Federal Trade Commission and U.S. Department of Justice

Joint Hearings on Health Care and Competition Law and Policy

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Health Plan Initiatives to Improve Quality and to Provide Information to Consumers

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INTRODUCTION

Good afternoon. I am Karen Ignagni, President and CEO of the American Association of Health Plans (AAHP).

AAHP is the national organization representing health plans providing coverage to approximately 170 million individuals nationwide. AAHP member health plans contract with large and small employers, state and local governments, as well as with public programs, including Medicare, Medicaid, the Federal Employee Health Benefits Plan (FEHBP), the State Children's Health Insurance (SCHIP) program, and the military's TRICARE program.

We commend the Federal Trade Commission and the Department of Justice for convening these hearings to address quality and consumer information, which are the building blocks for competitive markets, and for exploring the challenges and opportunities in these areas.

We appreciate the opportunity to be here today to discuss what our community has done to improve health care quality and to make the health care system more accountable. We are proud that our members' efforts have provided a roadmap for quality improvement, disclosure of data and advances in health care delivery.

Health policy experts have written compellingly about the need to empower consumers with information about their health care, and they have

explored the disturbing gap between what science suggests and what practitioners actually do -- the documented overuse, misuse and underuse of particular services. Health plans have taken concrete steps to address these challenges by:

- Disseminating information about the best available medical and scientific evidence to providers and consumers;
- Assessing progress in meeting externally determined and objective quality standards in such areas as diabetes care, post-heart attack treatment, and cancer screening;
- Publicly reporting this information in a format that allows consumers to make straightforward comparisons among plans on more than 50 performance benchmarks; and
- Measuring satisfaction with our administrative systems—including customer service, access to care, and claims processing.

These efforts being implemented across the country have achieved results. The National Committee for Quality Assurance (NCQA)—the independent, nationally recognized accrediting organization for health plans, has reported that health care quality for millions of Americans enrolled in health plans-- has improved substantially for the third straight year.[1] In addition, a significant number of health plans are already performing at or above benchmarks established in *Healthy People 2010* – a set of health objectives for the nation, developed by the Department of Health and Human Services' Office of Disease Prevention and Health Promotion.[2] Those accomplishments validate the importance of measurement and disclosure; they also frame the key question of whether all

participants in the health care system are ready to make a similar commitment. The answer to the question of whether stakeholders are ready to join health plans in being accountable to their patients, the public and state and local purchasers is relevant to the agencies convening this discussion because disclosure and performance measurement are keys to creating a transparent market and keys to ensuring that the market is competitive.

In my testimony today, I will discuss four matters:

- The challenge of making the market more competitive;
- What health plans are doing to promote safe and effective care and transparency throughout the health care system;
- The vital role of competition and antitrust law in promoting quality; and
- The need for continued enforcement to protect consumers.

DEFINING THE SCOPE OF THE CHALLENGE

The IOM Reports on Safety and Quality: In the last several years, the National Academy of Sciences' Institute of Medicine (IOM) has published two landmark reports that identify major problems in the safety and quality of care that patients receive. First, in 1999, the IOM issued a study estimating that as many as 98,000 people die each year as a result of preventable medical errors.[3] That is the

equivalent to a jumbo jet crashing every day. This report clearly laid out why there are safety issues, explained the most serious challenges and made specific recommendations for change.

Two years later, the IOM issued another report stating that, despite the significant advances that have been made in medical sciences and technology, our health care delivery system still fails to provide consistently high-quality care.[4]

To bring the benefits of medical science and technology to all Americans, the IOM proposed a framework for redesigning the health care system to improve the safety and effectiveness of care that patients receive. Several elements of this framework are particularly relevant to the topic of today's hearing. The IOM urged the following:

- Collaboration between health plans and practitioners to better incorporate the best available scientific evidence into everyday clinical practice;

- Public reporting about the performance of health plans and health care providers to create a "transparent" health care system in which patients can make informed decisions about treatment options, coverage, and where they receive their care; and

- Alignment of payment incentives with the delivery of safe and effective, high-quality care.[5]

We have developed our testimony to address how health plans are meeting these challenges, what the enforcement agencies can do and how we develop a national path to system improvement.

MAKING THE MARKET MORE EFFECTIVE

The Federal Trade Commission (FTC) and the Department of Justice (DOJ) are convening these hearings at a critical time when:

- health care costs have become consumers' number one concern;
- health care has become the central issue in labor-management negotiations;
- our regulatory system has become transactional not performance oriented;
- our legal system provides incentives to do everything possible, rather than provide effective care and to conceal – not report – mistakes;
- experts continue to decry the fact that care is not evidence-based;
- limited mechanisms exist to translate research into practice;
- information about health care quality is provided primarily by health plans;
- there continues to be efforts to loosen antitrust enforcement in the name of improving quality, but for the real purpose of creating cartels and other anticompetitive activities.

To understand the scope of these challenges, it may be helpful to remember that most Americans assume that more medical care is better medical care. Yet for decades, research has found evidence of overuse, underuse and misuse of health care services, which can be harmful to patients. During the 1980s, a series of RAND studies found that at least one-third of all medical and surgical procedures

performed in the United States were "of questionable benefit."[6]

More recently, several widely used treatments—hormone replacement therapy, autologous bone marrow transplants for metastatic breast cancer, and arthroscopic knee surgery for arthritis—were found to be ineffective and in some cases harmful. None of these treatments had undergone rigorous evaluation of safety and efficacy before being recommended to millions of patients.

Research by Dr. John Wennberg and others concluded that only a small amount of what is done for patients is evidence-based and that most of what is done is driven by other factors, such as the number of physicians in a given market, cultural preferences, and underlying health of the population in an area.[7] This trend has led to significant geographic variations in medical practice, life expectancy, and outcomes of care. Wennberg's *Dartmouth Atlas* reports that compliance with evidence-based guidelines was less than 20% in ten of the 306 hospital referral regions in the US, and only eight regions had compliance that exceeded 80%.[8]

Our challenges are eight-fold:

- All stakeholders need to commit to transparency, developing consensus on what to measure and publicly reporting it.
- We need to support a national effort that consistently translates clinical research into practice and disseminates these results.
- We need to convert to an evidence-based, not an opinion-based, health care system.

- We need to commit to care coordination through chronic disease management.

- We need to pay for quality and effectiveness, not for overuse, misuse and underuse.

- We need to disclose medical errors, providing essential legal protection to ensure that good deeds are not punished.

- We need to reform the malpractice system to enable the conversion from the present culture of blame to the culture of performance.

- We need to maintain and enforce current antitrust guidelines.

We are pleased to discuss these challenges today and to provide information and examples of health plans' commitment to measurement, disclosure and quality improvement.

ONGOING HEALTH PLAN INITIATIVES TO PROMOTE A SAFE AND EFFECTIVE HEALTH CARE SYSTEM

Health plans have used four types of strategies to promote a safe and effective health care system:

- Evidence-based practice guidelines;

- Report cards on health plan performance;

- Disease management programs for patients with chronic conditions; and

- Incentives to reward quality.

Evidence-Based Guidelines:

Today's health care providers are bombarded with information about research breakthroughs in treatment and new diagnostic tools. To convert this research into practice, medical specialty groups, government agencies, and private organizations, such as health plans, have developed *evidence-based clinical practice guidelines* based on this research. These guidelines have been developed in many areas, ranging from treatment of lower back pain to effective pharmaceutical therapy post-heart attack.

Clinical practice guidelines are "quality-improving strategies" that help health care providers practice in accordance with the best available evidence of effectiveness. The guidelines are "user-friendly statements that bring together the best external evidence and other knowledge necessary for decision-making about a specific health problem."[9] Good guidelines explicitly identify the "decision points" at which new research should be integrated with clinical experience to decide on a course of action. Guidelines don't tell a physician which decision to make, but identify the potential decisions that could be made as enhanced by new scientific evidence.

Health plans provide information on an ongoing basis to health care practitioners in their networks to help them keep abreast of the science and, thus, provide effective care. For example, the science shows that it is important for

patients with diabetes to have their hemoglobin A1C levels monitored two to four times per year and effectively control their glucose level at less than 7%. By measuring and reporting on patients' A1C levels, health care practitioners can determine which of their patients with diabetes need additional follow-up visits and treatment.

At the national level, AAHP has collaborated with the Agency for Health Care Research and Quality (AHRQ) and the American Medical Association (AMA) to implement and maintain the National Guideline Clearinghouse (NGC), which is designed to ensure that the latest medical evidence on new treatments and technologies gets into the hands of health care practitioners on a timely and regular basis. The NGC currently includes 1089 guideline summaries and receives over 10,000 visitors to the website each month.

Report Cards on Health Plan Performance:

Assessing quality improvement is contingent on having an accepted method to collect data. Health plans collect and report information on quality and performance using the Health Plan Employer Data and Information Set (HEDIS). This data set consists of more than 50 performance benchmarks to measure the extent to which participating providers are delivering treatments that have proven to be effective (e.g., use of beta blockers following heart attack, colorectal cancer

screening, cholesterol testing, and monitoring of blood glucose levels for patients with diabetes).

More than 90 percent of health plans – 271 plans nationwide that cover 72 million people – have collected HEDIS data and have had it audited.[10] HEDIS data are integral not only to private health plans; the Center for Medicare and Medicaid Services (CMS) also collects and reports HEDIS measures for Medicare+Choice plans, and the Office of Personnel Management (OPM) collects and reports HEDIS measures for HMOs that participate in the Federal Employees' Health Benefits Program (FEHBP). Health plan performance on these benchmarks is publicly disclosed (in an annual report and on NCQA's Web site) and is disseminated widely to the media. In addition, health plan-specific report cards readily are available to consumers on health plan web sites. This information helps employers and consumers make choices among various health care products, among various types of health plans, and among doctors, hospitals and others who deliver medical care.

Plans and employers also are combining HEDIS measures with information from employee satisfaction surveys to develop more comprehensive indicators of plan performance. For example, the data give employers working with health plans the ability to create incentives for employees to select plans that score well on composite quality indicators; in some cases, this takes the form of a specific

contribution to a benchmark plan, charging employees more in premium contributions and out-or-pocket costs to enroll in plans with less satisfactory quality records.

The GM Example:

> An ongoing project that health plans are undertaking in conjunction with one large employer, General Motors (GM), shows how reporting on quality and satisfaction benchmarks can promote competition on quality and price. Based on the HEDIS benchmark and on other industry standards for quality, GM identifies plans in which participating providers have demonstrated high performance in delivering safe, effective care. GM provides a score based on quality and price. Employees pay a lower premium for the plans that the company determines to be high-quality and cost-effective. Since the program was implemented, many employees have chosen the plans with the highest scores for quality and cost-effectiveness. This program has led to measurable improvements in health care delivery, and saved GM and its employees an estimated $5 million in 2001.

Disease Management:

Research indicates that approximately 20% of patients generate 80% of costs within a benefit plan. With the aging of our population, the numbers of people with chronic diseases are increasing along with the numbers of individuals with more than one condition. These developments have highlighted the need for improved programs to treat and control chronic conditions.[11] Disease management (DM) programs have been implemented by the majority of health plans to improve health care for patients with chronic illnesses. These programs have several

objectives: to identify individuals with chronic conditions, to provide early and continued intervention, and prevent the occurrences of catastrophic episodes. This leads to improved quality and cost effective treatment.

AAHP's 2002 annual survey found that the vast majority of health plans offer disease management programs to address the needs of patients with the following illnesses: diabetes; congestive heart failure; asthma; coronary artery disease; and high-risk pregnancies.[12]

Health plans have implemented many other creative programs throughout the country to provide evidence-based treatment for patients with diabetes, asthma, cardiovascular disease, and other chronic conditions. These include:

- **The Diabetes Initiative**: One example of a collaborative disease management program using evidence-based practice guidelines is the *Taking on Diabetes* initiative that AAHP and the American Diabetes Association have sponsored since 1997. To date, more than 250 health plans providing coverage for more than 5 million people with diabetes have participated in this initiative, which aims to reduce the negative health effects associated with diabetes. The result: significant and demonstrated improvements in the care of patients with diabetes, by increasing the percent of patients who receive eye exams, proper blood glucose monitoring, and monitoring for kidney damage.[13]

- **Asthma Care:** ConnectiCare's Better Respiration Equals Asthma Treatment and Health Education (BREATHE) program helps members with asthma become knowledgeable about asthma symptoms and treatment, enabling them to manage their condition and avoid life-threatening complications. As a result of the education and nurse case management provided through BREATHE, the rates of ConnectiCare members hospitalized for asthma dropped by 78%, and the percent of members going to emergency rooms due to asthma complications decreased by 71%. In

2002 and 2003, ConnectiCare expanded the focus of BREATHE to address pediatric asthma, specifically for children from birth through age four.

- **Care for Patients with Congestive Heart Failure:** PacifiCare has implemented a program that helps ensure that patients with congestive heart failure are taking appropriate medications to stabilize their heart condition and make lifestyle changes involving diet, exercise, and smoking cessation. The program provides information to physicians on the prescriptions that their patients with congestive heart failure are taking, and information to consumers on weight management, diet, exercise, and smoking cessation programs. Since implementation, 90% of those enrolled in the program are now taking their cardiac medication, 85% have received nutritional counseling and almost half have attended smoking cessation classes.

Additional examples are described in detail in two volumes I am attaching to this testimony and submitting for the record: *Innovations in Medicaid Managed Care* and *Innovations in Medicare Managed Care*, which document improvements that plans have made in the health and well-being of Medicare and Medicaid beneficiaries, in areas such as:

- Prenatal and postnatal care;
- Immunizations for children and adults;
- Cancer screening;
- Stroke prevention; and
- Cardiovascular disease

These documents provide examples from over 50 health plans in 20 different states that are working to improve health care for their enrollees.

Incentives to Advance Quality:

"Paying for quality" is a strategy that purchasers and payors are working on together to promote the delivery of safe, effective care. It changes the paradigm of the traditional fee-for-service system, where providers were compensated for how much they do, not how well they do it. Favoring quantity over quality is extremely costly and dangerous for most Americans. As one physician participant in a program sponsored by Anthem BC and BS of New Hampshire put it, the incentive is "a breath of fresh air. You get to be like everyone else in America: if you do good work, you actually make more money."[14]

The following are a few examples of the growing number of initiatives that align payment incentives with quality:

- **Pacific Business Group on Health and six health plans in California:** Aetna, Blue Cross of California, Blue Shield of California, CIGNA, HealthNet, and PacifiCare, in conjunction with the 45 employers participating in the Pacific Business Group on Health, implemented the "Pay for Performance" program this year. Under that program, each health plan creates an incentive program to give physicians a bonus for reaching specific goals in treating diabetes, asthma, and coronary artery disease; screening for breast and cervical cancer; and child immunizations. Performance on clinical benchmarks for providing safe and effective care account for 50% of physician groups' "scores"; measures of patient satisfaction account for 40%; and investment in information technology accounts for 10%.

- **Harvard Pilgrim Health Care** rewards performance among its network providers in meeting benchmarks for effective care. Harvard Pilgrim and its participating medical groups agree to link a portion of their payment to measures of performance in the areas such as adult diabetes care, pediatric asthma care, patient safety, and inpatient

utilization. To evaluate the performance of the medical group, the health plan uses effectiveness-of-care measures from HEDIS, as well as patient safety measures identified by The Leapfrog Group. (The Leapfrog Group – a coalition of over 100 public and private purchasers that are working to improve patient safety – has identified three patient safety hospital standards for measurement and reporting). For example, providers must increase the percentage of adult members with diabetes who are tested at least once annually for blood sugar, high cholesterol, and eye problems associated with diabetes, and report on their progress in meeting the three Leapfrog standards.

- **Anthem Blue Cross Blue Shield** in Virginia implemented Performance Extra in 1997 and continues to reward primary care physicians for meeting performance goals in: reducing upper respiratory illness; providing mammograms and well-adolescent visits at the recommended intervals; and reducing the number of patients who use tobacco. Nearly 2,500 doctors have received bonuses through this program.

- **Empire Blue Cross Blue Shield** is working with several of its large employer customers – IBM, PepsiCo, Xerox, and Verizon – to provide bonuses to hospitals that implement two of the Leapfrog standards: (1) implement computerized order entry systems (CPOE), in which physicians can order medications and other treatments; and (2) staff intensive care units (ICUs) with physicians who specialize in critical care medicine. The companies anticipate awarding approximately $2 million in hospital bonuses over the course of the three-year initiative. Empire will reward hospitals in their network that meet both the CPOE and ICU safety standards, with bonuses equivalent to: 4 percent of the hospital's claims for the five participating companies in 2002; 3 percent in 2003; and 2 percent in 2004. Hospitals will receive partial bonuses for achieving one of the two patient safety measures.

- **Blue Cross Blue Shield of Illinois,** the state's largest health insurer, will begin providing financial incentives and increased reimbursements for hospitals that improve their performance based on a number of quality indicators. Under the plan, the health plan and individual facilities or health systems will use a variety of national and state statistics -- including patient safety data, historical

performance and satisfaction survey results -- to determine the pay-for-performance reimbursement rates.

- **Anthem Blue Cross and Blue Shield of New Hampshire** also pays physician bonuses based on the use of mammography, Pap smears, and diabetic eye exams. The program rewards physicians for enrolling patients in disease management programs. Anthem pays primary care groups a bonus of $10 to $30 per member per year, depending on their performance.

- **Aetna** has experience with physician incentive programs dating back to 1987. In 2002, Aetna built on a previous initiative to establish the Quality Enhancement (QE) bonus program. Aetna defines several standard performance measures, including member satisfaction, medical record review, and access to care. Primary care physicians are eligible for a monthly bonus if they meet regional performance thresholds based on these measures. Aetna distributes monthly and ad hoc reports to provide primary care providers with feedback on their performance. An estimated 60 percent of Aetna's primary care physicians are paid a monthly bonus.

- **CIGNA HealthCare of Georgia:** CIGNA recently collaborated with participating providers to develop an incentive program called "Reward for Quality." Quality indicators include measurements such as whether patients diagnosed with congestive heart failure receive ACE inhibitors. The program places physicians into three payment categories for services rendered. The top tier is for physicians who exceed quality standards. Because provider performance will be measured bi-annually, the program allows for payment increases to reflect quality improvements in a timely manner.

Later in this week, the agencies will hear from senior representatives from UnitedHealth Group and WellPoint Health Networks. They each will provide specific examples of their companies' many initiatives in these areas.

THE IMPORTANCE OF QUALITY IN THE ANTITRUST CONTEXT

What the Antitrust Guidelines Allow:

Current antitrust and trade regulation law provides the legal framework in which health plans, providers, and other stakeholders in the health care system can both compete and collaborate to promote quality. As noted in a recent article in *Health Affairs*, "Competition law affects quality of care by influencing the conduct of providers and the institutional and structural arrangements through which health care is financed and delivered."[15] The law explicitly recognizes quality as a critical goal in the health care system and uses it as a guidepost for determining the types of provider communications that are pro-competitive and pro-consumer and, thus, which should be allowed under the antitrust laws. As a result, consumers win. But when competition is absent, there is little or no incentive for finding the best ways to meet consumer needs.

We believe that the existing *Health Care Antitrust Guidelines* provide an appropriate framework for competition. Some have argued that the Guidelines should be revised to allow physicians to bargain collectively with health plans, and have supported legislation at the federal and state levels to allow exemptions from competition laws. It is striking that the IOM's comprehensive agenda for improving the health care system *did* mention the need for legal reform to encourage the disclosure of medical errors but *did not* mention the need for

legislative or administrative changes to promote competition in the health care market. This is not surprising, in light of the extensive evidence already presented at these hearings by nationally recognized economists and antitrust experts, whose research shows that competition remains vigorous in health plan markets throughout the country and that changes in the law to sanction provider cartels are not warranted.[16] Unfortunately, experience has demonstrated that the issue of quality has too often been used to shield anticompetitive acts.

While we support the Guidelines in their current form, we remain concerned that in some cases the Guidelines, and even the Agencies' advisory opinions, may have the unintended consequence of encouraging anti-competitive activities. Statement 8 of the Guidelines allows physicians to form partially integrated joint ventures that allow them to remain in independent practice yet negotiate collectively. Under the Guidelines, these networks do not need to share financial risk. Rather, they can receive rule-of-reason treatment under the antitrust laws if they involve "substantial clinical integration" -- such as by implementing programs to evaluate and modify practice patterns to promote quality based on medical and scientific evidence of effectiveness.[17]

The FTC determined in its MedSouth advisory opinion that the physician group appeared to be engaged in a *bona fide* effort to integrate for the purpose of improving quality care based on evidence-based guidelines.[18] We are encouraged

by the FTC's warning in the MedSouth opinion that its approval of the venture was contingent on implementation of these quality improvement programs and on the physicians' continued ability to negotiate separately with health plans. Likewise, we acknowledge and appreciate the importance of the Commission's commitment to conduct "look-backs" to ensure that these assurances are upheld.

In some cases, the MedSouth opinion unintentionally may encourage physician affiliations that are *not* clinically or financially integrated as specified in the Guidelines. And, indeed, in several recent cases, the Agencies have found that physicians were forming joint ventures for the sole purpose of raising prices to anti-competitive levels.[19] The Agencies acted appropriately in these instances to break up provider cartels.

To ensure that the Antitrust Guidelines and the MedSouth opinion work as intended to promote competition, we urge continued vigilance by the Agencies, including "look-backs" at previously approved provider ventures. These retrospective analyses are critical to ensure that approved affiliations and combinations live up to the goals that they promised: to provide consumers the benefit of higher quality care and more efficient, effective health care delivery.

We urge the FTC to continue to oppose legislative proposals that would allow independent, competing physicians to form cartels and engage in collective bargaining. This type of legislation – including H.R. 1120, which was introduced

in the House in March 2003 – would lead to lower health care quality, higher health care costs, and reduce access to care. By permitting physicians providers to collude in negotiating favorable contract provisions, this legislation would enable providers collectively to refuse to cooperate in reporting on health care quality or refuse to be held accountable for the health care services they deliver. In addition, this legislation would allow competing providers to engage in price-fixing and boycotts that would drive health care costs to even higher levels. We believe these anti-competitive activities should remain illegal. Health care consumers are better served by a system that emphasizes vigorous competition as the key to promoting quality improvement innovations and controlling health care costs.

CONCLUSION

We share the Agencies' goals of promoting high-quality care for all Americans and helping ensure that consumers have the information they need to make health care decisions. Health plans have led the way in:

- measuring the performance of health care providers and health care organizations in providing safe and effective care;
- promoting transparency and public disclosure of health system performance in meeting quality goals; and

- working with health care practitioners and other stakeholders in the health care system to meet the IOM's goals of improving quality throughout the health care system.

The FTC and the DOJ play a critical role in promoting a vibrant, competitive health care market to improve quality and disseminate information that is useful to consumers. The current Antitrust Guidelines provide an appropriate framework for collaboration among health care organizations on initiatives that provide quality benefits to consumers. However, we remain concerned that these Guidelines and advisory opinions, such as MedSouth, may be used in ways that are contrary to their intent. Therefore, close scrutiny of proposed joint ventures and mergers among providers – as well as ongoing look-backs of these arrangements -- are needed to promote competition and protect the consumer.

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1 NCQA. *The State of Health Care Quality: 2002.* (2002) p.7.
2 Ibid.
3 National Academy of Sciences. Institute of Medicine (1999). *To Err is Human: Building a Safer Health Care System.* National Academy Press. Washington, D.C.
4 National Academy of Sciences. Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century.* National Academy Press. Washington, D.C.
5 Ibid.
6 RAND Health (1998). Research Highlights. *Assessing the Appropriateness of Care.* Santa Monica, CA.
Wennberg, J.E., & Cooper., M.M (1999). *The Dartmouth Atlas of Health Care in the United States.* Chicago, IL. AHA Press.
7 Ibid.
8 Ibid.
9 Sackett, D.L. et al. (2000). Evidence-Based Medicine: How to Practice and Teach EBM – 2nd Edition. London
10 National Committee for Quality Assurance (2002).
11 Selby, J. et al. (2002). Valuing the Disease Management Program in Health Plans. Paper based on Conference sponsored by AHRQ. Chicago, Il.
12 American Association of Health Plans (2002). 2002 Annual Survey of Health Plans. Publication Pending.
13 National Committee for Quality Assurance (2002). State of Health Care Quality 2002. Washington, D.C
14 Maguire, P. (2001). *As They Struggle to Improve Quality, HMOs try a New Incentive: Bonuses.* ACP-ASIM Observer. June 2001.

16 Wu, L. (April 23, 2003). *Economic Issues in Analyzing Competitive Effects in Health Insurance Markets.* FTC/DOJ Joint Hearings on Health Care and Competition Law and Policy. Session on Health Insurance Monopoly Issues-Competitive Effects. Washington, D.C.

17 Department of Justice and Federal Trade Commission *Statements of Antitrust Enforcement Policy in Health Care. (1996).* Statement 8: Physician Network Joint Ventures. Washington, D.C. See also Leibeluft, R.F. (May 7, 2003)

18 U.S. Federal Trade Commission (February 19, 2002). *Advisory Opinion, MedSouth, Inc.* Letter from Jeffrey W. Brennan to John J. Miles, Ober, Kaler, Grimes, & Shriver.

19 U.S. Federal Trade Commission (August 20, 2002). *Dallas-Fort Worth-Area Physician Group Agrees to Settle.* Press Release. Washington, D.C. See also: U.S. Department of Justice (January 10, 2003). USA v. Mountain Health Care Proposed Final Judgment and Competitive Impact Statement. *Federal Register.* 68(7). 1478-1482. U.S. Federal Trade Commission (May 2, 2003). *New Mexico Physicians' Association Agrees to Settle FTC Charges of Price-Fixing: Activities Allegedly Led to Higher Prices for Local Consumers.* Press Release. Washington, D.C.