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Ilene Knable Gotts

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## HEALTH CARE JOINT VENTURES AND THE ANTITRUST LAWS: A GUARDEDLY OPTIMISTIC PROGNOSIS

*Ilene Knable Gotts\**

"The times are indeed 'a-changin.' We are now experiencing a veritable second wave of 'alphabet' organizations in health care markets."<sup>1</sup>

One need only read the newspaper or tune in a television news program to realize that the future mechanisms by which health care services will be provided in this country are being debated. Only one fact is certain: health care delivery is going to change dramatically in the near future. Indeed, the health care industry is already undergoing substantial changes. There has been a clear trend toward consolidation of existing providers in the past five years. Furthermore, the creation of alternative delivery systems in anticipation of the changing health care spectrum has become commonplace throughout the country in the last year or so. It is not surprising, therefore, that the federal antitrust officials have focused much attention on the health care industry.<sup>2</sup> This article will discuss the

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\* B.A., University of Maryland, *magna cum laude*, 1980; J.D., Georgetown University Law Center, *cum laude*, 1984. Mrs. Gotts is a partner with the Washington D.C. office of Foley & Lardner and heads the firm's Legislative/Administrative Practice Group. She counsels clients on a variety of antitrust issues, including health care matters. Since 1992, Mrs. Gotts has served as the Chair of the Federal Bar Association's Health Care Subcommittee of the Antitrust Section. The author wishes to thank her partner, Howard W. Fogt, Jr., for his valuable insights, and her colleagues, Allison George, David Vanness and Ana C. Perloni, for their editorial assistance.

1. Mark J. Horoschak, Assistant Director of Competition, Federal Trade Commission, Remarks Before the Washington State Hospital Association (Sept. 25, 1993) [hereinafter Horoschak].

2. As reported by former Acting Assistant Attorney General Charles A. James in January 1992, from 1988 to 1992, the Antitrust Division alone gave more than 35 speeches on the application of antitrust to health care. Charles A. James, Presentation to the National Health Lawyers Ass'n 13-14 (Jan. 31, 1992). Furthermore, on September 15, 1993, the Federal Trade Commission (FTC) and Department of Justice (DOJ) issued six Joint Policy Statements concerning various aspects of health care. See *Department of Justice and Antitrust Enforcement Policy Statements in the Health Care Area*, 4 Trade Reg. Rep. (CCH) ¶ 13,150, at 20,758 (Sept. 15, 1993). These joint statements contain the latest stance of the federal enforcement agencies when evaluating health care activity and are non-binding on

antitrust implications of some of these changes.

### I. BACKGROUND

Medical care in the United States has traditionally been provided to patients through a fee-for-service indemnity model. In the 1940s, with the advent of the Kaiser Permanente Medical Plan, delivery systems appeared which departed from the traditional model. However, it was not until health care costs in this country had escalated at a rate of nearly twice that of the gross national product and reached almost \$700 billion annually, that consumers and employers began to shift their coverage from the traditional delivery systems to alternative delivery systems in meaningful numbers. This shift gained momentum in the 1980s and accelerated during the present decade. Indeed, while the insured population enrolled in managed care plans in 1989 was reportedly less than 5%, that number exceeded 50% in 1991. Nevertheless, as President Clinton noted in his health care reform policy statement, U.S. health care expenditures accounted for 14% of gross domestic product in 1992 and, if unchecked, would most likely approach 19% by the year 2000. To achieve health care reform in the dimensions proposed by the Clinton Administration, extensive usage of alternative delivery systems and consolidation of existing systems will be necessary.

The basic forms of alternative delivery systems that have been utilized in the last decade or so include health maintenance organizations (HMOs); preferred provider organizations (PPOs); independent practice associations (IPAs); physician hospital organizations (PHOs); and insurer hospital joint ventures.<sup>3</sup> In recent times, new collaborative arrangements among providers have been forming, such as "group practices without walls," and community care networks. Furthermore, the Clinton Administration health care reform package proposes creation of buying groups, referred to as "Alliances." For most purposes, this article will not distinguish among the various forms of alternative delivery systems, but instead generically refer to these collaborative arrangements as "joint ventures."<sup>4</sup>

While in some business respects joint ventures in the health care indus-

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courts or private litigation. Furthermore, they are subject to refinement and/or change by the federal enforcement agencies. *Id.*

3. For a glossary of terms used in the alternative delivery system context, see Appendix *infra*.

4. As FTC Assistant Director Mark J. Horoschak stated, "[A]lthough the phrase 'joint venture' is not a legal term of art, it does connote collaboration involving a meaningful level of functional integration among venturers." Horoschak, *supra* note 1.

try are unique, traditional antitrust principles nevertheless apply to them with equal force and effect. The antitrust officials do not doubt that the formation of joint ventures which realize efficiencies (and the opportunity for cost cutting), generally will be pro-competitive. However, the benefits of a joint venture may not be realized by society, and the overall impact of the venture can be anti-competitive, if the combination's real purpose and effect is to stifle competition or eliminate competitors from the market. Joint ventures may be challenged under section 1 of the Sherman Act,<sup>5</sup> as a concerted and unreasonable restraint of trade, or section 2 of the Sherman Act,<sup>6</sup> as monopolization or attempted monopolization. Joint ventures may also be challenged under section 7 of the Clayton Act,<sup>7</sup> particularly where there is an integration of pre-existing operations by the participants.<sup>8</sup>

Except where the conclusion is reached that the venture is a sham designed to cloak otherwise illegal conduct, joint activity in the health care setting is usually evaluated for Sherman Act section 1 purposes under a rule of reason approach that evaluates both the pro-competitive effects and anti-competitive effects of the venture to determine whether, on balance, the venture is pro-competitive. However, a sham venture will be deemed *per se* illegal and can even result in criminal liability for its participants. In today's enforcement environment, physicians and other providers run a serious risk of criminal investigation and prosecution if they engage in agreements to fix fees or to negotiate collectively with third-party payers to increase fees or to suppress or eliminate discounting.

In 1992, the Department of Justice (DOJ) brought its first criminal case involving health care professionals.<sup>9</sup> In *United States v. Alston*, the DOJ prosecuted three Tucson, Arizona dentists for their purported price-fixing activities. Defendants met with about fifty local dentists at one of the defendants' offices to discuss the fees provided by local health care plans. Subsequently, many of those present at the meeting mailed letters to the

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5. 15 U.S.C. § 1 (1988).

6. 15 U.S.C. § 2 (1988).

7. 15 U.S.C. § 18 (1988).

8. See *Nelson v. Monroe Regional Med. Ctr.*, 925 F.2d 1555 (7th Cir.), *cert. denied*, 112 S. Ct. 285 (1991); *State v. Mid Coast Anesthesia, P.A.*, 1991-2 Trade Cas. (CCH) ¶ 69,683 (Me. Super. Ct. 1992); *State v. Cardiovascular & Thoracic Assoc.*, 1992-2 Trade Cas. (CCH) ¶ 69,985 (Me. Super. Ct. 1991); *State v. Wenatchee Valley Clinic*, 1988-1 Trade Cas. (CCH) ¶ 68,118 (E.D. Wash. 1988); DOJ Business Review Letter to Surgical Associates of Western Connecticut, P.C., and Danbury Surgical Assoc. (Aug. 29, 1987).

9. *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992).

plans requesting higher fees. In response, the plans did in fact revise their fee schedules, which resulted in higher costs to plan members for some services. From this evidence the jury inferred a *per se* illegal price-fixing agreement.<sup>10</sup>

A more recent example of the willingness of the DOJ to prosecute doctors criminally occurred in the *United States v. Massachusetts Allergy Society*<sup>11</sup> case in which the DOJ conducted a thorough grand jury investigation. After all of the evidence was evaluated, the DOJ filed a civil complaint against the Society, a professional association of about fifty-five allergists, and four of the individual allergists practicing in Massachusetts. The complaint alleged that the defendants, along with others, conspired to fix and raise the fees paid for allergy services by certain HMOs. As part of the alleged conspiracy, defendants and their co-conspirators purportedly agreed to have the Society act as their joint negotiating agent to obtain higher fees from certain HMOs and to resist competitive pressures by third-party payers to discount fees. According to the DOJ, the members of the Society made no attempt to form a valid joint venture.<sup>12</sup>

Most joint activity will be evaluated in a civil setting. In analyzing such joint activity, the courts and enforcement agencies consider four factors: (1) Is the joint venture legitimate?; (2) What are the competitive effects of the venture?; (3) What are the possible anticompetitive effects of the venture?; and (4) Are there unreasonable ancillary agreements? The next four sections of this article will discuss each of these factors in greater detail. Finally, the last section of the article will address certain state efforts to provide so-called "state action" immunity for joint cooperative efforts by health care providers.

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10. *United States v. Alston*, 1991-1 Trade Cas. (CCH) ¶ 69,366 (D. Ariz. 1990), *aff'd*, 947 F.2d 1206 (9th Cir. 1992). The district court judge granted judgments of acquittal notwithstanding the verdicts for two dentists and ordered a new trial for the third defendant. The Ninth Circuit vacated these post-trial acquittal orders of the district court, but affirmed the order granting a new trial. The Justice Department then entered into a settlement with the defendants under which the defendant professional corporation pleaded *nolo contendere* and agreed to pay a \$5,000 fine as well as perform 250 hours of community service.

11. 1992-1 Trade Cas. (CCH) ¶ 69,846 (D. Mass. 1992).

12. Similarly, in *United States v. Burgstiner*, 1991-1 Trade Cas. (CCH) ¶ 69,422 (S.D. Ga. 1991), the DOJ conducted its investigation as if to seek criminal prosecution, but, due to the willingness of the defendants to enter into a civil consent decree, did not ultimately bring criminal indictments.

## II. IS THE JOINT VENTURE LEGITIMATE?

In the health care setting, concerted activity among health care providers runs the gamut from a permanent and full integration of the business operations of its participants to joint ventures in name only. The structure and purpose of the joint venture often are determinative of whether its conduct constitutes a violation of the antitrust laws.<sup>13</sup> A critical starting point in deciding whether a joint venture is legitimate, is the presence of a *pooling of resources or sharing of risk or the creation and/or marketing of a new product made possible only through the joint venture*.

In the landmark U.S. Supreme Court case, *Arizona v. Maricopa County Medical Society*,<sup>14</sup> this issue of risk sharing proved to be the critical starting point as well as the finale: the Court condemned as *per se* illegal an agreement between physicians to fix maximum fees for services through a joint venture arrangement because the joint venture lacked so-called "integrative efficiencies." The Court indicated that a health care plan involving multiple providers might avoid antitrust liability by integrating their activities and creating a joint venture. The Court in dicta recognized as legitimate joint activity the combining of "persons who would otherwise be competitors [to] pool their capital and share the risks of loss as well as the opportunities for profit."<sup>15</sup> Where there is risk sharing, the partnership is more likely to be regarded as a single firm competing with other sellers in the market.<sup>16</sup> However, the physicians in *Maricopa* had not attempted to pool their capital and share the risks of loss, but instead acted as independent entrepreneurs. Accordingly, their participation in the setting of maximum fees for the PPO constituted *per se* illegal horizontal price-fixing.

In contrast, the Court upheld a joint venture arrangement in *Broadcast*

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13. For an excellent discussion of the standards applied to determine the legitimacy of health care joint ventures, see Kevin E. Grady, *A Framework for Antitrust Analysis of Health Care Joint Ventures*, 61 ANTITRUST L.J. 765 (1993). See also Robert J. Enders, *An Introduction to Special Antitrust Issues in Health Care Provider Joint Ventures*, 61 ANTITRUST L.J. 805 (1993).

14. 457 U.S. 332 (1982).

15. *Id.* at 356.

16. *Accord Hassan v. Indep. Practice Assoc.*, 698 F. Supp. 679 (E.D. Mich. 1988) (holding IPA's reimbursement system did not constitute illegal price fixing because IPA was a legitimate joint venture that imposed no unreasonable restraint of trade); *Preferred Physicians, Inc.*, 110 F.T.C. 157, 162 (1988) (consent bans concerted price agreements, but permits integrated joint venture activities where competitors "pool their capital to finance the venture"). But see *Thompson v. Midwest Found. Indep. Physicians Ass'n*, 1989-1 Trade Cas. (CCH) ¶ 68,491 (S.D. Ohio 1988) (\$32.6 million jury verdict based on price fixing agreement among IPA members).

*Music, Inc. v. CBS*,<sup>17</sup> in which authors and composers granted non-exclusive rights to the American Society of Composers, Authors, and Publishers (ASCAP) and Broadcast Music, Inc. (BMI). In *BMI*, the Court found the necessary requisites to establish that "the integration of sales, monitoring, and enforcement against unauthorized copyright use"<sup>18</sup> in the form of a blanket license was effectively a new product which could not exist without the venture. However, in *BMI*, there was no sharing of risk or pooling of capital by the composers who used ASCAP and BMI. Perhaps what ultimately influenced the Court to permit the venture was the non-exclusive nature of the licenses.

Since the *Maricopa* and *BMI* decisions, the lower courts and antitrust officials have had numerous occasions to scrutinize the legitimacy of ventures. There has been a consistent willingness to condemn summarily under Sherman Act section 1 joint ventures that lack sufficient integration when the activities of the participants appear to be a "sham." The antitrust officials will look beyond the shell to determine the true purpose of the joint venture.<sup>19</sup> Generally, the greater the degree of integration, financial investment, and risk sharing as to whether the venture will be successful, the more likely it will be concluded that the joint venture is legitimate.<sup>20</sup> Therefore, there are two threshold issues that must be addressed in evaluating a particular joint venture under the antitrust laws: (1) the legality of the underlying conduct; and (2) the degree of risk sharing and integration by the participants.

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17. 441 U.S. 1 (1979).

18. *Id.* at 20.

19. See *Southbank IPA* (consent decree with IPA in Jacksonville, Fla., and 23 OB/GYN physicians who together comprised nearly entire staff of hospital. IPA allegedly agreed on the terms under which they would treat subscribers or employees of health plans); *United States v. Greater Bridgeport Individual Practice Ass'n*, 1993-2 Trade Cas. (CCH) ¶ 70,389 (D. Conn. 1993); *United States v. Mass. Allergy Soc'y*, 1992-1 Trade Cas. (CCH) ¶ 69,846 (D. Mass. 1992); see also Robert E. Bloch, *Antitrust in the Health Care Field: Cutting Edge Issues, Update and Perspectives from the Antitrust Division*, Remarks Before the NHLA (Feb. 19, 1993).

20. Statements made by the DOJ and FTC prior to the issuance of the Joint Statement appear to express different positions on the necessity of financial integration and risk sharing as to the antitrust implications of a valid joint venture. The DOJ has suggested that such requirements are not essential. See Charles F. Rule, *Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation*, Remarks Before Connecticut Bar Association and Connecticut Health Lawyers Association (Mar. 11, 1992). In contrast, the FTC requires such investment and risk sharing to establish a valid joint venture. See Mark J. Horoschak, *Antitrust Perspectives on Joint Ventures Among Health Care Providers*, Remarks Before the American Bar Association (Aug. 11, 1992).

### A. Purpose of Venture

The legitimacy of the venture often depends partly on the purpose of the activities undertaken. Joint ventures are considered *per se* illegal if the purpose of the venture is to fix prices, decrease competition, or monopolize a market. For instance, the joint setting of fees by competing physicians raises serious antitrust concerns, while the joint purchase of expensive high-tech equipment by two hospitals that then operate it separately raises little concern. Health care providers have violated the Sherman Act by agreeing on fee schedules,<sup>21</sup> the co-payment rates that would be accepted by the individual provider,<sup>22</sup> discounts,<sup>23</sup> and relative value guides.<sup>24</sup> The antitrust laws protect the right of a purchaser to have each competing seller decide independently whether to provide his or her service at the price offered by the purchaser.<sup>25</sup> Even though independent providers may not control the payer that sets the final fees, if that payer is confronted by a united group of providers who have expressly or impliedly threatened not to provide their services unless they get their "price," then the payer has lost control over its ability to set final fees.

Even without risk sharing, there may be certain actions that can be taken to minimize the antitrust risk of *per se* condemnation for joint ac-

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21. Cf. *In re Mich. St. Med. Soc'y*, 101 F.T.C. 191 (1983) (holding the Medical Society and its members violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, not the Sherman Act, and ordering the Medical Society and its members to cease from entering agreements to affect amount, manner of calculating, or terms of reimbursement and to cease from refusing to enter any participation agreement deemed unacceptable); see also *Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d 379, 386 (9th Cir.), cert. denied, 371 U.S. 862 (1962) (affirming conviction of pharmaceutical association and pharmacist on grounds that their agreements to fix prices violated § 1 of Sherman Act); *Colorado ex rel. Woodward v. Colo. Union of Physicians & Surgeons*, 1990-1 Trade Cas. (CCH) ¶ 68,968 (D. Colo. 1990) (consent prohibiting purported union from bargaining collectively with payers).

22. *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992).

23. *United States v. N. D. Hosp. Ass'n*, 640 F. Supp. 1028 (D.N.D. 1986) (agreement among association members not to grant a discount on hospital services to the Indian Health Service was declared unlawful under the rule of reason).

24. See *In re California Med. Ass'n*, 93 F.T.C. 519 (1979); *In re American College of Obstetrics & Gynecology*, 88 F.T.C. 955 (1976); see also *In re Association of Indep. Dentists*, 100 F.T.C. 518 (1982) (consent barring association constituting most of the area's dentists from bargaining or negotiating over price on behalf of member dentists); *In re Rochester Anesthesiologists*, 110 F.T.C. 175 (1988) (consent settling charges that anesthesiologists conspired to reject reimbursement levels proposed by Blue Cross plan and to force higher compensation from HMO).

25. *Superior Court Trial Lawyers Ass'n v. FTC*, 897 F.2d 226, (D.C. Cir. 1988), cert. denied *sub nom.* *Addison v. FTC*, 498 U.S. 1025 (1991); *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992).



tivities of health care providers. Perhaps the single most important step is to create a distance between the providers and the joint venture in the pricing of services. The judge in *United States v. Alston*<sup>26</sup> indicated that:

[H]ealth care providers who must deal with consumers indirectly through plans . . . face an unusual situation that may legitimate certain collective actions. Medical plans serve, effectively, as the bargaining agents for large groups of consumers; they use the clout of their consumer base to drive down health care service fees . . . In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price-fixing or a group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules. Thus, health care providers might pool cost data in justifying a request for an increased fee schedule . . . Providers might also band together to negotiate various other aspects of their relationship with the plans such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such concerted actions, which would not implicate the per se rule, must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals from the plans.<sup>27</sup>

Indeed, price terms can be set out in separate agreements with each of the providers, based on terms proposed by the payer. The contract between the provider and PPO will sometimes provide for automatic acceptance unless the provider opts out within specified time periods.

Some of the arrangements considered to minimize antitrust risk include: (1) having an independent party or committee establish the level of reimbursement; (2) utilization of a "messenger-model" PPO, in which the PPO simply communicates offers back and forth between individual providers and payers, and each provider makes a unilateral decision whether to participate in a particular contract; (3) the "super-messenger model," in which the PPO performs a similar function for price offers but does negotiate non-price terms on behalf of participating providers; and (4) the "attorney-in-fact model," in which the PPO negotiates ranges of fees with the payer and sometimes contracts on the providers' behalf. For instance, the *Maricopa* consent specifically permitted the physicians' group to use fee schedules prepared by an "insurer, government agency,

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26. 974 F.2d 1206 (1992).

27. 974 F.2d at 1214.

or other third-party payor.”<sup>28</sup> The messenger model appears to have been approved in a Federal Trade Commission (FTC) staff advisory opinion.<sup>29</sup> Some PPOs have characterized their role as having conducted “informational” discussions with the payer or even having made “suggestions” to the payer as to what rates of payment might be acceptable. However, if the payer perceives itself as being threatened, or if providers participating in discussions give the impression to other providers that they must participate in the deliberations, there is risk of *per se* condemnation.<sup>30</sup>

Some provider sponsored entities contract with payers on the basis of a fee schedule or reimbursement formula prepared by a hired consultant. While this can alleviate some of the risk, it does not always eliminate it.

### B. Integration

The federal enforcement agencies have grappled with the concept of integration for antitrust purposes. Traditionally, the DOJ was more lenient in these matters than the FTC.<sup>31</sup> The FTC generally defines integration as “the coordination or joining together of functions, such as production, management, promotion, distribution, financing, and debt collection.”<sup>32</sup> To some extent, the degree of integration is a function of the type of venture. Former Assistant Attorney General Paul McGrath identified the following types of arrangements as being indicative of integration: (1) agreement among physicians to accept discounted fees with no balance billing of patients; (2) utilization review by the PPO; (3) joint marketing; (4) PPO administration of claims; and (5) an agreement by a

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28. *Arizona v. Maricopa County Med. Soc’y*, 1983-1 Trade Cas. (CCH) ¶ 65,260 (D. Ariz. 1983)(consent).

29. See Letter from FTC Staff to Martin J. Thompson (June 20, 1991).

30. See *United States v. Mass. Allergy Soc’y*, 1991-1 Trade Cas. (CCH) ¶ 69,846 (D. Mass. 1992); *United States v. Burgstiner*, 1991-1 Trade Cas. (CCH) ¶ 69,422 (S.D. Ga. 1991).

31. Since only the Department of Justice brings criminal cases, the more lenient substantive approach taken by the DOJ decreases the chances of criminal prosecution.

32. See, e.g., FTC Statement of Enforcement Policy Regarding Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48,892 (1981) [hereinafter FTC Enforcement Policy Statement]; Letter from FTC Staff to Gilbert M. Frimet (Mar. 22, 1984); Letter from FTC Staff to Charles E. Rosolio (May 15, 1987); Letter from FTC Staff to Michael A. Durcheon, Esq. (Mar. 17, 1986); Letter from FTC Staff to Maryland Medicare Eye Associates (May 15, 1987); Letter from FTC Staff to Pan American Management Associates, Ltd. (June 27, 1989); DOJ Business Review letter to Frank Sanchez (Oct. 3, 1980); DOJ Business Review letter to Robert Taylor (Oct. 3, 1986); DOJ Business Review letter to Northern Mississippi Health Services, Inc. (Apr. 19, 1987); DOJ Business Review letter to Gregory G. Binford, Esq. (Jan. 7, 1993).

panel of limited size to bid for control against such groups.<sup>33</sup>

More recently, former Assistant Attorney General James Rill indicated that the DOJ looks for the same sort of integration in the health care setting as is typical in other business settings, *i.e.*, risk sharing, centralized operations, and marketing.<sup>34</sup> Indeed, a series of FTC advisory letters indicate that if the IPA is capitated, it is sufficiently integrated such that an agreement among participants as to price will trigger analysis under the rule of reason rather than be condemned under the *per se* rule. In contrast, PPOs are generally less integrated than IPAs and thus can raise more significant antitrust issues. In 1983, for instance, the DOJ threatened to challenge the Stanislaus Preferred Provider Organization. The PPO contained over 90% of the physicians in the area. Because of this fact, the DOJ believed the PPO had been formed to preempt capitated plans from entering the area since the participants agreed not to participate in other alternative delivery systems.<sup>35</sup> The PPO voluntarily disbanded.

In sum, it is not unusual for the controlling providers in a venture either to integrate a portion of their practices into the plan or make a substantial financial contribution to support the establishment or operation of the plan, even though they still compete with each other for patients outside of the joint venture. A plan may be partially integrated by centralization of marketing, billing and debt collecting functions, or by sharing the potential financial risks resulting from unanticipated high costs or utilization. The financial contribution may be in the form of a capital contribution by the group or may entail an indirect financial contribution to the plan's operation through a risk-sharing arrangement. Risk-sharing might be achieved by retaining some portion of the fees payable to participating providers and distributing them to the providers only if certain criterion, such as reduction in individual patient utilization, is

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33. A "partial integration" occurs when the participants combine for limited purposes but otherwise continue to operate as separate and independent economic parties. For instance, managed care plans are often sponsored and organized by providers (*i.e.*, physicians and hospitals) who, outside of the plan, compete against one another; care must be taken to ensure that these plans do not facilitate collusion among participating providers. A provider-sponsored or controlled plan, in which physicians or hospitals join together to market their services to third-party purchasers, creates the most concern because it comprises competing providers who make decisions regarding fees and provider membership and utilization can directly affect their competitors. FTC Enforcement Policy Statement, *supra* note 32, at 48,893.

34. See James F. Rill, Assistant Attorney General, Antitrust Division, Remarks Before the NHLA (Feb. 15, 1991); see also Grady, *supra* note 13, at 784.

35. See U.S. Dep't of Justice Press Release (Oct. 12, 1983).

achieved. Such an arrangement places the risk of adverse claims experience on the participants. Without any of the risk-sharing features described above, the prognosis for the joint venture under the antitrust laws is grave.

### III. PRO-COMPETITIVE EFFECTS

#### A. *Defining the Relevant Market*

The effects of the joint venture are not considered in a vacuum, but instead in the relevant geographic and product market in which the venture will exist. Therefore, the first step to determining the likely effects of the venture is to define the relevant market. This task is often critical to the outcome and consequently, can be extremely challenging. Market definition is determined by (and, conversely, determines) the range of alternatives available in the market, and, at times, even by the conditions for entry into the market. The goal is to identify any providers (actual or potential) offering a service or product that might be a viable substitute for the product or service at issue. In the case of magnetic resonance imaging (MRI), for instance, other MRIs in the area would be in the market, but most likely traditional X-ray equipment would not. For services, the relevant product market is likely to be defined around a particular medical specialty. In the case of a multi-specialty joint venture, several different product markets may have to be examined. The geographic market tends to be local in nature, although this too can vary depending on the specialty services involved. As stated in the oft-cited *United States v. E.I. du Pont de Nemours & Co.*<sup>36</sup> case, the relevant product "market is composed of products that have reasonable interchangeability for the purposes for which they are produced — price, use and qualities considered."<sup>37</sup>

Once the market has been defined, the analysis shifts to the structure of the relevant market, *i.e.*, the concentration of competitors in the market and the ease of entry into the market. Market power may be established by market share, but other factors are also relevant to the analysis.<sup>38</sup> If no significant barriers to entry exist, then it is unlikely that the venture will have market power. Stated another way, market power cannot be exerted where many existing competitors or potential entrants

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36. 351 U.S. 377 (1956).

37. *Id.* at 404.

38. *Ball Memorial Hosp. v. Mutual Hosp. Ins.*, 784 F.2d 1325, 1335 (7th Cir. 1986); Bloch, *supra* note 19.

(whose entry would be likely, timely, and sufficient) can offer price-disciplining substitutes. The existence of concentrated market conditions, however, will not doom the venture. In such situations, the venture may still be acceptable if structured to reduce the potential impact on competition.

### *B. Pro-competitive Effects from Joint Offering of Services*

Joint ventures frequently are efficiency-enhancing, especially when they are designed to make a new and expensive technology available to a community, and are narrowly focused on . . . operations where combining resources is likely to result in reduced costs and/or better services.<sup>39</sup>

As reflected in the above statement by FTC Chairperson Janet Steiger, joint ventures often produce positive effects without threatening competition. For instance, to the extent that hospitals or physicians join to share a service in which they do not compete, such as laundry services, medical repair services, or data processing, there will generally not be antitrust concerns because there will almost certainly be no adverse impact on competition in the market of providing those services.<sup>40</sup>

Furthermore, to the extent the joint venture offers new services that neither participant previously offered, the joint venture is less likely to trigger antitrust scrutiny. Joint ventures that provide services that the participants could not offer alone are most apt to be permitted. For example, if neither hospital could afford to offer MRI services and they jointly purchase a machine to provide such services, this would be deemed as positive from an antitrust point of view.

### *C. Pro-competitive Effects from Joint Purchasing Groups*

It is becoming increasingly common for health care providers, such as hospitals, to form joint purchasing groups. The Sixth Circuit, in *White & White, Inc. v. American Hospital Supply Corp.*,<sup>41</sup> recognized that such arrangements often exhibit great potential for cost-reducing efficiencies as members may realize economies of scale in purchasing, warehousing, and

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39. Janet Steiger, FTC Chairman, Remarks Before the NHLA (Feb. 19, 1993).

40. *Id.* See also *University Health, Inc.*, 57 Fed. Reg. 29,084 (Fed. Trade Comm'n. 1992); *Reading Hosp.*, 55 Fed. Reg. 3264, 3266 (Fed. Trade Comm'n. 1990)(consent approved voluntary separation of merged hospitals, with continued sharing of laundry, laboratory, and biomedical equipment repair services).

41. 723 F.2d 495 (6th Cir. 1983).

distributing goods, while the potential for anticompetitive effects is low.<sup>42</sup> Groups often are able to use their collective power to negotiate lower prices, thereby lowering costs.<sup>43</sup>

#### IV. ANTI-COMPETITIVE EFFECTS

On the other hand, certain joint ventures may have actual or potential market power and, thus, the ability to deter the entry of others or otherwise cause anticompetitive effects. Furthermore, such ventures can result in a diminution of competition in the marketplace. This section will explore the potential anticompetitive effects from collaborative activity.

##### A. Bottleneck or Essential Facilities

Joint ventures can create "bottlenecks" or become "essential facilities" for competitors. Denial of participation in a venture can be fatal to a competitor if such access is an essential source of supply or facility. When the denial is not justified by plausible pro-competitive reasons, it can result in *per se* illegal treatment by a court.<sup>44</sup> The essential facilities doctrine imposes liability only when one or more firms that control an essential facility, which cannot practicably be duplicated, deny reasonable access on a fair and non-discriminatory basis to another firm that cannot compete in the marketplace without such access. For instance, in recent years, a multitude of cases has been brought by physicians who were either denied or lost hospital privileges asserting that access to the hospital constituted an "essential facility."<sup>45</sup>

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42. See Arquit, Remarks Before the ABA Health Care Committee (Apr. 2, 1992); Assistant Attorney General Charles F. Rule, Remarks Before the Chemical Manufacturers Association (Oct. 21, 1985).

43. See generally Roger D. Blair & Jeffrey L. Harrison, *Antitrust Policy and Monopsony*, 76 CORNELL L. REV. 297 (1991); Roger D. Blair & Jeffrey L. Harrison, *The Measurement of Monopsony Power*, 37 ANTITRUST BULL. 133 (1992); Jonathan M. Jacobson & Gary J. Dorman, *Joint Purchasing, Monopsony and Antitrust*, 36 ANTITRUST BULL. 1 (1991); Jonathan M. Jacobson & Gary J. Dorman, *Monopsony Revisited: A Comment on Blair and Harrison*, 37 ANTITRUST BULL. 151 (1992).

44. *Accord* Northwest Wholesale Stationers v. Pacific Stationery & Printing Co., 472 U.S. 284 (1985); *Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022 (9th Cir. 1988), *cert. denied*, 493 U.S. 486 (1989); *Weiss v. York Hosp.*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985).

45. See, e.g., *Lie v. Saint Joseph's Hosp.*, 964 F.2d 567 (6th Cir. 1992); *Miller v. Indiana Hosp.*, 975 F.2d 1550 (3d Cir. 1992), *cert. denied*, 113 S. Ct. 1366 (1993); *Mann v. Princeton Community Hosp. Ass'n*, 956 F.2d 1162 (4th Cir. 1992); *Okusami v. Psychiatric Inst.*, 959 F.2d 1062 (D.C. Cir. 1992); *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989 (N.D. Ga. 1992); *Pudlo v. Adamski*, 789 F. Supp. 247 (N.D. Ill. 1992), *aff'd*, 2 F.3d 1153 (7th Cir. 1993), *cert. denied*, 114 S. Ct. 879 (1994); *Mandava v. Howard County Gen. Hosp.*, 1992-2

Similarly, if two physician groups control an area's kidney dialysis machines and decide to upgrade the equipment through a jointly owned facility, the antitrust officials would be concerned if no other kidney dialysis capacity was readily available in the market and competing nephrologists were not allowed access to the equipment for their patients. The risk of antitrust concerns would be greater in states that require Certificates of Need for potential competitors to enter.

The FTC is concerned with joint ventures where the joint venturers (e.g., doctors in a specialty) possess sufficient "referral power" in the venture product or service to be anti-competitive and raise barriers to entry.<sup>46</sup> In January 1990, the FTC challenged a nephrologist's tying of his inpatient dialysis services to outpatient facilities he owned when those facilities constituted 90% of the market.<sup>47</sup> Similarly, in *American Computech v. National Medical Care*<sup>48</sup> a jury awarded \$605,000 in actual damages and \$2.4 million in punitive damages to a San Diego, California, kidney dialysis center which was injured by the profit sharing arrangement its competing dialysis center offered area nephrologists. The Ninth Circuit affirmed the decision.<sup>49</sup>

Issues of provider channeling of patients to ancillary services or products can occur in a variety of settings. For example, it is not uncommon for orthopaedic surgeons to operate physical therapy centers and radiologists to own MRI or radiation therapy centers. In addition, the diversification of hospitals into new services, such as durable medical equipment (DME), has raised questions of whether the hospital is an essential facility with unique access to patients, thus improperly influencing patients to use the affiliated DME supplier.<sup>50</sup>

Also, on November 2, 1993, the FTC accepted proposed consent agreements with twenty-eight pulmonologists who owned two San Francisco area DME companies that provided home oxygen systems. The FTC al-

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Trade Cas. (CCH) ¶ 69,932 (D. Md. 1992); *Purgess v. Sharrock*, 806 F. Supp. 1102 (S.D.N.Y. 1992); *Flegal v. Christian Hosp. Northeast-Northwest*, 804 F. Supp. 1165 (E.D. Mo. 1992), *aff'd*, 4 F.3d 682 (8th Cir. 1993).

46. Deborah Owen, Remarks Before the Florida Orthopaedic Society (May 15, 1992).

47. *In re Gerald S. Friedman, M.D.*, No. 861-0072 (Jan. 24, 1990).

48. No. 89-55289, 89-55290, 89-55293 (1989), *aff'd*, 959 F.2d 239 (9th Cir. 1992).

49. *American Computech, Inc. v. Nat. Med. Care, Inc.*, 959 F.2d 239 (9th Cir. 1992).

50. *Advanced Health-Care Serv. v. Radford Community Hosp.*, 910 F.2d 139 (4th Cir. 1990); *M & M Med. Supplies & Serv. v. Pleasant Valley Hosp.*, 738 F. Supp. 1017 (S.D. W. Va. 1990), *aff'd in part and vacated in part*, 946 F.2d 886 (4th Cir. 1991), *cert. denied*, 113 S. Ct. 2962 (1993); *Key Enter. v. Venice Hosp.*, 703 F. Supp 1513 (M.D. Fla. 1989), *rev'd*, 919 F.2d 1550 (11th Cir. 1990), *reh'g granted and opinion vacated*, 979 F.2d 806 (11th Cir. 1992), *order vacated*, 9 F.3d 893 (11th Cir. 1993).

leged that because these pulmonologists constituted about 60% of the pulmonologists in the area, they were able to exert market power in the "DME home oxygen system" market. The consent specifies that no greater than 25% of the pulmonologists in the area may affiliate with the DME companies in order to prevent the DME companies from maintaining a captive source of referral large enough to confer market power.<sup>51</sup>

The antitrust officials and courts are also concerned about exclusion of products where participation in the plan is necessary to compete in the marketplace. Participation then becomes, in essence, an "essential facility." In *Oregon Physicians' Services v. Hahn*,<sup>52</sup> for instance, podiatrists challenged their exclusion from the Oregon Physician Service (OPS), a prepaid health care plan founded by between 90-93% of eligible physicians and osteopaths. At the time the podiatrists were denied membership, a majority of the OPS' governing board of trustees were physicians. The plaintiffs showed that many physicians were direct competitors to podiatrists. The court indicated that the "proper inquiry is whether practitioners sharing substantially similar economic interests collectively exercised control of a plan."<sup>53</sup> Also, strong evidence indicated that the exclusion of podiatrists was not based on cost containment considerations. Not all exclusions, however, will have the anti-competitive effects found to exist in *Hahn*.<sup>54</sup>

### B. Diminution of Competition

If the venture involves a high proportion of an area's providers in a service market, then the antitrust risk increases should participants explicitly or *de facto* agree not to participate in managed care other than through the joint venture. After all, while risk-sharing is important to establishing the creation of a legitimate joint venture, it can also provide

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51. *In re Homecare Oxygen & Medical Equip. Co.*, No. 901-0109 (Nov. 2, 1993); *In re Homecare Oxygen & Medical Equip. Co.*, No. 901-0020 (Nov. 2, 1993).

52. 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983), *appeal after remand*, 860 F.2d 1501 (9th Cir. 1988), *cert. denied*, 493 U.S. 846 (1989).

53. 860 F.2d at 1508.

54. *See, e.g.*, *Barry v. Blue Cross*, 805 F.2d 866 (9th Cir. 1986) (court rejected a boycott claim based on a provision of the Blue Cross plan that prohibited participants from referring patients to non-participants without first notifying the patient that the physician was a non-participant. Since reimbursement rates differed on whether the physician was a "participating" physician, the referral clause operated to make a patient's choice of a non-participant less likely. The court, however, concluded that the referral clause was not an illegal group boycott because physicians could still refer patients to nonparticipating physicians and could contract with other plans).



the participants with the incentive not to compete.<sup>55</sup>

The DOJ/FTC Policy Statements indicate that absent extraordinary circumstances, the agencies will not challenge a physician joint venture that includes up to 20% of the physicians in each physician specialty who have active hospital staff privileges, practice in the relevant geographic market, and share substantial financial risk.<sup>56</sup> In relevant markets with less than five physicians in a particular specialty, a joint venture otherwise qualifying for the safety zone may include one physician even though this will result in a joint venture of more than 20% of the physicians in that specialty.

The antitrust safety zone applies equally to “exclusive” and “non-exclusive” networks. In contrast, for those ventures falling outside the safety zone, an “exclusive venture” raises significantly more risk of challenge than a non-exclusive venture. After all, exclusive management will restrict the ability of its members to affiliate with other networks and to contract individually with health insurance plans. Physician networks will be reviewed under the rule of reason if the physicians share substantial risk or if the physicians’ ability to associate enables them to offer a new product producing substantial efficiencies. The Policy Statements also recognize that in small rural markets, it may be necessary for purchasers of health care services to contract with a relatively large number of physicians to provide adequate coverage and choice for enrollers. In such markets, it is unlikely that the joint venture’s relatively large market share of some specialists will raise concerns so long as there is: (1) a demonstrated ability of health insurance plans to contract with physicians individually, if they so desire; (2) a possibility that other networks could be formed; and (3) benefits to health insurance plans from obtaining coverage provided by the network.<sup>57</sup>

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55. *Citizen Publ. Co. v. United States*, 394 U.S. 131 (1969) (profit pooling arrangement evidenced price fixing).

56. Dept. of Justice & FTC Antitrust Enforcement Policy Statements in the Health Care Area, 4 Trade Reg. Rep. (CCH) ¶ 13, 150 (Sept. 15, 1993).

57. On Sept. 28, 1993, the DOJ announced it does not intend to challenge a proposal by National Cardiovascular Network, Inc. (NCN) to establish a national network of cardiologists, cardiovascular surgeons and acute care hospitals. The Department characterized the NCN proposal as “similar to other recently developed alternative delivery systems featuring a national network of medical ‘centers of excellence’ that provide specialized medical care.” NCN would create a PPO of cardiac care specialists in 41 metropolitan areas nationwide to provide cardiac care to beneficiaries of large third-party payers. In 38 of the 41 metropolitan areas, NCN does not plan initially to contract with any cardiologists, cardiovascular surgeons, or acute care hospitals that currently compete with each other. In the other three cities, NCN assured the Department that it will not contract with more than

Similarly, the antitrust officials become concerned when the purchasing group has the power to force suppliers to sell at prices below a competitive level, thereby causing possible dislocation of market allocations and efficiencies.<sup>58</sup> In the mid 1980s, the DOJ adopted a 35/20 "safe harbor." If a group's volume accounted for less than 35% of the total capacity of the sellers in the market, then the DOJ considered it unlikely that purchasers were exercising monopsony power to drive down prices. The DOJ safe harbor applied to instances where the purchased good or service constituted up to 20% of the price of the final product. The concern here was that if the jointly purchased product constituted a higher percentage of the final price, there may have been anti-competitive pricing of the final product.<sup>59</sup> In 1991, then Assistant Attorney General James Rill announced that the DOJ would no longer automatically follow the 35% rule in the PPO setting and would instead use the analytic framework of the Merger Guidelines for such PPOs.

However, the DOJ/FTC Policy Statements set forth an "antitrust safety zone" that, absent extraordinary circumstances, protects from federal governmental challenge any joint purchasing arrangement among health care providers under the 35/20 rule. For joint purchasing arrangements that fall outside the antitrust safety zone, the Policy Statements identify several safeguards that may mitigate enforcement concerns that might otherwise arise. First, antitrust concern is lessened if members are not required to use the arrangement for all of their purchases of a particular product or service; however, members can be asked to commit to purchase a voluntarily specified amount through the arrangement so that a volume discount for other favorable contracts can be negotiated. Second, antitrust risk is lowered where negotiations are conducted on behalf

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20% of the cardiologists or cardiovascular surgeons with active admitting privileges at hospitals in the relevant geographic market, thereby availing it of the antitrust safety zone. See Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice, to Frederick H. von Unwerth, Esq. (Sept. 28, 1993).

58. See, e.g., *Mandeville Island Farms v. American Crystal Sugar Co.*, 334 U.S. 219 (1948) (competitors in highly concentrated market agreement concerning purchase price of sugar was per se illegal). One recent commentator indicated that to the extent that third-party payers combine efforts and jointly acquire services only from a single source, "it is unlikely that any group effort . . . could account for a sufficiently large percentage of potential 'purchasers' to raise an antitrust concern regarding foreclosure." Kathryn M. Fenton, *Antitrust Implications of Joint Efforts by Third Party Payors to Reduce Costs and Improve the Quality of Health Care*, 61 ANTITRUST L.J. 17, 36 (1992).

59. See Letter from James F. Rill, Assistant Attorney General, to Patrick McAdam, Esq. (Aug. 22, 1989) (on file with *J. Contemp. Health L. & Pol'y*); Letter from Charles F. Rule, Acting Assistant Attorney General, to Marc L. Fleischaker, Esq. (May 18, 1987) (on file with *J. Contemp. Health L. & Pol'y*).

of the joint purchasing arrangement by an independent employee or agent who is not also an employee of a participant. Finally, the Policy Statements advocate that the purchasing group and each individual participant keep communications confidential and not share information with the other participants. The enforcement agencies note that existence of a large number and variety of purchasing groups in the health care field suggests that entry barriers to forming new groups are not great and that, in most circumstances, it is not necessary to open a joint purchasing arrangement to all competitors in the market.

It is important to be cognizant of the distinction between purchasing an input jointly and entering into an agreement either to fix the price of inputs or to refuse to compete for certain inputs when considering the permissibility of a joint purchasing arrangement. For example, in 1992, the DOJ instituted criminal investigations of hospitals that had allegedly colluded in attempting to fix prices paid for nurses and other health care provider employees.<sup>60</sup>

## V. ANCILLARY AGREEMENTS

Joint ventures sometimes run afoul of the antitrust laws due to ancillary agreements that unreasonably restrain competition without contributing to the joint ventures' legitimate purposes. This section will address the improper usage of joint ventures to engage in group boycotts, to fix prices or restrict output for unrelated activities, or to raise entry barriers for potential competitors of the venture by imposing exclusivity requirements.

### A. *Group Boycotts*

A frequent ground for antitrust challenge by private parties and the government alike is for members of a venture to force customers or recalcitrant competing providers to agree to terms through threatened or actual concerted refusals to deal or boycott.<sup>61</sup> The federal enforcement

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60. See *In re Debes*, 57 Fed. Reg. 39,025 (Aug. 28, 1992) (consent concerning nursing home owners in Rockford, Illinois exchanging information about nurse registries in the area for five years and/or entering into joint purchasing agreements for nursing services for ten years); *All Care Nursing Serv., Inc. v. Bethesda Memorial Hosp., Inc.*, 887 F.2d 1535 (11th Cir. 1989) (hospitals agreed to deal only with selected agencies when hiring temporary nurses).

61. *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447 (1986) (found dentists liable for concerted refusal to cooperate with insurer utilization review requirement to submit X-rays in advance of treatment); *Reazin v. Blue Cross & Blue Shield*, 899 F.2d 951 (10th Cir. 1990), cert. denied, 497 U.S. 1005 (1990) (conspiracy to terminate a hospital provider that was

agencies have been particularly concerned about concerted efforts by providers to hamper the introduction of alternative delivery systems that compete with fee-for-service medicine.

In *United States v. Greater Bridgeport Individual Practice Ass'n*,<sup>62</sup> for instance, a legitimate IPA went beyond the scope of its mandate and engaged in what was, according to the DOJ, for all practical purposes, a boycott to obtain higher fees. The DOJ claimed that the IPA's conduct constituted a conspiracy, implemented by many of its approximately 670 members, by not contracting individually with an HMO. The complaint alleged that after the HMO and the IPA reached an impasse during contract negotiations, the IPA and its members, in response to the HMO's initiative to contract individually with the IPA's physicians, participated in a conspiracy not to contract individually with the HMO. One purpose of the conspiracy was purportedly to force the HMO to increase the fees it paid to the IPA.

The extent to which such conduct will be permitted (under either a *per se* treatment or rule of reason approach) will typically depend on the market shares of the participants.<sup>63</sup> Furthermore, the courts have been reluctant to strike down objective standards for the exclusion of certain

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aligned with other competing managed care programs and the announcement of this termination to all other hospitals was an unlawful attempt to limit competition in the health care financing market); *Pa. Dental Ass'n v. Med. Serv. Ass'n*, 815 F.2d 270 (3d Cir.), *cert. denied*, 484 U.S. 851 (1987) (agreement departicipating dentists in Blue Shield illegal under truncated rule of reason); *Hassan v. Indep. Prac. Assoc., P.C.*, 698 F. Supp. 679 (E.D. Mich. 1988); *In re Michigan State Med. Soc'y*, 101 F.T.C. 191 (1983); *Medical Staff of Broward Gen. Med. Ctr.*, 56 Fed. Reg. 49,184 (Sept. 27, 1991) (consent order prohibited physicians with staff privileges from threatening to boycott the hospital in order to coerce the hospital not to enter a business relationship with the Cleveland Clinic); *In re Medical Staff of John C. Lincoln Hosp. and Health Ctr.*, 106 F.T.C. 291 (1985) (consent order prohibited physicians from coercing hospital not to enter a relationship with urgent care facility which competed with physicians).

62. *United States v. Greater Bridgeport Individual Practice Ass'n*, 1993-2 Trade Cas. (CCH) ¶ 70,389 (D. Conn. 1993).

63. *See, e.g., Northwest Med. Lab., Inc. v. Blue Cross & Blue Shield*, 794 P.2d 428 (Or. 1990) (under rule of reason test, court found for defendants because defendant's 2.1% share of the health financial market was too small to establish anticompetitive effect); *Hassan v. Indep. Practice Assoc.*, 698 F. Supp. 679 (E.D. Mich. 1988) (court rejected claim of allergists who were denied membership in an IPA because (1) the plan was a legitimate joint venture, with physicians sharing the risk of loss, as well as opportunities for profit, by accepting capitation payments from the HMO; (2) these arrangements made a new product available to consumers from traditional fee-for-service physician services; and (3) the HMO's 20% share of the health care finance market, the absence of significant barriers to entry, and a recent price decrease by the HMO in issue). *Accord Capital Imaging Associates, P.C. v. Mohawk Valley Med. Associates*, 791 F. Supp. 956 (N.D.N.Y. 1992), *aff'd*, 996 F.2d 537 (2d Cir.), *cert. denied*, 114 S.Ct 388 (1993).

classes of providers where it was not shown that the exclusion resulted in a significant diminution of competition in the marketplace.<sup>64</sup>

### *B. Exclusive Arrangements*

The same issues of exclusion arise in an exclusive contract setting. According to FTC Assistant Director of Competition Mark Horoschak:

Exclusive arrangements are likely to endanger competition only if the [managed care plan] using them is able to obtain, and retain exclusivity commitments from such a large proportion of the physicians in the area or in a particular specialty, that the other plans are deprived of access to the physicians they need to operate effectively.<sup>65</sup>

In addition, the exclusive affiliation of providers with a plan may constitute a significant barrier to entry for other alternative delivery systems.<sup>66</sup>

In evaluating an exclusive arrangement, courts typically consider the degree of market foreclosure involved (*e.g.*, the percentage of suppliers of health care services). In the context of PPOs and IPAs, in certain circumstances, exclusion of certain providers from the group is not only permitted under the antitrust laws, but even encouraged. Therefore, PPOs need not be overly concerned about excluding physicians or hospitals as participants because the essential feature of a PPO is its selectivity. Indeed, the primary competitive risk of a PPO is over-inclusiveness rather than exclusion. Thus, the exclusion of some interested providers will likely promote competition among panels and is a necessary part of the process.<sup>67</sup> In some respects, the DOJ/FTC Policy Statement is more conservative than individual opinions issued by the enforcement agencies and courts.<sup>68</sup> Neither agency will usually challenge a PPO where the

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64. *Capital Imaging Associates*, 791 F. Supp. at 967 (exclusion of radiologists from an IPA that contracted with an HMO did not have an adverse effect on competition since the HMO contracted with only 6.75% of licensed physicians in the market, competed with 53 other HMOs and enrolled 2.3% of subscribers in the health care financing market; none of these physicians were precluded from referring non-HMO patients to the excluded radiologists). See *Blue Cross v. Kitsap Physicians Serv.*, 1982-1 Trade Cas. (CCH) ¶ 64,590 (W.D. Wash. 1981); *In re Medical Serv. Corp.*, 88 F.T.C. 906 (1976).

65. Mark J. Horoschak, Remarks Before the ABA (Aug. 11, 1992).

66. *Hassan*, 698 F. Supp. at 695.

67. Paul McGrath, Remarks Before the ABA (March 22, 1985). See *supra* notes 27-28 and accompanying text.

68. See, *e.g.*, Letter from Charles F. Rule, Acting Assistant Attorney General, to Frank Sanchez (Oct. 3, 1986) (on file with *Journal of Contemporary Health Law & Policy*) (no opposition to pharmacy sponsored PPO's pricing activities which involved 30% of pharmacies participating, and up to 50% in rural areas).

panel provides a competitive alternative rather than a blockade to competition in local markets.<sup>69</sup>

The federal enforcement agencies currently consider the impact of an exercise of market power on managed care plans relevant. PPOs and IPAs are formed, in most cases, to negotiate with managed care plans. Such plans, because of their use of selective contracting, are better able to respond to price increases.

One important factor that the agencies consider is the extent to which the members of the venture have agreed to use the venture as their exclusive agent in contracting with managed care plans. Exclusivity can either be explicit or implicit. In determining implicit exclusivity, the agencies consider the physicians' conduct as well as a variety of market characteristics, including the number of physicians in the venture and where they have staff privileges. The concern is that a large PPO or IPA that acts as the exclusive bargaining agent for its members may be able to set supra-competitive fees or deter the development of managed care. An "exclusive venture" also raises significantly more risk of challenge because it restricts the ability to affiliate with other networks or to compete individually.

Some exclusive arrangements have been scrutinized and ultimately challenged by federal and state enforcement agencies. In *Ohio ex rel. Celebrezze v. Greater Cleveland Hospital Ass'n*,<sup>70</sup> for example, the state challenged an association that accounted for 90% of the hospitals in the Cleveland area when it attempted to establish an insurance plan in which only member hospitals could participate and which refused to contract with other insurers except at higher rates. A consent order was entered into with the association that prohibits the association from conspiring to discourage hospitals from organizing, operating, or contracting with other plans.<sup>71</sup>

Criteria for PPO membership related to cost efficiency, historical utilization, and willingness to comply with utilization review are legitimate considerations.<sup>72</sup> The criteria used to select plan participants may be im-

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69. See also *U.S. Healthcare, Inc. v. U.S. Healthsource, Inc.*, 1992-1 Trade Cas. (CCH) ¶ 69,697 (D.N.H. 1992), *aff'd*, 986 F.2d 589 (1st Cir. 1993) (court rejected an HMO's challenge of an optional exclusivity clause in contracts entered into between another HMO and primary care physicians because the defendants controlled only 4-5% of the state's population).

70. 1983-2 Trade Cas. (CCH) ¶ 65,685 (N.D. Ohio 1983).

71. *Id.*

72. *Hassan*, 698 F. Supp. at 679 (refusal to readmit allergist was a cost containment

portant to the policy's defense.<sup>73</sup> However, the elimination of competition among providers (by combining services or allocating markets) to halt costly duplicative services and ensure quality care has been rejected by the courts as well as the federal enforcement agencies.<sup>74</sup>

### C. Restraints on Subscriber's Choice of Providers

Another type of ancillary restraint entails requiring the payers to contract exclusively with the joint venture or providing the payer or its subscribers with financial incentives (e.g., "deductibles" or "credits") to use the venture. Arguably, the former of these practices, and perhaps even the latter practice, constitutes a "tying" arrangement under which subscribers are foreclosed from other sources of care. Absent a showing of market power on the part of the venture,<sup>75</sup> however, it is unlikely that the venture will be found to have foreclosed meaningful competition in the local provider payer markets.<sup>76</sup>

### D. Spillover Effects

In less than fully integrated joint ventures, there may be some concern about collaboration that will spill over into areas where there is existing competition between the joint venturers. As former FTC Competition Bureau Director Kevin Arquit stated: "A legitimate joint venture may justify certain restraints so long as they are reasonably necessary to attainment of efficiencies."<sup>77</sup> Care should nevertheless be taken to ensure that the exchange of information by participants for the venture does not facilitate price fixing or concerted refusals to deal with the individual par-

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measure); *Northwest Med. Lab., Inc. v. Blue Cross & Blue Shield*, 794 P.2d 428 (Or. 1990)(limited panel was used to control utilization).

73. *EGH, Inc. v. Blue Cross Blue Shield*, 1991-2 Trade Cas. (CCH) ¶ 69,642 (D. Or. 1991) (competitive bidding); *Capital Imaging Associates v. Mohawk Valley Associates*, 791 F. Supp. 956 (N.Y.N.D. 1992), *aff'd*, 996 F.2d 537 (2d Cir.), *cert. denied*, 114 S. Ct. 388 (1993) (geographic location of the provider relative to the patient population and sufficient capacity of range of services to support patient population may be legitimate bases for exclusion of a plan participant).

74. *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (5th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987). *But see* Horoschak, *supra* note 65.

75. The analysis of market power should include consideration of any distinct geographic areas and specialized services or providers that could give the venture some ability to affect competition adversely.

76. *See generally* Enders, *supra* note 13, at 824-25 (discussion of "tying" restraint).

77. Kevin J. Arquit, A New Concern in Health Care Antitrust Enforcement: Acquisition and Exercise of Market Power by Physician Ancillary Joint Ventures, Remarks Before the NHLA at 4-5 (Jan. 30, 1992) (on file with Journal of Contemporary Health Law & Policy).

ticipants in activities outside the ventures.<sup>78</sup>

Sometimes networks provide other services, such as allocating services among providers, approving budgets, or rationalizing overcapacity to avoid duplication. This may actually exacerbate antitrust concerns.<sup>79</sup> Spillover effects can often be minimized or eliminated by the imposition of structural safeguards and other measures designed to ensure that collaboration among participants stops with the venture.

One of the spillover concerns may be whether, as a result of the venture, participants share information about non-venture activities. While it may not be a violation of antitrust laws for competing providers to supply information on a voluntary basis to third-party payers, providers may be tempted to step over that line and agree on what they consider to be "appropriate" fees, or otherwise attempt to pressure or coerce payers to increase their fees. In such situations, the DOJ will focus on: (1) who initiated price discussions; (2) what, if anything, did the third-party payer request from the providers and what did the payer receive; (3) what, if anything, did the providers agree to; (4) what their objective was; and (5) whether there was any implied or express refusal to deny or threat to withhold services.

## VI. STATE ACTION IMMUNITY

A number of new state laws enacted in 1992 and 1993 aim to promote collective action in the health care field.<sup>80</sup> In adopting their laws, some of these states have attempted to provide state action immunity for the collaborative activities. However, the judicially created state action doctrine has recently been narrowly construed by the United States Supreme Court in *FTC v. Ticor Title Insurance Co.*<sup>81</sup> to immunize conduct only if

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78. Bloch, *supra* note 19, at 20; Owen, *supra* note 46.

79. See *State v. Wenatchee Valley Clinic*, 1988-1 Trade Cas. (CCH) ¶ 68,118 (E.D. Wash. 1988); Letter from FTC staff to F. Tim Witsman (May 12, 1991); Letter from Assistant Attorney General Sandy Litvack to William Kopit, Esq. (May 8, 1980).

80. These states include Colorado (Hospital Efficiency Cooperation Act, 1993 Colo. Sess. Laws 120, codified at COLO. REV. STAT. §§ 24-32-2701 et al.), Florida (Health Care and Insurance Reform Act, 1993 Fla. Laws Ch. 129, codified FLA. STAT. CH. 395.606), Georgia (Act of July 1, 1992, 1993 Ga. Laws 496, codified GA. CODE ANN. § 31-7-72-1), Iowa (1993 Iowa Legis. Serv. 380 (West)), Maine (1992 Me. Laws 814), Minnesota (1993 Minn. Sess. Law Serv. 345 (West), codified at MINN. STAT. ANN. §§ 625-2911 to 2021), Montana (1993 Mont. Laws 606), Oregon (1993 Or. Laws 769), Tennessee (Hospital Cooperation Act of 1993, Tenn. Rb. Acts 33, codified at TENN. CODE ANN. §§ 68-11-1301 to 1309), Texas (1993 Tex. Sess. Law Serv. 373 (Vernon)), and Washington (1993 Wash. Laws 492).

81. 112 S. Ct. 2169 (1992).



there is substantial state supervision of the activities. Indeed, the FTC staff recently commented on proposed legislation in North Dakota aimed at providing immunity to hospitals and health providers.<sup>82</sup> The staff indicated that the pending bills would not meet the active supervision requirement because they did not provide for scrutiny of the actions of the parties to an agreement after the issuance of a certificate authorizing the formation of the cooperative arrangement. Thus, even where state law purports to immunize providers, such providers should proceed cautiously with conduct that would likely raise antitrust concerns absent the immunity.

## VII. CONCLUSION

The cry for health care reform seems destined to increase the trend toward consolidation and employment of alternative delivery systems rather than the elimination of them. "Antitrust safety zones" currently are delineated by the federal enforcement agencies for certain joint conduct by health care providers. Similarly, sham joint ventures which have as their real mission such anti-competitive conduct as price fixing or concerted refusals to deal, will be summarily attacked as *per se* illegal. Providers must not use the formation of a venture as a guise to hide otherwise anti-competitive conduct or to slow initiatives to contain costs in the industry. A vast majority of joint ventures will neither be condemned *per se* nor protected under safety zone; instead most joint conduct will be subject to scrutiny under the rule of reason. First, the federal enforcement agencies and/or a court will consider whether there are "pro-competitive effects" from the conduct. There is no doubt that health care joint ventures are desirable from an antitrust perspective given their facilitation of new services and efficiencies. Second, the anti-competitive effects will be evaluated. Finally, the ancillary or spillover effects of the venture will be evaluated. To minimize the risks of antitrust challenge, providers should not stray away from the venture's pro-competitive mission of creating efficiencies and offering new products and services or engaging in ancillary agreements that have adverse competitive effects. Failure to adhere to these principles raises the potential of both civil and criminal challenges under the antitrust laws.

## APPENDIX

An HMO is an entity that provides a package of health care services on a

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82. Letter from FTC Staff to David W. Huey (Mar. 8, 1993).

prepaid basis at specified facilities. There are two models for HMOs — a staff model in which the providers are employees of the HMO and an IPA-type model in which the providers are individual physicians who contract to provide services to the HMO on a capitated basis.

A PPO is an organization of health care providers who contract to provide their services to a defined group of patients on a reduced fee-for-service basis. PPOs often do not involve risk sharing.

An IPA is an association of individual providers who pool their resources and share expenses, *e.g.*, equipment, staff, recordkeeping. The IPA usually contracts with various health care plans to provide health care services on an “at-risk” basis to provide medical services to their subscribers.

A PHO is an arrangement between one or more hospitals and physicians on their medical staffs to provide health care services on a prepaid basis to third-party payers.

An insurer hospital joint venture is an arrangement between one or more hospitals and an insurer to offer a package of health care services on a prepaid basis. The insurer usually performs the administrative functions.

A “group practice without walls” involves the integration of private practice physicians into a group practice in which each doctor can retain separate offices, but administration is centralized and financial affairs are integrated.

A community care network entails the collaboration of various providers, such as a multi-hospital network and possibly physicians or physician organizations, which may negotiate with third-party payers and consolidate functions across a broad range, including capital budgeting, marketing, and the purchase of equipment.

