Physician-Run Health Plans and Antitrust
As the health care system changes and large managed care entities gain greater control in some markets, proponents of antitrust reform have expressed concern that physicians could lose their autonomy. To respond to this concern, the American College of Physicians has consistently argued that physicians should be allowed to establish their own health plans and networks to provide high-quality and cost-effective care. Moreover, the College has advocated utilization review reform and due process protections to empower physicians in their dealings with insurers.

Under current antitrust law, as interpreted by the federal enforcement agencies, physicians already have the legal authority to form their own health plans and networks, and many state medical societies are sponsoring such plans. The law also allows physicians to operate the clinical components of a health plan, regardless of who owns it. Moreover, physicians can share information about quality, utilization, and, in some circumstances, fees. An examination of federal enforcement agency actions since the mid-1970s shows that physician networks have rarely been challenged. In light of market developments, however, the College has urged the federal antitrust agencies to analyze the effect of their current enforcement policies on physician activities and adopt a more flexible approach. Further monitoring and analysis of the changing health care marketplace are necessary to ensure that physicians are being treated fairly and to determine which factors spur or inhibit the development of physician-run health plans and networks.


As the health care delivery system undergoes dramatic change, some have argued that antitrust reform is necessary to help physicians. Thus far, the courts and enforcement agencies have treated the health care industry as they do every other industry: Providers are prohibited from engaging in certain behaviors (such as price fixing) that will have an anticompetitive effect on the market for their services.

Proponents of antitrust reform argue that changes in the law will allow physicians to form health plans to compete with plans sponsored by insurers, hospitals, and other entities. Specifically, reform advocates say that the law must be changed because, unlike insurers, physicians are inhibited from forming their own preferred provider organizations (PPOs) and other partially integrated delivery systems (1). They also argue that the limitations placed on legitimate physician plans are overly burdensome (2). Advocates of reform say that the combination of these policies has a chilling effect on the development of physician-run plans (3).

Therefore, without changes, insurer-based plans will not be forced to compete with physician-run PPOs that, according to their advocates, will provide better care at a lower cost. In addition, reform proponents say, PPOs and other partially integrated models are transition measures that will give physicians the expertise they need to eventually develop and run risk-bearing, integrated plans. Because these models are gaining a larger and larger share of the market (1), denying physicians the chance to form PPOs will have lasting effects in the marketplace, and reform is necessary to “level the playing field” (4).

Others argue, however, that statutory changes are unnecessary because, under existing law, physicians already have the freedom to engage in and have engaged in nearly all managed care activities, including forming and running their own health plans. This view holds that it is inappropriate to compare physician-run PPOs with insurer PPOs in the antitrust context, as some reform advocates do. An insurer-sponsored plan is a vertical arrangement between a purchaser and a group of suppliers. In contrast, a physician-sponsored PPO is a horizontal arrangement among a group of competitors and is therefore subject to antitrust scrutiny. A truly analogous situation is one in which all insurers collectively decide how much they would charge their subscribers (3).

Moreover, reform opponents argue, because the marketplace is changing rapidly and health plan structures are changing with it, modifications to the antitrust statutes could “lock in” immunity for certain behavior that is anticompetitive or for structures that will soon be obsolete.

Basic Antitrust Principles

The antitrust laws are designed to encourage economic competition. Senator John Sherman, sponsor...
of the federal law, said that as a free people, Americans "should not submit to an autocrat of trade, with power to prevent competition and to fix the price of any commodity." Section 1 of the Sherman Act provides that "every contract, combination... or conspiracy, in restraint of trade or commerce... is declared to be illegal" (5). Although the Supreme Court has said that the word "every" should not be read literally, some activities are deemed so detrimental to competition that they are themselves violations of the law. That is, once it has been proven that the defendant participated in one of these activities, a violation of the Sherman Act is presumed.

Chief among these activities is price fixing among competitors. The bedrock principle of antitrust law since its enactment more than 100 years ago has been that only through price competition can the U.S. consumer be sure to have access to high-quality goods and services at a fair price. Thus, price fixing is illegal regardless of the reasonableness of the prices set or the market power of the competitors. In fact, price fixing is deemed so detrimental to our economic system, and its prohibition is such a critical part of antitrust doctrine, that the Supreme Court has said that "[t]he anti-competitive potential inherent in all price-fixing agreements justifies their... invalidation even if pro-competitive justifications are offered for some" (6).

In general, if an activity is not found to be a price-fixing scheme, the enforcement authorities and courts use the "rule of reason" test to determine whether the activity complies with antitrust law. This requires a fact finder to evaluate all relevant market factors and balance the procompetitive and anticompetitive effects of the activity to determine whether it unreasonably hurts competition. If the anticompetitive effects outweigh any market efficiencies, the activity will be declared illegal (Lerner A. Unpublished report for the U.S. Physician Payment Review Commission. Antitrust and physician involvement in managed care: is reform needed?).

**Actions of the Federal Enforcement Agencies**

Because of the recent changes in the health care market, physicians have had to consider new relationships and undertake new activities. For example, they have tried to form health plans, either alone or jointly with hospitals. They have also negotiated with managed care organizations and other insurers about reimbursement, utilization, and other issues.

In this context, physicians and other health providers have expressed anxiety about their potential exposure to antitrust enforcement (2). In response, in September 1993, the Federal Trade Commission and the U.S. Department of Justice published a set of policy statements. These statements were designed to provide antitrust guidance to parties who were planning to engage in certain activities. The statements included "safety zones"—activities that would not be challenged if no extraordinary circumstances were present. In addition, the statements described how the agencies would approach conduct outside the safety zones (7). The zones protect the following areas: 1) certain hospital mergers; 2) joint ventures among hospitals to purchase, operate, and market high-technology or other expensive medical equipment; 3) the collective provision of information by physicians to purchasers of health care services to help resolve issues about the mode, quality, or efficiency of medical treatment; 4) participation by competing hospitals in surveys of prices and costs, provided that the data are not used to coordinate prices or costs; 5) joint purchasing arrangements among health care providers; and 6) physician network joint ventures composed of no more than 20% of the physicians in any specialty in a geographic market who have active hospital staff privileges and who share substantial financial risk (7).

Because antitrust law is fact-specific, decisions about the legality of an arrangement are made on a case-by-case basis. However, the statements make clear that "the inclusion of certain conduct within... the safety zones does not imply that conduct falling outside the safety zones is likely to be challenged" (7). Moreover, the agencies made a commitment to provide advisory opinions on proposed activities within 90 days after all necessary information is received (7).

In September 1994, the agencies issued a revised set of policy statements. The purpose of these statements was to allow for the development of new and better methods of delivering health care to consumers while simultaneously protecting consumers by preserving and promoting competition (8). The statements expanded on the previous ones and added guidance on other issues. Specific changes from the initial statements included the following: 1) revising the statement on high-technology equipment to cover joint ventures involving existing, as well as new, equipment; 2) creating a provision allowing physicians to provide purchasers with current and historical fee-related information, provided that the information is not shared among competing providers; 3) setting out the analytical principles that apply to multiprovider networks; and 4) adding a new safety zone that allows physician network joint ventures that are "nonexclusive" to make up 30% of the physicians in a specialty in a geographic market who share financial risk. The 20% rule still applies in exclusive joint ventures, except when...
there are fewer than five physicians in a particular specialty in the relevant market (9). In addition to these statements, the enforcement agencies have issued several advisory opinions, giving further insight into the criteria for legality.

**Antitrust Laws and Physician Networks**

Antitrust issues arise when physicians attempt to act collaboratively, either by creating their own health plan or within the auspices of an insurer-based health plan. In particular, there are antitrust concerns when physician activities suggest joint establishment of fees or threats of concerted refusals to deal (Lerner A. Unpublished report for the U.S. Physician Payment Review Commission. Antitrust and physician involvement in managed care: is reform needed?). Specific concerns include price fixing, the size or market power of the physician network, and the percentage of physician participation in that network.

**Price-Fixing Issues**

The Supreme Court has ruled that many different types of arrangements among competitors constitute price fixing. However, the enforcement agencies and the courts have made it clear that in certain well-defined circumstances, competing physicians may engage in collaborative behavior that affects price. Specifically, if physicians jointly create a new entity or integrate their activities and share risk (for example, through capitation or fee-withholding arrangements), joint price setting will not be considered price fixing (10). The policy rationale is twofold. First, at least in theory, because the merged practices are no longer competitors, individual physicians will act in the interest of the joint venture rather than in their individual economic interests. Second, the new entity can provide other services (such as administrative services and quality assurance) more efficiently than can the existing entities individually.

Enforcement agency officials have argued that risk sharing ensures that the members of a physician network have an incentive to work together to improve the efficiency and performance of the whole network. In situations in which risk sharing does not exist, officials say, physicians have incentives to act in their own economic interests. Therefore, the traditional antitrust principle that prohibits joint price setting by competitors will apply (Kursh G. Recent activities of the antitrust division in the health care field. Speech presented 5 April 1995).

Thus, physicians who form an integrated network in which they share financial risk for the cost of the care provided will not be challenged in the absence of excessive market power.

**Market Power and Percentage of Physicians**

A physician network is protected if the physicians share substantial financial risk and the network stays within certain limitations governing the percentage of participating physicians in the relevant geographic market. These limits, expressed in the Federal Trade Commission–Department of Justice policy statements, reflect the concern that networks with excessive market power will be able to charge prices that are greater than market levels.

However, it is important to remember that the limits in the policy statements are general guidelines, not literal standards. In fact, the Department of Justice recently approved the formation of non-exclusive provider plans that exceeded the 30% limit. One plan was a physician-sponsored network in Kentucky that would encompass 37% of the physicians in the market; the other was a California plan that could involve 50% of the chiropractors in a market (Bingaman A. Personal communication).

Thus, physician joint ventures that fall outside the safety zone will still be allowed if the procompetitive effects (such as improved efficiency of service delivery) outweigh any anticompetitive effects. According to Anne Bingaman, Assistant Attorney General for Antitrust, “only those combinations that will harm the American consumer by raising prices, decreasing quality or availability of services, or discouraging innovation face antitrust challenge” (Personal communication).

**Legislative Proposals**

Despite the guidance from the Federal Trade Commission and the Department of Justice, the American Medical Association and other medical organizations have lobbied the U.S. Congress to enact additional statutory protections for certain activities.

Last year, it seemed possible that some antitrust changes would be enacted within the context of Medicare reform. The Medicare Preservation Act, the legislative proposal developed by the House Republican leadership, contained provisions designed to amend the antitrust laws. Specifically, these provisions provided that contract negotiations between unintegrated networks of physicians and those delivery networks that directly contract with Health Care Financing Administration and accept capitation to care for Medicare beneficiaries (so-called “provider-sponsored organizations”) would be exempt from the per se prohibitions on price fixing. Rather, the negotiations, as well as other conduct
taken while the terms of the contract are being carried out, would be judged under "rule of reason" analysis. The bill also required the federal enforcement agencies to promulgate guidelines to implement this provision within 120 days of enactment (11).

The Senate Medicare reform legislation did not contain any antitrust provisions (12). However, the Conference Report—the version of the legislation that ultimately passed both houses of Congress—did contain the House bill's antitrust exemptions. In addition, the bill clarified that the activities of the provider-sponsored organizations would also be exempt from the per se prohibitions (13). Because the President vetoed the bill as part of the larger budget negotiations, it is unclear whether any antitrust reform legislation will be enacted.

**Antitrust Laws and Physician Networks: An Enforcement History**

Although the antitrust laws have been a source of confusion in the medical community, little evidence suggests that they have been a barrier to physicians forming joint ventures or engaging in other legitimate activities in the health care market. An analysis of federal enforcement agency actions since the mid-1970s indicates that the Department of Justice and the Federal Trade Commission do not challenge physician networks if no extraordinary circumstances are present. Since 1975, the Federal Trade Commission has brought only 11 price-fixing actions against groups of physicians. (Although the federal enforcement agencies have brought other cases against physicians in the past two decades, those cases did not involve network formation issues. Instead, they involved issues that are beyond the scope of this paper.)

In these cases, the Federal Trade Commission found that groups of physicians were attempting to either negotiate fees collectively or create a joint venture without sufficient integration or were threatening a boycott of certain payers. Consequently, they were engaging in illegal behavior.

An example is *Michigan State Medical Society*, 101 F.T.C. 191 (1983) (14). In that case, the society, through an organized campaign, obtained its members' permission to collectively terminate participation in Medicaid and other third party payer programs if the payers did not adopt reimbursement policies acceptable to the society. The Federal Trade Commission determined that this was merely a method for competing physicians to agree on prices or negotiate collectively. In addition, despite this collective action, the physicians did not bear risk. Thus, the Commission determined these actions to be illegal (14).

Moreover, from September 1993, when the policy statements were released, to January 1996, the Federal Trade Commission issued 11 advisory opinions on physician networks and has indicated that only one network would be challenged. In addition, none of the 10 business review letters on physician networks issued by the Department of Justice during that time indicated that a proposed venture would be challenged. Thus, under existing law, physicians can form their own health plans and networks, and, if no extraordinary circumstances are present, they will not be challenged. Recent activities in the marketplace support this view as physicians across the United States implement various integration plans, including the development of physician-run health plans. For example, the Pennsylvania Physician Healthcare Plan, a self-described physician-owned and controlled managed care organization, recently announced that it is proceeding with its application for a health maintenance organization license and is investigating the process of establishing a PPO. (Brown G. Personal communication). Moreover, the California Medical Association received clearance from the Federal Trade Commission in November 1995 to launch its statewide health maintenance organization (15). In fact, as of June 1995, 22 state medical societies had embarked on projects to develop and implement physician-run health plans and networks (16).

Physicians can also form their own PPOs. To do so, they must develop a structure wherein individual physicians do not agree on prices with each other or threaten to boycott. An example is the messenger model, in which a third party transmits information, such as a contract offer, from the payer to the group's members. The messenger has no power to bind the members to the contract. Instead, the members decide, without consulting among themselves, whether or not to accept the offer. The messenger conveys that information back to the payer. Under this model, a payer could contract with an entire network of providers while dealing with a single "messenger" (10).

A comparison of two proposed physician-run PPOs—one that was approved and one that the Federal Trade Commission indicated would be challenged—shows that if the network is structured properly, it will pass the enforcement agencies' antitrust test.

**Physician Care, Inc.**

This physician network in Kentucky provides an example of how a physician-run PPO can pass the antitrust test of the Department of Justice. In addition, this case shows that the safety zones of the
Federal Trade Commission and the Department of Justice are merely general "rules of thumb" and not strict barriers. Physician Care, Inc., is a nonexclusive organization composed of about 37% of the physicians in its market area. The executive director of this organization negotiates contracts with third-party payers. Once finalized, a contract is submitted to the individual member physicians, each of whom has the opportunity to accept or reject the contract. No Physician Care physician has access to another member's fees or other financial information.

Physician Care establishes utilization standards and other measures to contain costs and develops quality assurance and patient education programs and practice guidelines. The physicians share risk by providing services at a capitated rate or on the basis of discounted fee-for-service rates with a 20% withholding of their fees. The withholding is distributed among the physicians only if the group's cost containment and utilization goals are met.

The Department of Justice announced that it would not challenge the plan because it is a bona fide joint venture in which the participating physician members share substantial financial risk by participating in the capitated or fee-withholding arrangements. Consequently, the Department of Justice concluded that Physician Care has the potential to be procompetitive even though the network contains more physicians than the number specified in the safety zone. In fact, the Department of Justice noted that the percentage representation greater than 30% appears necessary to provide adequate coverage for enrollees. In addition, the Department of Justice noted that participation by physicians will not have a spillover collusive effect because the physicians will not have access to specific pricing data and will not directly negotiate fees. Thus, the Department of Justice concluded that the procompetitive effect of providing residents with an alternative health system outweighed any possible anticompetitive effects (Bingham A. Personal communication).

ACMG, Inc.

In an advisory opinion, the Federal Trade Commission informed ACMG, Inc., that its proposed PPO posed substantial antitrust risks. ACMG, a management consulting service, sought to create a statewide PPO sponsored by the Montana state medical society. ACMG expected to enroll more than 50% of Montana's practicing physicians in its network.

According to the compensation contract between participating physicians and ACMG, physicians were required to agree in advance to accept, as payment in full for a service, an amount determined by ACMG to equal the 88th percentile of the fees regularly charged. The PPO would retain 15% of the allowable charge as a withhold in a "risk pool."

The Federal Trade Commission found that the proposed plan posed a "substantial risk" for violating the antitrust laws. In particular, the agency was concerned that participating physicians would not share substantial financial risk. Because physicians would be reimbursed at almost full charges, and because it was anticipated that each physician would have only a few PPO enrollees as patients, the Federal Trade Commission believed that a 15% withhold would not pose sufficient risk to provide an incentive for physicians to practice cost-effectively. The agency found that the structure proposed by ACMG "appears to involve a horizontal agreement on price among competing physicians." Moreover, the agency found that because of its size and the absence of market competition, the PPO could attain excessive market power (Horoschak M. Personal communication).

Rural Markets

Another concern raised by antitrust reform advocates is that the federal safety zones do not account for special market conditions in rural areas. For example, in some areas with small numbers of physicians, the 20% threshold seems to be an impractical barrier to the formation of physician networks (17).

In response, in their 1994 policy statements, the Federal Trade Commission and Department of Justice added language about how the law will be enforced in rural areas. For example, for both exclusive and nonexclusive physician networks, the policy statements note that in relevant markets with only a few physicians in a particular specialty, a physician joint venture could include a physician from that specialty even though it would result in the venture consisting of more than the threshold percentage of physicians in that specialty (9).

In addition, the policy statements contain detailed examples of physician joint ventures that are "unlikely to raise significant antitrust concerns." These examples involve physician networks in rural areas that make up a large percentage of physicians in the relevant market. In fact, one example involves a network with all the physicians in a small,
rural county. The statements point out that although these networks would fall outside the safety zone, they would not be challenged under the antitrust laws if the procompetitive effects from the network’s formation outweigh any anticompetitive effects (9).

The Department of Justice approval of Physician Care illustrates this point. The agency noted that the proposed network would contain as much as 37% of primary physicians in some markets and a higher percentage of some specialties. However, the agency found that in the largely rural areas where this network would operate, those percentages appear to be necessary to provide services (Bingaman A. Personal communication).

The recent opinion by the U.S. Court of Appeals for the Seventh Circuit in Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic (18) reinforced this principle. In that case, the court held that the physician-run Marshfield Clinic and its health maintenance organization did not violate the antitrust laws simply because they had a large market share.

Blue Cross and Blue Shield had contended that it was shut out of the market in north central Wisconsin because Marshfield and its health maintenance organization dominated the area. The court was not sympathetic to this argument, even though it recognized that because of the sparsity of physicians in the area, the physicians employed by the Marshfield Clinic have a large share of the market for physician services. In fact, in one county, every physician was employed by Marshfield.

The court noted that there are instances in which a single entity will have no competitors simply because the market is too small. Regarding medical services, the court said that it is not only acceptable but desirable that the physicians in these areas work for the same firm. “If an entire county has only 12 physicians,” the court explained, “one can hardly expect or want them to set up in competition with each other.” Given the amount of technology and specialization in medical services today, the court said that 12 physicians competing in a county “would be competing to provide horse-and-buggy medicine” (18).

Despite this enforcement history, some observers have maintained that antitrust laws are barriers to market entry for physician networks. Specifically, they argue, uncertainty about enforcement of the laws may have a chilling effect on the development of innovative care delivery systems (3). Others have argued that the Federal Trade Commission and Department of Justice’s conditions for legality as written in the policy statements and expressed in specific cases are too restrictive. According to this thinking, the agencies’ enforcement policies often incorrectly presume anticompetitive results when physicians organize networks (19).

To respond to this concern, the Federal Trade Commission announced that it is seeking information from physicians, other health care providers, employers, and other purchasers of health care services about new types of market arrangements that may offer efficiency benefits without the risk for competitive harm. Specifically, the agency will study issues such as the types of plans that could meet payers’ needs, including types that may be perceived to violate current antitrust standards, and the nature and magnitude of efficiencies that may flow from networks that do not meet the policy statements’ risk sharing requirement (Whitener M. Antitrust, Medicare Reform, and Health Care Competition. Speech presented 5 December 1995). The agencies’ review will be completed later this year.

Representatives of the American College of Physicians recently met with Federal Trade Commission officials and argued in support of physician networks and health plans as procompetitive market innovations. The College urged the agency not only to resist taking any enforcement actions that would stifle physician integration efforts but also to revise their enforcement guidelines to provide more flexibility for physicians. Specifically, College representatives argued that some groups or networks of physicians provide high-quality and cost-effective care even if they do not share substantial financial risk as defined by the policy guidelines.

**Conclusion**

As the health care delivery system evolves, different varieties of managed care plans are developing. Antitrust reform advocates properly raise the critical issue of how to ensure that physicians retain their autonomy in the face of the large managed care entities that increasingly dominate the market.

The College will continue to fight for policies that allow physicians to form their own health plans in the belief that plans run by physicians will provide higher-quality care at a lower cost. Moreover, to empower physicians in their dealings with insurers, the College remains committed to its policies that advocate utilization review reform and due-process protections for physicians. The College will monitor the market to ensure that physicians are being treated fairly and will continue to give physicians information and advice about how to adapt to marketplace changes in their communities. The College will also continue to press the federal enforcement agencies to analyze the effect of their policies on the development of physician networks and de-
velop a more flexible enforcement policy toward them.

Although antitrust issues are an important consideration in market activities, current law allows physicians to organize into networks and form their own health plans. They can also operate the clinical components of health plans regardless of who owns or governs the plan. Moreover, physicians can share information on quality, utilization, and, in some circumstances, fees.

The enforcement agencies have clearly indicated which activities will not be challenged if no extraordinary circumstances are present. Even if a proposed activity falls outside one of these safety zones, however, it may not pose an antitrust risk. To withstand an antitrust challenge, a physician network must be sufficiently integrated so the physician-members of the network bear substantial financial risk. In some instances, the venture will also be required to use a prescribed structure to ensure that individual physicians do not agree on prices with each other or threaten to boycott.

The prohibition on physicians collaborating to fix prices or threatening to boycott is identical to the treatment received by every other market and industry. In addition, an analysis of actions by the federal enforcement agencies in the past 20 years indicates that the Federal Trade Commission and the Department of Justice will rarely challenge a physician network. Moreover, research indicates that physicians and other health care providers have been able to form their own health plans and enter the market. In fact, 20% of all PPOs and 15% of all health maintenance organizations are provider owned (20).

In sum, physicians have substantial leeway to organize in various ways under current law as interpreted by the recent federal policy guidelines and as enforced by the federal agencies in the past two decades. Moreover, in addition to providing guidance, the policy statements also provide enforcement agencies with flexibility as the delivery system changes and new relationships and entities take shape.

However, because of the rapid pace of change and the potential for large insurer-based plans to dominate the market, it would be appropriate for the federal enforcement agencies to collect information on the growth and development of physician-run health plans and analyze which factors spur or inhibit their progress. In addition, the agencies should periodically promulgate updated statements that contain new safety zones. This will ensure that physicians receive guidance as the marketplace changes and will give them the assurances they need to proceed with their integration efforts.

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References

5. 15 U.S. Code §1.