Statement

of the

American Medical Association

to the

Committee on Small Business
United States House of Representatives

RE: Small Business Competition Policy: Are Markets Open for Entrepreneurs?

Presented by William A. Hazel, Jr., MD

September 25, 2008

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The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on Small Business regarding Small Business Competition Policy. We commend Chairwoman Velazquez, Ranking Member Chabot, and Members of the Committee for your leadership in recognizing that important changes in the health care market warrant new approaches to health care antitrust policy.

Current health care antitrust enforcement policy unduly restricts physician collaboration, especially among small physician practices. As such, it has chilled physician attempts at joint contracting,[1] hindered physicians' ability to participate in the full spectrum of health care initiatives, and perpetuated a severe imbalance in the market whereby dominant health insurers that have enjoyed unfettered consolidation force physicians to adhere to contracts that create obstacles to providing optimal patient care and unduly restrict their autonomy. We believe that the Federal Trade Commission (FTC) should provide for more flexibility on physician joint contracting in order to allow small practices to collaborate on Health Information Technology (HIT) and health care quality improvement initiatives. In addition, the Department of Justice (DOJ) must more aggressively challenge health insurer mergers. These steps would restore balance to the health care market and help to ensure an innovative and efficient health care system.

ANTITRUST LAW AND POLICY

Current Antitrust Policy

Despite recent developments and changes in the health care market, enforcement policy—embodied today in the *Statements of Enforcement Policy in Health Care* (the Statements)

[1] Since April 2002, the FTC has brought at least 25 cases against physician groups based upon contracting arrangements with health insurers. All but one of the groups chose to settle with the FTC rather than engage in a protracted, financially devastating legal battle.

developed jointly by the FTC and the DOJ during the 1990s—casts an overly suspicious eye on physician collaboration through network arrangements. Specifically, the Statements give too little credence to the benefits of physician collaboration that do not fit within the agencies' rigid models of allowable "integration"—attributes that make a joint arrangement sufficiently likely to generate efficiency such that application of a reasonableness standard in evaluating the joint arrangement is appropriate—and overestimate the anticompetitive potential of physician collaborations that lack market power and therefore lack the ability to restrain trade. Arrangements that have benefits to the health care system while posing little risk of anticompetitive injury should be embraced so that physicians may engage in pro-competitive joint arrangements that result in efficiencies and improved patient care and coordination.

The initial version of the Statements was released in September 1993. They reflected efforts to provide clarity to medical professionals and companies by articulating policies that had emerged previously only in advisory letters, speeches, and consent decrees. As originally issued, the Statements contained eight separate policy statements, including one on "Physician Network Joint Ventures."[2] Statement 8 identified two features of particular importance: (1) the network's percentage or "share" of the physicians in each physician specialty practicing in the relevant geographic market; and (2) whether the physicians had integrated their practices by sharing "substantial financial risk."[3]

According to the Statements, sharing "substantial financial risk" could be accomplished in one 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. The existence of either of these examples of substantial financial risk meant that the physician collaboration, if challenged, would be evaluated under the rule of reason standard.[4] The absence of any evidence of substantial financial risk would result in summary condemnation as *per se* illegal price fixing.[5]

With the rapid expansion of managed care in the 1990's, the requirement of financial risk-sharing as the defining feature of a legitimate physician network proved to be unduly restrictive. Contrary to early predictions, in most areas of the country physician capitation proved to be an unpopular and highly controversial payment methodology. Employers

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[2] The FTC declared in Statement 9, that networks that are not substantially integrated can instead use a "messenger model" arrangement to facilitate their individual contract negotiations with health plans and avoid price fixing. Essentially, proper implementation of the messenger model is achieved when the messenger shuttles between health care professionals and payers, carrying offers on reimbursement rates in a back-and-forth process that eventually will yield a rate acceptable to both the professional and the plan.

[3] In the specific context of physician contracting networks, only the sharing of "substantial financial risk" was embraced as sufficient to allow a network to be evaluated under a reasonableness standard. Other forms of integration—structural, functional, or transactional—were not considered adequate.

4 The so-called "rule of reason" has been the hallmark of judicial construction of the antitrust laws. Under its aegis, the anticompetitive consequences of a challenged practice are weighed against the business justifications upon which it is predicated and its putative pro-competitive impact, and a judgment with respect to its reasonableness is made.

[5] *Per se* illegality conclusively presumes the challenged practices to be unreasonable. In other words, when a per se offense (such as price fixing among competitors) is charged, all the government must establish is that the defendant has, in fact, engaged in the proscribed practice; illegality follows as a matter of law, no matter how slight the anticompetitive effect, how small the market share of the defendants, or how proper their motives.

wanted broad networks that allowed patients a significant choice among physicians, without perceived incentives to ration care. Yet the definition of "substantial financial risk" adopted by the agencies raised a substantial barrier to the participation of physician-led contracting networks.

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." 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 create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[6] 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 efficiencies associated with financial risk sharing—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 FTC issued a staff advisory letter to MedSouth, Inc., an Independent Practice Association (IPA) based in Denver, Colorado with over 400 physicians.[7] And in 2007, the FTC 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.[8] The MedSouth and GRIPA letters demonstrate how high the bar has been set for physician networks seeking to clinically integrate. While the MedSouth and GRIPA proposals are not identical, they bear significant similarities.[9] Both MedSouth and GRIPA made significant investments in capital and resources, using myriad consultants, lawyers, 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. Both networks developed clinical practice guidelines and procedures for monitoring their compliance, and both networks were "non-exclusive," meaning that payers choosing not to support the clinically integrated program would not lose access to any desirable physicians who were participating in the network.

Importantly, in both instances, the FTC advisory letters noted no apparent anticompetitive motivation for the physicians' efforts. Despite this lack of anticompetitive motivation and the significant time and resources employed, however, neither MedSouth nor GRIPA achieved agency approval easily or without significant caveats. Both advisory letters reflected intensive agency investigation of the networks' history, purposes, contracting mechanisms, disciplinary methods for non-compliant physicians, and strategies for producing efficiencies. Each involved a searching examination of the so-called

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

[7] Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to John J. Miles (Feb. 19, 2002) *("MedSouth").*

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

[9] Notably, both networks were originally built for capitation, but needed to adapt in the face of market resistance. Thus, both MedSouth and GRIPA were constructed "as if" the physicians were sharing substantial financial risk. Only when risk contracting proved to be commercially infeasible did the networks see FTC approval for their clinical integration programs.

"ancillarity"[10] of the networks' pricing mechanisms to its efficiency-enhancing potential. And each left the agency plenty of room to bring a later enforcement action if the networks' operations could not later be shown to produce significant efficiencies.

The MedSouth and GRIPA advisory letters reflect the extremely high level of clinical integration required by the FTC. Absent vast resources, such as those available to MedSouth and GRIPA, most physicians are effectively barred from forming physician networks. Without such networks, physicians cannot work collaboratively on costly and involved health care quality initiatives or participate in balanced negotiations with health insurers. We believe that where such collaborative efforts have no ability to restrain trade, there should be more flexibility for physicians to jointly contract.

Current Antitrust Law

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 Statements impose restrictions tighter than required either by 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, there is 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 pro-competitive benefits."[11] 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.[12]

RECENT CHANGES IN THE HEALTH CARE MARKET

Over the past several years, health care market conditions have changed in significant ways that suggest a need to revisit the antitrust landscape. Health plan consolidation has severely limited physicians' ability to advocate on behalf of themselves and their patients. Also, market and regulatory developments are encouraging physician integration for the purposes of purchasing and using HIT and measuring and improving medical care. Rather than protect potential physician clinical integration efforts, current enforcement agency policy discourages them. They have only recognized as lawful, efforts that are out of reach for small and solo physician practices.

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[10] Ancillarity refers to whether a price mechanism is "reasonably related to the integration and reasonably necessary to achieve its pro-competitive benefits." *See, e.g., NCAA v. Board of Regents of the Univ. of Oklahoma,* 468 U.S. 85 (1984).

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

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

Uncontrolled Health Insurer Market Power and Consolidation

The health insurer market has also changed significantly due to a wave of mergers among large HMOs and health insurers over the past decade, steadily eroding the competitive payer market.[13] In the last decade, over 400 health insurer mergers, only three of which have been challenged by the DOJ, have resulted in an increasingly consolidated payer market.[14] This consolidation has resulted in the steady increase of premiums, even as patient co-pays and deductibles have expanded, effectively shrinking the scope of coverage, and an extreme imbalance in insurer-physician contracting that threatens all aspects of patient care.

The power garnered by health insurers through rapid, large-scale consolidation has not been used to the advantage of patients or physicians. Patient premiums have soared in this increasingly consolidated market and physician reimbursement has decreased. As premiums have risen, many employers have stopped providing coverage, reduced the scope of benefits provided, and/or asked employees to pay a higher share of the overall premium. As of 2006, premiums for employer-based health insurance rose more than twice as fast as overall inflation and wages for the seventh straight year.[15] Since 2000, the amount that workers pay toward family health care coverage has skyrocketed 84 percent[16] and five million fewer workers were receiving job-based coverage in 2006 than in 2000.[17] During the same period, average wages have increased only 20 percent.[18] These skyrocketing costs have directly contributed to an increase in the number of uninsured. Research shows that a one percent increase in premiums results in a net increase in the uninsured of 164,000 individuals.[19]

Like America's patients, physicians have not been the beneficiaries of these increases either. Powerful insurers have depressed physician revenues.[20] The median real income of all U.S.

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[13] In 2000, the two largest health insurers, Aetna and UnitedHealth Group (United), had a total combined membership of 32 million people. Due to aggressive merger activity since 2000, including United's acquisition of California-based PacifiCare Health Systems, Inc., and John Deere Health Plan in 2005, United's membership alone has grown to 33 million. Similarly, WellPoint, Inc. (Wellpoint), the company born of the merger of Anthem, Inc. (originally Blue Cross Blue Shield of Indiana), and WellPoint Health Networks, Inc. (originally Blue Cross of California), now owns Blue Cross plans in 14 states. In 2005, WellPoint acquired the last remaining Blue Cross Blue Shield plan, the New York-based WellChoice. Consequently, in 2005, WellPoint covered approximately 34 million Americans. Most recently, United acquired Sierra Health Systems in Nevada, allowing United to acquire over 50 percent of the Nevada market, including a 90 percent share of the health maintenance organization (HMO) market. Irving Levin Associates*, supra*.

[14] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets /* 2007 Update, 1

[15] The Kaiser Family foundation and Health Research Educational Trust; *Employer Health Benefits 2006 Summary of Findings.*

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] Chernew, M., Cutler, D., and P. Keenan, "Increasing Health Insurance Costs and the Decline in Insurance Coverage," Health Services Research, August 2005.

[20] Depressed physician reimbursements contribute to higher costs to patients. That lower physician fees paid by insurers may result in higher prices to patients was emphasized by R. Hewitt Pate, a former Assistant Attorney General of the Antitrust Division, in a statement before the Senate Judiciary Committee:

> A casual observer might believe that if a merger lowers the price the merged firm pays for its inputs, consumers will necessarily benefit. The logic seems to be that because the input purchaser is paying less, the input purchaser's customers should

physicians remained flat during the 1990s and has since decreased.[21] Health plan executives and shareholders, on the other hand, are reaping enormous monopoly profits.[22] Recent reports on health insurer profits show that the profit margins of the major national firms have experienced double-digit growth since 2001.[23] United and WellPoint, specifically, have had seven years of consecutive double-digit growth that has ranged from 20 to 70 percent year after year (through 2003).[24]

In addition to effecting costs, payments, and profits, consolidation has given way to an environment in which health plans are able to dictate important aspects of patient care and material contract terms to physicians.[25] Physicians have little to no ability to influence insurer contracts that touch on virtually every aspect of the patient-physician relationship.[26] This means that physicians must agree to contracts that often include provisions that make it difficult, if not impossible, for them to promote what they deem to be the highest quality patient care. For example, many contracts define "medically necessary care" in a manner that allows the health plan to overrule the physician's medical judgment and require the lowest cost, but not necessarily optimal, care for the patient. Others require compliance with undefined "utilization management" or "quality assurance" programs that often are nothing more than thinly disguised cost-cutting programs that penalize physicians for providing care they deem necessary.

These contracts also often dictate material terms. They may refer to "fee schedules" that are never provided and can be revised unilaterally by the health insurer. Many contracts, in fact, allow the health insurer to change *any* term of the contract unilaterally. These contracts also frequently contain such unreasonable provisions as "most favored payer" clauses—clauses requiring physicians to bill the dominant health insurer at a level equal to the lowest amount the physician charges any other health insurer in the region[27]—and "all products" clauses—

> expect to pay less also. But that is not necessarily the case. Input prices can fall for two entirely different reasons, one of which arises from true economic efficiency that will tend to result in lower prices for final consumers. The other, in contrast, represents an efficiency-reducing exercise of market power that will reduce economic welfare, lower prices for suppliers, and may well result in higher prices charged to final consumers.

Lower input prices for physician services do not lead to lower consumer output prices for health premiums. Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care, " 71 Antitrust L.J. 949 (2004).

[21] Ha T. Tu, Paul B. Ginsburg, "Losing Ground: Physician Income, 1995-2005," Center for Studying Health Systems Change Tracking Report No. 15 (June 2006).

[22] James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," Health Affairs, Vol. 23 No. 6 (2004).

[23]See id. at 19-20

[24] See id.

[25] *See generally* American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2007 Update, at 5.

[26] Many contracts, in fact, are essentially "contracts of adhesion"—standardized contracts that are submitted to a weaker party on a take-it or leave-it basis and do not provide for negotiation.

[27] This permits the dominant health insurer to guarantee that it will have the lowest input costs in the market, making it that much more difficult for new payers to enter the market.

clauses requiring physicians to participate in all products offered by a health insurer as a condition of participation in any one product.[28]

Despite the improper restrictions and potential dangers of these contracts, current imbalance in the market dictates that physicians typically have no choice but to accept them. Any alleged "choice" is illusory given that choosing to leave the network often means terminating patient relationships and drastically reducing or losing one's practice. Because medical services cannot be stored or exported, physicians have limited options for selling their services. If physicians were to refuse the terms of the dominant health plan, they would likely suffer an unrecoverable loss. Consequently, a physician's ability to terminate a relationship with a health plan depends on that physician's ability to make up for the loss by switching to an alternative insurance coverage plan. Where alternatives are lacking, physicians are forced to accept unfair contracts.[29] Furthermore, even where there are alternatives, physicians are limited in their ability to encourage patients to switch plans, as patients can only switch employer-sponsored plans once a year during open enrollment, and even then, they have limited options and could incur considerable out-of-pocket costs.[30]

In this environment, the antitrust enforcement agencies need to do more to protect competition in health insurer markets. They should also acknowledge that their present antitrust policies on physician networks incur the considerable cost of discouraging important forms of physician clinical integration. Therefore, these policies require revision.

Insufficiency of Integration models

Integration, as currently envisioned by the FTC, does not provide a viable option for the vast majority of physicians hoping to contract jointly. Financial risk sharing, as described in the Statements, has largely fallen out of favor. Employers and other purchasers of health care coverage have largely rejected payer-provider risk sharing arrangements. While clinical integration provides a nominal alternative, as noted above, the MedSouth and GRIPA letters suggest a level of investment that for small physician practices is at best an enormous obstacle and at worst a complete bar to physician collaboration. Likewise, the messenger model, the alternative to integration, is not adequate. It is confusing and complex and has proven to be a minefield for many physicians who have attempted to make use of it.

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[28] This often includes the health insurer reserving the right to introduce new plans and designate a physician's participation in those plans. Given the rapid development of new products and plans, the inability of physicians to select which products and plans they want to participate in makes it difficult for physicians to manage their practices effectively.

[29] The DOJ, in its 1999 challenge of the Aetna/Prudential merger recognized that there are substantial barriers to physicians expeditiously replacing lost revenue by changing health plans. It also noted that this imposes a permanent loss of revenue. *United States v. Aetna*, Revised Competitive Impact Statement, Civil Action 3-99CV1398-H (N.D.Tex, 1999), available at: http://www.usdoj.gov/atr/cases/f2600/2648.htm. The DOJ reiterated this position in its challenge to the UnitedHealth Group/PacifiCare merger. *See United States v. UnitedHealth Group Inc.,* Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005), *available at* http://www.usdoj.gov/atr/cases/f213800/213815.htm.

[30] *See id.*

Recent Health Care Initiatives

Another significant change in the health care market is the desire to implement HIT and the rise of quality and consumer directed health care initiatives. There are increasingly focused efforts on developing methods of promoting and measuring quality. At the same time, the federal government is seeking to encourage physicians and other providers to invest in HIT to facilitate the collection and sharing of clinical data. On the payer side, employers are favoring plans that put increasing responsibility on patients to participate actively in choosing (and paying for) care. 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.[31]

The shift towards performance-based reimbursement provides a good example of the strong incentives for physicians to collaborate with one another to collect and analyze quality data. "Pay-for-performance" (P4P) reimbursement is "now routinely used by both private and public payers in the U.S. health care system."[32] A majority of commercial HMOs use P4P, and recent legislation requires Medicare to adopt performance-based incentives.[33] As the adoption of P4P spreads and its use expands, physicians in small practices will be increasingly motivated to align in networks in order to have the capability to participate in these programs. Such arrangements will have a strong potential to enhance efficiency, but will not necessarily rise to the level of clinical integration recognized by the agencies.

PHYSICIAN COLLABORATION WILL IMPROVE HEALTH CARE

Joint contracting by physicians in a network can result in significant cost savings for both payers and 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.[34] Because physicians still practice predominantly in solo practices or in small groups[35], creating a physician panel can be a very time-consuming and expensive task and can be a barrier to entry or expansion for new or less significant insurers. 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

[31] *See* H. Pham and P. Ginsburg, "Unhealthy Trends: The Future of Physician Services," 26 Health Aff. 1586, 1590 (2007) ("widespread adoption [of HIT] will occur only when … [most physicians] practice in large networks that have adequate capital and can both make unified decisions regarding the investment in and optimal use of the integrative potential of the technology.").

32 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).

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

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

[35] Almost three-quarters of physicians in solo or small-group practice settings *See,* Solo and Small Group Physician Practices Can Reap Benefits from Electronic Health Records, But Face Challenges, The Commonwealth Fund News Release, Sept. 12, 2005, can be found at http://www.commonwealthfund.org/newsroom/newsroom_show.htm?doc_id=296456

approximately $50,000,000."[36] When the physicians themselves undertake the initial task of network formation, payers may substantially reduce the costs of entry and expansion.[37] Joint contracting thus has the potential both to reduce costs for payers and to increase competition in payer markets. These are cognizable benefits, with real potential to lower premiums and expand coverage for America's patients.

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 businesspeople 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 patient, physicians, and payers. The effect is to enhance the efficiency of the physicians' practices and make them more responsive to the demands of competition.

Likewise, joint contracting can provide the resources physicians need for creating networks that will facilitate collaboration on HIT. Currently, however, physicians are unable to capture the financial returns or significant benefits from HIT that are necessary to offset the daunting implementation costs. Instead, those benefits and financial returns accrue mainly to health plans or patients, rather than physicians. The benefits of HIT fall into two basic categories. First, the system may reduce the costs of running a medical practice. It is unlikely, however, as noted by the Congressional Budget Office, that a solo practitioner or a small group practice will realize any real, internal cost savings from information technology systems.[38] Second, these systems can create cost savings by increased availability of patient data and reducing things such as duplication in services provided to patients. For instance, HIT may reduce the frequency of primary and specialty physicians ordering the same test.

This is a common problem recognized in economics—the problem of externalities. An externality arises when an individual cannot recover the costs of investing in an asset because most of the benefits fall to an individual whom the investor has no way of charging for the benefit.[39] In the health care context, the benefits of costly HIT systems[40] do not produce the necessary incentives for physicians to invest in them. For this reason, only 14

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

[37] Any doubt concerning the intrinsic efficiency of physician networks should be eliminated by the thriving rental network business that has emerged to supplement inadequate networks.

[38] *See* Congressional Budget Office, "Evidence on the Costs and Benefits of Health Information Technology," (May 2008) (hereinafter "CBO Report") at 19-20.

[39] Building roads is a good example, as is putting air filtration systems on factories. When the externality is large and the upfront costs for the investment are significant in relation of the expected recoverable benefit, a market failure occurs. This market failure means the investment is not made and consumers are made worse off.

[40] Acquiring and implementing an Electronic Health Record (EHR) system, for example, entails a significant financial investment. One study examining such acquisition costs for solo or small group practices estimated that "[i]nitial EHR costs were approximately $44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about $8,500 per FTE provider per year." R.H. Miller, et al., "The Value of Electronic Health Records in Solo or Small Group Practices," 24 *Health Aff* 1127, 1130 (2005).

percent of physicians have minimally functional Electronic Health Record (EHR) systems.[41] Solo or single partner practices, accounting for about half of all doctors, had the lowest level of comprehensive EHR use—7.1 percent of solo practitioners and 9.7 percent of those with a partner.[42]

While joint negotiation may have an impact on costs for physician services, it will reduce overall system costs. HIT systems will create efficiencies that will improve care and likely reduce costs. According to the CBO report, HIT has the potential, if adopted widely and used effectively, to save the health care sector about $80 billion annually (in 2005 dollars).[43] Thus, gains in the form of market efficiencies, reduced utilization, and increased availability of patient data will offset higher costs for networks to implement HIT. The FTC recognized this in its GRIPA advisory letter:

> 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).[44]

How well HIT lives up to its potential, however, depends in part on how effectively financial incentives are realigned to encourage the optimal use of the technology's capabilities.[45] In the current environment, health insurers, the entities most likely to benefit from cost savings, have demonstrated little interest in implementing these systems and are unlikely to make substantial investments in HIT in the future. Given the expense of HIT implementation and the inability of physicians, the group to which the burden of implementation has fallen, to capture the majority of benefits and returns, physicians should be permitted to negotiate jointly with payers to properly allocate cost savings. Without the ability to recoup some of the expense of these systems by joining a network and achieving increased contracting efficiencies, it will be difficult, if not impossible for many physicians across the country to make the significant investments in time and money that the adoption of such a system would require.

Joint contracting is also essential for those physicians in small or solo practices who wish to participate in performance-based payment initiatives. The data and coordination required for these programs is out of reach for the majority of physicians. The FTC in its GRIPA advisory letter recognized this when it noted that implementing a program in which different subsets of physicians are participating in different payer contracts "could interfere with the network's ability to effectively gather data and monitor and evaluate physician performance under the program." Currently, most performance-based payment initiatives are specifically targeted at medical groups or networks rather than small practices. As a Commonwealth Fund study on P4P recently noted:

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[41] Office of National Coordinator for Health Informational Technology (July 2007).
[42] *Id.*
[43] CBO Report, at 18
[44] *GRIPA* at 27
[45] CBO Report at 7.

> 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.[46]

Physicians, who still practice predominately in small groups, lack the scale to participate in quality and HIT programs. By teaming up in a network, small practices may gain the magnitude for the care coordination, aggregation of data, and purchasing power required for the implementation of these initiatives.

CONCLUSION

The health care antitrust landscape has changed. FTC and DOJ policies that have led to aggressive antitrust enforcement actions against physicians, unfettered consolidation of health insurers, and limited opportunities for physicians to collaborate on important initiatives should be re-examined. Physician joint contracting provides ready access to physician panels, fair, efficient, and informed contract negotiations, and economies of scale to participate in HIT and quality programs. In addition, most physician networks pose no threat to competition. Rather than restraining trade, a more flexible approach to joint contracting will have a pro-competitive result—promoting and rewarding efficiency and innovation in the health care system. Thus, we encourage the FTC to revisit the Statements to accommodate the needs of the changing health care market.

[46] 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.