

# PHYSICIAN MEDICAL COOPERATIVES USING THE AGRICULTURE MODEL – LEGAL AND STRUCTURAL ANALYSIS

Michael T. Goldstein, M.D., J.D.  
Kern Augustine Conroy &  
Schoppmann, P.C.  
New York, NY

The delivery of healthcare in the United States is undergoing a rapid transformation. Medicine is shifting from the private practice model to hospital-based employment and large group practices. Hospital mergers have created large vertically integrated institutions with huge market shares. Physicians who want to remain independent are seeking entities which enable them to compete in the evolving healthcare marketplace. These include independent practice associations (“IPAs”), accountable care organizations (“ACOs”) and quasi group practices.

Rather than try to invent new entities, this article proposes the adoption of a business model, the agricultural cooperative, which has been in existence since the early days of the American Republic. This article will discuss the history and structure of an agricultural cooperative, a proposed structure of a physician medical cooperative and legal issues involved in the formation of a physician medical cooperative.

## History

The history of cooperatives in the United States dates back to colonial times. Benjamin Franklin was involved in the founding of the first known cooperative in the colonies, a mutual insurance company called “the Philadelphia Contribution-ship for the Insurances of Houses from Loss by Fire, a mutual fire insurance company established in 1752.”<sup>1</sup> Soon after a cheese production cooperative formed in the early 1800’s in Goshen, Conn.<sup>2</sup> Cooperatives expanded with the onset of the Grange movement in

1867.<sup>3</sup> Cooperatives sold goods, including farm supplies, to their members in cooperative-owned stores, operated grain elevators and tobacco warehouses, exported wheat and marketed agricultural products and wool.<sup>4</sup> By 1920 there were “as many as 14,000 farmer cooperatives.”<sup>5</sup>

Cooperatives play an important role in the modern economy. “Cooperatives handle, process, and market farmers’ products; negotiate with processors and other buyers on their behalf; enable them to purchase inputs at a discount; and provide them credit and other financial services.”<sup>6</sup> There are over 3,000 farmer cooperatives across the United States, whose members include a majority of the nation’s two million farmers.<sup>7</sup> According to the National Cooperative Business Association, there are more than 29,000 U.S. cooperatives with approximately 73,000 places of business, owning more than \$3 trillion in assets, generating \$654 billion in revenue, \$75 billion in wages and benefits and employing over two million people.<sup>8</sup>

Supply and marketing cooperatives account for a third of total farm sector revenue and input purchases.<sup>9</sup> However, cooperatives also involve other sectors of the economy, including credit unions, cooperative housing, and other business entities. “Franchisees, governmental units, hardware and grocery stores, florists and numerous other businesses use cooperatives to market their products and secure the supplies they need at competitive prices.”<sup>10</sup>

## Categories and Examples

Cooperatives fit into the following categories: consumer, purchasing and shared, service, worker, producer and hybrid.<sup>11</sup> Consumer cooperatives,

which are the most common, are for the purpose of purchasing goods or services.<sup>12</sup> Credit unions and electricity cooperatives are also common.<sup>13</sup> Examples include members of the Credit Union National Association and members of the National Rural Electric Cooperative Association (which contains 900 rural electric companies). Purchasing and shared service cooperatives enable businesses to jointly purchase goods and services and to compete with “big box” competitors.<sup>14</sup> This enables them to reduce costs and improve performance.<sup>15</sup> Examples include Best Western Hotels, Ace, True Value and Do It Best.<sup>16</sup>

Worker cooperatives are businesses that are owned and democratically governed by their employees,<sup>17</sup> such as Cooperative Home Care Associates, the nation’s largest worker cooperative, with more than 1,000 members providing home care in the New York metropolitan area.<sup>18</sup> Producer cooperatives are most commonly agricultural cooperatives<sup>19</sup> such as Land O’Lakes.<sup>20</sup> A hybrid cooperative is a multi-stakeholder venture where individuals with conflicting interests, i.e. consumer and supplier work together.<sup>21</sup> An example is Oklahoma Food Coop, which is a producer/consumer cooperative.<sup>22</sup>

In all instances cooperatives are a mechanism where smaller entities with a common interest can join together to compete in the marketplace with larger entities. Cooperatives must adapt to the realities of the marketplace to survive. The purchasing and shared service corporations, which include supermarkets and hardware stores, must be competitive with the larger entities. They must adapt to the changing business environment.

## Cooperative Characteristics

Cooperatives are state chartered corporations that can be either for

profit or nonprofit.<sup>23</sup> A cooperative is collaboration of individuals, who would otherwise be competitors, for their mutual benefit. By acting together, cooperatives take advantage of economies of scale, market clout, bargaining power and efficiency.<sup>24</sup> Capital comes from the direct contribution of the members, including sale of stock, membership fees, withholding of shareholder income, and retention of profits.<sup>25</sup> The liability of each shareholder is limited to his/her contributions to the cooperative.<sup>26</sup> Cooperatives operate under a user owner principle where the stakeholders benefit from the profits and are obligated to maintain its economic viability.<sup>27</sup> The cooperative is controlled by the shareholders, with each shareholder having only one vote.<sup>28</sup> In some cooperatives high volume users will have additional votes.<sup>29</sup>

What is unique to cooperatives is the patronage refund system. Under that system, cooperatives provide services and pay for goods at market prices with non-retained earnings distributed at the end of the fiscal year to the patrons as cash or equity based on their proportion of total use.<sup>30</sup> For cooperatives this is authorized under Section 4 of the Capper-Volstead Act.<sup>31</sup> Cooperatives do not pay federal income tax as a business entity.<sup>32</sup> Instead, a cooperative receives a pass through designation, with the taxes paid by the individual or business who receives the funds in accordance with IRS Subchapter T Cooperatives tax code. This provides an incentive for each owner to maximize the use of the cooperative. Most cooperatives are not concerned about making a profit. "Many cooperatives don't pay any dividends on capital. Others pay a modest return, in line with state and federal statutes that bar substantial payments."<sup>33</sup>

## Legal Issues for Cooperatives in General

Cooperatives came into existence prior to the Sherman Antitrust Act.<sup>34</sup>

That Act, enacted in 1890, was designed to prevent the restraint of trade through the formation of trusts and monopolies.<sup>35</sup> There were concerns that cooperatives, which were cooperative ventures of competitors, were in violation of the Act. Cooperatives that existed before the Sherman Antitrust Act were thus now at risk of prosecution. This gap in legal protection for agricultural cooperatives was partly remedied by Section 6 of the 1914 Clayton Act,<sup>36</sup> which provided antitrust protection for agricultural organizations that existed for the purpose of mutual help, provided that the entity was not for profit and had no capital stock.<sup>37</sup> However, most cooperatives are state chartered corporations that can either be nonprofit or for profit; thus not all of them were protected under the Clayton Act.

To afford greater antitrust protection to agricultural cooperatives, in 1922 Congress passed the Capper-Volstead Act.<sup>38</sup> "The Capper-Volstead Act's proponents viewed cooperatives as a bulwark against 'middlemen' and 'speculators' that unfairly preyed on both farmers and consumers. Small, individual farmers could sell their crops and livestock only to few large corporate entities that then processed and distributed agricultural products. According to the Act's proponents, these entities then paid farmers unjustifiably low prices, while in turn charging consumers high prices."<sup>39</sup>

The Capper-Volstead Act was intended to level the playing field between the farmer and the purchasers by "(1) enabling farmers to combine, forming a countervailing power to bargain effectively with purchasers; and (2) enabling farmers to process, distribute, and market their products more efficiently and potentially bypass middlemen altogether."<sup>40</sup> Farmers were to benefit through fair prices and consumers were to benefit from lower costs.<sup>41</sup> This law is unchanged since its enactment in 1922.<sup>42</sup>

The goals of the Act, as stated by Senator Arthur Capper (R.-Kansas

1919-1949), one of its sponsors, were to reduce costs through greater efficiency, reduce speculation, decrease middleman profits, stabilize the food supply, and allow the farmers to bargain collectively.<sup>43</sup> The Capper-Volstead Act also allowed cooperatives to return earnings to members.<sup>44</sup>

The Capper-Volstead Act offers agricultural cooperatives significant antitrust protection. However, such protections are not absolute. Agricultural cooperatives are subject to Federal Trade Commission ("FTC") civil investigations and Department of Justice ("DOJ") criminal prosecutions when their actions fall outside the protection of the Act. Agricultural cooperatives which are state-chartered corporations can also be subject to state antitrust law.

## Physician Medical Cooperative

### Rationale

The proposed physician medical cooperative, to succeed, must adapt to the realities of the healthcare marketplace. Regardless of the payment model, physician cooperatives need to provide cost effective, quality healthcare at a competitive price while affording its physician members income and quality of life conditions that are competitive or superior to other alternatives. Patient satisfaction and quality metrics must be competitive. The purpose of the physician medical cooperative would not be to generate a profit for the cooperative but instead to enable its members to compete against larger entities in the healthcare marketplace.

The cooperative concept has worked in many other businesses but has not been attempted by physicians. Historically medicine has until recently been thought of as primarily a profession. Cooperatives have generally been businesses. Now that medicine has evolved to a business model, organizational structures that have worked for other businesses need to be considered. The

*continued on page 34*

# Physician Medical Cooperatives Using the Agriculture Model

continued from page 33

cooperative is one such example of an innovative healthcare delivery system.

Healthcare delivery is already restructuring. Larger group practices and vertically integrated healthcare systems with physician employees are replacing small group physician practices. Physicians in private practice have declined from 57 percent in 2000 to 39 percent in 2012 and are declining at a rate of two percent per year.<sup>45</sup> Just like the family farm that faced extinction from consolidation and powerful processors, physicians in private practice are facing extinction.

Individual physicians lack the economy of scale, efficiencies and the collective bargaining power of joint ventures. However, it can be argued that the preservation of cost-effective private practice physicians is necessary to maintain both diversity and maintain competition in the marketplace.

There is a huge parallel between farming in 1922 and medical practice today. The private practice and small group physicians are selling their professional services, instead of agricultural products, to a small number of health insurance company purchasers. These purchasers are paying physicians declining fees while at the same time increasing the price consumers pay for health insurance. As a result, profits for health insurance companies have increased dramatically.<sup>46</sup> Reducing the spread in the case of healthcare means reducing the percent of the premiums paid by consumers and employers that is retained by the insurance companies. The parallel situation between the farmers of 1922 and the physicians of today suggests that rather than reinventing the wheel with new business entities, physicians should copy, with industry-specific modifications, the successful model of the agricultural cooperative.

Senator Arthur Capper, the principal sponsor of the Capper-Volstead

Act in the Senate was concerned that with regard to farming there was too big a spread between the payment to the farmer and the cost to the consumer.<sup>47</sup> The Capper-Volstead Act that provided antitrust protection for cooperatives came into existence to give the farmers bargaining power to deal with the middleman. "According to the Act's proponents, these entities then paid farmers unjustifiably low prices while, in turn, charging the consumer high prices. This meant these large firms were 'collecting their tribute from both the farmer and the consumer.'"<sup>48</sup>

The same situation exists in medicine. The middleman in healthcare is the insurance company. The spread between the payment to the physician and other providers and the costs to consumers is the loss ratio. When a higher percentage of premiums are retained, above costs, the profits increase. For example, from 2001-2007 there was a 466 percent increase in health insurance company profits.<sup>49</sup> Despite the rising insurance premiums, physician income has declined, suggesting that the increase in premiums has not been used to compensate physicians but has instead been retained by the insurance companies as increased profits.<sup>50</sup>

The Capper-Volstead Act was supposed to enable the farmers to remain in business and protect the food supply.<sup>51</sup> Here too, the situation is analogous to modern medical practice. There is a projected growing shortage of physicians in the United States,<sup>52</sup> which will jeopardize the availability of healthcare. Private practitioners are being driven out of business at a rate of two percent per year by their inability to compete with larger entities.<sup>53</sup> Many of these physicians will join larger entities, but older physicians who constitute a significant percentage of active physicians will in large numbers retire. This will further

exacerbate the impending physician shortage. Physician medical cooperatives could enable physicians to preserve private practice, enable them to be more competitive and efficient, provide better care and enable them to be fairly compensated while controlling costs.

## Physician Medical Cooperative Legal Structure

A physician cooperative would have same legal structure and purpose of a farming cooperative. Each physician would contribute capital and become a shareholder in the cooperative. The cooperative would be incorporated in the state where the physicians are practicing. The cooperative would be governed by a board of directors elected by the physicians in a democratic fashion with each physician having one vote. The purpose of the cooperative would not be to make a profit but instead to mutually benefit all of the physician stockholders. The cooperative, if permitted by law, will distribute patronage to the physician stockholders based on proportionate use.<sup>54</sup> Patronage distribution by a physicians' cooperative is an untested area of the law. It is possible that it may be violation of the Stark Law. This will be discussed in Stark Law analysis section.

## Operational Model

The physician medical cooperative model would be designed to financially integrate independent practitioners. Joint volume purchasing would lower costs of supplies. Employee benefits, including health insurance could be jointly purchased at a discount. The cooperative physicians could provide a preferred provider network for their employees. Billing for professional services and credentialing could be centralized, reducing individual office overhead. Claims adjudication, quality assurance and follow-up on denied claims could be centralized. Marketing

for the cooperative would be a joint venture. The members would be required to adhere to certain standards to maintain the quality of the cooperative name branding. The cooperative could bargain collectively for professional fees, terms and conditions. There is the possibility for both risk sharing contracts and capitation contracts.

The cooperative could enable physicians to enhance the care provided to patients of cooperative members. Equipment sharing could enhance cooperative members' ability to provide more comprehensive services at a lower cost. Access to on-site medical devices could eliminate institutional referrals and facilitate treatment. Cooperatives could jointly own radiology services with radiologists being members of the cooperative. Ambulatory surgery centers could also be owned by the cooperative.

All specialties would benefit in different ways. Primary care specialists would benefit most from laboratory and radiology services. Many specialties would benefit from other diagnostic testing and medical device usage. Surgical specialties would benefit from the ambulatory surgery. Radiologists would benefit from the radiology center. The cooperative would develop income streams from these ancillary services, enabling them to compete with hospitals and large group practices that currently have these income streams.

If healthcare changes from a fee-for-service to an outcome-based model, the cooperative and its members would have the infrastructure and operational capacity to compete and provide services in that environment. The cooperative model enables physicians to maintain their private practices and control their own hours, patient volume and overall productivity while still reaping the benefits of a joint venture. The cooperative model would enable physician members to compete on a level playing field

with large group practices and vertically integrated healthcare systems. The preservation of private practice would preserve diversity and competition in the marketplace. Costs could be kept lower due to competition.

#### **Disadvantages**

This model has limitations. Cooperative physicians would still have to manage all of the expenses and headaches of operating their own business. An employed physician does not have these responsibilities. In a group practice only the managing partners have to deal with the management of the practice. In the group practice setting, as physicians become partners they acquire equity in the group practice. In contrast, physicians who are stockholders in a cooperative should not expect to acquire equity beyond their original investment.

#### **Comparisons to Other Organizational Structures**

A cooperative is distinguishable from an IPA because it is more encompassing. In a clinically integrated IPA model, there would be collective bargaining, but there would not be shared facilities, nor secondary income streams from these shared facilities. The two models would be similar in that they could jointly market, share information, work together for increased efficiency, reduce overhead through group purchasing and share management. Both physician medical cooperatives and IPAs can incorporate medical homes into their model. They can both be structured for capitated and risk sharing contracts.

A cooperative is different from a group practice in that the latter is totally integrated. There is a single entity, with the group managing all of the overhead costs and operating shared facilities.

The cooperative structure is designed to have all of the integration features of an IPA combined with the joint ownership of facilities and equipment common to a group

practice, while preserving the physicians' ownership of their own practices.

## **Other Cooperatives in Healthcare**

Cooperatives are already being explored in areas related to healthcare. One example of a healthcare cooperative is New Seattle Massage.<sup>55</sup> This cooperative, consisting of more than 25 licensed massage therapists in Washington State, has been in existence since 1981.<sup>56</sup> In this cooperative, each massage therapist is self employed and paid directly for his or her services.<sup>57</sup> The massage therapists contribute a portion of their fees for shared costs, such as "laundry, receptionist, facility rent & upkeep, administration and advertising."<sup>58</sup> The therapists' purpose of forming the cooperative was "to better serve our clients and ourselves. Our facility offers clients amenities none of could offer individually (steam room, sauna, showers)."<sup>59</sup> They define themselves as a blend of "supply and marketing cooperative types."<sup>60</sup> Each massage therapist decides which insurance plans to accept.<sup>61</sup>

This cooperative does engage in two activities that could generate regulatory concerns, price fixing and incentives. The price fixing consists of having all members of the cooperative charge the same fees for paying patients.<sup>62</sup> The cooperative also offers the incentive of the use of a sauna or steam room combined with a shower, towel and locker only to clients that have had a massage (regardless whether it is covered by insurance or paid for out of pocket) for a cost of \$5.00.<sup>63</sup> This discounted service could be considered as an incentive for patients to come to these therapists for healthcare services. It could be viewed as a kickback to the patient.

Price fixing in any industry is subject to federal and state antitrust laws and regulations. If the cooperative is viewed as a single legal entity similar to a group practice, then uniform pricing of services is not price fixing.

*continued on page 36*

# Physician Medical Cooperatives Using the Agriculture Model

continued from page 35

The federal anti-kickback statute only applies to federal healthcare programs. If none are involved, and there is no state law that makes the practice of discounted sauna, steam room and shower services unlawful, then this incentive would not violate any laws.

## Antitrust Analysis of Physician Medical Cooperatives

### Clayton Act

Collective action by competitors involving interstate commerce is a *per se* violation of the Sherman Antitrust Act.<sup>64</sup> However, there is an exemption under the Clayton Act:

The labor of a human being is not a commodity or article of commerce. Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor, agricultural, or horticultural organizations, instituted for the purposes of mutual help, and not having capital stock or conducted for profit, or to forbid or restrain individual members of such organizations from lawfully carrying out the legitimate objects thereof; nor shall such organizations, or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws.<sup>65</sup>

In the past, the practice of medicine was considered to be entrepreneurial and therefore subject to the antitrust laws.<sup>66</sup> However the medical profession and the reimbursement scheme have changed since the earlier Supreme Court rulings.

Physicians' services now for the most part are paid by Medicare and commercial carriers using a resource based relative value scale ("RBRVS"). Each procedure that a physician performs has a designated Current

Procedural Terminology ("CPT") code. For each CPT code there are a specific number of Relative Value Units assigned to it that are subdivided into work relative value units, overhead relative value units and malpractice relative value units.<sup>67</sup> RBRVS determines prices based on three separate factors: physician work (52 percent), and overhead, split out as practice expense (44 percent) and malpractice expense (four percent).<sup>68</sup> Every payor, including Medicare, pays a fixed amount for each Relative Value Unit. Fees are determined for a particular CPT code by multiplying the number of Relative Value Units for the code by the dollar value per Relative Value Unit.

If there were a legal determination at an appellate level that the work of physicians in their private offices was providing labor then they could form organizations that would be protected from antitrust actions within the safe harbor of the Clayton Act. This would represent a quantum shift in organization power on behalf of the physicians. Medical societies, as nonprofit entities without capital stock that are organized for mutual benefit, could then form physician bargaining organizations and other mutual benefit activities that would resemble cooperatives under the Clayton Act.<sup>69</sup>

### Department of Justice and Federal Trade Commission Guidelines

The FTC and DOJ have created guidelines and safe harbors under the antitrust laws for physician organizations that are either clinically or financially integrated.<sup>70</sup> The goal of the guidelines, which apply to physician joint ventures, is "to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition."<sup>71</sup>

Cooperatives can be structured to comply with these guidelines through financial or clinical integration or both.

With regard to compliance with the antitrust laws there are three categories of organizations, each falling into three different analysis categories: violation *per se*, safe harbor and rule of reason.<sup>72</sup>

### Violations Per Se

Violation *per se* entities are out of compliance with the guidelines to such an extent that they are subject to antitrust prosecution by the FTC and the DOJ. "Antitrust law treats naked agreements among competitors that fix prices or allocate markets as *per se* illegal."<sup>73</sup> Physician medical cooperatives do not fall into this category.

### Safe Harbors

Safe Harbors or safety zones are different for exclusive and non-exclusive physician joint ventures. An exclusive joint venture must have 20 percent or less market share in each specialty.<sup>74</sup> A non-exclusive joint venture must have 30 percent or less market share in each specialty.<sup>75</sup> In both instances there must be substantial financial risk sharing as defined in the guidelines.<sup>76</sup> A physician medical cooperative can be either exclusive or non exclusive; however, to avoid Stark issues the members must provide at least 75 percent of their services through the cooperative entity.<sup>77</sup>

Because of the different requirements for exclusive and non-exclusive networks, the FTC provides the following cautions and guidelines.<sup>78</sup>

Physician networks that qualify for antitrust protection "must share substantial financial risk in providing all the services that are jointly priced through the network."<sup>79</sup> The FTC offers the following rationale for using risk sharing as the determining factor of financial integration: "Risk sharing provides incentives for the

physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians.<sup>80</sup> The FTC gives examples of risk sharing that would fall into the safe harbor. These include capitation, services for a percentage of the premium, incentives to physicians to achieve cost containment goals through withholding a percentage of the fees and/or establishing cost utilization targets, or coordination of care among specialists for a fixed fee.<sup>81</sup>

The FTC also recognizes that new forms of risk sharing could develop.<sup>82</sup>

Entities that fall within the safety zones outlined by the FTC guidelines pass muster. A physician medical cooperative could be fashioned to fall within these safety zones. However, if a physician medical cooperative did not fall within these safety zones, it still could be protected from antitrust action using the rule of reason analysis.

#### **Rule of Reason Analysis**

It is most likely that a physician medical cooperative would be evaluated under the rule of reason. The principle behind the rule of reason is that “physician network joint ventures that fall outside the antitrust safety zones also may have the potential to create significant efficiencies, and do not necessarily raise substantial antitrust concerns.”<sup>83</sup> The FTC further states that “[t]he Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, their goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition.”<sup>84</sup>

In theory, a physician medical cooperative which is modeled after the tried and true agricultural cooperative model, an acceptable joint venture model, should be an acceptable organizational structure under the rule of reason analysis. However the rule of reason is a three-part test; all three parts must be passed in order for a joint venture to be approved by the FTC.

“Step one: Define the relevant market. The Agencies evaluate the competitive effects of a physician network joint venture in each relevant market in which it operates or has substantial impact. In defining the relevant product and geographic markets, the Agencies look to what substitutes, as a practical matter, are reasonably available to consumers for the services in question.”<sup>85</sup>

“Step two: Evaluate the competitive effects of the physician joint venture. The Agencies examine the structure and activities of the physician network joint venture and the nature of competition in the relevant market to determine whether the formation or operation of the venture is likely to have an anticompetitive effect. Two key areas of competitive concern are whether a physician network joint venture could raise the prices for physician services charged to health plans above competitive levels, or could prevent or impede the formation or operation of other networks or plans.”<sup>86</sup>

“Step three: Evaluate the impact of procompetitive efficiencies. This step requires an examination of the joint venture’s likely procompetitive efficiencies, and the balancing of these efficiencies against any likely anticompetitive effects. The greater the venture’s likely anticompetitive effects, the greater must be the venture’s likely efficiencies.”<sup>87</sup>

#### **Rule of Reason Analysis**

As noted above, the healthcare marketplace is changing. According to a recent New York Times article, “about 39 percent of doctors nationwide are independent, down from 57 percent

in 2000, according to estimates by Accenture, a consulting firm.”<sup>88</sup>

The first step under the rule of reason test is defining the relevant market. The relevant market with regard to healthcare is changing. As noted previously, the total private practice market share is currently 39 percent and declining.<sup>89</sup> The majority of care is now being provided by vertically integrated hospital systems and large medical groups. The fewer the number of hospitals and large groups in an area, the fewer choices available to consumers. The relevant market is therefore evolving from a fragmented market of mostly independent physicians to a smaller market of large vertically integrated healthcare providers.

Physicians forming cooperatives would replace a portion of the fragmented private practice market share and with an integrated competitor to the larger existing and dominant healthcare organizations. Cooperatives would simply become another integrated entity in a marketplace dominated by integrated entities. Each physician medical cooperative would draw its membership from the independent practice pool of physicians. Since this pool is only 39 percent of the market and not all physicians would become members of a cooperative, arguably the cooperative or cooperatives that form in a market would never dominate the market.

The second part of the three-part test is “[e]valuate the competitive effects of the physician joint venture.” This test in part relates to the price of healthcare.<sup>90</sup> Two key areas of competitive concern are whether a physician network joint venture could raise the prices for physician services charged to health plans above competitive levels, or could prevent or impede the formation or operation of other networks or plans.<sup>91</sup> Looking at network formation first, physician medical cooperatives will most likely form in markets where private practitioners are sufficiently

*continued on page 38*

# Physician Medical Cooperatives Using the Agriculture Model

*continued from page 37*

motivated by market forces to give up a certain degree of autonomy in exchange for remaining competitive with large vertically integrated hospital systems and or large medical groups.

An example of a market where hospital consolidation is limiting consumer choice of healthcare is Boise, Idaho. "A little over half of the 1,400 doctors in southwestern Idaho are employed by St. Luke's or its smaller competitor, St. Alphonsus Regional Medical Center."<sup>92</sup> In such a marketplace where competition is declining due to hospital consolidation, a physician medical cooperative that would create an alternative healthcare option could preserve competition. The physician medical cooperative option could also increase physician choice by giving physicians the option not to sell their practices to hospitals.

The other concern is pricing above competitive levels. The goal of a physician medical cooperative is arguably not to raise prices above competitive levels but instead to raise fees of physicians to economically sustainable levels yet lower than the new market levels created by vertically integrated entities. Hospital consolidation, by comparison, is raising prices significantly:

But the consolidation of health care may be coming at a hefty price. By one estimate, under its current reimbursement system, Medicare is paying in excess of a billion dollars a year more for the same services because hospitals, citing higher overall costs, can charge more when the doctors work for them. Laser eye surgery, for example, can cost \$738 when performed by a hospital-employed doctor, compared with \$389 when done by an unaffiliated doctor, according to national estimates by the independent Congressional

panel that oversees Medicare. An echocardiogram can cost about twice as much in a hospital: \$319, versus \$143 in a doctor's office.<sup>93</sup>

Moreover, because hospitals are receiving substantially higher fees for the same physician services than private practitioners, hospitals can offer physicians higher salaries. To preserve competition, physician income in the cooperative model must be competitive with hospital salaries. If not, the hospitals with the lure of higher salaries will attract the physicians away from the cooperative.

Therefore, a properly designed cooperative with acceptable fees would keep fees below the market dominant hospital fees and meet the second concern of this step of the test.

The third part of the three-part test is: "[e]valuate the impact of pro-competitive efficiencies. This step requires an examination of the joint venture's likely procompetitive efficiencies, and the balancing of these efficiencies against any likely anti-competitive effects."<sup>94</sup> A properly structured cooperative must have the ability to compete and be cost effective. This must be designed into the structure of the organization.

Because of lower regulatory costs, a physician medical cooperative that owns diagnostic and therapeutic equipment can provide services at lower prices than a vertically integrated hospital system. Cooperatives lower costs via the sharing of equipment by many users, spreading the costs, increasing use and avoiding the individual ownership by many physicians of expensive underutilized equipment. Cooperatives maintain branding through quality assurance. There is an economy of scale regarding the group purchase of supplies, employee benefits and insurance. Billing can be

consolidated and pre-screening of claims can be conducted. Defective claims would be corrected before submission. Insurance company processing of clean, pre-audited claims would lower claims processing costs. Joint ownership spreads risk and cost and makes services available. Unnecessary referrals would be reduced.

Therefore, a properly structured cooperative would comply with the three-part rule of reason test. Some cooperatives could even be crafted to fall within the safe harbors. It is essential that knowledgeable attorneys play an active role in the structuring and legal compliance of cooperatives. If the cooperative model succeeds, then more defined standards for antitrust compliance should evolve.

## Stark Analysis

The Stark Law and its regulations make it unlawful for physicians to refer patients for Designated Health Services ("DHS") to other entities in which they or their family members have a financial interest, unless an exception applies.<sup>95</sup>

For a physician medical cooperative to offer the most benefits to its members, it would need to fall within the group practice exception protection under Stark.<sup>96</sup> Structuring a group practice in the following manner should conform to the group practice definition.

A physician medical cooperative would be formed as a corporation under the laws of the state in which it was formed comprising two or more physicians.<sup>97</sup> Physicians would supply the same full range of services that they had provided before the formation of the cooperative.<sup>98</sup> Billing would have to be done with an authorization to bill in the name of the cooperative with the funds being passed through

to the members, after deducting overhead expenses based on a pre-arranged agreement.<sup>99</sup> The cooperative would have to function as a unified business under the regulations.<sup>100</sup>

Additional compensation cannot be given based on the value of referrals to the cooperative. However, it does not mean that if too much money were taken out for overhead expenses that the excess could not be refunded to the members on a proportional basis. This refund of excess withholding is consistent with the profits and productivity bonus exception, provided that the refund is related to services personally performed.<sup>101</sup>

If there are Stark Issues with regard to the patronage refund component of a physician medical cooperative, then patronage refunds may be saved by 15 USC § 13b, which states that “[n]othing in this Act shall prevent a cooperative association from returning to its members, producers, or consumers the whole, or any part of, the net earnings or surplus resulting from its trading operations, in proportion to their purchases or sales from, to, or through the association.”<sup>102</sup> To determine which law would control, if there is a conflict, would require a judicial determination based on extensive conflict of law analysis.

Profits based on referrals would have to be shared. It is unclear if sharing of expenses based on proportional use is permissible. There is a risk that it would be interpreted as a pay for click under the Stark Laws, as opposed to an overhead sharing arrangement for jointly owned equipment.<sup>103</sup> Overhead sharing of equipment can be structured to comply with the Stark laws and regulations.<sup>104</sup> Physicians in the cooperative on the aggregate would have to devote at least 75 percent of their physician professional encounters within the cooperative structure.<sup>105</sup>

A cooperative structured in this manner could be designed to qualify for Stark’s group practice exception.

The cooperative could also petition the Secretary of the Department of Health and Human Services to modify the regulations to fit the cooperative model.<sup>106</sup>

## Anti-Kickback Concerns

The Anti-Kickback statute makes it a felony to knowingly and willfully receive or pay anything of value to influence the referral of federal healthcare program business.<sup>107</sup> Violation of the law can result not only in jail time but also fines and administrative penalties.<sup>108</sup>

The Department of Health and Human Services’ Office of Inspector General (“OIG”) has created safe harbors; failure to fall into a safe harbor is not *per se* illegal but must be analyzed on a case-by-case basis.<sup>109</sup> One of the safe harbors is the Investments in Group Practices.<sup>110</sup> If the group practice meets the Stark Definition of a group practice, then it falls into this safe harbor.<sup>111</sup> The second Anti-Kickback safe harbor that could apply is the Shared Risk Safe Harbor.<sup>112</sup> Therefore, arguably a physician medical cooperative could be found in compliance with the Anti-Kickback statute.

## Conclusion

The cooperative model is a long-standing method by which independent business owners who would otherwise be competitors join forces for their mutual benefit. Agricultural cooperatives, which do not engage in anticompetitive activity, have long been regarded as a procompetitive market force. One third of our agricultural production is from cooperatives. With 39 percent of physicians in independent practice, it is likely that physician medical cooperatives could emulate in healthcare the important role agricultural cooperatives play in preserving a competitively priced food supply.

Physician medical cooperatives differ from agricultural cooperatives because they do not have the specific antitrust protection of the Capper-Volstead Act.<sup>113</sup> Instead they must comply with the FTC guidelines for health-care, the Stark law and Anti-Kickback statute.<sup>114</sup> Some cooperatives could be designed to fall within the FTC safe harbors but most will have to pass the three-part rule of reason test. The patronage refund system used in cooperatives, where excess profits are returned to members in proportion to use, can only relate to services personally performed; otherwise it could raise Anti-Kickback and Stark issues.

This nation is in an era where healthcare costs are too high and innovative and cost effective solutions are necessary. Physician medical cooperatives should be allowed to enter the marketplace. Once formed, only economically viable cooperatives that serve their members and society by providing quality healthcare at a competitive price will survive.



**Michael T. Goldstein, M.D., J.D.**, is a *cum laude* graduate and past member of the Law Review of Pace University School of Law. He is Of

Counsel to the New York offices of Kern Augustine Conroy and Schoppmann, P.C. In addition to practicing law, he is a practicing board certified ophthalmologist specializing in corneal surgery. He is a graduate of SUNY Downstate Medical Center. He is the Secretary and member of the Board of Directors of the New York County Medical Society. He serves on the Operating Room and Standardization Committees of the New York Eye and Ear Infirmary and the Networking and Contracting Committee of Continuum Health Partners IPA. He is admitted in New York, Connecticut and California. He can be contacted by email at [mgvisionny@aol.com](mailto:mgvisionny@aol.com) and [mgoldstein@drlaw.com](mailto:mgoldstein@drlaw.com).

*continued on page 40*

# Physician Medical Cooperatives Using the Agriculture Model

continued from page 39

The opinions expressed in this article are those of the author and not attributed to any of the organizations with which he is affiliated.

## Endnotes

- <sup>1</sup> Co-ops 101: An introduction to Cooperatives, Rural Business-Cooperative Services, U.S. Department of Agriculture, Cooperative Information Report 55, April 1997, slightly revised June 1997 Ch.1.
- <sup>2</sup> *Id.*
- <sup>3</sup> *Id.*
- <sup>4</sup> *Id.*
- <sup>5</sup> *Id.*
- <sup>6</sup> Christine Varney, *The Capper-Volstead Act, Agricultural Cooperatives, and Antitrust Immunity*, The Antitrust Source, Dec. 2010, available at [www.antitrustsource.com](http://www.antitrustsource.com).
- <sup>7</sup> *Id.* at 3.
- <sup>8</sup> Available at <http://www.ncba.coop/ncba/about-co-ops/research-economic-impact>.
- <sup>9</sup> *Id.* at 3.
- <sup>10</sup> Co-ops 101 Ch1.
- <sup>11</sup> Available at <http://www.ncba.coop/ncba/about-co-ops/co-op-types>.
- <sup>12</sup> Available at <http://www.ncba.coop/ncba/about-co-ops/co-op-types/consumer-cooperatives>.
- <sup>13</sup> *Id.*
- <sup>14</sup> Available at <http://www.ncba.coop/ncba/about-co-ops/co-op-types/purchasing-a-shared-service-cooperatives>.
- <sup>15</sup> *Id.*
- <sup>16</sup> *Id.* at 2.
- <sup>17</sup> Available at <http://www.ncba.coop/ncba/about-co-ops/co-op-types/worker-cooperatives>.
- <sup>18</sup> *Id.*
- <sup>19</sup> Available at <http://www.ncba.coop/ncba/about-co-ops/co-op-types/producer-cooperatives>.
- <sup>20</sup> *Id.*
- <sup>21</sup> Available at <http://www.ncba.coop/ncba/about-co-ops/co-op-types/hybrid-cooperatives>.
- <sup>22</sup> *Id.*
- <sup>23</sup> Co-ops 101 Ch.5.
- <sup>24</sup> Co-ops 101 Ch.2.
- <sup>25</sup> *Id.*
- <sup>26</sup> *Id.*
- <sup>27</sup> *Id.*
- <sup>28</sup> *Id.*
- <sup>29</sup> *Id.*

- <sup>30</sup> *Id.*
- <sup>31</sup> 15 USC § 13b (2011) §13b. Cooperative association; return of net earnings or surplus.  
Nothing in this Act shall prevent a cooperative association from returning to its members, producers, or consumers the whole, or any part of, the net earnings or surplus resulting from its trading operations, in proportion to their purchases or sales from, to, or through the association.
- <sup>32</sup> See <http://www.sba.gov/content/cooperative> at 2.
- <sup>33</sup> *Id.*
- <sup>34</sup> Sherman Act of 1890 15 USC § 1, 2012.  
Sec. 1. Trusts, etc., in restraint of trade illegal; penalty  
STATUTE-  
Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding \$100,000,000 if a corporation, or, if any other person, \$1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court  
Sec. 2. Monopolizing trade a felony; penalty  
STATUTE-  
Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding \$100,000,000 if a corporation, or, if any other person, \$1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court.
- <sup>35</sup> 15 USC §§ 1, 2, 2012.
- <sup>36</sup> 15 USC § 17, 2012.  
Sec. 17. Antitrust laws not applicable to labor organizations  
STATUTE-  
The labor of a human being is not a commodity or article of commerce. Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor, agricultural, or horticultural organizations, instituted for the purposes of mutual help, and not having capital stock or conducted for profit, or to forbid or restrain individual members of such organizations from lawfully carrying out the legitimate objects thereof; nor shall such organizations, or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws.
- <sup>37</sup> *Id.*
- <sup>38</sup> *Id.*

- <sup>39</sup> C.Varney at 2.
- <sup>40</sup> Co-ops 101 Ch.1.
- <sup>41</sup> *Id.*
- <sup>42</sup> Baarda, J, Antitrust Policy and Farmer Cooperatives, Univ. of Ak. LLM Course, 2007 at 5.
- <sup>43</sup> Available at [http://en.wikipedia.org/wiki/Arthur\\_Capper](http://en.wikipedia.org/wiki/Arthur_Capper).
- <sup>44</sup> 15 USC § 13b (2011) §13b. See *supra* note 31.
- <sup>45</sup> Julie Creswell and Reed Abelson, *A Hospital War Reflects a Bind for Doctors in the U.S.*, N.Y. Times, November 30, 2012.
- <sup>46</sup> *Id.* Reed Abelson, *Health Insurers Making Record Profits as Many Postpone Care*, N.Y. Times, May 13, 2011.
- <sup>47</sup> C. Varney at 3. See also 62. Cong. Rec. 2058-60 (1922).
- <sup>48</sup> *Id.* at 2.
- <sup>49</sup> The Truth-O-Meter, available at [www.politifact.com/truth-o-meter/statements/2011/jan/19/chris-van-hollen/rep-chris-van-hollen-says-insurance-company-profit](http://www.politifact.com/truth-o-meter/statements/2011/jan/19/chris-van-hollen/rep-chris-van-hollen-says-insurance-company-profit).
- <sup>50</sup> Mary A. Moon, *Physician Work Hours, Fees on 10-Year Decline*, Skin and Allergy News, April, 2010 at 31; Reed Abelson, *Health Insurers Making Record Profits as Many Postpone Care*, N.Y. Times, May 13, 2011.
- <sup>51</sup> C. Varney at 2.
- <sup>52</sup> Available at <https://www.aamc.org/newsroom/300770/cspanwj.html> Nationwide doctor shortages, expected to grow to more than 90,000 by 2020, are driven by a growing, aging population and a 15-year freeze on Medicare funding for residency training positions.
- <sup>53</sup> Julie Creswell and Reed Abelson, *A Hospital War Reflects a Bind for Doctors in the U.S.*, N.Y. Times, November 30, 2012.
- <sup>54</sup> 15 USC § 13b (2011). See *supra* note 44.
- <sup>55</sup> Available at <http://www.newseattlemessage.com/index.html>.
- <sup>56</sup> *Id.*
- <sup>57</sup> Available at <http://www.newseattlemessage.com/coop.html>.
- <sup>58</sup> *Id.*
- <sup>59</sup> *Id.*
- <sup>60</sup> *Id.*
- <sup>61</sup> Available at <http://www.newseattlemessage.com/insurance.html>.
- <sup>62</sup> Available at <http://www.newseattlemessage.com/Pricing.html>.
- <sup>63</sup> Available at <http://www.newseattlemessage.com/insurance.html>.
- <sup>64</sup> *AMA v. U.S.* 317 U.S. 519 (1943), *Williams v. St. Joseph Hospital* 629 F.2d 448 (1980).
- <sup>65</sup> 15 USC § 17.
- <sup>66</sup> *AMA v. US*, 317 U.S. 519 (1943).

67 Available at <http://medicarenewsgroup.com/news/medicare-faqs/individual-faq?faqId=0c650502-238a-42e8-95b5-ecaf16e80626>.

68 Available at <http://medicarenewsgroup.com/news/medicare-faqs/individual-faq?faqId=0c650502-238a-42e8-95b5-ecaf16e80626>.

69 15 USC §17.

70 8. Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Physician Network Joint Ventures, available at <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm>.

71 *Id.* A physician network joint venture is a physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services.

72 *Id.*

73 *Id.*

74 Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Physician Network Joint Ventures, available at <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm>.

75 *Id.* The safe harbor rule for non exclusive joint ventures is "The Agencies will not challenge, absent extraordinary circumstances, a non-exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 30 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market."

76 *Id.*

77 See Stark analysis section.

78 *Id.* 3. **Indicia of Non-Exclusivity.**

Because of the different market share thresholds for the safety zones for exclusive and non-exclusive physician network joint ventures, the Agencies caution physician participants in a non-exclusive physician network joint venture to be sure that the network is non-exclusive in fact and not just in name. The Agencies will determine whether a physician network joint venture is exclusive or non-exclusive by its physician participants' activities, and not simply by the terms of the contractual relationship. In making that determination, the Agencies will examine the following indicia of non-exclusivity, among others:

(1) that viable competing networks or managed care plans with adequate physician participation currently exist in the market;

(2) that physicians in the network actually individually participate in, or contract with, other networks or managed care plans, or there is other evidence of their willingness and incentive to do so;

(3) that physicians in the network earn substantial revenue from other networks or through individual contracts with managed care plans;

(4) the absence of any indications of significant de-participation from other networks or managed care plans in the market; and

(5) the absence of any indications of coordination among the physicians in the network regarding price or other competitively significant terms of participation in other networks or managed care plans.

79 *Id.*

80 *Id.*

81 *Id.* "(1) agreement by the venture to provide services to a health plan at a "capitated" rate;

(2) agreement by the venture to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;

(3) use by the venture of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:

(a) withholding from all physician participants in the network a substantial amount of the compensation due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole; or

(b) establishing overall cost or utilization targets for the network as a whole, with the network's physician participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and

(4) agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties [sic] offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors."

82 *Id.*

83 *Id.*

84 *Id.*

85 *Id.*

86 *Id.*

87 *Id.*

88 Julie Creswell and Reed Abelson, *A Hospital War Reflects a Bind for Doctors in the U.S.*, *NY Times*, Nov.30, 2012 at 1.

89 *Id.*

90 *Id.*

91 *Id.*

92 Julie Creswell, *supra*.

93 *Id.*

94 FTC Statement, *supra*.

95 42 U.S.C. § 1395nn(2010) and 42 C.F.R. § 411.350-411.389 (2004).

96 42 U.S.C. § 1395nn (h)(4)(A) (2010) and 42 C.F.R. § 411.352 (2004). 4. Group practice.

(A) Definition of group practice  
The term "group practice" means a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation,

not-for-profit corporation, faculty practice plan, or similar association—

(i) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel,

(ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group,

(iii) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined,

(iv) except as provided in subparagraph (B) (i), in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician,

(v) in which members of the group personally conduct no less than 75 percent of the physician-patient encounters of the group practice, and

(vi) which meets such other standards as the Secretary may impose by regulation.

(B) Special rules

(i) Profits and productivity bonuses.

A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals.

97 42 U.S.C. § 1395nn (h)(4)(A) (2010).

98 42 U.S.C. § 1395nn (h)(4)(A) (i) (2010).

99 42 U.S.C. § 1395nn (h)(4)(A) (ii) (2010).

100 42 C.F.R. § 411.352 (2004).

(f) Unified business. (1) The group practice must be a unified business having at least the following features:

(i) Centralized decision-making by a body representative of the group practice that maintains effective control over the group's assets and liabilities (including, but not limited to, budgets, compensation, and salaries); and

(ii) Consolidated billing, accounting, and financial reporting.

(2) Location and specialty-based compensation practices are permitted with respect to revenues derived from services that are not DHS and may be permitted with respect to revenues derived from DHS under § 411.352(i).

101 42 U.S.C. § 1395nn(h)(4)(B)(i) (2010).

102 *Id.*

103 42 U.S.C. §1799nn is commonly referred to as the Stark Law. Under the Stark law, a physician cannot refer Designated Health Services that are funded by a federal health program to an entity in which the physician (or his/

continued on page 42

# Physician Medical Cooperatives Using the Agriculture Model

continued from page 41

her immediate family members) has a financial interest. The law is complex with a huge body of federal regulations to interpret the law.

<sup>104</sup> Ericka Adler, *Physician Shared Diagnostic Facilities – A Practical Guide to Formation and Regulatory Requirements*, Physician Organizations, American Health Lawyers Association, Physician Organizations Practice Group, 14:2 September 2011.

<sup>105</sup> 42 U.S.C. § 1395nn(h)(4)(A) (v) (2010).

<sup>106</sup> 42 U.S.C. § 1395nn(h)(4)(A)(vi) (2010).

<sup>107</sup> Federal Anti-Kickback Law and Regulatory Safe Harbors Fact Sheet November, 1999. Available at <http://oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm> at 1.

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* at 3.

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 4.

<sup>113</sup> 7 USC § 291-2.

<sup>114</sup> Available at <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm>.

---

## Chair's Corner

continued from page 2

And even with all these accomplishments, I am confident that the best is still to come.

We have exciting new publications in the pipeline. Our newest groups, Nursing and Allied Healthcare Professionals, In-house Counsel and Government Attorneys, are firmly established and based on the discussions at the leadership meeting are poised to take off. The opening of the health insurance exchanges under the Patient Protection and Affordable Care Act will pose many new questions and challenges, only some of which can we now foresee. The Section will be actively involved in educating our members, policy-makers and the public about the Health Insurance exchanges. As we move into the era of healthcare reform, the Health Law Section will no doubt be at the forefront of the legal and policy debate in fulfillment of our mission to enhance the practice of health lawyers and improving the understanding and development of health laws.

I look forward to this coming year with great enthusiasm as I am confident that under the guidance of our new leadership, the Section will further strengthen the services we provide to our members and become an even more influential voice in shaping health law and policy. Our incoming Chair, the Honorable Kathleen Scully-Hayes, Chief Deputy Administrative Law Judge for the Social Security Administration, is the first judge to Chair our Section. Prior to becoming an ALJ she was with the Office of General Counsel for the Department of Health and Human Services. She brings a wealth of experience in health law and the Section as well the perspective of a career government attorney. Words are inadequate to express my admiration for her leadership, my appreciation for the unwavering support she has given me this year and my deep gratitude for her friendship. Kathye will have, as I did, the support and insight of accomplished and experience Council officers, Chair-Elect Michael E. Clark, Vice-Chair Bill Horton, Budget Officer Hien McCombs and our newest officer, Secretary Joyce Hall, who has already distinguished herself by the quality and breadth of her commitment to the Section.

Of course, as our leaders know well, the true hard work of the Section is performed by our exceptional and wonderful staff. Wanda Workman, our Section Director, is an accomplished professional who embraces and meets new challenges through her exceptional managerial skills, deep experience, and unfailingly upbeat attitude. Wanda's can-do spirit was key to many of the Section's most important accomplishments this year. Simeon Carson, our Associate Director, has been the backbone of the section for many years. He possesses the rare gift of being able to exert quiet leadership. He moves the Section and its leaders steadily forward in an unassuming yet effective manner. I have observed over the years that Simeon always seems to have the answer or solution or idea you need even before you knew you needed it. In the comparatively short time that Jason Billups has been our Administrative Assistant he has proven himself to be an effective, dedicated and personable professional. He fits right into the ethos established by Wanda and Simeon. Our newest staff members, Nancy Voegtle, our new Senior Meeting Planner, and Naomi Shicly, our new Program Specialist are experienced and already contributing to the Section. We are pleased to have them on board. Collectively, our Staff routinely achieves amazing results. I have found there is nothing they cannot do – except perhaps say no. I thank all of them personally, especially Wanda and Simeon, for guiding and supporting me this year.

There are many benefits to Section membership (as I say at every opportunity) but truth be told the *best* part of Section involvement is the friendships you form. Serving as Chair was far more demanding than I anticipated but far more rewarding, as well. When you get right down to it, the position demands that you spend a lot of time with fascinating, funny, caring, talented men and women collaborating to advance the cause of a mission-driven organization. I don't know that it can get any better than that. Certainly, for me, this year as Section Chair could not have been any better. I thank all of you who made it possible.

– David