

Antitrust Considerations In Establishing Medical Provider Networks

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Medical providers, mainly physicians and hospitals, often run afoul of the antitrust laws when attempting to form networks for the purpose of negotiating with large payors such as health maintenance organizations or insurance companies. Such problems can be minimized, and perhaps avoided altogether, by advance analysis and planning, and by structuring such networks in a manner designed to comply with the antitrust laws. With the rise of managed care and increasing consolidation on the payor side, antitrust jurisprudence has also evolved to permit and even encourage consolidation on the provider side. This is particularly true where it can be shown that such consolidation reduces costs while also improving the quality of care through practice protocols and standards and other cost containment and quality enhancing programs. This article will describe and focus on some simple steps that the provider community should follow in establishing networks, and safeguards that should be observed to minimize antitrust risk.

Background

Price fixing by competitors is per se (i.e., automatically) illegal under the antitrust laws. Price fixing is a broad concept. It may potentially be found to exist virtually any time competitors communicate about prices or other terms of sale followed by an effect on prices or other terms of sale. *Catalano Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980). For a time, it was thought that the price fixing prohibition did not apply to "learned" professions but this notion was dispelled by the Supreme Court in its 1975 *Goldfarb* decision. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). The medical provider community first encountered the per se price fixing prohibition in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982). In *Maricopa*, a medical foundation composed of approximately 70% of the physicians in the Phoenix area established a maximum fee schedule for patients insured under several health insurance plans. Despite the fact that such schedules may have operated to reduce, or at least contain, the cost of healthcare, the United States Supreme Court, by a slim 4-3 majority, held that adherence to such schedules by competing physicians was per se illegal price fixing.

Although managed care was in its infancy at the time of the *Maricopa* decision, the *Maricopa* decision nonetheless triggered a firestorm of criticism in the provider community. As managed care gained acceptance, payor organizations began to implement capitation and other similar risk sharing compensation arrangements to displace the traditional fee for service model. This worsened the problem for the providers. In a nutshell, the payor side could negotiate on behalf of large groups of enrollees, but the physicians and hospitals could not collaborate under *Maricopa*. There were, however, three aspects to the *Maricopa* decision that eventually were used to give providers some flexibility to form networks and jointly negotiate fees without running afoul of the price fixing prohibition.

The first aspect of the Maricopa decision is the statement in the majority opinion that the defendant medical foundations were not analogous to partnerships or other joint arrangements where competitors pool their capital and share the risks of loss. This was a recognition of the antitrust principle, which predates even the per se prohibition of price fixing, that price restraints ancillary to such joint ventures are judged under the "rule of reason" rather than the per se prohibition. *U.S. v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898) aff'd 175 U.S. 211 (1899). This is because such joint ventures may integrate the parties' productive assets in a manner that increases the firm's efficiency and enables it to compete more effectively. *Northwest Wholesale Stationers v. Pacific Stationary*, 472 U.S. 284 (1985).

Under the rule of reason, the decision-maker (i.e., the court or enforcement agency) analyzes the market power of the joint venture participants to determine the legality of the restraint. See *SCFC ILC Inc. v. VISA USA, Inc.*, 36 F.3d. 958 (10th Cir. 1994). The rule of reason also requires the decision-maker to consider such factors as the nature of the market in which the conduct occurs, possible anticompetitive effects, whether the efficiencies outweigh the possible anti-competitive effects, and whether the restrictions imposed by the conduct are reasonably necessary to achieve the efficiencies.

The second aspect of Maricopa was that the medical foundation in that case accounted for a high percentage -- 70% -- of the physicians in the Phoenix area. This raised the possibility that joint ventures composed of a smaller percentage of the market may be permissible. See, e.g., *Rothery Storage & Van Co. v. Atlas Van Lines*, 792 F.2d. 210 (D.C. Cir. 1986).

The third aspect, emphasized more by the dissent, was the non-exclusive nature of the restraint. This meant that the physicians in Maricopa were not prevented from providing services independently from the foundations, or from charging different fees to patients who were covered by insurance plans unrelated to the foundations. While this non-exclusivity was not sufficient to save the Maricopa foundation themselves, it has been a major factor in permitting many subsequent physician and multi-provider networks.

THE DOJ/FTC GUIDELINES

In the years since Maricopa, the courts and the federal antitrust enforcement authorities, namely the Department of Justice (the "DOJ") and the Federal Trade Commission (the "FTC"), have fashioned a series of guidelines which, in some circumstances, permit providers to join together for the purpose of negotiating and setting fees to be paid by large payor organizations. See, e.g., *Hassan v. Independent Practice Assn.*, 698 F. Supp. 679, 688-90 (E.D. Mich 1988). In 1996, the DOJ and FTC released a revised set of guidelines for analyzing healthcare antitrust issues. The nine statements, called "Statements of Antitrust Enforcement Policy in Health Care" (the "Guidelines"), replaced nine policy statements originally issued in 1994. While the Guidelines deal with many healthcare related antitrust issues, Statements 8 and 9 deal specifically with physician networks and multiprovider networks.

The Guidelines articulate the general antitrust principle that, in the absence of market power, price restraints ancillary and reasonably necessary to a legitimate joint venture are judged under the rule of reason. *Broadcast Music, Inc. v. CBS*, 441 U.S.1, 23-24 (1979); *National Bancard Corp. v. VISA USA, Inc.*, 779 F.2d. 592, (11th Cir. 1986). The more recent "Antitrust Guidelines for Collaborations Among Competitors," published in draft from by the DOJ/FTC on October 1, 1999, also embrace the principle that restraints otherwise per se illegal may be permissible if reasonably related to the procompetitive benefits from an efficiency-enhancing integration of economic activity. Draft Guidelines, p. 4.

The Healthcare Guidelines, however, describe the type of economic integration sufficient for a provider network to gain joint venture status, primarily capitation and other forms of risk sharing. In the past, all non-risk sharing joint pricing arrangements were almost certain to be viewed as per se illegal. The 1996 Guidelines, however, introduced the concept of "clinical integration" as a method to create a legitimate joint venture short of risk sharing. As generically described in the Guidelines, clinical integration consists of an "ongoing program to evaluate and modify the practice patterns of network participants to create a high degree of interdependence and cooperation among them." Now, if there are significant efforts to perform utilization review, quality assurance, and other similar functions, and if there is substantial investment in the infrastructure necessary to actually carry out these programs, providers may be permitted to jointly negotiate fee schedules, relative value scales, per diems, and other non-risk sharing pricing arrangements.

The Guidelines establish "safety zones" which describe provider network joint ventures that are highly unlikely to raise substantial antitrust concerns. Statement 8 of the Guidelines sets forth a safety zone for exclusive physician network joint ventures that comprise no more than 20% of the physicians in any specialty in a geographic market who have active hospital privileges and who share substantial financial risk. Because non-exclusive networks do not, as a general rule, restrict competition among the network participants, non-exclusive physician network joint ventures come within a separately stated safety zone: they will not be challenged unless they include more than 30% of the physicians in any specialty in a geographic market who have active hospital privileges and who share substantial financial risk.

As the Guidelines explicitly state, however, networks falling outside of the safety zones are not necessarily unlawful under the antitrust laws, but indeed may be procompetitive and lawful. Networks falling outside of the safety zones (i.e., the network contains an impermissible percentage of physicians in a particular specialty in a geographic market, or the network participants do not share substantial financial risk) are subject to further factual inquiry and analysis to determine whether they are permissible under the antitrust laws.

The main sources of further guidance in the healthcare antitrust area are business review letters and advisory opinions published by the federal enforcement authorities, and consent decrees with respect to provider networks the DOJ/FTC found objectionable. These business review letters and advisory opinions often approve networks with much higher market shares than the "safety zones" under the Guidelines, but show a low degree of tolerance for networks that are not true joint ventures but simply sham vehicles to fix price and otherwise eliminate competition among physicians.

Set forth below is a list of four steps which should be followed when attempting to form antitrust compliant provider networks. These steps are designed as both a practical and analytical model. The first step relates to some early negotiation antitrust rules applicable to any business transaction, including the creation of a provider network. The second step relates to the exclusivity issue since the antitrust rules differ somewhat for exclusive and non-exclusive networks. The third step relates to the market power issue because, even if the network is a legitimate joint venture, there is a limit to the number of competing physicians in a local area that can be included in the network. The fourth step describes the various methods one can use to obtain joint venture status. So long as these steps are observed, and the network is a true joint venture which does not exceed the market power thresholds described above, the providers should be able to collectively agree on prices or other terms of sale and otherwise jointly market their services outside the scope of Maricopa decision.

Step One: The Early Negotiations and Communications

As with other industries, even the most pro-consumer healthcare business deals can be wrecked at the outset if it appears that their purpose is to raise prices, restrict output, or otherwise engage in cartel-like behavior. The source of such a "purpose" is often found in e-mails and other memoranda of medical directors, physicians, consultants or staff members describing or discussing a proposed network or similar transaction. Use of phrases such as "stabilize or rationalize the market," "split or allocate patients," "protect fee levels," "increase our bargaining power," "increase leverage against payors," or "capture market share and power" can be the death knell to the formation of a proposed network before it even gets off the ground. The Guidelines themselves note that where it is clear that the network is merely a vehicle to engage in naked anticompetitive conduct, it will not be approved.

Thus, it is critical at the outset of the transaction to educate those involved in the negotiations and communications about the risks of using language in memos, e-mails, or oral discussions which does not accurately describe the purpose of the proposed network, and which may create unnecessary and unjustified antitrust risks. Many medical provider networks have the ability to both create economic efficiencies (i.e., cost savings) and improve the quality of care by the adoption of practice standards and protocols, implementation of preventative healthcare measures, utilization review and quality assurance procedures, and similar programs for large groups of enrollees or fee for service patients. It is these attributes of a network that must be emphasized, and avoidance of inflammatory, overstated rhetoric when explaining the rationale of the proposed network is crucial.

Step Two: Determine Whether The Network Will Be Exclusive Or Non-exclusive

An exclusive provider network is one in which the physicians, hospitals or other medical providers in the network are precluded from offering medical services other than through the network itself. In many cases, there may be legitimate medical or business reasons for such exclusivity. As in industries outside the healthcare area, such exclusivity restrictions are judged under the rule of reason and often upheld unless the parties have market power. *Northwest Wholesale Stationers v. Pacific Stationers*, 472 U.S. 284 (1985); *Rothery Storage & Van Co. v. Atlas Van Lines*, 792 F.2d 210, 224 (D.C. Cir. 1986). As discussed above, however, the safety zone market share thresholds are lower for exclusive networks than non-exclusive networks (i.e., 20% for exclusive networks and 30% for non-exclusive networks). Thus, the exclusivity issue should be addressed early in the negotiation process.

The Guidelines provide, however, that the terms of the contractual relationship are not always dispositive on the issue of whether the network is exclusive or non-exclusive. One must also consider the actual conduct of the providers involved to determine whether a network is truly non-exclusive. Such "indicia" of nonexclusivity, as articulated in the Guidelines, include the existence of viable competing networks and that physicians actually do contract with other networks. See, e.g., *Children's Healthcare, P.A.*, DOJ Business Review Letter (March 1, 1996); *In re M.D. Physicians of Southwest Louisiana, Inc.*, File No. 941-0095 (FTC June 19, 1998).

Step Three: Determine Whether The Proposed Group Has Market Power

The concept of market power under the antitrust laws is elusive and complex. For business planning purposes, however, it is generally determined by market share. Exactly what market share level creates market power is also uncertain, although a general rule of thumb is the market share must be at least 30% to raise serious concerns. *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2, 26-29 (1984). As noted above, the Guidelines create safety zones of 20% for exclusive networks and 30% for non-exclusive networks with the caveat that higher levels, in some situations, may be acceptable. In fact, the enforcement authorities have

approved, in business review letters, many networks having market shares of 40% or more in the relevant market. See, e.g., Dermnet, Inc., DOJ Business Review Letter (Dec. 5, 1995)(43.5%); Mid-South Physician Alliance, Inc., DOJ Business Review Letter (Mar. 30, 1995)(42%); California Chiropractic Association, DOJ Business Review Letter (Dec. 8, 1993)(50%). In rural areas where there may be a small number of providers, particularly specialists, the tolerable market shares may be much higher since otherwise there would not be a sufficient number of providers in a network to attract significant payors to the area. See, e.g., Physician Care, Inc., DOJ Business Review Letter (Oct. 28, 1994).

A difficult up front task is to determine the relevant antitrust market in which to measure market shares. Antitrust markets have two dimensions. The first dimension is product market. The traditional formulation is that the product market includes all products or services that are reasonably interchangeable in use, commonly referred to as "demand substitutability." *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377 (1956). The second dimension is geographic. It includes the area in which the seller operates, and to which the purchaser can practicably turn for supplies. *Morgan Strand Wheeler & Biggs v. Radiology, Ltd.*, 924 F.2d 1484, 1490 (9th Cir. 1991). The proper definition of both product and geographic markets is a hotly contested issue in many health care antitrust cases. See, e.g., *FTC v. Tenet Healthcare*, 186 F.3d 1045 (8th Cir. 1999).

With respect to product market definition, the demand substitutability test will often result in each physician specialty being considered a separate market. Thus, for example, primary care physicians may not be in the same product market as cardiologists, and the market share tests must be applied separately for each specialty represented by the particular network. See, e.g., *Dermnet, Inc.*, DOJ Business Review Letter (Dec. 5, 1995) (dermatologists, plastic surgeons, and dermatopathologists viewed as participants in three separate product markets); *Children's Healthcare, P.A.*, DOJ Business Review Letter (March 1, 1996)(primary care pediatricians and general practitioners viewed as participants in separate product markets). In many cases, however, there may be an overlap of services provided by different specialties and, if so, this justifies including services from more than one specialty or category in the same market. See, e.g., *The Heritage Alliance and Lackawanna Physicians Organization*, DOJ Business Review Letter (Sept. 15, 1998)(family practitioners, general practitioners and internists viewed as participants in the same product market); *Allied Colon and Rectal Specialists*, DOJ Business Review Letter (July 19, 1996)(colon and rectal surgeons and general surgeons who perform surgical procedures involving the colon and/or rectum [e.g., allopathic and osteopathic general surgeons] viewed as participants in the same product market).

Geographic markets are generally limited to the city or county where the network is located, or sometimes even smaller subdivisions within cities or counties. As a general rule, the geographic market for specialized physician services (e.g., thoracic or cardiac surgery, oncology and hematology) will be larger than the geographic market for primary care services. Generally, the geographic market is the area in which patients can practicably obtain medical treatment. Except for some types of specialties, this usually will be a local area. See, e.g., *Children's Healthcare, P.A.*, DOJ Business Review Letter (March 1, 1996); *Dermnet, Inc.*, DOJ Business Review Letter (Dec. 5, 1995).

Step Four: Obtaining Joint Venture Status

The most important step that must be taken to fall outside the Maricopa rule is to ensure that the provider network is sufficiently integrated so as to constitute a bona fide joint venture under the antitrust laws. *Northwest Stationers*, supra, 472 U.S. 284 (1984). While the term joint venture has a variety of definitions in antitrust law, when applied to provider networks it generally is satisfied by risk sharing arrangements. See *Hassan v. IPA*, supra, 698 F.Supp. at 688-90. Such arrangements include, but are not limited to, capitation,

agreements by the network to provide services to a health plan for a predetermined percentage of premiums or revenue from the plan, or withholding a substantial amount (typically 15-20%) of compensation from provider participants with distribution to them if and when the group meets certain cost containment or utilization goals. The common characteristic among risk sharing arrangements is to create financial incentives to reduce or contain costs and utilization and make members of the group interdependent. Since many programs implemented in conjunction with risk sharing compensation arrangements involve wellness or other preventative healthcare measures, they are often seen as promoting quality as well as economic efficiency.

In lieu of such financial risk sharing, the 1996 amendments to the Guidelines also introduced the concept of "clinical integration" as a method to obtain joint venture status, and thus rule of reason treatment. Clinical integration is a form of nonfinancial integration which achieves the same goals as risk sharing – interdependence among network participants and financial incentives to reduce costs and utilization and maximize operational efficiencies.

As provided above, the Guidelines generically define clinical integration as an "ongoing program to evaluate and modify practice patterns by the physicians and create a high degree of interdependence and cooperation to ensure quality." Much like risk sharing programs themselves, clinical integration requires the development of practice standards and protocols, monitoring compliance with them, and the imposition of penalties, either financial or possibly even expulsion, on those who do not meet the standards. It also requires an investment of human and monetary capital, usually in the form of information systems to monitor compliance. See DOJ/FTC Guidelines, Statement 8, Section B.1; Yellowstone Physicians, L.L.C., FTC Staff Advisory Opinion (May 14, 1997).

The business review letters, advisory opinions and consent decrees, as well the Guidelines themselves, provide the following examples of programs which can be implemented by provider networks to satisfy the twin goals of cost savings and quality of care:

(a) Establishing mechanisms to control utilization of healthcare services that are designed to control costs and assure quality of care, including:

Quality and utilization goals;

Regular evaluations of individual participants and the network as a whole in meeting quality and cost effectiveness goals;

Adoption of practice standards and protocols;

Review of care in light of practice standards and protocols;

A remedial action program to modify individual participants' clinical practices where necessary (e.g., when a participant fails to adhere to utilization guidelines). This program should include financial and non-financial sanctions;

A case management program;

A "preauthorization of services" program;

A quality assurance/peer review committee;

Concurrent and retrospective review of inpatient hospital stays;

Providing payors with reports of costs and quality of services provided, and on the network's success in meeting its utilization and quality goals;

(b) Selectively choosing network physicians who are likely to further efficiency and quality objectives (i.e., establishing credentialing rules and standards).

(c) The significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies. Such investment could include:

Information systems to gather data and measure performance against cost and quality benchmarks and to monitor patient satisfaction; and

Hiring of a medical director and support staff to implement and maintain cost savings and quality enhancement programs.

Another issue that often arises is whether the provider network retains joint venture status if some of its payor contracts involve risk sharing and others are traditional fee for service contracts requiring no risk sharing or clinical integration. Although no reported court decision deals with this issue, the answer appears to be "yes" at least where the risk sharing contracts are a substantial majority of the business, providers are paid according to the same fee schedule used to pay them under the risk sharing arrangements, and are subject to the same utilization and cost reduction mechanisms as used on the risk sharing contracts. Mayo Medical Laboratories, FTC Staff Advisory Opinion (July 17, 1996); DOJ/FTC Guidelines, Statement 8, § C.1.

CONCLUSION

The foregoing steps are the "basics" in setting up a "rule of reason" provider network which will be able to collectively negotiate fees with payors, and otherwise agree on prices without running afoul of the Maricopa rule. It should be apparent that, particularly with respect to market power issues and joint venture status, a specific factual analysis is necessary and the outcome may vary depending on the individual competitive situation. Nonetheless, in terms of provider networks, the antitrust laws have come a long way since the Maricopa decision, and now contain some flexibility that permits the provider side of the health care equation to collectively negotiate fees with the payors. © 1999 Sheppard, Mullin, Richter & Hampton LLP.

Practice Areas

Litigation