RURAL HEALTH NETWORK EVOLUTION IN THE NEW ANTITRUST ENVIRONMENT

Neil P. Motenko
Nutter, McClennen & Fish, LLP

Ira Moscovice, Ph.D.
Anthony Wellever, M.P.A.
Rural Health Research Center
Institute for Health Services Research
School of Public Health
University of Minnesota

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Introduction

The 1996 Policy Statements now give explicit encouragement to several types of rural health network formation and activity, thus paving the way for a "new" antitrust environment that is more sensitive to the special problems of competition and market power in rural areas.

This paper is designed to help equip rural health leaders with a realistic, up-to-date overview of antitrust issues relevant to rural health care and specifically to rural health networks.

Rural Health Network Evolution in the New Antitrust Environment has three major content areas: 1) the basics of antitrust and health care (**Appendix**), 2) the antitrust issues relevant to rural health care networks (**Chapters 1 and 2**), and 3) the strategies that can allow network development without running afoul of antitrust laws (**Chapters 3 and 4**).

Chapter 1: Antitrust for Health Care Provider Networks: Issues of Practical Concern

The antitrust issues of practical concern for health care networks generally, whether urban or rural, fall into two categories: (a) pricing and "integration" and (b) network membership and size.

Price-fixing among competitive health care providers is unlawful on its face (the legal term is *'per se'*). Integrated joint ventures are entitled to determine their pricing. In the absence of financial risk sharing, network pricing could be achieved through the use of a "messenger model."

The 1996 Policy Statements on physician networks expanded the criteria for financial risk-sharing. They also articulate a newly recognized avenue (beyond financial risk-sharing) which can justify joint pricing by network providers: clinical integration. The Statements suggest that substantial clinical integration can be key to justifying such joint pricing.

Size and exclusivity issues comprise the second major area of antitrust concern for provider networks. Selective contracting encourages the network to choose providers based on competitive factors such as quality of care, productivity, willingness to share risk, experience, and fit with the network's culture. It also rewards networks that select providers who know how to (a) manage utilization, (b) practice effectively under capitation or other

risk-sharing arrangements, and (c) achieve economies of scale and administrative efficiencies.

In general, exclusive dealing is unreasonable only when a significant percentage of buyers or sellers is frozen out of a market as a result. The Statements identify five criteria used to determine whether a network is exclusive or not.

A rural health network risks a challenge to "unreasonable exclusionary conduct" if it excludes a class of providers, including allied health care professionals, without sufficient procompetitive justification -- especially when the exclusion is motivated by attempting to remove the competitive threat posed by that group to physician groups.

As long as a network's procompetitive benefits outweigh its anticompetitive harm, the agencies have frequently announced their intention not to challenge networks, especially non-exclusive ones, with market shares substantially above 30 percent. It is more risky for the network to be too big than for it to make selective, procompetitive decisions about "who's in and who's out."

Chapter 2: Antitrust Law and Enforcement Applied to Rural Health Care Providers

The "relevant market" for antitrust purposes defines the parameters (in terms of services and geography) in which the network's power to control prices or exclude competition within the market will be assessed. The definition of the relevant market is thus critical to the analysis of the market power of a health care provider network.

Judicial focus is shifting from static analysis of where patients currently go for health care, toward a dynamic analysis of where health care consumers practically *might* turn. This shift is of particular importance to rural health care providers, whose facilities are often located at significant distances from other providers.

To the extent that rural hospitals formed a network to achieve clinical or administrative efficiencies, their horizontal agreement (for example, on pricing) arguably does *not* raise antitrust problems if there is no competition among the parties.

If any recent case reinforced fears — ultimately misplaced — about the application of the antitrust laws to rural providers, it was *Marshfield Clinic*. Although holding that Marshfield Clinic did not have monopoly power in the regions of North Central Wisconsin at issue, the court did suggest that the Clinic was a monopolist with respect to those areas so small that it employs all of the "handful" of physicians in that particular region. The court characterized the Clinic as holding a *natural monopoly* in those areas.

This "natural monopoly" finding has special significance for rural providers because it recognizes: (a) that a rural market may be too small to support more than one firm, and (b) that physicians practicing in groups are better able to provide modern medical care to rural residents.

Chapter 3: Considerations for Rural Health Networks

Antitrust Counseling Suggestions

1. Pricing

Joint pricing remains the most sensitive type of conduct under the antitrust laws. It must be undertaken only with careful guidance in light of developing law and enforcement policies. Health care provider networks that wish to engage in joint pricing of their services have three potential approaches available to them: (a) shared financial risk, (b) clinical integration, and (c) the messenger model

2. Exclusive Contracting

Rural networks wanting to enter into exclusive relationships with providers need to: (a) carefully review and document the efficiency justifications for the exclusive arrangements before entering into them, and (b) balance those justifications against the anticompetitive effects of the arrangements. In addition, the efficiencies should not be achievable through others measures that would restrict competition significantly less.

3. Network Structure and Market Power

Once a rural health network is constituted and particularly if it has market power, it should avoid engaging in conduct which may substantially foreclose competition in a market. Such a network should especially avoid excluding classes of providers that supply competitive services in the market (such as allied health care professionals), unless well-supported procompetitive justifications exist.

On the other hand, if the efficiencies *can* be justified, the courts and agencies have shown considerable flexibility to rural providers seeking to affiliate, even when the affiliation involves market power.

4. Documenting Efficiencies

A rural health network seeking to justify its market power must explain — and document — the efficiencies it expects to realize. This should be done, if possible, *before* the transaction creating the network is approved by the decision makers, e.g., the respective boards of directors or trustees of the parties.

Networks seeking to justify joint pricing ancillary to clinical integration, or a high degree of market power, may want to engage an accounting firm to analyze and quantify the efficiencies to be expected from network operations.

5. Making Sure the Network Behaves Properly

In addition to complying generally with the law, three specific guidelines should be followed in network development efforts to ensure proper network behavior:

- Avoid any appearance of price-fixing or collusion.
- Create a confidentiality agreement.
- Foster a procompetitive — not an anticompetitive — mindset.

6. Interacting with the Agencies

In some instances it may be advisable to initiate an informal dialogue with an antitrust enforcement agency, or to request a formal business review letter or staff advisory opinion.

7. Obtaining Payer and Community Support

It is often extremely helpful for a rural health network to garner payer and community support. Antitrust enforcement agencies have accorded significant weight to the views of such parties.

Chapter 4: Considerations for Legal and Health Policymakers

Even if based on a competitive model, health care market reforms — and the evolution of antitrust policy — must depend on an evaluation of how competition works in health care markets. To the extent that health care market characteristics and imperfections are more pronounced in rural areas, antitrust policy must display some flexibility.

The very uncertainty about whether and how competition plays out in rural health care markets, combined with the unique circumstances of those markets, bears on the ongoing development of antitrust law and policy in the following ways:

- the application of the *per se* rule
- exclusive dealing
- monopolization and "natural" monopoly
- market power
- immunities and exceptions

1. Sparing Application of the *Per Se* Rule

Rural network development remains in its early stages, and tends to proceed incrementally. Given its tenuous nature, antitrust policy should treat such development with considerable caution. *Bona fide* rural health networks should thus be given the benefit of the

doubt as to whether they are (even at the outset) sufficiently integrated to be accorded rule of reason treatment for their ancillary arrangements and to be free from the operation of the *per se* rule.

2. Exclusive Dealing

The agencies' emphasis on non-exclusivity must be balanced, however, against the potential desirability, and the procompetitive effects and efficiencies, offered by exclusivity (e.g., to ensure efficient operations or support capitated arrangements). Such exclusivity may be important, if not indispensable, to the development of cost-effective rural delivery systems, even if such systems may have somewhat more market power than is customarily considered acceptable in other markets.

3. Monopolization and "Natural Monopoly"

Natural monopolies are defensible in certain circumstances because they can be comparatively efficient and have greater incentives to innovate. Courts should consider the procompetitive efficiencies that monopolist rural health networks (natural or otherwise) can generate.

There is considerable confusion, however, about the type of conduct that constitutes unlawful monopoly leveraging, in and outside of the health care area. Given this confusion and the inconclusive nature of the few court decisions in the health care area on such leveraging, this area of law needs clarification.

4. Market Power

Antitrust law and policy should be sensitive to the following factors which can often hinder the ability of rural health networks with purported "market power" to actually control or distort pricing:

- the increasing presence of managed care in rural areas
- the potential for the exercise of buyer power
- the relatively high proportion of Medicare and Medicaid patients in rural areas
- broadening concepts of the geographic market, focusing on where patients potentially *could* go for services, not just where they do go now.

5. Immunities and Exemptions

Antitrust immunities and exemptions do not make for good competition policy. Many states have enacted legislation designed to provide immunities for pre-approved network proposals that receive Certificates of Public Advantage. However, in the absence of *active* state supervision, these statutes would probably *not* insulate networks from antitrust scrutiny.

INTRODUCTION

RURAL HEALTH REFORM VS. ANTITRUST CONCERNS

The health care marketplace continues to reform itself even as governmental reform efforts are largely stalled. These marketplace reforms will influence the delivery of rural health care in the coming years. Indeed, the advent of managed care and the recent inclusion of rural areas in the service areas of numerous HMOs have drawn increasing attention from providers, residents, and policymakers.

In response to actual or anticipated marketplace reforms, rural providers have been engaging in a wide variety of network arrangements. These networks range from loose affiliations that may engage in joint purchasing or other administrative functions to integrated systems in which providers share substantial financial risk.

However, this heightened interest in joining forces to participate in market-driven initiatives has been tempered -- particularly though not exclusively in rural areas -- by fears of antitrust litigation. The Marshfield Clinic suit (*Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*)[1] sent shivers through rural providers and health administrators across the nation. Even though the initial jury verdict against Marshfield was reversed by the appeals court in 1995, many concerns linger about what is permissible, what isn't, and what one's competitors -- or the government -- might decide to challenge under antitrust statutes.

This working paper is designed to help equip rural health leaders with a realistic, up-to-date overview of antitrust issues relevant to rural health care and specifically to rural health networks. The antitrust laws are designed to foster competition and to protect consumers from the negative effects of market or monopoly power. Often perceived as a barrier to legitimate provider collaboration, the application of these laws has actually promoted competition in health care markets and thwarted efforts of providers, including "sham" networks, to limit the innovative and cost-effective delivery of health care. The 1996

Policy Statements[2] now give explicit encouragement to several types of rural network formation and activity, thus paving the way for a "new" antitrust environment that is more sensitive to the special problems of competition and intended or unintended monopolies in rural areas.

DEMYSTIFYING ANTITRUST FOR RURAL HEALTH NETWORKS

The axiom "knowledge is power" definitely applies to rural health decision makers who increasingly operate in a competitive environment. ***Rural Health Network Evolution in the New Antitrust Environment*** is designed to help replace misinformation and unfounded fears with informed awareness of how antitrust affects the rural health care "landscape".

Our primary audience is rural health care providers and executives who are knowledgeable in the health field but who have little or no legal background. Health policymakers and urban-based health organization leaders comprise a second target audience. We also expect this working paper to be a useful resource to lawyers who may be knowledgeable about antitrust statutes and policies but less familiar with antitrust in the health care arena, especially in rural areas; nevertheless, our first goal is to make relevant antitrust issues clearly understandable to the non-legal reader.

WHAT'S HERE AND HOW TO USE IT

Rural Health Network Evolution in the New Antitrust Environment has three major content areas: 1) the basics of antitrust and health care, 2) the issues relevant to rural health care networks, and 3) the strategies that can allow network development without running afoul of antitrust laws.

The Basics

We encourage all readers who are relatively new to antitrust concepts to start by reviewing the Appendix: Antitrust Basics. This helpful primer begins with a concise review of the laws and a brief explanation of the concepts fundamental to the application of those laws (e.g., the *per se* rule, the rule of reason, market power and the relevant market). The second section introduces seven organizational arrangements or activities covered by antitrust laws that are most relevant to health care (e.g., price-fixing, group boycotts, monopolies).

Other readers may wish to go directly to the chapter or chapters that interest them most, and then consult the Appendix as needed for explanations of unfamiliar concepts. Full citations for cases, laws, letters, and other relevant material (plus some additional commentary) are provided in the endnotes to each chapter.

The Issues

This section, comprising Chapters 1 and 2, identifies and explains antitrust issues pertinent to health care networks and to rural health care.

- **Chapter 1** identifies the two major issues of antitrust concern for health care networks -- joint pricing and selective or exclusive contracting -- and discusses each in turn.

- **Chapter 2** reviews the ways in which antitrust laws have been recently enforced in health care, and specifically in rural health care, and describes the current antitrust environment for rural health care networks.

The Strategies

In this section, we recommend strategies and approaches to help foster effective rural health network development while minimizing antitrust exposure, and offer observations on the desirable evolution of antitrust policies in this relatively new arena.

- **Chapter 3** outlines the major options available to rural health networks and suggests several safeguards to minimize antitrust exposure during development and/or operation.

- **Chapter 4** reviews the current status of antitrust policy interpretation, points out areas that need clarification to support further market efficiencies, and suggests helpful approaches to legal and health policymakers.

We hope that a basic understanding of how antitrust laws and policies apply to rural health networks will dispel unreasonable fears, alert policymakers to legitimate issues that require attention, and encourage responsible and innovative forms of provider networking in rural areas.

INTRODUCTION ENDNOTES

1. Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995).

2. U.S. Dep't of Justice & Federal Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. CCH) ¶ 13,153 (1996)(hereinafter "1996 Policy Statements").

The Issues

CHAPTER 1

ANTITRUST FOR HEALTH CARE PROVIDER NETWORKS: ISSUES OF PRACTICAL CONCERN

Providers are developing a wide variety of network arrangements in response to marketplace reforms. These networks range from loosely affiliated arrangements such as preferred provider organizations (PPOs) and non-risk-sharing independent practice associations (IPAs), to integrated delivery systems in which the providers share substantial risk. Some networks have become known as "virtual mergers." In those cases, the providers cede substantial financial and operational control to a "superparent" company or joint venture entity, but retain significant autonomy over their missions and certain major decisions.

Networks can pursue different objectives, including:

- establishing a physician-based (or physician-and-hospital-based) vehicle, such as a PHO or an IPA, by which to contract with managed care companies and third-party payers;
- joint venturing with a payer or managed care organization (MCO);
- engaging in direct contracting with employers to provide health services to employers and dependents;
- linking with a tertiary care facility or with a network that has one; or
- developing an insurance product.[3]

To understand the implications of the antitrust laws for various kinds of rural health care networks, we need to start by identifying the antitrust issues of practical concern for networks generally, whether urban or rural. These issues fall into two general categories: pricing and risk sharing, and network membership.

- Pricing and "Integration"

  How can providers within the network jointly price their products and services without running afoul of the prohibitions against price-fixing?

- Network Membership

  How should providers decide on the structure and composition of the network — "who's in and who's out" — without violating the antitrust laws?

The two main sections of this chapter address each issue in turn.

PRICING AND "INTEGRATION"

Unintegrated Competitors

Unintegrated competitors in a "network" may not lawfully agree on network pricing. Price-fixing among competitive health care providers is unlawful on its face (the legal term is 'per se'). This holds true regardless of any procompetitive justifications or effects that may be claimed.[4] "Sham" IPAs or networks are composed of providers who do not integrate finances or operations, but who organize with the primary purpose of increasing fees or boycotting payers who do not subscribe to desired fee (or copayment) levels. Such "networks" have been the subject of widely publicized consent decrees barring that behavior[5] — if not requiring outright dissolution of the network.[6]

"Integrated" Joint Ventures

Integrated joint ventures <u>are</u> entitled to determine their pricing. When risk-sharing "alternative delivery systems" (e.g., HMOs) developed in the marketplace, antitrust law and enforcement both encouraged such development and justified it (under conventional joint venture analysis) as the procompetitive introduction of new and efficient delivery systems with the potential of lowering costs to consumers. As the enforcement agencies proceeded to thwart alleged "sham" networks designed to increase fees, they evolved a definition of an

"integrated joint venture" which would be entitled to price its product as it saw fit under the antitrust laws.

Pre-1996 policy.

Before the issuance of the 1996 Policy Statements, the government defined the *integrated, risk-sharing joint venture* relatively consistently, as follows:

> A joint arrangement to provide prepaid health care services in which physicians who would otherwise be competitors pool their capital to finance the venture, by themselves or together with others, and to share substantial risk of adverse financial results caused by unexpectedly high utilization or costs of health care services.[7]

Until recently, the government continued to define such joint ventures in essentially the same terms in decrees issued to cease the anticompetitive conduct of providers.

Federal antitrust enforcement decrees and opinions — and to some extent the courts[8] — focused on *financial risk-sharing* as the principal form of "economic integration" that would justify joint pricing among providers in a network. Financial risk-sharing was the only type of provider integration explicitly identified by the 1994 joint agency Policy Statements as a safe basis for such pricing. These Policy Statements established "safety zones" that included two specific examples of such risk-sharing: (a) capitation, and (b) the withholding of provider remuneration, to be supplied to the providers in the network only if they succeed in achieving meaningful cost containment and utilization goals.[9] Only in the 1996 Policy Statements did the government elaborate on other types of economic integration that could justify such network pricing.

The messenger model.

In the absence of risk-sharing (or unspecified "other forms" of economic integration as would satisfy the policy statements), network pricing could be achieved through a

messenger model.* Under this model, the messenger serves merely as a conduit of information about proposed contract terms between individual providers within the network and the payer. The messenger may *not* serve as a negotiating agent on behalf of the providers without risking liability as the agent of a price-fixing conspiracy. The 1996 Policy Statements continue to reflect this view, although they provide somewhat more flexibility for the messenger. (For example, a messenger may be given standing authority to accept on behalf of individual providers, for a specified period of time, fee levels specified in advance by the provider.)[10]

Experienced practitioners tend to regard the messenger model as burdensome and unworkable, and instances of its successful operation are few and far between. It can, however, potentially provide a more efficient way for payers to deal with network providers on pricing issues than dealing separately with each provider.

Unanswered questions.

Before the issuance of the 1996 Policy Statements, the law and the government's previous policies left important questions unanswered -- or answered unsatisfactorily, from the standpoint of providers. For example, how much of a capital contribution to a network would be enough, *absent* "financial risk-sharing" in the sense described above, to establish the network as an "integrated joint venture" entitled to price its services jointly? This was never answered with any specificity.

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*A consent decree defined "messenger model" to mean: ... the use of an agent or third party to convey to payers any information obtained from individual providers about the prices or other competitive terms and conditions each provider is willing to accept from payers, and to convey to providers any contract offer made by a payer, where each provider makes a separate, independent, and unilateral decision to accept or reject a payer's offer; the information on prices or other competitive terms and conditions conveyed to payers is obtained separately from each individual provider; and the agent or third party does not negotiate collectively for the providers, disseminate to any provider the agent's or third party's or any other provider's view or intentions as to the proposal, or otherwise serve to facilitate any agreement among providers on prices or other competitive terms or conditions (*United States v. Health Care Partners*, 1996-1 Trade Cas. (CCH) ¶ 71.337 (Feb. 15, 1996) (consent order)).

The apparent restrictiveness of the agencies' views of "integration" and "risk-sharing" became increasingly viewed as a deterrent to legitimate efforts of providers to engage in procompetitive activities in the marketplace. Emphasizing that "financial risk-sharing is ...not necessarily the only way" to structure a health benefit plan so as to encourage procompetitive accountability of the providers,[11] the government issued its 1996 Policy Statements.

The 1996 Policy Statements: Back to the Conventional Wisdom

In August 1996, in response to these concerns, the Federal Trade Commission (FTC) and the U.S. Department of Justice released revised policy statements on physician and multiprovider networks.[12] Like its predecessor, the 1996 Policy Statements on physician networks establishes "safety zones" for joint network pricing which features "financial risk-sharing," but it expands the types of risk-sharing which qualify explicitly for "safety zone" treatment of network pricing. Statement 9 on multiprovider networks does not provide safety zones, but indicates that the antitrust principles applicable to pricing and other agreements among providers within such networks will be examined in much the same way as those within physician networks. [13]

Thus, in addition to capitation and risk withholds, examples of such risk-sharing also include: 1) the provision of services to a health benefit plan for a predetermined percentage of premium or revenue from the plan; 2) network-wide cost or utilization targets, with providers subject to substantial financial rewards or penalties based upon group performance in meeting the targets; and 3) so-called "global fee" or "all-inclusive case rate" arrangements.[14]

More importantly, the 1996 Policy Statements treat those pricing arrangements falling outside the safety zone in a more explicitly permissive fashion, even if those arrangements do not feature "financial" risk-sharing. This treatment is along the lines of conventional joint venture analysis, employing the rule of reason to determine if the network

"is likely to produce significant efficiencies that benefit consumers, and [whether] any price agreements ... are reasonably necessary to realize those efficiencies."[15]

The Statements point to three elements of network integration, including:

1) mechanisms to control utilization of services that are designed to control costs and assure quality of care;

2) selective choice of network providers who are likely to further these efficiency objectives; and

3) significant investment of capital, both monetary *and* human, in a network infrastructure and capability necessary to realize claimed efficiencies.[16]

Clinical integration: a newly-recognized justification for joint pricing.

Essentially, the 1996 Policy Statements articulate an important avenue (beyond financial risk-sharing) which can justify joint pricing by network providers: clinical integration. The Statements recognize that clinical integration can generate significant efficiencies that justify joint pricing where necessary to achieve those efficiencies.

The examples in the Statements suggest that clinical integration must be substantial in order to justify such joint pricing. The first example in Statement 8 (physician networks) and 9 (multiprovider networks) specifies the following types of clinical integration:

- quality and utilization goals,
- evaluation of physician performance,
- modification of physician practices,
- case management,
- pre-authorization of some services,
- concurrent and retrospective review of inpatient stays,
- practice protocols and standards,
- investment in information systems, and
- hiring of a medical director and support staff to monitor the foregoing.

Do *all* of these activities have to be undertaken for a network to qualify as "clinically integrated"? And, whether or not all are required, what *level of participation* is required for any one activity (e.g., case management)? The 1996 Policy Statements are not clear on

either of these important points. ***In our view, the key is sufficient clinical integration, in whatever form(s), to encourage participating providers to behave in procompetitive ways***, i.e. to control costs and utilization and to create efficiencies to achieve those goals. (See **Chapter 3** for additional discussion and recommendations.)

WHO'S IN, WHO'S OUT: SELECTIVE CONTRACTING, MARKET POWER AND EXCLUSIONARY CONDUCT

How big can a network be before it obtains anticompetitive market power? What are the risks inherent in the decisions to exclude some providers — or classes of providers — and to contract selectively or exclusively with others? ***Size and exclusivity issues comprise the second major area of antitrust concern for provider networks.*** The first two sections discuss permissible **selective contracting** and **exclusive contracting**, respectively. The third section addresses **unreasonable exclusionary conduct**, and the fourth section explains the current view of **network size and market power**.

Selective Contracting

Selective contracting can drive the competitive process. When California became the first state to allow payers to contract selectively with providers, payers and providers could negotiate discounted rates in return for expected volumes of patient referrals. By creating competition among providers seeking to be chosen to contract with third-party payers, selective contracting gives providers "incentives to increase the quality and cost efficiency of care," through the implementation of such measures as utilization review and practice guidelines.[17]

Selective contracting encourages the network to choose providers based on competitive factors such as quality of care, productivity, willingness to share risk, experience, and fit with the network's culture. It also rewards networks that select providers who know how to (a) manage utilization, (b) practice effectively under capitation or other

risk-sharing arrangements, and (c) achieve economies of scale and administrative efficiencies.[18] In addition, selective contracting can help the network avoid becoming "overinclusive," i.e., including in the network so many of the providers in a given market as to generate antitrust concern by foreclosing other actually or potentially competing networks from access to the physician market.[19]

Court challenges to selective contracts.

On the other hand, the excluded provider or class of providers may claim that the exclusion was anticompetitive, for example, the result of an unlawful group boycott, exclusive dealing or tying arrangement. Generally, such claims are not viewed very charitably by the courts and government agencies. As the FTC staff has noted in one of its advisory letters, the foreclosure effect of an overinclusive network "raises far more substantial competitive concerns and antitrust risk" than does the concern about providers excluded from a network.[20]

Rather than viewing selectivity as necessarily anticompetitive, courts have recognized that networks must have the freedom to be selective about membership in order to achieve a level of efficiency and quality that makes their product desirable. Thus, for the most part, claims asserted by health care providers who have been excluded from physician networks, hospitals, and health plans have met with failure.**[21]

One court upheld the expulsion of allergists from a IPA that had capitated contracts with a managed care organization, on the ground that the allergists engaged in excessive testing and did not promote the cost containment goals of the IPA. The exclusion of plaintiffs was "justified by enhancing efficiency and making the market more competitive."[22]

Other key cases in this area find the courts upholding the exclusion of a private radiology group from membership in an IPA servicing the subscribers of an HMO,[23] and the

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**The excluded physician must establish *all* of the elements of a claim under the Sherman Act. Thus, such claims do not succeed when the physician fails to adequately define the relevant market or fails to show the anticompetitive effect of the challenged activities on that market.

exclusion of an internist from a PPO against his claims that, in excluding him from membership, it unlawfully restricted the size of the PPO panel and discouraged providers from referring PPO enrollees to non-PPO physicians.[24] In these two cases, the courts found that plaintiffs had failed to establish that the exclusions adversely affected competition.

Selective contracting reaffirmed.

The 1996 Policy Statements reaffirm the government's view that, by limiting provider panels, selective contracting can achieve quality and cost containment goals, as well as enhance the multi-provider network's ability to compete against other networks. Selective contracting can also ensure that the network can generate sufficient patient volume to justify price concessions or adherence to quality control. As long as the market can support several multi-provider networks (which is often not the case in rural environments), selective contracting is not likely to be anticompetitive. The Policy Statements confirm conventional antitrust analysis that an adverse effect on competition depends "not on whether a particular provider has been harmed by the exclusion, but rather whether the exclusion reduces competition among providers in the market and thereby harms consumers."[25]

Exclusive Contracting

The rationale permitting selective contracting also extends to exclusive contracting. As noted above, exclusive dealing contracts among providers at different levels in the chain of supply (i.e., *vertical* arrangements) are subject to scrutiny under the rule of reason.[26] The law does not condemn such vertical exclusivity *per se* because "the incentives for and effects of such arrangements are usually more benign than a horizontal arrangement among competitors..."[27] In general, exclusive dealing is unreasonable only when a significant percentage of buyers or sellers is frozen out of a market as a result.[28]

Unsuccessful court challenges to exclusive contracts.

Market definition and market power are critical factors in any case that challenges exclusive dealing. In the most important case on this issue, the United States Supreme Court upheld an exclusive contract (and an alleged "tying" arrangement) between a hospital and a group of anesthesiologists where the hospital had no more than 30 percent of the patients in the relevant geographic market (*Jefferson Parish v. Hyde*).[29] The court found that the hospital was not in a position to "force" consumers to purchase the anesthesiologist firm's services because the hospital lacked sufficient power in the "tying" product: acute care in-patient services.[30] Thus, if consumers did not like the "tying" arrangement, they could get their inpatient services from other hospitals.

Another court upheld an exclusive dealing clause in a contract between an HMO and the doctors who provided primary care for it. A competing HMO challenged the arrangement on the grounds that it restrained competition by tying up 25 percent of the physicians in the market. Noting that in cases challenging exclusive dealing arrangements "judgments for plaintiffs are not easily obtained," the court held that the plaintiff's claim failed to demonstrate that the arrangements

> foreclose[d] so much of the available supply or outlet capacity that existing competitors or new entrants may be limited or excluded (*U.S. Healthcare*).[31]

The court also cited the legitimate and benign purposes often served by such arrangements, including assurance of supply or outlets, enhanced ability to plan, reduced transaction costs, and creation of loyalty.[32]

Safety zones for exclusivity.

The 1996 Policy Statements on physician networks also recognize that exclusive arrangements are procompetitive in appropriate circumstances. The Statements identify five criteria used to determine whether a network is exclusive or not. Essentially, these criteria focus on whether providers are free to, and do, participate in other networks, and

whether other networks are capable of forming in the market.[33] The Statements also set forth a "safety zone" for "exclusive" physician networks: A physician network in which members share substantial financial risk is "safe" if it constitutes 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market.

Of significance for rural areas, in markets with fewer than five physicians in a specialty, an exclusive network otherwise qualifying for the safety zone may include one physician from that specialty on a nonexclusive basis, even though the inclusion of that physician results in more than 20 percent of the physicians in the specialty.[34] Networks outside the safety zone may well pass muster under a rule of reason analysis, and whether a network is exclusive or non-exclusive will be relevant to the analysis. ***A non-exclusive arrangement is more likely to survive antitrust scrutiny.***[35]

Exclusivity can eliminate competition unlawfully.

Particularly for rural providers, a key counterexample to the courts' generally permissive view of exclusive dealing arrangements appears in *Oltz v. St. Peter's Community Hospital*.[36] In that case, the court upheld a finding of liability of St. Peter's, the predominant of the two local hospitals. The court upheld a finding that anesthesiologists had conspired in anticompetitive fashion with a rural hospital in Helena, Montana, which enjoyed an 85 percent market share for general surgical services in Helena, to enter into an exclusive staff agreement resulting in the termination of a competing nurse anesthetist's staff privileges. In doing so, the court upheld a jury finding that the anesthesiologists' "goal was, at least partially, the elimination of Oltz [the nurse anesthetist] as a direct competitor of the anesthesiologists."[37]

The court took pains, however, to reject "the assertion that no rural hospital could lawfully grant an exclusive contract" if the hospital were found liable. Noting that the "absence of a goal to remove Oltz and reduce the competition for the patients whom he

served would have dramatically altered the outcome of the case," the court was explicit that its decision could not be "read as establishing any rule applicable to other situations involving rural hospitals engaged in exclusive contracts for staff privileges. The legality of those arrangements will depend on their individual case merit," evaluated under a rule of reason analysis.[38] ***The implication: A rural hospital with market power may still be able to enter into exclusive contracts with staff physicians or physician groups where justified by procompetitive factors.***

Unreasonably Exclusionary Conduct

A category of exclusionary conduct which is viewed with relative disfavor involves the *exclusion of a class of providers*, including allied health care professionals, by physicians or physician groups. In several cases, courts have found that a decision by a group of providers to exclude whole categories of competitive providers (such as podiatrists, nurse anesthetists, psychologists, nurse anesthetists or chiropractors) without sufficient procompetitive justification may constitute an unlawful boycott under the antitrust laws.[39]

These cases are relevant to health care networks that may have an incentive to exclude certain groups of providers, especially allied health care providers, whose services are not contemplated by the network's benefit package.[40] ***Where decisions to exclude groups of providers are motivated by and/or have the effect of excluding the competitive threat posed by such professionals to network provider members, antitrust issues will arise.***

The Network's Size and Market Power: What is Too Big?

As noted above, market power is the power to control prices or exclude competition.[41] Market *share* supplies evidence of whether a defendant has market power, but it is not the only factor in the analysis. Other factors include the ease of entry into the market, the elasticity of supply and demand, the number of firms in the market, and market trends.[42]

Market share safety zones.

The antitrust enforcement agencies have established various "safe harbors" or safety zones in the past 15 years for physician networks such as PPOs. (A physician network joint venture is defined in the 1996 Policy Statements as "a physician-controlled venture in which the member physicians collectively agree on prices or other significant terms of competition and jointly market their services.")[43] These market share safe harbors have ranged from 20 percent[44] to 35 percent.[45] The 1993 agency Policy Statements[46] promulgated a safety zone for physician networks comprised of 20 percent or less of the physicians in the market, as long as they shared risk appropriately.

The 1994 policy statements continued to provide this safety zone for "exclusive" physician networks (i.e., where the physicians are not free to contract with other networks). They also define a 30 percent safety zone for non-exclusive networks, subject to the caveats described above and potentially applicable in rural situations.[47] These thresholds reappear in the 1996 Statements.[48]

These safety zones can be exceeded in both rural and urban areas. Even beyond the safety zones, networks will be analyzed under a rule of reason analysis. ***Accordingly, where a network's procompetitive benefits outweigh its anticompetitive harm, the agencies have announced their intention not to challenge networks, especially non-exclusive ones, with market shares substantially above 30 percent.***[49] Numerous examples now exist of such agency approvals of physician or multiprovider networks that exceed the safety zone. Networks have been approved consisting of 54 percent of the podiatrists in New York State,[50] 40 percent of all family practitioners in a state,[51] and 78 percent of all colon and rectal specialists in a county.[52] Two recent agency letters have accorded such flexibility to rural provider networks (see discussion in **Chapter 2** under "Networks, Joint Ventures and Exclusive Dealing").

Ensuring nonexclusivity.

Provider networks that are nonexclusive (i.e., which leave the providers free to contract with other networks, and that allow other networks meaningful access to alternative providers) are much more likely to survive antitrust scrutiny. But the 1996 Policy Statements clarify that networks must be "nonexclusive" in fact, not in name only, and set out five indicators of non-exclusivity:

1) Viable competing networks or plans with adequate provider participation currently exist in the market.

2) Providers in the network actually participate in other networks or contract individually with health benefits plans, or there is other evidence of their willingness and incentive to do so.

3) Providers in the network earn substantial revenue outside the network.

4) There are no indications of significant de-participation from other networks in the market.

5) No indications exist of coordination among the providers in the network regarding price or other competitively significant terms of participation in other networks or plans.[53]

Although the agencies have articulated more liberal views about the market shares permissible for specific non-exclusive networks, each advisory letter is based upon the extensive facts submitted to, and sometimes investigated by, the agency issuing the letter. It is thus important to understand that each situation would be evaluated on its facts. As noted, overinclusiveness in a network "raises far more substantial competitive concerns and antitrust risk than does exclusion of providers."[54] In other words, ***it is more risky for the network to be too big than for it to make selective, procompetitive decisions about "who's in and who's out."***

CHAPTER 1 ENDNOTES

3. Allan Fine, *Rural Hospitals Have Advantages for Integration: Network Options Help Providers Survive in Rural Setting, Integrated Health Care Delivery Systems*, April 1996, at pg. 3 & 6.

4. *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

5. *See, e.g., U.S. v. Classic Care Network, Inc.*, 1995-1 Trade Cas. (CCH) ¶ 70,997 (E.D.N.Y. 1994); *Southbank IPA*, 114 F.T.C. 783 (1991) (consent order); *Medical Staff of Broward General Medical Center*, 56 Fed. Reg. 49,184 (1991)(consent decree 56); *United States v. Burgstiner*, 1991-1 Trade Cas. (CCH) ¶ 69,422 (S.D. Ga. 1991) (consent order).

6. *Southbank IPA, supra,* note 5.

7. *Preferred Physicians, Inc.*, 110 FTC 157, 162 (1988) (consent order).

8. *See, e.g., Hassan v. Independent Practice Associates*, 698 F. Supp. 679 (E.D. Mich. 1988).

9. U.S. Dept of Justice & Federal Trade Comm'n, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,793 (1994) (hereinafter "1994 Policy Statements"). The statement purported to allow for "other forms of economic integration" that might be established to be effective, but no specific such forms achieved any wide recognition. *Id.* at 20,788. Global fees for heart surgery were approved for a network of cardial vascular surgeons in 41 cities nationally. Letter from Ann K. Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice, to Frederick H. vonUnwerth, on behalf of National Cardiovascular Network, September 28, 1993; *but see* Letter from Mark J. Horoschak, Deputy Director, Bureau of Competition, Federal Trade Commission, to Jacqueline C. Cox of Competitive Strategies, Inc., July 11, 1995.

10. 1996 Policy Statements, *supra* note 2, at 20,831, 20,834-35.

11. *Hearings on HR2925 Before the House Committee on The Judiciary* 104th Cong. (1996) Statement of Robert Pitofsky, Chairman of the Federal Trade Commission (hereinafter "Pitofsky Testimony").

12. These are the most recent iterations of Statements 8 and 9 of the joint policy statements; Statements 1 through 7, dealing with a variety of other conduct such as mergers, joint ventures to purchase or market highly specialized facilities or capabilities, and exchanges of competitively sensitive information, were also released

with the 1996 Policy Statements, but without change from the 1994 version.

13. 1996 Policy Statements, *supra* note 2, at 20,826-20,835.

14. *Id.* at 20,816.

15. *Id.* at 20,817. Antitrust practitioners and the agencies recognize that this type of integration may well have justified joint pricing under the framework of the 1994 Policy Statements. The explicit recognition of clinical integration as an important way to justify joint pricing, however, provides important new guidance and a changed perception in the marketplace about the flexibility of the Policy Statements.

16. *Id.*

17. David Schactman and Stuart Altman: Market Consolidation, Antitrust and Public Policy in the Health Care Industry, Agenda for Future Research, (February 1995) (Unpublished manuscript on file with the Institute for Health Policy, The Heller School, Brandeis University).(hereinafter "Shactman and Altman"), 2; guidelines; Nguyen, N. and Denick, F. "Hospital Markets and Competition: Implications for Antitrust Policy." *Health Care Management Review* 19:34-43, 1994; Robinson, J. and Phibbs, C. "An Evaluation of Medicaid Selective Contracting in California," *Journal of Health Economics*, 8:437-455, 1990.

18. *See* 1994 Policy Statements, *supra* note 9, at 20,789.

19. As discussed in Chapter 2, this was one of the claims in *Marshfield Clinic*, 65 F.3d 1406. The claim was rejected by the Seventh Circuit Court of Appeals.

20. Federal Trade Comm'n, Staff Advisory Opinion to California Managed Imaging Med. Group, Inc. (Nov. 17, 1993).

21. *See, e.g., Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.*, 924 F.2d 1484, 1491 (9th Cir. 1991); *Brown v. Our Lady of Lourdes Medical Ctr.*, 767 F. Supp. 618 (D.N.J. 1991), *aff'd*, 961 F.2d 207 (3d Cir. 1992).

22. *Hassan*, 698 F. Supp. at 694. *See also Northwest Medical Laboratories, Inc. v. Blue Cross and Blue Shield of Oregon, Inc.* 794 P.2d 428 (Ore. 1990)(rejecting claims that providers confining referrals to other HMO providers constituted unlawful group boycott, given absence of market power and benefits or exclusivity to effective utilization and quality of care).

23. *Capital Imaging Assocs., P.C. v. Mohawk Valley Medical Assocs., Inc.*, 996 F.2d 537 (2d Cir. 1993), *cert. denied*, 510 U.S. 947 (1993).

24. *Levine v. Central Florida Medical Affiliates*, 72 F.3d 1538 (11th Cir. 1996), *cert. denied*, 117 S.Ct. 75 (1996).

25. 1996 Policy Statements, *supra* note 2, at 20,830.

26. *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961).

27. *U.S. Healthcare Inc. v. U.S. Healthsource, Inc.*, 986 F.2d 589, 594 (1st Cir. 1993).

28. *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. at 45 (O'Connor, J., concurring).

29. *Id.* at 2.

30. *Id.* at 26-28.

31. *U.S. Healthcare*, 986 F.2d at 595.

32. *Id.* Of course, quality of care and/or efficiency justifications have supported judicial approval of exclusive arrangements between hospitals and exclusive provider groups in many cases. *See, e.g., Smith v. Northern Mich. Hosps., Inc.*, 703 F.2d 942 (6th Cir. 1983); *Bellam v. Clayton County Hospital Auth.*, 758 F. Supp. 1488 (N.D. Ga. 1990).

33. 1996 Policy Statements, *supra* note 2, at 20,815.

34. *Id.* The safety zone for nonexclusive networks is 30 percent or less, with a similar qualification for markets with fewer than four physicians.

35. *Id.* at 20,818-19. As noted, the Statements do not provide for safety zones for multiprovider networks, but many of the same principles apply to those networks. *Id.* at 20,826-35.

36. 861 F.2d 1440 (9th Cir. 1988).

37. *Id.* at 1449.

38. *Id.*

39. *See, e.g., Hahn v. Oregon Physicians Service*, 868 F.2d 1022 (9th Cir. 1989) (for statewide PPO consisting of 90% of eligible MDs and DOs in Portland, Ore., to exclude podiatrists from membership and discriminate against them in reimbursement system could violate antitrust laws), *cert. denied*, 493 U.S. 846 (1989); *Reazin v. Blue Cross & Blue Shield of Kansas, Inc.*, 899 F.2d 951 (10th Cir. 1990)(Blue-Shield-initiated conspiracy to exclude hospital dealing with insurer's competitor), *cert.*

Justice, Business Review Letter to California Chiropractic Ass'n. (Dec. 8, 1993) (approving network which included 50 percent of all chiropractors in the state).

50. U.S. Dep't of Justice, Business Review Letter to Preferred Podiatric Network, Inc. (Sept. 14, 1994).

51. U.S. Dep't of Justice, Business Review Letter to Itasca Clinic & Grand Rapids Med. Assocs. (Mar. 19, 1996).

52. U.S. Dept. of Justice, Business Review Letter to Allied Colon and Rectal Specialists (July 1, 1996).

53. 1996 Policy Statements, *supra* note 2, at 20,815.

54. Letter from Mark J. Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission, to J. Bert Morgan (Nov. 17, 1993).

CHAPTER 2

ANTITRUST LAW AND ENFORCEMENT APPLIED TO RURAL HEALTH CARE PROVIDERS

Should antitrust enforcement apply differently to rural health care markets? This possibility was raised by the Chairman of the Federal Trade Commission, Robert Pitofsky, in his 1996 remarks to the U. S. House of Representatives Committee on the Judiciary:

> The 1994 Guidelines' treatment of potential collaboration among providers in rural areas shows how the enforcement agencies' antitrust analysis adapts to existing market conditions. Because of the scarcity of many types of providers in most rural areas, collaboration may require the participation of a proportion of competing providers that would raise serious questions in other geographic markets. Several examples in the Guidelines illustrate how antitrust analysis takes account of competitive conditions such as the need for a certain level of provider participation in order for a joint venture to operate efficiently.[55]

This is a particularly significant observation coming from an authority as respected as Chairman Pitofsky. It bodes well for continued flexibility on the part of the government, as long as the conduct of the rural network is procompetitive, rather than anticompetitive.

The definition of the "relevant market" for antitrust purposes is the starting point for an analysis of competitive effects. The "relevant market" defines the parameters (in terms of services and geography) in which the network's power to control prices or exclude competition within the market will be assessed. ***The definition of the relevant market is critical to the analysis of the market power of a health care provider network.*** In this chapter we first examine the *courts' evolving views of geographic markets* and then examine the *concepts of monopoly power and natural monopoly* as they have been applied to rural health markets. The final section of the chapter focuses on *network joint ventures and exclusive dealing arrangements.*

SHIFTING VIEWS OF RURAL HOSPITAL MARKETS AND MERGERS

Cases dealing with hospital mergers have generated the most extensive development of health care antitrust law. In these cases, the *product market* is usually defined as the provision of inpatient acute care hospital services (see **Chapter 1**). The concept of relevant *geographic markets*, however, is more of a moving target.

Historically, most courts viewed hospital markets as highly localized. Based on analyses of physician admitting privileges and patient admission or discharge patterns, they concluded that:

> [p]eople want to be hospitalized near their families and homes, in hospitals in which their own — local — doctors have hospital privileges.[56]

In addition, physician markets have been viewed as generally localized.[57]

More recent decisions, however, have recognized that patients and third-party payers are now far more sensitive to cost.[58] Courts increasingly accept the argument that consumers, particularly subscribers to managed care plans, will travel to secure less expensive services, even if it means traveling a greater distance or to an unfamiliar doctor or hospital.

Thus, judicial focus is shifting away from static analysis of where patients currently go for health care, toward a dynamic analysis of where health care consumers practically might turn.[59] This shift is of particular importance to rural health care providers, whose facilities are often located at significant distances from other providers. Two recent decisions with particular significance for rural health care providers (the Ukiah merger case and the Dubuque merger case) have clarified these trends.[60]

The Ukiah Merger Case

In *In re Adventist Health System/West*,[61] (commonly known as the "Ukiah" merger case), Adventist Health System/West (AHS), which operated Ukiah Adventist Hospital (UAH) in Ukiah, California, acquired Ukiah General Hospital (UGH). UAH combined the two hospitals in 1988 and began operating as a 94-bed acute care facility. The only other

acute care general hospital remaining in Ukiah was the 56-bed Mendocino Community Hospital. The FTC issued a complaint against AHS and UAH, charging that the acquisition of UGH violated Section 7 of the Clayton Act.

In the FTC proceedings, the parties essentially agreed that the relevant product market was the cluster of products and services offered by acute care hospitals to inpatients. This left the geographic market as the parties' main battleground. The nearest town to Ukiah, Willits (approximately 23 miles away), had a 38-bed hospital; Lakeport, 34 miles from Ukiah, was home to a 63-bed hospital. The urban center nearest to Ukiah was Santa Rosa, 60 miles south, the site of two acute care general hospitals, one with 225 beds and the other with 145 beds.

The Commission's expert argued for a narrow geographic market including the hospitals in Ukiah, Willits, and Lakeport. The respondents' expert argued that the proper geographic market included, besides the hospitals suggested by the Commission, the hospitals in Santa Rosa and several other hospitals in other counties. The judge rejected both experts' proposed markets and found that the proper geographic market included the hospitals of Ukiah, Willits, Lakeport, and Santa Rosa. It found that, based on the market, UAH's acquisition of UGH did not confer market power on UAH and was not likely to substantially lessen competition.

For rural hospitals, perhaps the most significant aspect of the Administrative Law Judge's decision is the fact that it found hospitals 60 miles apart to be within the same market. The Court recognized that patients from the Ukiah-Willits-Lakeport area often traveled to Santa Rosa for medical care that could have been obtained closer to home. Thus these residents could travel to Santa Rosa if AHS attempted to impose a monopolistic price increase.[62] Moreover, the judge found that "the creation of a hospital which is larger and more efficient than UGH and UAH will provide better medical care than those hospitals could."[63]

The Dubuque Merger Case

More recent commentary on the markets of rural hospitals was provided in *United States v. Mercy Health Services* (widely known as the "Dubuque merger case").[64] In this case the Antitrust Division of the Department of Justice challenged the merger of the two hospitals (both regional hospitals) in Dubuque. Seven rural hospitals "in the area" of Dubuque were scrutinized by the court as it considered proposed geographic markets.

In the end, the court concluded that those hospitals were not in the same market as the merging hospitals largely because they were not able to "provide the broad range of services which the majority of their patients require and... not adequately staffed and do not have the equipment to do many inpatient surgical procedures."[65] The court agreed that, "Persons living any distance from the rurals simply do not seek them out for care...."[66] It noted the difficulty rural hospitals have in obtaining "qualified doctors and nursing staff willing to live and work in a rural community."[67]

Expanding Market Definition

Both *Mercy Health* and the recent *Freeman Hospital* case (approving a hospital merger in Joplin, Missouri)[68] illustrate how courts and the FTC have adopted an expanded view of the distances patients can be expected to travel in order to seek hospital care. Five or ten years ago, 25 or 35 miles was considered the limit, or even beyond the limit.[69] In *Adventist*, this distance was found to be 60 miles. *Mercy* now suggests that 70 to 100 miles may be acceptable, and *Freeman Hospital*, at least 54 miles. This has particular import for networking rural hospitals which, by their nature, are usually located a substantial distance from other hospitals.

The notion that rural patients will travel finds support in empirical studies. "Many rural hospitals are believed to be marginal economic enterprises ... with low census, and they may be bypassed by rural residents, who believe that a more sophisticated, higher quality of care is available at urban medical centers.[70] Thus, insured patients have been found to often

bypass rural hospitals for more comprehensive and higher technology services of metropolitan hospitals.[71,72]

Implications for Rural Networks

These studies and cases thus suggest that, although patients may well migrate from rural hospitals to urban or regional ones, the converse may not be true. Even if rural hospitals compete with their (relatively) nearby urban or regional counterparts, this does not necessarily mean that, within the same geographic sphere, they would compete with each other. To say that patients would travel for arguably better care at the regional center does *not* mean that they would travel to a comparable but more distant rural hospital.

Thus, to the extent such rural hospitals formed a network to achieve clinical or administrative efficiencies, their (horizontal) agreements (for example, on pricing) arguably do *not* raise antitrust problems because of the absence of competition among the parties. The recent Business Review Letter from the Justice Department to Sierra ComCare, Inc. recognizes this situation.[73]

Opinion of Managed Care Payers

Finally, another factor of import to the agencies in evaluating rural health care mergers is the opinion of managed care payers. A Department of Justice (DOJ) Business Review Letter in early 1996 addressed the proposed merger of two physician medical clinics in Grand Rapids, Minnesota. One clinic employed 25 percent of the relevant market's primary care physicians and 16 percent of the general surgeons. The other employed 15 percent of the primary care physicians and 16 percent of the general surgeons. Although the DOJ believed the merger could raise anticompetitive concerns, it declined to challenge the merger on the grounds that no third-party payers expressed any concern.[74]

MONOPOLY POWER, "NATURAL" MONOPOLIES AND RURAL MARKETS

In the health care context, Sherman Act Section 2 claims are frequently based upon the "essential facilities" doctrine, i.e., where a monopolist controls an essential facility and denies its use to a competitor, rendering the competitor unable to compete.[75] To demonstrate denial of access to an essential facility, an excluded provider has to demonstrate that the exclusion caused substantially more than inconvenience, or even some economic loss: The plaintiff must show that the exclusion constitutes a 'severe handicap' that threatens to eliminate competition in the market for that service.[76]

Marshfield Clinic

If any recent case reinforced fears — ultimately misplaced — about the application of the antitrust laws to rural providers, it was *Marshfield Clinic*.[77] That case took a limited view of the essential facilities doctrine. The case was brought by two plaintiffs — Blue Cross & Blue Shield of Wisconsin and Compcare, Blue Cross's affiliated HMO -- against the Marshfield Clinic, a nonprofit corporation owned by its 400 employee physicians. Marshfield Clinic operates 21 branch offices throughout North Central Wisconsin.[78] The Blues charged that the Clinic had monopolized the HMO and physicians services markets in rural Wisconsin and had engaged in a variety of other anticompetitive actions, foreclosing the Blues from access to these markets.

The jury verdict favored the plaintiffs and awarded approximately $48 million in treble damages and attorneys fees. However, the Seventh Circuit Court of Appeals reversed that verdict and rejected the plaintiffs' claims:

- that the clinic had unlawfully monopolized the market;
- that HMOs form a separate market from other forms of health care financing, such as PPOs;
- that the Clinic-affiliated HMO had contracted with such a large portion of the region's physicians that Compcare could not find enough "independent" physicians with which to contract in the claimed "HMO market"; and

- that comparatively high prices, in and of themselves, demonstrated monopoly power.

Although holding that Marshfield Clinic did not have monopoly power in the regions of North Central Wisconsin at issue, the court did suggest that the Clinic was a monopolist with respect to those areas so small that it employs all of the "handful" of physicians in that particular region. Here the court characterized the Clinic as holding a *natural monopoly.*[***79] The court also rejected claims that the clinic was an "essential facility," which must provide access for competitors, on the grounds that Blue Cross had not demonstrated the clinic's control over even 50% of any properly defined market.

This "natural monopoly" finding has special significance for rural providers because it recognizes:

- ***that a rural market may be too small to support more than one firm, and***
- ***that physicians practicing in groups are better able to provide modern medical care to rural residents.***

The case is also significant because the court rejected a contention that every small town in North Central Wisconsin constituted a tiny geographic market, in many of which the Marshfield physicians were monopolists. Instead, the court favored a more "plausible" market of all physician services in North Central Wisconsin.[80]

Despite fears fueled by the trial and the verdict, the ultimate outcome of *Marshfield Clinic* supplies a resounding endorsement of physician practice consolidation in rural areas. Moreover, it implicitly accepts the potential market power that those practices will inevitably entail. On the other hand, the case does not go so far as to sanction agreements among providers not to compete in a situation where competition is viable, including among practice

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[***] "If the Marshfield Clinic is a monopolist in any of these areas, it is what is called a "natural monopolist," which is to say a firm that has no competitors simply because the market is too small to support more than a single firm. If an entire county has only 12 physicians, one can hardly expect or want them to set up in competition with each other. We live in the age of technology and specialization in medical services. Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support. Twelve physicians competing in a county would be competing to provide horse-and-buggy medicine. Only as part of a large and sophisticated medical enterprise such as the Marshfield Clinic can they practice modern medicine in rural Wisconsin." 65 F.3d at 1412-13.

groups, alliances or networks in a given geographic area. The authors expect that the agencies will continue to be vigilant about the potential anticompetitive effects of monopoly power in local hospital and physician markets.[81]

Leveraging Monopoly Power "Downstream"

Another significant recent development bearing upon the exercise of monopoly power in rural areas — even by a natural monopolist — are those cases and proceedings involving the leveraging of a hospital's or provider's power in the monopolized market into a second, or "downstream," market, to the detriment of competition. For example, it could be unlawful, under certain circumstances, for a monopolistic hospital to insist that its patients receive their durable medical equipment from a hospital-affiliated supplier, to the exclusion of competitive suppliers. This rationale underlies recent consent decrees imposed by the government upon several physician-hospital organizations (PHOs) that attempted to leverage their market or monopoly power to exclude competitive ancillary or outpatient providers or managed care efforts from the market.[82]

Although this area of law is not yet well-developed, it suggests that hospitals or other providers with monopoly power risk antitrust exposure if they favor (e.g., by directing referrals to) their affiliated suppliers of ancillary services or facilities, to the detriment of competitive suppliers. A safer option is to create a "level playing field" when providing information and choices among such suppliers (for example, in the discharge planning process).

NETWORKS, JOINT VENTURES AND EXCLUSIVE DEALING

The antitrust enforcement agencies will be particularly flexible toward the market power of networks with relatively high market shares if their relationships with their constituent providers are **non-exclusive**. The hypothetical "examples" in the 1996 Policy Statements that address rural physician and multi-provider networks also reflect the

considerable flexibility afforded to networks that do *not* qualify for a safety zone. The agencies provided the following examples of where they would not challenge network conduct:

- a non-exclusive rural IPA comprising more than half the general practitioners and all of the specialists in the relevant market, formed in response to the expressed need of a payer to include more local physicians in the plan it markets to local employers, and providing services on a capitated basis.[83]

- a non-exclusive rural IPA comprising all of the local physicians who agree to join a clinic, at the request of a managed care plan, in a part of the state where no physicians currently practice, and to implement utilization review procedures established by the plan, with an agent acting as a "messenger" (under the messenger model) for purposes of fee negotiations between individual providers and the plan, and negotiating on behalf of the network non-fee related aspects of the contract, oriented toward achieving network efficiencies.[84]

- a non-exclusive PHO in which the physicians, who are losing patients to providers in nearby Big City, agree on the prices they will charge through the PHO under a fee schedule providing for discounted fees and the availability of a bonus up to 20 percent if utilization targets, agreed to with payers, are met, thereby providing significant financial incentives for the physicians to meet cost-containment goals.[85]

Two recent agency enforcement letters also reflect flexibility toward rural providers. The Justice Department agreed not to challenge Sierra ComCare, Inc., a non-exclusive network in Ridgecrest, California, consisting of a community hospital (the only acute care hospital in the vicinity) and virtually all of the physicians in the area. The network proposed to employ the messenger model to contract with payers and to restrict the flow of competitively sensitive information among the providers. The approval is grounded on 1) the non-exclusivity of the network, and 2) the use of a "properly designed and implemented" messenger model to avoid provider collusion on price.[86]

The Department also agreed recently not to challenge a proposed non-exclusive network of 21 small rural hospitals in Wisconsin (RWHC Network, Inc.). This network

intended to negotiate fees with payers on a discounted-fee-for-service basis (and ultimately under risk-sharing arrangements), through a third-party administrator. Critical to the approval was the fact that the network hospitals were geographically dispersed and did not compete with each other, but rather with a larger, more sophisticated regional medical center to which patients "outmigrated."

The government noted that, under the circumstances posed, the network would allow managed care plans to negotiate with the hospitals in an efficient and cost-effective manner. In addition, no managed care plan or other third-party payer had expressed concern about the network.[87] These business review letters and policy statements clearly acknowledge, implicitly if not explicitly, the need for flexibility in antitrust enforcement involving rural providers, particularly those in non-exclusive networks.

CHAPTER 2 ENDNOTES

55. Pitofsky Testimony *supra* note 11, at 8.

56. *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990), *cert. denied*, 498 U.S. 920 (1990).

57. 1996 Policy Statements, *supra* note 2, at 20,815 n. 26. *Cf. Morgenstern v. Wilson*, 29 F.3d 1921,(8th Cir. 1994), *cert. denied*, 115 S.Ct. 1100 (1995).

58. *See, e.g., United States v. Mercy Health Services*, 902 F. Supp. 968, 973 (N.D. Iowa 1995)(observing that managed care has resulted in price competition among hospitals and patients considering out-of-pocket expenses in health care choices), *vacated as moot* [after settlement], Nos. 95-4253, 96-1051, 1997 WL 78396 (8th Cir. Feb. 26, 1997).

59. See *FTC v. Freeman Hospital*, 69 F.3d 260, 269 (8th Cir. 1995); *Mercy Health Services*, 902 F. Supp. at 978.

60. The 1994 Policy Statements on hospital mergers provide a safety zone which could apply to a number of rural hospital mergers. 1994 Policy Statements, *supra* note 9, 20,774. The agencies explicitly recognize that small rural hospitals are unlikely to achieve the efficiencies that larger hospitals enjoy, other than through a merger with another hospital. Even outside the safety zone, the agencies note that hospital mergers may be procompetitive under certain circumstances.

61. Dkt. No. 9234 (FTC Dec. 9, 1992) (initial decision) (WESTLAW, FATR-FTC).

62. *Id.* at *31-32. The Judge also relied on testimony from third-party payers that if AHS attempted to impose a monopolistic nontransitory price increase, patients could be diverted to Santa Rosa. According to one insurer, the 30-to-45 minute drive meant the Santa Rosa hospitals were "not that far away." *Id.* at 17.

63. *Id.* at *33. The Administrative Law Judge's decision was affirmed when reviewed by the full Commission, *In re Adventist Health System/West*, which found that the Commission staff failed to carry its burden of proof that Ukiah-Willits or Ukiah-Willits-Lakeport was the relevant geographic market. Dkt. No. 9234 (FTC Apr. 1, 1994) (final order) (WESTLAW, FATR-FTC).

64. 902 F. Supp. at 975.

65. *Id.* at 977.

66. *Id.* at 980. *Cf. Rockford Memorial Corp.*, 898 F.2d at 1285 ("ridiculous" and "contrary to common sense" to propose that third party payers and residents of a mid-sized city "will be searching out small, obscure hospitals in remote rural areas if the prices charged by the hospitals in [the city] rise above competitive levels.")

67. *Id.*

68. *Freeman Hospital*, 69 F.3d 260.

69. *See, e.g., Bhan v. NME Hospitals, Inc.*, 669 F. Supp. 998, 1006 (E.D.Cal. 1987), *aff'd*, 929 F.2d 1404 (9th Cir. 1991), *cert. denied*, 502 U.S. 994 (1991); *In re American Medical International, Inc.*, 104 FTC 1, 197 (1984), *modified*, 104 FTC 617 (modified order), *modified*, 107 FTC 310 (modified order).

70. Jon B. Christianson, Alternative Delivery Systems in Rural Areas, 23 Health Services Research, (1989), at 875; also noting, interestingly, that urban-based alternative delivery systems serving rural areas might consider using less costly rural hospitals and specialists where appropriate. This thought runs contrary to the judicial views in *Mercy* and *Rockford Memorial*.

71. Beth C. Fuchs, Health Care Reform: Managed Competition in Rural Areas, Congressional Research Services Report For Congress (1994), at pgs. 8-9, citing a study that reports the majority of health care dollars spent by rural residents are spent outside their local communities: Christianson, J. and I. Moscovice, "Health Care Reform for Rural Areas," in Alpha Center, *Health Care Reform in Rural Areas: Report of an Invitational Conference*, (Washington, D.C., 1993), pp. 24. *See also*, Bronstein, J. and Morrisey, M., "Determinants of Rural Travel Distance for Obstetrical Care," *Medical Care*, 28:853-65 (1990) (citing empirical results adding to evidence that rural hospitals do not exist in isolated medical markets, but compete with other rural and urban hospitals for patients; Rolinski, F. and Kurz, R. "How the Public Chooses and Views Hospitals," *Hospitals and Health Services Administration*, 29:58-67 (1984) (noting that "nearness to home" was not ranked among the top four factors selected by survey respondents among nine factors involved in the choice of a hospital).

72. Another study observes that, in urban merger cases, it is inappropriate to include rural areas in the market definition, because one-way patient migration does not bar significant monopolistic price increases. Worden, G., "The Limited Relevance of Patient Migration Data in Market Delineation for Hospital Merger Cases," *Journal of Health Economics*, 8:363-76 (1989).

73. U.S. Dep't of Justice, Business Review Letter to Sierra ComCare, Inc. (Aug. 15, 1996), discussed near the end of Chapter 2. The 1994 Policy Statements on hospital mergers provide a safety zone which could apply to a number of rural hospital mergers. 1994 Policy Statements, *supra* note 9, at 20,774. The agencies explicitly recognize that small rural hospitals are unlikely to achieve the efficiencies that larger hospitals enjoy, other than through a merger with another hospital. Even outside the safety zone, the agencies note that hospital mergers may be procompetitive under certain circumstances. *Id.*

74. U.S. Dep't. of Justice, Business Review Letter to Itasca Clinic and Grand Rapids Medical Association (Mar. 19, 1996).

75. *See MCI Communications Corp. v. AT&T*, 708 F.2d 1081, 1132 (7th Cir. 1983), *cert. denied*, 464 U.S. 891 (1983). In arguing their monopolization claims, health care providers have alleged that they were denied access to such "essential facilities" as hospitals and other medical buildings and equipment (*see, e.g., Smith v. Northern Michigan Hosp., Inc.*, 703 F.2d 942 (6th Cir. 1983); *Konik v. Champlain Valley Physicians Hospital Medical Center*, 561 F. Supp. 700 (N.D.N.Y. 1983), *aff'd.*, 733 F.2d 1007 (2d Cir. 1984), *cert. denied*, 469 U.S. 884 (1984)), medical staff privileges, patient referrals (*see, e.g., Advanced Health-Care Services, Inc. v. Radford Community Hospital*, 910 F.2d 139 (4th Cir. 1990); *see also Key Enterprises of Delaware, Inc. v. Venice Hospital*, 919 F.2d 1550 (11th Cir. 1992), *opinion vacated for reh'g en banc*, 979 F.2d 86 (11th Cir. 192), *dismissed as moot* [after settlement], 9 F.3d 893 (11th Cir. 1993), *cert. denied sub nom, Sammett Corp. v. Key Enterprises of Delaware, Inc.*, 511 U.S. 1126 (1994)), and health care provider networks *(see American Health Systems, Inc. v. Visiting Nurse Ass'n. of Greater Philadelphia*, 1994-1 Trade. Cas. (CCH) ¶70,633 (E.D.Pa. 1994)(hospital patient referrals may constitute an essential facility).

76. *Advanced Health-Care Services*, 846 F. Supp. at 498 (*citing Twin Laboratories, Inc. v. Weider Health & Fitness*, 900 F.2d 566, 569-70 (2d Cir. 1990)).

77. *Marshfield Clinic*, 65 F.3d 1406.

78. *Id.* at 75,373.

79. *Id.* at 1412-1413.

80. *Id.* at 1411.

81. Notwithstanding the trend toward broader geographic markets in recent merger cases hospital geographic markets are still considerably smaller, in most cases, than the

market at issue in *Marshfield Clinic* and other cases involving health care financing. *See, e.g., Ball Memorial Hosp. v. Mutual Hosp.*, 784 F.2d 1325 (7th Cir. 1986); *Reazin*, 899 F.2d 951.

82. *Montana Associated Physicians, Inc./Billings Physician Hospital Alliance, Inc.*, 61 Fed. Reg. 56682 (Nov. 6, 1996) (proposed consent order) (Jan. 13, 1997) (consent order); *United States v. Woman's Hospital Foundation*, 61 Fed. Reg. 21489 (Apr. 23, 1996) (proposed consent decree); *United States v. Healthcare Partners*, 1996-1 Trade Cas. (CCH) ¶ 71,337 (Feb. 15, 1996) (consent order); *United States v. Health Choice of Northwest Missouri*, 60 Fed. Reg. 51808 (Oct. 3, 1995) (proposed consent order).

83. 1996 Policy Statements, *supra* note 2, at 20,824-20,825 (Statement 8, Example 6).

84. *Id.* at 20,825 (Statement 8, Example 7).

85. *Id.* at 20,833-20,834 (Statement 9, Example 3).

86. U.S. Dep't of Justice, Business Review Letter to Sierra ComCare, Inc. (Aug. 15, 1996).

87. U.S. Dep't of Justice, Business Review Letter to RWHC Network, Inc. (Nov. 12, 1996). *See also* U.S. Department of Justice, Business Review Letter to the Oklahoma Physicians Network-IPA, Inc. (Jan. 17, 1996) (agreeing not to challenge non-exclusive statewide IPA which would include more than 30 percent of the specialists in certain rural and semi-urban markets, where a majority of the IPA's membership would be practicing in price-competitive urban areas and would have an incentive to ensure that the IPA's services were priced competitively).

The Strategies

CHAPTER 3

CONSIDERATIONS FOR RURAL HEALTH NETWORKS

An awareness of pertinent antitrust issues should inform the plans and actions of providers contemplating development of a rural health network. However, as we have tried to show in the preceding two chapters, would-be developers have considerable scope for creative approaches as long as they exhibit procompetitive intent and their networks are appropriately structured. Effective antitrust counseling can help a network organize itself and act in ways that minimize antitrust exposure. Rural provider networks can engage in a number of activities that may help generate efficiencies and foster competition in rural areas.

In this chapter we offer specific suggestions for developing and operating rural health networks. The first section briefly reviews **six potentially useful network activities** that, if properly structured, are permissible under antitrust laws. The second section offers **antitrust counseling suggestions for current and proposed networks.**

POTENTIAL ACTIVITIES AVAILABLE TO RURAL PROVIDER NETWORKS

At least six categories of activities may be of particular interest to rural health networks:

- joint buying arrangements for hospital or pharmaceutical supplies
- joint purchase and/or marketing of expensive or high-tech equipment
- joint ventures to offer specialized clinical or other expensive health care services
- administrative efficiencies
- service consolidations
- investment in information systems

This is not meant to be a comprehensive list; however, each of these activities could help network providers realize efficiencies and improve their ability to compete.

Joint Buying Arrangements

Joint buying arrangements among hospitals and physicians can help obtain volume discounts and reduce transaction costs. Joint purchasing arrangements can involve the purchase of pharmaceutical products, computer or information systems, equipment and/or supplies. By lowering input costs, joint purchasing arrangements can be of potential benefit to providers and can help generate more cost-effective delivery of health care services. In some circumstances, such arrangements may enable rural providers on the fringe of urban areas to compete more effectively with their urban counterparts.

Joint Purchase and/or Marketing of Expensive or High-Tech Equipment

The antitrust enforcement agencies will not generally challenge hospital joint ventures involving the joint purchase and/or shared ownership, operation and marketing of high-technology or other expensive equipment and services.[88] Such equipment includes, for example, MRI or CT scanners, lithotripsy equipment, and mobile health care devices.

Joint Ventures to Offer Specialized Clinical or Other Expensive Health Care Services

Providers, especially hospitals, will often pool resources in order to offer specialized clinical or other expensive health care facilities or services which the individual hospitals might not otherwise be able to offer. The enforcement agencies tend to view these kinds of ventures with favor.[89] For example, the Statements cite an example of two rural hospitals that decide to share the costs of developing an open heart surgery program at one of the hospitals. Depending on the facts, these kinds of ventures can be procompetitive.

Administrative Efficiencies

Rural provider networks can engage in shared claims administration, joint billing, and other types of administrative collaboration without undue concern about antitrust violations.

Service Consolidations

Depending on the circumstances, there are many ways in which hospitals in an integrated network can consolidate service lines to enhance efficiency. Providers must take care to avoid dividing up service arrangements so as to eliminate existing competition. On the other hand, the appropriate consolidation of clinical services, particularly as an outgrowth of clinical integration designed to manage care more effectively and efficiently, can be undertaken in a variety of areas. Examples include open heart or other surgery; respiratory care or other high-end tertiary services; and ancillary services such as laboratory, housekeeping, biomedical or home care services. (Obviously, such consolidation would depend upon the reasonable ability of patient populations to use the now-consolidated service.)

Investment in Information Systems

The joint investment in information systems can be a key to realizing efficiencies in many or most of the above areas. It is particularly important in connection with successfully achieving clinical and administrative efficiencies. Information-based integration (in the form of practice guidelines or clinical protocols, improved information about diagnoses and/or case review and peer review) can help improve the quality of services offered by rural providers. These strategies can also enhance rural providers' ability to compete with urban providers, where that is geographically possible.

Each of the above areas of potential collaboration within rural networks is possible under the antitrust laws and potentially beneficial to rural providers. ***Networks formed to achieve these kinds of purposes, as well as to deal through the messenger model with***

managed care or other third-party payers, have met with the approval of the antitrust enforcement agencies. This is true even where such networks involve nearly all of the providers in a rural area, or providers that do not (for the most part) compete.

ANTITRUST COUNSELING SUGGESTIONS

Every rural health network should be aware of seven aspects of planning and operating in which antitrust issues need to be considered:

1. pricing and financial or clinical integration
2. selective and exclusive contracting
3. network structure and market power
4. documenting efficiencies
5. making sure the network behaves properly
6. interacting with the agencies
7. obtaining payer and community support

This section of **Chapter 3** addresses each area in turn and offers practical suggestions for achieving network goals without running afoul of antitrust laws. Networks should also be aware of the potential benefits and hazards of "state action immunity" legislation (see **Chapter 4** for a brief overview of state-level immunities).

1. Pricing and Financial or Clinical Integration

Joint pricing remains the most sensitive type of conduct under the antitrust laws. It must be undertaken only with careful guidance in light of developing law and enforcement policies. Health care provider networks that wish to engage in joint pricing of their services have at least three potential approaches available to them: (a) shared risk, (b) clinical integration, and (c) the messenger model.

a) Shared risk. Providers probably continue to be safest engaging in joint pricing within the network if they **share substantial economic risk**. Such shared risk gives them incentives to control costs and excessive utilization within the network. Numerous forms of risk-sharing are recognized: capitation; risk withholds; global fees for specific cases,

treatments or procedures; percentage-of-premium or percentage-of-revenue arrangements; and cost or utilization targets for the network as a whole (with attendant rewards or penalties if providers as a group meet or do not meet the targets).

b) Clinical integration. The 1996 Policy Statements now explicitly recognize the reasonableness of joint pricing ancillary to substantial integration — principally clinical integration — that is designed to achieve cost containment and/or to improve the delivery of care. Therefore greater flexibility should exist to structure pricing arrangements, including those with third-party payers, as network providers desire.

This potential flexibility, however, will require the substantial clinical integration which the Policy Statements contemplate. What constitutes sufficient clinical integration short of the extensive steps specified by way of example in the Statements? That important point remains to be developed in future agency letters and case law.

However, in the authors' view, three steps are especially helpful to establish the sufficiency of clinical integration: 1) the network's investment in information systems ("monetary" investment), and 2) the network's designation of a medical director and staff (investment in "human" capital), in order to achieve its cost-containment and utilization goals; and (3) selective contracting with quality providers. These steps can help a network monitor provider utilization of services according to medical criteria which are cost-effective but assure quality.

As with any joint venture, the need to recover a tangible and quantifiable investment in the venture's new or improved product and service provides a compelling reason why it would be "reasonably necessary" for the sellers of the product and service to control the terms of sale, including price, in order to justify the investment.

To the extent that the new Policy Statements sanction such joint pricing not only where there is provider risk-sharing (which may be difficult or impossible to achieve in rural areas), but also where such pricing is reasonably necessary to achieve the kinds of efficiency-enhancing clinical integration which may be both easier (than financial risk-sharing) to

achieve in rural areas and desirable from a quality-of-care standpoint, the Statements provide not only greater flexibility but also the right incentives for network conduct in rural areas.

The question for rural networks will be whether they have the ability, motivation and sufficient capital (monetary and human) to invest in and achieve this kind of integration. On the other hand, the relative absence of technology or information's systems, the geographic dispersion of its members, or the evolution of its members' practices, may make it relatively difficult for a rural network to achieve clinical standards or protocols. This may be especially true if the network's providers have widely divergent abilities, habits or patterns in the diagnosis or treatment of illnesses. It may well be precisely in these situations, however, where such clinical integration may do the most good, and needs to be encouraged by flexible antitrust rules about joint pricing.

This, of course, begs the question of why joint pricing would be necessary to achieve such integration. The network would have the burden to demonstrate why. ***If the network undertakes joint provider pricing ancillary to clinical integration, it should take care to at least document, if not quantify, both (a) the efficiencies the network is trying to achieve, and (b) the investment which is designed to produce those efficiencies.***[90]

c) Messenger model. In the absence of sufficient integration to justify joint pricing, the loosely affiliated network must not engage in network-wide pricing without the use of the "messenger model" (as discussed in **Chapter 1**). Although the 1996 Policy Statements offer a slightly more flexible version of the messenger model than did their 1994 counterparts, in most situations it will be of limited utility.

2. Selective and Exclusive Contracting with Providers

The benefits of selective and exclusive contracting have been recognized. However, agency letters and policy statements have focused on the virtues of *non-exclusivity* in provider networks. The benefits of *exclusive* arrangements and the circumstances

(hypothetical or otherwise) in which they are justified receive far less attention under the Policy Statements.

Exclusive arrangements should receive more attention, especially given the increasing recognition of the potential need for exclusivity to achieve efficiencies or justify capitation. As FTC Commissioner Varney noted in discussing exclusive arrangements,

> My sense is that much of the special nature of rural markets will be captured by efficiencies arguments and, consequently, that the best way to ensure that we are sensitive to rural concerns is by being sensitive to efficiency concerns.[91]

Rural networks wanting to enter into exclusive relationships with providers need to: (a) carefully review and document the efficiency justifications for the exclusive arrangements (before entering into them), and (b) balance those justifications against the anticompetitive effects of the arrangements. In addition, the efficiencies should not be achievable through other measures that would restrict competition significantly less.[92]

3. Network Structure and Market Power

Once a rural health network is constituted, and particularly if it has market power, it should avoid engaging in conduct which may substantially foreclose competition in a market. Such a network should especially avoid excluding classes of providers that supply competitive services in the market (such as allied health care professionals), unless well-supported procompetitive justifications exist. On the other hand, if the efficiencies *can* be justified, the courts and agencies have shown considerable flexibility to rural providers seeking to affiliate, even when the affiliation involves market power.

Rural physicians, hospitals or PHOs must also be careful to avoid leveraging their market or monopoly power into downstream markets, such as those for home health care or durable medical equipment. They must also avoid committing their members to potentially anticompetitive contractual restrictions. These would include "rights of first refusal" or "rights of first opportunity" under which member physicians must give the PHO "first crack"

at those opportunities. Such "rights" can have the effect of excluding other providers (e.g., competitors' outpatient or ancillary care facilities) from a meaningful opportunity to compete for those managed care arrangements.[93] ***If consumers are given information about, access to, and choice among competitive providers, antitrust problems should be avoided.***

4. Documenting Efficiencies

A rural health network seeking to justify its market power must explain — and document — the efficiencies it expects to realize. This should be done, if possible, *before* the transaction creating the network is approved by the decision makers, e.g., the respective boards of directors or trustees of the parties.

The 1996 Policy Statements allow for consideration of efficiencies achieved by networks (such as those in the form of reduced administrative costs, improved cost controls, case management and quality assurance, and economies of scale) that will benefit consumers in the form of reduced prices or higher quality. However, those efficiencies cannot be achievable through means that would be significantly less restrictive of competition.[94]

Networks seeking to justify joint pricing ancillary to clinical integration, or a high degree of market power, may want to engage an accounting firm to analyze and quantify the efficiencies to be expected from network operations. This is a step which parties to a proposed merger often take, especially if the market power of the merged parties may generate antitrust concern and the parties need compelling evidence of the countervailing procompetitive efficiencies benefitting consumers. Whether this makes sense for a network, which may have more limited resources and/or different kinds of efficiencies than a merger generates, much be evaluated in each situation.

The federal antitrust enforcement agencies have recently released revisions to their merger guidelines to elaborate how they will analyze efficiencies claims. They echo much of the previous thinking on the subject, and will affect the analysis of network efficiencies. From these guidelines, the Policy Statements, experience, and other guidance provided by

the agencies,[95] it can be generalized that "efficiency" justifications require most or all of the following to be convincing:

- They should be substantial and documentable. Efficiencies should be quantified and itemized.

- They should be specific to the transaction, i.e., not otherwise practicably achievable.

- They should outweigh or reverse the potential anticompetitive harm of the transaction, *e.g.*, by preventing price increases. The greater than potential, the greater the efficiencies must be.

- They should be likely to be realized.

The three main types of efficiencies achievable by rural health networks include:

(a) Clinical efficiencies. These can be achieved as described in the 1996 Policy Statements, or potentially through the rationalization and consolidation of specific service lines within integrated networks so as to minimize or eliminate duplication. This, however, raises the fundamental question of whether the service line allocation is ancillary to legitimate joint venture efficiency-enhancing conduct, or instead involves anticompetitive restrictions. Thus, the agencies will often inquire into the claimed efficiencies to be derived through clinical integration.

(b) Administrative efficiencies. These may be easier than clinical efficiencies to establish, for example, through reduction of specific staff and management personnel. They are not, however, generally as significant or network-specific.[96]

(c) Ancillary services. The consolidation of ancillary facilities may achieve efficiencies.[97]

Of potential significance in rural situations, and quite interestingly in light of the *Marshfield Clinic* language about "natural" monopolies, the newly revised merger guidelines state, "Efficiencies almost never justify a merger to monopoly or near-monopoly."[98]

The agencies have emphasized that cost savings and efficiencies should be developed and documented* as a part of the planning of the transaction, *and not as an

"after the fact" or "post hoc" rationalization for the proposed merger.[99] Counsel should work closely with the client representatives or experts who are participating in the development of efficiency justifications. The claimed justifications should (a) accord with common sense, (b) not be so complex as to be incredible or invite independent problems, and (c) seem likely to be achieved.[100]

5. Making Sure the Network Behaves Properly

In addition to complying generally with the law, three specific guidelines should be followed in network development efforts to ensure proper network behavior:

a. Avoid any appearance of price-fixing or collusion.
b. Create a confidentiality agreement.
c. Foster a procompetitive — not an anticompetitive — mindset.

5.a. Avoid any appearance of price-fixing or collusion.

The competitors considering the formation of a provider network must be especially careful to avoid exchanging information on competitively sensitive subjects which could facilitate price-fixing. The exchange of price information, including within network development efforts, can easily facilitate price-fixing. On the other hand, exchanges necessary to develop a capitated model or other risk-sharing arrangements within the network may need to occur. Such exchanges should be undertaken with antitrust guidance. The enforcement agencies have been paying very close attention to pre-merger or pre-network collusion.

5.b. Create a confidentiality agreement.

Competitors considering the formation of a network should enter into confidentiality agreements governing exchanges of confidential, proprietary or competitively sensitive information. Such agreements commonly restrict:

- the use of the information exchanged,
- the parties with access to it,
- the timing of the exchanges, and
- the disposition of the information should the parties terminate discussions.

These specifications protect the confidential status of the information *and* assure that it is not used for anticompetitive purposes.

5.c. Foster a procompetitive — not an anticompetitive — mindset.

Networks should keep in mind their procompetitive purposes and avoid the expression, in meetings and in documents, of anticompetitive intent or anticipated anticompetitive effects. "Bad" documents tend to dominate the dynamics of an investigation or trial into allegedly unlawful conduct under the antitrust laws. Thus, the generation and flow of documents should be reviewed, and any consultants retained by the network should be sensitized to antitrust considerations.

With these three cautions in mind, network development efforts will have considerable flexibility in achieving their objectives, including through the use of teams or task forces to study specific issues such as clinical savings, pricing in accordance with risk-sharing models, administrative consolidations, governance, marketing, and a wide variety of other subjects which networks often consider.

6. Interacting with the Agencies

Rural health networks should consider whether it would be advisable to initiate an informal dialogue with an antitrust enforcement agency, or request a formal business review letter or staff advisory opinion. There are a number of reasons *not* to engage in this latter undertaking, but situations do exist where a formal request may be advisable, particularly where the parties wish to minimize risk by obtaining clear guidance before proceeding with a transaction.

7. Obtaining Payer and Community Support

It is often extremely helpful for a network to garner payer and community support. Although not dispositive, courts and antitrust enforcement agencies accord significant weight to the views of third-party payers, and of the community, toward network development.

SUMMARY

As long as the competitive model lies at the heart of the health care system and provides the engine for reform, it is critically important that antitrust enforcement be aggressive enough to enhance the evolution of such reform, but also that it be flexible enough not to chill the development of legitimate and efficient provider networks. The widespread fear of antitrust violations could easily threaten the development of procompetitive health care services in some rural communities.[101]

The authors believe these fears are often overstated and unfounded. Health care executives need to recognize the markedly increased flexibility provided to rural networks by government policies, especially those policies articulated since the beginning of 1996. Various marketplace and operational impediments do continue to face provider networks,[102] and the development of integrated rural health networks remains "a social experiment."[103] Antitrust issues should not be ignored; neither should unreasonable antitrust fears prevent the exploration of creative rural network options.

CHAPTER 3 ENDNOTES

88. 1996 Policy Statements, *supra* note 2, at 20,801-20,803. The Policy Statements also view customary joint purchasing arrangements with favor. *Id.* at 20,812-14.

89. *Id.* at 20,806-08.

90. *See* subhead "Documenting Efficiencies" later in this chapter.

91. "New Directions of the FTC: Efficiency Justifications and Hospital Mergers and Vertical Integration Concerns," Remarks of Commissioner Christine A. Varney, Federal Trade Commission, before the Health Care Antitrust Forum, Chicago, Illinois (May 2, 1995).

92. 1996 Policy Statements, *supra* note 2, at 20,819, 20,830.

93. *In the matter of Baycare Health Partners, Inc.*, Commonwealth of Massachusetts, C.A. No. 94-5653 (Mass. Dist. Ct. Oct. 20, 1994).

94. 1996 Policy Statements, *supra* note 2, at 20,819, 20,830.

95. *See* Revision to the Horizontal Merger Guidelines issues by the U.S. Department of Justice and the Federal Trade Commission, released April 8, 1997; 1992 U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13,104, §4.0; Remarks of Mary Lou Steptoe, Acting Director, Bureau of Competition, Federal Trade Commission, "Efficiency Justifications for Hospital Mergers," before Practicing Law Institute, San Francisco, CA (June 17, 1994) (hereinafter "Steptoe"). *See also* Remarks of Stephen C. Sunshine, Deputy Assistant Attorney General, Antitrust Division, Department of Justice, "Market-based Reform of Health Care Delivery: Where Does Antitrust Fit In?" before the Brookings Health Affairs Conference, Brookings Institution, Washington, D.C., January 23, 1995 (hereinafter "Sunshine").

96. Steptoe, *supra* note 95, at 18. ("Almost any merger will create opportunities to reduce personnel and overhead expenses, which generally represent only modest potential cost savings.")

97. *See* 1994 Policy Statements, *supra* note 9, at 20,775-79 (Statement 2).

98. Revision to the Horizontal Merger Guidelines, *supra* note 93.

99. Steptoe, *supra* note 95, at 26.

100. *Id.* at 23.

101. *See* Jon Christianson and Ira Moscovice, "Health Care Reform and Rural Health Networks," *Health Affairs*, Fall 1993, at 72.

102. *See generally,* Ira Moscovice et al., "Rural Hospital Networks: Implications for Rural Health Reform," *Health Care Financing Review* 17, 53-67 1995.

103. Id. At 23.

CHAPTER 4

CONSIDERATIONS FOR LEGAL AND HEALTH POLICYMAKERS

Despite the special characteristics and imperfections in health care markets, the courts, including the U.S. Supreme Court, have essentially treated health care the same as any other industry.[104] Indeed, the Court professes an abiding faith that competitive market forces are "the best method of allocating resources in a free market. . . . [T]he statutory policy [of the Sherman Act] precludes inquiry into the question whether competition is good or bad."[105] The fact that health care markets are currently reforming themselves in large part based on a competitive, rather than a regulatory, model lends support to this notion.

It is, of course, important to remember that competition does not solve all problems in the health care marketplace — especially the problem of access of the poor, uninsured or underinsured to the health care system. This is ultimately an issue for legislators and regulators. Access problems must be solved, however, in the context of what remains fundamentally a competitive system. Given its benefits, competition should be encouraged to operate freely to lower price, improve quality and increase access to the full extent it can achieve these goals.

But even if based on a competitive model, health care market reforms — and the evolution of antitrust policy — must depend on an evaluation of how competition works in rural health care markets. To the extent that health care market characteristics and imperfections are more pronounced in rural areas, antitrust policy must display some flexibility.

The very uncertainty about whether and how competition plays out in rural health care markets, combined with the unique circumstances of those markets, bears on the ongoing development of antitrust law and policy in five ways:

- the application of the *per se* rule
- exclusive dealing
- monopolization and "natural" monopoly
- market power
- immunities and exceptions

In this chapter we review each of these areas and point out specific areas in which antitrust policy needs further clarification. We also offer suggestions for policy directions that would encourage appropriate development and operation of rural health networks while preserving the intent of the antitrust laws.

SPARING APPLICATION OF THE *PER SE* RULE

The uncertainties and differentiating factors just mentioned, combined with the need to encourage efficient rural provider networks, argue against application of the *per se* rule in rural health care markets except in the most egregious instances of anticompetitive collusion. It is axiomatic under the antitrust laws that the courts will be reluctant to impose *per se* treatment when faced with unique or novel circumstances or when unfamiliar with a challenged arrangement.[106] Although the Supreme Court has not exempted the health care industry generally from *per se* treatment, it has stepped back from such treatment in one case (*Indiana Federation*).[107] On the other hand, the FTC recently embraced the *per se* rule in a case which many thought could have been better decided under the rule of reason.[108]

The 1996 Policy Statements take a very significant step in this direction by (a) articulating bases, other than financial risk-sharing, for providers to engage in joint pricing decisions or other procompetitive collaborative conduct within a network (especially if that network features substantial clinical integration) and (b) applying rule of reason analysis to such conduct.

But the 1996 Policy Statements raise many new questions about the types and degree of clinical integration which will be considered sufficient, and in what contexts, to justify horizontal conduct (joint pricing, service allocations among network providers, etc.). In addition, the agencies and the courts will need to address how differently, if at all, the

answers to such questions will apply in light of the different way competition may operate in rural areas.

It is appropriate to be wary of joint pricing in light of the market power providers often have in rural areas. On the other hand, the new Policy Statements arguably give rural providers important incentives (as much as if not more than their urban counterparts) to engage in more clinical integration, more efficient delivery of care, and investments oriented to those ends. Incentives now exist for rural health networks to evolve into more tightly affiliated forms to achieve those goals. Unduly restrictive interpretations of what clinical (or other) integration is sufficient to remove network providers from application of the *per se* rule for joint pricing arrangements may chill such evolution.

For example, as suggested above, it may be relatively difficult for a rural network to achieve uniform clinical standards or protocols, given presumably widely divergent abilities, habits or patterns of rural providers in the diagnosis or treatment of illnesses. It may well be precisely in these situations, however, where clinical integration is most important. Arguably, there should be stronger incentives in rural areas for providers to develop such clinical integration, even though it may necessarily be more difficult to achieve it to the same degree as might be achieved in urban areas, given greater resources and possibly more advanced technology and protocols. Antitrust policy should take these market differences into account.

In addition, rural networks would profit from technical assistance in (a) achieving procompetitive financial and/or clinical integration of the sort contemplated by antitrust policy, and (b) complying with the laws — antitrust, fraud and abuse, tax and licensing, to name a few — which apply to such network development.

Rural network development remains in its early stages, and tends to proceed incrementally. Given its tenuous nature, antitrust policy should treat such development with considerable caution. ***Bona fide rural health networks should thus be given the benefit of the doubt as to whether they are (even at the outset) sufficiently integrated to be accorded***

rule of reason treatment for their ancillary arrangements and to be free from the operation of the per se *rule.*

EXCLUSIVE DEALING ARRANGEMENTS

The flexibility in the enforcement agency letters and policy statements given to networks with market shares that exceed the "safety zones" depends heavily on the non-exclusivity of the network. The agencies' emphasis on non-exclusivity must be balanced, however, against the potential desirability and the procompetitive effects and efficiencies offered by exclusivity (e.g., to ensure efficient operations or support capitated arrangements). At least one FTC Commissioner has recognized this need for balance:

> In rural areas, for example, the number of providers is by nature limited. I would caution against any rule that would, across the board, make it impossible for rural providers to engage in procompetitive exclusive arrangements. I stress procompetitive arrangements, because I also believe that consumers in rural areas should be able to expect the same procompetitive benefits of the antitrust laws that we afford consumers everywhere.[109]

To be or not to be exclusive is one of the key issues facing rural providers who want to structure more integrated networks using arrangements which involve physician loyalty, commitment, recruitment opportunities and economic incentives that exclusivity can provide.

The agencies recognize that, because of the scarcity of providers in rural areas, networks "may require the participation of a proportion of competing providers that would raise serious questions in other geographic markets."[110] As noted, the 1996 Policy Statements contain a number of examples in which rural networks with relatively high market shares would be acceptable. In general, however, the Policy Statements presume that those networks would be non-exclusive.

There is a tension between the antitrust policy which encourages non-exclusive relationships between networks and their constituent providers (particularly where the market share of the network is relatively high) and the countervailing need for exclusivity to: (a)

ensure sufficient physician loyalty, (b) achieve efficiencies such as utilization controls and/or (c) sustain viable capitation arrangements. The literature on the operation of health care markets in rural areas endorses the need for exclusivity in several ways. For example, a preferred provider organization with a relatively non-exclusive network may have a limited ability to exert utilization controls on its participating providers.[111]

In addition, exclusive arrangements provide powerful incentives to promote physician loyalty and ensure that physicians will see enough patients to increase the likelihood that those physicians will engage in capitated arrangements or other cost-effective behavior.[112] Exclusive contracting between health plans and their providers may also help achieve the most direct and effective competition *among* integrated health plans.[113]

For the agency's Policy Statements to put such emphasis on non-exclusivity for provider networks may provide perverse incentives for rural health care networks. ***The procompetitive benefits and efficiencies from exclusive arrangements in rural areas need to receive greater attention, if not emphasis and deference, by the courts and antitrust enforcement agencies, and in agency policy statements.*** Such exclusivity may be important, if not indispensable, to the development of cost-effective rural delivery systems, even if such systems may have somewhat more market power than is customarily considered acceptable in other markets.

MONOPOLIZATION AND "NATURAL" MONOPOLY

Marshfield Clinic, a case of significance in many ways for rural providers, is particularly important because it treated the clinic as a "natural monopolist" if it were a monopolist at all. (See **Chapter 2**.) This raises an intriguing but unresolved issue about the circumstances under which the existence of a single integrated provider network might be justified by a "natural monopoly" defense.

As *Marshfield Clinic* noted, a natural monopolist has no competitors "simply because the market is too small to support more than a single firm."[114] The natural monopolist has

the potential to use economies of scale to expand its capacity at a lower cost than that of a new firm entering the market.[115]

Natural monopolies tend to arise in small markets,[116] in markets where firms must sink substantial start-up costs and where the relatively small marginal cost of serving additional customers gradually decreases as the firm recoups its investment.[117] Rural health care markets frequently possess these characteristics, particularly hospitals or health plans serving a limited number of patients in a localized area.[118] It would not apply as often to physicians or their networks unless they were so tightly integrated and involved such substantial investments as to be a "natural" monopoly group of the sort described in *Marshfield Clinic*.

Under Section 2 of the Sherman Act, a "natural" monopoly can be a legal one.[119] The fact that the monopolist comes by its power naturally rebuts the "willful acquisition or maintenance" element of a Section 2 claim.[120] Natural monopolies are defensible because in certain circumstances they can be comparatively efficient [121] and have greater incentives to innovate.[122]

In analyzing the conduct of a monopolist, natural or otherwise, courts and agencies should consider the procompetitive efficiencies that rural health networks can generate. This consideration should inform the analysis of whether a monopolist has engaged in a restraint in order to "willfully acquire" power, as opposed to achieving legitimate natural monopoly efficiencies. *Marshfield Clinic* is evidence of such flexibility.

Of course, a rural provider will have to be careful about how it views the relevant market if it wishes to assert a natural monopoly defense. It is usually in the provider's best interest, in rebutting presumptions of market power, to define the relevant geographic market as broadly as possible. However, the provider seeking "natural monopoly" treatment may choose to view the market in which it is "natural" to monopolize as relatively small.

In any event, there will be rural markets where, given the presence of monopolists -- particularly "natural" ones -- the competition model will not work well, or at all. In those instances, some regulation may be appropriate, even though the monopolist may not be

violating the antitrust laws (Section 2 of the Sherman Act) prohibiting the *unlawful* exercise of monopoly power.

Finally, it can be unlawful for monopolists -- natural or otherwise -- to leverage their power into "downstream" markets. (See **Chapter 1.**) There is considerable confusion, however, about the type of conduct that constitutes unlawful monopoly leveraging, in and outside of the health care area. ***Given this confusion and the inconclusive nature of the few court decisions in the health care area on such leveraging, this area of law needs clarification.*** Such clarification could provide more certainty about the scope of permissible behavior for rural providers that may be monopolists, "natural" or otherwise.

MARKET POWER: FACTORS IN RURAL MARKETS MITIGATING AGAINST ITS UNLAWFUL EXERCISE

The statements of Federal Trade Commission Chairman Pitofsky and Commissioner Varney echo the need for antitrust law and policy to be sensitive to the needs of rural areas and to the potential for development of rural health networks.[123] ***Such sensitivity should include recognition of the following factors which can often hinder the ability of rural health networks with purported "market power" to actually control or distort pricing:***

- The **increasing presence of managed care** in rural areas, which encourages utilization review and potentially efficient provider consolidation.

- The potential for the **exercise of buyer power** in rural areas, which are often dominated by only one or two insurers, giving rise to positive outcomes for enrollees.[124]

- The relatively high **proportion of Medicare and Medicaid patients** in rural areas.[125] The moderating influence of such government payments on provider control over market pricing was a factor recognized in *Ukiah*.[126]

- Broadening **concepts of the geographic market** within which the provider operates, including a focus on where patients could go in the event of a price increase (and not just where they go now). It is now recognized that

regional hospitals are effective competitors with rural hospitals, but not vice versa, and that rural patients will travel for services they perceive to be better -- or less expensive (see **Chapter 2**).

IMMUNITIES, EXEMPTIONS, AND ANTITRUST POLICY

Simply put, antitrust immunities and exemptions do not make for good competition policy. Blanket exemptions from the antitrust laws do not necessarily promote the overall purposes of health care reform, particularly reform based on the competitive model.[127]

Many states have enacted legislation designed to provide immunities for pre-approved network proposals that receive Certificates of Public Advantage.[128] These statutes are designed to take advantage of the so-called "state action immunity" within the antitrust laws. Under state action immunity legislation, the actions of private parties can be immune from antitrust scrutiny if they are undertaken 1) pursuant to a clearly articulated and affirmatively expressed state policy to displace competition with regulation, and 2) under active state supervision.[129]

It is generally considered, however, that in the absence of* active *state supervision, these statutes would* not *effectively insulate networks from scrutiny. Thus, providers who obtain the Certificate of Public Advantage subject themselves to either active state regulation, or potential regulatory oversight. In either case, they remain subject to continued antitrust exposure if the oversight is not deemed sufficient. The provider network will know whether it was successfully "immunized" only when the antitrust suit seeking treble damages is resolved.[130]

A number of state immunity statutes probably do not specify a program of active state supervision sufficient to immunize the networks seeking protection.[131] Thus, generally speaking, the statutes have been little used.[132]

To a large extent, effective antitrust counseling can guide the modeling of a rural health network in such a way as to minimize antitrust exposure. Admittedly, this approach does not eliminate the threat of treble damage litigation entirely. The preferred answer to

this dilemma lies in (a) further clarification of the law, (b) more flexible guidance from the enforcement agencies, and (c) careful conduct of the network in a procompetitive fashion.[133]

CHAPTER 4 ENDNOTES

104. *See Arizona v. Maricopa County Medical Society*, 457 U.S. at 349-51; *Jefferson Parish Hosp. District No. 2 v. Hyde*, 466 U.S. at 25-26, n. 41, 42 (citing cases).

105. *National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978).

106. *See Broadcast Music v. Columbia Broadcasting System*, 441 U.S. 1, 9-10 (1979).

107. *FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986).

108. *California Dental Association*, 5 Trade Reg. Rep. (CCH) ¶ 24, 007 (1996). *But see Massachusetts Board of Registration in Optometry*, 110 FTC 549 (1988); Remarks of Joel I. Klein, Acting Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice, "A Stepwise Approach to Antitrust Review of Horizontal Agreements," before ABA Section of Antitrust Law (Nov. 7, 1996).

109. Varney *supra* note 91.

110. Pitofsky Testimony *supra* n. 11 at 8; *see* 1994 Policy Statements, *supra* note 9, at 20,791-20,792.

111. Beth C. Fuchs, Health Care Reform: Managed Competition in Rural Areas, Congressional Research Services Report For Congress (1994), at 22.

112. Thomas L. Greaney, Managed Competition, Integrated Delivery Systems and Antitrust, 79 Cornell Law Review, 1507 (1994), at 1536.

113. Fuchs, *supra* note 111, at 35; Jon Christianson and Ira Moscovice, Health Care Reform and Rural Health Networks, *Health Affairs*, Fall 1993, at 60; Ira Moscovice et al., "Rural Hospital Networks: Implications for Rural Health Reform," 17, 53-67, 1995 (noting that integrated rural health networks may not be effective "unless their members have a closely integrated financial future").

114. *Marshfield Clinic*, 65 F.3d at 1412.

115. George Cyer Springstein, *Government Regulation and Monopoly Power in the Electric Utility Industry*, 33 *Case W. Res. L. Rev.* 240, 245-46 (1983); C. Kaysen & D. Turner, *Anti-Trust Policy*, 191 (1959). Credit for much of this material and these sources goes to an excellent paper by David R. Campbell, student at Boston University Law School, *Doc, Stock and Barrel; Anti-Trust Liability of Rural Health Plans' Acquisition of Primary Care Physicians*, term paper for course on Health Care

Anti-Trust, Professor Frances H. Miller (April 27, 1994).

116. Neal W. Hamilton & Anne M. Caulfield, *The Defense of Natural Monopoly in Sherman Act Monopolization Cases, 33 DePaul L. Rev.* 465, 474 (1984); *See, e.g., Lorraine Journal Co. v. United States*, 342 U.S. 143 (1951).

117. Richard A. Posner, *Natural Monopoly and Its Regulation*, 21 *Stan. Law Review* 548, 570 n.48 (1969).

118. *See* Clark C. Havighurst, *Doctors and Hospitals: An Anti-Trust Perspective on Trade Relationships*, 1984 *Duke L.J.* 1071, 1160 (1984) (indicating that many hospitals enjoy monopoly positions due to economies of scale); Campbell, *Supra* at 17.

119. *E.g., Hecht v, Pro-Football, Inc.*, 570 F.2d 982, 991 (D.C. Cir. 1977), *cert. denied*, 436 U.S. 956 (1978); *United States v. Aluminum Co. of America*, 148 F.2d 416, 429-30 (2d Cir. 1945) (*Dicta*).

120. *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966).

121. Campbell, *supra* at note 115, at 18; Hamilton & Cawlfield *supra* at note 116, at 488; Williamson, "Economies as an Anti-Trust Defense: The Welfare Trade-Offs," 58 *Am. Econ. Rev.* 18, 21-23 (1968).

122. Posner, *supra* note 117, at 560, 577-8; R. Kronick *et al.*, "The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition," 328 *New Eng. J. Med.* 151 (1993).

123. See *supra* notes 11 and 91.

124. Beth C. Fuchs, Health Care Reform: Managed Competition in Rural Areas, Congressional Research Services Report For Congress (1994), at 34.

125. Allan Fine, *Rural Hospitals Have Advantages for Integration: Network Options Help Providers Survive in Rural Setting*, Integrated Health Care Delivery Systems, April 1996, at pg. 3.

126. In re Adventist Health System/West, Dkt. No. 9234 (FTC Dec. 9, 1992) (initial decision) (WESTLAW, FATR-FTC), at *32.

127. Key Health Care Reform Bills, *supra* note 40 at 59.

128. *See* Tina E. Kondo et al., *The Role of Antitrust Immunity in the Washington State Health Care Market*, Report to the Washington State Legislature (Dec. 15, 1995)

(hereinafter "Washington State Report.")

129. *FTC v. Ticor Title Insurance Co.*, 504 U.S. 621 (1992); *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). It should be noted that the state action immunity applies to municipalities or public authorities acting under the direction of the state pursuant to a clear state policy (prong (1), above). *Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985); *Askew v. DCH Regional Health Care Authority*, 995 F.2d 1033 (11th Cir. 1993), *cert denied*, 510 U.S. 1012 (1993).

130. Washington State Report, *supra* note 128, at 64-65.

131. *Id.* at 62, 64-65.

132. *Id.* at 65.

133. *Washington State Report*, *supra*, note 128; Sarah S. Vance, *Immunity for State-Sanctioned Provider Collaboration After Ticor*, 62 Antitrust L.J. 409 (1994).

CONCLUSION

In many ways, antitrust laws and policy have been "catching up" with the developments in the health care marketplace. Although they leave many questions unanswered, the 1996 Policy Statements are a potentially important step forward in the development of appropriate competitive models for rural health care markets.

Is there the need for a "new approach" toward the application of antitrust law and enforcement to rural health care providers attempting to form networks? Unless one advocates immunities and exemptions, probably not. Managed care is starting to infiltrate rural areas, and provider networks are forming, promising to promote competition there. ***Therefore, it is important for health policymakers to permit application of the antitrust laws to enhance that competition -- and to thwart the most egregious forms of anticompetitive conduct that impede managed care or innovative health care delivery systems.***

However, policymakers do need to appreciate the unique problems faced by rural providers. These include insufficient population to sustain important forms of financial risk sharing, the need for "critical mass" or market power to achieve efficiencies, and the potential value of exclusive relationships in providing procompetitive incentives to providers who may not otherwise be attracted to rural areas. In addition, rural providers need encouragement to engage in investments in clinical integration without fear of liability under the law.

It is, in short, critical that antitrust law not chill the tenuous development in rural areas of procompetitive or efficiency-enhancing collaborative arrangements and consolidations, including the provider networks that tend to seek the efficiencies managed care plans seek. As Chairman Pitofsky[134] and Judge Posner[135] have observed, competition in rural areas does not necessarily require, or even work best in, an atomistic market. Competition may actually

require collaboration to generate efficiencies -- and to support the practice of excellent medical care in rural areas.

CONCLUSION ENDNOTES

134. Pitofsky Testimony *supra* note 11.

135. *Marshfield Clinic*, 65 F.3d at 1412-13.

APPENDIX

ANTITRUST BASICS

THE PURPOSE OF THE ANTITRUST LAWS

The antitrust laws are designed to preserve and enhance competition by insuring that market forces can operate, free from distortions by anticompetitive conduct, to (a) achieve the best and most efficient use and allocation of resources, and (b) encourage the development of new products and services for the benefit of consumers.

THE BASIC STATUTES

- Section 1 of the Sherman Act generally prohibits any "contract, combination or conspiracy" that unreasonably restrains trade.[136]

- Section 2 of the Sherman Act prohibits monopolization, attempts to monopolize, and conspiracies to monopolize a market.[137]

- Section 2 of the Clayton Act, commonly referred to as the "Robinson-Patman Act," provides among other things that a *seller* may not discriminate in price between purchasers of goods of like grade and quality where the discrimination may result in substantial competitive injury. A *buyer* may also be liable for price discrimination for knowingly receiving or inducing an unlawful price discrimination.[138]

- Section 3 of the Clayton Act prohibits exclusive dealing arrangements, tying arrangements (i.e., any situation in which the seller forces the buyer to purchase an unwanted good or service in order to be allowed to purchase another desired good or service) and output, and requirements contracts involving the sale of a commodity, if the effect may be to substantially lessen competition.[139]

- Section 7 of the Clayton Act prohibits any merger, acquisition or joint venture that may substantially lessen competition or tend to create a monopoly.[140]

- Section 5 of the Federal Trade Commission Act broadly proscribes "unfair methods of competition" and "unfair or deceptive acts or practices."[141]

KEY CONCEPTS AND RULES RELEVANT TO HEALTH CARE

Familiarity with six basic concepts and rules is essential to an understanding of how antitrust law applies in the health care area.

1. Agreement or Conspiracy

Antitrust violations under Section 1 of the Sherman Act require proof of an unlawful "contract, combination or conspiracy." An agreement or conspiracy has been defined as "a conscious commitment to a common scheme designed to achieve an unlawful objective."[142] An unlawful agreement need not be formal or written to be proven as an agreement. It can be expressed or implied, explicit or tacit, and proved by circumstantial evidence.[143]

2. Horizontal v. Vertical Relationships

"Horizontal" relationships involve relationships among actual or potential competitors. "Vertical" relationships involve those among entities at different levels in the chain of supply or distribution.

3. The *Per Se* Rule v. the Rule of Reason

***Per se* rule.**

Courts apply the *per se* rule to conduct which has such a "pernicious" effect on competition as to lack any redeeming virtue.[144] Agreements or conduct of this sort are unlawful on their face, and are conclusively presumed to be unreasonable under Section 1 of the Sherman Act. Courts will not consider claims of justifications or benefits in support of such conduct.

Arrangements that are *per se* unlawful include:

- price-fixing,
- horizontal allocation of territories, customers or markets,
- some concerted refusals to deal (group boycotts), and
- some tying arrangements.

Rule of reason.

In applying the rule of reason, by contrast, a court conducts a detailed inquiry into the effect on competition of a challenged practice and determines whether that practice *unreasonably* restrains trade. In essence, the court will balance the procompetitive and anticompetitive effects of the restraint.[145] In this process, the court takes into consideration a wide variety of factors, including market conditions and justifications for the restraint.[146]

4. Defining the Relevant Market

To determine the effect on competition in a market (for a rule of reason analysis), the market must be defined. Relevant market analysis has two dimensions: the *product* market and the *geographic* market.

The product market.

The *product* market is composed of products or services which have "reasonable interchangeability" in terms of their prices, uses and qualities.[147] In the health care area, such markets might be defined by the "cluster of services" in inpatient acute care hospital services.[148] One or more physician specialties or subspecialties, such as open heart surgery, could comprise a product market.[149] The courts have also recognized a product market for "health care financing" in which insurers, HMOs, and other forms of financing health care services compete.[150]

There is also an evolving concept of *"network"* markets, i.e., focusing on competition among health care provider networks within a specific geographic area.[151] Given the wide range of activities in which multi-provider networks engage, their competitive impact must

be analyzed in each market in which they operate. Sometimes market definition is not clear-cut, insofar as different specialists may compete with each other in certain areas -- i.e., ob/gyn's and family practitioners, pediatricians and internists, allergists and pulmonologists, etc.

The geographic market.

The relevant *geographic* market is the geographic area in which the sellers of products or services operate, and to which purchasers can practicably turn for such products or services.[152] Put another way, the geographic market would be the area within which producers can raise prices without driving customers to other areas to purchase the product or service. Increasingly, the focus on geographic market definition has included not only where consumers or patients *currently* go (e.g., for hospital services) but where they *could* practicably go (or be sent by a third-party payer) in the event of a price increase.[153]

5. Market Power

Market power exists in a relevant market when prices can be raised above levels that would be charged in a competitive market.[154] Market share is often a good indication of market power. Consideration is also given to other factors, including technological superiority, ease of entry, pricing and market trends, and the relative size of competitors and overall concentration in the market.[155] Generally, the greater the market share, the more potential for a restraint to be anticompetitive.

6. Effect on Competition

To violate the rule of reason, the anticompetitive effect of a challenged restraint must outweigh its procompetitive impact.[156] The restraint must impact not just a particular provider or competitor; it must affect competition generally in the relevant market.[157]

INTRODUCTION TO ANTITRUST AND HEALTH CARE

The antitrust laws cover seven types of arrangements that are most relevant in health care settings. This section of the Appendix briefly introduces each one and summarizes its applicability to the health care arena.

- price-fixing
- market allocation
- concerted refusals to deal (group boycotts)
- joint ventures
- exclusive dealing
- monopolization
- mergers

The final section provides an overview of enforcement and penalties.

1. Price-Fixing

When competing firms agree to fix or otherwise stabilize the prices (minimum or maximum) they will charge for products or services, they are engaged in *per se* unlawful price-fixing.[158] Illegal price-fixing can also result from the mere exchange of price information if that exchange tends to facilitate price agreement or stabilize prices.[159]

In the health care industry, providers may not jointly agree to set fees unless they are sufficiently "integrated" as a group.[160] The Supreme Court has held that a corporation and its officers or employees are legally incapable of conspiring with each other because they comprise a single entity under the law of conspiracy.[161] But some courts have held that the participants in provider groups can be deemed separate persons or entities capable of conspiring among themselves. For example, the physician members of an HMO are legally capable of conspiring among themselves if they have some control over the HMO, and also operate independent private practices.[162] Providers who are not economically integrated may

face civil or criminal antitrust exposure if they combine to set fees.[163] This area is explored in more detail in **Chapters 1 and 3.**[****164]

2. Market Allocation

Horizontal conspiracies allocating territories, dividing up customers, or otherwise agreeing not to compete have been treated as *per se* illegal.[165] This issue is relevant to health care networks that contemplate an allocation of service lines among their provider members.

3. Concerted Refusals to Deal (or Group Boycotts)

Some group boycotts are *per se* unlawful, particularly if they are horizontal or fi they target a competitor in order to cut off access to a supply, facility or market necessary to compete. In addition, one or more of the boycotting firms must be dominant in the market, and there can be no plausible efficiency justifications.[166] Boycotts keyed to an effort to increase reimbursement rates are also *per se* unlawful.[167] Increasingly, however, the rule of reason has been applied to group boycott claims *not* featuring one or more of these factors. This has happened in two cases in the health care area.[168] So-called "vertical" boycotts are judged under the rule of reason if no element of horizontal boycott exists.[169]

In health care, group boycott issues arise most frequently in hospital staff privileges cases: Excluded physicians claim that a hospital and its staff agreed to the exclusion from access to the hospital. Courts have rejected these claims in cases where the adverse effects on competition were not proven; or where there has been potential for such denials of staff privileges to create and enhance competition when based, for example, on quality of care issues or the benefits of exclusive dealing arrangements.[170] In the absence of such justifications, however, such conduct may be *per se* unlawful.[171]

[****]Vertical price-fixing (resale price maintenance) is also *per se* unlawful, but that issue comes up far less often in the health care area, especially since the flurry of cases which held that an insurer, as "buyer," is entitled to set insurance reimbursement rates on behalf of its insureds and does not constitute an unlawful buyer conspiracy.

In numerous instances, efforts to boycott alternative delivery systems or managed care initiatives have become the subject of antitrust enforcement proceedings. For at least the past fifteen years, federal and state antitrust enforcement has thwarted boycotts and similar practices designed to restrict competition, and has helped facilitate the development of new, often innovative, forms of health care, such as HMOs and PPOs.[172]

4. Joint Ventures

An arrangement which might otherwise be *per se* unlawful can be lawful, under a rule of reason analysis, if it represents a legitimate joint venture. Such ventures involve, among other things, the pooling of resources, the integration of operations or facilities, the introduction of new products or services and/or the sharing of risks — especially when such conduct is procompetitive and would not have been undertaken in the absence of the joint effort.[173]

Arrangements among competitors that, standing alone, might be viewed as unlawful "restraints of trade," can be legitimate under the rule of reason if they are "ancillary," or related, to a legitimate joint venture and are reasonably necessary to its effective operation.[174] The recently revised *joint policy statements of the federal antitrust enforcement agencies, the U.S. Department of Justice and the Federal Trade Commission* provide guidance on the types of health care provider joint ventures that can be lawful, and the kinds of arrangements "ancillary" to them that may be lawful.[175]

5. Exclusive Dealing

In an exclusive dealing arrangement, a buyer agrees to purchase a type of product or service exclusively from a single seller, or a seller agrees to sell only to the buyer. Exclusive dealing arrangements can be challenged under Section 1 of the Sherman Act or Section 3 of the Clayton Act.[176] To challenge an exclusive dealing arrangement under the Clayton Act,

the plaintiff must prove that the arrangement substantially precludes competition in a relevant market.[177]

In the health care area, hospitals sometimes engage in exclusive contracts with a group of providers where the parties agree that no other providers will be granted privileges to render medical services similar to those covered by the contract. Generally, these types of agreements are defensible under a rule of reason analysis.[178]

6. Monopolization

There are three types of monopoly-related offenses under the antitrust laws: actual monopolies; attempts to monopolize; and conspiracies to monopolize.

- **Actual monopolies.**

It is unlawful monopolization to possess monopoly power in a relevant market *and* to willfully acquire or maintain that power to the detriment of competition. Monopoly power is "the power to control market prices or exclude competition."[179] To be unlawful, the "willful acquisition" of that power must be through exclusionary, anticompetitive or predatory conduct, as distinct from growth or development as a consequence of a superior product or business or historic accident.[180]

If a firm possesses monopoly power, it may not refuse to deal with another in order to gain competitive advantage, destroy a competitor, or preserve or extend its monopoly.[181] Under the so-called "essential facilities" doctrine, a firm controlling a facility to which a competitor must have access to compete must provide such access on a fair and non-discriminatory basis.[182]

In the health care context, if a hospital denies a physician or other practitioner access to the hospital facility, the excluded physician may have an "essential facilities" claim under certain circumstances. However, since the grant of a given hospital's privileges is usually

not essential to a physician's ability to practice in light of available alternatives to the physician, most of the cases have denied such claims.[183]

There are also limits on the ability of a monopolist to "leverage" its power to harm competition in a *separate* market.[184] For example, extending a monopoly in acute care inpatient services into the market for other businesses such as long-term care, durable medical equipment or rehabilitation services may, in some circumstances, constitute unlawful monopoly leveraging.[185]

- **Attempts to monopolize.**

To unlawfully attempt to monopolize a market, the alleged violator must have a specific intent to acquire monopoly power within a relevant market,[186] and a "dangerous probability" of succeeding in achieving a monopoly if its conduct is left unchecked.[187]

- **Conspiracies to monopolize**.

A conspiracy to monopolize involves (a) the existence of a combination or conspiracy; (b) an overt act in furtherance of the conspiracy; (c) a substantial amount of commerce affected; and (d) specific intent to monopolize. As discussed in **Chapter 2**, where a given market cannot sustain more than one firm, it may be a defensible "natural monopoly."

7. Mergers

Mergers, acquisitions of stock or assets, and joint ventures which tend to lessen competition or create a monopoly are prohibited by Section 7 of the Clayton Act, whether they are horizontal, vertical or "conglomerate." To determine the legality of a merger, a court will define the market and then analyze (a) the market share of the firms involved, (b) the market structure and concentration, (c) the potential adverse competitive effects, (d) the

ease of entry into the market, (e) the asserted efficiency justifications, and (f) the potential for a failing firm defense.[188]

Hospital mergers have occupied most of the attention devoted by the courts to mergers in the health care area.[189] Most of the early merger cases involved what the courts ultimately deemed to be unacceptable increases in concentration in already-concentrated markets, where the only two, or two of three, hospitals in a given market decide to merge.[190] The government has been less successful in more recent merger cases, largely because of developing notions of larger geographic markets (and, thus, lower concentration in those markets).[191]

ENFORCEMENT AND PENALTIES

The federal antitrust laws are enforced by two agencies, the U.S. Department of Justice (through its Antitrust Division), and the Federal Trade Commission (FTC). In addition, private parties can sue under the antitrust laws for damage to business or property. States can also sue, either as private parties for purposes of federal antitrust law, or under their own antitrust laws.

In civil suits under the antitrust laws, plaintiffs injured in their business or property are entitled to recover treble damages and attorneys' fees. There are also criminal penalties, in the form of imprisonment and/or fines, under the antitrust laws. Criminal exposure is generally confined to price-fixing arrangements.

The Department of Justice and the states (but not the FTC) are authorized by statute to bring criminal proceedings where warranted. Criminal violations under the Sherman Act are felonies punishable by imprisonment for up to three years and/or fines of up to $350,000 for individuals and $10 million for corporations per violation. Alternatively, a defendant may be fined up to twice the gross gain or twice the gross loss if any person derives pecuniary gain from the offenses or if the offense results in pecuniary loss to a person other than the defendant.

Under the federal and state antitrust laws, the enforcement agencies (in the states, through Attorneys General) are authorized to investigate possible anticompetitive conduct and to initiate proceedings under the relevant antitrust laws.

APPENDIX ENDNOTES

136. 15 U.S.C. § 1 (1996)

137. 15 U.S.C. § 2 (1996).

138. 15 U.S.C. § 13 (1996).

139. 15 U.S.C. § 14 (1996).

140. 15 U.S.C. § 18 (1996).

141. 15 U.S.C. § 45(a)(1) (1996).

142. *Monsanto Co. v. SprayRite Service Corp.*, 465 U.S. 752, 764 (1984).

143. See *Eastern States Retail Lumber Dealers' Ass'n v. United States*, 234 U.S. 600, 612 (1914).

144. *N. Pacific Ry. Co. v. United States*, 356 U.S. 1, 5 (1958) (emphasis added).

145. *National Soc'y of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978)

146. *Board of Trade of City of Chicago v. United States*, 246 U.S. 231, 238 (1918).

147. *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 404 (1956); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962).

148. *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990), *cert. denied*, 498 U.S. 920 (1990).

149. *See Robinson v. Magovern*, 521 F. Supp. 842, 878 (W.D. PA 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 459 U.S. 971 (1982).

150. *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995), *cert. denied*, 116 S.Ct. 1288 (1996); *Ball Memorial Hospital, Inc. v. Mutual Hospital, Inc.*, 784 F.2d 1325 (7th Cir. 1986); *U.S. Healthcare, Inc. v. U.S. Healthsource, Inc.*, 1992-1 Trade Cas. (CCH) ¶ 69,697 (D.N.H. 1992), *aff'd*, 986 F.2d 589 (1st. Cir. 1993).

151. 1996 Policy Statements, *supra* note 2, at 20,828.

152. *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961)

153. *See, e.g., FTC v. Freeman Hospital*, 69 F.3d 260 (8th Cir. 1995); *United States v. Mercy Health Services*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot* [after settlement], Nos. 95-4253, 96-1051, 1997 WL 78396 (8th Cir. Feb. 26, 1997).

154. *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2, 27 n. 46 (1984).

155. *See generally Ball Memorial Hosp., Inc.*, 784 F.2d at 1336.

156. *National Society of Professional Engineers*, 435 U.S. 679.

157. *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977).

158. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940); *Goldfarb v. Virginia State Bars*, 421 U.S. 773 (1975); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

159. *United States v. Container Corp. of America*, 393 U.S. 333 (1969).

160. *Maricopa County Medical Soc'y*, 457 U.S. at 356; 1996 Policy Statements, *supra* note 2, at 20,817.

161. *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 769 (1984).

162. *See Capital Imaging*, 996 F.2d at 544; *Hahn v. Oregon Physicians Service*, 868 F.2d at 1028-29 (9th Cir. 1989), *cert. denied*, 493 U.S. 846 (1989); *Hassan v. Independent Practice Assocs., P.C.*, 698 F. Supp. 679, 692 (E.D.Mich. 1988).

163. *See U.S. v. Alston*, 974 F.2d 1206 (9th Cir. 1991).

164. *See generally Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut Inc.*, 675 F.2d 502, 505 (2d Cir. 1982); *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F. Supp. 230, 233 (N.D. Cal. 1981), *aff'd per curiam*, 677 F.2d 47 (9th Cir. 1982), *cert. denied*, 459 U.S. 1016 (1982).

165. *Palmer v. BRG of Georgia, Inc.*, 498 U.S. 46 (1990); *United States v. Topco Assocs.*, 405 U.S. 596 (1972); *Timken Roller Bearing Co. v. United States*, 341 U.S. 593 (1951); *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.*, 792 F.2d 210 (D.C. Cir. 1986), *cert. denied*, 479 U.S. 1033 (1987), suggested that the *per se* rule was eroding in this context. *But see, e.g., Palmer, supra*, and *General Leaseways v. National Truck Leasing Ass'n*, 744 F.2d 588 (7th Cir. 1984).

166. *Northwest Wholesale Stationers v. Pacific Stationery and Printing Co.*, 472 U.S. 284, 298 (1985).

167. *Alston*, 974 F.2d 1206 (involving criminal charges against Arizona dentists for attempting to increase copayments under prepaid dental plans); *In re Michigan State Medical Society*, 101 FTC 191 (1983).

168. *Jefferson Parish Hosp. District No. 2 v. Hyde*, 466 U.S. 2 (1984); *FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986).

169. *See, e.g., Oreck Corp v. Whirlpool Corp.*, 579 F.2d 126 (2d Cir. 1978), *cert. denied*, 439 U.S. 946 (1978).

170. *Lie v. St. Joseph Hospital* of Mount Clemens Mich., 964 F.2d 567 (6th Cir. 1992); *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 842 (3d Cir. 1982); *Miller v. Indiana Hospital*, 814 F. Supp. 1254 (W.D. Pa. 1992); *aff'd*, 975 F.2d 1550 (3d Cir. 1992), *cert. denied*, 507 U.S. 952 (1993); *Friedman v. Delaware County Memorial Hospital*, 672 F. Supp. 171 (E.D. Pa. 1987), *aff'd*, 849 F.2d 600 (3d Cir. 1988); *Pontius v. Children's Hospital*, 552 F. Supp. 1352 (W.D. Pa. 1982).

171. *Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985); *Sweeney v. Athens Regional Medical Center*, 709 F. Supp. 1563, 1573 n.4 (M.D. Ga. 1989).

172. *See, e.g., Commonwealth of Virginia v. Physicians Group, Inc.*, 1995-2 Trade Cas. (CCH) ¶ 71,236 (W.D. Va. May 16, 1995) (consent final judgment); *U.S. and State of United States v. Healthcare Partners, Inc.*, 1996-1 Trade Cas. (CCH) ¶ 71,337 (D. Conn. Feb. 15, 1996) (consent final judgment)(D. Conn. filed September 13, 1995); *United States v. Health Choice of Northwest Missouri, Inc.*, 1996-2 Trade Cas. (CCH) ¶ 71,605 (W.D. Mo. Oct. 22, 1996) (consent ordered); *Physicians Group, Inc.*, 60 Fed. Reg. 25,223 (1995) (proposed order) (final order issued August 11, 1995); *Puerto Rican Physiatrists* (La Associacion Medica de Puerto Rico), 60 Fed. Reg. 35,907 (1995) (consent order); *Trauma Associates of North Broward, Inc.*, (consent order), 59 Fed. Reg. 63,805 (1994) (consent order); *Medical Staff of Doctors' Hospital of Prince George's County*, 110 FTC 476 (1988)(consent order); *see also* Statement of Howard M. Metzenbaum, Chairman, Senate Judiciary Committee Subcommittee On Antitrust, Monopolies & Business Rights before the Senate Finance Committee Subcommittee On Medicare & Long-Term Care (May 7, 1993); Janet L. McDavid, *Antitrust Issues in Health Care Reform*, 43 DePaul L. Rev. 1045 (1994).

173. *See, e.g., Broadcast Music Inc. v. Columbia Broadcasting System*, 441 U.S. 1, 23 (1979).

174. *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 282 (6th Cir. 1898), *modified*, 175 U.S. 211 (1899); *Rothery Storage & Van Co.*, 792 F.2d at 224.

175. 1996 Policy Statements, *supra* note 2. The policy statements are discussed in detail in **Chapter 1**.

176. They are evaluated under the rule of reason as illustrated in *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984); See *also Standard Oil Co. of Cal. v. United States* (Standard Stations), 337 U.S. 293 (1949).

177. *See Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961).

178. *See U.S. Healthcare, Inc. v. U.S. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993); *Coffey v. Healthtrust, Inc.*, 955 F.2d 1388 (10th Cir. 1992); *Collins v. Associated Pathologists Ltd.*, 844 F.2d 473 (7th Cir. 1988) *cert. denied*, 488 U.S. 852 (1982); *Konik v. Champlain Valley Physicians Hospital*, 733 F.2d 1007 (2d Cir. 1984), *cert. denied*, 469 U.S. 884 (1984); *Smith v. Northern Michigan Hospitals, Inc.*, 703 F.2d 942 (6th Cir. 1983); *Bellam v. Clayton County Hospital Authority*, 758 F. Supp. 1488 (N.D. Ga. 1990).

179. *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391 (1956).

180. Compare *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 610 (1985) with *Ocean State Physicians Health Plan v. Blue Cross and Blue Shield of Rhode Island*, 883 F.2d 1101, 1112 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990). *See also Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451 (1992).

181. *Aspen Skiing Co.*, 472 U.S. at 604-05; *Otter Tail Power Co. v. United States*, 410 U.S. 366, 377 (1973).

182. *Otter Tail*, 410 U.S. 366; *United States v. Terminal Railroad Association of St. Louis*, 224 U.S. 383 (1912).

183. *McKenzie v. Mercy Hospital of Independence, Kansas*, 854 F.2d 365 (10th Cir. 1988); *Konik*, 561 F. Supp. at 719-24 F.2d 1007 (2d Cir. 1984); *Robles v. Humana Hospital Cartersville*, 785 F. Supp. 989 (N.D. Ga. 1992); *Pontius v. Children's Hospital*, 552 F. Supp. 1352, 1370 (W.D. Pa. 1982).

184. *Otter Tail*, 410 U.S. 366 (1973); *Fishman v. Wirtz*, 807 F.2d 520 (7th Cir. 1986); *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980).

185. *Key Enterprises, Inc. v. Venice Hospital*, 919 F.2d 1550 (11th Cir. 1990), *op. vacated for reh'g en banc*, 979 F.2d 806 (11th Cir. 1992), *dismissed as moot* [after settlement], 9 F.3d 893 (11th Cir. 1993), *cert. denied sub nom, Sammett Corp. v. Key Enterprises of Delaware, Inc.*, 511 U.S. 1126 (1994); *Advanced Health-Care Services, Inc. v. Radford Community Hospital*, 910 F.2d 139 (4th Cir. 1990); *M&M Medical Supplies and Service, Inc. v. Pleasant Valley Hospital*, 981 F.2d 160 (4th Cir. 1992), *cert. denied*, 508 U.S. 972 (1993).

186. *Times Picayune Publishing Co. v. United States*, 345 U.S. 594, 626 (1953).

187. *Swift & Co. v. United States*, 196 U.S. 375, 396 (1905). *See generally Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447 (1993).

188. *See United States v. Von's Grocery Co.*, 384 U.S. 270 (1966); *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586 (1957); Merger Guidelines, *supra* note 95, at 20,571 - 20,574.

189. *See FTC v. Freeman Hospital*, 69 F.3d 260 (8th Cir. 1995); *United States v. Mercy Health Services*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot* [after settlement], Nos. 95-4253, 96-1051, 1997 WL 78396 (8th Cir. Feb. 26, 1997); *United States v. Carilion Health System*, 892 F.2d 1042 (4th Cir. 1989); *FTC v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991); *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990), *cert. denied*, 498 U.S. 920 (1990); *Hospital Corp. of America v. FTC*, 106 FTC 351 (1985), *aff'd*, 807 F.2d 1381, 1387 (7th Cir. 1986), *cert. denied*, 107 S. Ct. 1975 (1987)(hereinafter "*HCA*").

190. See, e.g., *Mercy Health Services*, *Rockford Memorial Corp.*, *University Health*, and *HCA*, *supra*.

191. *Freeman Hospital*, and *Mercy Health Services*, *supra*.