

On Your Behalf . . .

Legislative and Practice Affairs Division

What's New in Healthcare Antitrust? Not Much, say FTC, Justice Department

By David E. Willett, Esq., CSA Legal Counsel

Hopes that antitrust agencies would take a new look at laws precluding collective bargaining by physicians have been dashed once more, with the publication of a new report. For at least a quarter of a century, physicians have complained about the lack of a level playing field in their dealings with entities paying for medical services because of antitrust laws. The agencies which enforce those laws, the FTC and the Antitrust Division of the Department of Justice, regularly have been accused of applying the rules of the commercial marketplace to activities which are carried on in a unique environment. The delivery of medical services is not comparable to the production and sale of widgets, particularly because the patient-consumer seldom pays for the services purchased. Nonetheless, enforcement agencies have refused to depart from traditional antitrust rules forbidding collective action by competitors after the Supreme Court ruled that the antitrust laws apply to the “learned professions” (1975), and specifically to the medical profession (1982).

In September 2002, the FTC conducted a “workshop” to examine the health care field and the role of competition, as well as existing law. Then in February 2003, and into last September, the FTC joined with the Antitrust Division in holding 27 days of hearings. The goal was to obtain information and consider present circumstances which might affect the application of laws regulating competition by persons and entities providing or paying for health care.

On July 23, the two agencies released a 360-page joint report (http://www.healthlawyers.org/ofnotes/2004/ofnote_ftc_040729.cfm). Physicians (and other individual providers), hospitals, insurers, and pharmaceutical suppliers are separately addressed. In the medical community, there had been hope that these hearings would produce understanding and potentially a leveling of the playing field. AMA, CMA and numerous physician organizations testified or submitted comments. Hopes arose even though all prior experience suggested that these enforcement agencies would maintain their historic stance. They have done so.

Legislative & Practice Affairs—Cont'd

Despite this extensive effort, and an extensively footnoted report which refers to every IPA, HMO, P4P (“pay for performance”) or other alphabet soup arrangement which has surfaced over fifty years, the enforcers find no circumstances which warrant a change in the rules. Their credo remains

Vigorous competition, both price and non-price, can have important benefits in health care as well.... Vigorous competition can be quite unpleasant for competitors, however. Indeed, competition can be ruthless—a circumstance that can create cognitive dissonance for providers who prefer to focus on the necessity for trust and the importance of compassion in the delivery of health care services. Yet, the fact that competition creates winners and losers can inspire health care providers to do a better job for consumers.

Physicians particularly complain about the power payers exercise in contracting, compared to the ability physicians have to negotiate. They refer to the “monopsony” power payers often enjoy. A monopsony is the buyer’s equivalent of a seller monopoly, in which there is a single buyer, or at least a buyer with such significant market power as to allow that buyer to set the price. “Buyers” in health care are primarily health plans and insurers, not patients. The enforcers’ response is reminiscent of the classic criminal alibi, “I wasn’t there, if I was there I didn’t do it, and if I did it was an accident.” First, the report finds that health plans or insurers infrequently have monopsony power. Furthermore, it is usually difficult to determine whether a health plan is exercising monopsony power. And even if a health plan has monopsony power, the issue remains whether the plan has obtained or maintained that power through improper means. “If reimbursement levels are low due to lawfully obtained and exercised health care insurer market power, then there is no antitrust violation.” The agencies say that determining whether a health plan has monopsony power is “tricky,” and seem to find that determining the impact on competition is an intimidating task.

Physicians may actually agree with these conclusions. Organized medicine argued in these hearings that the system is sufficiently out of balance that changes in the law which would allow physicians greater latitude in acting collectively would actually improve competition and—not insignificantly—patient care. The enforcers are unmoved. In discussing all of the efforts and models which reflect efforts at collective action, the report is evenhanded. It finds that there are good things to be said about IPAs, physician hospital organizations, messenger models, and all of the other devices which have come down the pike, but also bad things to be said. The bottom line remains: only true financial or clinical practice integration will avoid antitrust risks. The description of necessary financial integration

Legislative & Practice Affairs—Cont'd

repeats what the agencies have said for many years. Referring to current interest in P4P arrangements, the agencies offer classic advice:

In determining whether a physician network joint venture is sufficiently financially integrated to warrant rule of reason analysis, the Agencies will consider the extent to which a particular P4P arrangement constitutes the sharing of substantial financial risk among the members of the joint venture, whether that sharing is likely to produce efficiencies, and whether any price or otherwise per se illegal agreements among the members are reasonably necessary to achieve those efficiencies.

Where clinical integration is contemplated, the report is particularly disappointing. Clinical integration has attracted particular attention from physicians, as a route permitting collective negotiation if participants integrate by sharing mechanisms which control costs and assure quality of care. Clinical integration amongst independent practitioners is not a new concept in medicine. The medical staff is an example. Physicians had hoped that the report might provide more detailed advice about clinical integration, from an antitrust standpoint. Past guidelines have indicated that mechanisms for integration must be real and substantial. The agencies have said that significant investment of capital, both monetary and human, in the necessary infrastructure may be needed. Disappointingly, the report lists questions which may be asked in evaluating a proposal which depends on clinical integration to satisfy antitrust objections, but provides no new guidance. The report sets out the general rule that “a joint venture will escape summary condemnation when joint price negotiations are reasonably necessary to achieve substantial efficiencies arising from the clinical integration,” but is wary about giving examples. It is not reassuring that the discussion of clinical integration, which acknowledges uncertainty amongst physicians as to requirements, is preceded by a statement similar to that discussing financial integration:

The Agencies will consider multiple factors to determine whether collective negotiation is reasonably necessary to accomplish the goal of achieving clinical integration. Participants in a joint venture that is not sufficiently integrated (whether financially or clinically) face significant antitrust risk if they attempt to contract jointly.

The agencies say that there is no justification for a change in the law which would allow collective bargaining by independent practitioners, and that such a change would hurt consumers, an argument which has successfully stymied all past attempts to obtain relief in Congress. Physicians are where they were before this exercise began. Simplistic efforts at collective action, however disguised, are vulnerable to challenge. Challenge is likely. It may be possible to structure new

Legislative & Practice Affairs–Cont’d

approaches which avoid antitrust prohibitions, by integrating practices in a fashion which makes joint negotiation of financial terms necessary to overall success of a venture which offers improved efficiency and quality of care. However, putting such a venture together is no small task. It requires ingenuity, great effort and considerable expense, with no guarantee that enforcers will smile on the outcome. In anesthesiology, financial integration of anesthesiology practices, through formation of professional corporations or partnerships, will remain the most common response to antitrust restraints.

Outpatient Surgery–Be Sure the Setting is Accredited

By William E. Barnaby, Esq., CSA Legislative Counsel

As surgeries increasingly are performed in free-standing outpatient settings, including physicians’ offices, participating anesthesiologists should be careful to confirm that their care is being rendered in either a licensed or accredited setting. The administration of anesthesia in unauthorized settings can result, and has resulted, in sanctions against physicians’ licenses to practice in California.

Lists of physicians disciplined by the Medical Board of California (MBC) appear in each issue of the *Action Report*, the quarterly MBC publication. Careful readers of the July 2004 issue have noted that a physician received a public letter of reprimand because he “administered general anesthesia to patients at an uncertified surgical center.” A public letter of reprimand is a “lesser form of discipline,” according to the MBC. But it is nonetheless disclosed on the physician’s profile on the MBC web site and is reportable to the National Practitioner Data Bank (NPDB). This disclosure may not necessarily be disastrous to a physician’s practice, but it is a negative most physicians would prefer to avoid.

The administration of anesthesia in unauthorized settings can result ... in sanctions against physicians’ licenses ...

The law in question was enacted in 1994 (AB 595, Speier) and took effect July 1, 1996. Its basic purpose was the promotion of patient safety in surgeries outside of hospital operating rooms and licensed clinics. Widely reported incidents of deaths and serious injuries resulting from surgeries performed in physicians’ offices and other free-standing facilities during the early 1990s had prompted an investigation by the MBC. The ensuing MBC report on “Unregulated Outpatient

Legislative & Practice Affairs–Cont’d

Surgical Settings” led to the introduction in 1993 of AB 595 by then-Assemblywoman Jackie Speier (D-San Mateo).

The legislation proved to be very controversial with various medical specialties having differing views and insisting on a place at the bargaining table. It was the top priority of the MBC and had momentum from press accounts of unfavorable patient outcomes, but it still took two years to overcome hurdles in working its way through the legislative process.

CSA supported the effort and played a major role in defining the threshold which triggers the law’s applicability. In this connection, the law prohibits physicians from performing any procedure in an unauthorized outpatient setting in which anesthesia, other than local or peripheral nerve blocks, is used in doses that **“have the probability of placing a patient at risk for loss of the patient’s life-preserving protective reflexes.”** While this definition may be less than perfect, nothing better has since been found to replace it.

CSA’s contribution was acknowledged in a letter from the author, Jackie Speier, who currently serves in the State Senate. She thanked us on behalf of CSA, saying “your efforts on behalf of patient safety, especially given the dynamics of the issue, diversity of specialties involved, and controversy surrounding the regulation of outpatient facilities is nothing short of truly commendable.”

The law defines a number of legally acceptable settings, including surgical clinics or hospital outpatient units licensed by the California Department of Health Services or certified by Medicare, or **those accredited by an agency approved by the Medical Board of California (MBC)**. For authorization of surgical sites in physicians’ offices, accreditation by one of the four agencies approved by the MBC—the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation for Ambulatory Surgery Facilities, the Joint Commission on Accreditation of Hospitals and Health Systems, and the Institute for Medical Quality—is the most commonly used mechanism.¹

Subsequent legislation (AB 271 of 1999) affecting outpatient surgery settings require:

- ▶ written reports to the MBC of deaths or transfers of patients to acute-care hospitals,
- ▶ participating physicians to have medical malpractice insurance coverage, and

Legislative & Practice Affairs–Cont’d

- ¹ For additional information about outpatient surgery centers, please see the MBC notice reprinted on pages 17-18.
- ▶ a minimum of two staff persons on premises, including a physician and a licensed health care professional having current certification in advanced cardiac life support (ACLS).

In a somewhat similar vein, a general anesthesia permit from the Dental Board is necessary in order to administer general anesthesia in dental offices where the dentist is not authorized to administer general anesthetics. For physicians, these permits are limited to individuals who have successfully completed a postgraduate residency program in anesthesiology recognized by the American Council on Graduate Medical Education. A related point to keep in mind is that the Dental Board issues permits to individual licensees, while the MBC requires accreditation of surgical settings.

Outpatient surgery can be safe and convenient for many patients under appropriate circumstances. Outpatient settings can also offer attractive venues for anesthesiologists to practice. Facilities may be well equipped and surgeons may have fine qualifications but, even so, may lack the official imprimatur required by law. Government regulation of outpatient surgical settings hinges to a great degree on the type and level of anesthesia administered. Anesthesiologists are called upon to administer anesthesia in a wide variety of settings. Where a facility is owned or managed by someone else, it is not the anesthesiologist’s responsibility to obtain the necessary license, certification or accreditation. Nonetheless, the anesthesiologist should confirm that proper legal authorization has been obtained and is up-to-date.

Office surgeries recently have been touted on television as a path to almost instant beauty. Don’t let an “extreme makeover” jeopardize your medical license.

Liability Coverage Required for Practice at Outpatient Surgery Centers (Medical Board of California)

Physicians who practice at licensed or accredited outpatient surgery centers are required by state law and regulations to maintain malpractice liability insurance in the amount of not less than \$1 million per incident and not less than \$3 million per year.

The required liability insurance must be issued by a carrier or indemnity trust specified in Business and Professions Code section 2216.2. Physicians who fail

Legislative & Practice Affairs—Cont'd

to obtain adequate liability insurance from an approved carrier or indemnity trust may be disciplined by the board for unprofessional conduct.

On occasion, MBC investigative staff encounter physicians who are unaware that there are no exceptions to these statutory provisions. For example, a bond is not a lawful alternative to malpractice insurance.

Physicians can obtain a packet of information regarding the laws and regulations associated with outpatient surgery settings by contacting the Licensing Programs at (916) 263-2645.

A common inquiry received by the board pertains to the expiration of outpatient surgery center accreditation. Once the accreditation expires, the facility must obtain new accreditation from one of the board's four approved accreditation agencies.

Physicians may avoid the expiration of their outpatient surgery center accreditation, and any disruption to their surgical practice, by keeping track of the due dates for recertification inspections and by ensuring that all of the information required by the accrediting authority is available at the time of the inspection.

Steven M. Thompson, a Friend of Medicine, Californians, and the Quintessential Lobbyist, Gentleman and Friend

By William E. Barnaby III, Esq., CSA Legislative Advocate

On August 17th of this year, the House of Medicine, the Capitol community, and Californians in general, lost a great friend and advocate with the passing of Steven Munch Thompson—Vice President for Government Affairs and Chief Lobbyist for the California Medical Association (CMA)—due to a brief, but valiant, battle with cancer.

Steve had served in that capacity since 1992, and had the unequalled ability to serve and balance a constituency sometimes regarded as long on ego, short on political savvy and primarily conservative, with a political and policy-making government that is equally long on ego, but now short on institutional memory and controlled by members with a propensity to liberal tendencies. Steve could, and did, bridge the gap between the House of Medicine—often perceived in the Capitol as headstrong, rich, conservative physicians—and the Legislature, which has been run mainly by Democrats for the past four decades—often perceived as being left of the political spectrum, and not necessarily sympathetic to physicians' concerns.

Legislative & Practice Affairs–Cont’d

Prior to Steve’s leadership at CMA, he had a long and distinguished history of public service in and around California State government and politics.

Steve started his Capitol career in 1964 as an assistant economist for the Department of Water Resources. In 1966, he moved to the Legislative Analyst’s Office (the non-partisan office that analyzes California State budget issues). In 1967, he was chosen as the consultant to the Assembly Health Committee, then chaired by Assemblyman Gordon Duffy (R-Hanford). It was in this capacity that Steve and my father cemented a long-standing friendship. Bill Sr. was the consultant to the then Senate Health & Welfare Committee. In this mutual capacity as consultants dealing with health issues for each house of the Legislature, they relied on each others’ analyses of bills as legislation moved through the process.

In 1971, Steve was one of the principal consultants to the then Assembly Ways & Means Committee, then chaired by Assemblyman Willie L. Brown, Jr., (D-San Francisco). Steve held this position until 1974 when he left the legislature to open his own consulting business in the private sector. [Brown had lost his bid to become Speaker to Leo T. McCarthy (D-San Francisco), and thus Brown lost his chairmanship of Ways & Means and much of his staff.]

In 1981, Brown was elected Speaker as a compromise candidate between the battling McCarthy and then Assemblyman Howard L. Berman (D-San Fernando Valley). Steve returned to the Capitol as Brown’s Chief of Staff (COS). The COS to any Speaker is a powerful position, and Steve was able to use it to help improve the health care delivery system both for providers and patients.

In 1985, Steve left the Capitol again to work in the private sector, only to return again a year later as the Director of the Assembly Office of Research (AOR). He headed the AOR until hired away from the Legislature by the CMA in 1992. He served CMA faithfully, diligently and without comparison until his untimely and sudden departure.

Steve’s many legislative legacies include the program recently named after him, the Steven M. Thompson Physician Corps Loan Repayment Program, to help defray medical school loans for new physicians who agree to work in medically underserved areas. At the same time, he was able to maintain collegial relationships with representatives of converse interests, members of the Legislature and Congress, the federal and state Executive Branch and bureaucracies, and many other difficult constituencies. Additionally, he was able to build a team of young, talented, effective lobbyists to assist him in trying to implement CMA’s sometime overreaching agenda. He has mentored many in the lobbying corps.

Legislative & Practice Affairs–Cont’d

Steve was an enigma of sorts. He championed the rights of the downtrodden by constantly advocating for the expansion of healthcare insurance, and other benefits, to those less fortunate while he himself came from a comfortable background. A native Sacramentan, Steve graduated from C.K. McClatchy High School, one of only two public high schools serving the City of Sacramento at that time. McClatchy, situated in the “Land Park” area of Sacramento, generally served the more affluent areas of Sacramento. Steve grew up in Land Park while his father was an Assistant United States Attorney, and his grandfather was a retired California Appellate Court Justice. He then went on to graduate from U.C. Berkeley.

He was an unabashed liberal and “critical thinker” even before entering the University of California at Berkeley, according to U. S. Representative Robert Matsui (D-Sacramento), who was a friend of Steve’s since junior high school. Matsui, one of the many who eulogized Steve at his funeral, noted that even as a teenager, when you were a friend of Steve’s, you were considered “in.” There are still many of us who considered ourselves “friends of Steve.”

When Willie Brown eulogized Steve, there were many good stories that cannot fit in this article. But the funniest one was Brown stating how he could now see Steve and Kathleen Snodgrass (Brown’s general counsel, when he was Speaker, who also recently passed from cancer) telling the “All Mighty” that someone else would be joining them in the future, and that person would be taking over the “All Mighty’s” job. After we had all laughed, Brown deadpanned that it was just “good advocacy and advance work” on Steve’s part.

Steve was a mentor to many of us in the capitol community and beyond. He had the patience to explain things that, at times, I have found lacking in my senior business partner. Perhaps it was his acknowledgment of my coming to their aid, as designated driver, on more than one occasion when I was a teenager.

Steve was also able to overcome a problem that plagues millions of people, including myself—stuttering. Of those that stutter as a child, approximately 75% “outgrow” stuttering by adolescence, leaving the remaining 25% stutterers for life, except for a few. Steve, by using hard-work, discipline and a good dose of self-confidence, was able to become not only a “fluent” speaker, but one of the most effective, persuasive, and dynamic speakers around. This is most likely the source of his deep, baritone voice mentioned in a *Sacramento Bee* editorial piece. We were supposed to have lunch at some time in the near future, and he was going to give me some pointers on how to improve my public speaking. Unfortunately, no one knew how little time was left.

Legislative & Practice Affairs–Cont’d

Steve chaired the CMA staff meeting every Monday, up until a few weeks ago, which was open to most specialty society lobbyists. Steve knew very well of my continued stuttering and would call on me to speak, knowing full well I preferred to remain silent. When I privately told Steve I did not want to speak because of the stuttering, he countered that avoidance was not the way to handle the problem and he would never “let me off the hook.” At the last CMA legislative workshop that we both attended, he told me in the strongest possible terms that the only way to deal with this “problem” was to hit it head on and have more confidence—the recipe he’d used very successfully. Steve, I will try.

There is a much repeated phrase from *The Great Gatsby* that says to the effect—it is better to let a man know how you feel about him during his lifetime than pay tribute to him after he is gone. In this case both are true. All of us hopefully let Steve know of our feelings, and he certainly deserves this modest tribute.

Steve Thompson was a great man. Throughout his 40 years in public service, he helped millions of Californians who didn’t even know he existed. Some of the state’s most important strides in health care were his creations. He championed big issues (for example, SB 2—employer mandated health care) but never forgot the important stuff like making sure friends and colleagues had the best medical care possible—while unfortunately ignoring his own. A devoted and doting husband and father, his humor and élan brightened anyone who came in contact with him. [REDACTED]

Brilliant, committed, and passionate—in a world where most of us strive to make a difference—**he did make a difference!**

Tribute to Steven M. Thompson, Legislative Advocate for CMA

“His passion for health care is like none other that we have ever seen. His knowledge is like none other that we have seen. He was a premier legislative advocate and did for the California Medical Association what we want legislative advocates to do for all of their organizations, and that is to help guide them to move beyond their special interests.”

—Jackie Speier, California Senator, District 08

CMA Physician’s

Legislative & Practice Affairs–Cont’d

**Confidential Assistance Line
(650) 756-7787 or (213) 383-2691**