

**ON INTEGRATION, PHYSICIAN JOINT CONTRACTING, AND QUALITY:  
TAKING A FRESH LOOK AT SOME “SETTLED” QUESTIONS**

**Presentation to the Federal Trade Commission  
Workshop on Health Care Competition Law and Policy  
Washington, D.C.  
September 9, 2002**

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Good morning. My name is Catherine Hanson. I am the Vice-President of Legal Affairs and General Counsel for the California Medical Association. I am here to offer the perspective of the American Medical Association and practicing physicians generally on the application of the antitrust laws to physician conduct.

At the outset, let me assure you that we who represent the medical profession support efforts to promote competition in the health care system. We recognize that competition may lead to quality improvements, innovation, and enhanced access to medical services. At the same time, we think that competition in health care needs to be understood in proper context. Health care is, in significant respects, different from other types of commerce. Because patients often lack the information they need to make wise choices, they rely on medical professionals to help them to understand their options and to advocate their interests. Too often, when physicians join together to try to address legitimate concerns and to promote the interests of their patients, the antitrust laws seem to get in the way.

We believe it is 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 simply do not hold up to close examination. They are not compelled by statutes or case law, or

even by an understanding of how markets work. Rather, they are simply assumptions – assumptions which have never been proven and which, in our view, have outlived any purpose they once may have served.

Today, we would like to try to identify some of these assumptions and explain why we believe the Commission should revisit them. We also offer some specific recommendations for change in enforcement policy. The assumptions we address concern three general areas: integration, physician joint contracting, and quality.

Our central message boils down to this: When physicians create a network to market their services jointly to a health plan, 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. The Rule of Reason is up to the task of distinguishing between physician networks that are truly harmful to competition and those which are benign. Application of the Rule of Reason to both fee-for-service and risk contracting will allow greater flexibility, more room for innovation, and, ultimately, a more competitive and better health care system.

### **Core Principles Worth Re-Examining**

1. ***“Capitation and other forms of risk contracting are ‘more efficient’ than fee-for-service medicine.”*** The first assumption I want to address concerns the relative efficiency of the two principal types of contracting for physician services – fee-for-service and at-risk. Fee-for-service contracts establish an agreed-on payment amount for each medical service covered by the contract. Risk contracts may be based on capitation (a per member per month amount for each covered person) or substantial fee withholds, in which a portion of each

payment is held back to establish a pool from which costs in excess of a target amount can be recovered. The essence of a risk contract is that it transfers from the health plan to the physicians all or a portion of the risk that the medical costs of an insured population will exceed budgetary projections.

Both of these types of contracting are commonly found in health care markets. And both types are regularly adopted and used by payers. But physician-sponsored networks that adopt a fee-for-service approach are exposed to much higher antitrust risks than networks that engage in risk contracting. Setting aside the special case of “clinical integration” (which we discuss below), physician-sponsored fee-for-service networks are subject to the *per se* rule and are thus banned outright. By contrast, risk contracting by such a network is permitted. Indeed, not only does risk contracting receive Rule of Reason treatment, it is almost always deemed lawful under the Rule of Reason because of the supposed efficiencies of risk contracting.

Why does competition policy distinguish so starkly between these two methods of contracting, both of which are commonly used by payers around the country? The agencies have taken the position that capitation and the use of withholds promote efficiency by giving the physicians an incentive to contain costs. As explained in the *Health Care Policy Statements*,<sup>1</sup> financial risk-sharing is usually “a clear and reliable indicator that a physician network involves sufficient integration by its physician participants to achieve significant efficiencies.”<sup>2</sup> By contrast, joint contracting on a fee-for-service basis has been thought to hold no such promise of efficiencies, and has therefore been treated as illegal *per se*.

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<sup>1</sup> U.S. Dept. of Justice & Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care (1996) (“Health Care Policy Statements”).

As a factual matter, it is far from clear whether risk contracting by physicians really is “more efficient” than fee-for-service. To the extent this question has been studied to date, the results have been inconclusive.<sup>3</sup> The agencies’ position therefore appears to be based on supposition rather than proven fact. If one were to seriously undertake to address this question, one would have to gather and compare data on the overall costs and quality of care of both capitated and fee-for-service physician networks. For a variety of reasons, this would be a daunting task.

Any proper study of the relative efficiency of fee-for-service and risk contracting by physician networks would need to take into account a number of factors that often are not included in tabulating health care costs. For example, the study would need to consider the administrative costs of risk contracting, including the costs of legal and regulatory compliance. And the study would also need to include the cost of any reductions in quality that may result from one system of payment versus the other.<sup>4</sup> Such costs may include the costs of follow-up care when appropriate services are limited or denied in the first instance. They may also include reductions in quality resulting from actuarially unsound capitation rates. The effect of risk contracting on quality is itself a highly controversial, and unsettled, question – but one that antitrust policy should take into consideration as better data emerges.

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<sup>2</sup> *Health Care Policy Statements*, Statement Number 9.

<sup>3</sup> Cf. K. Sullivan, “On the ‘Efficiency’ of Managed Care Plans,” *Health Affairs* 139 (July/August 2000); L. Casalino, “Canaries in a Coal Mine: Physician Groups and Competition,” *Health Affairs* 97 (July/August 2001) (“[c]apitation is simply a payment method, neither a panacea nor the root of all evil. The degree to which capitation encourages organizations to compete on quality and efficiency depends on the market context within which it is used.”).

<sup>4</sup> See, e.g., R Miller & H. Luft, “Does Managed Care Lead to Better or Worse Quality of Care?” *Health Affairs* 7 (Sept./Oct. 1997).

An additional cost that is all too familiar to those of us in California is that of physician bankruptcies resulting from inadequate capitation rates. In California, where risk contracting is the norm rather than the exception, dozens of medical groups and IPAs have declared bankruptcy since 1999, and dozens more face the prospect of doing so.<sup>5</sup> Together, these groups and IPAs were responsible for providing medical care for over 2.5 million people. These groups were simply not being paid enough to cover the costs of the medical care required by their patient populations.<sup>6</sup> Their bankruptcies caused enormous disruptions in care and dislocations in the market, with many individuals losing access to their physician of choice – or, indeed, to any physician at all. Similar circumstances have unfolded in other states.<sup>7</sup> Risk contracting, as its name suggests, inherently involves the possibility of a downside – the costs of which must be taken into account.

But even if it were demonstrably true that one form of contracting is “more efficient” than another, there is a more fundamental question to address: Is it the proper role of

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<sup>5</sup> J. Robinson, “Physician Organization in California: Crisis and Opportunity,” *Health Affairs* 81, 85 (July/August 2001) (“Low payments, expressed most clearly in dismal per member per month capitation rates, are the proximate cause of the difficulties inflicting medical groups and IPAs in California.”); Lentz, “Closure Count: Report Enumerates California Medical Group Failures,” *Modern Physician* (Aug. 1, 2001)

<sup>6</sup> “It is clear that plan payment rates have to meet provider expenses over time to sustain risk transfer arrangements, but that has not been the case in many instances for a number of reasons. Some providers have been overly optimistic about their ability to manage care. Others may have been naïve in rate negotiation and actuarial estimation. Still others accepted risk for costs they could not be expected to control, or they encountered unexpectedly large cost increases. In other situations, plans may have used the threat of exclusion from their networks to gain providers’ acceptance of what provide to be inadequate rates, or refused to include realistic updates to reflect changing conditions.” R. Hurley, J. Grossman, T. Lake, & L. Casalino, “A Longitudinal Perspective on Health Plan-Provider Risk Contracting,” *Health Affairs* 144, 152 (July/August 2002).

<sup>7</sup> See, e.g., Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to John J. Miles (Feb. 19, 2002) (“*MedSouth*”) (noting that many IPAs in Denver “experienced significant financial difficulties under [capitation] contracts, and a number of the organizations declared bankruptcy.”).

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.<sup>8</sup>

When regulators do intervene, the cure can be worse than the supposed malady. Consider a physician network that wants to accept risk, but is unable to persuade the payer, who prefers to contract on a fee-for-service basis.<sup>9</sup> Rather than risk being accused of price fixing, the network abandons the discussions, leaving the payer with one less competitive alternative. Or, the payer might seek to take advantage of the situation and demand that the physicians accept an inadequate capitation rate. In effect, the physicians end up trading off a competitive market rate in exchange for antitrust protection. In all of these scenarios, competition is distorted by an enforcement policy that favors one method of contracting over the other.

**2. “Joint contracting by physicians on a fee-for-service basis offers no potential for transactional or other efficiencies.”** Current enforcement policy assumes that physician joint contracting on a fee-for-service basis never offers any significant efficiencies. (Again, we set aside for the moment the special case of “clinical integration”). We believe this assumption is mistaken.

To illustrate, consider the example of a hypothetical – but fairly typical – physician-sponsored network. The network includes a large number of physicians in the

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<sup>8</sup> See C. Havighurst, “Are the Antitrust Agencies Overregulating Physician Networks,” 8 *Loyola Consumer L. Rptr.* 78, 90 (1996) (“putting doctors at financial risk in treating their patients is not so obviously a wise and prudent policy that all physician-sponsored health plans should be forced into that mold.”).

<sup>9</sup> In many markets, payers resist or refuse outright to enter into risk arrangements with physicians. Their reasons may include business considerations, pressures from employers, lack of confidence in the physicians to manage risk, or concerns regarding legal liability. See R. Hurley, *et al.*, *supra* n. 6, at 149.

community, consistent with the desire of many employers and patients for a wide choice of physicians. Before a physician is admitted into the network, the physician's credentials must be reviewed and approved by the network's credentials committee to assure that the physician meets the network's quality standards. The network is truly non-exclusive – in other words, the physicians are free to contract independently outside the network, and they do in fact give independent consideration to payer contracts proposed to them directly rather than through the network. Payers thus have an option: They can build their own network by approaching physicians individually, or they can approach the network and thereby obtain ready access to a panel of qualified physicians covering a broad geographic area and a wide variety of medical specialties. Assume, too, that payers (including self-insured employers) 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.

Preliminarily, before addressing the question of efficiencies, it is important to note the differing antitrust treatment of our hypothetical physician-sponsored network and the national or regional PPO with which it competes. The national or regional PPO can contract with insurers and HMOs on a fee-for-service basis. The physician-sponsored network cannot. If it attempted to negotiate such a contract with a payer, it could be accused of price fixing. Its only lawful option is to do risk contracting – an option that the physicians in the network may not be prepared to handle, and that payers may not want.

Consider, also, how little threat is actually posed to competition by our hypothetical physician network. The network is non-exclusive, both in name and in fact. The physicians actively and independently consider contracts presented to them outside the network.

Thus, a payer who is unable to reach a “package deal” with the network can go directly to its physicians. Rather than restraining trade, it would seem that the physicians’ decision to offer their services as a package creates an additional option for purchasers, and is therefore manifestly procompetitive.<sup>10</sup>

The Supreme Court’s decision in *Maricopa*<sup>11</sup> is sometimes viewed as creating a strict *per se* prohibition against fee-for-service contracting by a physician-sponsored network. But the decision need not, and should not, be read so broadly. First, *Maricopa* was a 4-3 decision that is in tension with other Supreme Court cases holding similar joint arrangements to be subject to the Rule of Reason.<sup>12</sup> Second, in *Maricopa* there was no factual record before the Court on the potential efficiencies of joint contracting; the parties did not argue the point. Absent a developed record on efficiencies, the case should not be viewed as offering the final word on the subject. Finally, the Commission has already recognized that “clinical integration” offers sufficient prospect for efficiencies to take joint pricing outside *Maricopa*. The same should be true of other forms of integration, if it is true (as we explain below) that these too may be efficiency-enhancing.

Let’s now turn to consider the efficiencies that would be offered if our hypothetical physician network were permitted to offer a “package price” for the services of its

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<sup>10</sup> 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.”).

<sup>11</sup> *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

<sup>12</sup> See, e.g., *Broadcast Music, Inc. v. CBS*, 441 U.S. 1 (1979) (“*BMP*”); *National Collegiate Athletic Association v. Board of Regents*, 468 U.S. 85 (1984) (“*NCAA*”).

members. We submit that joint contracting by the network – and by others like it – would offer transactional efficiencies that cannot, and should not, be easily dismissed. These transactional efficiencies are not merely the *de minimis* efficiencies offered by any cartel. Rather, they are efficiencies that can result in significant cost savings both for the payer and for the physicians.

On the payer side, physician joint contracting can make it possible for a payer to obtain ready access to a panel of physicians offering broad geographic and specialty coverage. Because physicians still practice predominantly in solo practice or in small groups (see Figure 1), 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.”<sup>13</sup> When the initial task of network formation is undertaken by the physicians themselves, payers may substantially reduce the costs of entry and expansion. In this sense, the formation of a fee-for-service physician network can be viewed as a “new product” under the Supreme Court’s decisions in *BMI*, *NCAA*, and *Maricopa*.<sup>14</sup>

Joint contracting can also reduce costs on the physician side. Again, the opportunity for efficiencies arises from the atomistic structure of the physician market. (Figure

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<sup>13</sup> *United States v. Aetna*, No. 3-99CV1398-H (N.D. Tex.) (complaint filed June 21, 1999).

<sup>14</sup> *BMI*, 441 U.S. 1 (1979); *NCAA*, 468 U.S. 85 (1984); *Maricopa*, 457 U.S. 332 (1982); *see also* F. Easterbrook, “Maximum Price Fixing,” 48 U. Chi. L. Rev. 886, 898-99 (1981) (noting that transactional efficiencies of joint contracting may justify treating physician network as a ‘new product’ as in *BMI*); H. Hovenkamp, *supra* n. 10, at § 5.6 (network at issue in *Maricopa* should have been found lawful under the Rule of Reason because it was non-exclusive and reduced transaction costs); California Business and Professions Code section 16770 (health care provider contracting networks are “a new product within the healthcare marketplace...”).

1). Most practices are simply too small to afford to hire businesspersons and lawyers to review their contracts with payers. Whereas payers have sophisticated actuarial and financial resources to enable them to evaluate contract proposals, physicians are often in the dark when they consider a contract. For example, physicians often sign contracts that allow the payer to unilaterally lower the payment rates stipulated to in the agreement.<sup>15</sup> By pooling their resources, physicians may be able to individually negotiate from a more informed position. The effect is to lower the physicians' costs – without in any way restraining competition.

In other contexts, courts and antitrust agencies have recognized that transactional efficiencies may be sufficient to take conduct out of the *per se* category.<sup>16</sup> Why should physicians be treated differently? Ironically, while enforcement policy continues to dismiss any potential efficiency from fee-for-service networks, the market has generally shifted away from risk contracting.<sup>17</sup> The “flight from risk” has been attributed to many factors – not least the desire of many employers and individuals for health plans that do not place physicians under financial incentives to withhold care.<sup>18</sup> Should antitrust policy really stand in the way of physicians participating in the market to respond to this consumer demand? Should our hypothetical physician network be prohibited from competing on an even keel with the national or regional PPO?

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<sup>15</sup> See *Anesthesia Care Associates Medical Group, et al. v. Blue Cross of California*, No. 986677 (Calif. Super. Ct. Aug. 22, 2001) (treating such provisions as contracts of adhesion).

<sup>16</sup> See generally D. Balto, “Cooperating to Compete: Antitrust Analysis of Health Care Joint Ventures,” 42 *St. Louis Univ. L.J.* 191, 223-25, & nn. 192-97 (1998) (citing cases and other authorities).

<sup>17</sup> See R. Hurley, *et al.*, *supra* n. 6, at 144.

<sup>18</sup> *Id.* at 144-45; see A. Hillman, “Financial Incentives for Physicians in HMOs – Is There A Conflict of Interest?” *New Eng. J. Med.* 1729-34 (Dec. 31, 1987).

Once the potential efficiencies of joint contracting are recognized, the Rule of Reason provides the appropriate tool for balancing those efficiencies against the potential for harm to competition. Under the Rule of Reason, a variety of factors need to be considered.

Professor Havighurst summarized some of the relevant considerations as follows:

- Did the physicians genuinely intend to offer a competitive alternative in the market?
- What percentage of physicians in the geographic market are participants in the venture?
- Do the participating physicians participate in networks that are not physician-controlled?
- How sophisticated and effective are purchasers of physician services in the relevant market?
- How vigorous is competition generally in the relevant market?<sup>19</sup>

We do not propose that physician networks be free to engage in manifestly anticompetitive behavior. Quite to the contrary, outright boycotts or naked agreements on price (unrelated to the network's contracting activities) may continue to be treated as illegal *per se*. Our point is simply that, absent such egregious conduct, fee-for-service contracting should not be exposed to the heavy artillery of the *per se* rule.

**3. “Physician networks that want the flexibility to contract on a fee-for-service basis can simply become clinically integrated.”** In the 1996 version of the *Health Care Policy Statements*, the agencies recognized for the first time the possibility that a fee-for-service network might be deserving of Rule of Reason treatment if it was “clinically integrated.” In the

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<sup>19</sup> Havighurst, *supra* n. 8, at 88.

ensuing six years, clinical integration became the unicorn of health care antitrust – much talked about, never seen. Earlier this year, however, the Commission spotted the unicorn for the first time, in a staff advisory letter to MedSouth, Inc., an IPA of over 400 physicians based in Denver, Colorado.<sup>20</sup>

The *MedSouth* letter is notable in a number of respects, and it provides some important guidance. At the same time, we think the letter demonstrates how daunting a project clinical integration really is. For most physician groups, the level of investment called for in *MedSouth* is simply not an option. Moreover, the Commission’s letter is laced with caveats which seem to indicate that even a physician network with an extraordinarily high level of integration will continue to be exposed to significant antitrust risk.

Let me highlight just a few of the critical facts. MedSouth worked for over a year with a health care information technology firm and a national clinical laboratory company to develop a program with two major parts: (1) a web-based electronic clinical data record system designed to permit the physicians to share clinical information on their patients and to monitor data relating to utilization, adverse drug reactions, medical errors, and medical outcomes, and (2) the development of over 100 clinical practice guidelines and the implementation of performance goals linked to those guidelines. Although the staff letter does not indicate precisely how much time and money was invested in this project, there can be little doubt that the physicians’ investment was sizeable. 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.

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<sup>20</sup> See n. 7, above.

A few other facts about *MedSouth* are worth noting. First, the physicians assured the staff that they intended to contract on a non-exclusive basis – *i.e.*, 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 assuaged any concern about the physicians’ ability or desire to harm competition.<sup>21</sup> Second, it appears that MedSouth planned to wall off its physicians from direct involvement in contracting. The letter indicates that the physicians proposed to use an outside consultant to develop a fee schedule and, if necessary, gather information from each MedSouth physician on a confidential basis. This approach sounds like a miniature version of the “messenger model” (although it dispenses with some of that model’s most burdensome features).

Third, the letter notes that MedSouth proposed to take a fee-for-service approach only after disastrous experiences with risk contracting. Specifically, MedSouth and other IPAs in the market accepted capitation until “[m]any of these groups experienced significant financial difficulties under those contracts, and a number of the organizations declared bankruptcy.” In light of this experience, “payers and most physician groups, including MedSouth terminated their capitated contracts.” Does the staff’s recital of this history suggest that the Commission would be less tolerant of a physician network that was just starting out on a fee-for-service basis, before trying capitation and meeting market resistance?

For all their efforts to invest, innovate, and implement appropriate safeguards, the MedSouth physicians received a go-ahead from the Commission staff that can best be described as tepid. The letter concludes with these remarks:

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<sup>21</sup> See n. 10, *supra*, and accompanying text.

Based on all the factors discussed above, we have concluded that we would not recommend a challenge to MedSouth fully implementing the program and then offering it to payers on a collective basis. As long as doctors are, in fact, willing to deal individually on competitive terms with payers who do not want the package price, as you represent will be the case, significant anticompetitive effects appear unlikely. . . . If, however, MedSouth’s member physicians are able to use collective power to force payers to contract with the network or to pay higher prices, then absent evidence that substantial efficiency benefits outweighed likely anticompetitive effects, we likely would recommend that the Commission bring an enforcement action. . . . This office will monitor MedSouth’s operations and the behavior of its physician members for indications that the proposed conduct is resulting in significant anticompetitive effects.

The message from the Commission appears to be this: “You may proceed, but at your own risk. And we will be watching you.”

*MedSouth* represents a thoughtful attempt by the Commission staff to deal with an innovative effort by physicians to improve quality, coordinate care, and provide new services within the confines of antitrust restrictions. But it demonstrates how high the bar has been set. After years of work, a very substantial investment, and lots of physician and consultant time, the IPA walked away with a lukewarm, conditional go-ahead. And a pointed reminder that the Commission may change its mind at any time.

**4. “*The messenger model represents a viable alternative for physician networks that do not want to become financially or clinically integrated.*”** When all else fails, the final option for a physician network that is not sufficiently integrated to negotiate prices is to adopt the “messenger model.” 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.<sup>22</sup>

The messenger model is an invention worthy of Rube Goldberg, the renowned cartoonist and inventor of whacky contraptions. It is purely a device for maintaining antitrust compliance, with no independent business justification. It is cumbersome and difficult to administer. Not surprisingly, it 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 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, 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.

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<sup>22</sup> *Health Care Policy Statements*, Statement 9.

In the end, the machinations of the messenger model provide 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.

5. *“As long as health care markets remain price-competitive, quality will take care of itself.”* We are pleased to see that the Commission has included health care quality among the issues to be addressed at this conference. As you know, quality is an issue that we consider to be of the utmost importance. Yet we are concerned that, when it comes to antitrust enforcement in health care, quality is too often viewed as a secondary consideration, a tag-along issue – or, worse still, a code word for collusion.

The need to ensure quality is part of what distinguishes medicine from other professions and other industries. Medical services are not a commodity. Subtle differences in approach may make a life or death difference. Quality is the driving consideration which guides the medical decision making of physicians and patients.

Yet the Commission has given remarkably little guidance to the medical community on the proper role of quality considerations in antitrust analysis. We suggest that the role of quality in health care competition is an issue on which significant additional guidance and study is needed, reflecting ongoing work in this area by recognized private sector medical experts. Specific questions might include:

- What is quality in health care? How does one measure it?

- What is the role of quality or perceptions of quality in driving health care purchasing decisions?
- How does one determine whether higher prices are attributable to higher quality? Does it make any difference if they are?
- What is the effect of payer market power on quality? What sort of evidence is necessary to demonstrate an anticompetitive impact on quality?
- Does the need to ensure quality in health care ever justify joint activities that might otherwise be prohibited?
- When do joint activities that enhance quality “count” as efficiencies?

### Conclusion

Thank you for the opportunity to present our views to the Commission. In

closing, I'd like to summarize our recommendations:

1. Physician networks that contract with payers should generally be examined under the Rule of Reason rather than the *per se* rule, whether they contract on an at-risk or fee-for-service basis. The *per se* rule should be reserved for naked price-fixing agreements or boycotts to enforce them.
2. In applying the Rule of Reason to physician networks that do fee-for-service contracting, transactional efficiencies should “count.” The extent of these efficiencies will of course depend on market conditions. Because there have been few applications of the Rule of Reason to such networks in the past, additional guidance should be given on that subject.
3. Clinical integration, rather than being viewed as a prerequisite to Rule of Reason treatment, should be recognized as offering efficiencies that are taken into account under the Rule of Reason.
4. The Commission should do further study of the role of quality in health care competition, and should give guidance to physicians on the role that quality considerations play in antitrust analysis.