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An Elegant Theory

Robert Willoughby Jones, Long Island neurosurgeon, sits at the little desk which has been his office workbench for 20 years. On the yellow formica surface of the desk is a bill from his professional malpractice insurance carrier for his 1985 policy. The bill is in the amount of $101,000, reflecting a 52% increase over the previous year.

Dr. Jones could hardly deny the underlying realities which necessitated the increase. He himself had spent the morning in a lawyer's office having his deposition taken in a malpractice suit filed against him for his failure properly to diagnose a pituitary tumor. The symptoms had been ambiguous. At the time of the first visitation testing procedures were expensive and even risky. It was decided to wait and watch, and then the woman failed to return regularly as requested. Many months later, she saw another physician. A tumor was diagnosed.

Dr. Jones knows that the legal profession, not the medical profession, dictates the diagnostic procedures which are required in the practice of medicine. Physicians must

test in accordance with the community standard for the appropriate diagnostic procedures. In the evolution of the law, the controlling community standard has become the national standard. The doctor in Muskogee, Oklahoma is held to the standard of the Mayo Clinic. In the absence of affirmative advice mounting to an abbreviated medical education, a physician may not rely upon the fact that the patient has declined the expense and the ordeal of sophisticated diagnostic procedures. Is a Catscan available? Then under the national community standard, Catscans must be used, and hang the cost. Dr. Jones sighs ruefully and murmurs: "It is an elegant theory."

The theory community standard drive physician liability first came to general public recognition in the mid-1970's, when fewer than five malpractice suits filed annually for every 100 doctors. Today, there are at least 16 malpractice suits filed for every 100 doctors. Settlements and jury soar to the stratosphere and inflate health care costs by as much as $40 billion a year. An AMA study has estimated that defensive medicine--that is the ordering of unnecessary tests and treatment simply to fend off damage suits--has raised health care costs between $15 billion and $40 billion each year.

The problem of longer hospital stays, more tests and more treatments is one component of the national problem

of rampaging health costs. The nation's total expense for health care, which stood at $12.7 billion in 1950, is forecast to be $456.4 billion by the end of this year. Last year health care consumed 10.5% of the gross national product. Of that, the nation's 454,000 doctors received $62 billion and the 7,000 hospitals got $135 billion. These amounts represent an increase of 262% over 1972 expenditures. During the same period, the overall consumer price index climbed only 130%. Thus, inflation does not fully explain the escalation of costs. The explanation must lie in an unconstrained diffusion of new health care costs for everything from Catscanners to malpractice litigation. Also to be considered is the market power that doctors derive from the fact that most health care costs are paid by third parties rather than by the patients themselves.

Responding to this escalation and to the potential insolvency of the medicare trust funds, Congress and the Social Security amendments of 1983 altered the mechanism for medicare hospital payment from a cost-based system to a prospective payment system, the so called DRG's. Under a diagnosis related groups system, for each patient, hospitals are paid a predetermined rate depending upon that patient's diagnosis. The more complicated the condition of the patient, the more money the hospital will receive from medicare. If a patient is treated more conservatively the hospital--to put

it crassly--the hospital can pocket the change. Some argue that from this arrangement hospitals have an incentive to push a patient into more lucrative diagnostic categories. Once procedures are performed, hospitals arguably may have an incentive to discharge patients before they are fully recovered, since payment depends upon diagnosis, not length of stay. Similar developments in hospital reimbursement have occurred at the state level for medic-aid patients. In his book, "Can Hospitals Survive," J. Goldsmith relates that many hospitals have found it increasingly difficult to contain costs within the reimbursable amount set by these government regulations. The result is a pushing off of costs from the public sector to the private sector, and a constant escalation of private sector health costs. Sadly, what is lost in all these debates about health care costs is the fact that health expenditures reflect not only costs, but also the greater quantity of services provides to a national population which is both increasing, and aging. The number of people in the United States over 65 will increase 21% per year for the remainder of this decade. This rate of increase is two and a half times the rate of increase for the general population. At the same time this over 65 age group utilizes hospital services approximately 10 times as much as the general population. Moreover, the maintenance of life is surely one of society's prime obligations. How much,

physicians legitimately ask, is "too much" when it comes to expenditures for the care of human life?

Health economists tell us that consumers are not much concerned about the "too much" question of the cost of medical care. For this reason, they say, even the rising oversupply of providers in the health care market does not increase necessarily competitive pressures toward cost containment.

In the midst of this controversy hospitals have sought to determine what if anything could be done to remain viable. In desperation, they and other providers, have experimented with new structural arrangements to contain costs.

On such new concept is called the Preferred Provider Organization, or P.P.O.

A PPO is a group of doctors and hospitals that negotiates a contract with a company, union or insurance firm to provide medical services for reduced fees. In return, the provider is promised increased patient volume and prompt payment. In the current lineup of health insurance programs, a PPO falls between a Health Maintenance Organization (HMO) such as Kaiser Permanente and the traditional fee-for-service arrangement.

In practice, a PPO works like this: a company offers the plan to its employees, as an option. They do not

have to sign up for it, or contribute to its upkeep. When they require medical care, they are free to make a choice. Under the company's traditional health insurance plan, for which they pay up to 30% of the premium, they can go to their own doctor but usually must pay a deductible of 20% of the bill. Or they can select any doctor in the PPO network, for which the deductible is waived and a nominal fee of $10 or less is charged. The PPO may be sponsored either by providers, such as physician organizations, hospitals, and foundations for medical care or by insurers, such as Blue Cross, Blue Shield, self-insured employers and commercial insurance companies. Variations on the basic model abound. Two hybrid type PPO's are being established in the hospital industry. In the first, an insurer-sponsored PPO, an insurance company or self-insured employer contracts for the hospital for discount charges in exchange for inducing or requiring its policyholders to attend the "preferred" hospital. In the second type of PPO model, the "hospital-sponsored provider-based PPO" the hospital purchases physician services by contracting with providers, granting the providers access to the hospital in exchange for discounted fees.

The objective in these arrangements from the perspective of the insurer or the employer is the reduction of costs. The objective in these arrangements from the per-

spective of the hospital, or the providers, is an increase in market share. While these objectives facially appear simple and laudable, complexities ramify. For lo and behold the arrangements may violate the antitrust laws.

If a PPO arrangement has the effect of setting the compensation paid by a third-party payor to either competing hospitals or competing physicians, the arrangement may constitute illegal horizontal price fixing.

In Arizona v. Maricopa Medical Society, 102 S.Ct. 2466 (1982), the Supreme Court condemned as per se illegal a maximum fee arrangement by members of the county medical association Foundations for Medical Care. When a court invokes the per se rule, the defendant may not justify its conduct by arguing that no harm was done or that the conduct was intended to correct harmful competitive circumstances. The Court in Maricopa believed that the fee arrangement destroyed price competition among competing independent physicians and could not be justified as a means to faciliate negotiations between member-physicians and third-party payors. The Supreme Court explained that "the claim that the price restraint will make it easier for customers to pay doesn't distinguish the medical profession from any other provider of goods or services."

The Maricopa court did suggest, however, that a group of providers might be able to agree on price if they

integrated their operation either to form a bona fide joint venture or partnership or to offer a unique service which none of the members could offer independently. But the HMO-like structure of such restrictive arrangements are not necessarily attractive to independent minded prospective members of the PPO. And, under traditional joint venture analysis, such combinations could only be antitrust assessed on the basis of such factors as the need to combine to offer a new service, the market share of the members of the joint venture, and whether the joint venture involved shared management and risk of loss.

Many legal scholars have argued that, given how poorly the health care industry conforms poorly to the model of competition upon which the antitrust laws are premised, restraint should be exercised in applying antitrust principles to this area of the economy. PPO's are now in a position of legal risk. In consequence, such arrangements will not be pursued as vigorously by entrepreneurs as they might have been under a judicial policy more favorable to such experiments. As it stands, confusion and caution underlies every PPO move.

I have touched in a simplified fashion upon only one, the central, of the antitrust issues which have been raised. Even on this one issue, the issue of price fixing, the actual advice which an antitrust lawyer must give, under

the presently diverged views of the courts, the scholars, and the enforcement agencies, necessarily is complicated, guarded and uncertain. Typical of this kind of guarded (and almost useless) advice was that given by the attorney general of the State of Wisconsin, by a letter dated February 9, 1984, to Wisconsin Senator John O. Norquist, who asked:

> "Under what circumstances is it legal and appropriate for health care providers to join together in a joint venture. What parameters and guidelines can you delineate for the providers so that they may proceed without violating antitrust law?"

In response, Norquist was told:

> "It is often difficult to state in the abstract into which category a particular price-fixing agreement would fall absent a clear understanding of the details of the joint action. Given these details, a court or enforcement agency such as ours reviewing a particular business arrangement would most likely balance the anti-competitive impact of the joint action against its pro-competitive aspects."

The Supreme Court has done little to bring clarity to the area. Despite its broad language that the setting of maximum fees was illegal per se under the antitrust law, the Court in Maricopa made formalistic distinction revolving around which party initiates the price fixing, apparently suggesting that insurer-sponsored physician group price fixing may result in an arrangement which would withstand challenge. It is submitted that never before has an antitrust court measured the ality of a price fix by the good motives of its sponsor. Moreover, a price-fixing agreement initiated by an insurance company for a physician group constituting 80% of the local market would most certainly not escape antitrust scrutiny. Does Maricopa therefore stand for the proposition that an insurance-sponsored PPO will not be subject to per se treatment in the absence of a high market share or collusion among contracting providers? No one knows. Thus, uncertainty and risk abound in health care antitrust law, and the hospital, does not know what to do. It is damned if it does not implement substantial plans for cost containment, and under the developing antitrust law, equally damned if it does. The advising lawyer's fallback position is a recitation of the traditional rubric of our national antitrust statute that a conspiracy under the antitrust laws may arise from any unity of purpose or common design and understanding, or any meeting of the minds in an unlawful arrangement, and that any

combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing price is illegal per se. And that these rules apply to the health industry notwithstanding the fact that in that industry the judiciary has little experience and that there may be pro-competitive justifications for the fee setting procedure.

It is an elegant theory.