

PHYSICIAN NETWORKS AND THEIR IMPLICATIONS FOR COMPETITION IN HEALTH CARE MARKETS

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INTRODUCTION

The physician market is being transformed in dramatic ways [1]. One of the most notable areas of change has been tremendous growth in physician networks, such as independent practice associations (IPAs). As of August 1996, there were approximately 4000 IPAs with an average of 300 physicians each, up from approximately 1500 in 1990 [2]. Physician networks are made up of otherwise independent physicians that join together to market themselves collectively to health insurers, and in some cases, directly to employers. Normally, independent competitors are not allowed to set prices jointly. The key question here is whether these networks represent an efficient response to the changing structure of health care markets or strategic attempts to increase market power.

FEDERAL POLICY

Federal antitrust enforcement policy concerning physician networks is spelled out in Statement 8 of the Department of Justice and Federal Trade Commission's 'Statement of Antitrust Policy in the Health Care Area' [3]. Physician networks

falling outside the agencies' safety zones [4] and meeting the agencies' stated criteria, such as bearing substantial risk (capitation contracts) or engaging in extensive clinical integration (programs to monitor, evaluate, and change clinical practices by the networks physicians) are evaluated under rule of reason analysis. In other words, the potential efficiency gains are weighed against the potential anticompetitive effects.

POTENTIAL EFFICIENCY GAINS

While the efficiency gains due to fully integrated physician groups have been documented, they are not well documented for physician networks. It is unclear whether physicians who form networks, but maintain independent practices, realize significant economies. For example, a recent study of 12 metropolitan markets found that members of networks had incompatible information systems, multiple protocols, and duplicate capacity and services [5]. However, there is potential for economies due to shared administrative and management functions, such as billing and contracting, and potential for economies and higher quality care due to shared monitoring functions, such as quality assurance, utilization review, and case management. Economic theory suggests that

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the extent to which a network realizes efficiencies or provides higher quality care will depend, in part, on the network's internal incentive structure. This implies that a network's incentive system may be a key indicator of the potential for pro-competitive effects. At this point, however, little is known about the relationship between networks' internal incentive structures and costs, prices, and quality of care.

There are efficiencies due to group risk bearing [6], although their magnitude for networks is unknown [7]. It is more efficient for multiple physicians to jointly bear the risk related to the frequency and treatment costs of medical problems experienced by the insured population. Joint risk bearing allows physicians to take advantage of the law of large numbers, reduces the incentive for risk bearing physicians to cream-skim (not accept the sickest, most costly to treat patients), and reduces the incentive for risk bearing physicians to underprovide care (deny necessary, but costly, treatment).

On the other hand, however, as network size increases, so does the potential for inefficiencies due to a free-rider problem [8]. In larger networks individual physicians may bear only small consequences for their own costly treatment decisions, and thus physicians may be more likely to provide unnecessary and costly treatments.

In addition, it is worth noting that all of these potential impacts on efficiency are related to network size, not control. It is unclear whether it matters if networks are controlled by physicians, insurers, or other parties.

ANTICOMPETITIVE EFFECTS

Until recently the consensus was that local markets for physician services were characterized by monopolistic competition (no barriers to entry and many sellers) [9], and thus there was little concern about anticompetitive behaviour due to high levels of market concentration. The recent horizontal consolidation among physicians, however, may facilitate two types of collusion among physicians: (1) within network collusion, or in other words, collusion between the otherwise independent physicians that make up each network; and (2) across group/network collusion or collusion between the otherwise competing groups and networks in a geographic market. The first type of

collusion has been the focus of recent cases. The second type of collusion is likely to become a bigger problem as the number of markets characterized by a few dominant health care networks increases [10]. For example, the California Healthcare Association predicts that within the next 5–10 years there will be only three to seven health care networks in California [11].

Both types of collusion are more likely to occur in markets with significant entry barriers, and managed care appears to be raising the height of entry barriers in this market. Under managed care there has been a shift from 'patient-driven' to 'payer-driven' competition [12]. As a result, physicians are competing for contracts with payers, such as HMOs and PPOs, rather than competing directly for individual patients. This has significant implications for the issue of who are the potential entrants in markets for physician services. For multiple reasons, including the push to minimize the costs of contracting, payers appear to be more likely to contract with networks or groups. Thus, physicians in solo practice may be at a disadvantage in the competition for managed care contracts and may be deterred from entering markets characterized by high or increasing managed care penetration.

Accordingly, entry is most likely to occur in two ways. A new group/network can form among physicians already practicing in the local market [13] or physicians new to the local market can jointly enter as a new group/network. However, physicians choosing the second type of entry may be deterred by incumbents' absolute cost advantages and by sunk costs (costs that cannot be recovered upon exit from the market). Incumbent physicians' absolute cost advantages may arise from their access to and control over superior inputs, such as admitting privileges at the only local hospital or at the highest quality or most cost-effective hospital. For example, in recent Marshfield Clinic cases [14], evidence was presented that the physicians of the Marshfield Clinic had prevented physicians from entering the local market for physician services by controlling who obtained privileges at key hospitals in the area. For example, only Marshfield physicians comprised the hospital credentialing committee that approved physician staff privileges at Saint Joseph Hospital (the only hospital in town) [15].

The sunk costs of jointly entering with other physicians who are new to the local market may

also raise entry barriers. These sunk costs include the costs of developing a positive reputation or good will with consumers in the local market and the costs of finding referral partners (physicians to refer to and receive referrals from). Interestingly, brand names, such as Med-partners or the Mayo Clinic, appear to be playing an increasingly important role in the market for physician services [16]. To the extent that brand names in the market for physician services begin to play a similar role to brand names in other consumer product industries, the national physician management companies and large physician groups may face lower sunk costs of entering local markets, and thus, may face lower barriers to entry. However, even the physicians associated with brand-name groups/networks have to incur the sunk costs of establishing referral partners.

EFFECTS ON HOSPITAL AND INSURANCE MARKETS

In addition to decreasing competition in the market for physician services, horizontal consolidation among physicians may decrease competition in the market for hospital services and/or the market for health care financing. To the extent physicians: (1) have market power in the market for physicians' services; and (2) have vertical relations with hospitals (for example, physician-hospital organizations) or have vertical relations with insurers (for example, physician owned HMOs), physician consolidation can have an impact on competition in these markets, as well [17].

ANTITRUST ENFORCEMENT ACTIONS

In the past 5 years federal agencies have brought numerous actions challenging price-fixing and boycotts by physician organizations. For example, in 1996 the FTC took action against Montana Associated Physicians, Inc. (MAPI), a physician organization comprised of 115 physicians in about 36 independent practices in Billings, Montana [18]. The physicians agreed to settle charges that MAPI had orchestrated boycotts and agreements among its physician mem-

bers to fix the prices they would accept from insurers. The FTC complaint alleged, for example, that MAPI urged members to submit higher prices than they were currently charging to a PPO that was seeking to enter the local market.

More recently, the FTC issued a complaint charging the Mesa County Physicians IPA in Grand Junction, Colorado with fixing prices and reducing competition [19]. The IPA includes 85% of the physicians in private practice in Mesa County. The IPA allegedly approved a fee schedule to be used by the IPA's Contract Review Committee in reviewing contract offers from payers, asked members to show the Committee all contracts offers received by individual physicians, and encouraged members not to deal with new health plans or to deal with them, but only on terms approved by the IPA. According to the complaint, these anticompetitive practices raised prices, excluded some insurers from the local market, and forced some third-party payers to contract with the IPA in order to obtain physician services.

CONCLUSIONS

In the 1990s physician networks have become an increasingly important organizational form in the market for physician services. Although there are some potential efficiency gains from this form of organization, it is not obvious that these efficiencies of necessity derive only from a network. The touted savings come from economies of scale in administration, management, and monitoring, and group risk bearing. However, many of these services and insurance for risk bearing physicians can be purchased from third parties. Specialized firms which sell practice management services abound, as do clinical monitoring firms, and firms selling 'reinsurance' to physicians accepting risk based payments.

The anticompetitive potential from such arrangements is greatest where the members of the network constitute a significant part of the market and there are significant entry barriers. Further, as physicians' incomes are eroded by the growth of managed care, physicians may have increasingly strong incentives to collude. Antitrust authorities should continue to keep a watchful eye on these organizations.

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