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Antitrust Safety Zones for Physician Network Joint Ventures: Physician, Heal Thyself

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> *I swear by Apollo the physician . . . and all the gods and goddesses that according to my ability and judgment I will keep this oath . . . . Into whatever houses I enter, I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption . . . .*
>
> — The Hippocratic Oath[1]

Introduction

When Hippocrates, the "father of medicine,"[2] penned this canon of ethics for physicians, he certainly could not foretell its similarities to modern antitrust laws. The Hippocratic Oath, from a micromanagement perspective, aimed at potential abuse and corruption among physicians, while two millennia later, Congress promulgated the Sherman Antitrust Act[3] from a macromanagement perspective to preserve free and unfettered competition in the marketplace as a whole.[4] The goal of protecting the consumer from unfair practices premises both documents.

The medical profession has evolved therapeutic miracles and lifesaving treatments during the two millennia since Hippocrates, with a majority of these advances occurring in the last several decades.[5] However, the economic, legal and business environment for physicians[6] has also changed dramatically, especially in the last

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1. Hippocrates of Cos, *The Hippocratic Oath* (400 B.C.), *in* 3 THE ENCYCLOPEDIA OF PHILOSOPHY 6-7 (Paul Edwards ed., 1967).

2. The Greek philosopher Hippocrates of Cos lived between 460-377 B.C. and is often referred to as the "father of medicine." The Hippocratic Oath is part of the Hippocratic Collection which consists of works primarily from the Hippocratic School and probably contains only a few of Hippocrates' own works. The Hippocratic Oath is the most famous of this collection, yet its true authorship is unclear. The Oath has been the ethical code for physicians since ancient Greece. *See generally* THE ENCYCLOPEDIA OF PHILOSOPHY, *supra* note 1, at 6-7.

3. 15 U.S.C. § 1 (1994).

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Id.

4. Northern Pac. R.R. v. United States, 356 U.S. 1 (1958). Justice Black stated, "The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade." *Id.* at 4.

5. Erik Eckholm, *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994, at A1.

6. The term "physician" is used throughout this comment, but the thesis of the paper can apply to

twenty years,[7] perhaps the most significant upheaval being increased competition for patients among physicians. Consequently, many doctors have been forced to join innovative health care provider networks that promise adequate patient populations so that the individual physician might survive in this new environment.[8] The formation of these complex physician alliances often creates, whether intentionally or unintentionally, targets for antitrust actions by the federal government and private parties. Until recently, little guidance has been given to physicians about what practices are acceptable within the ambit of antitrust legislation.

On September 27, 1994, the Federal Trade Commission (FTC) and the Department of Justice's Antitrust Division (DOJ) (the Agencies) jointly issued the "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust" (the joint statement),[9] superseding their antitrust guidelines for health care alliances issued a year earlier.[10] The Agencies intended to resolve any antitrust uncertainty surrounding the formation of physician network joint ventures with this enforcement policy statement which established, *inter alia*, antitrust safety zones encompassing certain physician network joint ventures that will not be challenged, absent extraordinary circumstances, under the antitrust laws.[11] Their joint statement also instituted antitrust guidelines for the Agencies to analyze physician network joint ventures falling outside these prescribed safety zones.

Despite these guidelines, some commentators argue that federal antitrust laws must be reformed to protect physicians from antitrust sanctions and to facilitate cooperative ventures between physicians.[12] At the same time, other commentators contend that federal antitrust regulations, as presently written and sensibly enforced, provide the

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most health care providers, such as dentists, radiologists or cardiac technicians.

7. *See* Eckholm, *supra* note 5, at A2.

8. Carl H. Hitchner et al., *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273, 275 (1994) (discussing various integrated deliver systems for health care providers).

9. U.S. Dep't of Justice & U.S. Federal Trade Comm'n, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*, Antitrust & Trade Reg. Rep. (BNA) No. 67, at 385 (Sept. 27, 1994) [hereinafter *Revised Joint Statement*].

10. 4 Trade Reg. Rep. (CCH) ¶ 13,150 (Sept. 15, 1993) [hereinafter *Joint Statement*].

11. *See Revised Joint Statement*, *supra* note 9, at 387. On September 27, 1994, The Department of Justice and the Federal Trade Commission jointly issued nine statements of their antitrust enforcement policies regarding mergers and joint activities among health care providers.

> The nine statements cover: (1) Mergers among hospitals; (2) Hospital joint ventures involving high-technology or other expensive health care equipment; (3) Hospital joint ventures including specialized clinical or other expensive health care services; (4) Providers' collective provision of non-fee-related information to purchasers of health care services; (5) Providers' collective provision of non-fee-related information to purchasers of health care services; (6) Provider participation in exchange of price and cost information; (7) Joint purchasing agreements among health care providers; (8) Physician network joint ventures; and (9) Analytical principles relating to multiprovider networks.

Id.

12. *See generally* EDWARD B. HIRSHFELD, THE CASE FOR ANTITRUST REFORM FOR PHYSICIAN GROUPS 97 (PLI Commercial Law & Practice Course Handbook Series No. 694, 1994) (arguing that federal and state antitrust laws should be reformed to facilitate certain cooperative activities by physicians).

needed flexibility for physicians to form legitimate joint ventures.[13] Although the joint statement moves toward elucidating antitrust guidelines for physician network joint ventures, it falls short of reaching the goal of truly facilitating physician alliances that could ameliorate the health care crisis.[14]

This comment proposes a practical approach to avoiding the antitrust risks surrounding the development, structure and implementation of physician network joint ventures. The FTC and DOJ joint statement can serve as a foundation upon which pragmatic modifications can be built to reduce the risk of and to optimize the ability to form legitimate physician networks. Although this comment suggests considerable refinements, the end result is achieved without affronting the intent of the antitrust laws.

Part I of this comment provides a historical perspective of the market realities driving increased competition among physicians today. Part II presents an outline of the development of antitrust jurisprudence within the health care industry. Part III focuses on the organizational structure of the major types of physician network joint ventures. Part IV defines today's legal standards for legitimate joint ventures. Part V highlights the salient non-price fixing antitrust litigation involving physician network joint ventures. Part VI focuses on the original FTC and DOJ joint statement as historical precedence to future refined guidelines. Part VII examines the validity of criticisms of the original joint statement by several industry policy makers and the American Medical Association. Part VIII highlights the restrictiveness of the newly revised joint statement. Part IX examines the transformations occurring in today's health care provider market that indicate the ineffectiveness of the safety zones. Part X suggests modifications to the revised joint statement for the formation of physician network joint ventures. Although these suggestions only address federal antitrust laws, they could apply equally as well to state antitrust laws.

I. Health Care Market Realities

The traditional view of a physician has been a "person skilled in the art of healing."[15] This perception has positioned the profession prominently and respectfully throughout the centuries. As a result, physicians have been rewarded handsomely for their skills. However, the comfortable lifestyles of physicians have been criticized recently because of what some claim are profligate profits at their patients' expense.[16]

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13. David L. Meyer & Charles F. Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 171 (1994) (arguing that federal antitrust laws provide sufficient flexibility for collaborative health care delivery efforts).

14. Letter from Kirk B. Johnson, General Counsel, American Medical Association, to Anne K. Bingaman, Assistant Attorney General, Antitrust Division, United States Department of Justice, and Janet D. Steiger, Chairman, Federal Trade Commission (Oct. 6, 1993) (on file with the American Medical Association) [hereinafter AMA Letter].

15. THE RANDOM HOUSE UNABRIDGED DICTIONARY OF THE ENGLISH LANGUAGE 1462 (2d ed. 1987).

16. *See generally* HOWARD METZENBAUM, ANTITRUST ENFORCEMENT: PUTTING THE CONSUMER FIRST 579 (PLI Commercial Law & Practice Course Handbook Series No. 694, 1994) (discussing the reasons against antitrust reform based on the testimonies given at the March 23, 1993, meeting of the

This shift in society's perception of physicians seems driven in part by the escalating health care costs, currently rising at a rate outpacing inflation and far exceeding annual cost of living increases.[17] During 1993, national health care expenditures accounted for more than 14% of the United States' Gross Domestic Product (GDP), and outlays for health care are projected to increase at more than 10% each year.[18] The Department of Commerce predicted that health care expenditures will exceed one trillion dollars and account for a record 15% of the nation's GDP for 1994, and this estimate appears to be remarkably accurate.[19]

A. The Financing Crisis

In a free market economy, rising expenditures for products usually indicate a strong demand and reflect the consumers' willingness and ability to pay for the product.[20] But in the health care microcosm, consumer necessities drive demand. To further compound the current health care financing crisis, consumers are frequently unable to evaluate most products or services. More importantly, the cost of health care products and services often exceed the consumers' ability to pay.[21] Thus, rising expenditures in the health care microcosm will lead inevitably to a financial "crisis" of gargantuan proportions.[22]

This monetary crisis in health care has been chronicled by virtually every media pundit, and even President Bill Clinton opined that "America's businesses will never be strong; America's families will never be secure; and America's government will never be solvent until we tackle our health care crisis."[23] Indeed, a majority of Americans believe that the country's health care system is in a crisis.[24]

Physicians find themselves at the epicenter of this crisis, unable to find shelter, and this country's citizens are hardly sympathetic. In a recent poll, 81% of Americans said that physicians charged too much for their services, and more than half believed

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Antitrust, Monopolies and Business Rights Subcommittee of the Judiciary Committee chaired by Senator Metzenbaum). *But see* Julius B. Richmond, M.D. & Rashi Fein, M.D., *The Health Care Mess: A Bit of History*, 273 JAMA 1, 69 (1995) (arguing that the public image of the national health care crisis is inconsistent with historical records).

17. Murray S. Monroe, *Health Care: Current Antitrust Issues*, 20 N. KY. L. REV. 365, 365 (1993).

18. Kevin E. Grady, *A Framework for Antitrust Analysis of Health Care Joint Ventures*, 61 ANTITRUST L.J. 765, 765 (1993).

19. Robert Pear, *$1 Trillion in Health Care is Predicted*, N.Y. TIMES, Dec. 29, 1993, at A12.

20. *Id.*

21. *Id.*

22. Arnold S. Relman, *Patients Can't Play the Health Market*, NEWSDAY, Nov. 17, 1993 at 117. Arnold S. Relman is editor-in-chief emeritus of the *New England Journal of Medicine* and a professor at Harvard Medical School.

23. President William J. Clinton, A New Direction, State of The Union Address to the Joint Session of Congress (Feb. 17, 1993), *available in* LEXIS, Newswire Library, Presdc File.

24. Julie Kosterlitz, *Brinkmanship*, NAT'L J., July 9, 1994, at 1648 (stating that a CNN-USA Today poll indicates 62% of Americans believe the health care system is in a crisis); *see also* William Schneider, *Health-Care Bill Is in Crisis: Republican Arsenal Could Block Reform*, BOSTON HERALD, July 10, 1994, at 25 (stating that a CNN-USA Today poll indicates 51% of Americans believe the health care system is in a crisis).

physicians deserved some or all of the blame for the American health care crisis.[25] Even physicians agree that health care financing is in critical condition.[26] However, most physicians insist that they are not the cause of the problem.[27] As one physician lamented, "To blame the physicians is like blaming the police for crime."[28]

Who or what then is the cause of the health care "crisis"? Shifts in the financial structure of the health care industry have radically restructured American medicine in the last ten years, and this social reordering is the real culprit.[29] Before this decade, consumers purchased their health care components in a piecemeal manner.[30] The consumer first chose a health insurance carrier, then selected a physician, and if necessary, decided on a hospital with their physician's guidance.[31] In most cases, there was no contractual relationship that tied together these three players into a health care purchasing unit.[32] More importantly, health care providers usually were paid whatever they charged to treat the patient with the only guideline being a usual and customary fee stipulation.[33] But this traditional fee-for-service structure is falling to society's demand to rein in the runaway costs of health care.

B. The Cure of Competition?

In an effort to quell the crisis of escalating costs, the federal government and private insurers instituted cost controls on health care providers in the early 1980s,[34] beginning the end of the traditional financing of the health care delivery system. Perhaps the most significant cost containment measure of this age was the 1983 revision of the Social Security Act[35] which restructured the hospital payment system under Medicare.[36] Under this restructured payment scheme, hospitals no longer received retrospective reimbursement for the actual cost plus a profit percentage for treating hospitalized patients. Instead, compensation to hospitals shifted to a prospective payment system of 453 fixed price formulas known as diagnostic related groups (DRG) to determine payments for treating individual Medicare patients.[37]

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25. Melinda Beck et al., *Doctors Under the Knife*, NEWSWEEK, Apr. 2, 1993, at 28.

26. *Id.*

27. *Id.*

28. *See id.* (quoting Tim Norback, executive director of the Connecticut State Medical Association).

29. *See* Relman, *supra* note 22, at 117.

30. *See* HIRSHFELD, *supra* note 12, at 104.

31. Jonathan B. Baker, *Vertical Restraints Among Hospital, Physicians and Health Insurers That Raise Rivals' Costs*, 14 AM. J.L. & MED. 147, 147-48 (1993).

32. *Id.*

33. *See* HIRSHFELD, *supra* note 12, at 103.

34. John Horty, *The Changing Perception of the Hospital: A Prescription for Survival*, 24 DUQ. L. REV. 367, 371 (1985).

35. Act of Sept. 3, 1982, Pub. L. No. 97-248, tit. I, § 101(b)(3), 96 Stat. 335 (codified as amended at 42 U.S.C. § 1320b-5 (1988 & Supp. V 1993)). Regulations promulgated pursuant to this statute may be found at 42 C.F.R. §§ 405.470-.477 (1994).

36. *See* Horty, *supra* note 34, at 371.

37. *See generally* 42 U.S.C. § 1320b-5 (1983).

Many private insurers quickly followed with similar disease specific plans for payment of hospital costs.[38]

About this time various merger and contractual affiliations among hospitals, physicians, and insurers began to form in a proactive attempt by these groups to sustain their own profit margins.[39] The insurers typically provided a pool of beneficiaries, while the physicians and the hospitals provided the health care services. These providers joined together *ex contractu* in an effort to lower the cost of providing health care and to enhance their own profitability.[40] These organizations, known as health maintenance organizations (HMOs)[41] or managed care organizations (MCOs), manage the provision and payment of a wide range of health care services provided to their enrolled clientele.[42]

The emergence of MCOs squeezed the compensation of participating physicians in several ways.[43] First, some MCOs negotiated discounted fee contracts with the physicians.[44] Second, some MCOs withheld a percentage of the fees and only returned this withhold if certain patient treatment utilization or underutilization goals were met.[45] Third, some MCOs paid physicians a fixed annual amount to perform all of the specified health care procedures for the MCOs beneficiaries, known as a capitation arrangement.[46] And finally, some combination of these payment methods was the modus operandi for most of these new conjoined entities.[47]

In addition to the MCO affiliations, independent physicians also began to form health care delivery networks among themselves.[48] Although these physician organizations vary, a typical network consists of a group of competing physicians that cede some of their individual financial and managerial autonomy to a network organization so that these doctors might access expanded patient populations from various health care purchasers, such as MCOs, the government, or large employers.[49]

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38. *See* Horty, *supra* note 34, at 371.

39. *See* Baker, *supra* note 31, at 148.

40. *See* HIRSHFELD, *supra* note 12, at 105.

41. *See infra* notes 111-14 and accompanying text for a more detailed discussion of health maintenance organizations.

42. *See* HIRSHFELD, *supra* note 12, at 103.

43. *See id.*

44. Daniel McGlinn et al., *A Day in the Life of A Physician*, 73 MICH. B.J. 142, 142 (1994)

45. David S. Hilzenrath, *In Managed Care, Some Doctors Trip on the Bottom Line*, WASH. POST, Aug. 8, 1994, at A1. The author explains utilization goals in regards to withhold as

> [when] health plans withhold a portion of the doctors' payments — 20 percent, for example — until the end of the year, when they [the plan administrators] measure how patients' expenses for things such as specialty referrals, hospital care and prescription drugs compare with a target amount. Depending on the result, the doctors receive none of the withheld money, some of it or all of it, plus a possible bonus.

Id.

46. *See* Baker, *supra* note 31, at 150. Capitation is a method of compensation where "doctors and hospitals contract to provide care for all patients of the HMO during a year in exchange for a fixed fee per patient." *Id.*

47. *See id.*

48. *See* HIRSHFELD, *supra* note 12, at 103.

49. *See* Meyer & Rule, *supra* note 13, at 172.

These physician networks usually offer services at reduced rates, essentially replicating the provider component of the MCOs, but retaining the flexibility to deal with multiple health care purchasers.[50]

The days of purchasing health care in separate components are now long gone, and health care reform is forcing collaborations among health professionals whose common goal is to reduce costs so that their own income level is preserved. Although these collaborative efforts among competitors are premised on the lofty goal of reducing health care costs, many of the physician networks operate at the edge of antitrust violations. Therefore, reasonable antitrust guidelines are needed to allow physician network joint ventures to operate, or the nation's health care crisis is destined to worsen if such alliances are struck down by judicial decree or agency fiat.

II. Antitrust Policy

While the economics of health care enterprises has undergone a metamorphosis, the principles of antitrust laws remain little changed.[51] In broad terms, the philosophical goal of antitrust law is to eliminate business practices that interfere with free competition; however, two operational requirements, one economic and one social, are necessary to achieve this philosophical objective.[52] Socially, a market environment based on diffusion of economic power leads to the maximization of individual opportunity.[53] Economically, the maximization of market efficiency leads to enhanced consumer welfare.[54] Although endorsing these laudable goals, the health care industry has not infrequently tried to exempt itself from antitrust laws and has oftentimes succeeded.

A. Antitrust Laws and the Health Care Industry: Refusing Treatment

The health care industry's first response to an antitrust challenge was the lawyerly argument that the practice of medicine was not a "trade" as articulated in the Sherman Act.[55] The district court in *United States v. American Medical Association*[56] agreed with this argument but was later reversed by the Court of Appeals for the District of Columbia.[57] However, upon review, the United States Supreme Court left this "trade

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50. *See id.*

51. *See* Relman, *supra* note 22.

52. Northern Pac. R.R. v. United States, 356 U.S. 1, 4 (1958).

> The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive the preservation of our democratic political and social institutions. But even were that premise open to question, the policy unequivocally laid down by the Act if competition.

Id. at 4-5.

53. *Id.*

54. *Id.*

55. AMA v. United States, 317 U.S. 519, 527 (1943).

56. United States v. AMA, 28 F. Supp. 752, 757 (D.C. Cir. 1939).

57. United States v. AMA, 110 F.2d 703, 710 (D.C. Cir. 1940).

distinction" question unanswered when it refused to directly address the issue of "whether a physician's practice of his profession constitutes trade. . . under the Sherman Act."[58]

Thirty-two years later, in *Goldfarb v. Virginia State Bar*,[59] this trade denomination issue reappeared, but this time the focus was whether the practice of law was "commerce or trade."[60] The Virginia State Bar argued "that Congress never intended to include the learned professions within the terms 'trade or commerce' in section 1 of the Sherman Act."[61] Nevertheless, the Court reasoned that such a broad interpretation would allow lawyers "to adopt anticompetitive activities with impunity."[62] Therefore the *Goldfarb* Court concluded that "[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act, nor is the public-service aspect of professional practice controlling in determining whether section 1 includes professions."[63] Thus, the Court indirectly resolved the question it left unanswered in *American Medical Association, D.C.*;[64] and the purview of section 1 of the Sherman Act emphatically reaches the practice of medicine.

B. Medical Care: Interstate Commerce or Local Treatment?

Undaunted, the health care industry devised another approach to exempt itself from antitrust laws, claiming the practice of a learned profession is local in character and not involved in interstate commerce. The medical profession reasoned that medical care involved only intrastate commerce and thus fell outside the purview section 1 of the Sherman Act.[65] The operative legal theory of the profession in the mid 1950s was that medical practice, *a priori*, should remain sacrosanct, outside antitrust scrutiny.

In *United States v. Oregon State Medical Society*,[66] the United States Supreme Court determined that any effect on interstate commerce was "sporadic and incidental"[67] and failed to invoke the Sherman Act. In the Court's view "the sale of medical services, . . . [was] not trade or commerce within the meaning of Section 1

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58. AMA v. United States, 317 U.S. at 528 (deciding whether the business operations of Group Health Association, Inc., an early version of an HMO, was trade within the meaning of the Sherman Act).

59. 421 U.S. 773 (1975).

60. *Id.* at 786.

61. *Id.*

62. *Id.* at 787.

63. *Id.*

64. 28 F. Supp. 752 (D.C. Cir. 1939).

65. 15 U.S.C. § 1 (1994).

> Every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both punishments, in the discretion of the court.

Id.

66. 343 U.S. 326 (1952).

67. *Id.* at 339.

of the Sherman Anti-Trust Law . . . ."[68] Even though the government showed that some payments were made to out-of-state doctors, the Court curiously held that the Medical Society's activities were "wholly intrastate."[69]

Subsequent Supreme Court decisions weakened this "wholly intrastate" opinion of the earlier cases. In *Hospital Building Company v. Trustees of the Rex Hospital*,[70] Justice Marshall overruled a previous Fourth Circuit opinion[71] that held the provision of hospital and medical services were "strictly local, intra-state business."[72] Justice Marshall found that "[a]s long as the restraint in question 'substantially and adversely affects interstate commerce, the interstate commerce nexus required for Sherman Act coverage is established."[73] Marshall reasoned that a restraint on competition within a local hospital was "sufficient to establish a 'substantial effect' on interstate commerce under the Act."[74]

Four years later, the Supreme Court refined its local character argument in *McLain v. Real Estate Board of New Orleans, Inc.*[75] Although *McLain* involved activities outside the health care arena, the Court's reasoning applies as well to the local character analysis in a health care context. The *McLain* Court held that jurisdiction under the Sherman Act is satisfied if the business "activities which allegedly have been infected by a price-fixing conspiracy are shown 'as a matter of practical economics' to have *a not insubstantial effect on the interstate commerce* involved."[76] However, two differing judicial interpretations of the "not insubstantial" test have developed since *McLain*: (1) the "general business activities"[77] test, and (2) the "infected activities"[78] test.

The "general business activities" test originated in the Ninth Circuit in *Western Waste Service Systems v. Universal Waste Control*[79] which construed *McLain* to mean that general business activities, independent from the challenged activities, must have an effect on interstate commerce to invoke the jurisdiction of the Sherman Act.[80] Although *Western Waste* lacked any connection to the health care industry, the Court's broad interpretation of activities affecting interstate commerce seems to foreclose the argument that health care provision is only local in character. Virtually any activity in the health care setting potentially has a nexus to interstate commerce under the

68. *Id.* at 338.
69. *Id.*
70. 425 U.S. 738, 743 (1976).
71. 511 F.2d 678 (4th Cir. 1975).
72. *Id.* at 682.
73. *Rex Hospital*, 425 U.S. at 743 (quoting Gulf Oil Corp. v. Copp Paving Co., 419 U.S. 186, 195 (1974); Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 384 U.S. 219, 234 (1948)).
74. *Id.* at 744.
75. 444 U.S. 232 (1980).
76. *Id.* at 246 (emphasis supplied) (quoting Goldfarb v. Virginia State Bar, 421 U.S. 773, 784 n.11 (1975)).
77. Western Waste Serv. Sys. v. Universal Waste Control, 616 F.2d 1094, 1097 (9th Cir. 1980), *cert. denied*, 449 U.S. 869 (1980).
78. Crain v. Intermountain Health Care, Inc., 637 F.2d 715, 723 (10th Cir. 1980) (en banc).
79. 616 F.2d 1094 (1980), *cert. denied*, 449 U.S. 869 (1980).
80. *Id.* at 1097.

Western Waste test. In fact, according to one commentator, the "general business activities" approach in *Western Waste* has such broad jurisdictional reach that the interstate commerce requirement for the Sherman Act is meaningless.[81]

In *Crane v. Intermountain Health Care, Inc.*[82] the Tenth Circuit rejected the *Western Waste* general business activities analysis stating that "the challenged activity may in every practical economic sense be unrelated to interstate commerce."[83] The court set forth its standard by refusing "to presume the nexus between the challenged activity and interstate commerce."[84] The *Crane* court interpreted *McLain* to require "a critical relationship between the interstate commerce involved and the defendants' activities which allegedly have been infected by illegality."[85] Based on this "infected activities" test, the challenged activity itself must have a "not insubstantial effect" on interstate commerce.[86]

The *Crane* "infected activities" test and the *Western Waste* "general business activities" test split the circuits on the interpretation of the *McLain* interstate commerce test. Nevertheless, both decisions illustrate that the provision of health care can affect interstate commerce sufficiently to trigger antitrust jurisdiction. Therefore, the local character argument by the medical profession earlier in this century for limiting the reach of antitrust laws is justified only in the narrowest of circumstances in modern health care and most likely is not apposite.

C. State Action Exception: The Parker Prescription

The health care industry's most recent attempt to find limits to antitrust laws is the judicial recognition that certain state actions perforce provide antitrust immunity. The Supreme Court in *Parker v. Brown*[87] held that a state is not prohibited from acting in its sovereign capacity to impose restraints on competition.[88] In *Parker*, the Court held that a state program restricting competition among raisin growers in that troubled industry was immune from the Sherman Act because it was an action by the state.[89]

This state action exception was further refined in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*[90] The *Midcal* Court established a two prong test for recognition of a state action exception, requiring the challenged conduct to be "clearly articulated and affirmatively expressed as state policy"[91] and "actively supervised by the state itself."[92]

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81. Robert J. Enders, *Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges*, 17 LOY. U. CHI. L.J. 331, 339 (1986).
82. 637 F.2d 715 (10th Cir. 1981) (en banc).
83. *Id.* at 724.
84. *Id.*
85. *Id.* at 723.
86. *Id.* at 724.
87. 317 U.S. 341 (1943).
88. *Id.* at 351-52.
89. *Id.*
90. 445 U.S. 97 (1980).
91. *Id.* at 105.
92. *Id.*

To satisfy the first prong of the *Midcal* test, a state policy need not compel a state actor or state regulated party to act in a noncompetitive manner. Indeed, the actor or state is permitted to engage in anticompetitive conduct in order to achieve the state goals.[93] The second prong focuses on the state's necessary and active participation in the challenged activity.[94] In *Southern Motor Carriers Rate Conference, Inc. v. United States*,[95] state action immunity for private parties was only available "when the challenged activity is undertaken pursuant to a clearly articulated policy of the state."[96]

However, state action is not an absolute exemption for antitrust litigation in the health care industry as shown in *Patrick v. Burgett*.[97] The Supreme Court ruled that eleven Georgia physicians could not claim that their peer review of competing physicians was an extension of state regulatory powers and thus immune from the antitrust laws.[98] The *Patrick* Court reasoned that "[t]he state does not actively supervise [the competitive restraint] unless a state official has and exercises ultimate authority over private [medical staff] privilege determinations."[99]

The state action exception is a potential defense to federal antitrust actions in the health care industry, but the requirements are rather narrow, necessitating statutory support acknowledging the possible anticompetitive effects of the state action. Additionally, the statute must require active state involvement in the challenged process.[100] *Parker* and its progeny make it clear that, absent a state mandated regulation and state supervisory participation in the challenged activity, the state action exception is unlikely to be an effective barrier to antitrust actions.

D. The Future of Antitrust Actions in Health Care

Judicial interpretations of the antitrust laws' applicability to the health care industry has evolved along a continuum, from the pre-*Goldfarb* quasi-immunity status to the post-*Parker* limited exemptions. Our antitrust laws have moved to a limited tolerance of anticompetitive activities in all areas, including health care. This cautious advance of tolerance in antitrust scrutiny, not inconsistent with the social and economic goals of the antitrust laws, is faithful to Adam Smith's notion that the "invisible hand" of competition should guide the operation of the economy.[101]

Although the evolution of antitrust laws has promoted the philosophical goal of enhanced competition, the underlying social and economic goals do often conflict. When the social goal of diffusion of economic power to maximize individual opportunity runs contrary to the economic goal of maximizing market efficiency, antitrust laws are thrust into the conflict.

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93. *Id.*
94. *Id.*
95. 471 U.S. 48 (1985).
96. *Id.* at 63
97. 486 U.S. 94 (1988), *reh'g denied*, 487 U.S. 1243 (1988).
98. *Id.* at 105.
99. *Id.* at 102.
100. *Id.*
101. JOHN H. SHENEFIELD & IRWIN M. STELZER, THE ANTITRUST LAWS: A PRIMER 12 (1993).

If an economic interest has primacy in the judicial eye, then antitrust laws likely will be applied strictly to support competition. However, if the social interest appears just and dominant, permitting some anticompetitive activities might be necessary to promote exigent social goals, and consequently, the antitrust laws are likely to be more liberally construed by the courts to achieve the desired social end at the expense of competition.

In 1933 during the Great Depression, our country's social needs clashed with its economic goals requiring the Supreme Court to step into the fray and assess the applicability of the antitrust laws.[102] In *Appalachian Coals, Inc. v. Unites States*,[103] the Supreme Court allowed a majority of the Appalachian coal producers to eliminate competition among themselves in order to aid a depressed coal industry.[104] The Court permitted the arrangement reasoning that "[t]he interests of producers and consumers [were] interlinked. When industry is grievously hurt, when producing concerns fail, when unemployment mounts and communities dependent upon profitable production are prostrated, the wells of commerce go dry."[105]

Some commentators contend that *Appalachian* is "an anomaly in antitrust law with no status as a precedent."[106] They maintain that the "case was wrong even when decided, and clearly the result would not be the same today."[107] Notwithstanding these condemnations, *Appalachian* illustrates that sometimes the economic goals of antitrust laws override social goals in the Court's view.

Today's health care industry can be compared to the Depression-era coal industry. Certainly, the financing of health care has reached a crisis, and national debate rages over what remedies will resolve it. Physicians have taken the initiative with various joint ventures, but how these physician networks will be viewed by the courts under the antitrust laws remains problematic. Safety zones against antitrust investigation and penalties prescribed by the FTC and DOJ joint statement offer hope to the providers, but this safe harbor is shallow and is no breakwater to private antitrust actions.

III. Physician Network Joint Ventures

The changing economic structure of the health care industry catalyzed the formation of various physician network joint ventures, including managed care organizations (MCOs). Although the structure and operation of MCOs vary greatly, each is designed to reduce the cost of delivering health care while maintaining, and hopefully improving, the quality of the care. Indeed, health care economists with the AMA "predict that managed care will become the dominant type of health care plan

102. Appalachian Coals, Inc. v. United States, 288 U.S. 344, 351 (1933).

103. 288 U.S. 344 (1933).

104. *Id.* at 372.

105. *Id.*

106. John J. Miles & Mary Susan Philp, *Hospitals Caught in the Antitrust Net: An Overview*, 34 DUQ. L. REV. 489, 588 (1985).

107. *Id.*

throughout the nation by the end of the decade, without the intervention of government, due purely to the operation of market forces."[108]

As managed care has evolved, so too has the variety of physician networks to meet the industry's changing requirements. The major forms of MCOs tend to overlap and are best viewed as a continuum of health maintenance organizations (HMOs), preferred provider organizations (PPOs), independent practice associations (IPAs), group practices without walls (GPWWs),[109] medical foundations,[110] and numerous other structural entities. The FTC and DOJ joint statement specifically addresses only IPAs and PPOs, but there are sufficient connections to HMOs to require a brief overview of this particular form of physician network.

A. HMOs: One Stop Shopping

The HMO is probably the most highly recognized form of managed care network in today's health care continuum, but generally its composite structure is not widely understood.[111] An HMO is usually a prepaid health care network consisting of a centralized administrative and management organization, a health insurance carrier, and a group of participating health care providers who are either employees of the HMO or independent contractors providing services to the HMO's enrollees.[112]

Although the details of HMO structures can vary, their distinguishing characteristic is the integrated health care package providing management, payment, and delivery of all the enrollees' health care services by the single organization. The three major types of HMOs are further distinguishable by the relationships with participating providers. First, the "staff model" is the most staff integrated network with the HMO employing the providers. Second, the "group model" is less staff integrated, usually with contractual relationships between the HMO and groups of providers rendering

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108. *See* AMA Letter, *supra* note 14, at 3.

109. NEIL P. MOTENKO, ANTITRUST AND PHYSICIAN NETWORKS 229, 230 (PLI Commercial Law & Practice Course Handbook Series No. 694, 1994), *available in* Westlaw, JLR Library (Westlaw pagination at 3).

> In a GPWW, each physician practices independently in his or her own office. A variety of ownership options are possible. The separate offices may be combined as one legal entity, for which each office is a profit center. The GPWW may acquire some or all of the physicians' assets and employ the physicians on a salaried basis, or it may merely provide centralized administrative services for the member physicians' independently-owned practices.

Id.

110. Montenko describes medical foundations as follows:

> A medical foundation is a nonprofit organization which employs or contracts with physicians to provide medical services. Medical foundations may also own or affiliate with hospitals and managed care organizations. These entities enjoy the advantages of their tax-exempt status, including lower-cost financing and exemptions from local property taxes and federal payroll taxes.

See id., available in Westlaw, JLR Library (Westlaw pagination at 4) (quoting Tim Hudson, *Three Major Models*, HOSPS. & HEALTH NETWORKS, June 20, 1993, at 32).

111. *See* Eckholm, *supra* note 5, at A2.

112. HOSPITAL LAWYERS ASS'N, HOSPITAL LAW MANUAL, ch. 3, ¶ 1-3, at 2 (1993) [hereinafter HLA MANUAL].

professional services on a capitated basis.[113] Finally, the least staff structured version is the "IPA model," closely resembling the group model, but differing in the manner in which the fees are discounted with HMOs. In the typical IPA model, an HMO will contract with an IPA for provision of health care services and then compensate the providers or the IPA on a discounted fee basis.[114]

B. IPAs: Marketing Health Care Services

For the usual IPA marketing activities, participating health care providers maintain their individual practices but join together to market their services as an aggregate.[115] The IPA then functions as a unit to negotiate and contract with insurance companies, health care plans such as HMOs, and large employers. The IPA provides no health care directly, rather it arranges for health care provision through its member providers.[116]

Most IPA's function in two ways with prospective health care consumers. First, an IPA can contract directly with a health care plan[117] and agree to provide comprehensive health care to the health plan's subscribers.[118] IPAs also operate as a facilitator in the contractual negotiations between the participating providers and the health plans. In the commonly known "messenger model," the IPA works to negotiate the terms of the contract.[119] Contrary to a direct contracting IPA, the messenger model IPA normally has no power to bind the providers to agreements. The individual providers retain the final decision to accept or reject each health care plans' proposals.[120]

Both direct contracting and messenger IPAs exist to market the health care services of participating providers. Their primary marketing thrust seeks new purchasers of the providers' services using the promise that the IPA's providers will deliver the most cost effective, presumably least expensive, health care.[121]

C. PPOs: A Market for Health Care Services

While the IPA exists to market the services of its providers, a Preferred Provider Organization (PPO) assembles an array of providers from which health care services can be chosen by the health care consumer, i.e., the patient. Essentially, the IPA seeks to market its health care services across the board, while the PPO attempts to capture a specific patient population for its services.

The typical PPO arrangement arises when insurance companies and other health care plans contract with health care providers to deliver services preferentially to their

113. *Id.*; *see also* Baker, *supra* note 31. *See supra* text accompanying note 31 for an explanation of capitation).

114. HLR MANUAL, *supra* note 112, at 2.

115. *See* MOTENKO, *supra* note 109, at 2.

116. *See id.*

117. *See id.*

118. *See* HLA MANUAL, *supra* note 112.

119. *See id.*

120. *See id.*

121. *See id.*

members.[122] The PPO is not a health care services provider, but rather the doctors, hospitals and other health care providers deliver services pursuant to the PPO provider participation agreement.[123]

The payers, either insurance companies, large employers, or the government, contract with the PPO to gain access to the PPO's network of physicians and hospitals.[124] Each payer has member groups that are the beneficiaries of their plans and who are given choices of providers.[125] However, financial incentives generally encourage the beneficiaries to use PPO network provider's services as opposed to non-network providers.[126]

The two basic PPO structures are differentiated by the freedom of the beneficiaries' ability to choose their providers. The "gatekeeper plan" PPO requires a beneficiary to choose a primary care physician from the PPO network, and this primary physician then serves as a gatekeeper who regulates the beneficiary's access to medical care, providing authorization for referrals to specialist or other health care providers.[127] The PPO imposes financial penalties on the beneficiary if another primary care physician is chosen or the beneficiary fails to obtain approval for a referral.[128] In essence, the beneficiary is required to pay extra to override the referral recommendation of the gatekeeper physician.[129]

On the other hand, the "open panel" PPO does not require the beneficiary to use a network primary care physician to monitor health care decisions.[130] The beneficiary is allowed to choose a network or non-network provider and may do so whenever the provider's services are needed or are thought to be needed by the patient. However, most health plans that utilize open panel PPOs employ financial incentives for beneficiaries to choose a network physician.[131] Both the "gatekeeper" and "open panel" model PPOs create a pool of providers from which the beneficiaries can select their providers. Unlike the IPAs where the providers search for purchasers, PPOs allow the payers through their beneficiaries to search for the provider of their choosing within the PPO structure.

Because physician network joint ventures, such as IPAs and PPOs, can potentially achieve the procompetitive benefit of quality services at reduced costs, they are perceived as an integral part of the managed care remedy for the health care crisis. But in so aligning, networks of physicians that would otherwise be in competition, run risks of violating antitrust laws.

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122. *See id.*
123. *See id.* at ch. 3, ¶¶ 1-4, at 2-3.
124. *See id.*
125. *See id.*
126. *See id.*
127. *See id.*
128. *See id.*
129. *See id.*
130. *See id.*
131. *See id.*

IV. Evaluating the Legitimacy of Joint Ventures

The recent economic changes in the health care industry have lead to an explosion of joint ventures in which physicians are participants.[132] While some joint ventures are simply "cloaks for cartel-like activities,"[133] many joint ventures are legitimate collaborative efforts by physicians.

The quintessential question for analysis of these joint ventures is whether the collaboration is truly legitimate or simply a sham. While many antitrust risks, such as sharing information or using perceived collaborative power to negotiate fees, often lead to lower costs and increased efficiency,[134] distinguishing between legitimate and sham joint ventures caused one commentator to lament that "[n]o area of antitrust law is more murky than the application of the Sherman Act to joint ventures."[135]

A. Judge Taft Sets the Standard

Nearly ten years after Congress passed the Sherman Act, the Supreme Court first addressed the standard for of evaluating the legitimacy of joint ventures.[136] In *United States v. Addyston Pipe & Steel Co.*,[137] Circuit Judge Taft held invalid contracts "where the sole object of both parties . . . is merely to restrain competition, and enhance or maintain prices."[138] In so ruling, Taft established the ancillary restraint doctrine used to determine the difference between lawful and unlawful restraints of trade.

Under the *Addyston* opinion, an agreement would be judged reasonable and found lawful if (1) the restraint was "merely ancillary to the main purpose of a lawful contract," and (2) was necessary to achieve the goals of the lawful contract.[139] This reasonableness test was the beginning of the "rule of reason" test in antitrust law. Additionally, Judge Taft stated in dicta that the ancillary restraint doctrine was inapplicable and restraints were illegal when prices were set by any force other than competition.[140] Thus, the "per se" rule first entered the judicial analysis of antitrust law.

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132. 2 JOHN J. MILES, HEALTH CARE AND ANTITRUST LAW, § 13.01, at 13-1 (1994).

133. Robert Pitofsky, *A Framework for Antitrust Analysis of Joint Ventures*, 74 GEO. L.J. 1605, 1606 (1986).

134. *See* Grady, *supra* note 18, at 4.

135. *See* MILES, *supra* note 132, § 13.07, at 13-38.

136. United States v. Addyston Steel & Pipe Co., 85 F. 271, 281 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899); Although the Supreme Court published an opinion affirming the Sixth Circuit, this case is most often analyzed based on Circuit Judge Taft's opinion. The reason for this analytical variation is that 11 years after *Addyston*, Circuit Judge Taft was elected President of the United States, and 23 years after *Addyston*, President Taft was appointed to the United States Supreme Court.

137. *Id.*

138. *Id.* at 282.

139. *Id.*

140. *Id.* at 288.

B. Rise of the Rule of Reason

Two decades later in the landmark *Chicago Board of Trade v. United States*,[141] the Supreme Court examined a trade restriction imposed by the Board of Trade members, known as the "call rule," that prohibited members from purchasing or even offering to purchase the next day's grains at a price other than that day's closing bid. Justice Brandeis held that this call rule "was a reasonable regulation of business consistent with the Anti-Trust Laws."[142] Brandeis reasoned that this restriction had "no appreciable effect on general market prices" and only limited the time period during which traders were allowed to make prices on the grain.[143]

Although *Chicago Board of Trade* was not a "price fixing" controversy, its reasoning extends to include agreements between competitors that do affect prices. Paradoxically, price fixing agreements may still be permissible if the functioning of the market is improved as a result. The Court established a legitimacy standard for agreements between competitors, stating that "[t]he true test of legality is whether the restraint . . . merely regulates and perhaps thereby promotes competition or whether it . . . may suppress or even destroy competition."[144] The Court utilized a rule of reason test, examining for the following relevant facts: "[t]he history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, [and] the purpose or end sought to be attained."[145]

C. Refining the Rule of Reason

The Supreme Court in the last two decades has refined its legitimacy test for joint ventures among competitors. In *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*,[146] the Court refused to apply the per se rule to artists' agreements which allowed BMI to issue a "blanket license" to perform the copyrighted works owned by BMI's member artists.[147] In opting for a rule of reason test, the Court recognized that some agreements between competitors, such as price fixing, "are so 'plainly anticompetitive' . . . and so often 'lack . . . any redeeming virtue,' . . . that they are conclusively presumed illegal without further examination under the rule of reason."[148]

Nevertheless, the Court refused to apply the per se rule to the blanket license dispute, because the agreement was "designed to 'increase economic efficiency and render markets more, rather than less, competitive.'"[149] The Court reasoned that the blanket license, although an agreement to fix prices, was "not a 'naked restrain[t] of trade with no purpose except stifling competition', but rather accompanied the

141. 246 U.S. 231 (1918).
142. *Id.* at 239.
143. *Id.* at 240.
144. *Id.* at 238.
145. *Id.*
146. 441 U.S. 1 (1979).
147. *Id.* at 20.
148. *Id.* at 8.
149. *Id.* at 20.

integration of sales, monitoring, and enforcement against unauthorized copyright use."[150] More importantly, the Court concluded that without this agreement it would be cost prohibitive for BMI's artists to market their products at all.[151] As such, the Court remanded the case to the Second Circuit for a rule of reason analysis.[152]

D. Maricopa: Justice Stevens' Standard for Health Care Joint Ventures

Three years after BMI, the Supreme Court faced another price fixing agreement within the joint venture context, this time involving a health care joint venture.[153] The four-to-three decision in *Arizona v. Maricopa County Medical Society*[154] remains the seminal case for evaluating the legitimacy of health care joint ventures involving pricing issues.[155]

In *Maricopa*, physician members of the Maricopa Foundation, a medical society consisting of "70% of the practitioners in Maricopa County, Arizona,"[156] established among themselves "a schedule of fees that participating doctors agree[d] to accept as payment in full for services performed for patients insured" by Foundation-approved insurance plans.[157] Although the Foundation argued that the fixed price aided in marketing the physicians' services to insurance plans, the Court rejected this procompetitive justification.[158] Justice Stevens opined that setting maximum prices might "be a masquerade to fix uniform prices."[159] Therefore, Stevens held that "the anticompetitive potential inherent in all price fixing arguments justifies their facial invalidation even if procompetitive justifications are offered."[160]

Justice Stevens distinguished *Maricopa* from *BMI*, in which he was the lone dissenter, by holding that the Maricopa Foundation failed to create or market a new product.[161] Rather, as Stevens concluded, the Foundation's agreement concerned "the price at which each [physician] will offer his own services."[162] Moreover, Justice Stevens reasoned that the Foundation's "combination has merely permitted [the member physicians] to sell their services to certain customers at fixed prices and . . . to affect the prevailing market price for medical care."[163]

In his dissent, Justice Powell criticized the majority for its per se pigeonholing of the *Maricopa* joint venture, arguing that the majority ignored several procompetitive justifications for upholding this "new method of providing . . . medical services."[164]

150. *Id.* at 20.
151. *Id.*
152. *Id.* at 25.
153. Arizona v. Maricopa Medical Soc'y, 457 U.S. 332 (1982).
154. *Id.*
155. *See* Grady, *supra* note 18, at 769.
156. *Maricopa*, 457 U.S. at 339.
157. *Id.*
158. *Id.* at 349.
159. *Id.* at 348.
160. *Id.* at 351.
161. *Id.* at 356.
162. *Id.*
163. *Id.*
164. *Id.* at 357.

The closeness of the Justices' reasoning in the four-to-three decision demonstrates the thin line supporting the holding in this landmark physicians' antitrust case.

Justice Powell's cogent minority opinion notes that the Foundation's agreement "foreclose[d] no competition."[165] Indeed, the participating physicians were able to associate with non-Foundation insurance plans and treat patients from these plans, or even treat uninsured patients. The Foundation-approved insurance plans also were able to do business with physicians outside the plan, whether they were Foundation or non-Foundation physicians. The Foundation simply created a novel way to provide health care services, and no evidence indicated that competition was stymied. Justice Powell logically concluded that the "freedom to compete, as well as freedom to withdraw, [was] preserved."[166]

Despite Justice Powell's reasoning, the Foundation failed to convince the majority of the Court that the procompetitive justifications of a fee schedule warranted an exception to the per se rule. Nevertheless, Justice Stevens' closing comments suggested another option, that the Foundation's "arguments against application of the per se rule . . . are better directed at the Legislature."[167] Given the recent FTC and DOJ joint statement and the national debate over how Congress should reorganize health care, Justice Stevens' admonition was prophetic.

The antitrust implications of *Maricopa* remain important in the health care industry today.[168] After *Maricopa*, it is clear that efforts by legitimate joint ventures to fix prices will likely be struck down under the antitrust laws. In addition to the relative clarity of naked pricing issues within joint ventures, collaborative actions of physician network joint ventures also risk antitrust scrutiny in civil suits between private parties.

V. Exclusive Arrangements: A Cause for Alarm

Although no Supreme Court cases involving structural analysis of health care joint ventures have been heard since *Maricopa*, several lower court cases and a few Supreme Court cases in the last decade have sustained exclusive arrangements in the context of physician network joint ventures. Two major types of exclusive arrangements are typically scrutinized under in civil antitrust litigation: (1) exclusive physician arrangements, and (2) group boycotts by physicians.

A. Exclusive Physician Arrangements

An exclusive arrangement between a physician or a group of physicians and a hospital or a health care plan typically provides that no other physician will be permitted to perform specific health care services within the hospital or for the members of the health plan.[169] The procompetitive aspects touted for these exclusive arrangements are market efficiencies and decreased transaction costs.[170] However,

165. *Id.* at 360.
166. *Id.*
167. *Id.* at 354-55.
168. *See* Grady, *supra* note 18, at 769.
169. *See* Miles & Philp, *supra* note 106, at 492.
170. *See id.*

the anticompetitive aspects, such as potential market foreclosure, collusion and artificial barriers to market entry, present genuine antitrust risks.[171]

Antitrust challenges to exclusive physician arrangements are usually bifurcated. First, exclusive dealings between hospitals or health plans and physicians are examined under section 1 of the Sherman Act as restraints of trade foreclosing competing physicians from the market.[172] Second, tying arrangements between a hospital and patients, which require the purchase of a physician's services before the patient can receive the hospital's services, also fall within section 1 of the Sherman Act.[173]

The relationship of the parties in exclusive dealings can be a critical determinant of the antitrust violations. For example, if a physician is an employee of the hospital, the "conspiracy" element of an exclusive dealing action will be difficult to satisfy because the collusive element will be lacking between the physician employee and the hospital employer.[174] However, if the physician is an independent contractor, the hospital and the physician have conspiratorial capacity, thus the "conspiracy" element is unlikely to preclude an antitrust action.[175]

1. Exclusive Dealings

Exclusive dealings between a hospital and a physician or group of physicians are usually challenged because potential competitor physicians are prevented patient access, either in the hospital or in the geographic market.[176] Typically, the claims by plaintiff physicians that the defendants have unreasonably restrained competition have met with little judicial success, as these exclusive physician dealings are usually justified by the courts as legitimate vertical arrangements under the rule of reason analysis.[177]

In *Coffey v. Healthtrust, Inc.*,[178] the Tenth Circuit affirmed a summary judgment in favor of a defendant radiologist by characterizing an exclusive dealing contract between the defendant's radiologist group and a hospital as a valid vertical relationship.[179] The hospital in *Coffey*, concerned that the plaintiff's radiologist group was diverting patients from the hospital's inpatient x-ray department to the physician group's new outpatient radiology clinic, terminated its exclusive agreement with the group.[180] Then the hospital entered into an exclusive arrangement with another group of radiologists.[181]

171. *See generally* ROBERT E. BLOCH & DONALD M. FALK, ANTITRUST, COMPETITION, AND HEALTH CARE REFORM 9 (PLI Commercial Law and Practice Course Handbook Series No. 694, 1994).
172. *See* Miles & Philp, *supra* note 106, at 493.
173. *See id.*
174. *See id.*
175. *See id.*
176. *See id.*
177. *See id.* at 527.
178. 955 F.2d 1388, *rev'd on other grounds*, 1 F.3d 1101 (10th Cir. 1993).
179. *Id.* at 1393.
180. *Id.* at 1390.
181. *Id.*

The plaintiff radiologist brought an action under section 1 of the Sherman Act claiming that the contract between the new group and the hospital impacted competition detrimentally.[182] The Tenth Circuit held that the defendants had not violated section 1 because "the reshuffling of competitors . . . had no detrimental effect on competition."[183] More importantly, the plaintiff presented "no evidence that competition was in any way limited by the switch in exclusive providers" and the plaintiff "failed to define the relevant geographic market impacted by [the] alleged anticompetitive actions."[184]

The *Coffey* case turned on the plaintiff's failure to define the relevant market, but in reality the defendant lacked sufficient market power to restrict competition.[185] However, in *Tarabishi v. McAlester Regional Hospital*,[186] another Tenth Circuit case, the defendant likely had sufficient market power to restrain competition, but the plaintiff failed to present sufficient evidence of the defendant's relevant market power to survive summary judgment.[187]

In *Tarabishi*, the plaintiff physician planned to open an outpatient surgical clinic that would compete directly with a similar clinic operated by the only hospital in a rural Oklahoma town.[188] Two months before the plaintiff's clinic opened, the hospital revoked his hospital medical staff privileges with no apparent cause.[189] Because his privileges were revoked, the plaintiff was unable to admit his patients requiring inpatient treatment to the hospital, thereby preventing the doctor from operating in his new clinic.[190]

The plaintiff brought an action alleging, *inter alia*, that the hospital and its clinic conspired to restrain trade in violation of section 1 of the Sherman Act.[191] In affirming the summary judgment, the Tenth Circuit relied on the district court's holding that the plaintiff failed to define adequately "the relevant markets within which competition was allegedly affected."[192] The district court below had reasoned that the "failure to prove that Dr. Tarabishi's inability to use the facilities at the Hospital

182. *Id.* at 1391.

183. *Id.* at 1393.

184. *Id.*

185. At the district court, the plaintiff's expert economist testified that the relevant geographic market for the defendant hospital was the "area encompassed within the corporate limits of Edmond," Oklahoma. Coffey v. Healthtrust, Inc., 1 F.3d 1101, 1103 (10th Cir. 1993). Because the defendant hospital was the only hospital in that market, the plaintiff's expert concluded that it would have market power within that geographic area. The defendant submitted contradictory evidence which suggested that the geographic market was broader. The district court ruled as a matter of law that the defendant hospital enjoyed no market in the relevant geographic market which the court concluded was Edmond, Oklahoma and Oklahoma City where eight other hospitals were located. *Id.* The court based its decisions on the limited distance between Edmond and Oklahoma City. *Id.*

186. 951 F.2d 1558 (10th Cir. 1991).

187. *Id.* at 1568.

188. *Id.* at 1562.

189. *Id.*

190. *Id.*

191. *Id.* at 1570.

192. *Id.* at 1571.

affected competition, as opposed to Dr. Tarabishi himself as a competitor, doomed plaintiff's section one claims to failure."[193]

The *Tarahishi* case was not decided on the defendant's market power but was decided on the plaintiff's failure to prove that his privilege denial affected competition in the relevant market.[194] The district court criticized the plaintiff's expert witness for failing to define properly the relevant product and geographic markets.[195] Furthermore, the district court noted that experts failed to prove that the hospital even had power to control prices within those markets.[196]

The *Tarabishi* and *Coffey* opinions illustrate how exclusive dealings between hospitals and physicians can create antitrust litigation. Exclusive dealings clearly lacking sufficient market power, as in *Coffey*, will be deemed legitimate vertical restraints. However, a provider shown to have requisite market power, as not found in *Tarabishi*, must have significant procompetitive benefits for the exclusive deal to avoid antitrust violations.

2. Tying Arrangements

Agreements to sell one product or service (the "tying" element) conditioned only on the buyer purchasing a different product or service (the "tied" element) have become a marketing tool for health care services.[197] These types of arrangements become illegal when the seller "has sufficient economic power with respect to the tying product to appreciably restrain free competition in the market for the tied product. . . ."[198]

The United States Supreme Court in *Jefferson Parish Hospital District No. 2 v. Hyde*,[199] examined a tying arrangement between a group of physicians and a hospital. In *Jefferson Parish*, the East Jefferson General Hospital maintained a closed group medical staff policy.[200] Its anesthesia department exclusively contracted with one group of physicians to provide all the operating room anesthesiology services.[201] Dr. Hyde, a board-certified anesthesiologist, was denied staff privileges at the hospital due to this exclusive contract.[202] Hyde brought an antitrust action alleging that the hospital's exclusive contract violated section 1 of the Sherman Act,[203] arguing that the exclusive contract was a tying arrangement which required patients desiring access to the hospital's surgical facilities (the "tying" element) to purchase the anesthesiology

193. *Id.*
194. *Id.* at 1567
195. *Id.*
196. *Id.* at 1568.
197. Northern Pac. R.R. v. United States, 356 U.S. 1, 5-6 (1958).
198. *Id.*
199. 466 U.S. 2 (1984).
200. A closed group policy is similar to a closed hospital which is "[a] hospital which is open to physicians who are members of the staff, excluding all other physicians from practice." 1 J.E. SCHMIDT, ATTORNEYS' DICTIONARY OF MEDICINE, at C-198 (1986 ed.).
201. *Jefferson Parish*, 466 U.S. at 5-6.
202. *Id.* at 5.
203. *Id.* at 4.

services of the closed group (the "tied" element), therefore creating a per se restraint of trade violation.[204]

The district court concluded that the city of New Orleans, which had more than twenty hospitals, was the relevant geographic market of the hospital.[205] Because 70% of the patients in New Orleans used hospitals other than East Jefferson, the court held that the tying arrangement was not illegal per se.[206] Furthermore, the court held that the tying arrangement was not an unreasonable restraint of trade, because it had significant pro-competitive benefits.[207]

However, on appeal, the Fifth Circuit concluded that because "patients tend to choose hospitals by location rather than price or quality"[208] the relevant geographic market was the East Bank of Jefferson Parish.[209] Based on this locality reasoning, the Fifth Circuit reversed the district court and held that the tying arrangement was illegal per se under section 1, because the hospital had sufficient market power to affect competition adversely.[210]

In reversing the Fifth Circuit, the United States Supreme Court concluded that not all tying arrangements are illegal, reasoning "that every refusal to sell two products separately cannot be said to restrain competition."[211] However, Justice Stevens writing for the majority reasoned that the per se analysis was appropriate when the seller exploited its market power by forcing a purchaser to buy the tied product to gain access to the tying product.[212] Justice Stevens explained this conclusion:

> Our cases have concluded that the essential characteristic of an invalid tying arrangement lies in the seller's exploitation of its control over the tying product to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms. When such "forcing" is present, competition on the merits in the market for the tied item is restrained and the Sherman Act is violated.[213]

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204. *Id.* at 8.

205. Hyde v. Jefferson Hosp. Dist. No. 2, 513 F. Supp. 532, 542-43 (E.D. La. 1981).

206. *Id.*

207. *Id.* at 544. "We have noted in our findings of fact that there are many benefits arising from the closed system which result in improved patient care." *Id.*

208. Hyde v. Jefferson Hosp. Dist. No. 2, 686 F.2d 286, 290 (5th Cir. 1982).

209. *Id.*

210. *Id.* at 291.

211. Hyde v. Jefferson Hosp. Dist. No. 2, 466 U.S. 2, 11 (1984).

212. *Id.* at 9; *see also* Diane M. Meibaum, *Jefferson Parish Hospital District No. 2 v. Hyde: An Omen for Future Antitrust Challenges?*, 20 NEW ENG. L. REV. 175, 189 n.131 (1984-85) ("Justice Stevens appeared to chastise the concurring members of the Court who urged abandonment of the per se rule by stating: "It is far too late in the history of our antitrust jurisprudence to question the proposition that certain tying arrangements pose an unacceptable risk of stifling competition and therefore are unreasonable 'per se.'") (citation omitted).

213. *Jefferson Parish*, 466 U.S. at 12.

In applying this analysis to East Jefferson General Hospital's contract, the Supreme Court first determined that the arrangement included the requisite two products.[214] Next, the Court rejected the Fifth Circuit's locality reasoning and held that the relevant market was metropolitan New Orleans.[215] Therefore, the hospital lacked sufficient market power in the tying element (hospital services) to force the purchase of the tied element (the anesthesiology services) which would trigger a per se condemnation of the exclusive contract.[216] Furthermore, Justice Stevens held that the record was insufficient to conclude that the exclusive contract adversely affected competition for anesthesiology services in the New Orleans market.[217]

Some commentators posit that *Jefferson Parish* provides no dramatic shifts in the way tying arrangements will be analyzed,[218] and one court even held that *Jefferson Parish* "makes no change in the law concerning the use of a per se standard in tying cases."[219] Nevertheless, another commentator argues that *Jefferson Parish* " raise[s] the hurdles a plaintiff must leap to meet the requisite burden of proof for per se condemnation."[220] To confuse the issue even further, a subsequent case rejected the *Jefferson Parish* per se standard in favor of the rule of reason analysis.[221]

Although *Jefferson Parish* makes it clear that physician plaintiffs denied privileges based on a preexisting exclusive contract will have difficulty winning, the legacy of *Jefferson Parish* illustrates that tying arrangement cases may be subject to confusion and misapplication by courts. As physicians and hospitals contemplate these types of exclusive contracts, these inherent antitrust risks must be recognized. Despite the doubtful success of many antitrust actions, these challenges are likely to increase. As the health care industry becomes more competitive and the challenge to seek and maintain access to patients becomes more difficult, physicians foreclosed from hospitals by exclusive contracts certainly will continue to bring these actions.

B. Group Boycotts by Physicians

Typically, group boycotts are exclusive agreements among competitors who refuse to deal with a competitor or a group of competitors. This discriminatory action often precludes an individual or group who is the subject of a boycott from enjoying a competitive advantage shared by those involved in the boycott.[222] For example, in the health care context, a group boycott claim might include a physician or group of physicians excluded from participating in a health care network.[223] Conversely, a

214. *Id.* at 24.

215. *Id.* at 26-27.

216. *Id.* at 29.

217. *Id.*

218. *See* Miles & Philp, *supra* note 106, at 534.

219. Mozart Co. v. Mercedes-Benz, 593 F. Supp. 1506 (N.D. Cal. 1984) (holding that the per se analysis is applicable in tying arrangements if the *Jefferson Parish* standards are satisfied).

220. *See* Meibaum, *supra* note 212, at 194.

221. *See* Rockland Physicians Ass'n v. Grodin, 616 F. Supp. 945, 954 (S.D.N.Y. 1985).

222. *See* MILES, *supra* note 132, § 15.05, at 15-78.

223. Capital Imaging Assocs. v. Mohawk Valley Medical Assocs., 996 F.2d 537 (2d Cir. 1993), *cert. denied*, 114 S. Ct. 388 (1993).

group boycott claim might arise if a group of physicians jointly refuse to adhere to the contractually prescribed requirements of a managed care organization or an insurance plan.[224]

In *Federal Trade Commission v. Indiana Federation of Dentists*,[225] the United States Supreme Court analyzed a group boycott by dentists who collectively agreed to withhold x-rays from insurers.[226] Justice White, writing for a unanimous Court, observed that "[a]lthough this Court has in the past stated that group boycotts are unlawful per se, we decline to resolve this case by forcing the Federation's policy into the 'boycott' pigeonhole and invoking the per se rule."[227] In adopting a rule of reason analysis, Justice White concluded that "the per se approach has generally been limited to cases in which firms with market power boycott suppliers and competitors in order to discourage them from doing business with a competitor."[228]

In *Indiana Federation*, a group of dentists conspired and refused to submit patient x-rays to insurers for use in the insureds' benefits determination. The Court held that "[w]hile this is not price fixing as such, no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement."[229] Although the Federation argued that "its policy of withholding x-rays was reasonable because the provision of x-rays might lead the insurers to make inaccurate determinations of the proper level of care,"[230] the Court held that the practice was an unreasonable restraint of trade.[231] Justice White explained the Court's reasoning as:

> A refusal to compete with respect to the package of services offered to customers, no less than a refusal to compete with respect to the price term of an agreement, impairs the ability of the market to advance social welfare by ensuring the provision of desired goods and services to consumers . . . .[232]

The Federation further argued that "[n]otwithstanding its lack of competitive virtue, [its] policy. . , should not be deemed an unreasonable restraint of trade."[233] The main support for this contention was that the Federal Trade Commission's findings failed to prove that the Federation had the requisite market power to restrain trade.[234] The Court held that "proof of actual detrimental effects on competition. . . can obviate the need for an inquiry into market power."[235] Therefore, the Court reasoned, because

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224. FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).
225. *Id.*
226. *Id.* at 451.
227. *Id.* at 458 (citing United States v. General Motors, Inc., 384 U.S. 127 (1966); Klor's Inc. v. Broadway-Hale Stores, 359 U.S. 207 (1959)).
228. *Id.* at 458.
229. *Id.* at 459 (quoting National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 692 (1978).
230. *Id.* at 452.
231. *Id.* at 459.
232. *Id.*
233. *Id.* at 460.
234. *Id.*
235. *Id.*

the Federation's policy resulted in several insurers being unable to obtain the requested x-rays, "the challenged restraint was unreasonable even in the absence of [an] elaborate market analysis."[236]

The *Indiana Federation* opinion highlights potential antitrust risks inherent in group boycotts where a group collectively agrees not to deal with a network. Conversely, in *Capital Imaging Associates. P.C. v. Mohawk Valley Medical Association*, [237] the Second Circuit analyzed a boycott when a health care network excluded members from network participation.[238] In *Capital Imaging*, a group of radiologists, Capital Imaging Associates, brought an antitrust action against Mohawk, an HMO, and another radiologist group alleging that the defendants had violated section 1 of the Sherman Act by conspiring to exclude these radiologists from its "IPA model" HMO.[239] Because Mohawk was an IPA model HMO that required its patients utilize its physician panel exclusively, the plaintiff was excluded from access to Mohawk's pool of patients.[240] The district court granted a summary judgment in favor of the defendants.[241]

On appeal, the Second Circuit affirmed the district court's summary judgment reasoning that the plaintiff failed "to demonstrate that a genuine issue of material fact exist[ed] with respect to [Mohawk's] strength in the market place."[242] In reality, the court noted, Mohawk lacked the requisite power to charge supracompetitive prices or force its members to accept inferior quality health care.[243] The court recognized that the plaintiff could meet its burden of proving a restraint of competition by "proof of actual detrimental effects."[244] Nevertheless, the Second Circuit concluded that the plaintiffs failed to offer such proof, and in fact, the plaintiffs conceded in "its brief that whether or not it [was] admitted into the physicians' association, the fee for radiological services [in the market] would remain the same."[245]

The *Capital Imaging* and *Indiana Federation* cases demonstrate that physician network joint ventures face potential antitrust difficulties in collective negotiations with health care payers. When the physician network is the subject of a boycott or the physician network's activities are construed as a boycott, antitrust scrutiny is aroused in the FTC and DOJ, as well as in the courts. Possible civil judgments become a looming specter when physicians or networks conspire to exclude other competitors. Nevertheless, some activities that might be construed as a boycott can have beneficial competitive effects, such as lower health care premiums achieved by negotiations or

236. *Id.*

237. 996 F.2d 537 (2d Cir. 1993), *cert. denied*, 114 S. Ct. 388 (1993).

238. *Id.* at 540.

239. *Id.* at 541. *See supra* note 114 and accompanying text for a discussion of the "IPA model HMO."

240. *Id.*

241. 791 F. Supp. 956, 968 (N.D.N.Y. 1992).

242. Capital Imaging Assocs. v. Mohawk Valley Medical Assocs., 996 F.2d 537, 547 (2d Cir. 1993), *cert. denied*, 114 S. Ct. 288 (1993).

243. *Id.*

244. *Id.* at 546 (quoting FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 460-61 (1986)).

245. *Capital Imaging*, 996 F.2d at 546. There was no indication in the case that the beneficiaries of the Mohawk HMO were forced to accept inferior quality health care.

lower operational costs for an HMO realized by elimination of duplicative services. In order to achieve these benefits, antitrust scrutiny regarding possible competitive activities between providers and networks must be reduced, lest the desired physician collaborations create antitrust liabilities.

C. Solutions and Directions: Where to Turn?

In the past, antitrust risks have been barriers to health care collaborations that might have improved quality and decreased the cost of health care.[246] When hospitals, physicians and other health care providers entered into new collaborative arrangements to position themselves better in an increasingly competitive health care market, antitrust issues inevitably arose. Moreover, federal antitrust policies have given little guidance to health care providers to delineate joint activities and business arrangements that would not be scrutinized for antitrust violations.[247] Because the potential risks are serious and the guidelines inadequate, health care providers entering into collaborative arrangements often "set sail on a sea of doubt"[248] unsure if their joint ventures will pass antitrust muster or whether there are any safe harbors in the doubtful antitrust sea.

VI. Enforcement Agencies' Position on Health Care Provider Networks

A. Initial Response: Original Joint Statement

To the relief of many and the consternation of the administration, President Clinton's health care reform package achieved no substantive changes in the governmental financing of health care, but it has produced noticeable changes in health care antitrust policy. The Clinton Administration's shift in philosophy was dramatized on September 15, 1993, when the FTC and DOJ stepped toward a more liberal construction of health care antitrust enforcement policies by jointly promulgating the "Statements of Antitrust Enforcement Policy in the Health Care Arena (original joint statement)."[249] First Lady Hillary Clinton, flanked by Assistant Attorney General Anne K. Bingaman of the DOJ, Chairman Janet D. Steiger of the FTC, U.S. Sen. Howard Metzenbaum (D.-Ohio),[250] and U.S. Rep. Jack Brooks (D.-Tex.),[251] announced that the joint statement would "allow

246. Hillary Clinton, Remarks at the Department of Justice Press Conference on the Antitrust Policy Statements for the Health Care Industry (Sept. 15, 1993), *available in* Westlaw, Federal News Service Library [hereinafter First Lady's Remarks].

247. Christopher L. White, *Antitrust Reform: Many Changes Possible, But No Immediate Changes Foreseen*, HEALTHSPAN, June 1994, at 6, 6.

248. United States v. Addyston Steel & Pipe Co., 85 F. 271, 283 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899).

249. *See Joint Statement*, *supra* note 10.

250. Senator Metzenbaum was the Chairman of the subcommittee of the Senate Judiciary Committee that deals with federal antitrust issues.

251. Representative Brooks, from the Sixth District of Texas, was Chairman of the House Judiciary Committee.

physicians to get together to control costs, and . . . allow mergers that are competitive and save consumers money."[252]

Despite the joint statement's failure to create categorical immunities or exemptions, it defined certain "safety zones" for specific health care collaborations in which the Agencies would not challenge the participants absent extraordinary circumstances.[253] Specifically, the joint statement framed specific exclusions for hospital mergers, hospital joint ventures involving high-technology or other expensive health care equipment, physicians' provision of information to purchasers of health care services, hospital participation in exchanges of price and cost information, joint purchasing agreements among health care providers, and physician network joint ventures.[254] The tone for these statements was grandiloquent:

> [t]o provide education and instruction to the health care community in a time of tremendous change, and to resolve, as completely as possible, the problem of antitrust uncertainty that some have said may deter mergers and joint ventures that would lower health care costs. Sound antitrust enforcement will continue to protect consumers against truly anticompetitive activities.[255]

The original statement failed to achieve its stated goal, and a year later on September 27, 1994, the Agencies tried to clarify certain health care safety zones with a revised statement.[256] The revised section covering physician network joint ventures is essentially a wholesale adoption of the same section in the original statement. Nevertheless, an analysis of the development, structure and response to the original joint statement does offer some safety zones for collective activity of physician providers.

B. Physician Network Joint Ventures

To provide guidance for physicians that organize themselves into various joint ventures to market their services, the joint statement created safety zones, reasoning that "[b]ecause of their potential for providing quality services at reduced costs, IPA's, PPO's, and similar physician network joint ventures promise significant procompetitive benefits for consumers of health care services."[257] With this reasoning, the Agencies appeared willing to afford some structural leeway to joint ventures.

The statement indicated, *inter alia*, that these federal Agencies would not challenge, absent extraordinary circumstances, physician network joint ventures whose membership totals 20% or less of the physicians in a relevant geographic market and 20% or less of the physicians in each specialty within market.[258]

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252. *See* First Lady's Remarks, *supra* note 246.
253. *See Joint Statement*, *supra* note 10.
254. *See id.*
255. *See id.*
256. *See Revised Joint Statement*, *supra* note 9.
257. *See id.* at 20,764.
258. *See id.* The statement contains an exception for small communities with less than five

Additionally, to qualify for safety zone protection, the "physicians participating in a physician network joint venture must share substantial financial risk" of the network, thereby insuring that sham networks could not proliferate.[259] Joint ventures have "substantial financial risk," according to the statement, if they operate on a capitated basis or provide financial incentive for members to achieve cost-containment goals, such as fee withholds pending fiscally efficient performance.[260] Finally, this safety zone applies equally to "exclusive"[261] and "non-exclusive"[262] physician network joint ventures.

According to the joint statement, most networks with more than 20% of the physicians in a relevant market will be analyzed by a four part rule of reason approach.[263] First, the relevant market will be defined according to the services provided by the joint venture's physicians or by physicians "whom health insurance plans . . . consider substitutes for physicians participating in the joint venture."[264] Second, the competitive aspects of the joint venture will be analyzed to determine if the venture is likely to have an anticompetitive impact on the relevant market.[265] From the Agencies' perspective, nonexclusive joint ventures signal procompetitive benefits and generally will support upholding the joint venture, while exclusive joint ventures arouse anticompetitive scrutiny and are a presumption against the joint venture.[266] Third, the procompetitive impact will be analyzed to determine if the benefits outweigh the risks, considering the individual fiscal ramifications of each venture.[267] Finally, all ancillary agreements will be analyzed to determine if they "contribute significantly to the legitimate purposes of the physician network joint venture."[268]

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physicians in a given practice. The exception states that

> [i]n relevant markets with less than five physicians in a particular specialty, a physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty even though the inclusion of that physician results in a physician network joint venture consisting of more than 20 percent of the physicians in that specialty.

Id.

259. *See id.*

260. *See id.*

261. *See id.* "An 'exclusive' venture significantly restricts the ability of its members to affiliate with other physician network joint ventures and to contract individually with health insurance plans." *Id.*

262. *See id.* "A 'non-exclusive' venture . . . does not impose any significant explicit or implicit restriction on the ability of its members to affiliate or contract with such other organizations." *Id.*

263. *See id.*

> Physician network joint ventures will be reviewed under a rule of reason analysis and not viewed as per se illegal either if the physicians in the joint venture share substantial financial risk or if the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies.

Id. This passage included a footnote that stated, "This statement assumes that the joint venture is not likely merely to restrict competition and decrease output, such as, for example, an agreement among physicians that simply fixes the price that each purchaser will pay." *Id.*

264. *See id.* at 20,765.

265. *See id.*

266. *See id.*

267. *See id.*

268. *See id.* "This analysis of ancillary agreements also applies to physician network joint ventures

Where physicians have decided to form a joint venture but are uncertain of the antitrust implications under the revised joint statement, the Agencies have established an expedited review process and will respond to review requests within ninety days.[269] This review mechanism is indeed an improvement. Before, neither agency guaranteed responses to review requests within any specific period.[270] The accommodative language of the statement does indicate the current executive branch's willingness to provide "workable solutions" for "an industry that is facing rapid change"[271]

VII. Criticisms of the Original Joint Statement

A. FTC Commissioner's Dissent

A close reading of the original joint statement reveals flaws which undermine the effectiveness of the policy. Indeed, FTC Commissioner Deborah K. Owen dissented from endorsing the joint statement with an opinion indicating that the Agencies' endeavor was flawed *ab initio*.[272] Commissioner Owen based her dissent on the negative aspects of "the merger safety zone [that] outweigh the benefits generated by the remainder of the statements."[273] Despite the narrow focus of her dissent, the Commissioner's sweeping analysis finds several statement-wide flaws.

First, she was concerned, and rightly so, that "the exceptions from the safety zones for 'extraordinary circumstances' may undermine the [statement's] aim of predictability."[274] The statement contains no definition of the "extraordinary circumstances," and in fact, the statement offers no evidence of what the Agencies will consider as "extraordinary circumstances." Therefore, because of the inclusion of this ambiguous 'extraordinary circumstances" exception, joint ventures will fall in or out of the safety zones ultimately on the discretion of the Agencies. Consequently, predicting safety zones for physician network joint ventures seems hopeless without a more discrete regulatory definition of "extraordinary circumstances."

Second, Commissioner Owen was concerned that the Agencies had overstepped their authority by creating a special category of antitrust exceptions. In her view, the joint statement "effectively constitutes a special-interest antitrust exception that

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that fall within the antitrust safety zone." *Id.*

269. *See id.* at 20,757. The one exception is for review requests pertaining to hospital mergers outside the antitrust safety zone. *Id.*

270. Assistant Attorney General Anne K. Bingaman, Remarks at the Department of Justice Press Conference on the Antitrust Policy Statements for the Health Care Industry (Sept. 15, 1993), *available in* Westlaw, Federal News Service Library.

271. *See* First Lady's Remarks, *supra* note 246.

272. FTC Commissioner Deborah K. Owen, Health Care Industry Polices — FTC Member's Dissent, 4 Trade Reg. Rep. (CCH) ¶ 13,235 (Sept. 15, 1993) [hereinafter Commissioner Owen's Dissent].

273. *Id.*

274. *Id.*; *see also Joint Statement*, *supra* note 10, at 20,764 ("The Agencies will not challenge, absent extraordinary circumstances, a physician network joint venture comprised of 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market and share substantial financial risk.") (footnote omitted).

should more appropriately be accomplished through legislative action, if at all, and poses a serious question of unfairness" to other industries.[275] Although Commissioner Owen cited no specific examples of unfair application, she concludes that "[o]ther industries, including those experiencing similar, dynamic changes, will not be blessed with the same relief" as the health care industry.[276]

Her last criticisms, and perhaps the most damaging, arise from the lack of legislative involvement in the joint statement's drafting. As almost an afterthought, Commissioner Owen noted that "the risks posed by other legal action, such as private, treble-damages litigation, remain."[277] The lack of protection against private antitrust actions is clearly a major flaw in the joint statement, and the qualified immunity for only those antitrust actions brought by the Agencies is a flaw that might well have been prevented with legislative participation. Congressional involvement is surely no guarantee that this flaw would have been avoided, but the opportunity for a broader reaching joint statement would seem more likely in a bipartisan forum. Instead, the safety zones are so narrow as currently drawn that they provide little meaningful antitrust safety to the nation's health care providers.

B. Representative Canady's Failed Intervention

U.S. Rep. Charles T. Canady (R-Fla.)[278] effectively joined Commissioner Owen's dissent and attempted to salvage the joint statement's inapplicability to private actions by an amendment to the Clinton Health Care Reform legislative package.[279] Representative Canady incorporated all of the joint statement's provisions into his amendment, essentially codifying the statement and reiterating the exemptions for certain competitive and collaborative health care activities from the antitrust regulation by the Agencies, as well as for private actions.[280]

Under Canady's amendment, "the provision of health care services shall be exempt from the antitrust laws if (1) the activity is within one of the categories of safe harbors . . . ."[281] The physician network joint venture safe harbor section of the Canady amendment is virtually a verbatim recitation of the joint statement and exempts joint ventures that are "comprised of [twenty] percent or less of the physicians in each physician specialty who practice in the relevant geographic market and share substantial financial risk."[282]

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275. *See* Commissioner Owen's Dissent, *supra* note 272.

276. *See id.*

277. *See id.*

278. Representative Canady, from the Twelfth District of Florida, is a member of the House Judiciary Committee.

279. *See* Proposed Amendment to Subtitle G, H.R. 3600 (on file with Rep. Canady's office).

280. *Id.*

281. *Id.* Representative Canady's Amendment includes safety zones for activities of medical self-regulatory entities, participation in surveys, joint ventures for high-technology and costly equipment and services, hospital mergers, joint purchasing agreements, physician network joint ventures, and negotiations. *Id.*

282. *Id.*

On August 2, 1994, the House Judiciary Committee passed Representative Canady's amendment by the narrowest of margins, eighteen to seventeen.[283] At the center of the amendment's opposition was Rep. Jack Brooks (D-Tex.), who a year earlier was instrumental in the issuance of the original joint statement. Representative Brooks conceded at that day's press conference that he was "very pleased today that the Clinton Administration has. . . chosen to reject the exception route in favor of the clarification route . . . ."[284] Although Representative Brooks appeared to favor some antitrust protection for the physician network joint ventures, he favored control by governmental regulation rather than by binding legislation, claiming that the joint statement was "preventative medicine rather than radical surgery."[285] Although the original joint statement may have been preventative medicine, without protection from potential private antitrust actions, the revised joint statement provides little cure.

Representative Canady's amendment guiding leading health care providers to comprehensive safe harbors for physician network joint ventures was welcome navigation, but the amendment's effect was evanescent. As the amendment made its way through the House Judiciary Committee, support for the Clinton Health Care Reform legislative package faltered, and Canady's amendment for antitrust safety zones faded. The Canady plan represented a workable solution to the antitrust dilemma facing the health care industry, providing the needed protection from private antitrust actions, a critical ingredient missing from the original joint statement.

C. The American Medical Association's Safety Zone Prescription

The American Medical Association reacted to the original joint statement in a predictable, yet well reasoned, manner. In an October 6, 1993, letter to Assistant Attorney General Anne K. Bingaman and FTC Chairman Janet D. Steiger, AMA general counsel, Kirk B. Johnson, acknowledged that the joint statement was "in some respects, an improvement over the guidance that previously existed in this area."[286] However, Mr. Johnson also stressed that the AMA had "some serious concerns" regarding the limited scope of the joint statement's safety zones.[287]

In his twenty-one-page letter, Mr. Johnson expressed concern that the safety zones were not clear and substantial enough to provide a satisfactory organizational blueprint for physician networks. Unlike Representative Canady, who was concerned with procedural aspects of the original joint statement, Mr. Johnson focused on the substantive deficiencies of the statement. Specifically, he criticized

283. 140 CONG. REC. H7171-03 (daily ed. Aug. 2, 1994).

284. U.S. Rep. Jack Brooks, Remarks at the Department of Justice Press Conference on the Antitrust Policy Statements for the Health Care Industry (Sept. 15, 1993), *available in* Westlaw, Federal News Service Library [hereir after Rep. Brooks' Remarks].

285. *Id.*

286. *See* AMA Letter, *supra* note 14, at 1.

287. *See id.*

the safety zones as too narrowly defined[288] and too restrictive in the financial risk sharing requirement.[289]

The AMA's argument that the safety zones are too narrow gains support from Dr. Richard Kronick's study in the *New England Journal of Medicine*[290] which examined the minimum level of patient volume and minimum physician staffing necessary to sustain an HMO or other MCO structure. He found that urban physician networks would be able to enlist the necessary number of physicians to operate at the optimal staffing efficiency levels, yet remain within the narrow market percentage size constraints of the safety zones. However, in the rest of the country, the size limits of the original joint statement's safety zones "are far too restrictive and will not facilitate the formation of physician networks. . . ."[291] Based on Kronick's study, the market percentage size of the safety zones for physician network joint ventures in most parts of the country needs enlarging in order for the networks to operate successfully.

Recognizing the inherent difficulties of adopting antitrust safety zones, Mr. Johnson prefaced the AMA's recommendation for enlarging the zones by stating that:

> [t]he size limit for the networks is set at an arbitrarily low level in order to prevent a single network from pushing prices above competitive levels, and to prevent a single network from preventing other networks from forming and preventing other health care plans from being able to assemble their own networks. The AMA believes that the safety zone can be expanded without causing any problems in this respect.[292]

The AMA's suggested two tiered approach to the physician network joint venture safety zones distinguishes between exclusive and non-exclusive physician networks. For non-exclusive physician networks unable to restrict output and raise prices to

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288. *See id.*

289. *See id.*

290. Richard Kronick, Ph.D. et al., *The Marketplace in Health Care Reform — The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148 (1993).

> Abstract . . . . The theory of managed competition holds that the quality and economy of health care delivery will improve if independent provider groups compete for consumers. In sparsely populated areas where relatively few providers are required, however, it is not feasible to divide the provider community into competing groups. We examined the demographic features of health markets in the United States to see what proportion of the population lives in areas that might successfully support managed competition. Conclusion . . . . Reform of the U.S. health care system through expansion of managed competition is feasible in medium-sized or large metropolitan areas. Smaller metropolitan areas and rural areas would require alternative forms of organization and regulation of health care providers to improve quality and economy.

Id.

291. *See* AMA Letter, *supra* note 14, at 8.

292. *See id.* at 9.

supracompetitive levels, the AMA recommended increasing the threshold to 50% of the physicians in a relevant market and specialty.[293]

On the other hand, the AMA concluded that exclusive physician networks with greater potential to exercise market power should have a lower limitation on the percentage of physicians in the relevant market. In determining the appropriate size for exclusive physician networks, the AMA relied on analyses by former Assistant Attorney General for Antitrust Charles F. Rule[294] and former District of Columbia Circuit Judge and antitrust scholar Robert H. Bork[295] to propose that the size limit for the exclusive networks "be [thirty-five] percent of the market, both for aggregate numbers of physicians and for each specialty."[296]

The AMA also criticized the joint statement's burden of substantial financial risk sharing as too restrictive and urged that capitation and fee withhold arrangements be considered as qualifying risk sharing.[297] By relying on a fiscal risk sharing requirement, the joint statement precluded fee-for-service networks from the safety zones. Although the AMA conceded that fee-for-service networks lack the cost reducing incentives such as capitation and withholds, fee-for-service networks must necessarily use other techniques to reduce their costs to remain competitive.[298]

The AMA pointed to the judicial reasoning in *Arizona v. Maricopa County Medical Society*[299] for its recommendation that participating physicians' equity in joint ventures should satisfy the substantial financial risk requirement. In *Maricopa*, the United States Supreme Court defined risk sharing as arrangements in which "[p]ersons who would otherwise be competitors pool their capital and share the risk of loss and opportunity for profit."[300] Substantial physician investment in a network creates an incentive for the members to cut costs to achieve profits. As such, the AMA argued that equity investments should satisfy the risk requirement of the joint statement.

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293. *See id.* at 10.

294. *See id.* at 10 (citing Charles F. Rule, Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation, Remarks by the Assistant Attorney General, Antitrust Division, United States Department of Justice (Mar. 11, 1988), *available in* Westlaw, Federal News Library.

295. *See id.* at 10 (citing ROBERT H. BORK, THE ANTITRUST PARADOX — A POLICY AT WAR WITH ITSELF 278 (1978)).

> Mr. Bork's book develops the joint venture analysis upon which much of the [Joint] Statement is based. As an example of how the joint venture analysis could be applied, Mr. Bork states (at pg. 278): Thus, we should have no trouble with a group of small grocers, having only, say 30 or 40 percent of a relevant market, who pool their advertising funds to advertise jointly using media they could not afford individually, and who agree upon prices what will be advertised and charged. Rational merger law would permit an ancillary restraint that makes very limited merger of their activities effective.

Id.

296. *See* AMA Letter, *supra* note 14, at 10.

297. *See id.* at 11.

298. *See id.* at 12.

299. 457 U.S. 332 (1982).

300. *Id.* at 351.

VIII. The Revised Joint Statement: Reform without Relief

A. The Agencies Speak Again

On September 27, 1994, responding to a tide of criticism, the DOJ and FTC issued a revised joint statement of enforcement policy on mergers and collaborative activities in the health care industry, superseding the joint statement issued fifty-four weeks previously.[301] The "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust"[302] helped to clarify the policies first enunciated in the original joint statement. Unfortunately, the revised statement only emphasized the earlier shortcomings and provided little needed guidance for health care antitrust issues, particularly relating to physician network joint ventures.

The new antitrust enforcement policies expanded the original joint statement and covered: (1) mergers among hospitals, (2) hospital joint ventures involving high-technology or other expensive health care equipment, (3) hospital joint ventures involving specialized clinical or other expensive health care services, (4) providers' collective provision of non-fee-related information to purchasers of health care services, (5) providers' collective provision of fee-related information to purchasers of health care services, (6) provider participation in exchanges of price and cost information, (7) joint purchasing arrangements among health care providers, (8) physician network joint ventures, and (9) analytical principles relating to multiprovider networks.[303] The Agencies promised further that they would respond, normally within ninety days, to review requests for proposed health care joint ventures or other health care activities from providers.[304]

B. Physician Network Joint Ventures: More Bad Medicine

Despite the criticism and suggestions from many groups,[305] the FTC and DOJ made no dramatic changes to the physician network joint venture section in the revised joint statement. Although certain changes did address the AMA's criticisms, the Agencies fell short of creating meaningful safety zones for physician network joint ventures.

The Agencies adopted a two tiered approach patterned upon the AMA's suggestion of different policies for exclusive and non-exclusive networks. They reasoned that non-exclusive networks allowing members to seek business outside the joint venture would create more competitors in the market and make it easier for new competitors to enter the market.[306] Therefore, the Agencies formulated a new safety zone for non-exclusive physician network joint ventures which comprise 30% or less of the total physicians in each specialty in a relevant market.[307] In

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301. *See Revised Joint Statement, supra* note 9.
302. *See id.*
303. *See id.* at 1-2.
304. *See id.* at 2.
305. *See* AMA Letter, *supra* note 14, at 1.
306. *See id.* at 28.
307. *See id.*

creating this new safety zone, the Agencies cautioned participants "to be sure that the network is non-exclusive in fact and not just in name."[308] The Agencies provided four criteria that will be used when evaluating non-exclusivity.[309] Remarkably, the Agencies ignored the AMA's argument to expand the exclusive physician network joint venture safety zone's size limit to 35% and maintained the size limit at 20%.[310]

The Agencies also reiterated the substantial financial risk requirement, such as capitated fees or withholds, as necessary to qualify for the safety zone protection.[311] However, the Agencies recognized the AMA's suggestion that other forms of economic risk, such as equity investments, should qualify for the substantial financial risk threshold. The Agencies acknowledged that other variations of risk sharing would satisfy this requirement but failed to provide any specific examples.[312]

According to Assistant Attorney General Bingaman, under these new rules "procompetitive, cost-lowering transactions can [now] go forward" resolving in her opinion the impasse of joint ventures "not happening because of the fear of antitrust violations."[313] However, the revised joint statement fails to shed much new light on the policies set out in the original statement. Instead of providing clear antitrust guidance to the health care industry, the revised joint statement continues to blur the lines between acceptable collaborative ventures and anticompetitive activities. What Representative Brooks referred to as good "preventative medicine"[314] is no more than a palliative operation for a physical problem with our antitrust laws that may require massive reconstructive surgery, if allowed to continue uncorrected.

IX. Health Care Providers' Future

The clear trend for health care consumers, e.g., individual purchasers,[315] businesses[316] and the government,[317] is the consolidation of these groups into large cooperative purchasing alliances such as managed care organizations (MCOs),

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308. *See id.*

309. *See id.* The Agencies will examine the following indicia of non-exclusivity, among others: (1) That viable competing networks or plans with adequate provider participation currently exist in the market; (2) That providers in the network actually participate in other networks or contract individually with health benefits plans, or there is other evidence of their willingness or incentive to do so; (3) That providers in the network earn substantial revenue outside the network; (4) The absence of any indications of significant de-participation from other networks in the market; and (5) The absence of any indications of coordination among the providers in the network regarding price or significant terms of participation in other networks or plans. *Id.*

310. *See id.* at 27.

311. *See id.*

312. *See id.*

313. The Bureau of National Affairs, Inc., *DOJ, FTC Health Care Guidance Supersedes Last Year's Version*, 63 U.S.L.W. (BNA) 2214 (Oct. 11, 1994) [hereinafter *Revised Statement Press Conference*].

314. *See* Rep. Brooks' Remarks, *supra* note 284.

315. *See* Eckholm, *supra* note 5.

316. *See id.*

317. *See id.*

health maintenance organizations (HMOs) and preferred provider organizations (PPOs) that in turn will band into purchasing consortia.[318] Although the number of HMOs fluctuated little during the last decade, enrollment in the nation's nearly 600 HMOs has quadrupled to almost fifty million.[319] Enrollment in the nation's PPOs also experienced staggering growth in the last decade to almost 1800 PPOs with forty million enrollees by 1993. As the nation's health care consumers increasingly consolidate into these alliances, independent physicians face this new form of competitive pricing hobbled in their responses by the current antitrust risks imposed by the revised joint statement and by the threat of private antitrust actions.

As the health care market for the next decade transforms itself in response to these competitive pressures, the buyers of health care products and services and the suppliers of health care products may emerge as the dominant forces in the health care market for the next decade as a result of a shift of bargaining power among the major suppliers, consumers, and payers of health care services.[320] The competitive strength of physician providers may well diminish unless the antitrust environment allows efficient, procompetitive physician networks to evolve.

An example of this disparity in the physicians' relative bargaining strength compared to these large cartels can be seen when a traditional buyer of health care products and services determines that it is more efficient to provide its own physician services rather than purchase outside physician services. When this occurs, that former buyer of physician services becomes a competitor to the existing physician networks.[321] Several large, and some smaller, employers are beginning to discover that it is often more efficient, and even profitable, to build primary care facilities than to purchase the same physician services in the health care market.[322] These corporations typically hire primary care physicians as their own corporate employees, and the corporation's employees become the direct source of managed care enrollees.[323] These corporations can even offer their physician services to other local employers, and in this way a former buyer of health care services has simply backed into a health care provider network role.[324]

The financial strength and patient volume provided by these large corporations has always been an important negotiating tool, but now these employers can simply enter the health care market as a competitor if physicians and other health care

318. *See id.*

319. *See id.*

320. Alden Solovy, *Crafty New Players: New Power Strategies — The Battle for Control*, HOSP. & HEALTH NETWORKS, Dec. 20, 1994, at 24.

321. *Id.*

322. *See id.* "Delta [Airlines] took that step backward into health care by building its own primary care center. Other companies that have built their own primary care centers include Bethlehem Steel, Goodyear Tire & Rubber Co., R.J. Reynolds, and John Deere & Co." *Id.*; *see also Henryetta Glass Plant Offers On-Site Clinic*, DAILY OKLAHOMAN, Dec. 25, 1994, at C1 (discussing Anchor Glass' construction of an on-site health clinic).

323. *See* Solovy, *supra* note 320, at 24.

324. *See id.* at 26.

providers fail to accede to the terms dictated by the large corporations.[325] This backward integration illustrates the increasing power large employers have come to exert on health care delivery.

Another unlikely competitor to the physicians in the health care provision market are suppliers of health care products. Indeed, these companies may be the trendsetters for the reconfiguration of the health care provider market. Several of these former suppliers of health care products are presently integrating their workforce and organizations into the provision of health care services.[326] For example, a health care supply corporation might purchase "alternate-site" services, such as a physical therapy clinic, an outpatient clinic, or even a primary care facility, and apply its management expertise to invigorate these provider organizations with aggressive profit motivation. Although a seeming conflict might exist between a supplier corporation owning "alternate-site" facilities that compete directly with the supplier's hospital and doctor customers, the profitability of this trend will likely compel these corporations to diversify into these profit centers to sustain their own businesses. Strategic conflicts aside, this forward integration by health care supply corporations into the health service market heralds even more intense competition for patients among members of physician network joint ventures.

In addition to former buyers and suppliers of health care products and services entering the health care provision market, other large corporations, such as insurance companies[327] and even hospitals,[328] are organizing integrated health care delivery systems which include physician networks. These new competitor organizations are well positioned in the marketplace because they are vertically integrated, performing services for themselves that would otherwise be purchased from other sources. Not only do these new vertically integrated competitors have lower transactional costs, such as negotiating, contracting, and paying profits to third party providers, these corporations avoid some of the antitrust risks faced by the horizontally organized physician network joint ventures.

Typically these vertically organized competitors employ physicians to provide primary care formerly purchased from third party physicians. Because the corporation employs the physician, it is impossible for the payer and the provider to conspire in restraint of trade. For example, the corporation could organize an integrated delivery system containing a PPO employing 50% or more of the physicians in a relevant market and still not face a conspiracy to restrain trade challenge. The only antitrust risk these new corporate competitors face would arise

325. *See id.*

326. *See id.*

327. Chris Roush, *Your Doctor's Boss May be an Insurance Company*, BUS. WK., Sept. 19, 1994, at 112 (discussing the trend of insurance companies purchasing doctors' practices and employing the doctors).

328. *Id.*

under section two of the Sherman Act[329] if the corporation gains too large a share of the physician services market.

On the other hand, because physician network joint ventures are horizontal alliances of physicians that would otherwise be in competition with each other, they are at risk of a conspiracy to restraint of trade challenge under section one of the Sherman Act. Although the revised joint statement provides some leeway for physicians to aggregate their practices and cut their transactional and managerial costs, thus enabling them to negotiate better prices, the physician network joint ventures are usually unable to compete as effectively against these corporate organizations in providing cost efficient health care. This position was argued by AMA general counsel, Kirk B. Johnson, when he stated that the revised joint statements "place physicians at a serious disadvantage in comparison to non-physician networks."[330]

X. Workable Solutions on the Horizon

A. Expansion of the Safety Zones

The revised joint statement promised independent physicians an advantage in this competitive arena of quality health care at the lowest possible cost by allowing greater aggregation of physician providers in an attempt to provide more cost efficient health care. However, in the face of relentless competition, often from competitors with greater financial strength and control of patient resources, many physicians remain handicapped by the narrowness of these antitrust safety zones.

Some larger physician network joint ventures in metropolitan areas are able to accumulate the capital, managerial expertise, and requisite number of physician members without violating the safety zone percentage size limits.[331] However, in the rest of the country most physician network joint ventures are unable to operate efficiently or effectively within the current safety zone size limits.[332] The number of physician members needed in most areas of the country to satisfy the provider coverage required by managed care organizations and the capital requirements to operate is often greater than the current percentage size limits prescribed for physician network joint ventures by the Agencies' joint statement.

Safety zones for physician network joint ventures should be expanded to allow physicians in most parts of this country to develop effective alliances to compete

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329. 15 U.S.C. § 2 (1994).

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Id.

330. *See* AMA Letter, *supra* note 14, at 4.

331. *See id.* at 9-10.

332. *See id.* at 10.

on par with the new corporate competitors. The AMA's suggestion of two levels of size limits for networks represent a practical and workable solution, permitting the formation of cooperative arrangements, while keeping anticompetitive transactions in check.

An exclusive network restricts members from contracting outside the network and virtually controls the market for its members' services. The larger the exclusive network, the greater the potential to raise its prices and restrict other networks from entering the market. In the presence of non-exclusive networks, the threat of new competitors entering the health care provision market makes raising prices less appealing, and perhaps strategically more difficult, for the networks. Therefore, this market reality should prevent exclusive physician network joint ventures from gaining excessive market power when faced with non-exclusive competitors. If an exclusive network begins to charge higher prices, new competitors will simply enter the market to provide a more cost efficient alternative to the exclusive network. A 35% size limit for exclusive networks will allow physicians to compete more aggressively against the new non-exclusive competitors, but should preclude the exclusive networks from developing excess power in the market.

Non-exclusive physician network joint ventures allow members to contract outside the network, and thus are unable to control the market for its members' services. Therefore, non-exclusive networks are functionally unable to ratchet up prices or restrict other networks from entering the market. If a non-exclusive network did charge higher prices, other networks could form or other networks could enter the market and charge lower prices. The proposed 50% size limit for non-exclusive networks should allow the physician members to compete effectively against the new integrated corporate competitors, and market forces should prevent the non-exclusive networks from gaining excessive power by domineering the market.

The Agencies will certainly argue that the larger the safety zones, the more potential there is for anticompetitive activities. However, the more leeway physicians have to meet competition by collaboration, the more likely the collective groups can provide cost efficient delivery of health care. The inclusion of the "extraordinary circumstances" exception in the joint statement unfairly and arbitrarily penalizes physician networks. Even though the physician network joint ventures might gain market power under expanded safety zones, a well defined "extraordinary circumstances" exception would insure that truly anticompetitive activities are kept in check, regardless of whether the physician network fell outside the safety zones. Therefore, the expanded safety zone percentage levels suggested by the AMA will allow the formation of beneficial cooperative arrangements by physicians, yet maintain control over potential anticompetitive transactions.

B. A Necessary Ingredient: Private Action Immunity

When Assistant Attorney General Anne K. Bingaman expostulated that the revised statement provides "landmark additions to the previous statements. . . . [and] allow[s] procompetitive transactions while maintaining the line on anticompetitive

risks and transactions,"[333] she ignored one key issue; the revised joint statement only covers antitrust actions brought by the Agencies. Although the statement provides this modicum of security for physician networks, private antitrust action protection is lacking. Because private actions are the most frequent antitrust challenges,[334] a reassuring zone of safety requires protection from private actions, as well as from government intervention.

A barrier to the formation of many procompetitive, cost-saving collaborative efforts by physician networks is raised because the Agencies' safety zones have no legal effect on private antitrust challenges. A private action addition to the regulatory safety zones is essential to allow the evolution of physician networks, and legislative involvement via a codification of the joint statement could insure that safety zones provide shelter from private antitrust actions. Instead of bundling the antitrust safety zone legislation with other health care legislation, a safety zone specific legislation package ought to be presented for debate on the merits of its ability to provide appropriate civil antitrust protections.

This antitrust safety zone legislation should incorporate the expanded size limits suggested by the AMA to insure that physician network joint ventures can effectively compete with the other forms of integrated health care delivery systems. In order to create a true safety zone, this legislation must cover actions brought by the Agencies, as well as private actions brought under federal antitrust laws. Detailed guidelines also should be included to identify activities that would qualify as "extraordinary circumstances" which invalidate safety zone protection. Finally, the legislation should incorporate the current analysis schema used by the enforcement Agencies for physician network joint ventures falling outside the safety zone size limits.[335] Without these protections, physicians may be reluctant to enter into joint ventures for fear of antitrust violations. Physician network joint ventures must be given certain structural leeway in their organizational construction so they may build novel cost-saving organizations, ultimately benefiting all health care consumers.

XI. Conclusion

The health care industry is currently reconfiguring itself by cutting costs, modifying administrative procedures, and developing new health care collaborations for delivering service to the consumer. In the short term, the industry will continue to experience dramatic and rapid changes as the various entities realign themselves in response to market driven forces. In this era of change, health care providers require clear and decisive guidelines in forming collaborative arrangements among themselves to survive economically in an increasingly competitive marketplace.

The FTC and DOJ joint statement, first issued in 1993 and revised in 1994, was a small step in the right direction of modifying the antitrust perspectives for the

333. *See Revised Statement Press Conference, supra* note 313.

334. *See* AMA Letter, *supra* note 14, at 8.

335. *See Revised Joint Statement, supra* note 9 and accompanying text.

country as applied to the physician network joint ventures. However, enhanced protection from antitrust risks is necessary. Physicians will remain reluctant to enter into various procompetitive alliances without the certainty of an evenhanded application of antitrust laws, including agency regulations. If the revised joint statement lingers unchanged, antitrust laws may ultimately prevent physicians from entering into arrangements that could work "for the benefit of the sick."[336] However, if Congress and the Agencies work together to further modify the joint statement and enact true safety zone legislation, physicians will no longer face overly restrictive and sometimes arbitrary agency regulation. Then perhaps the medical profession can begin to "heal thyself."[337]

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336. *See* Hippocrates, *supra* note 1, *available in* THE ENCYCLOPEDIA OF PHILOSOPHY, *supra* note 1, at 6-7.

337. *St. Luke* 6:9.