

In addition, both MedSouth and GRIPA made significant investments in capital and resources, using a cadre of consultants and technology experts to assist in the effort. Both networks invested in electronic medical records and tracking technology to share information on their patients and to monitor data relating to utilization and medical outcomes. And both networks developed clinical practice guidelines and procedures for monitoring compliance with them. In both instances, the Commission advisory letters noted no apparent anticompetitive motivation for the physicians' efforts.

Despite these features, neither MedSouth nor GRIPA achieved agency approval easily or without significant caveats. Both letters reflected intensive Commission investigation of the networks' histories, purposes, contracting mechanisms, disciplinary methods for non-compliant physicians, and strategies for producing efficiencies. Each involved a searching examination of the so-called "ancillarity" of the networks' pricing mechanisms to their efficiency-enhancing potential. Each left the Commission plenty of room to bring a later enforcement action if the networks' operations could not later be shown to produce significant efficiencies.

Interestingly, however, both MedSouth and GRIPA included a structural feature which might have persuaded the Commission to forego such probing examination. Both networks were "non-exclusive" in the sense that members were permitted to, and did, participate in other contracting networks. The Statements make clear that whether a network is judged to be "non-exclusive" depends on the "physician participants' activities, and not simply by the terms of the contractual relationship."[25] In both MedSouth and GRIPA, the Commission was persuaded that the network was

designed to be truly non-exclusive. In practical terms, this meant that any payer that did not wish to support the physicians' experiment in clinical integration could simply walk away, without losing access to any desirable physicians who belonged to the network.

Without the ability to force any payer to accept its terms, it is difficult to see how either network could have an anticompetitive effect – even if it were not particularly adept at generating efficiency. Indeed, the Commission appeared to recognize as much when it stated in *GRIPA*:

> [I]t appears that, if GRIPA in fact operates as it has proposed, Rochester-area payers unwilling for whatever reason to negotiate and contract jointly with physicians through GRIPA nevertheless should be able to deal individually or through other networks in order to obtain the services of GRIPA's member physicians. Under these conditions, it appears unlikely that GRIPA's program would permit it or its physician members to exercise market power or have anticompetitive effects in the market for physician services in the Rochester area.[26]

If a non-exclusive network has no discernible mechanism by which to restrain trade, why require it to adopt all the bells and whistles of clinical integration in order to escape summary condemnation? Why not let it sink or swim in the market? One answer may be that the law simply does not leave room for such ventures. The AMA addresses that issue below.

B. Does Antitrust Law Leave Room For Greater Flexibility In The Concept Of Integration?

As their name attests, the Statements of Antitrust Enforcement Policy in Health Care represent enforcement policy rather than law. As such, the Statements do not necessarily stand at the outer boundaries of what antitrust law permits. Indeed, the AMA submits that the Statements impose restrictions tighter than required by either the law itself or by sound enforcement policy in the current market environment.

Outside the health care context, courts and the Agencies themselves apply a more flexible analysis than is found in the *Statements*. For example, in the Agencies' guidelines on competitor collaboration, the Agencies make no mention of financial or clinical integration. Instead, the *Competitor Collaboration Guidelines* ask more generally whether a joint venture involves "an efficiency-enhancing integration of economic activity" and whether any restraints are "reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits."[27] The Supreme Court, too, in its joint venture cases has eschewed any fixed formulation of what may constitute integration sufficient to warrant rule of reason treatment.

The Agencies' approach to integration has its origins in the Supreme Court's decision in *Arizona v. Maricopa County Medical Society*.[28] *Maricopa* involved physician foundations in Phoenix and Tucson, Arizona. Both foundations included a large number of the physicians in the community; the Maricopa County foundation included over 70% of the county's physicians. And both foundations established maximum fee schedules that were voted on and approved by their memberships. In a 4-3 decision, the Supreme Court held that these maximum fee schedules represented *per se* unlawful price-fixing agreements.

In so holding, the Court distinguished the foundations from "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit."[29] The physicians in the foundations did not put up capital; they did not accept capitation, but instead billed on a fee-for-service basis. Nor did the Court observe any other indicia of integration among the physician practices that comprised the foundations. By contrast, Justice Powell and the two justices who joined his dissent reasoned that the foundations were comparable to the joint licensing arrangements held subject to the rule of reason rather than the *per se* rule in *Broadcast Music Inc. v. CBS.*[30]

Since *Maricopa* was decided, the Agencies have struggled to determine its proper scope. Read for all its worth, *Maricopa* might be said to prohibit any fee-for-service contracting by a physician-sponsored network. But the Agencies have not read the decision this broadly, and for good reasons. *Maricopa* was decided by a closely divided Court and is in significant tension with other Supreme Court cases holding joint arrangements to be subject to the rule of reason.[31] Indeed, the strictest reading of *Maricopa* might prohibit even the robust programs of clinical integration considered in *MedSouth* and *GRIPA*.

Further, the principal issue before the Court in *Maricopa* was whether maximum price-fixing should be treated differently under Section 1 of the Sherman Act from minimum price-fixing. In upholding the application of the *per se* rule to both forms, the Court had no need to – and did not – consider the potential efficiencies of joint contracting. Nor did the Court consider whether the foundations' fee schedules had any actual harmful effect on competition.

In addition, *Maricopa* was decided in 1982, at the dawn of health care antitrust enforcement – only a few years after the Supreme Court held in *Goldfarb v. Virginia State Bar* that professions were subject to the antitrust laws.[32] Nothing in the decision suggests that it was intended to provide the final word on whether and under what conditions physician networks might qualify for rule of reason treatment. If anything, the decision can be criticized as a rush to judgment on a relatively new business form with which the judiciary lacked the experience usually considered necessary before a practice is deemed *per se* unlawful.[33]

Finally, the Supreme Court has long recognized that "the boundaries of the doctrine of *per se* illegality should not be immovable."[34] This principle applies to the antitrust Agencies as well as courts. Indeed, it is the Agencies that have often led the

way toward judicial abrogation of *per se* rules when "the economic realities underlying earlier decisions have changed."[35] For all these reasons, *Maricopa* should not be viewed as posing an obstacle to a more accommodating enforcement policy for physician networks.[36]

IV. A RECONSIDERATION OF EXISTING POLICY

This section describes a more flexible approach to analyzing the activities of physician networks engaged in joint contracting. It begins by describing the potential efficiencies of joint contracting by a physician network. It then considers whether joint pricing is "reasonably necessary" to the attainment of these efficiencies. Finally, it applies the rule of reason to the network's activities.

A. Efficiencies in Physician Network Contracting

The Agencies have long been skeptical of the potential for efficiencies in joint contracting by a physician network. In *GRIPA,* the Commission compared the transactional efficiencies of network contracting to those offered by a mere cartel.[37] The AMA believes the Agencies have been too dismissive. While the efficiencies offered by joint contracting in a physician network may not always be sufficient to warrant a favorable outcome under the rule of reason, these efficiencies should almost invariably be enough to avoid application of the *per se* rule. In the current environment, this is particularly true of networks formed to facilitate joint investment in and use of HIT.

Joint contracting by physicians in a network can result in significant cost savings both for payers and for physicians. On the payer side, joint contracting can make it possible for a payer to obtain ready access to a panel of physicians offering broad geographic and specialty coverage.[38] 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. In its complaint in *United States v. Aetna*, the Justice Department noted that "effective new entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years and costs approximately $50,000,000."[39] When the initial task of network formation is undertaken by the physicians themselves, the costs of entry and expansion for payers may be substantially reduced. Joint contracting thus has the potential both to reduce costs for payers and to increase competition in payer markets. These are cognizable efficiencies, with real potential to lower premiums and expand coverage for purchasers. Any doubt concerning the intrinsic efficiency of physician networks is eliminated by the thriving rental network business that has emerged to service the needs of self-insured employers and even national insurers with inadequate directly contracted networks.

Joint contracting can also make physician contracting more efficient and lead to better informed contract decisions. Most physician practices are simply too small to afford to hire businesspersons and lawyers to review their contracts with payers. Such practices do not have the resources to analyze complex contracts. Whereas payers have sophisticated actuarial and financial resources that enable them to structure and evaluate complex contract proposals, physicians are often in the dark when they consider a contract. By pooling their resources, physicians can spread the costs associated with the analysis of payer contracts, and develop appropriate counter-offers that can benefit physicians, payers, and patients. The effect is to enhance the efficiency of the physicians' practices and make them more responsive to the demands of competition.

Likewise, joint contracting makes it much more practical for physicians to create a network that will facilitate collaboration on information technology, data collection, and other programs designed to monitor patient care and improve quality.

Indeed, joint contracting is essential for those physicians in small or solo practices who wish to participate in performance-based payment initiatives. P4P initiatives are often specifically targeted at medical groups or networks rather than small practices. As a Commonwealth Fund study on P4P recently noted:

> Smaller groups generally have few incentives for care coordination, as they usually do not receive payment beyond the evaluation and management fees they are able to bill for acute visits. However, by banding together under the umbrella of organizations, and becoming eligible for performance payments through [the Medicare P4P Demonstration Project] or similar incentive programs, they have more motivation and support for care coordination.[40]

Under existing enforcement policy, however, physicians in small practices must either lose out on such programs or take the risk that their venture will fall short of the Agencies' notions of clinical or financial integration.

B. Is Joint Contracting "Reasonably Necessary" to the Attainment of Efficiencies?

For a joint venture to qualify for rule of reason treatment under the antitrust laws, it is not enough that the venture generate efficiencies. In addition, to the extent that the venture involves agreements on price, such agreements must be "reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits."[41] This requirement that price restraints be "ancillary" to the procompetitive features of a joint venture is well established in the *Statements* and in case law.[42] We think that, in the context of a physician network engaged in the acquisition and deployment of HIT, this requirement is readily met.

The Commission gave the issue of so-called "ancillarity" extensive consideration in its advisory letters to *MedSouth* and *GRIPA.* In the end, the Commission found that joint negotiation of network contracts was ancillary to the networks' procompetitive purposes. For example, in *GRIPA*, the network asserted that

it could establish an effective program of care coordination among its members only if all physicians were contractually bound at the same time. Achieving this goal required that the physicians be represented jointly rather than individually in contract negotiations with payers. As the Commission stated:

> Identifying up front a set network of physicians, all of whom will participate in all aspects of the program of integration regarding all patients covered under all GRIPA contracts, on its face appears calculated to assure that those efforts will have maximum application and efficacy. And this can only be achieved if GRIPA jointly negotiates the contracts with payers on behalf of all of its physician members.[43]

In reaching this conclusion, the Commission considered the proposition that, because some programs promoting clinical coordination and quality improvement are initiated and administered *by payers*, a physician-sponsored program cannot "ever be 'reasonably necessary' to achieving the efficiencies of clinically integrated programs."[44] The Commission properly rejected this conclusion. The standard for "ancillarity," after all, is one of *reasonable* necessity, not absolute necessity. It does not mandate a "one-size-fits-all" solution. As the Commission recognized, "[d]ifferent types of programs may have different strengths and weaknesses, and the market should determine which programs are most desirable." Moreover, "the competitive restraints that may accompany integrated physician-initiated network programs must be evaluated for their reasonable necessity in the context in which they occur."[45]

The same reasoning should apply generally to physician networks that acquire and use HIT to collect medical data regarding the physicians' collective performance and use it to enhance quality. Joint contracting is reasonably necessary to the efficiencies created by an HIT-driven network for several reasons. First, as in *GRIPA,* the network may need an up-front commitment from its physicians to participate in all contracts negotiated by the network in order to ensure the integrity of the network's

program of data collection and analysis. Without such a commitment, the network cannot know in advance how many physicians will participate, and therefore cannot effectively determine the degree to which the efficiencies of its quality improvement program will be realized.

Second, joint contracting makes it much more practical for physicians to make investments in HIT to monitor patient care and improve quality. HIT systems require considerable investments in time and money. As noted in a recent Congressional Budget Office report, acquiring an office-based HIT system costs between $25,000 and $45,000 per physician, with an additional recurring cost of 12 to 20 percent of that amount in annual operating and maintenance expenses.[46] In addition to these out-of-pocket costs, physicians must also "devote considerable time to training, to personalizing the system, and to adapting their work processes to achieve the maximum benefits."[47]

Physicians cannot be expected to bear such costs without a reasonable prospect of making a return on investment.[48] Yet, as the CBO report notes, from the perspective of a small physician practice, most of the benefits of HIT accrue to payers and other third parties. For example, information technology systems may reduce the frequency of primary and specialty physicians ordering the same test. Although physicians are committed to increasing the quality of care and reducing unnecessary care, neither primary care physicians nor specialists reap an economic advantage by eliminating this duplication. Network formation provides a method for physicians to deal with this "externality" – i.e., to internalize the gains of HIT while spreading its costs, which in turn makes it more likely that physicians will invest in HIT. If in this process the network were to charge higher unit prices than individual members, there remains the potential for overall savings to consumers. As the Commission recognized in GRIPA:

> Higher unit prices may be of little concern to a customer if they occur within integrated programs that result in lower total costs (e.g., through elimination of unnecessary and inappropriate utilization of services) and higher quality (e.g., better medical outcomes).

GRIPA, at 27.

Third, joint contracting addresses a potential "hold out" problem faced by networks that develop HIT. As documented in the CBO report, HIT is characterized by network effects: Some of its benefits increase in value as more providers purchase and use interoperable systems. Accordingly, physicians may wish to postpone the commitment decision until more of their colleagues have purchased systems, allowing them to benefit from others' experience. More importantly, many physicians may decide it is better to wait and see if the organization succeeds than to join it up front. To solve this hold out problem, the HIT network needs the up-front commitment of its physicians to participate in network contracts. This commitment makes it more likely that the HIT network will achieve the necessary critical mass to achieve efficiencies. Potential hold outs who are not willing to make that commitment risk exclusion from the network's contracts.

Because network joint contracting is reasonably necessary to achieving the efficiencies associated with the adoption and implementation of HIT, networks involved in the use of HIT should generally be accorded rule of reason treatment. The required nexus between joint pricing and the potential for efficiency is even more evident when the adoption of HIT is linked to alternative payment mechanisms. For example, in the context of P4P initiatives, most solo or small physician practices lack the scale to participate. By teaming up with other practices in a network, small practices may gain the scale necessary both for care coordination and for the aggregation of data necessary to implementation of performance-based incentives. Accordingly, negotiation by a network of performance-based incentives tied to the achievement of specified

quality goals by the network's members should be treated as "ancillary" to the network's procompetitive purposes.

3. Application of the Rule of Reason

Once the efficiencies of joint contracting are recognized both as non-trivial and as "ancillary" to a network's procompetitive purposes, the rule of reason provides the appropriate analytical approach for balancing those efficiencies against the potential for harm to competition. In the case of a non-exclusive network – one that does not prohibit its members, in law or in fact, from contracting with payers apart from the network – the potential harm to competition is minimal. As explained above, without the ability to force a payer to do business with the network, the physicians have no mechanism for forcing up fees.[49] Non-exclusive networks therefore should generally be found lawful under the rule of reason, without the need for extensive analysis.

Exclusive physician networks may require a more searching examination under the rule of reason. A critical consideration at the outset is the percentage of physicians in the geographic market who participate in the venture. If a large percentage of the available physicians participate in an exclusive network, the network may have the potential to exercise market power.[50] In that event, it then becomes appropriate to look at the competitive effects. Among the potential procompetitive effects, exclusivity may reflect the physicians' enhanced commitment to working together in the network to achieve efficiencies. Without exclusivity, physicians might not invest in a joint venture by coordinating their work, purchase expensive technologies like HIT, pool knowledge by educating each other on best practices, or engage in forms of practice supervision to advance patient care. Concerns about externalities – that are acute in the context of HIT – may make it impossible for the network to have initial success. In addition, exclusivity may help address physician concerns that some

members will "free ride" on the network's efforts by using the jointly-developed HIT to strike their own separate deals with payers. It is well-recognized that exclusive dealing arrangements are a common method of preventing free riding.[51]

In the analysis of an exclusive physician network possessing high market shares and engaged in the acquisition and use of HIT, additional considerations under the rule of reason may include:

- How much capital and time have the physicians invested in the acquisition, operation, and maintenance of HIT?
- How effectively is the network using HIT to collect and analyze medical data?
- To what extent is the network able to document cost savings and improvements in quality resulting from the use of HIT?
- To what extent has the use of HIT enabled the network to participate in performance-based payment or other alternative forms of reimbursement?

As is always the case under the rule of reason, these considerations should be carefully examined to determine whether the network's procompetitive benefits outweigh its anticompetitive effects. The fundamental point, however, is that competitive harm should not merely be presumed, but should be determined based upon a full consideration of the record.

V. CONCLUSION

Price-fixing is, and of course should continue to be, treated as the most serious form of antitrust offense. However, the Statements overestimate the anticompetitive potential that networks lacking market power have on the ability to restrain trade. Arrangements that create plausible efficiencies while posing little risk of anticompetitive injury should not face summary condemnation.

Also, antitrust enforcement policy must adjust to market developments. Presently, however, the Statements impede the ability of physician networks to achieve

plausible efficiencies through joint contracting on a basis that would allow for the implementation of HIT and the participation in P4P and other quality initiatives.

Accordingly, the AMA proposes the following modifications of the existing Statements to reflect changes in the health care market and antitrust law and to provide greater flexibility for physicians to engage in procompetitive joint arrangements.

4. Physician networks supported by plausible efficiencies should not face summary condemnation under the *per se* rule or the “inherently suspect” standard. The Agencies should explicitly recognize that joint contracting is ordinarily reasonably necessary to the attainment of the plausible efficiencies associated with implementing HIT or participating in P4P, among other physician collaborations on quality improvement.

5. Non-exclusive physician networks – those in which the physicians are genuinely available to contract with payers separately from the network – should almost always be found lawful under the rule of reason.

6. Exclusive physician networks should be evaluated under the rule of reason. Absent proof of market power or actual anticompetitive effects, such networks should be found lawful. If an exclusive network is shown to have market power or to result in anticompetitive effects, the network should be viewed under a full rule of reason analysis that balances the anticompetitive effects against efficiencies created by the exclusive network. Among the expected benefits of exclusivity that the Agencies should explicitly recognize are the elimination of free riding and the removal of obstacles to the acquisition and implementation of HIT.

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[1] Congressional Budget Office, “Evidence on the Costs and Benefits of Health Information Technology,” (May 2008) (hereinafter “*CBO Report”)*, at 1.

[2] American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2007) at 5, available at http:www.ama-assn.org/ama/pub/category/9573.html.

[3] *Id.*

[4] *Id.*

[5] *Id.* at 2.

[6] *See* Health Resources and Services Administration, *Physician Supply and Demand: Projections to 2020* (Oct 2006) (projecting a shortfall of approximately 55,000 physicians in 2020); *see also* Merritt, Hawkins, et al., *Will the Last Physician in America Please Turn Off The Lights? A Look at America’s Looming Doctor Shortage* (2004) (predicting a shortage of 90,000 to 200,000 physicians and that average wait

times for medical specialties is likely to increase dramatically beyond the current range of two to five week).

[7] Affidavit of Professor David Dranove at 6-7 (May 13, 2008) submitted in United States v. UnitedHealth Group Inc. and Sierra Health Service Civil No1:08-CV-00322.

[8] Mark V. Pauly, "Competition in Health Insurance Markets," 51 Law & Contemp. Probs. 237 (1998).

[9] Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004).

[10] See Testimony from "Examining Competition in Group Health Care," Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and "Health Insurer Consolidation – The Impact on Small Business," Hearing before the House Small Business Committee, 110th Cong. (Oct. 25, 2007).

[11] *In the Matter of North Texas Specialty Physicians*, FTC Docket No. 9312, slip op. at 46.

[12] *See* FTC Staff Advisory Opinion to MedSouth, Inc. (Feb. 19, 2002), at http://www.ftc.gov/bc/adops/medsourth.htm [hereinafter "MedSouth"] (acknowledging that many financially integrated IPAs have "experience significant financial difficulties under [capitated] contracts, and a number of the organizations [have] declared bankruptcy. In the wake of this experience, payers and most physician groups,…terminated their capitated contracts").

[13] *CBO Report,* at 18.

[14] *Id.* at 19.

[15] Office of National Coordinator for Health Informational Technology (July 2007).

[16] *Id.*

[17] *CBO Report*, at 19-20.

[18] *Id.* at 7.

[19] M. Rosenthal, B. Landon, et al., "Climbing Up the Pay-For-Performance Learning Curve: Where Are the Early Adopters Now?," 26 Health Aff. 1674 (2007).

[20] M. Rosenthal, R. Dudley, "Pay-for-Performance: Will the Latest Payment Trend Improve Care?," 297 J.A.M.A. 740 (2007).

[21] Pham & Ginsburg, *supra*, at 1596; *see id.* at 1590 ("One obstacle to performance measurement and incentive programs' have an impact remains the fragmented nature of U.S. care delivery systems.").

[22] U.S. Department of Justice & Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (Aug. 1996) (hereinafter "*Health Care Statements"* or "*Statements"*), at 72-73.

[23] Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to John J. Miles (Feb. 19, 2002) ("*MedSouth").* When the FTC took a second look at MedSouth five years later, the network had decreased in size to 280 physicians. *See* Letter from Markus H. Meier to John J. Miles (June 18, 2007).

[24] Letter from Markus H. Meier to Christi J. Braun & John J. Miles (Sept. 17, 2007) ("*GRIPA"*).

[25] *Health Care Statements,* at 66.

[26] *GRIPA,* at 26.

[27] *Antitrust Guidelines for Collaborations Among Competitors* (April 2000) (*"Competitor Collaboration Guidelines")* at § 3.2.

[28] *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982).

[29] *Id.* at 356.

[30] *Broadcast Music, Inc. v. Columbia Broadcasting System,* 441 U.S. 1 (1979) ("*BMI*").

[31] *See, e.g., BMI,* 441 U.S. 1; *National Collegiate Athletic Association v. Board of Regents,* 468 U.S. 85 (1984) ("*NCAA*").

[32] 421 U.S. 773 (1975).

[33] *See* 457 U.S. at 367 (Powell, J., dissenting).

[34] *Leegin Creative Leather Prods., Inc. v. PSKS, Inc.,* 127 S. Ct. 2705, 2721 (2007) (overruling *per se* rule against vertical price restraints).

[35] *State Oil v. Khan*, 522 U.S. 3, 21 (1997) (overruling *per se* rule against maximum vertical price-fixing).

[36] The Fifth Circuit's recent decision in *North Texas Specialty Physicians* is not to the contrary. ___ F.3d ___ (5th Cir. 2008). Indeed, rather than finding a *per se* violation by the physician network in that case, the court viewed the network's activities under the rule of reason.

[37] *GRIPA,* at 23 ("Any joint marketing arrangement, and indeed any cartel, provides transaction costs efficiencies when compared to engaging in individual sales transactions in markets with numerous participants.")

[38] *See* F. Easterbrook, "Maximum Price Fixing," 48 U. Chi. L. Rev. 886, 898-99 (1981) (noting transactional efficiencies of joint contracting by physician network).

[39] *United States v. Aetna,* No. 3-99CV1398-H (N.D. Tex.) (complaint filed June 21, 1999).

[40] M. Trisolini, G. Pope, et al., "Medicare Physician Group Practices: Innovations in Quality and Efficiency," The Commonwealth Fund (2006), available at www.commonwealthfund.org/usr_doc/971_Trisolini_Medicare_physician_group_practices_i.pdf.

[41] *Competitor Collaboration Guidelines* at § 3.2.

[42] *See, e.g., NCAA v. Board of Regents of the Univ. of Oklahoma,* 468 U.S. 85 (1984).

[43] *GRIPA,* at 19.

[44] *Id.* at 17.

[45] *Id.*

[46] *CBO Report,* at 17 (and studies cited therein).

[47] *Id.* at 19.

[48] *Id.* (noting that "many providers cannot generate the additional income necessary to justify the significant investment in time and money that the adoption of such a system would require").

[49] *See* H. Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* § 5.6 (1994) (a non-exclusive physician network is "absolutely inconsistent with the economics of cartelization: no cartel could restrict its output and raise price if it permitted its members freely to come and go, or to make unlimited 'non-cartel' sales.").

[50] The effect of high physician market shares on consumer welfare depends on the pre-existing concentration of health plan purchasing power. *See* Roger Blair & Jill Herndon, *Physician Cooperative Bargaining Ventures: An Economic Analysis,* 71 Antitrust L.J. 989 (2004); Tom Campbell, *Bilateral Monopoly in Mergers,* 74 Antitrust L.J. 521 (2007).

[51] *See e.g., Continental T.V. , Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977).