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Thomas L. Greaney

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IS ANTITRUST ANTI-AUTONOMY?

*Thomas L. Greaney**

AS ORGANIZED MEDICINE would have it, physicians today are yearning to compete even *more* vigorously, but feel they can do so only if they can control the networks through which they market their services while remaining in unintegrated, fee-for-service delivery systems that entail no sharing of risk. As a general matter, with respect to entry by new ventures, antitrust law takes the philosophy of letting a thousand flowers bloom, leaving it to the competitive marketplace (rather than the judiciary) to do the pruning. Where, however, it appears that kudzu may suffocate the garden, traditional antitrust principles require some judicious gardening. Organized medicine, it seems, is lobbying to fire the gardener, or at least send him on vacation until the end of the growing season.

Jack R. Bierig's article, *Physician-Sponsored Managed Care Networks: Two Suggestions for Antitrust Reform*, asserts that antitrust law has unfairly discriminated against certain physician networks, thereby denying the public of certain benefits (which are not specified) associated with this form of health care delivery system.¹ This Response contends that Bierig has misread the economic foundations of current law enforcement policies while advancing no sound basis for believing that consumers would be better off or markets more efficient under his reform proposals. While some improvement in interpreting the boundary between impermissible cartelizing schemes and legitimate network joint ventures is needed, there is no principled reason for allowing physicians to assemble in large networks that would risk undermining the competitiveness of medical services markets.

* Professor of Law, Saint Louis University. B.A., 1970 Wesleyan University, J.D., 1973 Harvard Law School. The research assistance of Megan Flaskamper is gratefully acknowledged.

1. Jack R. Bierig, *Physician-Sponsored Managed Care Networks: Two Suggestions For Antitrust Reform*, 6 HEALTH MATRIX 117 (1996).

I. ORGANIZED MEDICINE'S CRITICISMS OF COMPETITION POLICY

A. Background: The Movement to Limit Antitrust Oversight of Health Care Providers

Organized medicine's legislative and regulatory agenda betrays nostalgia for an era of professional sovereignty that cannot readily be reconciled with the premises of the modern competitive environment. Devoting unprecedented resources to lobbying efforts and political campaigns² during the frenzied health reform debate, health care providers sought to sculpt state and federal health reform so as to preserve their own incomes and autonomy. These efforts included a variety of legislative proposals to regulate managed care, curb application of antitrust laws, compel payors to contract with all providers, and derail health reform proposals that would have hastened the nation's switchover to managed care.³

In his Article, Bierig takes aim at a relatively narrow target: antitrust law's treatment of physician-controlled networks that do not share financial risk. (Bierig's Article reiterates his arguments made before the Physician Payment Review Commission last year. The Commission concluded that there was not sufficient evidence to warrant exempting physician-sponsored networks from the antitrust laws.⁴) It should be noted, however, that state and federal lawmakers have been treated recently to a much more wide-ranging assault on the application of antitrust to the health care industry. Over the years, representatives of the American Medical Association (AMA) and other physician groups

2. Rick Wartzman, *Foes of Health Care Reform Are Big Donors in Congressional Races, Study Shows*, WALL ST. J., Sept. 23, 1994, at A4 (reporting that one in every five dollars given to congressional candidates by political action committees and large donors came from those trying to defeat comprehensive health care reform).

3. See George Anders & Laura Johannes, *Doctors Are Losing A Lobbying Battle to HMOs*, WALL ST. J., May 15, 1995, at B1 (describing lobbying efforts in over 20 state legislatures to gain passage of the AMA's "Patient Protection Act" and other bills to subject HMOs and other managed care companies to regulation concerning their ability to drop participating physicians, to require that employers allow workers to go outside HMOs for a fee, and to assure easier entry for physicians into HMO networks). See also *Managed Care Perspectives: Medicaid, Medicare Managed Care Reforms Expected, Anti-Managed-Care Provisions to Be Hotly Debated*, MANAGED CARE WEEK, Jan. 23, 1995, at 1 (describing AMA's support for "any willing provider" legislation, which would require that managed care plans offer due process protection to deselected providers, and that HMOs offer point-of-service plans).

4. 1995 PHYSICIAN PAYMENT REV. COMM'N, ANN. REP. 284.

have advocated more sweeping changes in antitrust law, ranging from outright immunity for procedural restrictions upon federal enforcement agencies to broad safe harbors for physician networks.⁵ Hospitals,⁶ insurers,⁷ and pharmaceutical manufacturers⁸

5. *Health Care Revision: Hearing of the Subcomm. on Economic and Commercial Law of the House Comm. on the Judiciary*, 103d Cong., 2d Sess. (1994) (statement of Merle W. Delmer, M.D., Chair, Council on Legislation, AMA) (supporting legislation establishing safe harbors for any physician joint venture containing no more than 25% of providers in a given specialty in the relevant geographic market). See also *Health Care Reform: Do Antitrust Laws Discourage Cost Cutters or Defeat Price Gougers?: Hearing Before the Subcomm. on Antitrust, Monopolies and Business Rights of the Senate Comm. on the Judiciary*, 103d Cong., 1st Sess. 92-95 (1993) (statement of Richard F. Corlin, Vice Speaker, House of Delegates, AMA) (outlining the AMA's support of legislation which permits physicians collectively to negotiate issues of managed care administration and reimbursement with third party payors, requires managed care plans to establish physician advisement committees, grants medical professional organizations antitrust immunity when enforcing self-imposed quality standards, and grants antitrust immunity for health care fraud and abuse informants); James S. Todd, *Physicians as Professionals, Not Pawns*, HEALTH AFF., Fall 1993, at 145 (outlining AMA proposals to change antitrust enforcement to allow physicians, through their professional organizations, to negotiate fees, create joint marketing arrangements to negotiate with payors regardless of shared financial risk, form non-integrated physician groups to negotiate with "powerful" payors, and encourage physician committees to advise managed care plans); *AMA Suggests Refinement, Revisions of Health Industry Enforcement Policy*, 65 Antitrust & Trade Reg. Rep. (BNA) 487 (Oct. 14, 1993) [hereinafter *AMA Suggests Refinement*] (listing the AMA's suggestions to expand physician network safety zones from 20% to 50% of the physician market, include equity investment in physician joint ventures as substantial risk sharing, and propose safety zones for physician fee information sharing with purchasers); Michael deCourcy Hinds, *House Vote Would End F.T.C. Rules for Doctors*, N.Y. TIMES, Dec. 2, 1982, at A18 (describing AMA lobbying efforts for legislation to exempt medical professionals from FTC antitrust jurisdiction); Office of the Gen. Couns., *AMA, Antitrust Reform 4* (1995) (on file with author) (proposing legislation which would permit physician networks to offer fee-for-service plans, to expand range of fee withhold arrangements constituting risk sharing under 1994 Antitrust Enforcement Guidelines, to allow equity investment in physician joint ventures as risk sharing, to expand the maximum number of physicians in a particular specialty who are allowed to participate in a single physician joint venture, and to advocate state legislation granting physicians antitrust immunity); *AMA Policy Compendium 175* (1990) (on file with author) (advocating placing the FTC under Congressional authority, supporting legislation requiring courts to consider public interest aspects when reviewing health care delivery activity, and opposing restrictions on physician participation in health care plan decision making); Letter from Kirk B. Johnson, General Counsel, AMA, and John M. Peterson, Counsel, Chicago Medical Society, to Donald S. Clark, Secretary, FTC 1 (Apr. 30, 1992) (on file with *Health Matrix*) (requesting an advisory opinion regarding professional peer review of physician's fees).

6. See Fredric J. Entin et al., *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107 (1994) (identifying the need for more freedom in collaborative price structuring among hospitals to deliver health care effectively while remaining commercially viable and without violating the antitrust laws).

7. *New Coalition of Insurers Opposes Repeal of McCarran-Ferguson Exemption*, 66 Antitrust & Trade Reg. Rep. (BNA) 653 (June 16, 1994) (describing insurer group's opposition to modification of the industry's partial exemption from antitrust laws).

8. See Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Dep't. of Justice, to John R. Ferguson, Swidler & Berlin (Oct. 1, 1993) (announcing the Dep't of Justice's intention to oppose the Pharmaceutical Manufacturers Association's propo-

also have pressed claims for immunity, or limitations on antitrust scrutiny.

B. Antitrust and Autonomy

Lost perhaps in the provider lobby's fusillade upon antitrust is the central role that body of law has played in promoting autonomy. It has helped preserve an environment conducive to professional independence while at the same time rejecting the claims of those who would impose coercive governmental or private regulatory schemes upon health care professionals.

First, it should be remembered that antitrust enforcers led the battle against those who would have thwarted the development of innovative systems that, in many ways, promote professional values. HMOs, for example, enable physicians to integrate their activities and direct their practices in accordance with protocols, incentives, and guidelines that they, in their professional judgment, deem best for the patient. In addition, the courts steadfastly have resisted attempts by some to misuse the antitrust laws to prohibit professional collaboration in establishing practice guidelines, or to inhibit professional boards and societies from adopting standards and excluding those who do not meet the standards. Two notable Seventh Circuit cases upholding reasonable, non-coercive efforts of physicians collectively to promote such standards and dispense information to the marketplace illustrate the point. In *Marrese v. American Academy of Orthopedic Surgeons*,⁹ the court rejected a physician's claim that an unwarranted denial of membership in a professional academy amounted to an illegal boycott. The Court required proof of an effect on competition and held that the mere loss of referrals would not suffice, absent proof that the Academy had prevented others from dealing with the doctor. Similarly, the Court in *Schachar v. American Academy of Ophthalmology*,¹⁰ broadly upheld the rights of medical groups to agree upon and promulgate standards that

sal to set maximum price increases among its members).

9. 977 F.2d 585 (7th Cir. 1992) (unpublished opinion) (stating that the professional academy's denial of membership is not an antitrust violation even if it makes it harder for plaintiff to receive referrals).

10. 870 F.2d 397 (7th Cir. 1989) (ruling that the professional academy did not violate antitrust laws in declaring a surgical procedure experimental because the academy did not impose enforcement requirements on its members).

may disadvantage some competitors, provided there is no effort to constrain others to abide by those standards.

Nor is there any evidence that professional goals are in any way sacrificed by enforcement of the antitrust laws. The Bierig Article does not cite any studies that suggest that the core of professional activities—promoting and sharing research, developing scientific methods, and advancing knowledge to improve patient care—are inhibited by the limitations placed on physician networks that the Article describes. Indeed, quality measures, such as they exist, tend to show above average performance for risk-bearing HMOs.¹¹ Moreover, it appears that it is those very entities, such as HMOs in which physicians have assumed financial risk, that have taken the lead in assembling information and developing practice parameters designed to improve quality and assure the link between treatments and outcomes.¹²

Only under a very skewed definition of “professional autonomy” could it be said that antitrust law improperly interferes with professional judgments. Antitrust law preserves the opportunity of physicians to adopt methods and standards based on scientific principles that command widespread acceptance in their community. Moreover, it preserves autonomy in the sense of encouraging professional independence as long as collective actions do not coerce others or impair efficiency through the exercise of market power. Physicians are free to create, own, and operate integrated networks; to credential participants in such networks according to almost whatever criteria they may choose (for example, only doctors with Case Western Reserve diplomas); to participate in selective credentialing by hospitals and other institutions; to participate in certification of medical specialists and accreditation of hospitals; to assess medical technologies; to recommend all manner of guidelines, protocols, or parameters governing appropriate medical practice; and to engage in peer review of the conduct of their fellow practitioners.¹³ What they may *not* do is engage in coercive practices that prohibit others

11. Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1518 (1994) (showing, through a literature survey, better or equivalent quality of care results for HMOs compared with fee-for-service plans).

12. See *GHAA Survey Shows Premium Decline, Record Enrollment Increases for 1995*, 2 Health Care Pol’y Rep. (BNA) 2051 (Dec. 12, 1994) (reporting that 82% of HMOs use specific clinical practice guidelines and 85% require staff to develop and implement guidelines).

13. See generally BARRY R. FURROW ET AL., 1 HEALTH LAW §§ 10-5-10-15 (1995).

from pursuing alternative conceptions of what is in the best interests of their patients, or form loose, uncoordinated networks of solo practitioners that are primarily devices to assure coordinated pricing or cause other anticompetitive effects. Hence, the limits, if any, that antitrust imposes on providers has little to do with their core “professional” endeavors.

C. Antitrust and Network Rivalry

In today’s climate of burgeoning competition among managed care providers, the most important objective of antitrust is to preserve the opportunity for the development of rivalrous health plans in each local market. Inter-plan rivalry is central to a policy of reliance on the marketplace to improve the health care system, whether or not federal or state governments decide to “manage” competition through legislative reforms. Consequently, preservation of market structures conducive to competition ranks as the most crucial role for antitrust enforcement.

For health plans to offer services at competitive prices, they must have the benefit of vigorous rivalry among providers in each “product market” for provider services. Ideally, then, each physician service market should remain free of cartelization schemes or dominant or oligopolistic market structures. The experience of the last twenty years makes it clear that competition can be subverted by a variety of antitrust abuses ranging from garden variety cartels that impede network formation, to professional restraints that inhibit willingness to join networks that demand new ways of practice or payment, and to structural impediments to competition arising from “overinclusive” provider networks. The bottom line of appropriate antitrust policy is fostering development of efficiently configured networks to compete on the basis of quality, price, outcomes, and other variables that employers and subscribers care about.

Is antitrust law successfully preserving rivalrous provider markets? It appears that government antitrust policy, reflected in the cases, speeches, policy statements, and advisory opinions has a credible record in this regard. Federal and state agencies, for the most part, have sent out the right message in their public pronouncements, guidelines, and advisory opinions. Moreover, they have challenged anticompetitive conduct and consolidations that threaten competitive provider market structures. However, the overall effectiveness of antitrust enforcement may prove to

be rather a different story. State and federal agencies may be too overwhelmed by the sheer magnitude of consolidation to appraise carefully the situation in countless local markets. Criminal enforcement seems to have disappeared in the wake of the government's Pyrrhic victory in the *Alston* case.¹⁴ Meanwhile, antitrust doctrine in the areas of standing and antitrust injury may have eviscerated the private cause of action as a meaningful source of monitoring anticompetitive conduct or market structure.

It must be acknowledged that preservation of competitive network structures poses especially thorny problems. Recent economic analysis questions whether a sufficient number of efficiently sized provider networks will develop to support effective competition in many markets. Demographic evidence suggests that a significant proportion of local health care services markets lack the population base to support the minimum number of integrated delivery systems (IDSs) necessary for inter-plan rivalry.¹⁵ In antitrust terms, the concern is that the demographic features of many parts of the country dictate that only oligopolistic provider networks will emerge. Consequently, tacit or explicit collusion that will undermine the cost-containment benefits of competition is likely in these markets. Furthermore, in sparsely populated areas, it may be possible only to organize hospitals and physicians into one efficiently sized network.¹⁶ With so much of the faith in managed competition riding on inter-plan rivalry, the importance of antitrust policy directed at maximizing the number and competitiveness of plans in each market is evident.

14. *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992) (affirming *per se* analysis of conduct, but remanding for new trial).

15. See Richard Kronick et al., *The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148 (1993) (noting that only 42% of the nation's population live in areas that could support three or more "classic HMOs;" that 63% live in areas that could support three plans providing most primary and acute care services but sharing facilities for certain hospital and tertiary care; and that 71% live in areas that could support three plans offering primary care but sharing some basic specialty services like cardiology and urology). See generally Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1521-23 (1994) (discussing various proposals for reorganization of the health care delivery system).

16. Greaney, *supra* note 15, at 1521.

II. CRITIQUE OF THE AMA POSITION

A. Misunderstandings of the Ancillary Restraint Doctrine

The Bierig Article argues that with respect to physician-sponsored networks, the rule of reason has been misinterpreted by the Supreme Court and the federal enforcement agencies. Unfortunately, Bierig betrays a faulty understanding of the proper analytic framework for evaluating restraints of trade and joint ventures. Although the case law is somewhat murky on this point, William Howard Taft's seminal *Addyston Pipe* decision¹⁷ sheds a widely acknowledged beacon of light on the appropriate methodology for distinguishing cartels from legitimate joint ventures and evaluating the competitive significance of the latter.

That decision advanced a classification scheme that designates as "naked" those restraints whose purpose or evident effect is to suppress competition in the market as a whole. Agreements that eliminate some degree of competition but are necessary to effectuate a cooperative enterprise that enhances overall competition in the market are deemed "ancillary." The consequence of classification as an ancillary restraint is examination under the rule of reason to determine if, after balancing procompetitive and anticompetitive effects, its net effect is to harm competition.

Understanding Taft's ancillary restraint doctrine requires an appreciation of its doctrinal underpinnings. The *Addyston Pipe* opinion sought to establish a coherent and workable methodology that avoided early Supreme Court explications of the Sherman Act that had vacillated from literal interpretations (condemning all restraints), to imprecise categories (such as whether a restraint was "direct" or "indirect"), to open-ended inquiries into all relevant facts bearing on "reasonableness." Taft adopted a decidedly pragmatic approach, but one that is widely acclaimed for incorporating the essential economic considerations that should drive antitrust policy.¹⁸

Importantly for purposes of analyzing the Bierig Article, *Addyston Pipe* employs a functional analysis that focuses on the

17. *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *aff'd as modified*, 175 U.S. 211 (1899).

18. See, e.g., ROBERT H. BORK, *THE ANTITRUST PARADOX* 26-30 (1978) (discussing Taft's decision in *Addyston Pipe* as "one of the greatest if not the greatest, antitrust opinions in the history of law").

operational nature of alleged restraints. It makes its key inquiries into the function a restraint serves in ordering business activities among the parties and proffered justifications based on the restraint's utility in accomplishing that objective.¹⁹ This is to be contrasted with consequential assessments that look to ultimate effect and inquire into all relevant facts that shed light on the restraint's impact on social welfare. The narrower focus of functional analysis recognizes the limited ability of courts accurately to identify markets, estimate market power, and evaluate effects.

The foregoing perspective clarifies how the ancillary restraint doctrine should be applied. To avoid categorization as a naked restraint, defendant must establish both that the cooperative arrangement is of the kind that produces integrative or other efficiencies and that the restraint is reasonably necessary to achieve those benefits. Commentators have stressed that the necessity requirement should not be converted into a search for the least restrictive alternative.²⁰ Nevertheless, it is important to insist that the restraint have a valid and significant nexus to the efficiency-enhancing endeavor because that requirement provides at least modest assurance that competitors' cooperative efforts will redound to the benefit of consumers. To understand this point, it is important to bear in mind that a restraint may have one or both of the following functions: (1) the creation or exploitation of economic power, and (2) the facilitation of productive cooperation. The ancillary restraint doctrine rests on the premise that restraint closely linked to efficiencies, and necessary to achieve them, generally are more likely to serve the second function. In addition, in cases involving both functions, the ancillary restraint doctrine serves to bound collective activity by limiting the exploitation of power to the achievement of efficiency goals.²¹

19. *Addyston Pipe*, 85 F. at 291 (stating that to be ancillary, and hence exempt from a *per se* rule, an agreement eliminating competition must be subordinate and collateral to a separate, legitimate transaction). See also Peter C. Carstensen, *The Content of the Hollow Core of Antitrust: The Chicago Board of Trade Case and the Meaning of the "Rule of Reason" in Restraint of Trade Analysis*, 15 RES. IN L. & ECON. 1, 14 (stating that "[a] functional analysis focuses on whether or not the particular restraint can in fact have the function claimed for it and whether or not it is as limited as it can be to achieve only that functional goal.").

20. See, e.g., PHILLIP E. AREEDA, 7 ANTITRUST LAW ¶ 1505b (1986) (stating that "[t]he key difficulty in examining less restrictive alternatives lies in deciding how refined a distinction to make among the possible alternatives.").

21. See Carstensen, *supra* note 19, at 10 (stating that "[b]y definition, society sacrifices in a purely ancillary restraint no more economic value than is essential for the achievement of the legitimate, that is, socially sanctioned, primary objective.").

Ultimately, Bierig's analysis would have courts abjure summary condemnation (presumably under per se or other truncated forms of review)²² based upon consequentialist analysis. Specifically, his argument in favor of automatic rule of reason treatment for all networks rests on the assumption that numerous other networks controlled by insurers, employers and third party payors would prevent supracompetitive pricing.²³ By requiring proof of market power and other facts before condemning restraints, this approach would defeat the purpose of presumptive rules. The potential mischief of such a rule is seen in its application to the numerous "sham" PPOs and IPAs that have been dealt with in the past by summary condemnation by antitrust enforcers.²⁴ Forcing the government to establish a potential effect on price under the rule of reason almost certainly would defeat most prosecutions of such cases; given the strictures of proving a case under the defendant-friendly rule of reason (discussed below), one would expect these obvious cartels to go unpunished.

Moreover, Bierig scarcely mentions the other essential prong of the ancillary restraint doctrine: that is, that the restraint must be reasonably necessary to achieve the benefits of integration. There is no obvious nexus between physician joint ventures setting prices and achieving the presumed administrative and transaction cost savings of forming a network.

22. See *In re Massachusetts Bd. of Registration in Optometry*, 110 F.T.C. 549, 585 (1988) (adopting a three-prong inquiry into restraints of trade that permits "quick look" or truncated scrutiny and avoidance of the full requirements of the rule of reason).

23. Bierig, *supra* note 1. at 120. (stating that "[i]f physician-sponsored networks offering services on a discounted fee-for-service basis do not control costs, they will be economically unattractive and will fail in the marketplace."); *Id.* at 121 (stating that "[p]hysician-sponsored networks must be prepared to compete on the merits if they are to succeed in the market. They are in no position to dictate terms to purchasers. In these circumstances, it is both anticompetitive and unfair to require physician-sponsored networks to comply with prophylactic rules that are not applied to insurer-sponsored networks."). See also Jack R. Bierig, *Antitrust and Physician Involvement in Managed Care: Reform is Needed!* 18-19 (Jan. 11, 1995) (unpublished paper presented to the Physician Payment Review Commission) (on file with *Health Matrix*) (recommending like application of antitrust laws to physician-sponsored and insurer-sponsored networks).

24. Southbank IPA, Inc., 57 Fed. Reg. 2913 (Fed. Trade Comm'n 1992) (dissolving IPA by consent decree for unfair trade practices). See also Charles F. Rule, *Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation*, Address Before the Antitrust and Health Care Seminar of the Antitrust Section of the Connecticut Bar Association and the Connecticut Health Lawyers Association (Mar. 11, 1988), in JOHN J. MILES, 4 *HEALTH CARE & ANTITRUST LAW*, app. at E11 (1992) (discussing the evaluation of PPOs for antitrust violations); J. Paul McGrath, Assistant Attorney General, Antitrust Division, Remarks at the 33rd Annual ABA Antitrust Spring Meeting (Mar. 22, 1985), in JOHN J. MILES, 3 *HEALTH CARE & ANTITRUST LAW* (1992).

B. Price-Setting and Risk-Sharing

Bierig's second line of argument relies on a functional analysis more in keeping with the *Addyston Pipe* framework. Urging that physician-sponsored networks should be able collectively to set prices where they do not share risk through capitation or fee withholds, he argues that there are sufficient efficiency-enhancing benefits associated with offering a new service, shared administrative arrangements, and other cooperative efforts in PPOs that they should not be treated as simple price-fixing endeavors. In essence, Bierig can be understood to argue that a close appraisal of the functional relationship of the restraint to its legitimate, procompetitive purposes should prevent per se scrutiny.

To the extent that physician-controlled networks undertake cooperative activities that amount to significant integration of the kind just described, and that price agreements are necessary to realize those benefits, it might seem at first blush that price agreements among physicians in such plans should escape classification as a naked restraint. It is true that many PPOs undertake detailed reviews of participating physicians' utilization patterns and of the quality of care they provide. Often, case management and other forms of cooperative integration are present and effective sanctions, such as disaffiliation, are imposed upon physicians who do not meet the group's standards. Any plan with such restrictions would seem to produce a product that is truly distinct from the individual services provided by the PPO's members and qualify as a "new product" as that term is used in *BMI*.²⁵

Standing in the way, of course, is *Maricopa*²⁶, in which the Supreme Court held up risk-sharing as the talisman of a legitimate joint venture and struck down a plan whose principle integrative activities were assembling a network and performing administrative, utilization review, and negotiation services. *Maricopa*, moreover, raised (and answered in the negative) the legitimate question as to whether collective price-setting is a "reasonably necessary" corollary for the PPO to market itself efficiently.

As to the risk-sharing requirement of *Maricopa*, I have suggested that where legitimate integration does not include sharing in the risk of medical overutilization, antitrust analysis might accept other significant forms of integration and abandon its "all-

25. *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1 (1979).

26. *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982).

or-nothing" approach.²⁷ But at the same time, the finder of fact should not assume that modest integration is as likely to reduce the potential to harm competition as more complete integration. However, courts should be careful to avoid the trap of associating mere assembly of a network of providers with achievement of meaningful integration. Most cartels and virtually any form of "joint selling agencies" achieve some transaction cost economies. Yet, as the Supreme Court was careful to point out in *BMI*, only when those economies amount to an integration creating a "different product" will per se treatment be inappropriate.²⁸

In essence, a sliding scale should be developed for dealing with cases falling in the grey area of non-risk sharing integration: limited integration, stricter limits on market share, or perhaps a lesser burden of proof required of plaintiff. My proposal rests on several points. First, it is no secret that the rule of reason, as currently interpreted, has become a defendant's paradise. Few, if any, plaintiffs can shoulder the burden of proving markets, market power, absence of likely entry, likelihood of collusion, and the myriad of other requirements entailing highly speculative evidence that have been heaped upon them. The wisdom of allowing horizontal competitors engaged in price-setting while proffering only marginal efficiency benefits to enjoy the full splendor of the rule of reason seems dubious.

A second rationale for my approach is found in the reasons supporting the emphasis placed on risk sharing by the Supreme Court in *Maricopa* and the Department of Justice and Federal Trade Commission (FTC) in their joint policy statements on this subject.²⁹ Strict emphasis on the importance of providers sharing risk, and in particular, sharing the risk of overutilization or high costs of services, is entirely appropriate given the peculiar mar-

27. See Greaney, *supra* note 15, at 1529-32. See also Thomas L. Greaney & Jody L. Sindelar, *Physician-Sponsored Joint Ventures: An Antitrust Analysis of Preferred Provider Organizations*, 18 RUTGERS L.J. 513, 586-89 (1987) (noting that market share, market concentration, and procompetitive effect should be analyzed in identifying presumptive risk); FURROW ET AL., *supra* note 13, at § 10-35.

28. See *BMI*, 441 U.S. at 21 (stating that "[t]o the extent that the blanket license is a different product, [BMI] is not really a joint selling agency offering the goods of many sellers").

29. U.S. DEP'T OF JUST. & FED. TRADE COMM'N, STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST (1994), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,152 (Sept. 30, 1994) [hereinafter 1994 ANTITRUST ENFORCEMENT GUIDELINES] (noting requirement of shared risks as qualification of physician network joint venture for antitrust safety zone).

ket conditions of health services delivery and insurance.³⁰ For example, risk sharing through capitation deals effectively with moral hazard in insurance by forcing providers to bear the financial consequences of overutilization. That is, risk-based payment encourages providers to practice cost-effective medicine and mitigates the perverse incentives of insurance and information inadequacy. Moreover, providers sharing substantial risk of success of a network are more likely to maximize efficiencies associated with integration.

The essential point is that while less complete integration arguably may enhance efficiency by lowering certain transaction costs and joint expenses, such arrangements do not effectively go to the underlying incentives facing individual providers, especially where providers are members of multiple plans. Indeed, the "free-rider" and fragmentation problems associated with cost containment where individual health plans do not command participating physicians' loyalty and cannot capture the benefits of innovations in cost containment are exacerbated where there is no meaningful sharing of risks. Individual physicians simply have little reason to toe the line when reimbursement is not closely tied to their individual efforts to control costs.

C. Size of Networks

Bierig's second proposed reform would grant provider-controlled networks latitude to include large numbers of participating physicians. He suggests that antitrust doctrine should be interpreted to allow physician networks to include the same percentage of physicians in the market as do networks controlled by third party payors. Alternatively, he argues that legislation should fix an appropriate benchmark.³¹ Bierig does not attempt to defend this proposal seriously on legal or economic grounds. He offers no precedents or economic foundation for supposing that a horizontal combination of such magnitude should escape antitrust scrutiny. Instead, he advances vague notions of equity, claiming that physician networks suffer discriminatory treatment and are

30. For a more complete development of this argument, see Greaney, *supra* note 15, at 1531.

31. AMA-endorsed legislative proposals have suggested establishing safe harbors for networks comprised of 50% of the physicians in a market. See *AMA Suggests Refinement*, *supra* note 5, at 487.

prejudiced unnecessarily in the market. Of course, on a fully developed factual record, it may well be that a network possessing the legitimate integrative attributes discussed in the previous section could satisfy the necessity requirement by establishing the linkage between obtaining commitments from physicians to change their practice patterns and an agreement on fee levels.

Nevertheless, on Bierig's broader claim that competitive equity requires loosening restrictions on network size, the supposed inhibitions are more imagined than real.

Following *Maricopa*, even if integrative efficiencies are present, summary condemnation still may be appropriate because price-fixing is probably not necessary to achieve those benefits. There is no obvious reason why administrative coordination and network formation cannot go forward without physicians collectively setting their fees. Separate fee negotiations with physicians is entirely feasible: indeed, contrary to Bierig's claim, it is closely analogous to what third party payors routinely do to set up their own networks.

First, there is no hard and fast antitrust rule that would inhibit physicians forming networks where economies of scale or other factors dictate exceeding the thirty percent threshold. As the policy statements make clear, that figure only represents a "safety zone" that may be exceeded in small markets and other circumstances.³² Indeed, the agencies' advisory opinions have approved networks with physician panels that exceeded the safety zone.³³ More tellingly, enforcement actions make it clear that antitrust does not inhibit provider-controlled plans from assembling large networks of physicians: it limits only the degree to which core "owner" physicians can use their plan to advance price or utilization objectives. Consent decrees recently entered into be-

32. 1994 ANTITRUST ENFORCEMENT GUIDELINES, *supra* note 29, at ¶ 20,788-89 (noting that physician network joint ventures may exceed the 30% threshold under special circumstances without being held illegal *per se*).

33. Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, to George Miron, Feith & Zell (Dec. 8, 1993) (approving statewide California chiropractic managed care organization combining up to 50% of chiropractors in a relevant market); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, to Eugene E. Olson, Connolly, O'Malley, Lillis, Hansen & Olson (July 6, 1994) (approving Iowa provider network including more than 20% of physicians in 12 particular specialty areas); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, to John R. Cummins, Greenbaum Doll & McDonald (Oct. 27, 1994) (approving Kentucky provider network made up of 37% of area physicians).

tween the Department of Justice and two physician-hospital organizations permit provider controlled organizations to subcontract with a large number (indeed, potentially 100%) of the physicians in their markets.³⁴ A plan that meets the criteria suggested by the Antitrust Enforcement Guidelines may enter into subcontracts with an unlimited number of providers as long as the financial arrangements with the subcontracting physicians do not substantially replicate the compensation to the physician owners. By preserving incentives of the physician owners to bargain down the fees of subcontracting physicians, this arrangement promotes competitive pricing and does not lessen incentives for the subcontracting physicians to join competing plans. This option effectively demolishes the contention that physician networks are competitively harmed by antitrust's inhibition on their offering plans with wide provider choice. Thus, the law does not interfere with physician networks achieving efficiencies associated with larger membership than provided by the safety zone. In fact, there is no evidence that providers have been chilled in their efforts to form networks. Between fifteen and twenty percent of all managed care entities are provider-controlled, and nearly three-fourths of all state medical societies are in the process of establishing physician-sponsored networks.³⁵

More fundamentally, the different treatment of physician- and payor-controlled networks reflects the distinction, well-established in antitrust law and solidly rooted in economic theory, between the risks associated with vertical and horizontal restraints of trade. Simply put, vertical combinations are more likely to have integrative efficiency justifications, and to realize them, than are horizontal combinations. There is no reason to assume that independent third party payors willingly will overpay for physician inputs. By contrast, combinations of competing doctors jointly setting fees are hardly as likely to be vigilant in insisting on price concessions from their members. Moreover, as noted earlier, in this industry competitive risks associated with

34. *United States v. HealthCare Partners, Inc.*, No. 395-CV-01946RNC (D. Conn. filed Sept. 13, 1995), 61 Fed. Reg. 3731 (1996) (describing final consent judgment); *United States v. Health Choice of Northwest Missouri*, Civ. Action No. 95-6171-CV-SJ-6 (W.D. Mo. filed Sept. 13, 1995), 60 Fed. Reg. 51,808 (1995) (publishing final consent judgment).

35. See *PHYSICIAN PAYMENT REV. COMM'N*, *supra* note 4, at 294-95 (summarizing surveys and concluding that the evidence concerning enforcement of antitrust laws does not warrant legislative amendments to those laws).

horizontal combinations are particularly acute. Overly broad physician networks reduce the number of integrated health plans one can expect to develop in a market. As suggested by the *New England Journal of Medicine* study, a large proportion of the country can support only a limited number of plans and hence make the prospects of effective competition precarious.³⁶ Permissive antitrust rules that countenance large physician-controlled networks likely will reduce the number of effective competing plans in the numerous markets and entrench oligopolistic provider affiliations, thus undermining the benefits of managed competition.

D. The AMA's Plea for Legislative Relief

Bierig urges that if the antitrust laws cannot be interpreted to permit physician-controlled networks to develop as he proposes, Congress should adopt appropriate legislative exemptions. A vaguely worded legislative exemption would carry considerable risk. It may be construed in such a way as to make it impossible to prosecute garden-variety cartels, for example by allowing minimal integrative activities to necessitate full-blown rule of reason analysis. Moreover, the grounds for his claim that physicians need to combine in large networks they control remains unclear. Physicians already are free to form risk-sharing networks of all kinds, so the specific problem must lie with the requirement that physicians assume financial risk. This places the physician community in the untenable position of petitioning for leave to coordinate their pricing activities without undertaking to integrate their clinical practices or to assume financial arrangements that provide incentives and avoid overutilization of services. All this without a hint that physician control of networks would somehow improve service, competitiveness, or somehow uniquely add value. Coupled with the request to combine networks consisting of the lion's share of physicians in each market, the proposal begins to sound like a rear-guard action to slow the pace of managed care's reconfiguration of the physician marketplace.

36. See Kronick et al., *supra* note 15.

CONCLUSION

In an ideal world, antitrust analyses would appraise under the rule of reason those physician networks falling in the grey area between risk sharing and less-complete forms of integration, carefully weighing competitive harms against benefits. However, it bears reminding that, as an administrative system, antitrust law is only as good as the ability of judges, prosecutors, and lawyers to understand and apply it. As Justice Breyer has cautioned, “[r]ules that seek to embody every economic complexity and qualification may well, through the vagaries of administration, prove counter-productive, undercutting the very economic ends they seek to serve.”³⁷ Hence, antitrust law appropriately resorts to proxies. Given the peculiar economics of health care, risk sharing provides a passable proxy for the degree of integration and hence the likely efficiency benefits of physician network ventures. While a more refined analysis might be desirable, it would be necessary to take into account the extent of meaningful physician integration in assessing potential harms. Such finely tuned balancing may well prove to be beyond the ken of we mere mortals who labor in the vineyards of antitrust law.

37. *Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d 227, 234 (1st Cir. 1983).

