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Managed Competition, Integrated Delivery Systems and Antitrust

Thomas L. Greaney

MANAGED COMPETITION, INTEGRATED DELIVERY SYSTEMS AND ANTITRUST

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INTRODUCTION

From an efficiency perspective, the overarching challenge in reforming the nation's health care system is finding the means to mitigate market failure. Market interactions in health care have been distorted by the existence of imperfect and asymmetrically distributed information, the peculiar incentives that flow from the presence of insurance, and other market imperfections. While proponents of various legislative alternatives differ as to whether and at what social cost efficient markets can be put in place, at the core of virtually all comprehensive reform measures is the creation of mechanisms to counteract these deficiencies.[1]

Competition-oriented reforms attempt to "manage competition" by correcting market failures through a variety of means. Purchasing alliances gather and process information that is at present too costly for consumers and most employers to collect. Fixed benefit packages avoid confusion and enable consumers to compare alternatives. Along with community rating, fixed packages ameliorate the problems associated with risk selection whereby individuals adjust insurance purchases according to medical need and insurers seek favorable risks among their insured population through marketing and other measures. In addition, requiring purchasing alliances to pay plans according to the risk of the enrolled population reduces incentives to select healthy subscribers and avoid the sick.[2]

Anticipation of competitive reform has begun to radically reshape the supply side of the industry. In recent months, the market has undergone wholesale transformation manifested by increasing vertical and horizontal integration of entities delivering health serv-

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1 *See* ALAIN C. ENTHOVEN, THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE (1988); Alain C. Enthoven, *Health Consumer-Choice Plan* (pt. 1), 298 NEW ENG. J. MED. 650 (1978); John J. Inglehart, *Managed Competition*, 328 NEW ENG. J. MED. 1208 (1993); Paul D. Wellstone & Ellen R. Shaffer, *The American Health Security Act—A Single-Payer Proposal*, 328 NEW ENG. J. MED. 1489 (1993).

2 *See* PAUL STARR, THE LOGIC OF HEALTH-CARE REFORM 47-51 (1992).

ices and by consolidation of insurance and delivery functions.[3] Not only have providers flocked to so-called managed care health plans—health maintenance organizations (HMOs), preferred provider organizations (PPOs), and various hybrid entities—but integrated networks combining a full range of provider services and insurance in a single organization also have proliferated.[4] Integrated delivery systems (IDSs), as the latter are known, range from loose contractual affiliations to outright mergers of providers and insurers into a single corporate entity. In general, two important characteristics distinguish these arrangements. First, they possess some degree of functional integration of risk-based pricing, mechanisms for utilization review, and quality assurance systems. Second, they may involve close collaboration among providers on competitively-sensitive issues such as global pricing for services, allocation of markets among members, refusals to deal with non-affiliated providers, and elimination of redundant or excess capacity.

The configuration and competitiveness of integrated delivery systems are of critical importance to market-oriented reforms. These networks essentially serve as the central nervous system of the managed competition model, transmitting incentives from consumers and their purchasing alliances to providers while sending messages to the marketplace in the form of prices that signal to consumers the value (or resource costs) of health care services. Competitive reform theory posits that integrated delivery systems will constitute the organizational framework for controlling health care costs, advancing that goal in two ways. First, these systems will develop governance mechanisms and incentive systems to control provider behavior. Second, competitive interaction among rival systems will ensure that systems do not stray from the goal of cost containment.

Whether integrated delivery systems will realize these objectives hinges on the development of a legal infrastructure that will support

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[3] In the nomenclature of the health care industry, the term "delivery" refers to the furnishing of services by "providers," i.e., physicians, nurses, allied health professionals, hospitals, outpatient facilities, laboratories, and vendors of durable medical equipment (DME). Payment for these services is generally referred to as "reimbursement," a revealing usage that betrays medical professionals' belief that compensation is an entitlement and not a bargained-for exchange. *See* Clark C. Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697 (1986).

[4] *See* Frank Cerne, *The Fading Stand-Alone Hospital*, 68 HOSPS. & HEALTH NETWORKS, June 20, 1994, at 28 (reporting results Deloitte & Touche-Hosps. & Health Networks survey of 1743 hospitals and 43 health systems—67% of respondents' believed that having a PHO is necessary for acute care hospitals; 20% indicated they have a PHO in operation; and 13% indicated they have a PHO that is not yet operational); Spencer Rich, *U.S. Hospitals Aren't Waiting For Congress*, WASH. POST, June 21, 1994, at A4 (reporting results of an accounting firm survey finding 71% of hospitals either belong to or are in the process of developing integrated delivery systems and 81% of hospital executives predict that their hospitals will be parts of service networks within five years).

competition. This Article analyzes two key determinants of the competitive consequences of integrated delivery systems: the design of health care reform legislation and the antitrust principles applicable to the composition and activities of these networks. It proposes that in order to promote effective managed competition, both Congress and the judiciary should decide health care issues with a keen appreciation of the peculiar nature of health care markets.

Part I discusses the economic characteristics of health care that cause distortions in the market. It then assesses why "unmanaged" competition has failed to control costs and has cast a shadow over market-based reform strategies. Part II introduces the reader to several models of integrated delivery systems which are rapidly developing around the nation and appraises their capacity to help competitive markets function properly. Part III analyzes the promise of managed competition and describes certain flaws in various reform proposals that may undermine the development of competitive networks. Part IV traces the antitrust rules governing the formation and operation of integrated delivery systems. It suggests some justifications for these rules premised on the special economics of health care and urges that the judiciary and Congress resist appeals to weaken their force.

I
WHY HEALTH MARKETS ARE DIFFERENT AND WHY UNMANAGED COMPETITION HAS NOT WORKED

A. Market Failure in Health Care

Health care markets diverge in a number of important respects from the assumptions of neoclassical economics that define a perfectly competitive market. The persistence of these sources of market failure helps explain why competition has failed thus far to contain expenditure growth or to efficiently allocate health care resources.[5] This section identifies the imperfections in health care markets and traces their consequences.

For many years, providers dominated decisionmaking and institutional arrangements in the health care arena by successfully exploiting the special characteristics of health care delivery and insurance.[6] Later, as legal and other barriers to competition eroded, the imperfections of the health care market distorted incentives and economic outcomes so that the market was unable to perform its cost-economizing

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5 *See* ENTHOVEN, *supra* note 1, at 12-13; The Jackson Hole Group, The 21st Century American Health System or Managed Competition: A Proposal for Public and Private Health Care Reform, Policy Doc #2, 1-2 (1991).

6 *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982); Charles D. Weller, *"Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351 (1984).

function. Strategies designed to improve competitiveness seemed to have perverse results. In effect, the problem of "second best" may well have thwarted well-intentioned reforms: by correcting some, but not all, market imperfections, policymakers may have exacerbated conditions and worsened the performance of the health care marketplace.[7]

1. *Information and Agency Problems*

The prevalence of information gaps, asymmetric information, and agency problems interferes with competitive interactions in the health care marketplace.[8] Given the technical nature of medical information, the complexity of diagnoses and treatment alternatives, and the inherent uncertainty surrounding medical judgments, patients and third party payers find it difficult to evaluate the cost and quality of health services. To make matters worse, the information that is available is distributed asymmetrically among providers, patients, and payers. To some extent, this may permit physicians to "induce demand" for their services; at a minimum this phenomenon makes information costly for buyers to acquire.[9]

Closely related to the problem of asymmetric information are the difficulties presented by agency relationships in health care. Uninformed patients delegate authority to physicians to make appropriate decisions on their behalf.[10] However, because of the heterogeneous nature of health care services and the demands of patients, physicians

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7 For example, by reducing barriers to entry and increasing the supply of physicians without correcting information problems and dealing with moral hazard in insurance, regulators may have increased the amount of unnecessary or marginally beneficial care being supplied. *See* Jonathan E. Fielding & Thomas Rice, *Can Managed Competition Solve the Problems of Market Failure?*, HEALTH AFF. 216 (1993 Supp.); *see generally* R.G. Lipset & Kelvin Lancaster, *The General Theory of the Second Best*, 24 REV. OF ECON. STUD. 11 (1956); *see infra* Part I.B.

8 *See generally* SHERMAN FOLLAND ET AL., THE ECONOMICS OF HEALTH & HEALTH CARE 151-74 (1993); Mark V. Pauly, *Is Medical Care Different?*, *in* COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE 19, 28-30 (Warren Greenburg ed., 1978); Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

9 Financial incentives that reward practitioners who prescribe treatments of little marginal benefit compared to cost may foster excessive utilization of services. The extent to which induced demand is prevalent in the market is contested in the health economics literature. *See* PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS 76-109 (3d ed. 1988). For a discussion of information problems in health insurance markets and marketplace responses, see Thomas L. Greaney & Jody L. Sindelar, *Physician-Sponsored Joint Ventures: An Antitrust Analysis of Preferred Provider Organizations*, 18 RUTGERS L.J. 513, 528-31, 540-42 (1987).

10 Quality evaluations are especially difficult because they usually cannot be performed *ex ante*. Some economic goods, such as health care services, that cannot be evaluated by observation or use (i.e., the consumer may never know if a treatment was actually necessary) are referred to as "credence goods." Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 658-59 n.69 (1979).

cannot always act as appropriate surrogates. Moreover, there is often a divergence of interest because the physician-agent may have financial incentives that conflict with his role as agent.[11]

2. *Adverse Selection and Moral Hazard*

Information deficiencies compound other problems created by the existence of health insurance. Insurance reduces policyholders' vigilance about costs. This phenomenon, known as "moral hazard," implies that insured individuals will be more likely to seek care and to demand more expensive services than they would if they had to bear the full costs of these services. Moral hazard distorts markets, causes an inefficient allocation of resources, and in the extreme case, can destroy the marketability of insurance.[12] Insurers' ability to adopt strategies for controlling moral hazard is constrained by the lack of adequate information available to the insurer about the amount of care really needed by a particular patient. Moreover, the incentives of all parties to reduce moral hazard are limited by tax policies that subsidize the purchase of insurance.[13]

Adverse selection occurs when policyholders are able to anticipate health care needs more accurately than insurers and then act on that knowledge by adjusting their insurance purchases. This may result in excessive congregation of "bad risks" in certain plans.[14] The other side of the coin, "preferred risk selection," entails efforts by insurers to attract "good risks" through marketing, benefit design, and other strategies. Successful exploitation of this phenomenon results in some insurers' garnering healthy patients while their rivals are left with a higher-cost population base. This generates a cycle of selection that can segment the market.

3. *Heterogeneity of Services*

Another significant difference between conditions in the health care market and perfect market conditions is the fact that health care services are highly heterogeneous. Quality may vary considerably, depending upon such things as the professional's talents, training, attentiveness, and "caring" attitude. Other factors such as geographic location and variation in outcomes distinguish providers of health care services. Product differentiation may siguificantly affect the level of market power possessed by particular competitors and may en-

11 *See* FOLLAND ET AL., *supra* note 8, at 162-74.

12 *See id.* at 270-75; THOMAS G. MCGUIRE, FINANCING PSYCHOTHERAPY: COSTS, EFFECTS AND PUBLIC POLICY 51-60 (1988).

13 *See* Michael J. Graetz, *Universal Health Coverage Without an Employer Mandate*, DOMESTIC AFF., Winter 1993-94, at 79.

14 MCGUIRE, *supra* note 12, at 44-51.

hance the risks of anticompetitive conduct in relatively unconcentrated markets.[15]

4. *Mobility Barriers, Natural Monopoly, and Cartelization*

In contrast to perfect market assumptions that barriers to entry do not exist, sellers of health services are subject to impediments to mobility in the form of governmental and private licensing and practice requirements.[16]

Perfectly competitive markets have large numbers of buyers and sellers and are free of cartels or other private agreements to curtail competition. The health care market, by contrast, has a long history of private "self regulation"[17] and government-sponsored arrangements that restrict free competition. Moreover, many rural markets cannot support multiple hospitals or numerous specialists. It may be the case in such markets that only one integrated network can viably and efficiently offer services.[18]

5. *"Free Riders" and Fragmentation*

Another important shortcoming of the health care financing and delivery system is that it relies on highly fragmented provider "networks"[19] which do not command the loyalty of individual practitioners and inadequately compensate innovations in cost control. Economists have pointed out the transaction cost and public good consequences of this phenomenon. For example, in a market in which each physician belonged to ten PPOs or independent practice association (IPAs), the doctors each would have to assume the transaction costs of dealing with ten different utilization controls and reimbursement plans. Moreover, health plans would have little incentive to innovate in cost control because each would have to share with other plans the

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15 *See* Thomas J. Campbell, *Predation and Competition in Antitrust: The Case of Nonfungible Goods*, 87 COLUM. L. REV. 1625, 1630-35 (1987); Louis Kaplow, *The Accuracy of Traditional Market Power Analysis and a Direct Adjustment Alternative*, 95 HARV. L. REV. 1817, 1828 (1982); Richard Schmalensee, *Another Look at Market Power*, 95 HARV. L. REV. 1789, 1800 (1982) ("There is no general, universally applicable model of the competitive relationship among differentiated products.").

16 *See* 1 BARRY R. FURROW ET AL., HEALTH LAW §§ 1-4 to 1-22, 3-2 to 3-21 (1994).

17 *See, e.g.*, STARR, *supra* note 6; Greaney & Sindelar, *supra* note 9, at 531-38; *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, 63 YALE L.J. 937 (1954).

18 *See infra* Part III.

19 As used in this Article, the term "provider networks" refers to affiliations of doctors and-or hospitals that are not otherwise linked by an organizational structure. "Health plans" are entities supplying a provider network and a health insurance component. On the various kinds of integrated delivery systems, see *infra* Part II.

benefits realized from persuading physicians to adopt more efficient practice patterns.[20]

B. The Legacy of Market Failure: Explaining the Failure of Unmanaged Competition to Control Costs

Critics of market-based reform frequently point to the private sector's abysmal failure to contain costs during the "competitive revolution" of the 1980s as proof of the futility of reliance on competition. However, close examination of insurance practices and provider responses to the incentives of the health financing system reveals a marketplace highly responsive to economic stimuli. Unfortunately, those stimuli were the distorted signals influenced by regulation and the market imperfections discussed above, and, consequently, competition often produced perverse results.[21] Many practices ostensibly designed to adjust to competitive imperatives in fact reflected successful exploitation of market imperfections. For example, insurers became quite adept at attracting healthier patients and avoiding risks—efforts which contributed to market distortions and diverted energies from other cost-lowering strategies.[22] Risk selection enabled the insurance industry to make profits by directing efforts toward risk-improving strategies such as marketing, product differentiation, provider selection, and other steps rather than by putting direct pressure on providers to lower costs.

A related strategy among insurers has been product differentiation and market segmentation. Insurers have offered packages of products with widely varying payment and benefit features, thereby reducing consumers' ability to compare prices and segmenting the population into different package submarkets. This diversion from price competition has tended to reduce pressures to lower prices, or as Alain Enthoven has characterized the phenomenon, to make the demand curve for HMOs more inelastic.[23]

For their part, providers became quite adept at shifting the impact of competition onto others. As powerful third party payers (principally the government, HMOs, and larger employers) requested (or mandated) that hospitals and physicians accept lower payments, prov-

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20 *See* Richard Kronick et al., *The Marketplace in Health Care Reform—The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148, 149 (1993) (citing ALAIN C. ENTHOVEN, THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE (1988)).

21 For a description of the shortcomings of the market and the absence of the political and legal infrastructure necessary to support competition, see Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE J. ON REG. 179 (1988).

22 *See* STARR, *supra* note 2, at 40-42.

23 Alain C. Enthoven, *Why Managed Care has Failed to Contain Health Costs*, HEALTH AFF., Fall, 1993, at 27, 37-40.

iders skillfully redirected the burden of cost containment by effectively charging considerably higher prices to those buyers lacking the clout or the initiative to obtain discounts. This practice has been euphemistically referred to as "cost-shifting."[24] Physicians also avoided governmental efforts to control fees by increasing the aggregate volume of services provided in almost perfect synchronism with each "freeze" fee level.[25]

C. Economic Analyses of Managed Care

There is widely-accepted evidence that associates managed care with significant cost savings as compared to fee-for-service or traditional indemnity insurance.[26] However, an important lesson emerging from the nation's experience with unmanaged competition in recent years is that not all managed care systems are alike. Different organizational forms vary significantly in their capacity to control costs. For example, empirical studies reveal that HMOs and IPAs achieve appreciably greater cost reductions than PPOs and IPA point-of-service systems.[27] These differences are attributable to greater selectivity by network plans in choosing providers and the superior cost effectiveness of not covering services received out-of-network (as opposed to imposing financial disincentives for such services). In addition, a large number of studies show significantly greater savings attributable to staff-model and group-model HMOs than are realized

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24 Costs, of course, have little to do with what is being shifted. Providers were engaging in classic economic price discrimination, charging net prices reflecting higher margins to those with less elastic demand. *See* ROGER D. BLAIR & DAVID L. KASERMAN, ANTITRUST ECONOMICS 258-79 (1985).

25 *See* James B. Mitchell et al., *The Medicare Physician Fee Freeze*, HEALTH AFF., Spring 1989, at 21.

26 *See* Congressional Budget Office Staff Memorandum, The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures (1992) [hereinafter CBO Memorandum] (estimating that universal adoption of staff or group model HMOs would reduce national health expenditures by over 10%). *See also* Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations*, 321 NEW ENG. J. MED. 86 (1989); W. Pete Welch et al., *Toward New Typologies for HMOs*, 68 MILBANK Q. 221 (1990); David C. Stapleton, New Evidence on Savings from Network Models of Managed Care, Lewin-VHI, Inc. Report to the Healthcare Leadership Council (May 5, 1994) [hereinafter Lewin-VHI Report]. Some analysts contend that the magnitude of savings from managed care would be even greater than the level currently achieved by efficient plans if system reform included adequate incentives to choose cost-effective plans. Alain Enthoven & Richard Kronick, *Universal Health Insurance Through Incentives Reform*, 265 JAMA 2532 (1991).

27 Lewin-VHI Report, *supra* note 26 (reporting that network managed care systems save 23% over fee for service plans while point of sale plans save only 13% and preferred provider organizations save 11%). This study is particularly significant because it rigorously controls for differences in risk selection, benefit design and differences in markets.

through other forms of managed care.[28] The evidence regarding the effectiveness of competitive contracting in states such as California has led many economists to conclude that selective contracting is a key element in making competition work.[29]

Economic studies finding important differences in cost savings among plans of a given type shed further light on the variables affecting competitive performance.[30] These studies reveal significantly greater savings associated with higher patient volumes of network providers. In addition, markets where overall market penetration and competitiveness of HMOs is greatest foster increased cost effectiveness.[31] Thus, where participating physicians treat relatively few patients from an IPA network, the IPA realizes lower cost savings than do plans in which the physicians treat larger numbers of plan members.[32] A second important finding with respect to variations among plans of the same type is that savings are greatest where price competition is most intense.[33] A number of other studies report significantly greater provider discounts in markets with greater managed care competition.[34] Finally, there is some indication that managed care has slowed increases in physician compensation.[35] With notably slower growth in specialty areas, this suggests that managed care can rationalize physician reimbursement and the manpower market.

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28 *See* CBO Memorandum, *supra* note 26 (summarizing studies); Sheldon Greenfield et al., *Variations in Resource Utilization among Medical Specialties and Systems of Care: Results from the Medical Outcomes Study*, 267 JAMA 1624 (1992).

29 *E.g.*, David Dramove et al., *Is Hospital Competition Wasteful?*, 23 RAND. J. ECON. 247 (1992). *See generally* Paul A Paulter & Michael Vita, *Hospital Market Structure, Hospital Competition and Consumer Welfare: What Can the Evidence Tell Us?*, 10 J. CONTEMP. HEALTH L. & POL'Y 117, 166 (1994).

30 Lewin-VHI Report, *supra* note 26, at 5 (reporting variations among Aetna IPA plans as high as 35% in one market area and as low as 12% in another. Variations in savings for POS plans ranged from 1% to 24%; and savings for PPO plans ranged from 1% to 20%).

31 *Id.* at 30-41.

32 *Id.* at 6, 30-34 (reporting differences in cost savings based on the number of patients an IPA physician has; increases in volume from 100 to 1000 patients correlates with the decline of 6.4% in costs).

33 *Id.* at 28 (explaining variations in savings among plans of the same type to the magnitude of HMO penetration, market "maturity" as a managed care market and intensity of competition among HMOs). *See generally* Paulter & Vita, *supra* note 29 (summarizing studies).

34 *See, e.g.*, David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient Driven to Payer-Driven Competition*, 36 J.L. & ECON. 179 (1993); Glen A. Melnick et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217 (1992); Monica Noether, *Competition Among Hospitals*, 7 J. HEALTH ECON. 259 (1988).

35 Morley M. Robbins & Richard C. Loudermilk, *Lining Up Their Shots*, HOSPS. & HEALTH NETWORKS, May 20, 1994, at 30 (reporting results of a physician compensation survey showing that managed care has caused leveling of physician compensation since 1992 with decreases in compensation for certain procedure-based specialties, decreases or moderated growth in compensation for hospital-based physicians, and increased demand for primary care physicians).

II
A TAXONOMY OF INTEGRATED DELIVERY SYSTEMS

Anticipation of health care reform has generated extensive reorganization and innovation in the delivery of health care services in the last year. Horizontal integration—combinations of providers competing at the same level of care—increased significantly. For example, physicians have formed group practices, HMOs, "clinics without walls," and other arrangements that entail varying degrees of clinical and administrative integration. Hospitals have likewise combined in increasing numbers by merging with other hospitals and by forming joint ventures and informal alliances for sharing management and jointly purchasing, operating, or owning facilities and equipment. The most revolutionary development, however, has been the explosive growth of vertical integration producing new entities offering hospital, physician, and ancillary health care services and furnishing management and information support services to providers. Increasingly, vertical integration has gone beyond combining providers' services to combinations that link an HMO or other insurance plan to the service delivery functions.

Integrated delivery systems promote efficiency in several ways. Of particular importance to managed care contracting, they facilitate pooling of capital, spread financial risk, realize economies of scale, and align the interests of physicians and hospitals. Integration also fosters a "seamless" system that enhances quality by providing a comprehensive continuum of care from prevention through treatment and follow-up.[36]

Although something of a protean concept, the integrated delivery system may be broadly defined as an organization furnishing to insureds multiple levels of health services from affiliated providers and furnishing to providers insurance, case management, contracting, information services, or some combination of these.[37] The following taxonomy of integrated delivery systems describes the principal organizational features and integrative benefits of several models. It should be noted, however, that there is considerable diversity among systems within each model and that many hybrid forms exist in this rapidly-evolving area.

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36 F. Kenneth Ackermann, III, *The Movement toward Vertically Integrated Regional Systems*, 17 HEALTH CARE MGT. REV. 81 (1992).

37 Carl H. Hitchner et al., *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273, 274 (1994); INTEGRATED HEALTH CARE DELIVERY SYSTEMS MANUAL (Allan Fine ed., 1993). *See generally* Kenneth L. Levine, *The Tax Status of Vertically Integrated health Care Delivery Systems*, 26 J. HEALTH & HOSP. L. 257 (1993); 20 TOPICS IN HEALTH CARE FINANCING: INTEGRATED DELIVERY SYSTEMS (Paul R. DeMuro ed., Spring, 1994).

A. Primordial Integration: Contractual Affiliations and Provider Networks

Physicians have established a wide variety of commercial linkages, including group practices,[38] Independent Practice Associations (IPAs),[39] Preferred Provider Organizations (PPOs), "clinics without walls" (CWWs),[40] and group and staff model HMOs.[41] These organizations may in turn affiliate with hospitals, usually by contract, to offer care. Alternatively, they may each separately affiliate with a third party, such as an insurance company or employer to offer services to enrollees of a health plan. Hospitals have likewise established networks such as PPOs, other managed care entities or "alliances," or joint ventures that enable them to jointly contract for the provision of services.

A distinguishing feature of IPAs, PPOs and CWWs is that they entail relatively little functional integration among providers in terms of practice management or patient care. This is especially the case when reimbursement for services is on a fee-for-service basis.[42] The entity supplies some administrative services, principally joint marketing and some form of utilization review, but physicians maintain their individual practices. Consequently, management of care is limited. Greater integration results from capitated payment and certain other forms of risk sharing because physicians must adopt practice styles that control costs, obtain data to set capitation rates, and share with each other services that promote effective cost control.[43] However, the assets of providers remain separate, and there is little vertical inte-

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38 Group practices are physician-controlled entities, usually partnerships or professional corporations, that operate as a single business entity, with common facilities, joint ownership of assets, and the sharing of profits, losses, and expenses. Some physician groups combine multiple specialties, while others consist exclusively of doctors in the same field of practice.

39 IPAs are entities that contract with physicians to provide services to enrollees of managed care organizations such as PPOs and HMOs. Physicians maintain their own practices and are reimbursed by the managed care organizations on either a fee-for-service or risk-sharing basis such as capitated payments. Hitchner et al., *supra* note 37, at 275 n.4.

40 The clinic without walls (or "group practice without walls") is an organization formed either through contract or establishment of a separate legal entity by sole practitioners or physician groups. The physicians or groups typically practice at multiple sites and retain ownership of practice assets. Depending upon the amount of integration desired, the entity may operate a central office to provide marketing, billing, or other services for the physicians. *See* FURROW ET AL., *supra* note 16, § 5-49; Levine, *supra* note 37, at 269 n.4.; James G. Wiehl, *Benefits and Detriments of Various Structural Models, in* INTEGRATED HEALTH CARE DELIVERY SYSTEMS MANUAL ¶ 410 (Alan Fine ed., 1993).

41 HMOs are discussed *infra* Part II.C.

42 Douglas Hastings, *Developing Integrated Delivery Systems: An Era of Change in Health Delivery and Financing, in* HEALTH LAW HANDBOOK (Alice G. Gosfield ed., 1994); Hitchner et al., *supra* note 37, at 277.

43 Hitchner et al., *supra* note 37, at 281.

gration among hospitals, physician practices, and the financing system.

B. Intermediate Forms of Integrated Delivery: Management Services Organizations (MSOs), Physician-Hospital Organizations (PHOs), and Foundation-Model Systems

A number of recent organizational innovations have sought to increase integration between physicians and hospitals to accommodate the demands of managed care contracting. These arrangements vary considerably in the degree of integration, the functions that are integrated, the magnitude and extent of financial risk sharing, and the allocation of governance authority. Many regard these arrangements as an intermediate step toward more comprehensive integration. In other words, they are useful primarily for helping to overcome resistance and hostility among physicians toward cooperative agreements that may entail sacrificing clinical and economic autonomy.

1. *Management Services Organizations*

Management services organizations (MSOs) are entities formed to provide management services and other assistance to affiliated physicians, group practices, clinics without walls, or other physician groups. Although they lack significant patient care and financial integration, these arrangements generally entail stronger linkages between physicians and hospitals than the forms discussed in the previous section. The typical MSO agreement involves either an acquisition of or contract to manage physician practices by an entity not controlled by physicians, usually a hospital or hospital-physician joint venture. MSOs perform a variety of functions for physicians including billing and collection, personnel management, and group purchasing. In addition, they supply administrative and information services necessary for managed care contracting, such as utilization review, management information systems, facility design, and negotiation services.[44] Hospitals participating in MSOs are able to obtain closer ties and affiliations with primary care physicians thereby assuring an adequate referral base for hospital services.

Many view the MSO as a transitional vehicle that assists hospitals and physicians in taking the initial steps necessary to participate in managed care contracting. However, as noted above, MSOs involve no risk-sharing and little financial or functional integration among

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[44] Typically, MSOs are hospital subsidiaries, separate corporations, or joint ventures in which hospitals and physicians share ownership. *See generally* FURROW ET AL., *supra* note 16, § 5-49; Hitchner et al., *supra* note 37, at 285-86.

participating physicians. Physicians surrender little in the way of autonomy. Overall, the principal integrative benefit of MSOs is their capacity to lower the transactions cost of risk-based contracting.

2. *Physician-Hospital Organizations*

Physician-hospital organizations (PHOs) link hospitals, physician groups, and sometimes other provider entities to form a network capable of contracting with third party payers to provide a comprehensive package of services. Although such physician-hospital ventures may be established by contract, PHOs are typically separate legal entities controlled by governing boards consisting of both physician and hospital representatives.[45] When formed by contractual agreement, the provider network operates through a single agent empowered to represent all providers in managed care contract negotiations. Sometimes the agent has legal capacity to bind the providers under a power of attorney.[46]

Although the PHO may bring together a large number of geographically-dispersed providers, it entails only partial integration because physicians and hospitals continue to function separately. PHOs do not establish hierarchical organizational structures.[47] In essence, the PHO operates as a negotiating agent on behalf of hospitals and physicians. Consequently, PHOs may enter into capitated contracts in their own name and establish financially integrated arrangements among participating hospitals and physicians. As with MSOs, however, the appeal of PHOs lies in their potential to reduce the transaction costs of securing agreements and to offer a package of quality and utilization controls that govern both medical and hospital services. The PHO model of organization also entails relatively little clinical integration among participants because providers continue to operate independently.

3. *Foundation-Model Systems*

Under the "foundation-model" IDS, a nonprofit foundation (usually a hospital subsidiary or an affiliate of a hospital through a com-

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45 While physicians or physician entities may or may not have an ownership interest in the PHO, as a practical matter, significant physician input into the affairs of the PHO is usually necessary. Commonly relied upon means for assuring physician input include board membership and bylaw provisions requiring physician approvals for specified transactions. However, impasses may arise from certain structural arrangements, such as when governance boards have equal representation from physicians and the hospital. *See* James G. Wiehl, *Advantages/Disadvantages of Integration Structural Models, in* INTEGRATED HEALTH CARE DELIVERY SYSTEMS MANUAL, *supra* note 40, at 11-16.

46 Hitchner et al., *supra* note 37, at 296.

47 Because the PHO does not invest in physicians' tangible assets, it requires a relatively small capital investment compared to other forms of integration. *Id.* at 296-97.

mon parent) establishes one or more clinics to offer all primary and specialty physician services and contracts with payers or consumers. It also employs or contracts with physicians and other professionals to provide services and owns and operates all aspects of the medical practices. In some cases, the foundation may own or be affiliated with its own HMO. In these situations it is comparable to the fully integrated delivery systems discussed in the next section that combine financing and delivery.

The advantages of the foundation-model IDS lie in its extensive coordination and integration of provider services and in its ability to help physicians obtain access to capital while also enabling them to retain autonomy over patient care matters.[48] In contrast to the MSO, the foundation-model system usually owns or operates one or more hospitals and outpatient clinics as well as the equipment, practice locations, medical records, and supplies of the medical practices of its affiliated physicians. Thus, there is considerably greater integration of the participating hospitals with the foundation-operated clinics. Where employment of physicians is permitted, the foundation model entails more comprehensive control over physician practices and hence greater integration of clinical activities.

C. Full Integration

The fully integrated system is one that combines comprehensive, integrated service delivery with the insurance function. Prototypical examples are those HMOs that own their own hospitals for the provision of acute care services and either employ staff physicians (staff model HMOs) or contract with group practice physicians (group model HMOs).[49] These arrangements are fully integrated in several respects. First, individuals must obtain all covered health services from the HMO; any services received from non-HMO providers are paid for by the consumer out-of-pocket. Thus, patients are closely bound to the HMO for their care. Second, physicians are employees or are paid through capitated payments and other financial arrangements that serve to align their incentives with those of the HMO. Finally, internalization of the insurance function within the entity enables the HMO to design and market to employers and individuals a single and complete package that integrates all provider and insurance services. In sum, the combination of functions and the align-

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48 For example, foundations supply a variety of support and other services, such as fund raising, administrative, informational, and negotiation services that link the functions of its provider affiliates.

49 *See* Hitchner et al., *supra* note 37, at 302-03. On the structure of HMOs and the legal issues affecting their operation, see FURROW ET AL., *supra* note 16, § 11-11; *see generally* Welch et al., *supra* note 26.

ment of consumer and provider interests is most complete in this kind of organization. Nevertheless, other integrated systems that combine delivery and insurance functions (such as a foundation operating an HMO) may approximate this form of integration, depending upon how closely they tie providers' allegiances to those of the integrated system.

III
REFORM PLAN DESIGN

Given the potential of integrated health plans to alleviate flaws in the health reimbursement system and their central role under the managed competition model, one would expect that the architects of health care reform proposals would seek to capitalize on that potential. Instead, many reform bills (including those purporting to rely most heavily on market-based reforms) contain features that are incompatible with effective competition among IDSs, and all neglect bold changes that would strengthen the prospects for development of efficient systems.

A. Demographic Constraints on the Managed Competition Model

A critical problem brushed aside by many advocates of market-based reform of the health care system is whether a sufficient number of efficiently-sized provider networks will develop to support effective competition in a given market. Demographic evidence suggests that a significant proportion of local health care service markets lack the population base to support the minimum number of IDSs necessary for inter-plan rivalry. In antitrust terms, the concern is that the demographic features of many parts of the country dictate that only oligopolistic provider networks will emerge. Consequently, tacit or explicit collusion that will undermine the cost-containment benefits of competition is likely in these markets. Moreover, in a number of sparsely populated areas, it may not be feasible to divide the hospitals and physicians into more than one efficiently-sized network. These markets have natural monopoly characteristics which require regulation of rates, allocation of resources, or other forms of governmental intervention.

The basis for these concerns is illustrated by an important study by Richard Kronick, David Goodman, and John Wennberg.[50] In order to estimate the minimum population required to support managed competition, the Kronick-Goodman-Wennberg study examined the staffing patterns at several large staff-model HMOs. Calculating

50 Kronick et al., *supra* note 20.

the number of enrollees served by primary care and specialty physicians and by acute care hospitals, the study estimated the population base necessary to support the various configurations of managed care organizations. Assuming, rather optimistically,[51] that at least three independent health plans are necessary to avoid oligopolistic interdependence and support effective competition, the Kronick-Goodman-Wennberg study makes the following findings:

- A population base of 1.2 million individuals is required to support three "classic HMOs" offering referral hospital services and using their own staff physicians. Forty-two percent of the nation's population lives in market areas of this sort.[52]
- A population of 360,000 could support three plans providing most primary care and most acute care hospital services, but would need to share hospital facilities and contract for tertiary services. Sixty-three percent of the population lives in markets of this sort.[53]
- A population of 180,000 could support three plans providing primary care and many basic specialty services, but the plans would have to share certain specialty services such as cardiology and urology. Seventy-one percent of the U.S. population lives in health markets of this sort.[54]
- A population of 30,000 would support three independent primary care networks but the plans would have to share all hospital services and hospital facilities. No estimate of the percentage of the population living in this market was provided.[55]

The Kronick-Goodman-Wennberg study is not as damning to the entire concept of managed competition as it may first appear. The underlying assumption that an efficiently-sized plan would mirror the "classic HMO" may prove unrealistic as evolving systems develop new methods for delivering services and allocating responsibilities among providers. Moreover, the study does not account for rapid changes in the market for specialized services; declining fee levels coupled with a surplus in manpower may alter the feasible mix of services available in sparsely populated markets. Finally, the study itself suggests that with only moderate sharing of personnel and facilities (primarily those relating to inpatient services) a significant portion (seventy-one percent) of the population could expect to find themselves in

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51 Concentration thresholds used in merger analysis identify serious competitive concerns when the number of equally-sized firms falls below five or six. *See* U.S. Department of Justice-Federal Trade Commission Merger Guidelines § 1.5 (1992) (mergers in markets with post-merger Herfindahl Index above 1800 regarded as highly concentrated, burden on defendant to show that the merger is not likely to be anticompetitive).

52 Kronick et al., *supra* note 20, at 150-51.

53 *Id.*

54 *Id.*

55 *Id.*

competitive markets.[56] In addition, markets with far smaller populations (30,000) could support workable competitive systems at the primary care level.[57]

B. Implications for Health Reform

The Kronick-Goodman-Wennberg study has important implications for the regulation of competition and the configuration of plans under health reform legislation.[58] As the authors point out, the data highlights the need to structure competition in a manner that encourages development of efficient and competitive plans.[59] In addition, the results argue for flexibility to permit development of alternative models of regulation for dealing with demographic limitations on the viability of competitive rivalry. In some instances, government interventions in the form of promoting cooperation, allocating resources, or regulating rates may be an appropriate response to natural monopoly market conditions.

The study also points out some glaring inadequacies in the configuration of most reform proposals before Congress. The attenuated competitive rivalry resulting from the dearth of plans in many markets is exacerbated by the exemption of large sectors of the population from full participation in competitive markets. Under all major reform proposals, Medicare beneficiaries, veterans, and others will continue to participate in financing plans that rely in large part on administered pricing (*e.g.*, fee-for-service reimbursement under a fee schedule for physician services and prospective payments based on diagnostic related groups for hospitals under Medicare). This exemption of a significant portion of the population, perhaps as much as twenty percent,[60] effectively removes a critically important base for developing a competitive number of health plans.

In addition, reliance on administered pricing for a significant portion of the population may slow the reconfiguration of delivery because large segments of the provider community will continue to take price and utilization signals from regulatory agencies. Incentives for physicians to join integrated systems or for those systems to invest in cost-containment or abstain from marginal investments will be

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56 *Id.* at 150.

57 *Id.*

58 Implications for antitrust policy are discussed *infra* Part IV.B.3.

59 Kronick et al., *supra* note 20, at 150-52.

60 The following table, prepared by the Congressional Budget Office, tabulates the number of individuals insured under different forms of insurance, grouped by the cost control effectiveness of each form. Individuals in Medicare and other public programs ("other public" in the table) will continue to obtain insurance from public programs that have little, if any, managed care.

weakened if a significant part of their patient base is driven by inconsistently administered pricing.

A similar problem exists with respect to other aspects of reform proposals that deflect segments of the population from the competitive market. For example, the Clinton Administration's Health Security Act requires that all health alliances contract with at least one fee-for-service plan and that reimbursement for these plans be set through collective negotiations between physicians and health alliances.[61] This inducement to fee-for-service plans may artificially inflate the demand for such plans and will reduce the population base available to managed care plans.

Another perverse twist is found in proposed legislation that would require managed care plans to accept all providers willing to abide by the plans' terms and standards.[62] Forced reimbursement of non-network providers dilutes the effectiveness of the network concept by diminishing the rewards to selective contracting; likewise, it weakens incentives to join competitive plans and sever ties with fee-

ALLOCATION OF POTENTIAL RECIPIENTS OF PERSONAL HEALTH SERVICES, BY PRIMARY SOURCE OF INSURANCE FUNDING AND LEVEL OF EFFECTIVENESS OF MANAGED CARE ARRANGEMENTS, 1990 (In millions)

Primary Source of Insurance Funding	Total	Level of Effectiveness of Managed Care Arrangement[a] I	II	III	IV
All Sources	259.6	16.7	65.5	119.4	57.9
Medicare	32.1	1.3	0	30.8	0
Medicaid	15.4	0.3	0	1.3	13.9
Private or other public	176.9	15.2	65.5	87.3	8.8
No insurance	35.2	0	0	0	35.2

SOURCE: Congressional Budget Office calculations based on data from the Social Security Administration's Office of the Actuary, the March 1990 supplement to the Census Bureau's Current Population Survey, and the Health Care Financing Administration.

[a] Managed care categories are defined as follows:
I. Staff- and group-model HMOs;
II. Effective utilization review incorporating precertification and concurrent review of hospital care;
III. Other forms of managed care;
IV. No managed care.

CBO Memorandum, *supra* note 26, at 10.

61 Health Security Act of 1993, S. 1757, 103d Cong. 1st Sess. § 1402 [hereinafter HSA].

62 Some bills would mandate that insurers or other plans include "any willing provider" as participating providers in their systems. *See N.Y. HMO Fears Any Willing Provider Law*, 27 PULSE 9 (July 29, 1994) (describing opposition to any willing provider provision in House Ways and Means Committee health reform bill). Others such as the Health Security Act would require that low-cost sharing HMOs and other plans offer reimbursement to "out of network" providers whether or not the provider contracts with the network. HSA § 1402.

for-service practice.[63] Despite the obvious inconsistency with the theory and structure of managed competition reforms, these provisions have found a surprisingly receptive audience in state and federal legislatures.

IV

POLICING MARKETS AND PROVIDER CONDUCT AFTER REFORM: THE ROLE OF ANTITRUST LAW

Antitrust has served as the nurse midwife to competition-based health care reform. Litigation has removed professional barriers to discounting, competitive contracting,[64] and affiliation with HMOs;[65] stopped dozens of private boycotts aimed at innovative financing plans;[66] and discouraged provider collectives from engaging in collusive bidding.[67] Antitrust law will almost certainly play an equally pivotal role in the post-reform era because the success of managed competition hinges upon assuring the competitiveness of provider networks and health plans. Despite the intense scrutiny applied by federal enforcement agencies and the courts in this area, some doctrinal underbrush remains in antitrust law that may impede smooth application of procompetitive policies to the institutional arrangements developing in anticipation of reform.

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63 The Federal Trade Commission has advised several states not to adopt "any wiling provider" legislation because it contends that bans on exclusive or preferential contracting deny the means of insuring providers a substantial portion of the plan's business. "Without that volume, a would-be contracting provider may be unable to achieve economies of scale and offer lower price terms or additional services." Letter from Michael O. Wise, Acting Director, Office of Competition Policy, Federal Trade Commission, to Honorable E. Scott Garrett (March 29, 1993). *See also* Terese Hudson, *State Laws: A Stumbling Block for Systems Integration?*, HOSPS. & HEALTH NETWORKS, April 20, 1994, at 40 (reporting perception of insurance industry that any willing provider laws increase costs and impair growth of integrated systems). The Health Security Act proposed to preempt all state laws that would compel health plans to contract with "any willing provider." HSA § 1407.

64 American Medical Ass'n, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd, by an equally divided court* 452 U.S. 676 (1982). *See generally* FURROW ET AL., *supra* note 16, §§ 10-27 to 10-29.

65 *See, e.g.*, Medical Serv. Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent decree order prohibiting concerted action to deny participation in Blue Shield plan to doctors who worked for an HMO). *See generally* FURROW ET AL., *supra* note 16, §§ 10-10 to 10-29.

66 The Federal Trade Commission has successfully challenged the activities of the medical staffs of Florida hospitals that conspired to prevent competition from the Cleveland Clinic, a multi-specialty group practice charging innovative "unit prices" for packages of health services in lieu of the conventional method of separate billing. Broward Gen. Medical Ctr., No. C-3344 (F.T.C. Sept. 10, 1991) (consent order); Holy Cross Hosp., No. C-3345 (F.T.C. Sept. 10, 1991) (consent order).

67 United States v. North Dakota Hosp. Ass'n, 640 F. Supp. 1028 (D.N.D. 1986); Michigan State Medical Soc'y, 101 F.T.C. 191 (1983). *See* FURROW ET AL., *supra* note 16, §§ 10-27 to 10-30.

Antitrust analysis examines the effects on competition of two types of joint activity: horizontal combinations and vertical combinations. Regarding horizontal combinations, there are several concerns. First, providers may form loose affiliations under the banner of creating a new health plan when, in fact, they contemplate little more than collusive bidding. Second, provider membership in these plans may entail unwarranted levels of concentration or exclusionary effects so as to imperil competition. That is, health plans may become so few in number that they will either exercise unilateral power over health care distribution or coordinate their policies to raise prices or otherwise restrict consumer choice. If provider-controlled networks garner enough market power to become entrenched oligopolistic networks, they can effectively insulate providers from competitive pressure, thus reducing rivalry among health plans and undermining the promise of managed competition.

Vertical harms are more indirect and, according to some economists, more imagined than real.[68] In any event, the focus of concern about vertical combinations—both collaborations and mergers—is that the aggregation of formidable players in the insurance, physician services, and hospital services markets will foreclose competition from other networks. This could occur through acquisitions, exclusive contracting with providers, and other arrangements that raise rivals' costs, or tactics that raise barriers to entry. Such strategies could subvert the promise of vigorous, inter-plan rivalry. Yet, because vertical integration promises significant cost savings and efficient health care delivery, it is necessary to make at least a rough determination of whether these benefits offset anticompetitive risks.

Indeed, integrated delivery systems raise issues that span the entire field of antitrust causes of action. It is not unrealistic to imagine a dominant IDS that presents problems involving monopoly, monopoly leveraging, price fixing, market allocation, boycott, tying, exclusive dealing, and anticompetitive mergers. This Article does not attempt to track all the possible theories under which an IDS may be subject to antitrust scrutiny but instead offers some guideposts to help chart the course of antitrust analysis over a shifting regulatory and economic landscape. Specifically, it posits that enforcement must be attuned to

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68 *See, e.g.*, Frank H. Easterbrook, *Vertical Arrangements and the Rule of Reason*, 53 ANTITRUST L.J. 135 (explaining that not all vertical restrictions should "be a subject of serious antitrust attention"); Richard A. Posner, *The Next Step in Antitrust Treatment of Restricted Distribution: Per Se Legality*, 48 U. CHI. L. REV. 6 (1981). While significantly limiting antitrust law's scrutiny of vertical restrictions, principally by expansion of the rule of reason and constriction of the Sherman Act's conspiracy requirement, the courts have not gone so far as to embrace a regime of per se legality. *See* HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE § 11.5-11.7 (1994).

both market imperfections that pervade the health care industry and to the dynamic regulatory environment reshaping that industry.[69]

A. Horizontal Restraints

The threshold question facing an integrated delivery system is whether the provider network is a true efficiency-creating collaboration (*i.e.*, a legitimate joint venture) or simply a cartel. The classic horizontal joint venture entails pooling of resources and sharing of risk among competitors with the goal of producing a product at less cost than would otherwise be possible or one that otherwise might not be offered at all.[70] The doctrinal consequence is that joint ventures are examined under antitrust's "rule of reason" which determines legality by weighing potential procompetitive benefits against likely anticompetitive harms. Cartels, by contrast, are subject to summary condemnation under the per se rule, which dispenses with inquiries into competitive effects or purposes.[71]

As is the case with many issues in antitrust, the answer to the question of whether an IDS is a legitimate joint venture turns on how one characterizes certain aspects of its operations.[72] First, one must determine whether the combination is "horizontal," *i.e.*, controlled by competing providers or their agents (in contrast to "vertical" network arrangements in which decisionmaking powers are vested with third parties unlikely to simply do the bidding of the providers). Second, one must determine whether the network is truly an "integration," *i.e.*, a bona fide joint venture that produces efficiencies or enables the collaborators to market a new product. Although guidance on both questions is readily available in the case law and the pronouncements of the enforcement agencies, close examination of market and regula-

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69 Despite the labyrinthine character of applying antitrust to integrated systems, it would be folly to absolve providers from antitrust scrutiny or relax the standard against which they are to be judged. Such actions would cause the benefits of managed competition to quickly unravel. Moreover, allegations of confusion and uncertainty in the marketplace appear vastly overstated in view of the countless policy statements, advisory opinions, and litigation brought by the FTC and Justice Department over the past fifteen years. *See* Thomas L. Greaney, *When Politics and Law Collide: Why Health Care Reform Does Not Need Antitrust "Reform"*, 39 ST. LOUIS U. L.J. (forthcoming 1994); Janet D. Steiger, Chair, Federal Trade Commission, *Testimony before the Senate Subcommittee on Antitrust, Monopolies and Business Rights*, March 23, 1993.

70 *See* Joseph F. Brodley, *Joint Ventures and Antitrust Policy*, 95 HARV. L. REV. 1521 (1982); Greaney & Sindelar, *supra* note 9.

71 *See* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982); *cf.* Broadcast Music, Inc. v. Columbia Broadcasting Sys., 441 U.S. 1 (1979). On the changing nature of the per se rule of reason modes of analysis, see PHILIP AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW § 1105 (1993 Supp.).

72 *See* Chicago Professional Sports, Ltd., Partnership v. National Basketball Ass'n, 961 F.2d 667, 672 (7th Cir.), *cert. denied*, 113 S. Ct. 409 (1992) (noting the importance of the process and cautioning that "characterization is a creative rather than exact endeavor").

tory factors in health care markets brings into sharp focus the importance of the law's insistence on efficiency justifications to avoid summary condemnation.

1. *Control*

A number of cases have dealt with the degree of control necessary to establish that a payment system is, in fact, a horizontal combination of providers. Several decisions characterize as horizontal price-fixing agreements plans whose governing boards are comprised of a majority of provider representatives or whose decisionmaking structure permits providers to establish reimbursement rates.[73] Other decisions suggest that the absence of formal power to elect a majority of members of the board, while not dispositive, will militate heavily against a finding of conspiracy.[74] Although mere solicitation of input from providers does not constitute the control necessary to establish liability,[75] a number of courts have been willing to examine a variety of other factors that may establish de facto control.[76]

As noted earlier, integrated systems include a wide array of governance arrangements that require shared responsibility among providers.[77] For purposes of untangling whether "control" is retained by the providers themselves, it is important to bear in mind the underlying economic interests of the parties involved in the arrangement. Hospitals and providers share the common objectives of obtaining maximum reimbursement and freedom from outside control. Driving the parties together are the physician's need for capital and a network

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73 *See* Hahn v. Oregon Physicians' Serv., 868 F.2d 1022 (9th Cir. 1988), *cert. denied*, 493 U.S. 846 (1989) (finding conspiracy where physicians' controlled board of payment plan); Addino v. Genesee Valley Medical Care, Inc., 593 F. Supp. 892 (W.D. N.Y. 1984) (finding price fixing where physicians controlled Blue Shield plan); Glen Eden Hosp. v. Blue Cross & Blue Shield, 740 F.2d 423 (6th Cir. 1984) (arguing that control by competing hospitals over Blue Cross reimbursement rates would establish an agreement to fix pricing and constitute unlawful price fixing); Saint Bernard Gen. Hosp. v. Hospital Serv. Ass'n, 712 F.2d 978 (5th Cir. 1983), *cert. denied*, 466 U.S. 970 (1984) (finding that control by competing hospitals of Blue Cross association amounted to price fixing over fee schedule restricting reimbursement to non member providers).

74 *See* Pennsylvania Dental Ass'n v. Medical Serv. Ass'n of Pa., 745 F.2d 248, 258 (3d Cir. 1984), *cert. denied*, 471 U.S. 1016 (1985) (finding no conspiracy where health care providers did not constitute a majority of the board despite the fact that dentists dominated advisory committees which approved broad actions and whose "recommendations" were consistently followed by the board).

75 *See* Barry v. Blue Cross of Cal., 805 F.2d 866 (9th Cir. 1986).

76 *See* Addino v. Genesee Valley Medical Care Inc., 593 F. Supp. 892 (W.D.N.Y. 1984). *See also* Hahn v. Oregon Physicians' Serv., 868 F.2d 1022 (9th Cir. 1988), *cert. denied*, 493 U.S. 846 (1989) (physician board members, although not themselves directly competing with podiatrists, shared similar economic interests with board members and physicians who were direct competitors of podiatrists). *See generally* Gary M. Smith, Comment, *Provider Control of Health Insurers: Are Doctors Still Calling the Shots?*, 34 ST. LOUIS U. L.J. 1079 (1990).

77 *See supra* Part II.

structure for contracting and the hospital's need for an adequate referral base for patient admissions.[78] Indeed, these factors are often the focus of negotiations establishing PHOs, MSOs, and other integrated networks. Moreover, although the nature of the physician-hospital relationship has shifted somewhat from earlier models in which physicians were able to dominate decisionmaking on most economic variables, business dealings between these parties today require close cooperation to guarantee joint maximization of profits.[79]

It is therefore unrealistic to assume, for example, that physicians participating in a hospital's PHO do not "control" the network simply because they cannot elect a majority of the entity's board or because they lack formal authority to set prices. Furthermore, granting board membership to nominally independent third parties such as local business interests, civic groups, or even academics should not automatically insulate these arrangements from characterization as a per se illegal horizontal combination. Ultimately, antitrust tribunals need to engage in a fact-specific inquiry into the nature of control and governance relationships of such associations in order to fix the true locus of authority within an integrated system. Where physicians or hospitals in an integrated system retain authority over price-setting, membership or other competitive factors, courts should not hesitate to characterize the arrangement as a horizontal agreement even though the provider group lacks structural control.

2. *Integration of Provider Activities*

As discussed above, the second key determinant of whether a provider network constitutes a cartel or joint venture is the nature and extent of integration among the providers. As a general matter, joint venture analysis assumes that the greater the integration, the more likely the arrangement will produce efficiencies and seek primarily to compete for business rather than cartelize the market. In *Arizona v. Maricopa County Medical Society*,[80] the Supreme Court refined this requirement for provider-controlled payment plans by noting that the physicians in that case could have avoided per se condemnation had they shared risks or created a "new product," the twin hallmarks of partnerships and other joint ventures that escape per se condemna-

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78 *See supra* Part II. *See also* Frank Cerne, *Capital Concerns*, HOSPS. & HEALTH NETWORKS, April 20, 1994, at 14 (noting the "transition from viewing hospitals as a stand-alone revenue generator to cost centers within integrated systems"); Dean C. Coddington et al., *Costs and Benefits of Integrated Healthcare Systems*, 48 HEALTHCARE FIN. MGMT. 20 (1994).

79 *See supra* Part II. *See also* James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, 51 L. & CONTEMP. PROBS. 7 (1988).

80 457 U.S. 332 (1982).

tion.[81] Besides informing the decision as to whether a cartel exists, the nature and extent of integration in an IDS may also play a role in analysis under the rule of reason. In other words, courts weighing pro-competitive efficiencies must appraise the cost-savings realizable from integration.[82]

The cases[83] and the Department of Justice-FTC Joint Policy Statements[84] have interpreted *Maricopa* to require that there be meaningful functional integration, a significant degree of risk-sharing through pooled capital, or other means for allotting risk of loss among providers controlling a network. For example, staff model HMOs in which participants share risk through capitated reimbursement epitomize the joint venture by coordinating practices and realizing economies of scale and scope.[85] On the other hand, loose confederations of doctors that share little more than an administrative apparatus to package bids to buyers are highly suspect.[86] Between these polar extremes falls the large, ambignous middle ground of many collaborative arrangements among providers in the market today. As discussed in Part II above, many MSOs and PHOs lack significant integration and do not share the risks for many of their contracting arrangements. Conse-

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81 *Maricopa*, 457 U.S. at 351 (finding facial invalidity for naked price fixing schemes, as distinguished from ventures offering new products or "other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit"). *See also* Broadcast Music, Inc. v. Columbia Broadcasting Sys., 441 U.S. 1, 23 (1979) ("Joint ventures and other cooperative arrangements are . . . not usually unlawful, at least not as price fixing schemes, where the agreement on price is necessary to market the product at all.").

82 U.S. Department of Justice and Federal Trade Commission, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*, 4 Trade Reg. Rep. (CCH) ¶ 13152, 20769 (Sept. 30, 1994) [hereinafter *Joint Policy Statements*]. These Joint Policy Statements, issued as this article was being finalized, revise and expand the agencies' previous statements, U.S. Department of Justice-Federal Trade Commission, *Statements of Antitrust Enforcement Policy in the Health Care Area*, 4 Trade Reg. Rep. (CCH) ¶ 13150, 20758 [hereinafter *1993 Statements*].

83 *See* Hassan v. Independent Practice Assocs., 698 F. Supp. 679 (E.D. Mich. 1988) (holding that physician-controlled IPA was sufficiently integrated where members accepted capitated payment to cover all medical services to enrollees of HMO and in which up to 15% of fees were withheld by the IPA as a "risk withhold" and only paid if the IPA's level of expenses permitted payment).

84 *Joint Policy Statements*, *supra* note 82, at 20793-20794. *See also* J. Paul McGrath, Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice, Remarks before the 33rd Annual Spring Meeting of the American Bar Ass'n, Antitrust Section (March 22, 1985); Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice, Remarks to Connecticut Health Lawyers Ass'n (March 11, 1988); Mark J. Horoshak, Assistant Director, Bureau of Competition, Federal Trade Commission, Remarks before the Washington State Hospital Ass'n (September 25, 1993).

85 *Maricopa*, 457 U.S. at 351.

86 The Justice Department and FTC have challenged a number of "sham" PPOs as price fixing agreements where provider networks were really thinly-disguised cartels. *See* Southbank IPA., 57 Fed. Reg. 2913 (F.T.C. 1993) (consent order); Preferred Physicians, Inc., 110 F.T.C. 157 (1988); U.S. Dep't of Justice Press Release regarding Stanislaus Preferred Provider Organization (Oct. 12, 1983).

quently, they risk characterization as price-fixing schemes and may not be credited with significant efficiency-enhancing benefits under the rule of reason.

Strong emphasis on the importance of providers sharing risks, and in particular sharing the risk of over-utilization or high costs of services, is entirely appropriate in health care markets.[87] Despite criticisms from organized medicine,[88] this standard is on sound footing when one takes into account the peculiar market conditions of health services delivery and insurance. Most important, risk sharing through capitation deals effectively with moral hazard in insurance by forcing providers to bear the financial consequences of overutilization. That is, risk-based payment encourages providers to practice cost-effective medicine and mitigates the perverse incentives of insurance and information inadequacy. In addition, providers assuming substantial risk of the success or failure of an integrated network are more likely to maximize efficiencies associated with integration.

Less complete integration in MSOs, PHOs, and provider-owned plans such as PPOs arguably enhances efficiency by lowering certain transaction costs through shared administrative expenses, joint negotiations, and utilization review.[89] However, these arrangements do not effectively align the underlying incentives facing individual providers, especially where providers are members of multiple plans. Indeed,

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87 The *Joint Policy Statements* set forth the following test for physician networks qualify for safe harbor treatment evaluating whether: they must either provide treatment at a capitated (or per subscriber) rate or provide financial incentives to members to achieve cost-containment goals, such as withholding compensation with distribution only if cost-containment goals are met. In contrast to previous pronouncements, however, the *Joint Policy Statements* provide that "the agencies will consider other forms of integration that amount to the sharing of substantial financial risk." *Joint Policy Statements, supra* note 82, at 20794. The agencies have been applying essentially this standard of integration in litigation for a number of years. *See* Southbank, IPA Inc., 57 Fed. Reg. 2913 (1992) (consent order) (prohibiting respondents from dealing collectively with third party payers unless they formed an "integrated joint venture," defined as collaborations involving pooling of capital and sharing substantial risk of adverse financial loss if costs or use of health services are unexpectedly high). *See infra* notes 89-90 and accompanying text.

88 *See* Letter from Joseph Painter, James S. Todd and Kirk B. Johnson, American Medical Association, to Janet D. Steiger, Chair, Federal Trade Commission (petition for advisory opinion) (Apr. 20, 1992); James S. Todd, *Physicians as Professionals, Not Pawns*, HEALTH AFF., Fall 1993, at 145, 146.

89 There must, of course, also be some link between the collective agreement to set prices and the efficiency tools of the plan. *See Maricopa*, 457 U.S. at 352 (noting that it is not necessary that the doctors do the price fixing when other means are available to obtain transactions cost savings). The enforcement agencies have not been entirely clear on this point. *Compare* Mark J. Horoschak, Assistant Director, FTC Bureau of Competition, Remarks Before the National Council of Community Hospitals (November 13, 1992) ("simply no logical connection between a price agreement and many of the activities that PPOs . . . engage in . . . [W]hile these activities may produce real, cognizable efficiencies . . . they do not justify a horizontal price agreement.") *with* Charles F. Rule, Remarks Before Connecticut Bar Ass'n, *supra* note 84 (deeming transaction cost and other savings sufficient integration to justify price agreements in provider-sponsored PPOs).

the "free rider" and fragmentation problems associated with cost containment where individual health plans do not command participating physicians' loyalty and cannot capture the benefits of innovations in cost containment[90] are exacerbated where there is no meaningful sharing of risks. Individual physicians simply have little reason to toe the line when reimbursement is not closely tied to their individual efforts to control costs.

Many integrated delivery systems will likely involve providers sharing substantial risk through capitation and will not be characterized as price fixing schemes. Such systems must then pass muster under the rule of reason which seeks to determine the net competitive effects of the collaboration. One ingredient in the mix, of course, is the existence of procompetitive efficiencies that lower the cost of medical care. The Agencies' Joint Policy Statements single out cost savings associated with the assumption of financial risk by the participating physicians "as meriting particular attention."[91] However, the foregoing considerations counsel that antitrust tribunals should avoid the impulse to assume that the existence of *some* integrative activity produces substantial procompetitive effects that offset the risks associated with concentration and product differentiation discussed in the following section. For example, free rider problems limit the usefulness of risk-sharing in certain integrated systems. That is, because risks are shared across the entire panel, individual physicians in an IPA suffer relatively insignificant financial consequences from particular treatment decisions for each patient. Depending on the reimbursement arrangements with the IPA, the physician may actually profit by making costly decisions. In any event, the penalty of the shared risk may not overcome physicians' ingrained habits of accommodating patients' demands for costly levels of care.[92]

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90 *See supra* Part I.

91 *Joint Policy Statements*, *supra* note 82.

92 Dennis A. Yao, Federal Trade Commission, Remarks before the Los Angeles County Bar Ass'n, *reprinted* in Trade Reg. Rep. (CCH) ¶ 50100 at 4886 [hereinafter Yao Remarks]. A sound application of these principles is found in a recent FTC staff advisory opinion concluding that a PPO in which physicians would collectively set prices did not constitute an agreement ancillary to partial integration among participating physicians. Although 15% of fees for each physician were to be withheld in a "risk pool," the fact that payments were to be made at the 88th percentile and that approximately 50% of all physicians in the state would be participating suggested that participants would not have strong financial incentives to adhere to cost-containment goals. Lacking sufficient incentives to alter "each physician's normal incentive to maximize his or her income by increasing the number of services provided to enrolled patients," the staff concluded that the risk withhold would not be a sufficient form of risk sharing. Letter from Mark J. Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission, to Paul W. McVay (July 5, 1994).

3. *Assessing Risks to Competition*

a. *Market Structure and Competitiveness*

Assuming a plan is sufficiently integrated to avoid per se illegality, the method of analysis shifts to examining the net competitive consequences under the rule of reason. A pivotal issue under this inquiry is the extent of the plan's market power.[93] In brief, the question becomes: how many providers may a provider-controlled network have? The antitrust enforcement agencies have delivered a number of pronouncements on this issue, the most recent being the Joint Policy Statements.[94] These statements suggest that a physician-controlled network would fall within a "safety zone" if it accounted for less than twenty percent of the physicians in a relevant market where the physicians contract on an "exclusive" basis.[95] For non-exclusive networks, the threshold for the safety zone is thirty percent.[96] The Joint Policy Statements go on to note that each specialty might constitute a separate relevant market for purposes of calculating the percentages, but allow that in rural areas where there would be fewer than five physicians in many specialties, a more flexible standard would apply. For physician networks falling outside the safety zone, an open-ended balancing under the rule of reason would presumably weigh efficiencies and risks based on market power.[97] The Joint Policy Statements view plans with exclusive arrangements with providers as more likely to raise competitive concerns because they leave less opportunity for formation of rival plans to dissipate the market power of the incumbents.

Federal advisory opinions have been inconsistent in this area, occasionally displaying inexplicable leniency by approving provider-

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93 Some courts and commentators have argued that the absence of market power should preclude a finding of liability under the rule of reason. *See* Fishman v. Estate of Wirtz, 807 F.2d 568 (7th Cir. 1986) (Easterbrook, J., dissenting in part) ("Liability in antitrust law almost always requires proof of market power. This is because market power is an essential ingredient of injury to consumers. Market power means the ability to injure consumers by curtailing output and raising price . . . no market power no violation."); Thomas M. Jorde & David J. Teece, *Rule of Reason Analysis of Horizontal Arrangements: Agreements Designed to Advance Innovation and Commercialize Technology*, 61 ANTITRUST L.J. 579, 602-03 (1993). *But see* Capital Imaging Assocs. v. Mohawk Valley Medical Assocs., 996 F.2d 537 (2d Cir.), *cert. denied*, 114 S. Ct. 388 (1993) (rejecting "safe harbor" approach based on market power alone).

94 *Joint Policy Statements*, *supra* note 82, at 20787-20788; *see generally* Thomas L. Greaney, *The Department of Justice/FTC Health Care Policy Statements: A Critique*, 11 ANTITRUST 20 (1994) (questioning the need for original policy statements and criticizing certain ambiguities and misstatements concerning applicable antitrust doctrines).

95 The Policy Statements define an "exclusive" network joint venture as one which "significantly restricts the ability of its members to affiliate with other physician network joint ventures and to contract individuality was health benefit plans." *Joint Policy Statements*, *supra* note 82, at 20787.

96 *Id.*

97 *Id.* at 20788.

controlled networks with high shares of providers in their relevant markets.[98] The Policy Statements and speeches of governmental enforcement officials have generated additional uncertainty. In particular, federal antitrust authorities have failed to articulate clearly the sources of market power in plans and have not given useful guidance on how those risks might be evaluated and weighed against offsetting benefits. As discussed below, a clearer delineation of competitive risks and a greater appreciation of the health market context is needed.

Overinclusive provider networks threaten competition in two ways. First, they may reduce competition in the market for provider services by, for example, lessening price or quality rivalry among physicians or hospitals that contract with insurers health plans or employers to deliver services. Second, they may impair competition in the financing-insurance market by reducing the feasible number of viable plans and hence increase the risk of oligopolistic behavior or segmentation. The probability and magnitude of these potential effects must be considered in light of the imperfections in health care financing and delivery markets.

The risk to competition in the provider services market from overinclusive networks is twofold. First, these networks have the potential power to unilaterally raise providers' prices due to their large share of providers or differentiation in the quality, service, or location of those providers. Second, provider networks able to coordinate their actions may exercise oligopoly power, consequently raising prices for the providers' services. Somewhat surprisingly, government agencies have often downplayed the risk of oligopolistic coordination and stressed the potential harms from a unilateral exercise of power.[99] However, as we have seen, the demographics of many local health care markets already make precarious the prospects of effective competition because of the limited number of providers available in those areas. Permitting overinclusive provider membership in networks will only exacerbate oligopolistic market structures for provider services and drive up prices for those services throughout the market. Hence,

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98 *Compare* Antitrust Division, U.S. Dep't of Justice Business Review Letter to Frank Sanchez (October 3, 1986) (Department of Justice announcing it does not plan to challenge PPO controlled by pharmacies constituting 30 to 50 percent of local markets) *with* letter from M. Elizabeth Gee, Assistant Director, FTC Bureau of Competition, to Michael E. Duncheon (March 17, 1986) (declining to approve provider-sponsored PPO based on providers' control over price terms).

99 *See, e.g.*, Charles Rule, Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice, Remarks Before National Health Lawyers Association (March 11, 1988) ("primary anticompetitive threat of a PPO is that . . . it may be implemented to prevent the formation of competing alternative delivery systems" by signing up "all or most providers in a market"). *See also Joint Policy Statements*, *supra* note 82, at 20789 (identifying as "key areas of competitive concern" whether a network joint venture can raise price above competitive levels or prevent formation of other ventures).

absent compelling evidence of scale economies, enforcement agencies and the courts should resist efforts of the provider community to stretch the twenty and thirty percent thresholds when examining networks under the rule of reason.[100] In addition, it should be observed that as the proportion of competing providers in networks increases, differentiation among networks also increases. While this may lessen to some extent the risks that providers will collude, economic analysis also suggests that this differentiation can cause prices to increase where integration is not complete.[101]

Provider concentration may also affect competition at the insurance or health plan level. Excessive membership of any competitively significant provider group on an exclusive basis will restrict the number of competing plans and hence worsen the oligopoly problem demonstrated in the Kronick-Goodman-Wennberg study.[102] That is, these markets will be deprived of effective competition because there will be too few rivalrous IDSs. Moreover, without exclusivity, widespread cross-membership in plans would enhance opportunities for coordination between plans as information, strategies, and cost-saving protocols are unlikely to remain secret. In sum, a central goal of antitrust policy must be to prevent development of overinclusive provider networks that will further reduce the number of viable competing plans or undermine their competitiveness. Hence, close attention should be paid to maintaining market structures that minimize risks of oligopolistic coordination.[103]

b. *Evaluating the Effects of Exclusivity*

One particularly vexing question in applying conventional concentration tests to provider-controlled networks has been the treatment afforded to exclusive contracts such as a commitment by a group of physicians to join only one integrated network. The original Joint Policy Statements released in 1993 generally regarded exclusive arrangements between plans and providers negatively but stopped short

100 *See, e.g.*, Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice to John R. Cummins, Esq. (October 28, 1994) (business review letter approving physician-controlled, nonexclusive network comprised of 37 percent of all physicians in service area and of percentages "significantly higher" than 30 percent in some specialties).

101 Gregory Vistnes, Multi-Firm Systems, Strategic Alliances and Provider Integration (1994) (unpublished manuscript on file with the Cornell Law Review).

102 *See supra* notes 50-60 and accompanying text.

103 *See* James F. Rill, Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice, Remarks to National Health Lawyers Ass'n (February 15, 1991) (rejecting prior safe harbors announced by Antitrust Division personnel and proposing that networks be analyzed under principles enunciated in Department of Justice Merger Guidelines); *Joint Policy Statements*, *supra* note 82, at 20789 (identifying competitive issues as including whether a physician network could raise prices above competitive levels and whether there were "many other" actual or potential physician networks).

of condemning such arrangements.[104] The revised Joint Policy Statements adopt a more tolerant view, announcing a new safety zone for exclusive physician network joint ventures and recognizing the potential for procompetitive effects in multiprovider networks.[105] The concept of exclusivity is not confined to formal contractual commitments. Factfinders need to determine whether market conditions or contractual arrangements create such strong disincentives to contract with other networks that providers are implicitly bound to only one network.[106]

Distrust of exclusivity is undoubtedly warranted in markets with a small number of rival networks and in which tying up a large proportion of the area's physicians in a few competitively crucial specialties can foreclose others from forming rival plans.[107] On the other hand, exclusive arrangements have great potential for promoting loyalty and commitment among affiliated providers and ensuring that physicians see enough subscribers to make it likely they will engage in cost-effective practices.[108] These arrangements also help networks prevent opportunistic behavior and may reduce a variety of transaction costs.[109] As discussed in Part I, economic analysis suggests that proliferating affiliations between managed care groups and physicians has attenuated loyalties and enabled providers to pursue a limited discounting strategy in their negotiations with managed care organizations.[110] Thus, a market with five competing networks, each contracting exclusively with twenty percent of the market's physicians, is likely to realize greater price competition and innovation than one in which each of five plans had contracts with all the doctors in the market. In sum,

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104 *See 1993 Statements, supra* note 82, at 20765.

105 *Joint Policy Statements, supra* note 82, at 20787-89 & 20796.

106 *See id.* at 20796 (listing practical indicia to determine whether a network is truly non-exclusive such as the extent of participation in other networks, past departicipation, and the presence of viable alternatives). *See also* Letter from Mark J. Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission, to J. Bert Morgan, Esq. (Nov. 13, 1993) (FTC staff advisory opinion cautioning that tacit agreement by radiologists in PPO not to join other panels or payor programs would support findings of market power where high percentage of radiologists in market belonged to PPO).

107 *See, e.g.*, Ohio v. Greater Cleveland Hosp. Ass'n, 1983-2 Trade Cas. (CCH) ¶ 65685 (N.D. Ohio 1983) (consent decree) (prohibiting association of 90 percent of hospitals from forming insurance plan that prohibited members from contracting with other plans except on equally favorable terms); U.S. Dep't of Justice, Press Release Regarding Stanislaus Preferred Provider Organization (Oct. 12, 1983) (announcing voluntary dissolution of provider-controlled PPO consisting of between 50 and 90 percent of area providers contracting exclusively with challenged plan).

108 *See infra* notes 122-24 and accompanying text.

109 *See* Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 44-45 (1984) (citing advantage from tied sale of hospital and anesthesiology services, including 24-hour coverage, standardization of procedures, efficient use of equipment, flexibility in scheduling and improved monitoring of quality of services). *See also* U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589 (1st Cir. 1993).

110 *See supra* notes 19-20, 26-35 and accompanying text.

exclusivity arrangements are a double-edged sword. Courts and enforcement authorities would be well-served by establishing guidelines as to the threshold at which exclusivity may change from a factor that promotes competition to one that retards it.

c. *Delimiting the Market in Which IDSs Compete*

The agencies skirt one other difficult issue posed by market imperfections. Their Joint Policy Statements acknowledge that market definition must investigate "what substitutes, as a practical matter, are reasonably available to consumers for the services in question."[111] This at best obliquely recoguizes that market definition should be sensitive to product differentiation and information gaps that may afford one plan or network the ability to raise prices or reduce quality without worrying about certain other plans perceived to be of lower quality or too remote geographically.

Though the dynamic nature of health insurance may complicate the inquiry, product market definition is likely to be of critical importance in competitive analyses because of the diversity of insurance products being developed. A particularly insightful decision by Judge Boudin in *U.S Healthcare, Inc. v. Healthsource, Inc.*[112] usefully analyzes this issue. While upholding a lower court finding that the proper relevant market consisted of all health care financing, the court acknowledged that a separate HMO market could exist, assuming differences between HMOs and other financing systems were proved. The court properly framed the issue as whether a sole supplier of HMO services could profitably raise prices over cost and suggested that facts such as usage patterns, customer surveys, specific features of the plans, and profit levels would assist the factfinder in answering the question.[113]

B. Vertical Issues and Integrated Delivery

On its face, vertical integration—the linking of hospitals, insurers, and physicians to create integrated systems—would seem to produce unmitigated competitive benefits. Vertical combinations, whether by contract or merger, can achieve efficiencies by reducing transaction costs, facilitating the pooling of capital, reducing uncer-

111 *Joint Policy Statements, supra* note 82, at 20795.

112 986 F.2d 589 (1st Cir. 1993).

113 *Id.* at 597. Even this complex factual investigation does not fully resolve the issue of which entities should be included in a properly defined product market. The finder of fact must also investigate the possibility of a "supply response," i.e., whether other firms, not currently selling in the product market would be likely to become a market participant within a short period of time in response to the exercise of market power. These "uncommitted entrants" may be treated as competitors in the product market where they do not have to incur significant sunk costs of entry and exit. See Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines § 1.32 (April 2, 1992).

tainty, and spreading risk.[114] In practical terms, vertical combination eases many of the administrative, information, and cost problems associated with assembling contracts for managed care contracting. Moreover, in contrast to horizontal integration, there is no direct enhancement of market power because market shares of individual providers are not aggregated. Potential harms from vertical integration—principally raising entry barriers for competitors and foreclosing markets or access to inputs that other plans need to compete—may not always lessen competition despite the fact they injure rivals. Consequently, antitrust treats vertical restrictions tolerantly by applying the rule of reason to all non-price restraints and permitting vertical mergers of large firms except in the most extreme circumstances.

Nevertheless, a growing economic literature has emphasized the potential harm to competition resulting from exclusionary practices that raise rivals' costs through vertical arrangements.[115] A firm that can successfully bid up the price of inputs or otherwise increase its competitors' costs can under certain conditions create or enhance its market power. For example, an IDS might acquire or contract exclusively with several strategically-important medical practices or prominent multi-specialty groups and consequently disadvantage rivals so that it can reap supracompetitive profits despite paying a premium to bid away the specialty practice.

A variety of antitrust claims are likely to grow out of vertical integration among providers and insurers. These potential claims span the universe of antitrust causes of action but for the most part center around several basic issues: exclusion of providers from networks, exclusive contracting, and foreclosure of competing integrated systems. The following sections discuss the application of antitrust doctrine to this area from the perspective of market imperfections and regulatory change.

1. *Exclusion of Providers from Integrated Delivery Systems*

Integrated systems involve selective contracting between providers and some part of the system. For example, a PHO may choose to admit only certain members of the hospital staff and an IPA network might affiliate with a specific hospital or radiology service. Increasingly, plans are likely to engage in "economic credentialing" and to expel practitioners whose utilization patterns are unacceptably high

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114 *See* HOVENKAMP, *supra* note 68, at 329-49; OLIVER E. WILLIAMSON, MARKETS AND HIERARCHIES: ANALYSIS AND ANTITRUST IMPLICATIONS (1975).

115 *See* Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 YALE L.J. 209 (1986). *See infra* notes 136-38 and accompanying text.

or who fail to meet other performance standards.[116] Excluded providers are likely to cry foul, claiming that their exclusion constitutes a restraint of trade, monopolization, or attempted monopolization.

Antitrust tribunals are well-schooled in dealing with these claims.[117] They have rejected a number of actions brought by excluded providers alleging illegal boycotts by provider-controlled plans that denied them participating provider status;[118] anticompetitive exclusive dealing between plans and selected medical groups or hospitals that foreclosed their opportunities to compete;[119] and monopolization by large insurers who refused to include the providers or who insisted on onerous terms.[120] Although each of the various antitrust rubrics under which exclusion may be challenged has its own conditions and proof requirements,[121] they all share a common requirement that procompetitive justifications underlie the exclusionary conduct. A brief review of the economic underpinnings of selective contracting suggests that such justifications should be readily available in cases alleging anticompetitive exclusion in the future.

It has frequently been observed that exclusion of providers is essential to the efficient functioning of managed care systems.[122] As

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116 "Economic credentialing" refers to the use of criteria relating to a provider's cost-effectiveness in using medical resources in determining whether to extend hospital staff privileges or establish other relationships with the provider. *See* John D. Blum, *Economic Credentialing: A New Twist in Hospital Appraisal Processes*, 12 J. LEG. MED. 427 (1991).

117 The pattern of unsuccessful suits involving exclusion payment systems mirrors the courts' experience in dealing with hundreds of cases involving denials of hospital staff privileges to physicians and allied health professionals. *See* FURROW ET AL., *supra* note 16, § 10-16 (noting that only a handful of the large number of suits have been successful but nonmeritorious litigation continues). Hopefully, this long history of unsuccessful litigation will have a deterrent effect on opportunistic suits claiming anticompetitive exclusion from payment systems.

118 Hassan v. Independent Practice Assocs., 698 F. Supp. 679, 694 (E.D. Mich. 1988) (finding exclusion of allergists who violated plan's cost containment protocols "justified by enhancing [economic] efficiency and making the market more competitive"). *But see* Hahn v. Oregon Physicians' Serv., 868 F.2d 1022 (9th Cir. 1988), *cert. denied*, 493 U.S. 846 (1989) (exclusion of entire class of practitioners violated Sherman Act where no plausible justification proffered).

119 U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d. 589 (1st Cir. 1993).

120 Capital Imaging Assocs. v. Mohawk Valley Medical Assocs., 996 F.2d 537 (2d Cir. 1993), *cert. denied*, 114 S. Ct. 388 (1993); Glen Eden Hosp. v. Blue Cross & Blue Shield of Mich., 740 F.2d 423 (6th Cir. 1984). Where an exclusion does not result from an agreement between the plan and another party or is not the action of a provider-controlled plan, courts have found no violation of § 1 of the Sherman Act because there is no plurality of actors. Section 2 claims (monopolization or attempted monopolization claims) have likewise been dismissed as a matter of law because a plan cannot monopolize a market in which it is not a competitor, and because the need to impose standards on providers constitutes a reasonable business justification for exclusion. *See Glen Eden*, 740 F.2d at 423; *Hassan*, 698 F. Supp. at 679. *See also* 2 JOHN J. MILES, HEALTH CARE & ANTITRUST LAW § 15.05 (1991).

121 *Healthsource*, 986 F.2d at 592.

122 *See, e.g.*, McGrath, *supra* note 84.

one analyst succinctly put it, selectivity in contracting enables plans "to control their costs and their reputations."[123] It acts as a spur to price competition because providers vie for participating provider status by lowering prices and practicing cost-effective, high quality medicine in return for the promise of more patients.

The imperfect market conditions of health care financing lead to other observations. Selective contracting is economically significant because it provides insurers with the means to fight moral hazard and provider-induced demand; providers risk losing access to patients if they fail to adhere to utilization protocols. In addition, where providers are organized to share risk through capitation, the power to exclude or expel is essential to the economic integration of the joint venture. Finally, selectivity confronts directly the two antitrust problems associated with assembling panels for integrated systems: overinclusiveness and fragmentation. That is, it provides the mechanism by which a plan can limit its panel to an efficient size but stop short of excesses that threaten to produce oligopolistic market structures. At the same time, it promotes the sorting-out process by which physicians ally themselves with a single or limited number of plans to avoid the fragmented loyalties and other problems associated with multiple plan membership. Thus, market failure considerations which underscore the procompetitive benefits associated with membership restrictions in integrated networks may play a prominent role in the balancing of competitive effects under the rule of reason.[124]

2. *Exclusive Contracting and Related Terms in Provider Contracting*

Integrated delivery systems are likely to engage in a number of contracting practices with providers that may have adverse effects on competition. For example, they may enter into exclusive contracts that prohibit providers from contracting with another system or from giving that system equally favorable terms.[125] An IDS might also require that providers sign "most favored nations" commitments promising to give the IDS the same price concessions given to any other system[126] or take other steps that weaken rival systems' ability to com-

123 PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS 315 (3d ed. 1988). *See also* J. Paul McGrath, Assistant Attorney General, Antitrust Division, Remarks Before the 33rd Annual American Bar Ass'n Antitrust Spring Meeting (March 22, 1985).

124 For a somewhat opaque account of the factors bearing on permissible exclusions from joint ventures, see *Joint Policy Statements*, *supra* note 82, at 20797.

125 U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589 (1st Cir. 1993).

126 Ocean State Physicians' Health Plan v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); United States and State of Ariz. v. Delta Dental Plan of Ariz., Civ. No. 94-1793, 59 Fed. Reg. 47349 (Sept. 15, 1994) (consent decree settling charges that defendant plan used "most favored nations" clauses in provider contracts to restrain competition with other plans). *See generally* FURROW ET AL., *supra*

pete.[127] Rivals are likely to attack these undertakings as illegal conspiracies (typically exclusive dealing) under Section 1 of the Sherman Act, or as abuses of monopoly power (or attempts to monopolize) under Section 2. Again, proof standards and requirements vary according to which antitrust theory is applied, but the principal underlying concern is that the plan may obtain or maintain market power either by foreclosing such a high portion of providers that rival plans enter the market or by raising the rivals' costs so that supracompetitive prices can be maintained.

Exclusive dealing claims involving health care providers have been the subject of extensive antitrust litigation.[128] Exclusive contracts between an IDS and providers generally violate Section 1 of the Sherman Act when they result in market foreclosures of substantial proportions (greater than thirty percent) and when other proof exists based on the nature, duration, and procompetitive benefits of the restriction that makes it likely that the arrangement will impair competition.[129] The ultimate concern with foreclosure is that so much of the market will be tied up by the exclusive dealing arrangement that single firm dominance or oligopoly is more likely because actual and potential rivals will not be able to secure an adequate supply of services to compete.[130] If entry is unrestricted and practicable, however, foreclosure poses little risk.

The First Circuit's analysis of an exclusive dealing arrangement in *U.S. Healthcare, Inc. v. Healthsource, Inc.*[131] illustrates the application of these principles to vertically integrated payment systems. The incumbent HMO in that case offered its physicians higher reimbursement if they agreed not to participate in any other HMO. With respect to a Section 1 claim filed by a rival HMO asserting foreclosure, the court found plaintiff's proof inadequate to establish that the price differen-

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note 16, § 10-39; Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers*, 69 N.C. L. REV. 863 (1990).

127 *See* Reazin v. Blue Cross & Blue Shield of Kan., 899 F.2d 951 (10th Cir. 1990), *cert. denied*, 497 U.S. 1005 (1991) (payor's termination of participating hospital affiliated with HMO coupled with threats to other hospitals and reduced hospital payments coerced hospitals and constituted willful maintenance of monopoly power). *See generally* FURROW ET AL., *supra* note 16, §§ 10-36 to 10-39.

128 On hospital contracts with hospital staff physicians see, *e.g.*, Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984). *See generally* FURROW ET AL., *supra* note 16, § 10-24 (analyzing cases). On exclusive dealing between providers and payment systems, see U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589 (1st Cir. 1993); FURROW, *supra*, §§ 10-35, 10-37.

129 *See* U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 594-96 (1st Cir. 1993); Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice, Remarks Before the Group Health Ass'n of America (February 28, 1989) (PPO or HMO controlling more than 35% of available providers and precluding them from dealing directly or indirectly through "most favored nations" clauses would pose antitrust problems).

130 HOVENKAMP, *supra* note 68, § 10.6b2.

131 986 F.2d 589 (1st Cir. 1993).

tial granted to exclusive physicians "operated economically to restrict doctors" and observed that plaintiff could offset any adverse effect by only modest efforts.[132] Further, in view of the duration of the exclusivity arrangement (initially 100 days, later shortened to thirty days), the defendant was obliged to introduce facts proving the restraint was not de minimis.[133] Finally, the court questioned the quantitative significance of the foreclosure, noting that if only twenty-five percent of the market's primary care physicians were under exclusive contracts, a significant number presumably were "available" to plaintiff.[134]

Confined as it was to the inadequacy of plaintiff's factual showing, *U.S. Healthcare* does not create a safe haven for exclusive dealing arrangements involving integrated delivery systems. One caveat that might be attached to Judge Boudin's approach to evaluating foreclosure is that close scrutiny of independent factors such as the magnitude of the financial incentive, the duration of the exclusivity, the extent of foreclosure, and the parties' intent may unduly fragment the inquiry. The ultimate questions should be whether the arrangement on balance creates a compelling incentive for providers to remain with the integrated system that offers exclusivity covenants and whether, given those incentives, viable alternatives are unavailable to other networks. Indeed, a number of economic factors suggest that such arrangements may merit the close attention of the courts. First, there are many local health care markets that are susceptible to foreclosure because of demographic factors limiting the number of viable integrated systems.[135] Second, there is ample grounding in the literature on strategic behavior to suggest that exclusive contracting may have anticompetitive consequences in such markets. It is feasible, for example, for an IDS (even one lacking significant market power) to forestall entry when it can lock up enough physicians to raise rivals' costs above minimum efficient scale.[136] Under certain circumstances, it may also succeed in assuring itself supracompetitive returns by these tactics even when it raises costs through exclusive dealing arrangements and even though entry is not entirely precluded.[137]

As one thoughtful observer has pointed out, the benefits of incumbency may also create strategic advantages that enable exclusive

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132 *Id.* at 595-96.

133 *Id.* at 596.

134 *Id.*

135 *See supra* Part III.

136 Eric Rasmussen et al., *Naked Exclusion*, 81 AM. ECON. REV. 1137 (1991); Steven Salop & David Shefman, *Raising Rivals' Costs*, 73 AM. ECON. REV. 276 (1983).

137 The most plausible scenarios would entail the IDS creating a "bottleneck" by obtaining exclusionary rights from the lowest cost providers or inducing collusion among the providers by creating an industry structure likely to generate high prices. *See* Krattenmaker & Salop, *supra* note 115, at 67.

dealing arrangements to exacerbate potential barriers to entry.[138] It should also be remembered that IDSs by their nature will usually entail wide geographic coverage and comprehensive service offerings. Thus, to be successful, entry will have to occur on a large scale and involve significant sunk costs. In these circumstances, a careful appraisal of the timeliness, likelihood, and effectiveness of new entry is required,[139] and the exclusive contract's short duration will not be dispositive in determining the prospects for competitive foreclosure.[140]

3. *Vertical Acquisitions*

Antitrust issues may also arise from vertical mergers. For example, when a hospital forms a foundation-model IDS by acquiring physician practices and facilities that provide ancillary services, competitive concerns about inter-system rivalry might arise. Antitrust doctrine is somewhat unsettled in this area because the Supreme Court has not addressed the issue in twenty-two years and because the enforcement agencies have been less than clear about the principles they apply.[141] Although the last Supreme Court case to address the issue found that a vertical merger violated the Clayton Act where the percentage of the market foreclosed was only ten percent,[142] most analysts agree that contemporary courts will require far larger market shares and look to other factors as well.[143]

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138 Commissioner Dennis Yao of the Federal Trade Commission identified the risks associated with exclusive dealing creating potential barriers to entry.

> If all providers are already "signed up" with incumbent health care networks, it will be difficult to establish a rival network. A new entrant would have to "bid" participating physicians away from exclusive deals with incumbents, and this could be very expensive. Individual physicians could take a "you first" attitude, reluctant to sacrifice a beneficial exclusive deal unless a sufficient number of other physicians have already signed up with a new plan to make it viable. For this reason, a new entrant might have to pay a significant premium to gain a critical mass of participating physicians. Thus, by raising the costs to new entrants by exclusive dealing, incumbent oligopolists might successfully maintain their market power.

Yao Remarks, *supra* note 92, at 4886.

139 Merger Guidelines, *supra* note 113, §§ 3.0-3.4.

140 I am indebted to Steven Kramer of the Antitrust Division of the Department of Justice for this observation.

141 The 1992 Merger Guidelines do not even discuss vertical mergers and the 1984 Merger Guidelines do not acknowledge foreclosure as a basis for challenging a merger. After almost ten years without challenging a vertical merger, however, the Clinton Administration's Antitrust Division has brought three such cases, all involving the communications industry. *See Access Requirement Resolves Division Concerns over AT&T/McCaw Merger*, 67 ANTITRUST TRADE REG. REP. 85 (July 21, 1994).

142 Ford Motor Co. v. United States, 405 U.S. 562 (1962).

143 *See* HOVENKAMP, *supra* note 68, § 9.4 (analyzing and discrediting most economic theories upon which vertical mergers have been challenged). For recent judicial expressions of skepticism about potential harm from vertical mergers, see Alberta Gas Chems. Ltd. v. E.I. Du Pont de Nemours & Co., 826 F.2d 1235 (3d Cir. 1987), *cert. denied*, 486 U.S. 1059 (1988); Fruehauf Corp. v. F.T.C., 603 F.2d 345 (2d Cir. 1979).

Under the economic analysis applied by the Justice Department, the primary concern with vertical mergers by integrated systems appears to be the risk of raising anticompetitive entry barriers. Vertical mergers create objectionable entry barriers only where three conditions are satisfied. First, the vertical integration in the market must be so extensive as to force entrants into the primary market to enter the secondary market simultaneously. Second, entry at the secondary level must make entry at the primary level more difficult. Finally, the structure and other characteristics of the market must be conducive to monopolization or collusion.[144] The Justice Department's approach may be criticized for paying exclusive attention to vertical mergers' effects on entry barriers and for failing to establish concentration thresholds at appropriate levels. Vertical mergers may cause harm to established competitors by raising their costs significantly without increasing entry barriers.[145] In addition, the Guidelines' suggestion that concerns about forced two-level entry will be obviated where the unintegrated capacity in the market will support two firms of efficient scale in the primary market is inconsistent with concentration thresholds generally relied upon for evaluating threats of oligopolistic coordination.[146]

An interesting, albeit perhaps extreme, example of the potential for anticompetitive harms flowing from vertical integration is found in the FTC's recent case involving the ownership by a number of pulmonologists of partnerships providing home oxygen services.[147] The Commission charged that the pulmonologists, who constituted approximately sixty percent of the practicing pulmonologists in the relevant markets, were able to obtain market power, create barriers to entry, and restrain competition through the vertical linkage of their provider services and oxygen delivery services. The effect of the vertical combination was especially strong in this case, as oxygen services are almost always prescribed by pulmonologists. Moreover, given the asymmetrical distribution of information between patient and provider, it is likely that the pulmonologists were able to influence their patients' choice of supplier. Despite the strong overtones of information imperfections in this case, the Commission did not rely on these facts to strike down all physician self-referrals. Instead, it agreed to a consent order directed at the structural problems in the market, and

144 Department of Justice, 1984 Merger Guidelines § 4.21.

145 *See* Krattenmaker & Salop, *supra* note 115, at 284-85 (finding guidelines' oversight significant "where entry barriers are already high so that rivals are dependent on established firms for their supplies of the input").

146 *Id.*

147 Home Oxygen & Medical Equip. Co., FTC File No. 901-0109 (Sept. 2, 1992); Homecare Oxygen & Medical Equip. Co., FTC File No. 911-0020 (Nov. 17, 1993) (consent order).

required divestiture of ownership interests to reduce to twenty-five percent or less the percentage of pulmonologists in each market owning a partnership interest in the venture.

Given the highly concentrated structure of many markets for delivery of health services and the likelihood that vertical integration will result in only a few fully integrated systems, it is probable that many acquisitions will meet the structural conditions specified in the Justice Department Guidelines. In other words, the development of competing health plans will be made virtually impossible where one or two IDSs have acquired most of the physicians' practices in an area or (more plausibly) have acquired all the practices in several strategically crucial specialty markets. As analyzed in the previous section, entry barrier concerns warrant close attention in IDS markets and cannot be lightly dismissed where scale economies and sunk costs are significant.[148]

CONCLUSION

If pooled consumer purchasing power is to control cost, a sufficient number of efficient and viable integrated delivery systems must be competing to attract subscribers with low-cost, high quality medical insurance and delivery. Conversely, if one or a few integrated networks dominate the market for physician or hospital services, rivalry on the main issues of health care cost control will likely dissipate. A central goal of health reform legislation, therefore, should be to establish a regulatory infrastructure that encourages the growth of rival IDSs while also developing regnlatory tools to deal with markets that cannot achieve that goal.

Vigilant and sensible antitrust enforcement is the second prerequisite for nurturing the conception of managed competition discussed in this Article. Despite the considerable emphasis on economic analysis in antitrust commentary and litigation in recent years, neither commentators nor judges have carefully explored the implications of market failure for antitrust doctrine in health care cases. Market imperfections add significantly to the competitive risks posed by restraints of trade and other conduct policed by antitrust law. Moreover, these conditions may diminish the likelihood that self-correcting market forces will ameliorate whatever dangers antitrust law misses. Economic evidence suggesting that a large part of the country can support only the bare minimum of efficiently-sized integrated systems adds to the challenge facing antitrust analyses.

148 *See supra* Part IV.B.2.